HealthLeaders Media | Intelligence

June 2012

Collaborating to Improve Care and Cut Costs

By Joe Cantlupe

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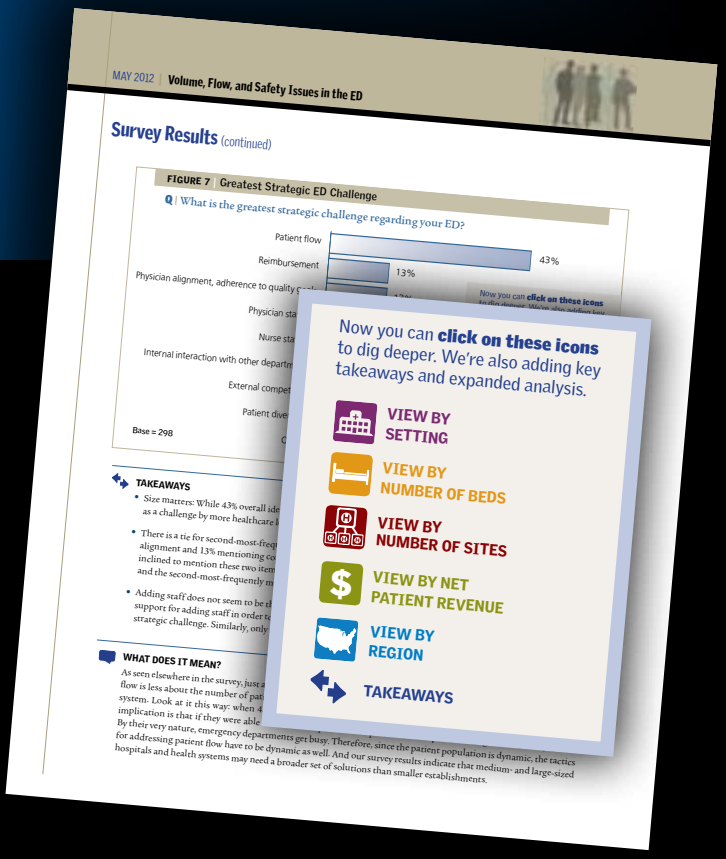

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Foreword

ASSEMBLING THE PIECES OF THE HEALTHCARE PUZZLE

Back in the good old days, healthcare providers used to hear the phrase "doing more with less," and we all marched to the beat of expanding service while focusing on cost reductions. Now the phrase has transformed into "doing less with less." We are an industry in rapid change with much of the old thinking being challenged.

No longer is growth and cost efficiency the panacea for organizational strength. Providers have successfully wrung out operational efficiencies using productivity systems and benchmarks for labor, and innovative contracting methods for supply chain and other necessary services. What is needed now is innovative leadership that focuses on a deeper dive into the operations of healthcare in the United States with the goal to improve quality while driving out waste in all aspects of the healthcare continuum.

The *2012 Economics of Better Care Survey* prepared for this HealthLeaders Media Intelligence Report tells us healthcare leaders believe that the top three most significant drivers of waste for their organizations are lack of care coordination, overutilization of services and procedures, and regulatory requirements.

Interestingly, when asked about the top three interventions most likely to significantly reduce the cost structure for their healthcare organizations, the response was centered on care coordination, process efficiencies, and automating systems and processes. One attribute that these interventions share is the imperative to build relationships aimed at improving the quality and cost outcomes that, as an industry, we are being asked to achieve. How well developed are your organization's alignment strategies with physicians? How about payers? Are you ready to enter into risk sharing or population-based patient management arrangements? While most respondents are not quite ready to entertain significant shift in risk, the industry is moving in this direction.

When we think of our role in supporting what is best for our communities and our patients, we have an opportunity to continue to build a relationship as a trusted source of healthcare through our focus on quality outcomes, transparency, access to patient information, services in the appropriate venue, and ultimately affordability in an age where costs have shifted significantly to the patient. Patient-centered care models, along with investments in information technology, allow for an unprecedented ability to manage care through the care continuum. This will only improve with time and focus.

We are an industry in transition, where leadership is key. The need for alignment is stronger than ever to be able to tackle tough issues such as overutilization and care coordination. Information technology will support this effort. We have many pieces to the puzzle that will become the healthcare system of the future. The question now becomes, how fast can we put the puzzle together?

Michelle Mahan
CFO
Frederick (Md.) Regional Health System
Lead Advisor for this Intelligence Report

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*** PREVIEW: New interactive chart with expanded information; a sample of what's coming in July.**

Methodology

The 2012 Economics of Better Care Survey was conducted by the HealthLeaders Media Intelligence Unit, powered by the HealthLeaders Media Council. It is part of a monthly series of Thought Leadership studies. In March 2012, an online survey was sent to the HealthLeaders Media Council. A total of 309 completed surveys are included in the analysis. The margin of error for a sample size of 309 is +/-5.6% at the 95% confidence interval.

ADVISORS FOR THIS INTELLIGENCE REPORT

The following healthcare leaders graciously provided guidance and insight in the creation of this report.

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About The HealthLeaders Media Intelligence Unit

The HealthLeaders Media Intelligence Unit, a division of HealthLeaders Media, is the premier source for executive healthcare business research. It provides analysis and forecasts through digital platforms, printed publications, custom reports, white papers, conferences, roundtables, peer networking opportunities, and presentations for senior management.

