Laying the Groundwork for Value-Based Payment

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As you consider some of the industry pressures toward value-based payment, what steps are you taking to prepare?

Anna Marie Butrie: In 2011, we started a repositioning effort across our entire system in which we challenged each of our ministries to identify strategic initiatives that would best prepare them for healthcare reform. For each ministry, we examined current financial, operational, and quality performance against similar data from competitors and considered the potential effects of healthcare reform on performance. We encouraged each ministry to develop initiatives that would allow achievement of a 3 percent operating margin and a 10 percent EBITA [a financial measure that examines earnings prior to interest, tax, amortization deductions]. As a result of this effort, some of our ministries are forming new strategic relationships with other hospitals and care continuum partners, such as home health agencies, ambulatory clinics, nursing homes, and rehabilitation centers. We are also developing standardized guidelines for performance improvement and exploring various physician alignment strategies. Sharing best practices on an internal portal helps communicate ideas across the system and allows ministries to benefit from sharing lessons learned.

Rosemary Rotty: We have established approximately 15 major service line groups that bring representatives from our financial department together with clinical leadership in different service areas, such as heart and vascular, musculoskeletal, surgery, and oncology. These teams meet monthly to discuss inpatient and outpatient activity and the revenue and expenses associated with each. Led by financial leaders, the meetings focus clinician attention on the financial aspects of providing care, demonstrating how care decisions have an impact on areas such as cost and payment. We have found that while physicians know medicine really well, they are not always as familiar with the financial piece of providing care. We use these monthly team meetings to peel back the onion and examine the details regarding business performance.

James Lee: Because we are based in Maryland, we have a unique reimbursement system in that we don't participate in prospective payment. Instead, we have been living in a value-based system for the past two years. All our payers are providing quality-based payment and looking at our compliance with core measures, HCAHPS [Hospital Consumer Assessment of Healthcare Providers and Systems], state-mandated measures related to hospital-acquired conditions, and readmission rates. One thing that has resulted from this new payment approach is that we have a much closer relationship with our quality department than we did before. For example, representatives from the quality department are now standing members of our reimbursement committee, and we are continually educating them on how work in improving quality affects payment.

PARTICIPANTS IN THIS HFMA EXECUTIVE ROUNDTABLE

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We have also been pursuing some strategic partnerships to reduce the likelihood of hospital readmissions. As an example, one of the reasons patients return to the hospital after discharge is that they are not taking their medication. Often they fail to get their medication for some reason—cost, access, concerns about side effects, and so on. To mitigate this factor, we have established a relationship with a retail pharmacy chain to fill patient prescriptions before discharge and deliver them to the patient bedside. This arrangement ensures that patients go home with their medication, which we have found improves adherence.

Bret Johnson: We are expanding our partnerships with physicians. Four years ago, we had three employed physicians. Now, we have more than 200. We also have expanded our home health, hospice, and palliative care services and have increased efforts to coordinate care among these services and the acute care division. In addition, we regularly meet with skilled nursing facilities to better coordinate care between the hospital and long-term care organizations. All of these changes have transformed our organization from a hospital-based system toward more of a total healthcare provider.

Lee: We also are enhancing our relationships with physicians. Depending on the physician and our needs, we are offering employment to physicians. Also, we are helping some physician practices implement an electronic health record. We ask them to select one of two vendors, assist them with navigating the implementation process, and ensure their system effectively interfaces with ours.

Butrie: Interestingly enough, we have found that physician alignment strategies vary by geographic location. There are certain states where physicians prefer to become employees, while in other areas, physicians want to remain independent and establish more of a network. We have been taking these local preferences into account as our ministries develop their physician alignment strategies to ensure the selected approach best matches the needs of each ministry.

What are some of the biggest challenges you face as you make the shift toward value?

