

HEALTHCARE COST CONTAINMENT

October 2019
hfma.org/hcc

SDOH initiative reduces readmission penalties in one year

By Holly Gould

One major factor in McLaren Port Huron's readmission rate reduction is the organization's emphasis on identifying and addressing patient social determinants of health. The focus is on educating patients and involving them in their healthcare plans.

Allocating capital to medical technology in the age of value-based payment	5
Don't let infections hurt your bottom line	9
5 guidelines for controlling contracted dining service costs while maintaining quality	12
Understanding physician costs is the first step in clinical cost transformation	14
Care coordination can reduce \$89 billion behavioral health cost impact	16

+ reducing Medicare penalties +

SDOH initiative reduces readmission penalties in one year

Holly Gould

Readmissions can be largely attributed to what happens after the patient leaves the healthcare organization.

McLaren Port Huron hospital reduced its Medicare penalty percentage for 30-day readmissions from 2.34% in FY18 to 1.85% as of April 2019. In fact, the hospital's overall all-payer readmission rate is trending down as well. That is no small task, considering that one of every six discharged patients in the U.S. is readmitted in fewer than 30 days, and a third of those within only seven days of discharge (Binder, L., "Medicare's Penalties for Readmissions Work, Despite Flaws," *Forbes*, 2019).

One major factor in this readmission rate reduction is McLaren's emphasis on identifying and addressing patient social determinants of health (SDOH). The focus is on educating patients and involving them in their healthcare plan.

Moving beyond penalties

A portion of any hospital's desire to reduce its readmissions rates is the Medicare Hospital Readmissions Reduction Program (HRRP), which is a Medicare value-based purchasing program that reduces payments to hospitals with excess readmissions. But it's about more than just avoiding penalties. Reducing readmissions improves patient outcomes and lowers costs in other ways, including fewer trips to the emergency department (ED), fewer acute events and less burden on payers.

Much of the research concerning how to reduce readmissions keeps coming back to one point — readmissions can be largely attributed to what happens *after* the patient leaves the healthcare organization. Even with a team of the most dedicated physicians, nurses and other clinicians, we can only do so much to address factors such as healthy eating, medication adherence and the availability of transportation to

follow-up appointments after the patient is discharged. And it's precisely these factors — all impacted by larger SDOH — that influence whether, and how soon, our inpatients become readmission statistics.

Focusing on high-cost conditions

McLaren focuses on patients with some of the most high-cost, high-risk chronic conditions, including chronic obstructive pulmonary disease (COPD) and congestive heart failure (CHF).

After discharge, 10% to 20% of COPD patients are readmitted within 30 days (Simmering, J.E., Polgreen, L.A., et al., "Identifying Patients with COPD at High Risk of Readmission," *Journal of the COPD Foundation*, 2016). Patients who are readmitted following a COPD hospitalization are at greater risk of mortality and have worse outcomes relative to patients who are not.

By reducing readmissions, McLaren is reducing Medicare penalties and providing patients with improved care experiences and outcome.

And the healthcare costs associated with COPD patients are high and growing. National medical costs attributed to COPD were \$32.1 billion in 2010 and predicted to reach \$49 billion by 2020 (*Chronic Obstructive Pulmonary Disease — COPD Costs*, CDC). And a study of individual worker productivity and healthcare costs found that patients with COPD incurred costs

Mary Mirabelli

Senior Vice President, Content Strategy and Delivery

Brad Dennison

Director of Content Strategy

Betty Hintch

Senior Editor/Content Project Manager

Deborah Filippek

Content Editor

Laura Ramos Hegwer

Contributing Editor

Linda Chandler

Production Specialist

Healthcare Cost Containment is published bimonthly by the Healthcare Financial Management Association, Three Westbrook Corporate Center, Suite 600, Westchester, IL 60154-5732.

Presorted nonprofit postage paid in Chicago, IL 60607.
©2019 Healthcare Financial Management Association.

Volume 12, Number 5

To order reprints, email reprints@hfma.org.

To submit an article, contact Betty Hintch at bhintch@hfma.org.

Material published in *Healthcare Cost Containment* is provided solely for the information and education of its readers.

HFMA does not endorse the published material or warrant or guarantee its accuracy. The statements and opinions in *Healthcare Cost Containment* articles and columns are those of the authors and not those of HFMA. References to commercial manufacturers, vendors, products, or services that may appear in such articles or columns do not constitute endorsements by HFMA.

ISSN 1945-6360

that were almost twice as high as costs for patients without COPD, after adjusting for comorbidities. Patients with COPD had significantly more than twice the odds of having a hospitalization or ED visit compared with patients in the non-COPD cohort (J.G., Patel, Coutinho, A.D., et al., “COPD affects worker productivity and health care costs,” *International Journal of Chronic Obstructive Pulmonary Disease*, 2018).

Much of the research concerning how to reduce readmissions keeps coming back to one point — readmissions can be largely attributed to what happens after the patient leaves the healthcare organization.

The numbers for CHF patients are no less daunting. CHF is the most common cause of readmission for Medicare patients in the U.S. (Chamberlain, R.S., Sond, J., et al., “Determining 30-day readmission risk for heart failure patients: The Readmission After Heart Failure scale,” *International Journal of General Medicine*, 2018). The 30-day readmission rates among CHF patients

The 4 Cs of social determinants of health

Healthcare providers can follow these key elements to address social determinants of health (SDOH) that impact patient outcomes and costs, according to Nicole Ashley, COO of Wellobp. An important consideration is building partnerships with community resources and possible business partners to accomplish these goals.

- 1. Community.** Hospitals, health systems, other providers and payers should coordinate to develop customized local lists of community resources based on specific population health needs.
- 2. Care.** Use screening to identify patient SDOH challenges.
- 3. Coordinate.** Based on screening results, the healthcare provider alerts the clinician or care team of patients that may be high-risk based on SDOH factors (e.g., food scarcity, transportation challenges, income barriers).
- 4. Connect.** The healthcare provider reaches out to both the patient and the appropriate community resource to make a connection and help ensure needed services are accessed. An alert system should be in place to notify providers that a connection cannot be made.

are 9.42% and 9.17%, for derivation and validation cohorts, respectively.