Upcoming Intelligence Report Topics

Clinical Quality and Safety

Patient Experience

Physician-Hospital Alignment

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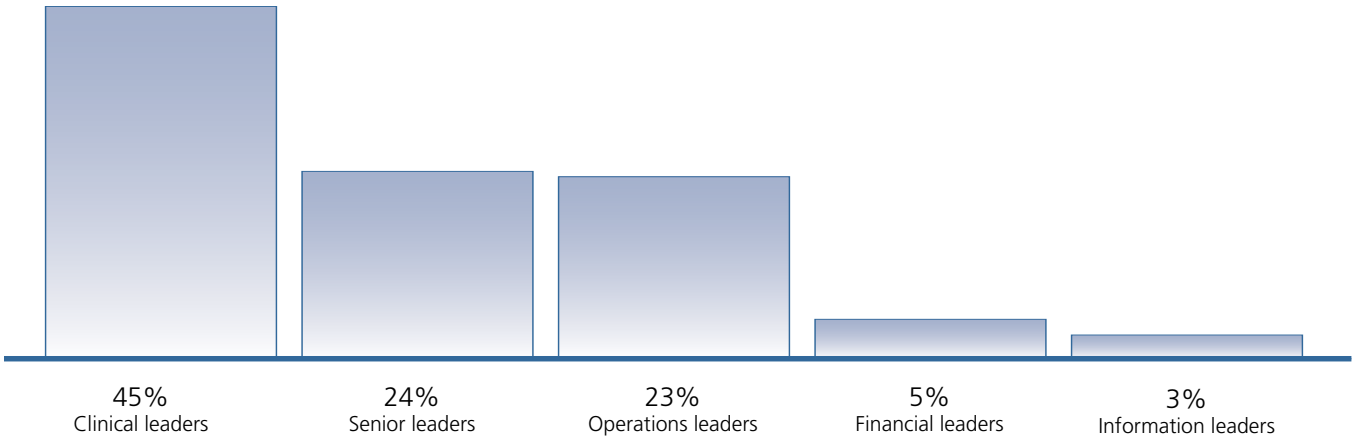
Respondent Profile

Respondents represent titles from across the various functional areas, including senior leaders, operations leaders, clinical leaders, financial leaders, and information leaders. They are from a variety of healthcare provider organizations including hospitals, health systems, and physician organizations.

Title

Base = 309



Senior Leaders | CEO, Administrator, Chief Operations Officer, Chief Medical Officer, Chief Financial Officer, Executive Dir., Partner, Board Member, Principal Owner, President, Chief of Staff, Chief Information Officer

Clinical Leaders | Chief of Orthopedics, Chief of Radiology, Chief Nursing Officer, Dir. of Ambulatory Services, Dir. of Clinical Services, Dir. of Emergency Services, Dir. of Nursing, Dir. of Rehabilitation Services, Service Line Director, Dir. of Surgical/Perioperative Services, Medical Director, VP Clinical Informatics, VP Clinical Quality, VP Clinical Services, VP Medical Affairs (Physician Mgmt/MD)

Operations Leaders | Chief Compliance Officer, Asst. Administrator, Dir. of Patient Safety, Dir. of Quality, Dir. of Safety, VP/Dir. Compliance, VP/Dir. Human Resources, VP/Dir. Operations/Administration, Other VP

Financial Leaders | VP/Dir. Finance, HIM Director, Director of Case Management, Director of Revenue Cycle

Information Leaders | Chief Medical Information Officer, Chief Technology Officer, VP/Dir. Technology/MIS/IT

Type of organization

Base = 309

Hospital	38%
Health system (IDN/IDS)	24%
Physician org	19%
Health plan/insurer	9%
Ancillary, allied provider	5%
Long-term care/SNF	5%
Government/education/academic	1%

Number of beds

Base = 117 (Hospitals)

1–199	47%
200–499	35%
500+	18%

Number of sites

Base = 74 (Health systems)

1–5	31%
6–20	32%
21+	36%

Number of physicians

Base = 59 (Health systems)

1–9	35%
10–49	27%
50+	38%

ANALYSIS

The Role of Teamwork and Technology in Better Care

By Joe Cantlupe

Initiating collaborative relationships is the key to improved quality, most healthcare leaders say. Many also agree that major increases in HIT spending are necessary, but others are more cautious about spending for technology improvements. And more than two-thirds see transparency as improving quality of care, while a sizeable minority has reservations about it, according to the *2012 HealthLeaders Media Economics of Better Care Survey*.

What Healthcare Leaders Are Saying

"There is an unwillingness of payers to gainshare or risk share with providers."

—CEO for a large health system

"The timing of moving from one payment methodology to another is tricky. We are living with a foot in both worlds and we have to navigate very carefully in order not to be ahead of the payment models."

—VP, director of operations for a medium-size health system

"Who makes the 'value' decision? Seems a pretty arbitrary determination to which a case-by-case challenge will be extremely costly and inefficient, further driving up overhead and slowing the revenue process."

—CIO for a medium-size hospital

"CFOs are so used to acute care days to measure success."

—CNO for a large hospital

"There is a continued lack of alignment between hospitals and physicians."

—Director of quality for a medium-size health system

"It is slow to develop in the Northwest. Patient participation is the biggest concern."

—Chief compliance officer for a medium-size hospital

"It will not be effective in reducing costs or utilization, and will not improve quality."

—CEO for a small health system

"It can have an overall effect on quality of care."

—Chief compliance officer for a health plan

Teamwork is an emerging focus, with nearly three-quarters (72%) entering collaborative care relationships, while 28% say they are not. At the same time, healthcare leaders are reluctant to engage in shared savings programs as a risk-sharing cost-reduction tactic: 63% say they have no plans for such programs, which are a foundation of the evolving accountable care organization models.

Michelle Mahan, CFO of the 309-licensed-and-staffed-bed Frederick (Md.) Regional Health System, says the survey shows that health systems are moving slowly into the collaborative models, especially in light of their expressed concerns over shared savings and cautiousness over transparency.

