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5 strategies for building a top-performing hospital

To be competitive under value-based business models, hospitals should build meaningful scale and scope, and they should focus on integration, cost, quality of care, and customer service.

Hospital strategy has changed dramatically in the past few years, driven in large part by measures in the Affordable Care Act (ACA) and the move toward value-based business models in health care.

Today's hospital leaders must manage to existing incentives while preparing for future challenges, such as the shift from fee for service to pay for performance, the transition toward more integrated care delivery and population health management, and the adoption of more patient-centric models of care delivery and management. This transition comes at a time when unemployment rates are high, financial stresses for hospitals are growing in magnitude, and demand for

healthcare services has increased (see the sidebar on page 2).

Hospitals should take steps now to better position themselves for the changes that are transforming the healthcare industry. Strategic objectives that hospitals should pursue to achieve success under healthcare payment and delivery reform include:

- > Building meaningful scale and scope
- > Focusing on more integrated care delivery and management
- > Attaining demonstrably high levels of clinical quality
- > Differentiating from the competition through superior customer service
- > Establishing a competitive cost position

Building Meaningful Scale and Scope

Establishing scale has become an increasingly important competitive strategy for hospitals and health systems due to declines in revenue growth, deteriorating payer mixes, consolidation in multiple sectors that has diminished the market position of some healthcare organizations, and expense increases that are outpacing payment.

Many hospitals and health systems are creating scale through geographic expansion, reaching beyond traditional service-area boundaries to provide care and service to patients in affluent and growing communities. Geographic growth strategies have taken many forms, including the

AT A GLANCE

A hospital's strategy for attaining high performance under value-based business models should focus on five key objectives:

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- > Focusing on more integrated care delivery and management
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development of facilities and primary care networks outside an organization's traditional service areas and acquisitions of or affiliations with existing providers in new markets.

Expanding an organization's geographic reach can mitigate competitive risk across markets, while achieving greater scale can improve the organization's access to capital and lower the costs of securing capital. In some markets, hospitals and health systems also are using scale as a defensive strategy to mitigate the negotiating leverage of an increasingly consolidated insurance industry.

Larger hospitals and health systems achieve economies of scale by making high-volume or bulk purchases, driving increased operational efficiency through specialization, and concentrating services and treatments for a particular condition in one location. Large systems also benefit from scope economies when care competencies such as care management are used to effectively and efficiently deliver services across multiple sites. For example, coordination of care among acute and post-acute settings can reduce hospital readmissions, avoiding payment penalties while improving the patient experience.

Partners HealthCare in Boston participates in the Institute for Healthcare Improvement's State

Action on Avoidable Rehospitalizations (STAAR) initiative. The goal of STAAR is to reduce avoidable readmissions by engaging multiple stakeholders—caregivers, payers, and patients and their families—in improving transitions in care. Partners' goal is to reduce avoidable readmissions by 30 percent over three years by coordinating care across eight post-acute care sites and a home healthcare agency. Partners' approach focuses on exchanging relevant patient information, educating and coaching patients, and engaging acute-care providers during the post-acute stage of care management and delivery ("Maximizing the Value of Post-Acute Care," *TrendWatch*, American Hospital Association, November 2010).

Achieving Real Integration

Successful hospitals and health systems recognize that positioning their organizations to achieve greater scale and scope is necessary in an era of reform, but this strategy alone will not make them more competitive. The shift in financial and utilization risk from payers to providers, and the associated changes in care delivery models that will result from healthcare reform, require access to and integration of a broad scope of services beyond the traditional focus on inpatient acute care.

Integrated care management and delivery can provide benefits such as increased volume and referrals, optimized payment under value-based payment programs, and lowered costs from reducing unnecessary utilization and providing care and service in less intensive (and expensive) settings. Improved patient satisfaction—often in response to reduced fragmentation and enhanced coordination of care—and the potential to improve health outcomes through care delivery models organized around the patient rather than the hospital also are key benefits.

Integration strategies employed by high-performing hospitals and health systems include:

- > Expanding lower-cost, geographically distributed primary and ambulatory care services to improve access to care

Environmental Stresses on Hospitals

A number of environmental factors are putting added stress on hospitals:

- > A slow economic recovery and high rates of unemployment have resulted in reduced healthcare benefits and fewer commercially insured patients.
- > Federal and state budget deficits have led to flat and declining payment rates from governmental payers. Commercial payers have limited their payment rate increases as well.
- > An increasing number of financially fragile independent hospitals and physician practices are moving toward consolidation.
- > Increased demand for services from an aging baby boomer population and from newly insured patients are taxing hospital and health system resources.

