Healthcare Transformation:  
*Collapsing Silos to Optimize Outcomes*
Objectives

• Review CMS Healthcare Transformation Targets and Measures

• Analyze why the shared responsibilities and goals impacts outcomes

• Demonstrate how a collaborative care model closes the gaps in delivery of care
Understanding Healthcare Changes Requires Complex Thinking

“Step out of your Comfort ZONE”
Define Value in Healthcare?

• Value is defined as outcomes

• *Value should always be defined around the customer*, and in a well-functioning health care system, the creation of value for patients should determine the rewards for all other factors in the system.

Cost reduction without regard to the outcomes achieved is dangerous and self-defeating, leading to false “savings” and potentially limiting effective care.
Patient Centric Value Proposition

- The average U.S. hospital has an operating margin of only 2.8 percent.

- Factor in CMS Risk and Liability Programs as mandated by health care reform, 9-11%.
  - Fiscal year 2013 (that's October 2012), Medicare began withholding 1 percent of reimbursement to create an incentive payment fund that rewards quality performance.
  - Approximately $850 million in Medicare payments redistributed, with hospitals fighting to win back those dollars based on a set of quality performance indicators.

- Clearly, this new paradigm requires a new focus, bringing into balance both financial performance and patient outcomes.
The Situation

- Dwindling Medicare fund
- Increasing demand, fewer “paying in”
- CMS needs to control cost, ensure quality
- Moving to align payment with performance
Healthcare Transforming From Inputs to Outputs

Health System Strategy, 2003
Old Era: “Growing Volume”

Inputs: Quantity
- Secure Prime Pricing
- Securing Access to Care
- Departmental Goals
- Contracts
- Niche Markets

Health System Strategy, 2013-2023
Emerging Era: “Value-Based Growth”

Outputs: Quality
- Attract Key Decision Makers
- Expand Access
- Comprehensive Care
- Compete on Outcomes
- Population Health

Key Stakeholders
ALL: Collaborative Care Model
**US Quality and Cost Drivers**

![Bar chart showing annual health care spending for patients with selected chronic conditions, BCBSM, 2008](chart1.png)

### Table: U.S. Health care spending breakdown, 2010

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition Specific Amount</th>
<th>Total Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congestive Heart Failure</td>
<td>$92,263</td>
<td>$41,058</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>$16,012</td>
<td>$16,012</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>$11,666</td>
<td>$11,666</td>
</tr>
<tr>
<td>Chronic Obstructive Lung Disease</td>
<td>$12,118</td>
<td>$12,118</td>
</tr>
<tr>
<td>Mental Disorders (including Dementia)</td>
<td>$11,101</td>
<td>$11,101</td>
</tr>
<tr>
<td>Diabetes</td>
<td>$10,491</td>
<td>$10,491</td>
</tr>
<tr>
<td>Asthma</td>
<td>$1,797</td>
<td>$1,797</td>
</tr>
<tr>
<td>No Selected Chronic Conditions</td>
<td>--</td>
<td>$2,781</td>
</tr>
</tbody>
</table>

*Source: Center for Medicare and Medicaid Services*
2013 CMS Transitions to Paying for Quality
Hospital Quality Reporting vs. Value Based Purchasing

**Hospital Inpatient Quality Reporting Program**

- Data Submission

2003 – Department of Health and Human Services developed Hospital Inpatient Quality Reporting (IQR) Program which requires hospitals to submit quality measures.

- Conditions include: acute myocardial infarction (AMI), heart failure (HF), pneumonia (PNE), surgical care improvement project (SCIP)

- Indicators include: process measures and patient experience 30-day mortality and readmission rates, patient safety indicators

Eligible hospitals that do not participate will receive an annual market basket update with a 2.0 percentage point reduction.

