

# Are You Ready for Value-Driven Health Care?



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**It's too late to read the handwriting on the wall when your back is up against it. —Anonymous.**

HFMA President and CEO Richard L. Clarke, DHA, FHFMA, captured the spirit of these words at HFMA's 2009 CFO Summit as he encouraged today's hospital leaders to focus not only on meeting next week's payroll, but also on the demands of the future.

President Obama believes that the nation cannot wait to tackle healthcare reform until the recession has neared its end. In the same way, noted Clarke, finance executives today must, despite economic turmoil, help prepare their organizations for the value-focused reforms to today's payment system that are sure to be a major component of this change.

Anticipated changes, challenges for providers, and strategies for preparation thus shaped the 2009 CFO Summit, an invitation-only event sponsored by Cerner. Through speaker presentations and roundtables, participants at the Phoenix event gave particular attention to:

- Use of episode-based pricing and payment to improve care effectiveness and efficiency
- Payer incentives to support enhanced physician and hospital alignment
- Strategies for instilling a culture of performance excellence

## ■ The Quest for Healthcare Value

Efforts to improve care coordination and efficiency can play a significant role in helping hospitals prepare for an increased focus on value, according to Francois de Brantes, CEO of Bridges to Excellence, a not-for-profit organization of employers, physicians, healthcare service providers, and other industry experts that supports provider innovations in healthcare delivery.

"What's getting the most attention from purchasers, policy-makers, and increasingly, some leading providers is episode-of-care pricing," he said.

Under such a structure, all services for an episode of care—physicians, labs, pharmacies, physical therapy—are bundled together to encourage team-based care and create joint responsibility among providers.

"Right now, 80 percent to 85 percent of care is delivered in nonintegrated systems," de Brantes said, noting that this lack of coordination of care can lead to excess spending.

"Across all types of episodes, chronic and acute, about 40 cents of every dollar goes toward potentially avoidable complications," he said. "Policymakers are starting to understand this waste and that it's possible to reduce complications by monetizing defects in care, which in essence means taking excessive variation out of the system."

Many seeking healthcare reform are examining ways reductions in excess spending could be used as an incentive to drive care improvement and efficiencies from providers. De Brantes pointed to the opportunities inherent in just one example, \$14,000 being spent on avoidable complications in treating a myocardial infarction. "That's more than a million dollars over 100 patients," he said. "What if providers could reinvest some of this money?"

Of course, the best way for structuring these incentives remains open to debate. Two options in particular have garnered considerable interest: Either stakeholders would agree themselves on a formula based on the intensity of services provided by the physicians and hospital relative to typical care, or an independent third-party would determine how the payment is divided.

De Brantes also noted that as care coordination improves, hospitalization volume is anticipated to decrease. "That's good for society—admittedly not good for the financial health of hospitals and everyone else on the receiving end under our current payment system," he said. "But the fact is we cannot continue as we have been." He added that the key to successfully bundling episodes will be creating the right mix of incentives to bind all the players together. Providers will need to focus on streamlining costs to prepare for the lower anticipated volumes.

Regardless of how structures for pricing and payment per episode of care ultimately shake out, it is still beneficial for today's hospitals to begin thinking about their revenue model in a slightly different way.

"Instead of just trying to fill a minimum number of beds, you should start thinking about the human and other capital you have and how to put that to use for physicians in the community for a price—maybe by leasing out some of your nursing staff—because the physicians are going to need help with resources," de Brantes said.

Like it or not, change seems inevitable. “Payment reform is not sustainable unless we can get consumers to engage in value arbitrage the way they do in all other walks of life,” explained de Brantes. “We’ve got to find a way to get consumers to shop, and episodes of care are really the only way to do that.”

## Payer Incentives for Aligning Physicians and Hospitals

As government and private payers seek opportunities for enhancing healthcare value through better quality and performance, a variety of programs are emerging to provide incentives for enhanced coordination between physicians and hospitals.

**Medicare Acute Care Episode (ACE) Demonstration.** The ACE project provides global payment for acute care episodes within Medicare fee for service (FFS). The global payment covers all Part A and Part B services, including physician services, pertaining to the inpatient stay for Medicare FFS beneficiaries. Goals of the three-year demonstration are to improve the quality of care for FFS Medicare beneficiaries; produce savings for providers, beneficiaries, and Medicare using market-based mechanisms; improve price and quality transparency for improved decision making; and increase collaboration among providers. Under the demonstration, participating hospitals have the option to reward individual clinicians, teams of clinicians, or other hospital staff who succeed with measurable clinical quality and efficiency improvements.