According to the CDC, About 5.7 million adults in the U.S. have heart failure, and the condition costs the nation an estimated \$30.7 billion each year. (*Heart Failure Fact Sheet*, Centers for Disease Control and Prevention)

Heart failure is an important contributor to both the burden and cost of national healthcare expenditures, with more older Americans hospitalized for heart failure than for any other medical condition.

(Heidenreich, P.A., Albert, N.M., et al., “Forecasting the Impact of Heart Failure in the United States,” *Circulation: Heart Failure*, 2013). By 2030, more than 8 million people in the U.S. (1 in every 33), will have heart failure. Between 2012 and 2030, real total direct medical costs of heart failure are projected to increase from \$21 billion to \$53 billion. Total costs, including indirect costs for heart failure, are estimated to increase from \$31 billion in 2012 to \$70 billion in 2030.

Social determinants of health					
Economic stability	Neighborhood and physical environment	Education	Food	Community and social context	Healthcare system
<ul style="list-style-type: none"> > Employment > Income > Expenses > Debt > Medical bills > Support 	<ul style="list-style-type: none"> > Housing > Transportation > Safety > Parks > Playgrounds > Walkability > Zip code/geography 	<ul style="list-style-type: none"> > Literacy > Language > Early childhood education > Vocational training > Higher education 	<ul style="list-style-type: none"> > Hunger > Access to healthy options 	<ul style="list-style-type: none"> > Social integration > Support systems > Community engagement > Discrimination > Stress 	<ul style="list-style-type: none"> > Health coverage > Provider availability > Provider linguistic and cultural competency > Quality of care
Health outcomes					
Mortality, morbidity, life expectancy, healthcare expenditures, health status, functional limitations					
Source: <i>Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity</i> , Henry J. Kaiser Family Foundation.					

Faced with these statistics, it was clear that reducing readmissions for these populations was essential for McLaren.

Combining technology and care coordination

My search led me to a patient engagement technology company that helps us identify SDOH factors and coordinates with local community resources in our area to help our patients get the services they need. The results include the following:

- > Better health outcomes for patients
- > Reduced readmissions for McLaren
- > Lower costs across the board

Within 24 hours of admission, our case managers screen patients via a tablet application. The screening asks about food scarcity, transportation, social/family support networks and exercise habits, among other areas. The COPD and CHF screenings include disease-specific education, questions and information in addition to

the standard SDOH inquiries. Patients who agree to the screening receive regular text messages with health information, including medication reminders and wellness tips for up to 30 days after discharge.

The COPD and CHF screenings include disease-specific education, questions and information in addition to the standard SDOH inquiries.

Based on patients' individual screening responses, the technology identifies patients who are at high risk for potential readmission as a result of their personal SDOH factors and sends an alert to case managers. As a second step, the technology company reaches out to the appropriate local resources in our community to help ensure the identified SDOH needs are

addressed. The company communicates directly with the patient and community resources to coordinate service delivery. If a connection can't be made, they alert us again to let us know that the patient may now be at even greater risk for readmission.

Based on initial positive results, we've recently expanded the use of the screenings from our COPD and CHF patients to our entire inpatient population — our case managers have offered the screening to more than 600 patients in the past year.

Identifying at-risk patients

McLaren's success can be attributed to identifying patients at risk of readmission and offering education, care coordination and follow up. By reducing readmissions, the hospital is reducing Medicare penalties and providing patients with improved care experiences and outcomes. +

Holly Gould

is clinical outcomes coordinator, McLaren Port Huron, Port Huron, Mich. (hgould2@porthuronhospital.org).



Improve revenue cycle performance with HFMA's MAP App



MAP App is an online benchmarking tool that helps hospitals, health systems, and physician practices:

- Measure revenue cycle performance
- Compare performance against data from 600+ facilities through custom peer groups, that you define
- Apply best practices, improve performance, and capture more revenue

For more information, customer success stories, and to request a demo, go to:

hfma.org/mapapp

hfma

The Heartbeat of Progress

hfma.org

Allocating capital to medical technology in the age of value-based payment

Terrance D. Hayslett

One way to account for the unique risks associated with value-based payment is to add an explicit risk premium to the organization's standard cost of capital calculation.

Medical technology has led to gains in quality and quantity of life; however, it has also been identified as one of the leading causes of the rising cost of healthcare (Jessup, A., *Health Care Cost Containment and Medical Innovation*, Office of Science and Data Policy, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services).

The acquisition of high-cost medical devices and equipment requires more extensive ROI analyses than traditional finance-based methods decision-makers use to determine if assets create value.

Ideally, the shift from fee-for-service (FSS) to value-based payment causes hospital decision-makers to blend the notion of value with a patient outcomes-based perspective of value. This will encourage a comprehensive approach to allocating capital that supports value creation.

Traditional finance-based perspective

Many hospitals have adopted a corporate finance methodology to investing in medical technology. To pursue investment opportunities, hospitals need access to capital, which often comes from external sources such as equity and/or debt investors. In exchange for supplying capital, investors expect ROI. This expected return is a function of the investment risk. It also represents a cost of capital to the organization that receives the funds.

The following equation shows the basic investment risk-return relationship and it also reveals the simplified formula for determining an organization's cost of capital. Where $E(R_i)$ is an investor's expected return, R_f is the risk-free rate of return

and RP_i is the risk premium (Pratt, S., *Cost of Capital*, John Wiley & Sons, Inc., 2014, Chapter 6, iBooks).

$$E(R_i) = R_f + RP_i$$

The R_f is the minimum rate of return required to compensate investors for the time value of money. It takes into consideration expected inflation and the corresponding diminishing purchasing power of the dollar (Peterson, P., Fabozzi, F., *Capital Budgeting: Theory and Practice*, John Wiley & Sons, Inc., 2002).

The risk-free rate is often determined based on the interest rate set for government-backed treasury bonds. The risk premium, RP_i , compensates investors for the risk associated with when and how much cash flow will be received from an investment. (Pratt, *Cost of Capital*, Chapter 6). Thus, if an investment is deemed risky due to the uncertainty surrounding its future cash flows, investors will place a higher risk premium on the investment and in turn expect a higher rate of return.

