ROUNDTABLE

Operational Excellence for Clinical Quality

Healthcare operations leaders today must drive operational efficiency and cost management to achieve necessary clinical outcomes. New models of care coordination and accountability require new operational strategies that integrate hospitals' business functions and medical mission. As reimbursements shift to pay-for-performance, hospitals and healthcare systems increasingly must work with a broad range of partners toward population health management, extending beyond the walls of their institutions. Physician alignment with this changing dynamic is essential, but getting incentives right can be difficult. HealthLeaders Media convened a panel of healthcare COOs to discuss how they and their systems can meet these demands and stay viable.

PANELIST PROFILES

JUDY BROWN
Executive Vice President and COO
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Roundtable Highlights

HEALTHLEADERS: *Mike, you introduced yourself as EVP for population health management. I was saying you were system COO for all four Virtua hospitals. You said the goal now is to go beyond the hospitals and essentially be a COO for your patient population beyond the four facilities. What's the goal for your organization, and what's the situation at the others?*

MICHAEL KOTZEN: In the past we've managed by facility, by hospital—but really, in the market we're in, we serve three counties. We're really trying to figure out the best way to serve each of those populations. So we're going to organize ourselves more around that. As for the system, it's looking at the whole continuum of care—everything from primary care physician offices all the way through the postacute services (some of which we own, some of which we will partner with)—and figuring out the best way to deliver service across the community. Now we're even starting to look at retail medicine and figuring out how to get into some of the retail market, as different competition is coming in, particularly with some of the larger drugstore chains and the like. But we're really trying to center it around a primary service area. ... Disease management is a big piece of it, but also wellness is a big piece, and there are different needs for different communities.

DOUG LUCKETT: We have the normal vertical integration you'd see in an independent health system. However, we do have plenty of market competitors in the postacute setting and actually the acute setting in a short distance from us in the Mecklenburg County [greater Charlotte, N.C.] area. Much like [Virtua], we're trying to build a system that helps when patients activate ... to be there for them early on and to keep their continuum strong. Right now, building an integrated operation and an integrated clinical side are our two main focuses. We're in the building stages right now, because again we don't own all the players in the markets, and don't need or want to do that. So we're doing a lot of ambassadorship work and initial quality and willingness work to make sure that the postacute players in our market will align with us for our patients' benefit.

KAE ROBERTSON: We're seeing a lot of focus on operating models, organizational structure, and clinical integration and alignment. I think we're seeing a foot in each boat for our health systems, trying to figure out at what point their hospitals become their cost centers as opposed to their revenue centers, and what is that continuum of assets or of partnerships to be able to manage the population's health. So there's this focus on reducing costs, improving quality, and the quality of health of the population, not just of that episode in an acute care facility.

"I think the shift in the **payer contract reimbursement methodologies** will make it hard to stay financially viable."

JUDY BROWN: The hospital is becoming a cost center. We're working on clinical integration with our physicians to align better with them. I started out as the CFO at East Jefferson, and I was immediately put on the board for the CI [clinical integration] organization. ... That's going to be aligned and more controlled by physicians. Sooner or later [the hospital is] going to become the cost center. By partnering with the physicians, however, I think you can make yourself of value to them. So if you really work closely with them, give them the data, work with them on pathways and things, you can make sure you're the cheapest delivery of care and the highest-quality delivery of care and they won't be able to go to a competing hospital and find that value. It's that coordination of care with them that we're looking to do—not become the cost center so much as a healthcare partner.

Judy Brown
Executive Vice President and COO
East Jefferson General Hospital

HEALTHLEADERS: *This shift that you're all describing creates huge challenges for COOs in particular. What are the biggest difficulties that you're going to face over time?*

BROWN: I think the shift in the payer contract reimbursement methodologies will make it hard to stay financially viable. You want to be efficient and you want high quality. But if you've got per diem contracts and you're reducing your length of stay, then the cost of care—and your reimbursement—may not be aligned with what you're trying to do. For instance, you may see your volume go down if, say, you're taking out duplicate imaging by coordinating between physicians so you don't have an x-ray every time patients visit a specialist. Then you're going to see your outpatient volumes drop. You may see your length of stay go down, and your

revenues—if they're not aligned with the payers—may go down. So while we're transitioning, it's going to actually hurt the hospitals financially unless they have a transition plan. I think that's the toughest part.

KOTZEN: The things that are going to make us successful financially in the future are the same things that potentially are going to be painful in the short term. … We're starting some negotiations, trying different things with care coordination, but we still have a significant amount of our payment coming from per diem or case-rate contracts.