**Medicaid quality-focused projects.** The Centers for Medicare & Medicaid Services (CMS) also has developed a Medicaid/Childrens Health Insurance Program quality strategy. More than 50 percent of states offer some type of pay-for-performance (P4P) program where Medicaid provides payment incentives based on quality, access efficiency, or successful outcomes.

**Independent projects.** Some innovative providers and commercial payers are coming up with alignment projects of their own. One such pilot project is taking place at not-for-profit Integris Health, Oklahoma City, the state’s largest healthcare system.

When CMS changed the way HMOs are funded to a system relying on patient severity and regional adjustment factors with hierarchical condition categories, Integris worried

that the move would mean a return to capitation—once again giving physicians incentives to minimize utilization. So the health system’s leadership agreed to a proposal from United Healthcare, whereby hospital, health plan, and physician group could share in the gains of improved quality, clinical documentation, and care management efficiencies.

“We wanted to develop the opportunity to share with the physicians and commercial payer the benefits of being able to provide better care,” explained Greg Meyers, system vice president at Integris.

The program works by reducing the medical loss ratio and by driving top line revenue to the health plan through improved documentation. The hospital and physicians then work together to manage the patient population. Ideally, there’s a surplus left over as a result of improved accuracy of coding, more preventive care in physicians’ offices, case management to ensure appropriate use of delivery sites, and real-time sharing of data.

“The surplus is shared among the health plan, our hospitals, and employed physicians,” Meyers said. “There is a significant opportunity to exceed traditional Medicare FFS payments for both the physicians and our hospitals.”

Part of the reason Integris was eager for its hospitals to be in the equation is that its employed physician group never received the full benefit of the wealth of information the hospitals generate.

“We were leaving literally hundreds of thousands of dollars on the table by not closing that loop between hospital and physicians,” Meyers said. “So we sat down as a group one day and came up with a way to create a database that is fed by our clinical and financial systems and their electronic medical records (EMRs), which generate ongoing reports. This arrangement opened up lines of communication that were pretty well shut down, allowing the system and the physicians to understand the economics on each other’s side.”

But there have been other, spillover effects. By having everyone meet to discuss management of the care process, Integris has substantially improved its accuracy of documentation and verification of medical necessity. These efforts should serve the organization in being better prepared for recovery audit contractor reviews. Also, Integris has been able to create efficiencies in its contracts (largely fixed-rate

DRG arrangements) with other major payers that are intrigued by the team concept of managing care through the complete continuum.

Perhaps the biggest benefit recognized so far is the opportunity for improved follow-up with patients. Meyers gives the example of determining whether a patient is compliant with hospital instructions regarding medication use. “Home health representatives will follow up with patients to ensure compliance and communicate their status because everybody in the care continuum is committed to this,” he explained. “If we generate a surplus, everybody’s going to get a reward. We allocate a share back to the home health agencies, physical therapists, or any others who may be involved once a patient leaves the hospital.”

## Is Employer-Sponsored Coverage on the Way Out?

It’s a distinct possibility, according to some attendees. “Maybe the burden on employers has just become too great, and we’ll need to renegotiate that social contract,” said John Travis, FHFMA, CPA, director and solution strategist—regulatory compliance, Cerner Corporation, Kansas City, Mo. Or perhaps we’re moving toward more of a defined-contribution model, said Greg Meyers, system vice president, Integris Health, Oklahoma City, “where employers give employees a chip for \$4,000 and they select their own benefit plans. That gets the employer out of the whole liability issue and maybe helps cap their costs.”

In the meantime, however, it’s vitally important to get employers, health plans, and hospitals at the table.

“Companies are going out of business, so insurers can’t drive premiums much higher,” noted Joe Fifer, FHFMA, CPA, vice president of finance, Spectrum Health, Grand Rapids, Mich. “Therefore there is a need to improve quality, which should drive down our costs. Because right now, very few employers ask about quality; they seem to assume that it’s a given.”

What’s still missing, Meyers said, is the third dimension: “We’re focusing on cost and quality, but what about service? Are we really meeting the needs of the patient?”