ANALYSIS (continued)

> "There's better coordination of care that is taking place, but we're at the starting point; it's definitely in its infancy."
>
> —Michelle Mahan, CFO, Frederick (Md.) Regional Health System

"There's better coordination of care that is taking place, but we're at the starting point; it's definitely in its infancy," Mahan says. "The healthcare continuum lacks alignment; however, it is moving in the right direction with certain new incentives, such as reducing readmissions. People are still getting too sick and going back to the hospital. We need to do a better job of preventive care, with patient-centered medical homes, for instance. The whole issue of care coordination, no question, we can do better."

The survey shows that 48% of healthcare systems anticipate a major increase in HIT spending over the next two years, but 34% describe their approach to HIT spending as an operations investment, and 24% see it as a cost of doing business; only 23% see it as a clinical investment. In describing the ROI associated with HIT spending, 42% expect net cost to decrease over time, but 31% anticipate it would increase.

Improving IT systems is absolutely the cost of doing business, says Ray Chicoine, COO of Monarch HealthCare in Irvine, Calif., a health system that includes 2,300 who contract with 18 hospitals in Southern California. "You have to have a robust infrastructure, from A to Z. None of it fits easily and none of it is cheap," Chicoine says. "I think you can't escape that fact. To be an effective, integrated delivery model, you will have to spend more on technology and that cost will continue to grow."

While 69% of healthcare leaders say greater transparency in healthcare will increase the quality of care, 35% said it would increase the cost of providing care.

The reason it's difficult is that so many health systems only have pieces of that care continuum, according to Julie Manas, president and CEO of the 349-licensed-bed Sacred Heart Hospital in Eau Claire, Wis., and division president of the Western Wisconsin division of Springfield, Ill.–based Hospital Sisters Health System, which includes the 193-licensed-bed St. Joseph's Hospital in Chippewa Falls. "While there is discussion about moving that patient as seamlessly as we can,

ANALYSIS (continued)

with incentives or lack of incentives, it's difficult because of the payment method and how we have been reimbursed. I'm embarrassed to say it drives some of our behaviors, but I think it does," she says. Attaining care coordination is "the Holy Grail," Manas adds.

When asked about interventions most likely to reduce the costs of healthcare, survey respondents identified these: adopt a care coordination plan, 69%; improve process efficiencies, 57%; automate systems and processes, 46%; and increase patient engagement, 44%.

The most significant drivers of waste were lack of care coordination, 44%; overutilization of services and procedures, 42%; and regulatory requirements, 41%.

> "To be an effective, integrated delivery model, you will have to spend more on technology and that cost will continue to grow."
>
> —Ray Chicoine, COO, Monarch HealthCare, Irvine, Calif.

When asked what initiatives their organization would adopt to control costs and improve care, 50% of the respondents say they would develop or join a patient-centered medical home; 48% say they would join an integrated delivery system. Manas says there are many variables involved in establishing a medical home, with success increasingly depending on patient responsibility.

Of those who have not embarked on a collaborative care program, 41% indicate they do not have interested partners to collaborate with, and 26% and 21%, respectively, acknowledge that their organization has no financial or strategic interest to do so. Mahan says the lack of interest might be attributed to healthcare systems "that could not find an interested partner, possibly because of demographics, or hesitancy within the culture of its relationship with physicians."

Chicoine explains that various organizations are dealing with coordinated care in different ways, depending on their needs and expectations, as a result of healthcare reform. "Some organizations are focused. They believe in coordinated care and population management," he says. In that way, it's "full steam ahead."

Other systems are more cautious, however. "There's a middle group that I would say has always

ANALYSIS (continued)

been supportive of more coordinated care, but just doesn't have the business need or the business model to put the time and energy into it," Chicoine adds. "Then there are the naysayers who are doing all they can to hang on to the status quo and maintain it as long as possible because their business model is based on inefficient volume-based care. A lot of hospitals, unfortunately, fall into that category."

The Centers for Medicare & Medicaid Services has offered financial incentives for physicians, hospitals, and other healthcare providers to participate in Medicare's shared savings programs as part of ACOs. A pilot has been established for 27 systems to serve more than 375,000 beneficiaries in 18 states.

> "[Shared savings is] an area that some health systems probably wish they could dip their toes into, but are not ready to dive in yet."
>
> —Shawn P. Griffin, MD, chief quality and informatics officer, MHMD-Memorial Hermann Physician Network, Houston

Despite the government incentives, Chicoine says many health systems are reluctant to take part in shared savings because of associated risks. "On one hand, the government is saying 'we're going to give you some incentives here to create some shared savings,' but if that shared savings is coming out of current revenues, for some systems it's very hard to get motivated even though they know it's the right thing to do," Chicoine says.

Shawn P. Griffin, MD, chief quality and informatics officer for the MHMD-Memorial Hermann Physician Network in Houston, says he is also not surprised by the lukewarm response to the shared savings plan. The network is a large clinically integrated IPA with more than 3,500 members, affiliated with the 12-hospital Memorial Hermann Healthcare System.

"I think there has to be sensitivity with any sort of shared savings program," says Griffin, noting that Memorial Hermann has applied to the Medicare ACO program. "It's an area that some health systems probably wish they could dip their toes into, but are not ready to dive in yet." Shared savings "requires up-front investments in personnel and information management infrastructure that may be costly on the possibility that these reforms will deliver savings and

ANALYSIS (continued)

> "While there is discussion about moving that patient as seamlessly as we can ... it's difficult because of the payment method and how we have been reimbursed."
>
> —Julie Manas, president and CEO, Sacred Heart Hospital, Eau Claire, Wis.

cover their costs in the end, which may take years to achieve," Griffin says.

