



Signature Leadership Series

Hospitals in Pursuit of Excellence: A Compendium of Action Guides 2013

July 2013

Dear Colleague:

To support hospitals during this time of important change, we are pleased to release the 2013 edition of **Hospitals in Pursuit of Excellence: A Compendium of Action Guides**.

This collection of action-oriented resources can help hospitals and health care systems design and implement strategies to deliver care that is safe, timely, equitable, effective, efficient and patient-centered. It will also assist health care leaders operating in the present volume-based environment shift to a performance-based system that is focused on delivering value.

This year's compendium includes resources to help meet these new and ongoing challenges:

- Move from the **first curve to the second**. Priority strategies are identified for hospitals and health care organizations moving from the volume-based first curve to the value-based second curve. In addition, a road map assists hospital leaders evaluate their progress toward the second curve.
- Prepare for **value-based contracts**. It will require planning, new skills and a new approach to health care delivery. Hospitals and other health care organizations will need to determine their role in developing care delivery networks and the value-based arrangements that are emerging in communities nationwide.
- Understand how **small and rural hospitals and care systems can develop effective population health partnerships** and balance the challenges and opportunities encountered in providing health management.
- Explore **advanced illness management (AIM) strategies** and understand why effectively integrating AIM into the continuum of care will position the hospital and health system to manage the gap between the first and second curve.
- **Understand palliative care**, which focuses on providing relief from symptoms, pain and stress to patients with serious illness. See what resources are necessary to understand the benefits and opportunities of providing high-quality palliative care services.
- Learn what **physician integration models** can contribute to sustainable success through a description of the groundwork and prerequisites required for successful hospital-physician integration. Also included are examples of physician-integration initiatives at organizations of different types and sizes.
- Discover how to actively **engage health care users** to improve outcomes and reduce health care costs. Explore the role of hospitals and health care systems in improving the overall health of the population and communities they are serving using a continuum for engagement from information sharing to partnerships.

- Understand how **cultural competence** can benefit your organization. Equity in care is more than just the right thing to do. It is vital to performance excellence and improved community health.
- Learn about the importance of **checklists in improving patient safety**. Striving to focus on patient safety and quality outcomes, health care professionals are using multiple methods to reduce patient harm and eliminate medical errors. One method that has seen ever-increasing implementation is the checklist.

The American Hospital Association will continue to support your efforts in performance improvement and care delivery transformation through *Hospitals In Pursuit of Excellence* and our ongoing policy work. Be sure to visit www.hpoe.org for the full set of improvement resources. The AHA website (www.aha.org), *AHA News* and *AHA NewsNow*, along with *H&HN Daily* and *H&HN*, will keep you apprised of overall developments and offer access to new resources and insights from *Hospitals In Pursuit of Excellence*. Educational programs such as the Health Forum/AHA Leadership Summit and HPOE webinars will help bring to life the lessons learned and practices from the guides and reports.

Thank you for all you do every day to pursue excellence in America's hospitals and health systems.

Sincerely,



Rich Umbdenstock
President and CEO

Table of Contents

Welcome Letter from Rich Umbdenstock

Table of Contents

Advanced Illness Management Strategies

August 2012

Palliative Care Services: Solutions for Better Patient Care and Today's Health Care Delivery Challenges

November 2012

Advanced Illness Management Strategies: Engaging the Community and a Ready, Willing and Able Workforce Part 2

December 2012

A Guide to Physician Integration Models for Sustainable Success

September 2012

Engaging Health Care Users: A Framework for Healthy Individuals and Communities

January 2013

Metrics for the Second Curve of Health Care

April 2013

Second Curve Road Map for Health Care

April 2013

The Role of Small and Rural Hospitals and Health Care Systems in Effective Population Health Partnership

June 2013

Becoming a Culturally Competent Health Care Organization

June 2013

Checklists to Improve Patient Safety

June 2013

Value-Based Contracting

July 2013

Available HPOE Guides



Advanced Illness Management Strategies

Part 1

August 2012

A report from the AHA Committee on Performance Improvement:

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The Committee on Performance Improvement's second report in 2012, *Advanced Illness Management Strategies: Engaging the Community and a Ready, Willing and Able Workforce*, can be found at:

<http://www.aha.org/aim-strategies-part2>

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Accessible at: <http://www.aha.org/aim-strategies>

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The APPENDIX identifies a number of valuable resources, including the AHA's Circle of Life information that can be found at www.aha.org/circleoflife.