Referring to a recent study by Mayo Clinic that projected the move from pay for performance to pay for value, Meyers said the whole idea in doing this project with United Healthcare is to try and make Integris the value provider in a very competitive marketplace. “The traditional P4P programs focus on processes; pay for value allows you to focus more on outcomes and satisfaction.”

## ■ Creating a Culture of Quality

Regardless of whether a provider participates in innovative pricing or partnerships as a means to enhance value, a variety of strategies are available to instill a culture of high quality and performance excellence.

Ardent Health System, a Nashville-based for-profit company that owns or operates 10 acute care hospitals, two multispecialty physician groups, and a 220,000-member health plan, has made an organizational commitment to quality. The following tenets are described as key to its value-driven culture.

**Quality should be a top-of-mind issue throughout the organization.** Ardent seeks to “achieve for each of our patients the best possible healthcare outcome.” This mind-set isn’t just the right thing to do, but it’s financially prudent as well, according to Steve Landgarten, MD, chief medical officer.

Higher cost doesn’t necessarily mean higher quality. Actually, there’s some evidence to the contrary. “The highest quality care is probably the most efficient and therefore has a lower cost,” Landgarten said. “As much as 30 percent of our clinical inputs cannot reliably be related to a favorable clinical outcome—it’s redundancy and waste. So we need to create a link between financial and clinical operations.”

**Processes and systems need to promote quality.** Fundamental ways in which Ardent demonstrates its pursuit of quality include making evidence-based medical practice the clinical standard and seeking to prevent adverse outcomes, eliminate never events, improve medication safety, and satisfy customers with a culture of attentive compassion.

**Metrics need to be measured and reported and tied to goals.** Measuring performance relating to specific quality-driving processes and comparing these data with internal and external benchmarks are important actions, noted Ardent CFO, Kerry Gillespie, FHFMA. For example, it's not enough to simply want a culture of attentive compassion and customer loyalty. Ardent develops metrics based on national norms for such things as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and Net Promoter Score and then shares performance on these metrics to drive service excellence. Executive compensation also is tied to performance on these metrics to ensure organizational commitment to the process.

Landgarten notes that when identifying metrics, those quality-driven areas with payment attached should warrant particular attention. "Where we're being paid externally based on a quality guideline, we want that quality guideline to be part of the methodology by which we measure ourselves as an organization, and by which we measure individual physician performance and we report it back to the physicians," he said.

**Clinical outcomes should be recognized as a principal driver of financial outcomes.** Landgarten stressed that everything medical staff leadership can achieve clinically is dependent on the trust of financial leadership that front-loaded investment in operating expense will have an ROI. CFOs need to know up front, said Landgarten, "that the ability to reduce hospital-acquired infections carries with it front-loaded cost, and that the net margin benefit may be three, six, or even 12 months away."

**Incentives must be aligned.** Again, issues of incentive alignment arise. Ardent has been given the go-ahead from CMS to join the three-year ACE project in orthopedics and cardiac care in its Tulsa market and orthopedics in its Albuquerque market.

The idea is to create value-based care centers by aligning incentives between hospitals and physicians via global pricing and cost-saving initiatives—and give Medicare beneficiaries an incentive to use them, explained Gillespie, noting that CMS will share 50 percent of its savings with beneficiaries, up to the amount of their Part B premium.

"The project will help us reduce the cost of care, because there's a built-in opportunity for gainsharing, without having

## Using Data to Drive Quality

"The point isn't so much how we measure or what we measure," said Sabbir Dadabhai, vice president and CFO, Redlands Community Hospital, Redlands, Calif. "It's whether the information is correct, and whether we are using the information to effect change."

Various people described reporting mechanisms designed to keep quality at the forefront and hold both clinical and financial leaders accountable, including:

- Drilling down to the individual physician level and making that quality data transparent and readily available
- Updating dashboards on patient satisfaction weekly
- Sharing report cards with physicians
- Expanding monthly operating reports to include quality scores, risk assessments, and action plans along with financial indicators
- Including the chief medical officer and chief nursing officer in department operational reviews and talking about engagement scores, customer experience scores, and new performance improvement initiatives as well as finances and operations
- Having the CFO round with clinical leaders and attend certain clinical meetings
- Putting quality measures first, on the organization's scorecard and when reporting to the board

to go through the relative arduous process of getting OIG [Office of Inspector General] preapproval. In the ACE demonstration project, physicians are allowed to share in cost savings achieved through better coordination of care between the physicians and the hospital, along with receiving public recognition for their participation," Gillespie said.