**Value-Based Purchasing (VBP) Program**

- Pay-for-Performance

2011-Congress authorized the hospital inpatient Value-Based Purchasing (VBP) Program through the Affordable Care Act. Initiative that rewards acute-care hospitals with incentive payments for the quality of care

- Built on the Hospital IQR measure reporting infrastructure.

- Hospital IQR measures that have had results published on Hospital Compare* for at least one year

- Funded by a 1% reduction from participating hospitals’ base operating diagnosis-related group (DRG) payments for FY 2013, increasing to 2% by FY 2017

- In FY 2013, about 1% of DRG payments to eligible hospitals will be withheld to provide the estimated $850 million necessary for the program incentives. Following is the schedule for future withholding:

  - FY 2013: 1.00 %
  - FY 2014: 1.25 %
  - FY 2015: 1.50 %
  - FY 2016: 1.75 %
  - FY 2017: 2.00 %
  - Succeeding years: 2.00 %

* BASELINE Performance Period:
  - July 2009 – March 2010

* FY13 Performance Period:
  - July 2011 – March 2012

* Payment Impact Period:
  - October 2012 – September 2013

**Hospital at Risk Upward of 11%**

* http://www.hospitalcompare.hhs.gov/*
CMS Quality Measures

• CMS defines “quality measures” as tools that help to measure or quantify health care:
  – processes
  – outcomes
  – patient perceptions
  – organizational structure and/or systems

• The Centers for Medicare and Medicaid Services (CMS) use quality measures for quality improvement, public reporting, pay-for-reporting programs, and pay-for performance.

• Goals include:
  – effective
  – safe
  – efficient
  – patient-centered
  – equitable
  – timely care
Hospital Inpatient Quality Reporting (Hospital IQR) program was originally mandated by Section 501(b) of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003.

- Initially, the MMA provided for a 0.4 percentage point reduction in the annual market basket (update for hospitals that did not successfully report.
- The Deficit Reduction Act of 2005 increased that reduction to 2.0 percentage points.

CMS Rapidly Moves toward Outcomes Payment Methodology

Hospital Acquired Conditions (HAC) Reduction Program
- 1%
- lowest-performing 25 percent that will be penalized

Hospital –Wide Readmissions
- ALL Cause

2012 Hospital Readmission Reduction Program
- 30-day
- AMI, HF, PN
- 2.00% Payment Impact

2013 Hospital Value-based Purchasing (HVBP)
- FY 14: The Total Performance Score (TPS) is comprised of 3 Domains:
  - Clinical Process of Care domain score: 45% (AMI, HF, SCIP, HAI)
  - Patient Experience of Care: 30% (8 Survey Questions)
  - Outcome Domain Score 25% Mortality (AMI, HF, PN)
- 1.25% Payment Impact
CMS Continues to Divide the Pie for Accountability

Future Years Value-Based Purchasing (FY 2013-2016)

FY 2013 Value-Based Purchasing (Discharges from October 1, 2012, to September 30, 2013)

FY 2016 Value-Based Purchasing (Discharges from October 1, 2015 to September 30, 2016)