How McLaren Health Care Is Achieving Greater Scale

McLaren Health Care in Flint, Mich., is an example of an integrated healthcare system that is positioning itself to achieve greater scale to better compete in an era of reform. It's a strategy the organization has undertaken despite the economic pressures of the region.

The economy has been slow to recover in Michigan. Unemployment rates are high, per capita personal income is low, and rates of growth lag national averages. Meanwhile, the state's Medicaid resources are stretched thin.

McLaren began as a single hospital, McLaren Regional Medical Center, and has grown primarily through acquisition of other hospitals and geographic expansion along the two major interstates that run through its service area in central and northern Michigan. Today, the system encompasses 11 hospitals and a full continuum of care that includes long-term care, home health care, behavioral health, physician services, and a health plan. The health system has doubled operating revenue in the past six years, from \$1.1 billion in 2006 to \$2.1 billion in 2011, and received AA ratings from Moody's Investors Service and Fitch Ratings earlier this year.

McLaren's most recent acquisition this past August was not of a hospital, but a health plan: Care Source Michigan, a 34,500-member Medicaid health maintenance organization (HMO). The transaction expands the number of counties covered by McLaren's existing HMO, McLaren Health Plan, from 30 to 50 counties. It also provides future growth opportunities in the Medicaid market in 2014, when Medicaid

eligibility will be expanded as part of the ACA. The larger customer base could further promote economies of scale and reduce administrative expenses per enrollee.

McLaren's vision for growth is to double in size, expanding its reach to contiguous states such as Indiana, Ohio, and potentially Illinois. Health system leaders have developed a disciplined approach for assessing and integrating new system members. McLaren develops a value scorecard prior to acquisition of a hospital, identifying the annual recurring revenue gains and expense savings that both parties will commit to as a result of the acquisition. Some of the most common areas of focus in the value scorecard are shown in the exhibit below.

Once the value scorecard is complete, a 90-day integration action plan is developed and implemented. The plan includes action steps related to communications, finance, operations, human resources, IT, organizational integration, and corporate structure/board governance integration. It is developed and implemented by the individuals who are accountable for successful integration in each area, which increases leaders' incentive and ability to execute the integration process in a timely and effective manner.

To further support effective integration of new members and enhance clinical decision making and care management across the system, McLaren is nearing completion of an initiative to replace its existing clinical and financial information systems with a single platform.

MCLAREN HEALTH CARE VALUE SCORECARD: AREAS OF FOCUS

Revenue Gains	Expense Savings
Physician recruitment and network development	Purchasing
Clinical program development/synergies	Productivity gains
Managed care contracting	Administrative and general services
Revenue cycle improvement	Clinical support and corporate overhead services
	Debt refinancing

- > Using telemedicine to monitor and manage chronic illnesses and conditions
- > Tightly aligning with physicians to develop and implement effective care delivery models and lead the patient care team in coordinating and managing care across the continuum
- > Supporting integrated care management and delivery with robust clinical and financial information systems

One care delivery model that incorporates many of these strategies is the patient-centered medical home (PCMH). This approach has demonstrated promising results as a vehicle for organizing and integrating components of the care continuum while improving the patient experience, improving quality outcomes related to population health, and reducing the cost of care.

The Agency for Healthcare Research and Quality (AHRQ) defines the PCMH as a model of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. Adoption of the PCMH has become widespread among major insurers and most state Medicaid and children's health insurance programs (both as funding sources and participants), as well as among thousands of physicians and practices nationally.

A recent review of cost and quality results for more than 30 PCMH initiatives reveals a favorable impact on health outcomes and quality of care, patient and healthcare provider experiences, and the reduction of unnecessary hospital and emergency department utilization (Nielsen, M., et al., *Benefits of Implementing the PCMH: A Review of Cost and Quality Result, 2012*, Patient-Centered Primary Care Collaborative). The exhibit on page 5 provides a sample of the cost and quality results for five PCMHs.

Attaining Demonstrably High Levels of Quality

The ability to outperform peers and consistently improve quality over time is critical for hospitals

so that they may avoid potential losses of revenue under value-based business models.

Readmission penalties are the most significant quality challenge that will impact hospital and health system finances in the near term. Data released by CMS in July 2012 indicated hospital readmission rates for myocardial infarction (MI), heart failure, and pneumonia had less than a 0.1 percent point change between the current three-year measurement period (2008-11) and the prior three-year interval (2007-10), with MI and heart failure rates decreasing and pneumonia rates increasing.