Cost of capital and the value of an asset

Cost of capital is an important corporate finance concept. It is the hook from which the value of an asset hangs. Two of the primary measures that are used to determine if value has been created are net present value (NPV) and internal rate of return (IRR). These metrics use the cost of capital to help ascertain the return generated over the life of an asset (Nowicki, M., "Determining the Value of a Capital Expense," *Leadership* newsletter, HFMA, July, 2014).

The NPV expresses an asset's profitability in dollars and is defined as the present value of future cash flows generated by an asset minus the initial cost of the asset. Cash flows are discounted to a present value via the organization's cost of capital. Relatedly, IRR expresses profitability as a percentage and reflects the minimum rate of return required to achieve breakeven. It is the return that makes the NPV of an investment equal to zero. Thus, from this perspective, value is created when an asset generates a positive NPV and/or its IRR exceeds the organization's cost of capital.

Healthcare policymakers are increasingly interested in a concept of value that links payment for healthcare services to improvements in patient outcomes at the lowest possible cost of care.

Patient-outcomes-based perspective

While the traditional risk-return relationship highlighted in the equation above yields valuable insight, it fails to explicitly identify the fundamental drivers of value and risk in a value-based payment environment. Healthcare policymakers are increasingly interested in a concept of value that links payment for healthcare services to improvements in patient outcomes at the lowest possible cost of care. Considering this extended notion of value, it is neither enough nor insightful to prioritize medical technology investment decisions based solely on the traditional corporate finance risk-return relationship. Although the traditional relationship accounts for certain types of market and project-specific risks, it does not explicitly analyze the risks associated with how cash flows are impacted by whether a technology improves patient outcomes at the lowest possible cost of care.

Under the FFS payment system, hospitals and health systems could more easily afford to adopt technologies without explicitly evaluating their impact on patient outcomes. However, as hospitals are increasingly being paid via value-based payment methods, capital allocated to medical technology based on the traditional corporate finance risk-return model will fail to capture the complete risk-return profile of the investment opportunity. As value-based payment and risk-bearing contracts become more prevalent, hospital leaders will be incentivized to broaden their analytical toolbox to incorporate methods that provide increased transparency and evidence into whether a technology adds value by improving patient outcomes at the lowest possible cost of care.

There is evidence that hospitals are responding to the new economic realities imposed by a changing payment system. One example is the development and implementation of hospital value-analysis committees. These are multi-disciplinary committees that utilize standard processes, data and evidence-based methodologies to determine the safety and value of new medical products and services (Premier, *Value Analysis Guide*, 2nd ed.).

Value-analysis versus healthcare technology assessment

Extensive health technology assessments (HTAs) take the concept of value analysis a step further. Although the HTA process is similar to value analysis, it is viewed as a more systematic and methodologically rigorous analytical tool.

HTA considers multiple criteria to help inform practical investment decisions, and they are conducted with the specific intent of evaluating and synthesizing the clinical benefits, risks, costs and comparative effectiveness of medical technologies, interventions and practices (del Llano-Senaris, J., Campillo-Artero, C., *Health Technology Assessment and Health Policy Today: A Multifaceted View of Their Unstable Crossroads*, Springer, 2015).

The International Network of Agencies for HTA, 2014, identifies the formal objectives of HTA as follows (Hopkins, R., Goeree, R., *Health Technology Assessment: Using Biostatistics to Break the Barriers of Adopting New Medicines*, CRC Press, 2015):

- > Identify evidence, or lack of evidence, on health intervention costs and benefits.
- > Synthesize health research findings about the effectiveness of different health interventions.
- > Evaluate the cost and cost-effectiveness of health technologies.
- > Appraise social and ethical implications of the diffusion and use of health technologies and their organizational implications.
- > Identify best practices in healthcare.

Although the health technology assessment process is similar to value analysis, it is viewed as a more systematic and methodologically rigorous analytical tool.

While the primary developers and users of HTAs are government and commercial payers, hospital decision-makers also need to be armed with increasingly sophisticated tools to help them make more evidenced-based decisions on how to allocate capital to medical technology.

Therefore, hospital-based health technology assessment (HB-HTA) was developed to help tailor the context of HTA to the hospital environment. HB-HTA is a focused type of technology assessment with the specific purpose of assisting hospital leaders with making value-based technology investment decisions (Sampietro-Colom, L., Martin, J., *Hospital-Based Health Technology Assessment: The Next Frontier for Health Technology Assessment*, Springer, 2015).

Hospitals need these tools to manage the array of new medical technologies. Many innovations have improved patient life expectancy and quality of life. However, there are a growing number of new technologies that claim these benefits at higher prices, but are supported by limited evidence. Compounding this problem is the awareness that some hospital decision-makers are influenced by the Gartner Hype Cycle, (Sampietro-Colom, L., Martin, J., *Hospital-Based Health Technology Assessment: The Next Frontier for Health Technology Assessment*, Springer, 2015), which suggests that technology expectations follow five key phases over a product's life cycle (Gartner Inc., Gartner Hype Cycle, 2019).

According to Gartner: "Each Hype Cycle drills down into the five key phases of a technology's life cycle.

Innovation trigger. A potential technology breakthrough kicks things off. Early proof-of-concept stories and media interest trigger significant publicity. Often no usable products exist and commercial viability is unproven.

The relationship between NPV, IRR and cost of capital

Profitability is the target metric for value creation; however, in a value-based payment environment, a focus exclusively on profitability tells only part of the value story.

If	Then	Value creation (financial)
NPV < 0	IRR < Cost of capital (i.e., expected return)	No
NPV = 0	IRR = Cost of capital	Breakeven
NPV > 0	IRR > Cost of capital	Yes

Source: Relationships Between the Internal Rate of Return (IRR), Cost of Capital and Net Present Value (NPV)

SEARCH
THE SHORT LIST.