"I think the general trepidation everyone feels will cause nervousness in every element of the ACO process," he adds. "Some organizations may be well-positioned, either by geography, population, or structure to do well with that framework, but in the most competitive environments, I think it will be limited to high-performing nimble organizations, such as ours."

As for IT, the availability of meaningful use money may spur more technology development even among reluctant healthcare systems, Manas says. To gain the government funds linked to technology, "It's a one-time shot and we're going to go after it. If you don't, you'll never get those dollars again."

Eventually, Mahan expects health systems to embrace shared savings and do better with care coordination programs. Improved population management programs will "ensure access to healthcare for the individual, likely at a much lower cost than is experienced today," she predicts.

Besides IT, Mahan says transparency must improve, especially in the hospital purchasing of medical devices, in which there are high costs attached to a lack of coordination between hospitals and physicians.

Indeed, there are so many issues hospitals and administrators have to deal with that "it feels like it's coming at you like a firehose," she says.

At least there's one regulatory element not of immediate concern. The Department of Health and Human Services has proposed postponing the compliance date for ICD-10 until October 1, 2013. ICD-10 expands thousands of inpatient procedure codes used for clinical, billing, and financial systems in healthcare. In the survey, 57% of respondents expressed relief at the delay, while 28% were frustrated. Mahan says she's happy about the postponement. "FRHS is a beta site for a

ANALYSIS (continued)

major IT company's next-generation hospital system, which is planned to go live five months prior to the original ICD-10 implementation date. It is, perhaps, for this reason that I'm on the side of the delay."

As healthcare leaders anticipate future economic issues, Mahan says one problem is that hospitals don't necessarily control their own cost base. "But if we have better alignment, with the idea of population management, and work toward ensuring the health of the individual, the cost of treating the patient could improve. It's better for the patient, and healthcare will be moving more toward a cooperative than competitive model," she concludes.

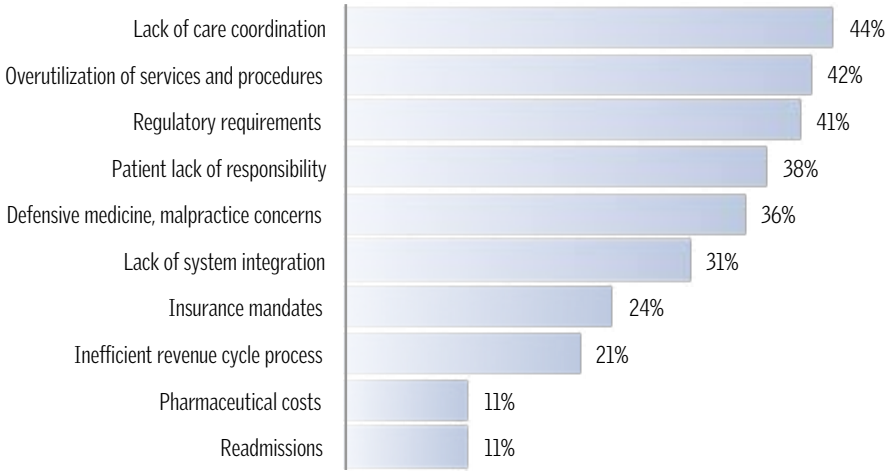
Joe Cantlupe is senior editor for physicians and service lines for HealthLeaders Media. He may be contacted at jcantlupe@healthleadersmedia.com.

To preview our new interactive report capabilities, turn to pages 14 and 19.

Survey Results

FIGURE 1 | Most Significant Drivers of Waste

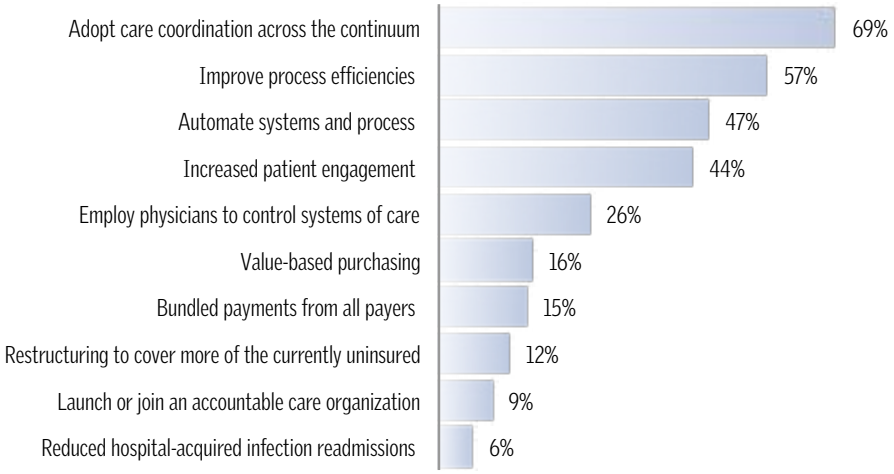
Q | What are the top three most significant drivers of waste for your healthcare organization?



Base=309, Multi Response

FIGURE 2 | Interventions Most Likely to Reduce Cost of Healthcare

Q | What are the top three interventions most likely to significantly reduce the cost structure of healthcare for your organization?

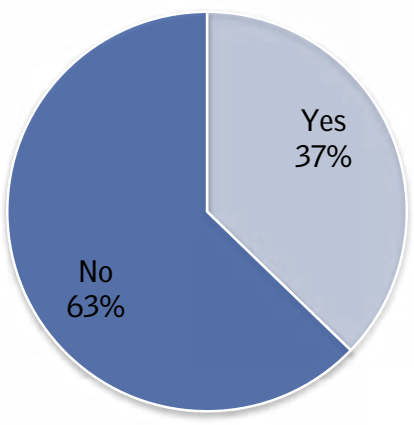


Base=309, Mulit Response

A SNAPSHOT OF OUR NEWLY EXPANDED INTERACTIVE REPORT, WHICH PREMIERES IN JULY

FIGURE 3 | Initiating a Shared Savings Program

Q | Are you initiating a shared savings program with payers or providers to assume risks as part of an effort to reduce costs?