Executive Summary

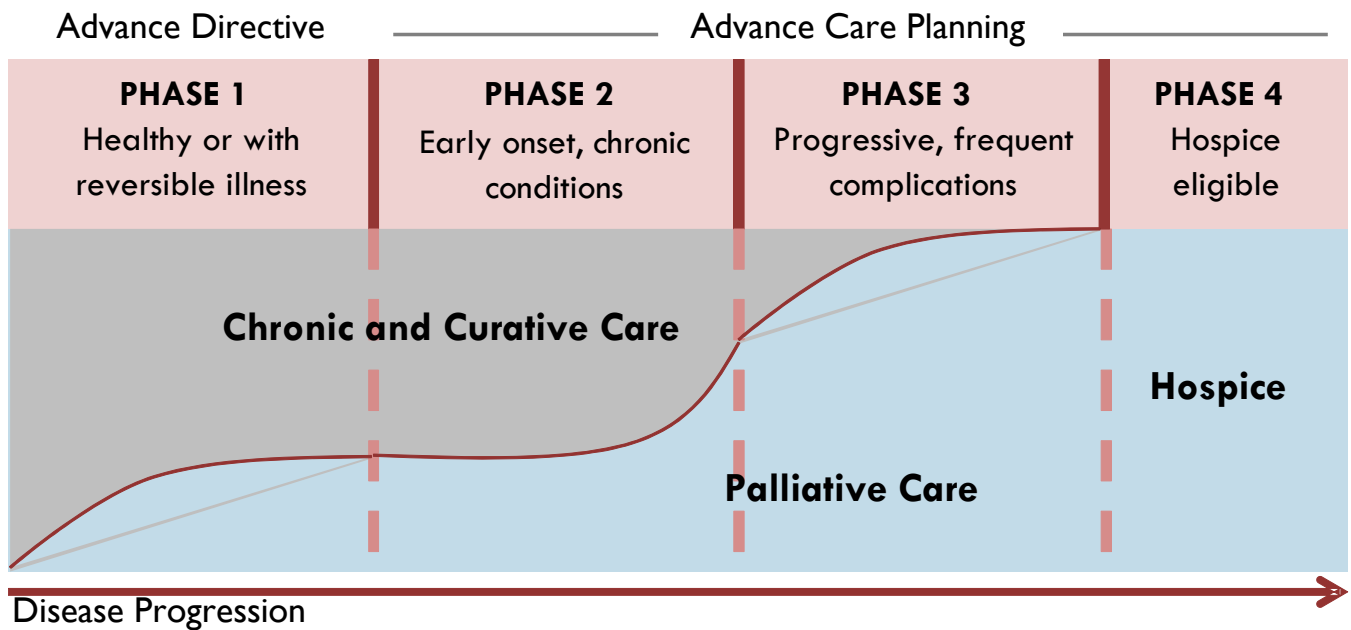
The American Hospital Association (AHA) Board Committee on Performance Improvement (CPI) was created in 2010 to support performance improvement across the AHA membership to align with the AHA's strategic platform—Hospitals in Pursuit of Excellence. The inaugural 2011 CPI report *Hospitals and Care Systems of the Future* is based upon economic futurist J. Ian Morrison's "first-curve-to-second-curve" framework. It describes the shift of payment incentives impacting health care providers' core business models in terms of care and service delivery and demonstrates why progressing from the first curve to the second curve is a vital transition for hospitals.

In 2012, CPI focused on approaches to managing *life in the gap*—the transition period between the first-curve and second-curve economic markets, specifically in **advanced illness management (AIM)**. Hospitals are uniquely positioned to implement best practice strategies to integrate AIM into the normal continuum of care, and ensure that the wishes of the patient and his or her family are carried out by the entire multidisciplinary care team throughout disease progression. Effectively integrating AIM into the continuum of care will position the hospital and health system to manage the gap between the first and second curve and support the transition to the second-curve business, care and service delivery model.

Defining AIM

While many people can and do recover from serious potentially life-threatening illnesses, such as cancer, the trajectory of "advancing illness" leads to death. That decline in health and physical and/or mental capacities needs to be matched by the nature, scope and goals of care. "End of life care", "serious illness" or "advanced illness" are some of the terms used to categorize the set of services for patients and families during the course of illness. The Coalition to Transform Advanced Care (CTAC) defines advanced illness as "occurring when one or more conditions become serious enough that general health and functioning decline, and treatments begin to lose their impact. This is a process that continues to the end of life." For the purpose of this report, AIM is being used as the overarching term.

As depicted in the figure on the following page, AIM evolves through four phases as the patient's health declines. During the first phase, people are basically healthy and can recover from reversible illnesses. Their major AIM actions are to have conversations with trusted family, friends and providers, and sign an advance directive. A person in phase two typically has manageable, early or stable chronic condition(s) for which palliative care may supplement disease treatment as part of maximizing quality of life. Phase three begins when the condition(s) continue to progress, placing increasing limits on the person's activities, independence and quality of life. The final phase begins when the person is deemed hospice-eligible. Although there are four main segments to AIM (advance directives, palliative care, advanced care planning and hospice care), successful programs integrate these four segments into one overarching AIM initiative. The treatment plan will increasingly be driven by the personal goals and decisions of the patient and his or her family.



Source: AHA CPI analysis, 2012, with contributions from 2012 CTAC data and 2011 Center to Advance Palliative Care data.

Why AIM?

Studies evaluating clinical, satisfaction and process measures explore the ability of AIM to reduce pain, increase quality, improve patient and family satisfaction and remove some of the inefficiencies within the health care system. Studies show that:

- Patients receiving palliative care have improved quality of life and fewer major depressive symptoms based on Functional Assessment of Cancer Therapy Scale (FACT-L)ⁱ
- Family and caregivers are five times more likely to have post-traumatic stress disorder and 8.8 times more likely to have prolonged grief disorder if the patient dies in the ICU compared to at home with hospice.^{ii iii}
- Medicare patients with AIM use 13.5 days of hospital care in the last two years of life compared to 23.5 as the national average^{iv}
- On average, patients who received palliative care incurred \$6,900 less in hospital costs during a given admission than a matched group of patients who received the usual care.^v

Goals of AIM and Strategies to Meet Them

The goals of AIM are to improve patient and family satisfaction, increase quality of care, reduce inefficiencies and increase care coordination. This will exist in an environment where:

1. All hospitals and care systems are able to support and deliver high quality AIM;
2. All health care professionals have the knowledge and skills to provide AIM care; and
3. Every patient and his or her family have the knowledge and skills to understand the benefits of advanced illness planning.

The literature points to three key strategies that hospitals should implement to pursue the goals of well-developed AIM initiatives:

1. **Access:** Patient access to AIM services can be greatly increased when all hospitals and care systems are able to support and deliver high quality AIM.
2. **Workforce:** Excellence in AIM depends upon educating and training all health care professionals to provide care over the continuum of health and decline.
3. **Awareness:** Patient and family AIM awareness and understanding of the benefits of advanced illness planning and management can be significantly raised through community-wide strategies.