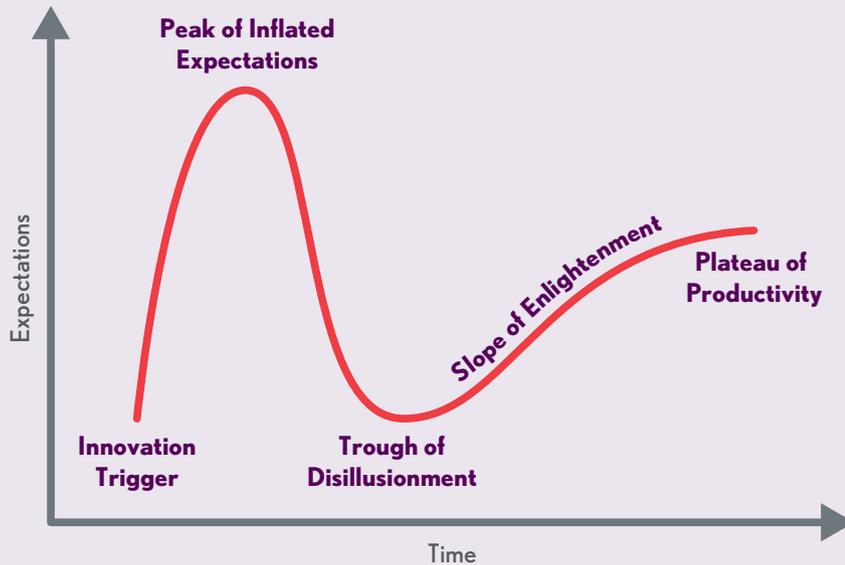
-  QUALITY
-  TECHNICAL SUPPORT
-  CUSTOMER SERVICE
-  VALUE

When products, services, and ROI calculators earn the designation “Peer Reviewed by HFMA,” you know they have been rigorously evaluated. Only those earning top marks make it on **THE SHORT LIST**.

Find your next solution.
hfma.org/peerreview

Gartner Hype Cycle

“Gartner Hype Cycle methodology gives you a view of how a technology or application will evolve over time, providing a sound source of insight to manage its deployment within the context of your specific business goals,” according to Gartner research.



Source: Gartner, *Gartner Hype Cycle*, 2019. <https://www.gartner.com/en/research/methodologies/gartner-hype-cycle>

Peak of inflated expectations. Early publicity produces a number of success stories — often accompanied by scores of failures. Some companies take action; many do not.

Trough of disillusionment. Interest wanes as experiments and implementations fail to deliver. Producers of the technology shake out or fail. Investments continue only if the surviving providers improve their products to the satisfaction of early adopters.

Slope of enlightenment. More instances of how the technology can benefit the enterprise start to crystallize and become more widely understood. Second- and third-generation products appear from technology providers. More enterprises fund pilots; conservative companies remain cautious.

Plateau of productivity. Mainstream adoption starts to take off. Criteria for assessing provider viability are more clearly defined. The technology’s broad market

applicability and relevance are clearly paying off.”

Thus, it has been suggested by the authors of *Hospital-Based Health Technology* that another benefit of implementing an HB-HTA is to help manage the hype cycle by controlling expectations and shortening the time period from innovation trigger to plateau of productivity (Sampietro-Colom, *Hospital-Based Health Technology Assessment*, Springer).

Comprehensive perspective

To gain a more comprehensive understanding of the risk-return profile of a medical technology and to minimize the impact of the technology hype cycle, it is my belief that it would be prudent for hospital decision-makers to formally imbed the evidence generated from value analysis or HB-HTA into the capital allocation evaluation process.

The standard risk-return equation (see page 5) conveys the expected return and cost of capital as a function of the risk-free rate of return and risk premium. Baked into this formula is the cost of capital for the overall health system or hospital. (Louis C. Gapenski, *Financial Analysis & Decision Making for Healthcare Organizations*, Irwin, 1996).

However, the organization-wide cost of capital figure may not account for the unique evidence risk associated with investing in medical technology in a value-based reimbursement environment.

One way to account for this risk is to add an explicit risk premium, which can be thought of as an evidence-risk premium, to the organization’s standard cost of capital

The impact of the evidence-risk premium on comprehensive value creation

Quality of evidence	Impact on risk premium ERP_i	Impact on expected return $E(R_i)$	Impact on cost of capital	Impact on NPV	Impact on IRR	Impact on comprehensive value creation (financial + patient outcomes)
Low	Increase	Increase	Increase	Unfavorable	Unfavorable	Unfavorable
High	Decrease	Decrease	Decrease	Favorable	Favorable	Favorable

Source: KMH Squared, LLC. Used with permission.

Key: Evidence-risk premium (ERP); Expected return [$E(R_i)$]; Net present value (NPV); Internal rate of return (IRR)

calculation. This is done to gain a more comprehensive risk-return assessment. An evidence-risk premium would reflect the results of value analysis or HB-HTA by revealing the level, quality and strength of evidence that supports the clinical and economic effectiveness of the technology. This evidence premium would have a direct impact on the expected return, cost of capital and discount rate used in medical technology investment valuation. The following equation is an example of how an evidence-risk premium (ERP_i) would modify the traditional risk-return equation.

$$E(R_i) = R_f + RP_i + ERP_i$$

The intuition behind this formula is that an investment in medical technology that is supported by low-quality evidence would necessitate a higher-evidence risk premium (ERP_i). Conversely, technology that is supported by high-quality evidence would require a lower ERP_i .

It is acknowledged that adding an evidence-risk premium is a highly subjective exercise. However, the argument for the addition of an evidence-risk premium is that an evaluation of the clinical and economic evidence supporting the effectiveness of medical technology should be explicitly accounted for when assessing the cash flow risk of investing in medical technology.

In an FFS payment environment, the traditional corporate finance risk-return relationship serves as a good framework for determining the value derived from allocating capital to medical technology. However, as policymakers seek to transform healthcare from a volume-driven system to a value-based system based on improved patient outcomes at the lowest possible cost of care, decision-makers will need to place more emphasis on the level, quality and strength of clinical evidence that supports medical technology value propositions. +

Terrance D. Hayslett

is the founder of KMH Squared, LLC, and is a member of HFMA's Georgia Chapter (thayslett@kmsquared.com).

Don't let infections hurt your bottom line

Laura Hegwer

Each catheter-associated urinary tract infection costs a hospital an additional \$13,973 on average, according to AHRQ estimates.

In this interview, Susan Bleasdale, MD, medical director of infection prevention and control and antimicrobial stewardship at UI Health in Chicago, describes the financial benefits of targeting health-care-associated infections (HAIs).

On how infections affect the bottom line.

Beyond affecting clinical outcomes, HAIs can have significant financial impacts, Bleasdale said. In 2008, the Centers for Medicare & Medicaid Services (CMS) stopped paying for HAIs, so now hospitals are on the hook for the costs.