Johnson: One of the biggest challenges is that clinically we are moving toward an outcomes-based approach to care, but the payment we receive for our efforts remains largely fee-for-service. This creates an environment with conflicting incentives. It's hard to make long-term strategic and financial decisions when your payment strategy doesn't match the clinical goals of your organization. Right now, there are a lot of initiatives directed toward taking better care of the chronically ill and limiting acute care episodes, but if payment models don't keep up, then the result is going to be lower revenue for acute care organizations.

Lee: I think we can all agree that conflicting incentives represent the largest challenge. Over the next five years, we will see a transition from quantity to quality, and riding that wave is going to be difficult.

Getting the right data on which to base both clinical and financial decisions is another significant hurdle. Although we have access to a lot of data as an industry, the key is getting the right data and using the information appropriately to make decisions. Health care is behind the times in terms of business intelligence. We need to catch up and take full advantage of this key resource.

Rotty: I agree. There is a phrase "more data are not better data," and I think that certainly applies here. The challenge we have is to generate accurate and timely information that we can use to identify issues and respond to opportunities. The IT spend needed to effectively gather and manage data is enormous, but if you don't commit to it, then you won't be able to leverage data in a meaningful way.

Butrie: I think making the switch from episodic care to population health management is another key challenge. The industry has been focused on episodic care that has existed in silos for so long that moving to a long-term population health management program is no small task. Although we all recognize the many benefits of population management, implementation of the approach has been limited because the current payment structures do not support it. Population health management programs will grow as acute care providers partner with employers and payers to meet the needs of our communities while managing the cost and quality of care delivered.

Johnson: Overall, I think the uncertainty and lack of clarity are definite concerns. For example, it is difficult to predict how healthcare exchanges will affect revenue and market share. Also, Medicaid expansion could have a dramatic effect as well, especially for states that may opt out of the program. These are some big unknowns that are less than a year away. Although it is an exciting time to be in health care, the road ahead will certainly be challenging.

As the industry shifts away from fee-for-service payment models, organizations may need to respond quickly to changing business dynamics. What are some steps you are taking to remain strategically agile?

Lee: Testing different value-based strategies on a small scale has helped us. For example, in 2009, we conducted a pilot among members of our employee health plan where we tested a patient-centered medical home (PCMH) model for managing the care of plan members with chronic conditions. This model addresses the 5 percent of health plan members that represent 65 percent of healthcare dollars. These individuals have more than one physician and take multiple medications. Using the PCMH model, we were able to realize a significant reduction in the cost of care among members with chronic conditions. We conducted the pilot with an eye on the future to test ideas and put processes in place that we can apply to a larger population. As conditions evolve, we can expand upon what we already know instead of starting from scratch.

Butrie: We are doing something similar. To help us better understand how to implement population health programs, we have been pursuing PACE [a program for all-inclusive care of the elderly] and LIFE [a program within PACE focused on living independently for the elderly]. These programs are designed for dual eligibiles, our patients insured under both Medicare and Medicaid, who are ages 55 and older. The programs allow patients to remain in an outpatient environment instead of long-term care facilities. Implementing these programs—there are nine currently operating across our ministries—has helped us understand how to better manage the health of a population, and specifically the dual elgible population. The programs not only assist us in preparing for future population health management but also support our mission to care for the most vulnerable.

Rotty: We are beginning to work directly with payers to create bundled payments for specific types of procedures. For example, our orthopedics department has developed bundled payment agreements for hip and knee replacements. To create these, we've thought about what makes the most sense in terms of which procedures, physicians, and facilities to bundle. We want to make sure that agreements are designed for the right payer, include the appropriate criteria and methodology, consider all the supplies, and take into account the various operating room, labor, and postoperative care costs. There is a lot to consider when developing a bundled payment agreement, but I think that starting to look at this type of model is helping us prepare for the future.