The current report frames the AIM issues and examines in further depth the first strategy on access to AIM services. A second report will examine workforce and awareness strategies.

Strategy: Increasing Access to AIM Services

Hospitals should examine how they can increase access to AIM services, both across their patient population and across the care continuum. Which treatments patients will want as illness progresses varies based on their age, specific condition, availability of medicine to sustain life and family and caregivers.

Larger organizations have the opportunity to develop full-scale initiatives, while smaller and rural hospitals and care systems may partner with other community entities to achieve the same goals. Successful organizations integrate specific characteristics of each service into one program that would best care for their surrounding populations. Other keys to success include:

1. Developing a multidisciplinary care team with leadership buy-in;
2. Identifying qualifying patients through evidence-based protocols;
3. Thinking beyond the traditional four walls of the hospital to promote AIM collaboration throughout the surrounding community; and
4. Using a performance improvement framework to measure, monitor, evaluate and adapt program between disease states and throughout time.

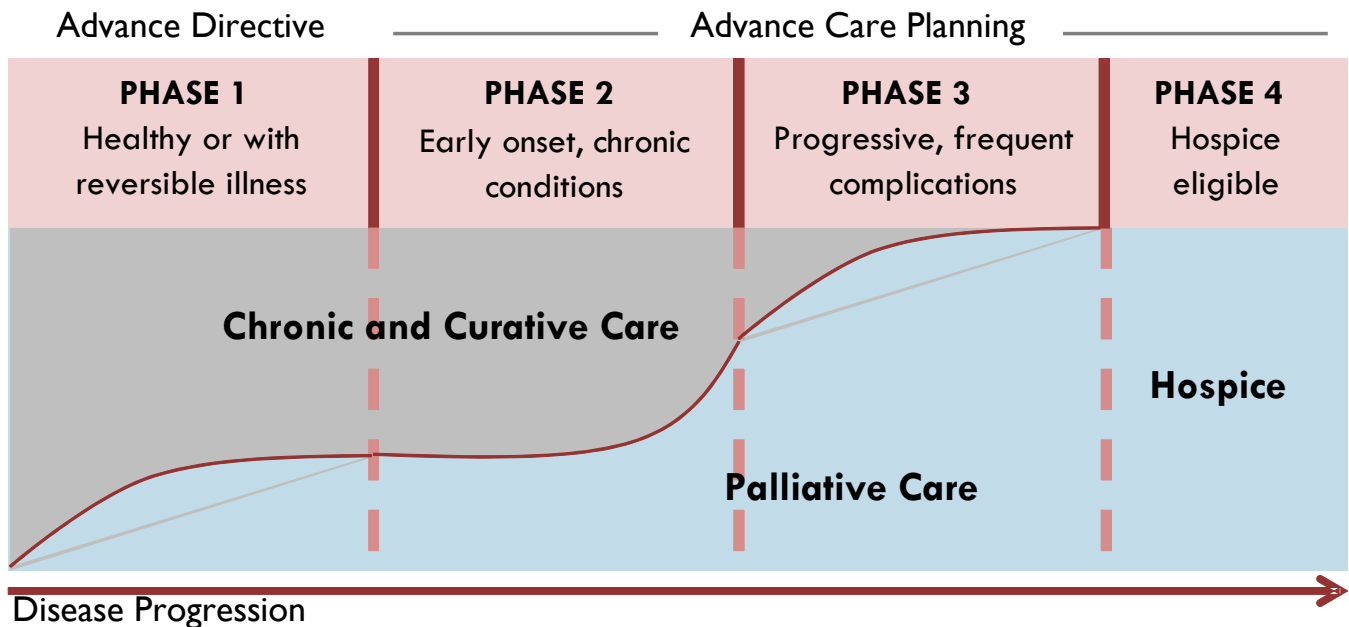
Defining AIM

The trajectory of “advancing illness” leads to death. While many people can and do recover from a serious illness, “advancing illness” can be managed and held in check for only so long (it can be decades, years or months) before it does not respond to existing chronic and curative treatments. Depending on the nature of the illness, it begins to limit what the person can do, produces complications that reduce quality of life, compromises their ability to live independently, and/or interacts with other chronic or emergent conditions to weaken the entire body. Managing its care requires proactive disease management, and balancing changing, expanding needs with the patient’s goals. Ideally, advancing illness is managed as a coordinated continuum of care where quality of life becomes the primary goal of care in its later phases.

Figure 1 depicts four continuous phases of AIM. As the patient progresses through each phase, the nature of care evolves, but the quality remains the same—person-centered, integrated care by a multidisciplinary team of health care professionals adhering to evidence-based, best practice guidelines. The treatment plan is driven by the personal goals and decisions of the patient and his or her family. During the first phase, people are basically healthy and can recover from reversible illnesses. Their major AIM actions are to have conversations with trusted family, friends, and providers and sign an advance directive. A person in phase two typically has manageable, early or stable chronic condition(s). Palliative care may supplement disease treatment as part of maximizing quality of life. Phase three begins when the condition(s) continue to progress, placing increasing limits on the patient’s activities, independence and quality of life. The final phase begins when the person is deemed eligible for hospice.

Although each phase can be denoted by a key marker, successful programs integrate these four segments into one AIM initiative, combining important aspects of each.

Figure 1: Phases of AIM



Source: AHA CPI analysis, 2012, with contributions from 2012 CTAC data and 2011 Center to Advance Palliative Care data.