Patient Experience of Care Dimensions

Clinical Process of Care

Outcome

Efficiency

Patient Experience of Care

Outcome

Efficiency

Clinical Process of Care

Patient Experience of Care

Outcome

Efficiency

Clinical Process of Care

Patient Experience of Care

Outcome

Efficiency

Clinical Process of Care

Patient Experience of Care

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Clinical Process of Care

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Efficiency

Clinical Process of Care

Patient Experience of Care

Outcome

Efficiency
**FY 2015 Finalized Domains and Measures/Dimensions**

### 12 Clinical Process of Care Measures

1. AMI-7a Fibrinolytic Therapy Received within 30 Minutes of Hospital Arrival
2. AMI-8 Primary PCI Received within 90 Minutes of Hospital Arrival
3. Hf-1 Discharge Instructions
4. PN-3b Blood Cultures Performed in the ED Prior to Initial Antibiotic Received in Hospital
5. PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient
6. SCIP-Inf-1 Prophylactic Antibiotic Received within One Hour Prior to Surgical Incision
7. SCIP-Inf-2 Prophylactic Antibiotic Selection for Surgical Patients
8. SCIP-Inf-3 Prophylactic Antibiotics Discontinued within 24 Hours After Surgery
9. SCIP-Inf-4 Cardiac Surgery Patients with Controlled 6 a.m. Postoperative Serum Glucose
10. SCIP-Inf-9 Postoperative Urinary Catheter Removal on Postoperative Day 1 or 2
11. SCIP-Card-2 Surgery Patients on a Beta Blocker Prior to Arrival That Received a Beta Blocker During the Perioperative Period
12. SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis within 24 Hours

### Domain Weights

- **Efficiency 20%**
- **Clinical Process of Care 20%**
- **Outcome 30%**
- **Patient Experience of Care 30%**

### 8 Patient Experience of Care Dimensions

1. Nurse Communication
2. Doctor Communication
3. Hospital Staff Responsiveness
4. Pain Management
5. Medicine Communication
6. Hospital Cleanliness & Quietness
7. Discharge Information
8. Overall Hospital Rating

### 5 Outcome Measures

1. MORT-30-AMI – Acute Myocardial Infarction (AMI) 30-day mortality rate
2. MORT-30-HF – Heart Failure (HF) 30-day mortality rate
3. MORT-30-PN – Pneumonia (PN) 30-day mortality rate
4. PSI-90 – Patient safety for selected indicators (composite)
5. CLABSI – Central Line-Associated Bloodstream Infection

### 1 Efficiency Measure

1. MSPB-1 Medicare Spending per Beneficiary measure

**Represents a new measure for the FY 2015 program that was not in the FY 2014 program.**
RISK & FINANCE

How are Hospitals Allocating Resources Under Financial Pressures?

The Perfect Storm
9% - 11% at risk

Hospital Outpatient
Quality Reporting
2% of OPPS APU

VBP
1% 2013
1.25% 2014
1.5% 2015
1.75% 2016
2% 2017

Readmissions
1% 2013
2% 2014
3% 2015

Meaningful Use
1%

Hospital Acquired
Infections
1%

Hospital Inpatient
Quality Reporting
2% of IPPS APU

SIECK
healthcare consulting
Healthcare Transformation
Are we at the Tipping Point?

Healthcare Stakeholders Re-aligning to Transition

- Consumers
- Payors
- Federal, State, and Local Healthcare Providers
- Industry Remodeling of Products and Services

Key Focus:
- Increase Quality
- Decrease Cost
- Increase Patient Satisfaction
- Reengineer the Care Process
- Eliminate Waste
- Breakdown Provider Barriers
- Increase Data Capabilities

Patient Protection and Affordable Care Act (PPACA), which became law on March 23, 2010
Accountability Continues to Pressure Providers
Care Connectivity: Composite Endpoints

Patient Care Continuum

Pre-planning impacts Post-planning and Outcomes

OP ED Measures → IP Structure and Process Measures → Patient Satisfaction → Discharge Planning → Hospital Readmissions

Quality, Cost, HCAPS → HVBP: Hospital Value Based Purchasing → Paying-for-Value

Pre-planning → Post-planning

OBS
CLINICAL INTEGRATION

• Clinical integration facilitates patient care by unifying all of a patient's providers and services.
• Clinical integration, all stakeholders share responsibility and information about patients, even as the patient's care evolves and moves from one department to another.
• Clinical integration improves hospital efficiency and patient-centered care.

Model faces hurdles such as:

- Lack of Direct Disease Management Data
- Lack of coordinated disease management teams
- Lack of hospital administrators front line connection

According to the American Hospital Association, clinical integration emerged as a major hospital trend in the late 2000s.