After CMS stopped paying for healthcare associated infections and implemented value-based payment, many hospitals focused on reducing CLABSIs and CAUTIs and are making progress.

The Agency for Healthcare Research and Quality estimates that each catheter-associated urinary tract infection (CAUTI) costs a hospital an additional \$13,973 on average. For central line-associated bloodstream infections (CLABSIs), the additional costs climb to \$48,108 per case, on average. Clostridium difficile, also known as C. diff, infections add another \$17,260 per case on average, while each surgical site infection (SSI) costs an additional \$28,219 on average.

And since the advent of the Hospital Value-Based Purchasing (VBP) program in 2012, HAIs have been affecting hospitals' bottom lines in other ways, Bleasdale

said. Specifically, through CMS's Hospital-Acquired Condition Reduction Program (HACRP), organizations that perform in the bottom quartile on HAIs will be penalized 1% of their Medicare reimbursement two years later. So, hospitals that were in the lowest quartile of performance in FY18 will have 1% of their Medicare reimbursements withheld in FY20.

And when it comes to Medicaid, many states also deny payment for some preventable conditions like HAIs, Bleasdale said. Given these significant clinical and financial implications, finance leaders should ensure their organizations have the proper staff and infrastructure to tackle these infections.

"Making sure that you have a robust infection prevention program can impact your overall reimbursement at the patient level from an outcomes perspective and also at the system level, from a Medicare and Medicaid reimbursement perspective," Bleasdale said.

On progress toward reducing HAIs. After CMS stopped paying for HAIs and implemented the VBP program, many hospitals focused on reducing CLABSIs and CAUTIs, Bleasdale said. Research shows they have made some progress. She points to a 2013 study that found a 43% reduction in vascular catheter-associated infections (which includes CLABSIs) after the VBP program was implemented (Peasah, S.K., McKay, N.L., Harman, J.S., et al., "Medicare non-payment of hospital-acquired infections: Infection rates three years post implementation," *Medicare & Medicaid Research Review*, 2013). However, the study did not show a drop in CAUTIs, which Bleasdale said are more difficult to correctly identify from chart abstraction than they are through direct clinical care.

On engaging staff. Leaders should recognize that the key to reducing these infections is engaging physicians, nurses and other team members, Bleasdale said. In fact, she credits a highly motivated staff at UI Health for reducing its rate of CLABSIs and CAUTIs by 60% from 2012 to 2014. “We had everyone engaged and that made a difference in getting people to pay attention to these issues and help prevent infections,” she said.

How they did it: After joining UI Health in 2012, Bleasdale’s team formed a task-force and gained C-suite support for their infection-control initiatives. “Because it affected our bottom line and patient outcomes, these initiatives became hospital priorities,” she said. “That gave us the resources to create the teams to support this.”

Unlike some organizations that follow a Comprehensive Unit-based Safety Program (CUSP) model that focuses on initiatives at the unit level to improve performance, UI Health implemented a broader infection control and prevention program organization-wide.

One of their most successful initiatives involved members of leadership, who rounded on the floors to question staff on why some patients still had a central line. Here, front-line engagement at the point of care created the positive change. “Education is important, but education does not always have a sustained impact,” she said. “Didactic lectures [on infection control] during grand rounds may not stick with people, but if you are engaging people at the actionable moment, that makes a difference.”

Currently, UI Health is in the top performance quartile for CLABSIs and CAUTIs in the VBP program. As such, they have not had a penalty and only have a limited number of HAIs that are not reimbursed. “Overall, we have a better bottom line because of that performance,” Bleasdale said.

On new HAI targets. In 2017, the VBP program added C. diff infections and SSIs so hospitals have more targets for avoiding Medicare penalties.

Currently, Bleasdale’s team is partnering with infectious disease pharmacists

on a strategy to reduce inappropriate C. diff testing in which they ask providers to reconsider ordering laxatives in some patients. Research shows that laxatives often trigger a higher than normal rate of false positives for C. diff.

If you are decreasing infections, you are decreasing patient care costs.

On components of an effective infection-control program. In Bleasdale’s view, one of the keys to reducing infections is to have an infectious disease physician who is responsible for leading the organization’s infection control and prevention team.

This physician also can champion the organization’s antimicrobial stewardship efforts. The CDC estimates that 20% to 50% of antibiotics prescribed in hospitals each year are unnecessary, and antimicrobial stewardship can help hospitals reduce that number, Bleasdale said.

Robust data collection is also critical to improve performance. At UI Health, leaders rely on a data-mining program to help them collect HAI data, which they report to the CDC’s National Healthcare Safety Network. Bleasdale also works with her organization’s analytics team to build dashboards with real-time HAI data that they can share with leaders and frontline staff.

In an organization’s HAI improvement efforts, a strong clinical documentation improvement (CDI) team also can be a valuable asset. “Having a robust CDI team is critical because HAIs affect your billing at the individual patient level and also your performance in other quality measures,” she said. Ideally, the CDI team should be integrated with the hospital’s quality improvement team to help improve performance.

On what else infectious disease specialists can do. A growing body of research also suggests that early intervention by an infectious

disease specialist can improve clinical and financial outcomes, Bleasdale said.

A 2018 study, found that getting infectious disease specialists involved early on in inpatient care was associated with nearly 23% shorter hospital stays (Schmitt, S., MacIntyre, A.T., Bleasdale, S.C., et al., “Early infectious diseases specialty intervention is associated with shorter hospital stays and lower readmission rates,” *Clinical Infectious Diseases*, Jan. 7, 2019). In addition, costs were almost \$11,000 less for patients who were seen by an infectious disease specialist early in their hospital stay, compared with those who were not seen by an infectious disease specialist. Infectious disease consultations also were associated with lower 30-day readmissions and lower costs 30 days post-discharge.

Advice for finance teams. Bleasdale sees a role for finance leaders to participate on infection control and antimicrobial stewardship taskforces. In particular, they can help ensure that clinical teams have the time and resources they need to work on these activities.