Doug Luckett
Executive Vice President and COO
CaroMont Health

LUCKETT: It's the timing of the carry of overhead, I think. Whether you're in a RVU or a net income model or whatever you might be with your physicians, it's tough for them to do a test of change with you unless you take that step. No payer contracts really honor the work we're doing on the value-based piece. … The thing that keeps me up at night, too, is that the acute care side has been built for years and years to be these aircraft carriers and battleships. You know, the things that the communities can count on in a hurricane. When a railhead accident comes, nobody goes running to an outpatient dermatology center or outpatient diagnostic center. They come right into a hospital. We've been asked to be stalwarts for the community, that we'll be there. Well, the bricks and mortar carry a high cost, and a lot of these facilities are aging. … The old model of financing definitely is going to go away. When you have a foot in one canoe and a foot in another canoe and you're going down the river, it's not very comfortable.

ROBERTSON: That's the hardest part. You're in this in-between stage. Yes, we know what we need for the future, [but] if we do that right now, we're hurting our bottom line. So what are the right smart steps to take now that set you up for the future, keep you moving financially and quality-wise in the direction you want to go? It varies by market because the payers are different by market. In some markets where they have sort of value networks, they're shifting work away from high-cost organizations. In that instance, you're being helped to put both feet into the same boat, but not all markets are like that. The difference in payers across the country drives some of the difficulty right now.

HEALTHLEADERS: *That's a particularly difficult challenge with population health management. People say, "Tell me what to do, doctor," but then they may not do it.*

KOTZEN: A lot of that is in changing what happens at the physician office. There is not only interaction with the physician, but it's also aligning nurse case managers at the office location who can do the follow-up, particularly with the disease management patients, even for wellness. It can't be in the traditional model. The doctor just is not going to have enough time to spread himself or herself out over that panel of patients. If you have a practice with three physicians today, does that evolve into a lesser number of physicians and a greater number of extenders or nurses to try to help manage that?

> **"The thing that keeps me up at night,** too, is that the acute care side has been built for years and years to be these aircraft carriers and battleships."

BROWN: But who pays for it? The physicians can't afford it. We're in a market where we only employ 50 physicians, and the rest of them are all in small independent groups. So it's really hard for them to pool resources. That's one reason we looked at clinical integration—it's one way we can align with the physicians and then partner with each other without being in one group. I think that has some momentum to really make a difference.

HEALTHLEADERS: *How can you as COOs … control those outcomes and ultimately control the bottom line?*

BROWN: One way is through service line teams that we have and the physician report cards. Let [physicians] know how their service line is doing, how we look in the publicly reported data. There's a lot of publicly reported data, and I don't think the physicians understand what is out there. They don't know what's out there on them. That's going to start picking up—and they don't want to be the ones left out of payer products. They're very competitive people. … It's really important that you be able to have a relational database where you can drill down and explain what's going on in that service line or that DRG or their practice and show where the variances are. … So show them the data, where they fall, where we as a hospital fall. [Physicians] want to be proud of the quality of care that they have.

KOTZEN: For our organization, the biggest thing is building in more predictability, because one thing that costs

us a lot of money is variability in outcomes. Whether that's from employed medical staff or independents or within a specialty or readmissions by a physician, using analytics [is important] to try to prioritize where we want to say, "There's one way of doing things." ... The more we're able to prove that those things work to the physicians and to our staff, we'll be able to really impact that variation. I think that's the biggest thing that's affecting both our cost and quality. The speed at which we're able to hardwire some of those things will determine how successful we are. ... On the top of my list is making sure we find ... the right way to [provide care] based on evidence and outcome, and how do we implement that quickly and broadly. Almost every time we're successful it's because we've been able to flatten out that variability. In any payment model, that's going to be important. Visibility of the metrics is important, too; people ought to know what we're looking at.

LUCKETT: It's relationship work more than ever now. There's no arm's-length distancing yourself from anything. The people who are still stuck in the command-and-control model of management are going to lose. The real conversation—vet your fears, vet your concerns, vet your ideas—will win. So we're trying to promote that.

ROBERTSON: I think that "control" is not a word that works as we move into the future. It is having more people who understand the work, who understand the tools, the data, the information. There's a lot of talent strategy that's going to be required in the future, so that you're developing physicians as businesspeople. You're developing your managers and directors to be businesspeople ... have them understanding the work, understanding the business, and being able to make good decisions for our patients.

HEALTHLEADERS: *Better IT systems are a requirement to do the kinds of things that we're talking about. Relationships are part of it, but transparency and care coordination rely on IT systems. Yet IT systems are a huge expense. How do you get your arms around this fastest-growing line item?*

LUCKETT: When you go down the path of IT investment now, the initial conversation today looks so much different than it did just four or five years ago. ... When we talked to our time and attendance vendor and our productivity management system vendors, we told them what it had to look like right out of the test environment—no hiccups. ... So your operation systems, your finance systems, your collection system, things like this, you have to get all the juice out of the squeeze day one out of the test environment into live. ... I'm not going to be your beta site. For our money, it needs to work, and 100%, day one. IT is a necessary thing. To have transparency, you've got to have the tools.