## What Does the Industry Need to Progress on Value?

Although much progress is being made at the individual level to improve value of healthcare delivery, some challenges still need to be addressed before widespread efforts truly take hold. In discussing the healthcare industry's need to prepare

for value-focused reforms, several senior financial executives suggested the following as keys to bringing about significant progress in clinical and financial performance.

**Need for improved funding of IT systems.** When considering a large-scale value-focused initiative, it's natural to ask whether the components driving value—the emphasis on quality and the meshing of clinical and financial goals—will work without truly great IT systems. As Ardent's Kerry Gillespie put it, "I don't know if the infrastructure is the key to making the process work, but without that infrastructure, we won't even know if it's working."

Doug Kell, HFMA, CPA, director of financial analysis and budgeting, Carondelet Health System, Tucson, Ariz., noted that transparency of information is central to correcting behaviors, and for that you need systems that create the flow of high-quality information through the loop. "The problem is that often the price tag for such capability is too big," he said.

The issue is deeper than funding, according to Greg Meyers with Integris. "I think there will be incentives in the stimulus bill and other legislation to help us catch up with the rest of the world. But just throwing a bunch of money into a black box is not going to make things any better," he said. "You have to have an infrastructure that measures quality and that appropriately defines episodes of care, so that clinicians and managers have a standard to measure themselves against."

Meyers challenged technology providers to "develop tools that help us effectively measure the inputs and outputs of clinical care."



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Quantitative documentation and reporting of clinical quality measures as well as financial performance requires strong IT going forward, he said: "And not standalone, diffused technology—but integrated technology that ties all of these disparate pieces together and gives providers a better handle on costs and pricing as well as what is meant by performance. This is the only way to provide value to consumers."

**The importance of recognizing—and then committing—to a long-term investment.** Willingness of the financial team to embrace change to the business model can be a challenge, noted Dennis Dahlen, CPA, senior vice president of finance, Banner Health, Phoenix. "A strategy we have found to be successful has been making a commitment to change the way we deliver care first, and then using that resolve and organizational drive to entice our medical staff's buy-in," he said. "This ultimately has helped our finance staff to recognize the potential for success with these changes."

Even when significant technology investments are recognized as important for reducing costly medication errors and improving efficiencies, organizations often must see the projects through for any ROI to materialize. Making such a long-term commitment can be difficult.

"With the recent capital market disruptions, we've asked ourselves whether we should continue with the remaining capital investment we need to get through a full CPOE [computerized provider order entry] implementation," Dahlen said. "We are probably 80 percent of the way there, so we quickly recognized that we really couldn't realize the ROI—the true clinical quality and financial benefits—until getting 100 percent in. So I think leadership's resolve to finish the project, even when the going gets difficult, is important."

**Tying in consumers.** Those in health care need to do a better job educating consumers, said John McGuire, executive vice president, St. Anthony's Medical Center, St. Louis, Mo. "The public thinks we're actually getting paid our charges," he said. "So this is not going to be easy. This is going to require a significant culture change."

Data depicting areas of quality and performance need to be not only transparent but also meaningful to consumers. The further step of linking this quality information to pricing—and, perhaps more important, to the consumer's

out-of-pocket expense—is key for a true value depiction and market differentiation.

**Ensuring savings are real.** Will savings through enhanced quality be dark green? That is, will they relate to costs that you can actually track and pull out of the system versus costs that don't directly fall to the bottom line? "We've all seen it over and over with cost-saving projects," HFMA's Richard Clarke said. "The cost just shifts over to some other place. Sustainable change that reduces cost overall is key." For the healthcare industry to truly embrace value-driven reforms, savings through efficiencies and clinical effectiveness will need to be recognized in a way that supports the process shifts and technology investments used to derive them.

## ■ Case Study: Value in Practice

With these tenets and challenges in mind, the next question naturally turns to what exactly development and implementation of an organizationwide value-driven initiative might look like. And although it's easy to dismiss value-driven initiatives founded in heavy IT investment and significant process change as beyond the reach of all but the largest providers, that doesn't have to be the case.