Analyze *why* the shared responsibilities and goals impacts outcomes
Executive View

Data…Data…More Data

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Clinical Process of Care Domain – 2006</th>
<th>Patient Experience of Care Domain – 2006</th>
<th>Total Performance Score</th>
<th>National Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>30.00</td>
<td>15.00</td>
<td>41.40</td>
<td>32%</td>
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</tbody>
</table>

Discharge Programs

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Number of Discharges</th>
<th>Number of Readmissions</th>
<th>Predicted Readmission Rate</th>
<th>Expected Readmission Rate</th>
<th>Excess Readmission Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Attack</td>
<td>240</td>
<td>63</td>
<td>23.1</td>
<td>19.9</td>
<td>1.2</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>910</td>
<td>276</td>
<td>29.1</td>
<td>24.0</td>
<td>1.2</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>507</td>
<td>130</td>
<td>22.9</td>
<td>18.1</td>
<td>1.3</td>
</tr>
</tbody>
</table>

Income Statement

<table>
<thead>
<tr>
<th>Period ending</th>
<th>Number of months in period</th>
<th>Cost report status</th>
<th>Inpatient Revenue</th>
<th>Outpatient Revenue</th>
<th>Total Patient Revenue</th>
<th>Contractual Allowance (Discounts)</th>
<th>Net Patient Revenues</th>
<th>Net Operating Income</th>
<th>Total Operating Expense</th>
<th>Net Income or (Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/31/2012</td>
<td>12</td>
<td>As Submitted</td>
<td>$892,408,832</td>
<td>$377,794,080</td>
<td>$1,270,202,012</td>
<td>$999,962,584</td>
<td>$570,239,328</td>
<td>$7,787,000</td>
<td>$80,479,320</td>
<td>$46,139,008</td>
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<tr>
<td>12/31/2011</td>
<td>12</td>
<td>Amended</td>
<td>$875,519,615</td>
<td>$328,721,472</td>
<td>$1,204,241,088</td>
<td>$671,320,088</td>
<td>$532,710,400</td>
<td>$7,624,304</td>
<td>$90,836,200</td>
<td>$10,183,299</td>
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<tr>
<td>12/31/2008</td>
<td>12</td>
<td>As Submitted</td>
<td>$801,103,462</td>
<td>$229,968,616</td>
<td>$1,050,072,028</td>
<td>$559,907,089</td>
<td>$466,164,989</td>
<td>$81,000,377</td>
<td>$90,320,836</td>
<td>$45,473,233</td>
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</table>

Patient Satisfaction

<table>
<thead>
<tr>
<th>Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collection Periods / Definitions</td>
</tr>
<tr>
<td>Measure</td>
</tr>
<tr>
<td>---------</td>
</tr>
<tr>
<td>Always</td>
</tr>
<tr>
<td>Always</td>
</tr>
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<td>Always</td>
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<td>Always</td>
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<td>Always</td>
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<td>Always</td>
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<tr>
<td>Always</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>High</td>
</tr>
<tr>
<td>Definitely</td>
</tr>
</tbody>
</table>

Throughput Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Footnotes</th>
<th>Hospital Score</th>
<th>National Average</th>
<th>State Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED-1b</td>
<td>Average (median) time patients spent in the emergency department before they were admitted to the hospital as an inpatient</td>
<td>2</td>
<td>508 minutes</td>
<td>275 minutes</td>
</tr>
<tr>
<td>ED-2b</td>
<td>Average (median) time patients spent in the emergency department, after the doctor decided to admit them as an inpatient before leaving the emergency department for their inpatient room</td>
<td>2</td>
<td>208 minutes</td>
<td>98 minutes</td>
</tr>
<tr>
<td>OP-18b</td>
<td>Average time patients spent in the emergency department before being sent home</td>
<td>203 minutes</td>
<td>135 minutes</td>
<td>155 minutes</td>
</tr>
<tr>
<td>OP-20</td>
<td>Average time patients spent in the emergency department before they were seen by a healthcare professional</td>
<td>66 minutes</td>
<td>34 minutes</td>
<td>58 minutes</td>
</tr>
<tr>
<td>OP-21</td>
<td>Average time patients who came to the emergency department with broken bones had to wait before receiving pain medication</td>
<td>30 minutes</td>
<td>38 minutes</td>
<td>54%</td>
</tr>
<tr>
<td>OP-22</td>
<td>Percentage of patients who left the emergency department before being seen</td>
<td>2%</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Most Common Approach….Drill Down by Department

Composite Outcomes = Reimbursement

Is this really the Solution?
Or just treating a hospital symptom!