The Centers for Medicare & Medicaid Services (CMS) Hospital Readmission Reduction Program places hospitals at risk for up to 1 percent of the organization's total revenue if they perform worse than expected compared with the national average on these three readmission rates. Effective October of this year, 2,200 hospitals began to lose a portion of this payment. Despite the financial penalties, a recent study indicated that hospitals' implementation of best practices associated with lower readmission rates has been variable (see the exhibit on page 6).^a Poor performance on quality measures may also jeopardize an organization's reputation and brand, given the increased public reporting requirements and associated transparency and availability of data on clinical quality and service.

Although quality improvement initiatives may lower the cost of care through reduced utilization and shifting of care to less intensive and less costly environments, most of these measures do not address the cost change needed to manage population health rather than episodic care. Until better information is available to measure changes in health status

a. Bradley, E.H., et al., "Contemporary Evidence About Hospital Strategies for Reducing 30-Day Readmissions: A National Study," *Journal of the American College of Cardiology*, published online July 18, 2012.

COST AND QUALITY RESULTS FOR FIVE PATIENT-CENTERED MEDICAL HOMES

Initiative	Healthcare Cost and Acute Care Service Outcomes	Health Outcomes and Quality of Care Results	Years of Data Review	Report Type
Colorado: Colorado Medicaid and SCHIP*	> \$215 lower per member per year for children	> Increased provider participation in CHIP program from 20% to 96% > Increased well-care visits for children from 54% in 2007 to 73% in 2009	2007-09	Peer-reviewed article: <i>Health Affairs</i>
Florida: Capital Health Plan (Tallahassee) 2012†	> 40% lower inpatient hospital days > 37% lower ED visits > 18% lower healthcare claims costs	> 250% increase in primary care visits	2003-11	Institute for Healthcare Improvement report
Oregon: CareOregon Medicaid and Dual Eligibles (Portland)	> 9% lower PMPM costs‡ > Reduced PMPM costs by \$89‡	> Better disease management among diabetics in one clinic: > 65% had controlled HbA1c levels versus 45% pre-PCMH#	2007-09	Commonwealth Fund press release
Pennsylvania: Geisinger Health System Proven-Health Navigator PCMH model (Danville) 2010, 2012	> Reduced hospital length of stay by half a day > 25% lower hospital admissions > 50% lower readmissions following discharge > 18% reduced inpatient admissions > 7% lower cumulative total spending§ (2005 to 2008) > Longer exposure to medical homes resulted in lower health care costs –7.1% lower cumulative cost savings (from 2006 to 2010) with an ROI of 1.7	> Improved quality of care: –74% for preventive care –22% for coronary artery care –34.5% for diabetes care	2005-10	Congressional testimony, PCPCC Outcomes Report, peer reviewed journal: <i>American Journal of Managed Care</i>
South Carolina: BCBS of South Carolina (Palmetto Primary Care Physicians) 2012**	> 14.7% lower inpatient hospital days > 25.9% fewer ED visits > 6.5% lower total PMPM medical and pharmacy costs		2008-11	BCBS industry report

Source: Obtained from *Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost & Quality Results, 2012*, Patient-Centered Primary Care Collaborative.

* Takach, M., "Reinventing Medicaid: State Innovations to Qualify and Pay for Patient-Centered Medical Homes Show Promising Results," *Health Affairs*, July 7, 2011.

† Report from Tallahassee Memorial HealthCare on Enhancing Continuity of Care, Institute for Healthcare Improvement, Aug. 1, 2011.

‡ Klein, S., and McCarthy, D., *CareOregon: Transforming the Role of a Medicaid Health Plan from Payer to Partner*, The Commonwealth Fund, July 22, 2010.

Miller, J., "Unlocking Primary Care: CareOregon's Medical Home Model," *Managed Healthcare Executive*, May 1, 2009.

|| *Reforming the Healthcare Delivery System*, Geisinger Health System, Presentation to Committee on Finance, United States Senate, Washington, D.C., April 21, 2009;

and Grumbach, K., and Grundy, P., *The Outcomes of Implementing Patient-Centered Medical Home Interventions: A Review of the Evidence on Quality, Access and Cost from Recent Prospective Evaluation Studies*, Patient-Centered Primary Care Collaborative, Nov. 16, 2010.

§ Gilfillan, R., Tomcavage, J., Rosenthal, M., Davis, D., Graham, J., and Roy, J., "Value and the Medical Home: Effects of Transformed Primary Care," *American Journal of Managed Care*, August 2010.