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VIEW BY NUMBER OF SITES

VIEW BY NET PATIENT REVENUE

VIEW BY REGION

TAKEAWAYS

TAKEAWAYS

- In early March 2012, when our survey was in the field, roughly two-thirds (63%) rejected a shared savings program as a risk-sharing cost-reduction tactic. Since then, CMS has named 27 additional organizations to begin the Medicare Shared Savings Program, and is examining another 150 applications for still another wave. It is likely interest in shared savings programs will grow.
- The concept finds more favor with health systems (47%) than with hospitals (28%) or physician organizations (29%).
- Our results demonstrate that acceptance of the medical shared savings concept is related to organization size. For example, nearly two-thirds (63%) of respondents from health systems with 21 or more sites are initiating a shared savings program, compared to just over one-third (35%) of those from health systems with five or fewer sites.

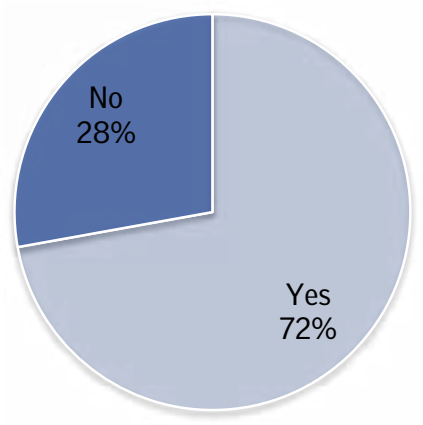
WHAT DOES IT MEAN?

If changes to reimbursement schemes don't give a financial manager the jitters, working out new partnership arrangements will. And shared savings programs threaten to do both. When one considers also that shared savings is the defining piece of CMS' ACO model, the Medicare Shared Savings Program, the reluctance of two-thirds of respondents can be put in perspective. And if a higher level of acceptance of shared savings programs is found in larger entities, it may have less to do with the steely resolve of healthcare leaders than with the comfort larger organizations may have dealing with a wider variety of business partners and medical collaborators. Another factor affecting response by size of organization may be that smaller organizations, with smaller patient populations, may feel more vulnerable to patients with costly maladies.

Survey Results (continued)

FIGURE 4 | Collaborative Care Relationships

Q | Are you embarking on collaborative care relationships with other providers and organizations to form a community of care?



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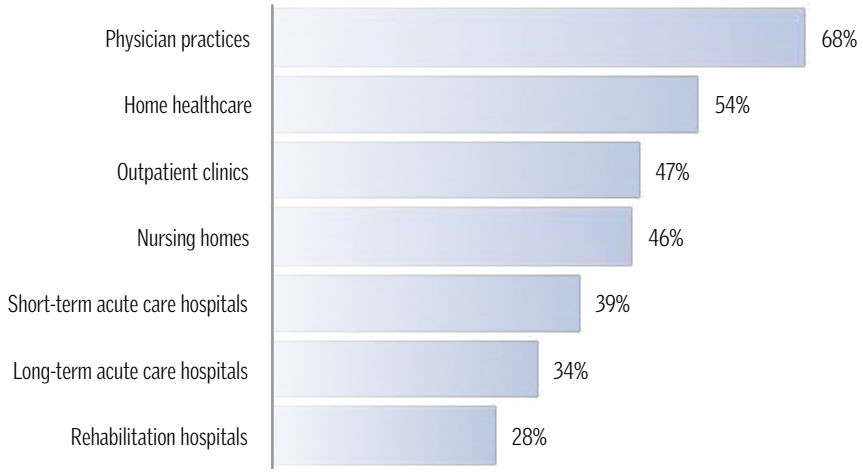
Type of organization

Among those embarking on collaborative care relationships



Base=223, Multi Response

Survey Results (continued)

FIGURE 5 | Reasons for Not Embarking on Collaborative Care Relationships

Q | If you are not embarking on collaborative care relationships with other providers and organizations to form a community of care, why not?