Cuts by Department

Emergency Department

Radiology

LAB

Housekeeping

Pharmacy

Tele Unit

Med-Surg
Lack of Integration Impacting Outcomes

Continuum of Care Process
Days of Care

Think Globally, Long Term, and with Accountability
Departmental silos are seen as a growing pain for most organizations of all sizes.

It is the duty of the executive leaders and management to prepare and equip their teams with the proper mind-set to break down silo mentality.
Moving Beyond Data Output—
The Emergence of Pushing the Power of Reporting Back into the Hands of the End-users

CMS.gov
Centers for Medicare & Medicaid Services

HIE
EMR

Hospital
Clinical Input

Navigating Big Data to Improve Bedside Care
• Measure
• Strategy
• Re-measure

Planning Stage
- Define Meaningful Use
- Certify EHR
- Education & Outreach
- Setup System for Incentive Distribution
- Setup System for Evaluation & Assessment

Incentive Stage
- Pay Medicare/Medicaid Incentives to Eligible EHR Users (Doctors & Hospitals)
- Physicians: 75% of Medicare allowable charges or a Maximum of $15K/physician 1st year, $12K for 2nd, $8K for 3rd, $4K and $2K for 4th and 5th.
- Hospitals: $2 million base year amount plus a fixed amount

Penalty Stage
- No Incentive after 2015/16
- Non EHR
  Physician: 1% reduction each year until 5% maximum
- Non-conforming Hospitals: deductions on annual basis

EMR MANDATE

ED
Med Surg
Tele
ICU
Find the Root Cause

Hospitals Fined $529 Million for Readmissions:

Table A. Readmission Penalties, Paid by Hospitals, for Five Conditions

<table>
<thead>
<tr>
<th>Condition</th>
<th>Initial Hospital Stay for</th>
<th>Penalty for Each Readmission above US Average Rate</th>
<th>Average Base Payment to Hospital for Initial Treatment</th>
<th>US Average Readmissions within 30 Days as % of Initial Hospital Stays</th>
<th>US Ratio of Admit to Readmit</th>
<th>Each Condition as % of Medicare Hospitalizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Failure</td>
<td>Heart Failure (Weak Heart)</td>
<td>$35,000</td>
<td>$8,000</td>
<td>23.6%</td>
<td>4.3</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>Heart Attack</td>
<td>$55,000</td>
<td>$10,000</td>
<td>17.5%</td>
<td>5.6</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>Pneumonia</td>
<td>$65,000</td>
<td>$8,000</td>
<td>17.7%</td>
<td>5.5</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>Empyema or Empyema of Lung</td>
<td>$35,000</td>
<td>$7,000</td>
<td>21.1%</td>
<td>4.7</td>
<td>4%</td>
</tr>
<tr>
<td></td>
<td>Knee or Hip Replacement</td>
<td>$285,000</td>
<td>$15,000</td>
<td>5.27%</td>
<td>19.0</td>
<td>5%</td>
</tr>
</tbody>
</table>