Advance Directives

Advance directives should be started during phase one. An advance directive is made by a mentally capable person regarding goals of care or treatments for a possible or probable health event. It can be expressed orally or in writing. While having a legal document is important, informing trusted family members, friends and care providers about one's intentions, values and preferences allows care providers and family to accurately interpret the patient's will while minimizing guilt.

Advance Care Planning

Anticipatorily planning is an ongoing process and should be based on potential or likely disease scenarios and future medical decisions. The patient and his or her family caregiver need to understand the disease course and make medical decisions based on that information. They need to reason and reflect about their preferences, discuss them and share their legal documents with those who need to carry out their intentions. With the objective of knowing, understanding and documenting a patient's preferences and intentions, an effective plan should include four main parts: 1) the selection of a well-prepared health care agent or proxy; 2) the creation of specific instructions that reflect informed decisions geared to the person's health state; 3) the availability of these plans to treating physicians; and 4) the incorporation of these plans into medical decisions.^{vi}

Palliative Care

Palliative care encompasses a broad spectrum of care services aimed at alleviating uncomfortable, debilitating, painful or embarrassing symptoms of a disease or side effects of treatment—such as hair loss and nausea from chemotherapy, or shortness of breath from chronic obstructive pulmonary disease. It can be provided concurrently with curative care (care to cure the patient of the disease) or by itself. It aims for achieving the best quality of life possible at any phase of a disease. Palliative care can be delivered in homes, hospitals, intensive-care units, clinics, nursing homes, assisted living or hospice. It can include emotional, social and spiritual care, as well as medical care.

Palliative care is employed to relieve the symptoms causing discomfort, anxiety and suffering as the body deteriorates. It can greatly improve the quality of life for persons with advancing illnesses and the quality of their time with friends and families. It can be provided in conjunction with other appropriate medical treatments, including curative and life-prolonging therapies (Figure 1). As the illness advances, the range of palliative care services utilized in treatment expands. Palliative care is provided by a multidisciplinary team of doctors, nurses, chaplains, social workers and other specialists who assess and treat symptoms, explore care goals, coordinate care, provide support for complex decision making and provide practical, spiritual and psychosocial support.^{vii}

Palliative care specialists recognize and know how to treat symptoms and their interrelationships. For example, a person suffering from end-stage heart failure may want cold water even though their extremities are cold and blue. This is because the heart is working to protect core organs, not extremities and the person may be too warm. Perhaps she suffers from a urinary tract infection (UTI) and becomes agitated, restless and confused. The UTI or medication could be contributing to the restlessness or present as delirium and confusion. The expertise of palliative care specialists can be illustrated by the kinds of symptoms and their interrelationships that they recognize and know how to treat while other health professionals might not recognize the interrelationship.

Hospice

Hospice is a philosophy and a comprehensive yet flexible set of services designed to meet the fluctuating, changing and expanding medical, social, emotional and spiritual needs of those approaching the last stages of life. In order to qualify for the hospice benefit, Medicare requires that two physicians certify a patient's prognosis of six months of life or less and the patient foregoing life-extending treatments. Rather than "fighting" the disease and attempting to cure it, hospice allows the advancing illness to take its course while making the patient as physically and mentally comfortable as possible. Its goal is to improve symptom management and quality of life for patients with a terminal illness. Intriguingly, patients often live longer under hospice care than patients who don't enter hospice.

Hospice care includes a broad array of palliative care and support services provided by a multidisciplinary team. Usually headed by a registered nurse, the team includes licensed practical nurses and social workers who meet regularly with the hospice medical director. The team is supplemented by on-call nurses, night nurses, chaplains, schedulers, volunteers and others. Although some hospices offer residential services, most care is delivered in the home or nursing home. Caregivers can receive instructions and guidance on how to care for their dying loved one. For example, they are trained on repositioning the person so they don't get bedsores, and transferring the person from chair to wheelchair to toilet and lifting them up again without injuring their own backs.

One of the most startling changes that family caregivers notice when working with hospice is how easily and quickly palliative medications are available to address new symptoms. At the outset of the relationship, the family caregiver has a long meeting with the registered nurse, during which they identify drugs that can be dispensed immediately and later checked with the patient's physician or the medical director. During this meeting, varying dosages and medication forms are discussed (liquids when swallowing pills become problematic; suppositories when swallowing anything is an issue). Therefore, when an uncomfortable symptom appears, the caregiver does not have to call the doctor, wait for a callback, wait for the pharmacy, and figure out how to get it delivered. Instead, the item has been anticipatorily preordered on the protocol, the nurse lets the pharmacy know what's needed, and within a short timeframe, the pharmacy delivers it to the home. The pharmacy also delivers listed pharmaceuticals (such as lorazepam and morphine) for which a log is kept and monitored to the drop.

Why AIM?

U.S. health care spending has increased dramatically for the past two decades, with care during the last six months of life driving a large part of that spending. According to the Agency of Healthcare Research and Quality (AHRQ), 5 percent of the population accounts for 49 percent of total health care expenses. Currently, 90 million people in the United States live with at least one chronic illness, and seven out of 10 die from chronic disease^{viii} and by 2050, the U.S. Census Bureau projects the population 85 years and older will reach nearly 21 million. As the population grows older, it is more likely to suffer from multiple, chronic diseases. Multiple chronic conditions typically require more clinical treatments, are costlier to treat, experience lower quality outcomes and demand higher care coordination to manage effectively.

American hospitals are rapidly filling with seriously ill and frail adults. Most people facing advancing illness will end up in the hospital at some point in their illness, typically at the end of life. However, more than 80 percent of patients say that they wish to avoid hospitalization and intensive care during the terminal phase of illness, according to the Dartmouth Atlas of Health Care. AIM success reduces hospital admissions and unnecessary utilization, improves clinical outcomes, patient and family satisfaction and length of stay and honors the wishes of the person being treated. Table 1 aggregates study results that have investigated the benefits of well-developed AIM programs.