“It takes investment in resources to have a robust and effective infection control and prevention program, as well as antimicrobial stewardship,” Bleasdale said. “But there is a high rate of return on that investment because if you are decreasing infections, you are decreasing patient care costs. And with the VBP program, you are affecting your reimbursement for other patients two years later. Small investments in personnel and infrastructure have a big return on investment.” +

This article is based in part on a presentation by Bleasdale and Robin Trotman, DO, FIDSA, at the 2019 HFMA Annual Conference.

Laura Hegwer

is a freelance writer and editor based in Lake Bluff, Ill. (laura@vitalcomgroup.com).

Interviewed for this article:

Susan C. Bleasdale, MD, FIDSA, FACP,

is medical director of infection prevention and control and antimicrobial stewardship at UI Health, Chicago (bleasdal@uic.edu).

BELONG TO THE HEARTBEAT OF PROGRESS.

Who says you can't have it all?

When you join HFMA, your dues unlock an all-access membership so you can get more of what you need to transform your career, your organization and the entire healthcare system.

Unlimited access means unlimited progress thanks to insightful content, professional certifications, and online education – all for one price.

And soon, you'll benefit from the totally redesigned digital platform – specifically engineered to help you thrive.

Have It All. Join Now.
hfma.org/join

hfma™

5 guidelines for controlling contracted dining service costs while maintaining quality

Stephen Carrabba

Master service agreement set-up and review guidelines ensure that milestones and safeguards are in place.

Hospitals and health systems spend large sums on food and food services and the stakes are high. Food quality and related service is visible to everyone and can impact patient and visitor experience and staff productivity. Food vendors become virtual partners. Agreements and relationships need to be managed to ensure optimal performance for the least cost and the process should be seamless.

Hospitals and health systems are looking to reduce time and overhead involved with staffing and running day-to-day food service operations in a market where the clientele increasingly demands more diverse dining options and service levels.

However, negotiating the service agreement is fraught with nuance, leaving organizations prone to potential errors that could end up costing hundreds of thousands, if not millions, in unexpected billings. Following these guidelines in the set-up and review of the master services agreement will help ensure that your entity has audit milestones and safeguards in place to ensure the optimal level of service and price for food and services provided:

Hiring practices and labor allowances.

Dining service providers should bring expertise in hiring and retaining qualified staff throughout all dining services areas, regardless of the labor market or payroll logistics. Contractual provisions in the form of guarantees will ensure that payroll costs stay within budget and that any costs associated with hiring, management and retention of staff are the financial responsibility of the dining services provider.

Food costs. Food cost is typically a large portion of any hospital spending. To ensure

that food costs remain within budget, contractual guarantees such as maximum cost per patient per day can be negotiated to ensure budget is met.

If expenses are trending higher than budget, the food service provider should offer a plan to reduce expenses with time-bound, measurable commitments.

In addition to contractual guarantees, rebates should be negotiated when appropriate. While many dining service providers offer their clientele favorable basket pricing, vendor volume food discounts provided to the servicer are often their most significant profit centers. A “market basket” comparison of major food items should be conducted to ensure that volume discounts earned by your dining services provider are being passed on to the client. The result of this analysis will assist in negotiating appropriate rebate percentages or dollars.

Capital expenses. Even though your dining services provider can be a great resource in assessing logistics and cost of updating dining service areas, beware of their offer of capital dollars in exchange for contractual concessions. Many times, they will provide funding in exchange for an additional term on the contract or to rectify service or cost concerns; what may appear to be a one-time source of financial relief

could end up costing your facility over the long run. It may make more sense financially to leverage this offer in negotiating annual recurring savings.

If the dining services contractor is looking for your organization to provide capital funding for new equipment purchases, ensure that the agreement language includes requirements that the contractor offer support for expenditures or draws on the line of credit provided on a quarterly basis to ensure that the spending is not adding to their profit margin.

Monthly/quarterly review. Contractual language requiring a quarterly review of year-over-year financials is a necessity to ensure the client is satisfied with operational performance. Schedule a quarterly business reviews with the food service contractor’s district manager or equivalent.

If expenses are trending higher than budget, the food service provider should offer a plan to reduce expenses with time-bound, measurable commitments.

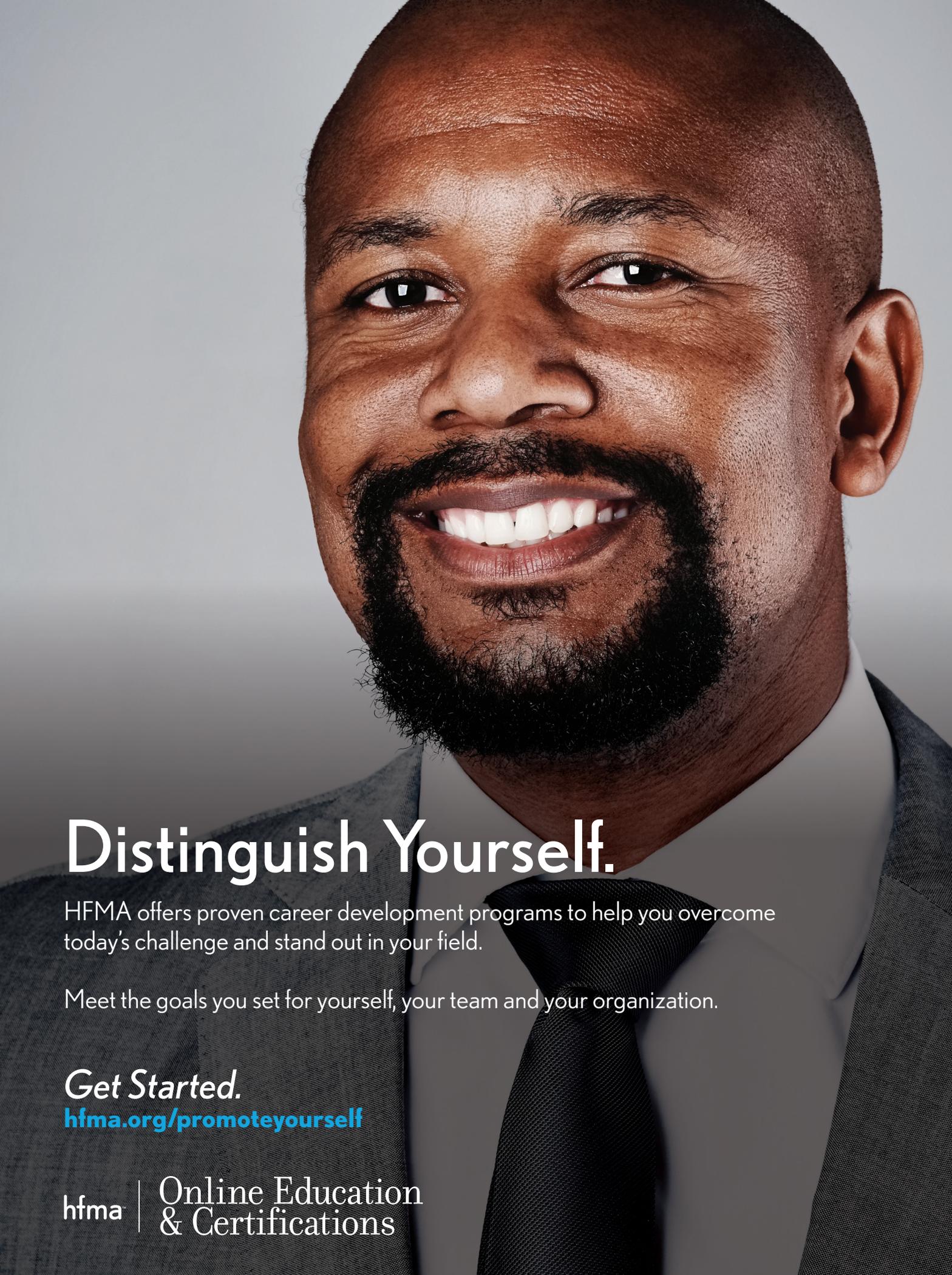
If revenue is trending unfavorable to budget, set the expectation that the contract food service provider must provide a comprehensive plan with time-bound measurable commitments.