Analysis 1-2 Data, Profiling, and Variance ID

AMI (-$) Acute Myocardial Infarction
STEMI/NSTEMI

Composite Outcomes Drives Reimbursement

AMI ALL Cases Outcomes Summary

<table>
<thead>
<tr>
<th>ICD-9</th>
<th>Mortality</th>
<th>Complications</th>
<th>30 Day Readmissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>410.01</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>410.1</td>
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<tr>
<td>410.11</td>
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<td>4</td>
<td>2</td>
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<tr>
<td>410.12</td>
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<tr>
<td>410.21</td>
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<tr>
<td>410.31</td>
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<td>410.41</td>
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<td>410.61</td>
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<td>410.71</td>
<td>9</td>
<td>10</td>
<td>52</td>
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<tr>
<td>410.81</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>410.91</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

NSTEMI

Composite Outcomes Drives Reimbursement
**Treat the Root Cause**

**Disease Management**

**Composite Outcomes Drives Reimbursement**

**AMI (≠$)**

Acute Myocardial Infarction

STEMI/NSTEMI

**AMI ALL Cases Outcomes Summary**

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<td>4</td>
<td>4</td>
<td>2</td>
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<td>1</td>
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<td>0</td>
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<td>0</td>
<td>0</td>
</tr>
<tr>
<td>410.91</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

**811 AMI**

Group (≠$29K)

NSTEMI Drives Outcomes:

Highest Mortality,
Complications,
Readmission

**673 NSTEMI**

Sub-Group (≠$1.8M)

Break Down and Delegate by Department

Care Team Solutions
Successful Outcomes Requires System Thinking
Demonstrate *how* a collaborative care model closes the gaps in delivery of care
Understanding “ALL” Stakeholders are part of the Intellectual Property….the Patient

“We must aggressively break down the barriers that stand in the way of more strategic collaboration among patients, executives, physicians, departments, payers, and industry.

The Silo Mentality: How To Break Down The Barriers Forbes 10/02/13
Here are 5 ways to encourage a unified Care Model:
1. Create a Unified Vision

A unified leadership team to encourage trust, create empowerment, and break managers out of the “my department” mentality and into the “our organization” mentality.

2. Work Towards Achieving a Common Goal

Focus Composite Endpoints (Quality, Cost, Patient Satisfaction)
– Understand how each can make an impact individually to identified objective

3. Motivate and Incentivize
– Eliminate silo covered execution and implementation

Encourage individual investment in growth

4. Execute and Measure
– The leadership team must establish a time frame to complete the common goal, benchmarks for success and delegate specific tasks and objectives to other members of the management team
– Regularly scheduled meetings with the intention to hold each employee accountable against their assigned task

Measure and report outcomes
– Teams thrive off routine and constant reinforcement

5. Collaborate and Create

Key factors in creating a thriving and productive team; knowledge, collaboration, creativity, and confidence
Departmental Silo Departmental Results

Disease Management Optimal Patient Outcomes

Transition Decisions to Collaborate Team for Composite Outcome Solutions

Combined Accountability

Executives
- CEO
- COO, CFO
- CMO, CNO

Department Heads
- Dept Chair
- Dept Directors
- Managers
- Front Line Staff

Process Improvement Teams
- Process Improvement Teams
- Lean Process
- Six Sigma

AMI

ED Measures

IP Measures

Medical Necessity

Optimal Outcomes

Pricing

AMI

Qualitative Care Improved 2.3%

Cost of Care Increased 6.7%

Acute Number in Days Decreased 52% to 3,924 in 2007

Patient Satisfaction...
Key ingredients that have contributed to the success of four high-performing hospitals

The key elements of a successful strategy can be organized into the following categories:

1. developing the right culture for quality to flourish; Collaborative Decisions
2. attracting and retaining the right people to promote quality;
3. develop and update the right in-house processes for quality improvement; and
4. giving staff the right tools to do the job.
High Performing Hospitals

Beth Israel Hospital, Boston, MA

- The effective use of multidisciplinary teams to study quality problems, drill down deeply to identify root causes, and develop a solid plan to correct the problems;
- An advanced IT system that supports this key problem-solving function;
- A long history and strong culture of serving the community and emphasizing patient care;
- A strong commitment to and involvement in quality issues from the top, at both the CEO and Board levels;
- The adoption of the Institute of Medicine's (IOM's) six domains of quality (safety, timeliness, effectiveness, efficiency, equity, patient centeredness) as a central framework for pursuing quality, with specific reporting requirements related to these measures;
- Relationships with a premier medical school and research departments that attract highly motivated, top-notch physicians;
- Preference for internal development of best practices, and
- A high-level, physician-led Health Care Quality department dedicated to improving performance.