Table I. Proven Results of AIM

Quality	Hospitals using AIM provide patients with improved quality of life, reduced major depression and increased length of survival.
	<ul style="list-style-type: none"> • Improved quality of life when referred to earlier palliative care based on Functional Assessment of Cancer Therapy Scale (FACT-L).^{ix} • Fewer patients in a palliative care group versus a standard group had major depressive symptoms (16% versus 38%).^x • Median survival among early palliative care patients is longer (11.6 months versus 8.9 months).^{xi} • Patients with cancer who died in an intensive care unit or hospital experience more physical and emotional distress and worse quality of life at the end of life compared with patient who died at home with hospice.^{xii} • Patients referred to hospice care over non-hospice care saw an increased mean survival of 29 days (varying by disease from 81 days for congestive heart failure to 4 days for prostate cancer).^{xiii}
Utilization	Overall, patients enrolled in AIM experience a lower utilization of clinical treatments and hospital admissions at the end of life, due to improved coordination and honoring the patient and family’s wishes.
	<ul style="list-style-type: none"> • Medicare patients with AIM use 13.5 days of hospital care in the last 2 years of life compared to 23.5 as the national average.^{xiv} • Fewer ICU admissions^{xv} and as much as an 85% reduction in ICU days.^{xvi} • Reduced number of ED visits (2002 CAPC survey) with one system experiencing a 25% reduction in ED visits for its AIM patients^{xvii} • Reduced hospital admissions, with one system seeing a 58% reduction in AIM patients.^{xviii} • Lowered number of laboratory tests and reduced pharmacy utilization (2002 CAPC survey). • Patients receiving earlier palliative care received less aggressive end-of-life care (33% vs. 54%). For example, this means the patient receives less chemotherapy 14 days or less before death, and more hospice care and less hospitalization in the last month.^{xix} • Palliative care recipients in four New York state hospitals spent less time in intensive care and were more likely to receive hospice referrals.^{xx}
Satisfaction	AIM programs lead to improved satisfaction scores for patients, family, caregivers and from the multidisciplinary AIM-trained staff.
	<ul style="list-style-type: none"> • Knowledge and respect of patient’s preferences.^{xxi} • Increased time devoted to family meetings and counseling.^{xxii} • Reduced family and caregiver depression, distress, and documented anxiety.^{xxiii} • Compare to hospice care at home, care in the hospital intensive care unit is associated with 5 times the family risk of post-traumatic stress disorder.^{xxiv} • Compared to hospice care at home, care in the hospital associated with 8.8 times risk of prolonged grief disorder.^{xxv}
Spending	Due to improved care coordination and associated prevention of crises, a secondary impact of AIM programs is the reduction in aggregate spending.
	<ul style="list-style-type: none"> • Palliative care patients discharged alive had adjusted net savings of \$1,696 in direct spending per admission and \$279 in direct spending per day, including significant reductions in laboratory and intensive care unit charges.^{xxvi} • Palliative patients who passed away while in admission to the hospital had an adjusted net savings of \$4,908 in direct spending per admission and \$374 in direct spending per day.^{xxvii} • On average, patients who received palliative care incurred \$6,900 less in hospital costs during a given admission than a matched group of patients who received usual care.^{xxviii} • Preliminary data indicates fewer hospitalizations amounting in an average savings per patient of about \$2,000 per month.^{xxix} • Hospitals experienced a positive net contribution margin of \$1,333 per AIM enrollment.^{xxx}

Source: AHA CPI analysis, 2012.

Where Are We Now?

Hospitals have been growing AIM program components and improving the care for serious illness. According to a recent study done by the Center to Advance Palliative Care (CAPC), palliative care programs are now available at more than 80 percent of hospitals with more than 300 beds, with more than 85 percent of hospitals having dedicated, trained AIM staff. From 2003 to 2007, the percentage of chronically ill Medicare patients dying in hospitals and the average number of days they spent in the hospital before their deaths both declined. The percentage of deaths associated with a stay in intensive care also decreased in most regions of the US.^{xxxi}