Among those not embarking on collaborative care relationships

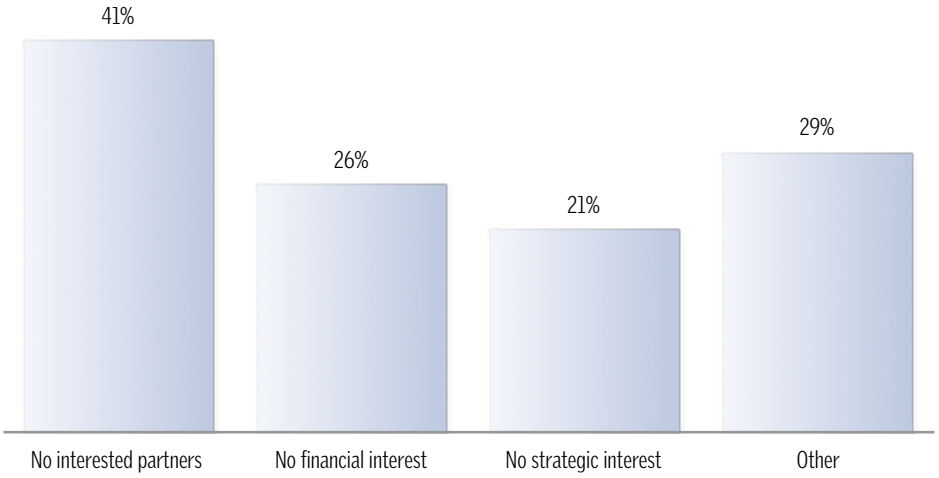


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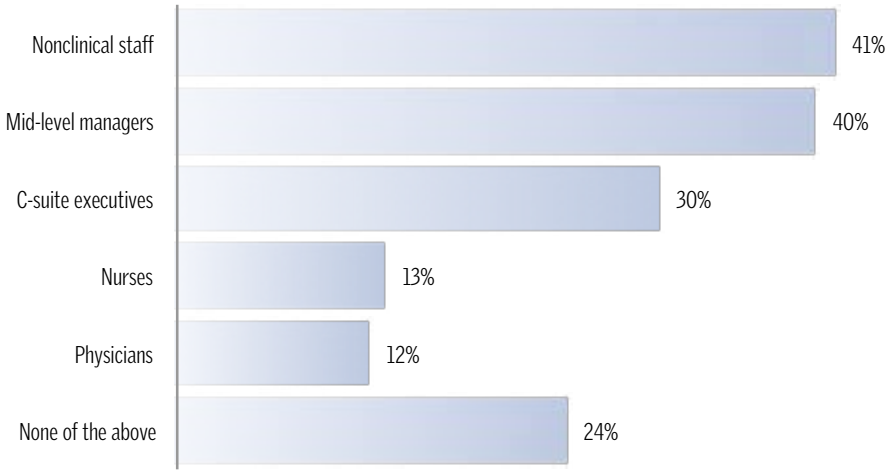
FIGURE 6 | Cuts in Salaries or Staffing

Q | Labor costs are among the top cost drivers in running a healthcare organization. Where can you find cuts that will yield worthwhile savings in terms of salaries or staffing?



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Survey Results (continued)

FIGURE 7 | Approach to HIT Spending

Q | Which best describes your organization's approach to HIT spending?

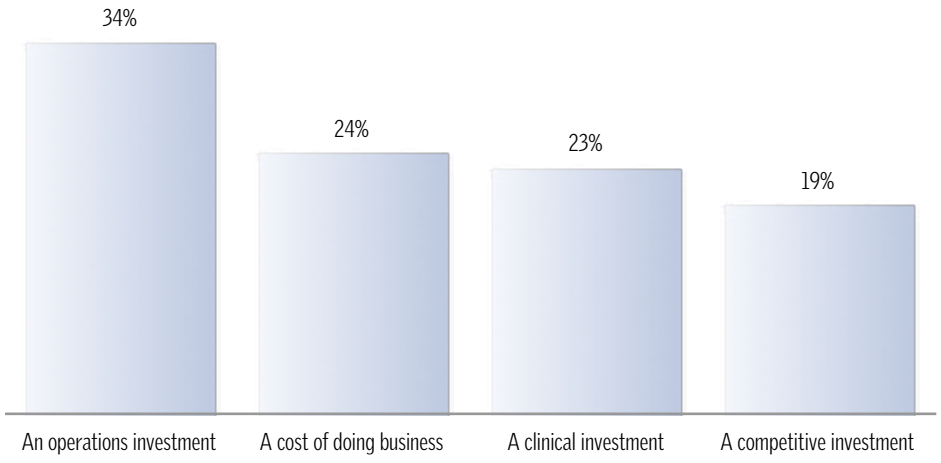

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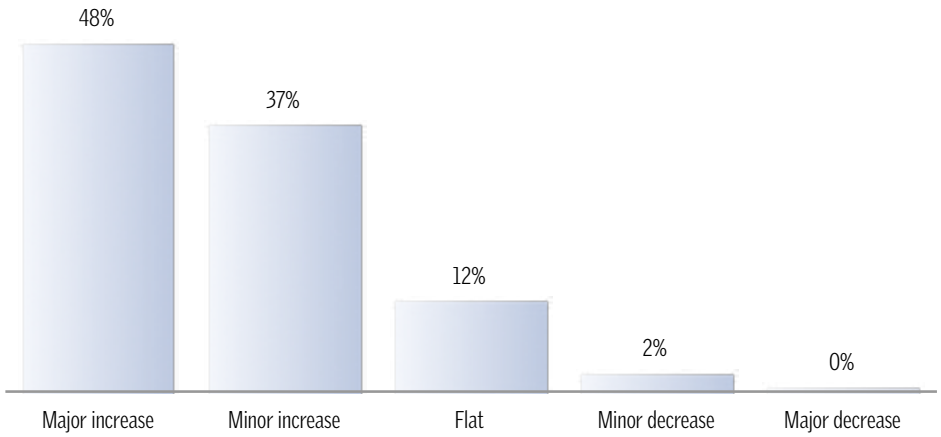
FIGURE 8 | HIT Spending Plans for Next Two Years

Q | Please describe your organization's HIT spending plans for the coming two years.



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Survey Results (continued)

FIGURE 9 | Reaction to ICD-10 Delay

Q | Which best describes your organization's reaction to the delay of ICD-10?