Jefferson Regional Med Center, Pittsburg, PA

- A rich history and culture that supports quality.
- Leadership at all levels committed to quality, as evidenced by a consistent willingness to commit resources and absorb financial losses, if necessary, to ensure that quality is not compromised.
- Mutual respect and strong relations across disciplines, including between the administration and clinical care staff (both doctors and nurses) and between physicians and non-physician care staff.
- A highly skilled nursing and medical staff.
- Local (i.e., clinical department or unit-based) ownership and accountability for quality and quality improvement (QI).
Develop Clinical Process Teams (CPT)

Dialogue:
- Free-flowing exchange of ideas among equals
- All ideas are solicited and are considered
- Best ideas rise to the top
Clinical Process Team (CPT)

Define your Target and let the Team Provides Solutions

Overarching Goal
Reduce:

- system failures
- duplication
- overuse, underuse, misuse
- inefficiency
- unnecessary repetition
- poor communication

Transition from Fragmented Delivery System to Clinical Process Team
“Close the Care Gaps”
Clinical Process Team (CPT) Focuses on Outcomes

<table>
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<th>Pathogen</th>
<th>Question</th>
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<td>Pneumonia</td>
<td>When Does Discharge Planning Begin?</td>
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**ED Measures**
- Timely Decision
- Turn-around-time (TAT)
- Throughput

**LAB Measures**
- Science
- Cost
- Direct/Indirect
- Implementation Strategy

**Radiology**
- Discharge
- Observation
- Admit

**Patient Disposition**
- Quality
- Cost
- Patient Satisfaction
- Medical Necessity

**Composite Outcomes**

### CMS Hospital Inpatient Quality Reporting Program Measures:
For FY 2016 Payment Determination

- **Acute Myocardial Infarction (AMI)** - Chart Abstracted - Quarterly
  - AMI 1: Ekg at arrival (Voluntary)
  - AMI 2: Aspartate aminotransferase (AST) (Voluntary)
  - AMI 3: Creatinine (Voluntary)
  - AMI 4: Troponin I (Voluntary)

- **Heart Failure (HF)** - Chart Abstracted - Quarterly
  - HF-5: Discharge instructions (Voluntary)
  - HF-8: Evaluation of left ventricular systolic function (Voluntary)

### CAP ALL Cases Outcomes Summary

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<thead>
<tr>
<th>ICD-9</th>
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<th>Complications</th>
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</table>
Famous quote by Francis Bacon
“knowledge is power”

There are a few key factors in creating a thriving and productive team:

* Knowledge
* Collaboration
* Creativity
* Confidence
What Distinguishes Leading Hospitals

• Willingness to invest and focus on long-term change and comprehensive quality integration (e.g., into all service lines and from the top of the institution to the bottom) are essential.
At the end of the day what is the Overarching Objective?

**Federal:** Optimize
Reallocation of Reimbursement based on Outcomes

**Hospitals:**
Provide a Better Patient Care Delivery Model

**Patient:**
Receive Better and Affordable Health Care
How do we get there?

Clinical integration facilitates patient care by unifying all of a patient's providers and services.

Key: A relation between medical interventions and health outcomes, as well as the relation between health outcomes and cost is critical in finding equity.