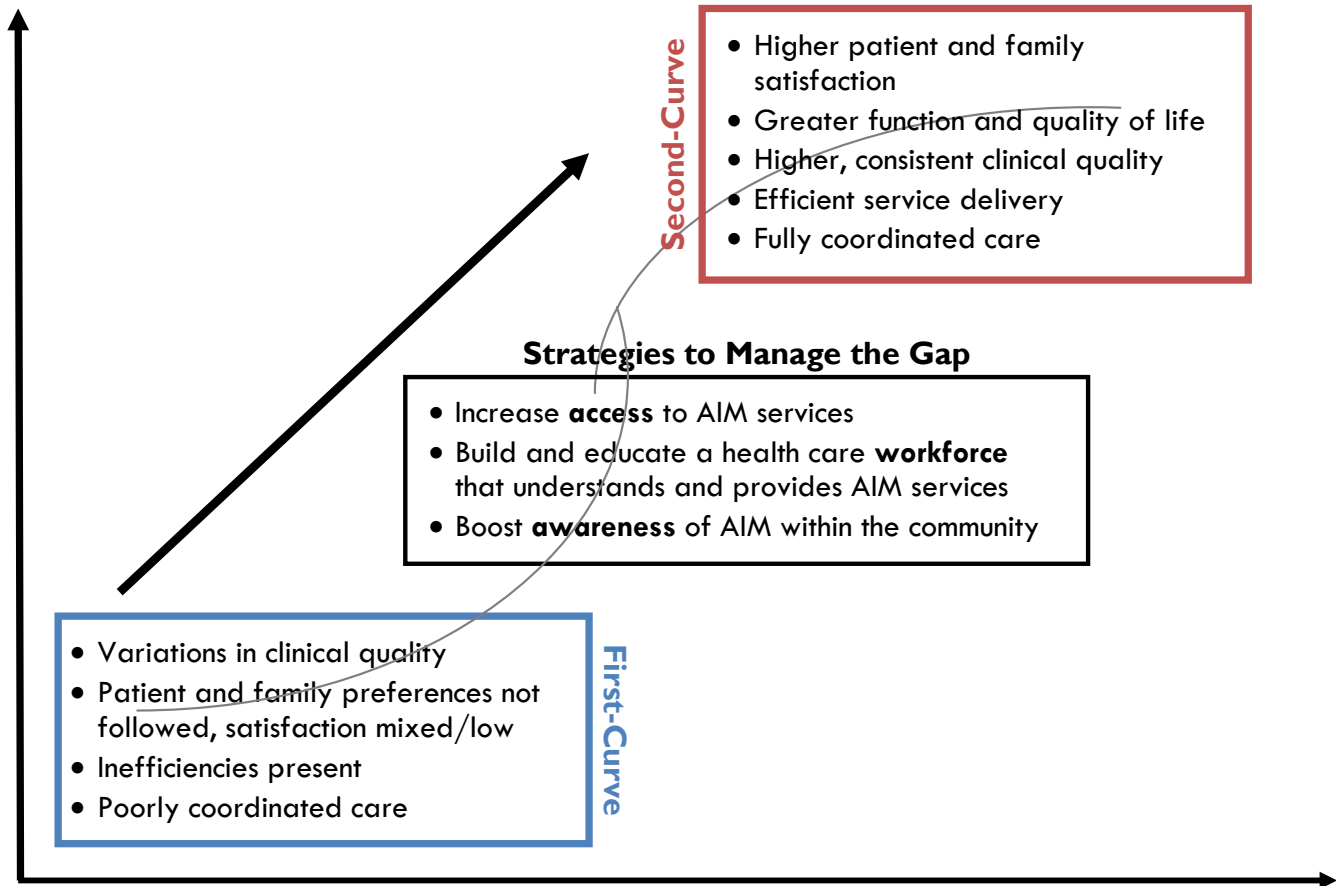
External policy and quality-focused organizations have started to push hospitals toward developing programs on their own or through external partnerships. The National Quality Forum, the Centers for Medicare & Medicaid and the Joint Commission have all either published quality metrics or created guidelines to advance AIM. Please see the **Appendix** for links to some of the external organizations.

Although hospitals have made significant gains, there is still room for improvement in both the number and coordination of AIM programs. For instance, while the percentage of Medicare beneficiaries dying in hospitals declined overall between 2003 and 2007, the Dartmouth Atlas found that during that same period there were sharp increases in the amount of physician labor per patient during the last two years of life, indicating that care can be further optimized to benefit the patient's wishes.

AIM Goals

The goals of AIM are to improve patient and family satisfaction and quality of life, increase clinical quality, reduce inefficiencies and increase care coordination. In a second-curve, value-based environment where incentives are aligned, a success AIM program includes: 1) all hospitals and care systems supporting and delivering high quality AIM; 2) all health care professionals possessing the knowledge, understanding and skills to provide AIM care; and 3) every patient and his or her family having the knowledge and skills to understand the benefits of AIM. Successful programs also address cultural sensitivities related to managing advanced illness.

Figure 2. Navigating AIM



Source: AHA CPI analysis, 2012.

While great strides have been made in AIM, the current volume-driven market has produced large variances in quality, unnecessary costs and utilization, low-patient satisfaction, and the inability to honor and follow the preferences of patients and their families.

Hospitals face several obstacles in the push toward AIM's second-curve goals. Current reimbursement schedules foster more inpatient care rather than proactively managing care in the outpatient setting. Some providers have mixed feelings about the use of AIM services. Many physicians and other clinicians still view AIM as an alternative to chronic and curative treatments, rather than as a simultaneously delivered adjunct to disease-focused, superior quality treatment. Low-community awareness of the availability, utility and benefits of these services also decrease use. Thus, despite the increasing availability of AIM services in U.S. hospitals and the evidence displaying the benefits, the use of AIM still remains low.

Strategies to Manage the Gap

As portrayed in Figure 2, the literature has pointed to three key strategies—**access, workforce and awareness**—that hospitals should implement to pursue the goals of AIM initiatives to increase clinical quality, reduce inefficiencies, coordinate care, improve patient and family satisfaction and quality of life. This report focuses on strategy one—**access**. A second report will focus on strategies two and three.

1. Increase access to AIM Services

Hospitals should provide patients and their families and caregivers support and services for each phase of the AIM process (defined in Figure 1). For larger organizations, this may mean the development of stand-alone palliative care services and hospices, while smaller and geographically challenged hospitals can turn to partnerships throughout the community to help provide these services. AIM services should not be seen as four unique segments but include elements integrated within the care continuum for all patients. Standards should be promoted and implemented as these programs develop further and quality of service is improved.

2. Build and educate a workforce that understands and can provide AIM services

Awareness among the clinical workforce is spreading, but most practitioners still require significant training both to provide and to communicate these services. The workforce must receive rigorous training to identify patients that would qualify and benefit from AIM services, communicate about these services, and coordinate and provide these services with a multidisciplinary team.