** BlueCross BlueShield Association, Patient-Centered Medical Home Snapshots.

based on the outcomes of care, perspectives on the value of care provided are speculative.

Providing Superior Customer Service

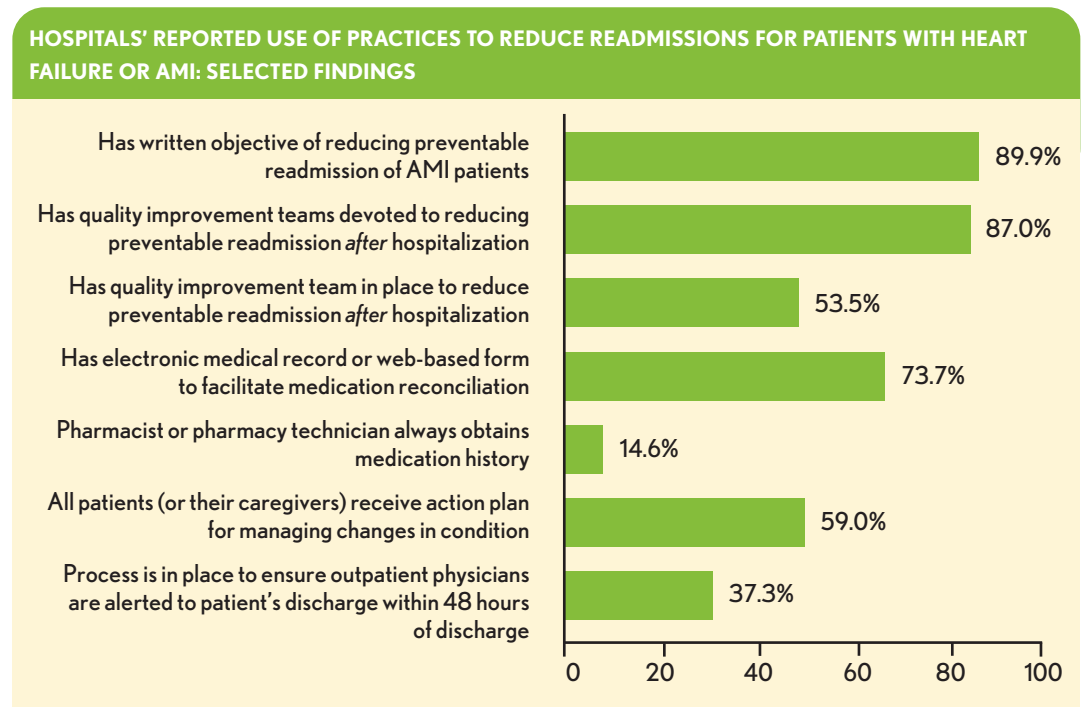
Achieving customer service excellence is another strategic imperative for high-performing hospitals and health systems. High levels of patient satisfaction are important to attract well-insured patients for both high-growth outpatient services and a shrinking pool of elective procedures where patients may shop for healthcare services.

The top determinants of patient satisfaction across inpatient, outpatient, and community-based care settings relate to communication (responsiveness and attentiveness to patient problems, sensitivity to personal and emotional needs), access to care (wait times), and care coordination (collaboration in care), according to the 2011 Press Ganey report. A study by the Medical Group Management Association found that using feedback from patient satisfaction surveys to educate providers about the importance of positive

behaviors and communication resulted in an increase of 7 percent more revenue per physician FTE (*MGMA Performance and Practices of Successful Medical Groups: 2011 Report Based on 2010 Data*).

The cost of patient dissatisfaction also should be considered. Industry experience indicates that a dissatisfied patient will tell 25 others about his experience. Behind every dissatisfied patient who complains, there are 20 dissatisfied patients who do not complain, only one of whom will return for care (Cunningham, L., "Calculating the Return on Investment of Great Service to Employees," Studer Group, May 16, 2012). In sum, creating a positive care experience accrues direct benefits to the organization and is a driver of positive clinical quality outcomes.

High-performing health systems have developed a transformational culture of quality that is patient centered with accountability for results, as well as a disciplined approach to implementing



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strategies intended to achieve exceptional versus incremental improvements. Best practices associated with high-performing health systems include the following:^b

- > Presence of a systemwide strategic plan for quality and safety, with measurable goals that are linked with operating and financial performance
- > Aligned quality goals and incentives, with individual performance accountabilities and compensation for administrative and physician leaders across the system
- > Leverage of data and measurement across the organization to set and monitor quality goals, populate and use dashboards to increase transparency of results, and promote timely identification of variances so that action to address problems may be taken quickly
- > Standardized care processes and active dissemination of best practices across the health system, including provision of staff education and skills development

Establishing a Competitive Cost Position

Industry observers have estimated that hospitals and health systems will need to reduce direct costs per case by as much as 25 percent as expense increases outpace the rate of revenue growth payer mixes shift. This revolutionary call to action will require more than traditional cost-reduction initiatives, such as supply chain management, capital spending freezes, and reductions in force. Instead, what is called for is a fundamental restructuring of the cost base by redesigning care delivery and administrative processes and functions.