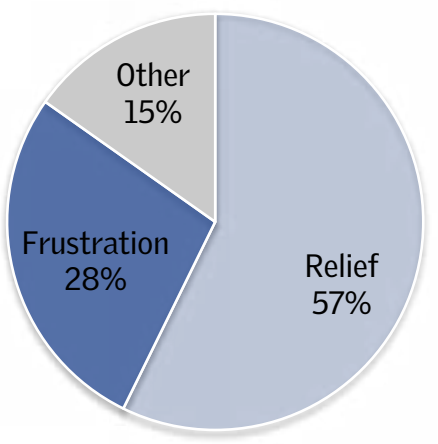

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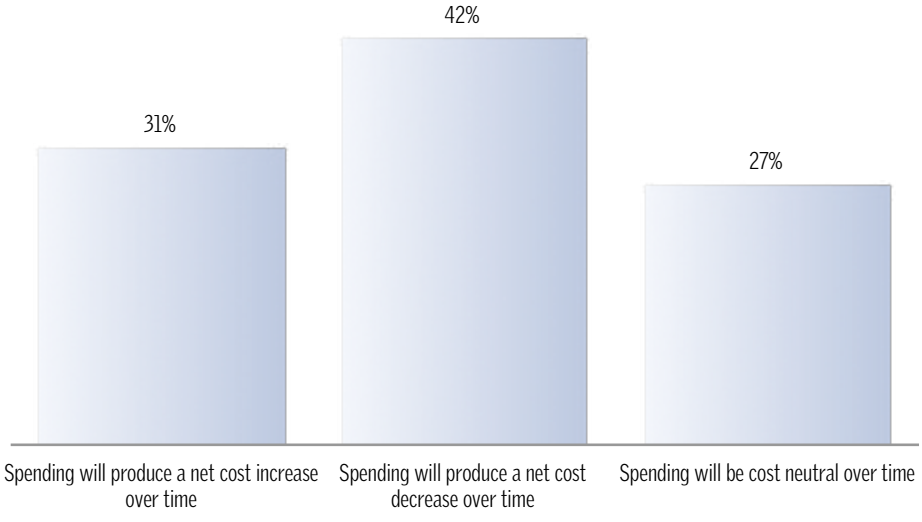
FIGURE 10 | ROI Associated with HIT Spending

Q | Please describe the ROI associated with your HIT spending.



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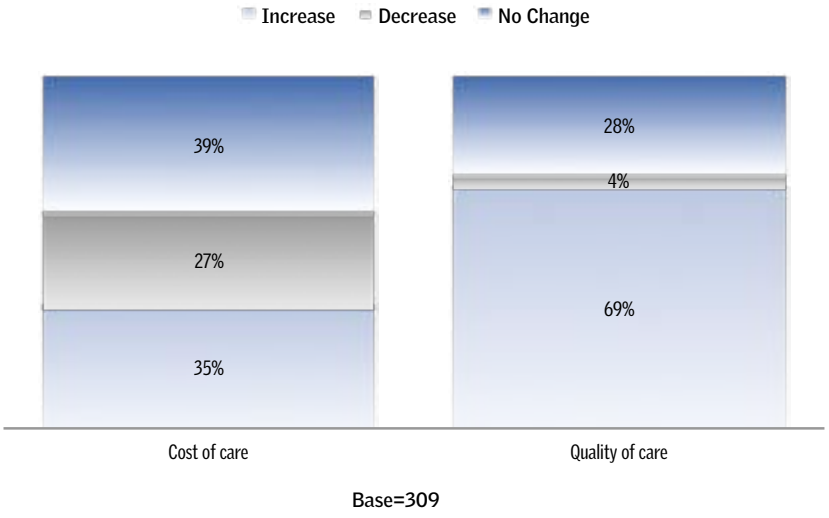
A SNAPSHOT OF OUR NEWLY EXPANDED INTERACTIVE REPORT, WHICH PREMIERS IN JULY

FIGURE 11 | Effect of Greater Transparency in Organizations

Q | How will greater transparency on healthcare cost and quality (through Hospital Compare and other programs) affect your organization?



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VIEW BY SETTING

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VIEW BY REGION

TAKEAWAYS

TAKEAWAYS

- Considering the effects of transparency on cost of care, only about one-quarter (27%) expect costs to decrease.
- Especially pessimistic, though, are physician organizations: nearly half (46%) expect costs to increase, and only 14% expect costs to decrease with greater transparency.
- Only half (51%) of this same group—physician organizations—expect quality of care to increase as a result of increased transparency. While that sounds like a lot, 77% of hospitals and 68% of health systems expect that transparency will have a positive effect on quality of care.

WHAT DOES IT MEAN?

The comparison of the two charts helps us put revenue, expenses, and profits in perspective. When considering the effect of increased transparency on cost, large proportions fall into each category. But delivering quality care is the principle mission of the enterprise, so we see that 69% of respondents expect that increased transparency will improve quality of care, while the thought that quality will *decrease* seems unthinkable to all but a few.

Survey Results (continued)

FIGURE 12 | Improved Efficiencies and ROI With Outpatient Care

Q | Will a drive toward outpatient care improve efficiencies and ROI for your organization?