KOTZEN: Another issue is that IT is not just a matter of more systems, it's more of the stuff that hasn't traditionally been IT. There's really not a piece of clinical equipment that you purchase that doesn't involve IT. ... Someone who has leadership in IT is managing a lot more than the order entry or charge systems of the past. We just opened our new hospital about a year ago. We had 160 active live systems day one. ... Basically everything touched IT—building automation to RFID tagging of patients. You'd like to say there's a return on that whole investment, but it's hard to be able to demonstrate that fully. You kind of have to look back one day and say, "All right, this stuff worked." Lots of times it does, sometimes not so much.

Physicians are so much more ready for IT today than they were even three years ago. We were very pleasantly surprised when we initially rolled out CPOE, to the point where they're asking for access to CPOE everywhere. This is independent and employed physicians alike. ... Five years ago, it was how we were going to get people to buy in to moving away from paper. Now it's more just making sure you have a good solution, and then you wrap the work flow around the technology.

Kae Robertson
Principal
Deloitte Consulting LLP

ROBERTSON: Picking up on the work flow side, you can use some of the things that other industries have to reduce headcount through technology. If your patients are ready for some of the self-service that you might find in the finance industry, how can you use that in your revenue cycle? Some of the invoice supply-chain tools that exist in big consumer products companies, how can you use that to reduce your back-office costs from your personnel? There are so many opportunities to use other industry learning in healthcare to reduce personnel costs in favor of technology. Think about admitting—you go into a hotel, and in half of them you can sign in just through the kiosk and get a key. But [hospitals] still have big registration admitting departments, not a kiosk system. I do my reservation in advance for my hotel. Wouldn't I do more of that for my hospital visit as well?

BROWN: Another challenge with IT, even though there's a lot of opportunities, is that each doctor is the specialist in their area. They tend to want the system that is the best-of-breed for them and for their productivity and what

they're trying to do for the patient. If you don't have a long-term IT strategy, you can have a lot of bolt-ons into your hospital information system, where you've created this mass of spaghetti that doesn't truly integrate as well as you need it to when you're talking about this care continuum. Same thing for physician EMRs. You have no control over what the independent physicians are buying. So we are looking to the vendors to set it up in standard formats, so that when we do develop these HIEs, we have a way to connect.

HEALTHLEADERS: *What's your take on HCAHPS scores? Are they about patient satisfaction or patient experience, or some of each and some of neither?*

Michael Kotzen
Executive Vice President for Population Health Management
Virtua

LUCKETT: I did correlation studies against the commercial satisfaction survey vendor I use and the HCAHPS scores. Some periods are highly correlated, and some periods are so far apart and so weak. What's the difference? We try to dig in to find out why. There's really no answer.

KOTZEN: We need a tool. I think the idea of hospitals having a standardized tool to measure that subjective perception is a good thing. The manipulation and how it's used for reimbursement is the subject of a much longer debate. I don't know that there'll ever be a perfect answer, but one of the things we talked about earlier was that our jobs are much more focused on the patient. You can't do that without getting some subjective information.

BROWN: I agree we need a tool. I'm not sure tying payments to [HCAHPS] is right when there are adjustments [in the scores]. It depends on where you live and your income level. There are so many adjustments. I think patients will vote with their feet, and we don't need HCAHPS to determine that payment and that penalty. We have outcomes, we have a lot more objective data to base payments on. The patients have a choice of where they go most of the time, and the payers have choices. So if we're not providing a good service, I think that is going to come out.

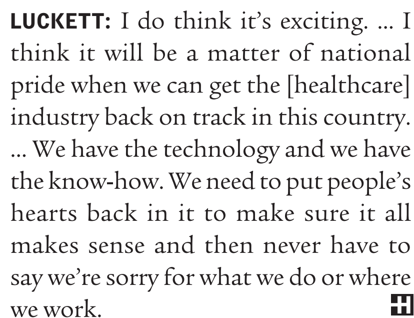
ROBERTSON: Unfortunately, I don't think HCAHPS are as much about clinical care as they are about service and perception. I agree with Judy that we have better ways to measure outcomes. But … in healthcare organizations across the country, you see a lot of variation in service and in some of the things that make a difference for patients and families. So if there is a way that we can use HCAHPS across the country to improve the perception or the service part, that is helpful.