P2P Communication

“Rapid Cardiac Disposition Protocol”

Standardizing Care Objective:

• Increase use of appropriate Medical Therapies
• Standardize appropriate diagnostics
• Decrease Hospital Stay
• Improve patient care and decrease cost

Treat the diagnosis not the unit!
Total Integrated Patient Care Model

Continuum of Care Process

Hours of Care

Clinical Process Team (CPT)

Outcome Measures
- Improved Patient Outcomes
- Improved Quality
- Improved Financial Performance
- Improved Patient & Physician Satisfaction
- Increased Accreditations

Think Globally, Long Term, and with Accountability
Reimbursement Based on Bundled Outcomes

Value-base Purchasing
Patient Centric Model
Healthcare Transformation

Bundled Reimbursement……..So Bundle the Solutions

Cross-functional Solutions

For many organizations, this means that not only do all employees of the company need to row in the same direction, but the executive teams must be engaged and at the forefront steering the boat.

A unified leadership team will encourage trust, create empowerment, and break out of the “my department” mentality and into the “our organization” mentality.

Healthcare is a Team Sport
FOR IMMEDIATE RELEASE

New Affordable Care Act tools and payment models deliver $372 million in savings, improve care

Pioneer ACO Model and Medicare Shared Savings Program ACOs part of plan to improve care and lower health costs across the health system

The Centers for Medicare & Medicaid Services (CMS) today issued quality and financial performance results showing that Medicare Accountable Care Organizations (ACOs) have improved patient care and produced hundreds of millions of dollars in savings for the program.

In addition to providing more Americans with access to quality, affordable health care, the Affordable Care Act encourages doctors, hospitals and other health care providers to work together to better coordinate care and keep people healthy rather than treat them when they are sick, which also helps to reduce health care costs. ACOs are one example of the innovative ways to improve care and reduce costs. In an ACO, providers who join these groups become eligible to share savings with Medicare when they deliver that care more efficiently.

ACOs in the Pioneer ACO Model and Medicare Shared Savings Program (Shared Savings Program) generated over $372 million in total program savings for Medicare ACOs. The encouraging news comes from preliminary quality and financial results from the second year of performance for 23 Pioneer ACOs, and final results from the first year of performance for 220 Shared Savings Program ACOs.
Future of Calculating Value

ROI in the future will not be based on how much profit is made on a test, or just whether your department met budget but on how much saving there is for the *episode of care (EOC)* or what spending is prevented by doing these tests.

Total Product Value = Optimal Episode of Care Payment = Hospital Profit

US Healthcare Moves to Paying for Outcomes “Not by Department”
By 2016 40% of selected diagnosis will be reimbursed based on outcomes. The big question…

"Can Hospitals Demonstrate Outcomes that will allow then to play in the same sandbox with Reimbursement Models".

Hospitals are just now catching up with private industry in building a process around composite endpoints, Quality, cost, and Patient satisfaction rather than traditional operational metrics.

“Partnerships, Solutions, and Outcomes are critical to survival”.

This does not require products and services to produce new clinical trials or expensive studies but it does require an organization to re-fresh their current processes demonstrating the impact to the organization, composite outcomes.

The language shifts from Traditional Measures to Composite Outcomes, and from Operational Focus to Patient Centric Care.

Hospitals have the components, it a matter of restructuring a different culture!
How to Transition your Organization to a Clinical Process Team

“Providing Solutions”

Value Analysis (VA) can mean many things to many people, such as standardizing supply decisions or making decisions about new products.

However, a true VA program is a process that analyzes and identifies opportunities to improve the value of any product or service where value equals quality divided by cost.

When selecting VA team members, consider each person's individual ability, level of analytical ability, attitude toward change, reliability, and interest in professional growth. Strive to create blended teams of managers, supervisors, and front-line staff. Choose team leaders who are willing to own projects and encourage others.

Organizational change has to come from the top - or at the very least, the goals of change need to be supported and promoted by leadership. Hospital leaders should provide goals, defined responsibility, and accountability for achieving them. Your organization must determine what you are trying to accomplish, who is accountable, and how you will define success.
THANK YOU!