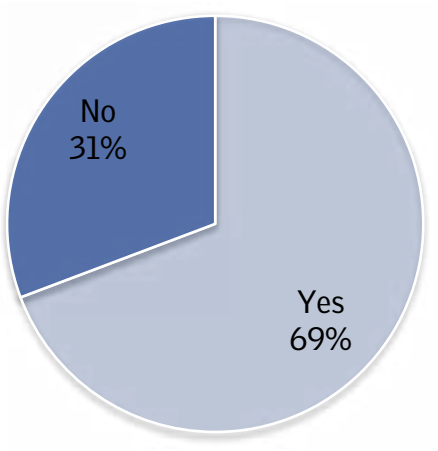

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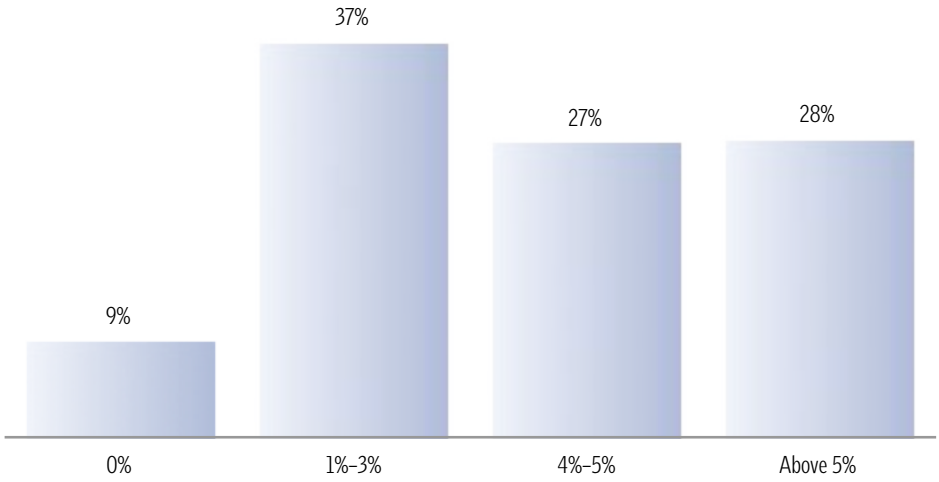
FIGURE 13 | 30–Day Readmission Rate

Q | What is your 30-day readmission rate overall?

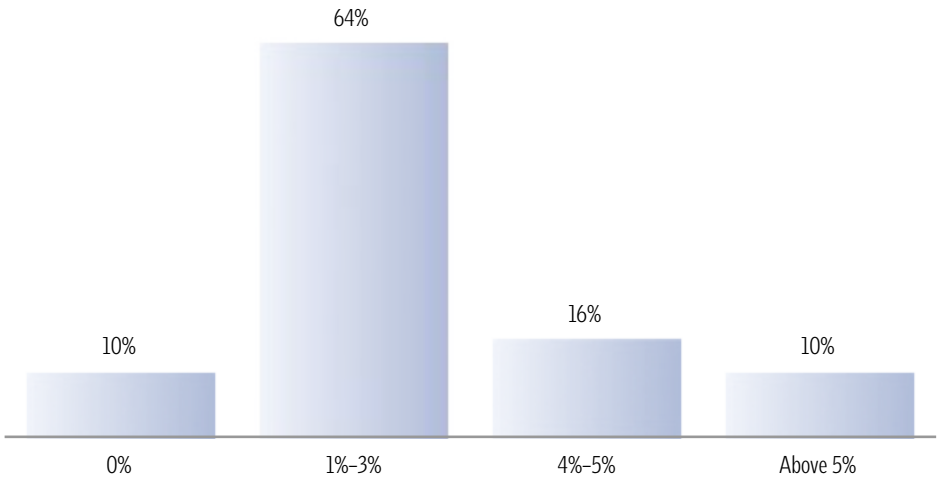


Base=309

Survey Results (continued)

FIGURE 14 | Goal for Readmission Rate

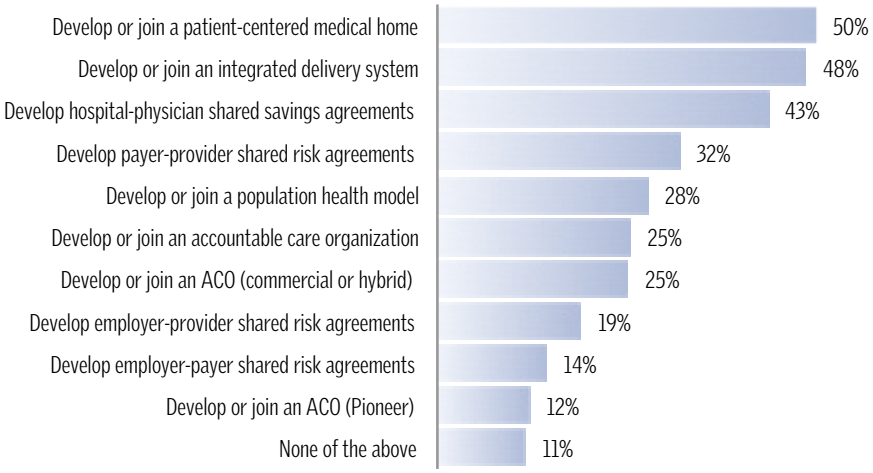
Q | What is a realistic goal for readmission rates at your organization?



Base=309

FIGURE 15 | Initiatives to Control Costs and Improve Care

Q | Which of the following initiatives has or will your organization adopt as a means to control costs and improve care?



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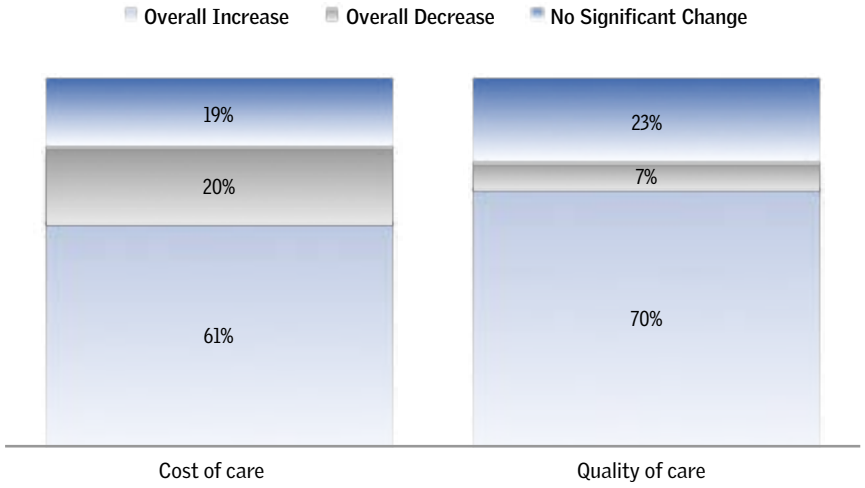
Survey Results (continued)

FIGURE 16 | Impact of Electronic Medical Records on Costs and Quality

Q | Please describe the impact of electronic records on costs and quality at your organization.



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