3. Boost AIM awareness within the community

Working with clinicians to reach patients about AIM services is an effective means to incorporate these programs within the care continuum. However, public awareness of AIM benefits needs to be increased. Patients currently equate hospice services with death. Patients will only recognize AIM benefits on improved quality of life and survival through increased community awareness and education. Communicating directly with patient populations about the availability of advance care planning services, as well as the patient and family role within the continuum, improves the results.

To effectively improve the prevalence of AIM programs and its integration into the care continuum, hospitals should expand AIM services, educate clinical and administrative staff, collaborate with other organizations, and spread awareness of AIM benefits throughout the community. Although the literature treats these strategies as separate, they are better understood as working together in an integral way. Access to services begins with availability, the supply side of the equation. Awareness of these services is essential to increasing demand for them. Having a workforce that can and will provide a continuum of care for advancing illness works both the supply and the demand sides. For AIM services to be available and beneficial, and for people to have access to skilled services, a well-trained workforce is necessary. That workforce needs to be an integral part of people utilizing AIM services.

Thus, these three strategies should be viewed as forming an interactive triangle whose three points need to be equal and connected, instead of separate pieces. If demand ramps up too quickly, would the hospital and hospice infrastructure of services be able to manage it? If people aren't educated about the benefits of AIM, will they utilize the programs when they become available? If the workforce isn't trained properly, will the programs be effectively carried out?

Increasing Access to AIM Programs

As the health of those with serious illness declines, chronic and curative treatment plans lead to significant increases in medical service utilization—ranging from specialist appointments and lab tests to procedures and hospital admissions. The average Medicare beneficiary with one or more chronic conditions consults with eight different physicians annually.^{xxxii} Research confirms that providing more care does not necessarily lead to better outcomes or truly represent the wishes of patients and their families.

Hospitals are in a unique position to increase patient access to AIM services by incorporating each of the specific phases (as defined in Figure 1) into the traditional patient-care continuum. Hospitals could change the ways medical services are utilized to improve outcomes and honor the wishes of patients and families.

Larger organizations may develop stand-alone initiatives, while smaller and rural hospitals and care systems may partner with other community entities to achieve the same goals. However, one strategy is consistent; hospitals and care systems need to integrate specific characteristics of each of the four phases into a single program. As with other implementation strategies, standards should be established as the programs continue to develop, and organizations must continually analyze the quality of their AIM services for improvement.

The remainder of this report provides:

- A programmatic framework for AIM;
- Metrics that can be used to measure progress; and
- Four case examples that illustrate the ability to provide and increase access to AIM services. Additional case studies may be found at AHA's Circle of Life website at www.aha.org/circleoflife and other resources identified in the **Appendix**.

AIM Program Framework

Hospitals understand the benefits of AIM but struggle with implementation. Complete program design varies among organizations. AIM decisions are some of the most difficult decisions made by clinical providers, patient and their families; therefore programs need to take into account the complexity and interdependence of issues. In addition to patient and family preferences, religious beliefs, cultural sensitivity and local practice patterns, workforce capabilities and financial incentives also shape the organization’s capacity for AIM development.

The chart below provides a basic framework that hospitals and health systems can use as a guide to coordinating AIM services and increasing access. There are no designations between AIM segments in the framework (advance directives, palliative care, advanced care planning and hospice care) because organizations should consider all four segments across the continuum, combine these into one program and decide which services would be best for the surrounding population. Program design will require adjustment once implementation begins to ensure continuous quality and to meet the changing needs of physicians, patients and families.

Develop planning team	<p>Since AIM impacts many clinical areas, it is important to form a multidisciplinary planning team. This will help ensure that the program meets the needs of patient and hospital.</p> <ul style="list-style-type: none"> • Physician leadership • Physicians (employed and community-based) • Nursing leadership • Nursing staff • Pain management specialist • Palliative/hospice leadership • Hospital senior administrator • Medical social worker • Clinical pharmacist • Nutritionist • Chaplain • Front-line administrators • Resource/case managers
Align with organization mission	<p>AIM involves clinical, psychosocial and spiritual elements. Therefore it is important to create a program that complements the specific organization’s mission and vision.</p>
Analyze current situation	<p>Organizations must perform quantitative and qualitative analysis on current capabilities based on current programs. This should be an internal and external capability assessment, identifying existing external resources and gaps in AIM services. Additionally, hospitals should calculate current metrics for a baseline and compare it to state and national trends to recognize strengths and areas for improvement.</p>
Set goals	<p>Hospitals and care systems must set a goal for the program breadth that they can support and identify external organizations to partner with to fill in gaps in the care continuum.</p>

<p>Develop individualized program based on capabilities</p>	<p>AIM initiatives must be hospital and community specific. Program design will vary based on several factors such as:</p> <ul style="list-style-type: none"> • Clinical staff interest • Current case management and discharge planning capabilities • Leadership priorities • Surrounding population demographics • Available workforce—physicians, nurses, social workers, etc. • Existing relationships with external AIM organizations • Hospital chaplaincy program status • Pain program status • Community interest in AIM • Multicultural environments • Available physical location
<p>Implement an integrated program</p>	<p>While implementation plans will vary, there are essential features of any initiative:</p> <ul style="list-style-type: none"> • Clinical and administrative leadership should have a strong consensus on the goals of the AIM program. • Metrics measuring access should be continually analyzed for progress • Guidelines should be written for evidence-based evaluation.
<p>Collaborate and educate</p>	<p>Hospitals should develop educational materials for all staff within the facility and throughout the community, in addition to materials for the larger population. This process of education and spreading awareness will be discussed in a separate publication.</p>
<p>Track progress</p>	<p>Hospitals must continually measure outcome, progress and various balance metrics to gauge improvement and recognize challenges to improving AIM access and availability. For true growth, metrics should be distributed to all staff involved in AIM for feedback.</p>

Source: AHA CPI analysis, 2012.