James R. Childers, FHFMA, CFO of Cobre Valley Community Hospital in Globe, Ariz., described his organization's experience. The 25-bed facility approached its dedicated value initiative in 2007 with what he terms as "a vision of the marriage between quality and reimbursement."

Led by its CEO and with the aid of an external consultant, Cobre Valley developed a strategy map for the organization and began to develop criteria to support being the best in service, quality, people, and practices. Childers outlines the major actions undertaken by the organization below.

**Establishing standards.** A quality team with the aid of an external consultant developed and identified standards for optimal work practices, organizational structures, and service efficiencies. Key to success was input from frontline staff.

**Integrating standards into day-to-day work life.** These standards were then incorporated into performance evaluations and executive compensation to ensure standards were instilled in the organization's culture. "We now require a signature accepting the standards on all job applications," noted Childers.

**Providing education.** To lay a solid foundation for change, education about the standards and their importance was provided throughout the organization, not just at the staff level but with the board, physicians, and management.

**Developing organizational structures of support.** Cobre Valley reenergized its quality council and created a new director of quality position.

**Creating scorecards.** Performance-driven scorecards are reviewed monthly in a formal meeting of the entire management team. These scorecards include HCAHPS measures as well as internal quality measures.

**Forming and training a revenue cycle team.** The organization placed increased emphasis on billing accuracy and payment. This includes new managers in most revenue departments and a focus on improving cash flow and reducing the hospital's investment in receivables.

"Our goal is to collect for our services," Childers said. "As a result, our hospital operates with double-digit operating margins and EBIDA [earnings before interest, depreciation, and amortization], which we're able to sustain because we achieve both our quality and revenue cycle indicators."

**Supporting process change and improved hospital-physician relationships with technology.** The cornerstone of the entire initiative is a five-year IT strategic plan, which is designed to bring the entire medical community together.

"We installed PACS [picture archiving and communication systems] in 2006, and order entry and scheduling in 2007," Childers said. "We have an EMR and real-time nursing documentation. We have developed a patient care inquiry model so all our community physicians can access patient records and review results as they need to from their offices or homes. The last piece, CPOE, should be in place in 2010."

## ■ Lessons Learned

The motivation for value demonstration is clear: As more comparative data about providers are placed before the public, demonstration of quality and performance becomes a matter of survival.

With this in mind, several lessons can be learned from those engaged in formal value-driving pursuits.

→ Leadership is essential to changing the culture of an

organization, specifically the engagement of the CEO. But the CEO can't do it alone. He or she needs support from the board and other members of the executive team, including the CFO. It's the role of finance to support and encourage the CEO in quality initiatives, because at the end of the day, quality will make a huge difference in the sustainability of the business.

The CFO and finance staff can also play a major role in helping determine what investments are needed to instill quality into the organization over the long term. This includes capital allocation and deployment of resources.

- The job ahead requires three components—people, process, and technology—working together. As Christine Sarrico, FHFMA, vice president and CFO, Enloe Medical Center, Chico, Calif., noted: "A lot of clinicians look to technology to take the error out of what they do. But while technology can absolutely enhance quality, it will never replace people and process. So we have to try to balance that investment." (One attendee provided a good real-world example: Following a very serious medication error, an organization is investing several million in pumps that provide hard stops on medication. What's gotten lost, however, is that the existing pump had a warning that more than one clinician overrode.)
- Those in health care are better able to measure quality today and to justify changes needed to meet community standards. But the industry generally still needs help in measuring and in presenting the data in a way that actually demonstrates the relationship of cost and quality.



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- The patient is where high-quality care needs to start and end; if healthcare providers keep the patient as true north at every step along the way, they won't go far astray. This means hospital administrators have to push past preconceptions that may say physicians are impossible to control and therefore work with. Hospitals can't build a culture of quality without physician engagement, and the industry can't make episode-of-care pricing work without physician buy-in.

As government, insurers, and consumers provide greater incentive for value-driven care, providers need to be prepared. Whether reviewing physician alignment strategies or prioritizing technology investments for improved data gathering and reporting, today's hospitals should assess their readiness for marketplace change founded in value. Those recognizing the urgency with which the industry must begin communicating improved quality and performance will be best positioned for the future—and less likely to find themselves backed against a wall.



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