Diner reviews. In addition to guarantees surrounding labor and food expenses, it may be appropriate to negotiate food and overall dining quality as a contractual guarantee. Your dining service contractor is the compensated expert and should be taking steps to enhance the dining experience and showcase your program to stakeholders.

To ensure that concerns are addressed, a contractual provision that can be utilized is tying quality to financial penalties. By integrating pre- and post-patient satisfaction surveys into the master service agreement, you’re incentivizing your dining service provider to enhance the patient experience while ensuring food pricing and service levels remain at optimal levels. +

Stephen Carrabba

is president and founder, Expense Consulting, Bloomfield, Conn. (s.carrabba@expenseconsulting.com).



Distinguish Yourself.

HFMA offers proven career development programs to help you overcome today's challenge and stand out in your field.

Meet the goals you set for yourself, your team and your organization.

Get Started.

hfma.org/promoteyourself

hfma | Online Education
& Certifications

Understanding physician costs is the first step in clinical cost transformation

Catherine Savage and David Blunt

Before you can address costs, you must know what they are.

While this statement seems obvious, it defines a problem for many healthcare finance professionals. In a recent survey of healthcare finance executives, more than 70% of respondents said they did not have a high degree of confidence in the accuracy of results from their existing cost accounting solution. Almost 50% said they had no or very limited use of cost and profitability reports to support strategic decision-making and influence financial and tactical planning (2018 State of Cost Transformation in U.S. Hospitals and Health Systems: Time for Big Steps, Kaufman, Hall & Associates, LLC).

A lack of actionable cost data is a particularly acute problem with respect to physician costs. Costs associated with the physician enterprise are a significant driver of patient care costs and service-line profitability, and health systems' need for accurate and trusted physician

cost data has only intensified. Physicians continue to migrate from independent to system-owned practices. New payment models push health systems to identify and remove unwarranted variations in the cost of care to realize savings against historical cost benchmarks or keep costs below a bundled price paid for episodes of care. Yet many health systems maintain a hospital-centric cost accounting structure that fails to provide actionable insights into physician costs across the care continuum.

Overcoming challenges to effective cost accounting

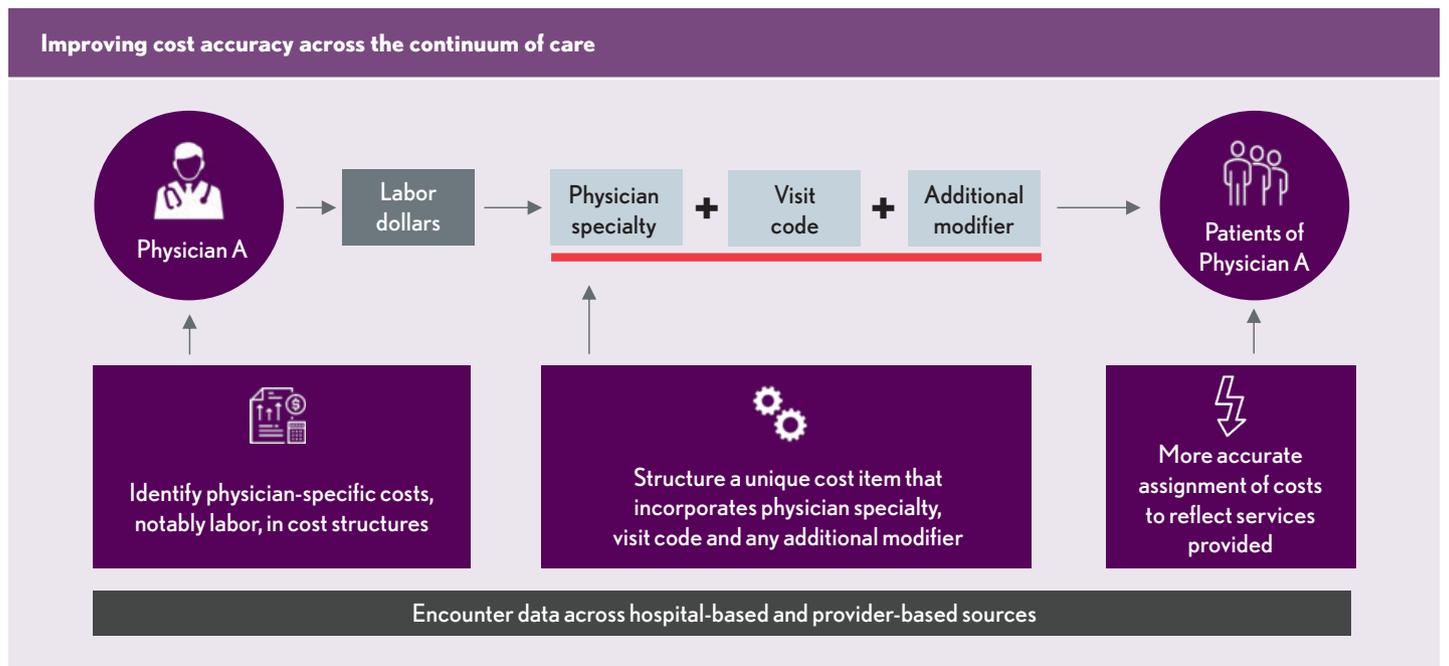
To gain insights into physician costs, finance leaders must be willing to move beyond traditional cost accounting methods to a cost accounting solution that addresses the following limitations:

Use of overly simplistic methods. Reliance on ratio of cost to charges (RCC) will never provide the granularity needed to accurately capture physician labor costs. A solution that can incorporate relative value units (RVUs) and micro-costing (e.g., to determine time spent at different sites of care) is essential.

Time- and resource-intensive processes. Time and resources will always be limited. A cost accounting solution must be efficient, with repeatable processes.

Lack of timely results. Reliance on data that is six months old — or older — restricts an organization's ability to respond in a timely manner.

A hospital-centric focus. As more care moves beyond an acute setting, finance leaders



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

must have the ability to accurately identify costs across the continuum of care.

Lack of buy-in from executive leaders and physicians. Combined, the limitations described in the preceding bullet points generate data that lack the specificity needed to build trust in the data's ability to inform decision-making. Stakeholders need a transparent process that identifies data sources and assumptions made in analysis of costing data.

The goal of physician costing is to complement existing hospital-based accounting processes by identifying physician-specific costs, notably labor, in cost structures and more accurately assigning these costs to patient-specific encounters (see the flowchart on page 14).

As the accuracy of physician cost data grows, so too will confidence in the data and its ability to serve as a tool to identify opportunities for improving physician performance, growing service lines or negotiating payments that better reflect the full costs of delivering care.

Getting started

The addition of physician costing to existing hospital-based costing processes should be approached as a work in progress: Physician cost data can be refined gradually to improve the data's specificity and value as a decision-making tool. It is nonetheless important to start with a plan, which includes the following steps:

Set the vision. Work with executive and physician leadership to define what the organization hopes to learn from physician cost data and what are its "need-to-know" priorities.

Map the approach. Sketch out an initial process for physician costing, including any assumptions regarding physicians' roles in the process.

Build the costing structure. Start with the information available now. For example, the process might begin with RCC data on the understanding that a transition to RVUs will be required to achieve the desired granularity of information.

Data need not be perfect before it is shared with stakeholders; more important is transparency about how the data was collected and what it can show and what it cannot.

Get feedback and refine. Share the data with key executive and physician leaders and educate them on what insights it provides and how it differs from cost data they have seen before. Use their feedback to refine the costing structure.

Tolerate imperfection. Data need not be perfect before it is shared with stakeholders; more important is transparency about how the data was collected and what it can show and what it cannot.

Once the costing structure is in place, the addition of more refined costing units (e.g., RVUs instead of RCC) and costing techniques (e.g., assignment of physician costs to sites of care depending on average time spent at different sites) will add both specificity and value to the information provided

by cost reports. Again, transparency about how the data is collected and what insights it provides will continue to build trust in the data.

The value of physician cost data extends across multiple dimensions.

It can contribute to:

- > Service line analysis, by supporting cost and margin analysis across care settings (hospital, medical group, home health, etc.)
- > Financial planning, by supporting full business case development across many strategic initiatives
- > Physician analysis, by providing comparative physician data on costs and utilization and identifying areas for executive and managerial focus on unwarranted variations in care and cost reduction opportunities
- > Pricing and contracting, by informing negotiations that secure payments sufficient to ensure full cost coverage.

Physician costs should be an integral part of any health system's performance improvement and cost transformation efforts. Taking time to plan for the expansion to physician costing and to educate key stakeholders on the process and intended results will help ensure a successful costing initiative. The right cost accounting solution will then provide a powerful tool to define, understand and address physician costs. +

Catherine Savage

is assistant vice president, Kaufman, Hall & Associates, LLC, Chicago, Ill. (csavage@kaufmanhall.com).

David Blunt

is senior software implementation consultant, Kaufman, Hall & Associates, LLC, Chicago, Ill. (dblunt@kaufmanhall.com).



healthcare financial management association

Three Westbrook Corporate Center
Suite 600
Westchester, IL 60154

To subscribe, call 800-252-HFMA, ext. 2,
or visit hfma.org/hcc

NONPROFIT ORG
U.S. POSTAGE
PAID
PERMIT NO. 1737
PEWAUKEE, WI

Sponsored by



www.kaufmanhall.com

+ healthcare costs at a glance +

Care coordination can reduce \$89 billion behavioral health cost impact

Behavioral health issues account for about one quarter of all emergency department (ED) visits, according to a Premier analysis. One of the primary reasons for ED visits associated with mental health conditions is lack of access. Nearly 40 percent of adults with severe mental illness — such as schizophrenia or bipolar disorder — received no psychiatric treatment in the previous year, according to the 2012 National Survey on Drug Use and Health. Among adults with any mental illness, 60 percent were untreated. National shortages of mental health professionals and affordable psychiatric

care means that in many communities the ED is where patients seek care.

A continuum of care program is one way hospitals and health systems can address this challenge. For example, Henry Ford Allegiance Health, a 475-bed health system in Jackson, Michigan, used a cross-continuum of care management program that streamlined access to behavioral health and community services and decreased wait times in the ED, according to a Premier report. Other results include reduced opioid overdoses and readmissions and \$430,000 in consolidated savings. +

The cost impact of mental health

Total U.S. health spending for mental illness treatment	\$89 billion
Per visit ED cost to care for an average patient with psychiatric service needs	\$1,198-\$2,264
Percentage of adults with a mental, behavioral or emotional health disorder	18.5%
Percentage of ED patients who present with mental health issues	7%-10%

Source: *Ready, Risk, Reward: Improving Care for Patients with Chronic Conditions*, Premier