HEALTHLEADERS: *What message would you like to leave with the readers of HealthLeaders magazine?*

BROWN: Healthcare is, as we keep hearing, broken. It's become unaffordable. … So we have to figure this out with all the partners and people at the table. Not just the physicians that we talked about a lot today, but our corporate partners, too. We don't have a silver bullet. We've kind of gotten ourselves boxed into a corner. No one knows more about our industry than we do, so we need to be sitting down figuring it all out with all the players instead of letting the government figure it out. … The consumer, the patient, has a role in this. We talked about compliance and health and wellness. … We're going to have to figure out a way to charge those who don't want to be compliant. They're costing the system a lot of money. We have to get them to realize they're as much the problem as anyone else.

ROBERTSON: I think industry leaders are committed to high-quality care and high service levels. They want to do the right thing. Physicians want to do the right thing. Having alignment of payment and reimbursement is important; having transparency of information and data is important. Forums like this create the opportunity for people to dialogue.

KOTZEN: If you look at the change that's happened in the past couple of years, it's happened without an ACA. It happened before the Supreme Court or any of that. Yes, there's a little bit of a reaction out of fear of what's going to be different, but for the most part it's the industry that's making the changes. Reimbursement will change a little bit; we're going to get it from one bucket and not the other. But the changes being made by the healthcare institutions will make it better for patients in the community. At the end, it's hard to argue with a lot of these things, even though we're kind of shooting in the dark at some of the measurements. Whether we measure 30-day readmissions the right way, it's still a good thing to do things that will prevent patients from having to come back into the hospital. To be able to influence making the system better, it's pretty exciting.



LUCKETT: I do think it's exciting. … I think it will be a matter of national pride when we can get the [healthcare] industry back on track in this country. … We have the technology and we have the know-how. We need to put people's hearts back in it to make sure it all makes sense and then never have to say we're sorry for what we do or where we work.

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Rx: *Next*

Real accountability: Will you guarantee the care you provide?

Market evolution

Health Reform has brought the term 'accountability' to the forefront of debate when it comes to alternative models for reshaping the future care delivery environment. While there is a lot of talk about accountability, much of the current dialog seems to lack the type of urgency that will be required to achieve real, transformational change.

Much of the discussion on accountability today remains anchored in today's health-system centric, fee-for-service world. Many health systems would say they are already 'fully accountable.' Stepping back, many industry observers say the provider community remains far from providing the level of accountability that consumers and purchasers experience in other sectors of our economy. The concept of offering a 'money back' guarantee for high quality, safe, and cost effective care is quickly rejected by most provider executives, citing numerous reasons: Patient non-compliance, pre-existing conditions, dependence on other players in the eco-system, and many more.

Implications for health providers

While the widespread application of warranties may be in the distant future for many providers, limited introduction of specific guarantees could be helpful and strategically disruptive for organizations to consider in the near-term:

- *Internal strategic alignment:* Rallying a team around a 'guaranteed product' could place the hard edges on strategic direction and dramatically stimulate new thinking on models of care, incentive alignment, and patient engagement;
- *Competitive differentiation:* As costs come down and quality metrics become more aligned across providers, the introduction of a guarantee could support a provider's efforts to stand out in their marketplace, stimulating near-term growth and enhancing brand perception.

While the concept of guarantees may seem remote for most providers, there are likely two ways to think about health care warranties:

- Guaranteeing a health outcome that depends primarily on the treatment quality, i.e., accountability resides mainly with the health provider for initial treatment and outcome;
- Guaranteeing a health outcome that depends on health behavior changes, i.e., patient and provider share accountability for care process and health outcome.

Guaranteeing health outcomes is not without challenge, given the multi-factorial nature of health maintenance and restoration. But health systems that are willing to vouch for the care they provide can make a strong statement and may position themselves apart from their peers, driving increased accountability in the health care delivery system.

Examples of industry warranties

Costco
"We guarantee your satisfaction on every product we sell with a full refund."[1] Costco also extends the manufacturer's warranty on televisions, projectors, and computers to two years from the date of purchase.

Mercedes-Benz
"You invested in Mercedes-Benz. Now Mercedes-Benz has your back."[2] All new Mercedes-Benz vehicles are protected for defects in material or workmanship for 48-months or 50,000 miles.

Questions to consider

- How do you hold your medical staff accountable for the outcomes of patients they treat?
- Are you ready, today, to guarantee the product you deliver?
- What measures of success are you willing to put forward in your 'warranty statement?'

Authors
Michael Cohen
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[1] Costco product warranty: http://www.costco.com/Service/FeaturePage.aspx?ProductNo=11467191 and http://www.costco.com/service/featurepageleftnav.aspx?productno=11204333, accessed 3/13/2012

[2] Mercedes-Benz USA limited warranty: http://www.mbusa.com/mercedes/service_and_parts/warranty, accessed 3/13/2012

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