Johnson: Since there is so much change right now, we have tried to focus on what we know. The market is demanding better care for the chronically ill, which requires coordinating care throughout the continuum. We are investing in clinical quality initiatives and clinical technologies to support this effort. Five years ago, we were more attuned to growing market share; today, quality outcomes are top priority. By examining issues such as mortality, readmissions, and infections and working across different settings to drive down occurrence rates, we are enhancing the overall quality of care we provide. We are also making sure we maintain a strong balance sheet so that as things become clearer, we can continue to make investments and expand our strategic partnerships and care networks.

What steps are you taking to change from process- to outcomes-based measures?

Butrie: We began moving from process- to outcomes-based measured four years ago, when we implemented our advancing clinical transformation program. Through this program, all of our ministries are monitoring and sharing best practices related to standardized performance measures for hospital-acquired conditions, readmissions, length of stay, denials, and write-offs. A clinical dashboard is used to monitor performance against specific targets. Because the dashboards contain many outcomes-based indicators, one enhancement we are testing is scoring each ministry based on performance with a group of these outcomes-based measures. We are trying to determine what measures should comprise the grade and what targets should be associated with each measure. The goal of this approach is to provide an at-a-glance snapshot of performance to identify which ministries excel, and where the ministries need some assistance to improve.

Lee: Priorities are definitely changing. For example, whether a patient comes back to your hospital after receiving treatment is much more important than it used to be. As such, we are starting to track things we didn't before, focusing on not just whether certain processes and procedures are being done, but what the outcomes of those processes and procedures are. One way we are changing our mindset is to link incentives

for our managers to outcomes. We are setting things up so that there is a direct impact on compensation for managers depending on whether our organization meets established targets.

Johnson: We also are ramping up our ability to measure outcomes outside the hospital. Our readmission rate is not only a direct result of our performance but also the performance of our healthcare partners. We are starting to track readmissions by location and identify where readmissions are really coming from at a more granular level.

In addition, to identify patients who are at high-risk for readmission, we have developed a risk-scoring tool that we use at discharge to assess potential risk factors, such as chronic conditions, multiple medications, and so forth. For those patients scored as being at high risk, we make follow-up calls and work to coordinate other services to prevent readmission.

Rotty: We have been implementing process improvement methodologies to examine quality and outcomes from an organizational perspective. We offer Lean training [a management philosophy based on the work of Toyota that emphasizes stripping out waste to enhance performance] across the organization and many employees have obtained their white belts and are now working toward a yellow belt. We have found that it gets people thinking about changing outcomes rather than just processes.

What advice do you have for other hospital executives as they manage the shift toward value in their own organizations?

Butrie: I cannot overstate the importance and value of piloting concepts around population management and value-based payment. Engaging in a pilot allows you to understand how everything works before you roll it out on a large scale. It can also help in negotiations with payers and employers.

Lee: We have found it essential to test ideas even if we don't have a perfect process to test, because you are never going to have a perfect process. Small trials allow you to identify the big issues to fix and keep you moving in the right direction so you don't spend all of your time aiming and not firing.

Rotty: I also think that organizations need to invest in infrastructure to navigate the coming payment landscape. Capital is needed for IT systems that foster clinical integration across the care continuum, education that focuses staff on process improvement, and data collection and billing systems that streamline workflow and offer business intelligence. Without strong infrastructure in place, an organization is going to have difficulty managing the shift toward value.

Lee: There is so much changing in health care right now, it is tempting to work on everything at once. Unfortunately, with that approach, you will do a lot of things, but none of them very well. I think organizations need to focus their attention on a few things, zeroing in on those that have the greatest positive effect on their facilities and patients. Although these priorities may be similar in general, the specifics are going to be different for every organization. Hospitals need to commit time to identifying their priorities and making plans to address them.

Johnson: My best advice? Get started. Not only are Medicare and Medicaid tying payment to quality outcomes and value, commercial payers are as well. Over the next few years, there is going to be significant dollars at risk. If you're not focused on getting your organization ready for value-based payment now, then you better shift your focus quickly. ■