This approach is consistent with bundled payment models that provide a single payment for multiple providers to cover all services in a patient's continuum of care, thereby aligning

incentives for participating providers, with the goal of improving quality of care and efficiency.

A number of alternative approaches to improving quality while reducing costs are emerging. Early results from CMS's Acute Care Episode (ACE) Demonstration program are promising (Herman, B., "2 Major Lessons from CMS's Bundled Payment ACE Demonstration," *Becker's Hospital Review*, April 3, 2012). Under this program, bundled payment includes all Medicare Part A and Part B services, including physician services related to cardiovascular and/or orthopedic treatment.

Participating hospitals are paid a negotiated discount on fee-for-service rates, in addition to rewards for improving clinical quality and efficiency. Results achieved by Hillcrest Medical Center in Tulsa, Okla., and Lovelace Health System in Albuquerque, N.M., during the first two years of the program are striking: Hillcrest estimates it has saved \$1.59 million in cardiac and orthopedic services, based in part on adjusted payment rates and decreased readmission rates and LOS. And the combined savings on orthopedic implants for both hospitals is expected to reach \$300,000 annually. Keys to success include using the bundled payment framework to identify ways to reduce variation in care and improve quality by actively engaging physicians in managing these service lines.

Blue Cross Blue Shield of Massachusetts' (BCBSMA's) Alternative Quality Contract (AQC) began its five-year term in 2009. In partnership with 11 participating physician groups, the AQC takes responsibility for the full continuum of care for participating consumers, regardless of where the care is provided. The payment model combines a per-patient global budget with significant incentives for improving quality of care. Through this program, healthcare spending decreased an average of 2.8 percent over two years compared with spending in nonparticipating groups (Song, Z., et al., "The 'Alternative Quality Contract,' Based on a Global Budget, Lowered Medical

b. Yonek, J., Hines, S., and Maulik, J., *A Guide to Achieving High Performance in Multi-Hospital Health Systems*, The Commonwealth Fund, March 29, 2010.

Spending, and Improved Quality,” *Health Affairs*, July 2012). Savings resulted from shifting procedures to lower-priced facilities and reducing utilization. Quality of care also improved in the areas of chronic care management, adult preventive care, and pediatric care.

These examples, as well as the improvements in cost and quality outcomes recorded by PCMHs, support the following strategies for establishing a competitive cost position while maintaining or improving quality:

- > Reduce undesirable or inappropriate practice variation by adopting evidence-based practices and standardized protocols.^c
- > Eliminate care that is unnecessary or avoidable by providing routine wellness and preventive care, seamless transitions between care settings, and improved management of care by a team of health professionals led by the primary care physician.
- > Provide care in the least intense and lowest-cost medically appropriate setting.
- > Develop and adopt innovative care delivery models, such as PCMHs, that focus on improving population health through disease management and greater patient engagement.

Key Competencies and Capabilities

The amount of change taking place through the industry will place substantial demands on healthcare leaders as they manage to the current and emerging set of incentives while preparing

c. Researchers at Dartmouth have documented significant variation in spending per Medicare beneficiary and support this approach (see *Report of the Task Force on Variation in Health Care Spending*, American Hospital Association, Jan. 10, 2011).

for more change ahead. Successful execution of these strategies will require strengthening existing organizational and leadership competencies and developing new skill sets.

Change management skills will be needed to lead the process and behavior change that will be required in organizations to succeed in an era of reform. Commitment to innovation and a willingness to break new ground will be essential to creating care delivery models and approaches that promote improved health outcomes and reduce the overall cost of care. Collaboration with other providers, physicians (both inside and outside the organization), payers, employers, and consumers to improve care coordination and care management across the continuum will be especially critical.

During periods of great change, when uncertainties are pervasive and risk abounds, the temptation to wait and see how things will play out can be powerful. However, planning amid change—driven by constant monitoring of emerging successes and leaders’ willingness to step forward and ensure that resources are being leveraged to meet the needs of all stakeholders—can and must occur if hospitals and health systems are to survive in an era of reform. ●

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