AIM Metrics

Metrics are useful to evaluate the current state of the organization, monitor progress, identify challenges and recognize unforeseen results of a coordinated AIM program implementation. There are many options that can be analyzed, and organizations may see statistical quantitative differences at different phases in program development and implementation. Gaining an understanding of the metrics in the beginning will aid teams in appropriate program development. Organizations will not be able to measure all of the metrics below, but should choose the ones that make the most sense for their situation. Metrics will vary by disease state. ^{xxxiii}

Outcome Metrics

How is the system performing? What are the patient-centered results?

<ul style="list-style-type: none"> • Meeting patient preference on longevity and quality of life • Rate of major depression • Pain control scores • Symptom management control scores 	<ul style="list-style-type: none"> • Family and caregiver depression, distress, anxiety (post traumatic stress disorder/prolonged grief disorder) • Patient satisfaction • Family and caregiver satisfaction
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Process Metrics

Is the hospital performing as expected?

<ul style="list-style-type: none"> • Hospice referrals/consults • Palliative care referrals/consults • Advanced care planning discussions • Frequency of goal documentation 	<ul style="list-style-type: none"> • Percent of patients with advance directives • Treatment decisions consistent with instructions • Days with at-home hospice care • Inpatient hospice length of stay
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Balancing Metrics

What happened to the hospital after improvement in outcome and process metrics? What are the unanticipated consequences?

<ul style="list-style-type: none"> • Clinical staff retention and satisfaction • Independent physician satisfaction • Emergency department utilization • Hospital stay cost • 30-day readmissions rates • Spending per admission • Medical specialist visits • Surgery in last month of life 	<ul style="list-style-type: none"> • Days of hospital care in last 2 years of life • Admissions in last 6 months of life • ICU admissions and length of stay • ICU days in last 2 years of life • Laboratory utilization • Pharmacy utilization and spending • Treatment aggressiveness (chemotherapy 14 days or less before death, imaging studies in the last week of life, etc.)
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Source: AHA CPI analysis, 2012.

Successful AIM Examples

Reducing readmissions through streamlined AIM

Mercy Medical Center, Cedar Rapids, Iowa, has a well-developed AIM program that spans the entire continuum. This program has made a large impact on readmission rates. The hospital is ranked in the top 3 percent for readmission rates for heart attack, heart failure and pneumonia.^{xxxiv}

What they did

Mercy participates in the Iowa Physician Order for Sustaining Treatment (IPOST) program that is modeled on the Physician Orders for Life-Sustaining Treatment Paradigm program (www.polst.org). IPOST is a collaborative tool recognized by emergency medical technicians and organizations that promote communication of the patient's wishes. Specific medical orders, signed by a physician, travel with the patient across the care continuum and care venues—nursing facility, hospital, home—and can be revocable or altered by the patient at any time.

Before a form is signed, a palliative care team leads a discussion about advanced care planning, the date of which is posted on the wall within the facility. This multidisciplinary team—typically the patient's physician, a palliative-care consulting physician, an advanced-practice nurse, a social worker, the patient and his or her family—develop a care plan centered on the patient's preferences. This discussion is guided by a facilitator specifically trained to have these conversations, a program called Respecting Choices. This palliative-care consult is provided to patients that meet a specific level of complex illness or serious health conditions. They are identified by frequent visits to the emergency department, unnecessary inpatient admissions or prolonged lengths of stay.

Hospice of Mercy is also part of the Mercy Medical Center system. Run by the same leadership as the palliative-care program, the hospice program develops care plans both for the home and for the 12-bed inpatient facility. Analysis revealed that readmission rates were highest when patients were discharged to the nursing home, so Mercy deployed hospice nurses to provide care in these nursing homes, making it more likely that a patient transfer to the hospital only when clinically necessary.

Keys to success

- Multidisciplinary effort from the beginning
- Identifying qualified patients upon emergency department usage, unnecessary inpatient admissions or prolonged lengths of stay
- Leadership crosses the AIM continuum
- Well-designed advance care planning discussions using a team approach and documented with IPOST forms that can be honored across settings of care.
- Promoting AIM throughout the surrounding community.^{xxxv}

Providing palliative consults for rural providers through the Rural Palliative Care Network

Fletcher Allen Health Care, a university-based health system in Burlington, Vermont, serves rural areas in Vermont and northern New York. While the organization has an AIM program through a large donation, it created the Rural Palliative Care Network to provide palliative and hospice care education to physicians and patients throughout the region.

What they did

There are four main components to the Rural Palliative Care Network:

1) Telephone hotline available 24 hours a day, seven days a week

This assists both referring physicians and patients.

2) Telemedicine consults for patients

The Fletcher Allen team provides palliative-care consults for patients before transferring them to the facility's medical intensive care unit. During these consults, the palliative team answers questions from the patient, his or her family, the MICU-attending physician, or the referring physician. This begins relationship and team building.

3) Mentorship program for community providers

Community physicians can receive one day of training from the Fletcher Allen palliative care team.

4) Visits to hospitals to observe palliative care services

Fletcher Allen palliative care team members visit other community hospitals and physician practices to educate different audiences about the benefits of AIM services.

Keys to success

- Knowledge of the specific communities
- Establishing a care team, consisting of the patient, physician and family
- Educating physicians and others in the community on available services^{xxxxvi}

Structuring disease-based AIM transitions program for better outcomes

Sharp Hospice, part of Sharp Healthcare, San Diego, established their AIM program called Transitions. It focuses on keeping patients at home rather than in the hospital while managing advanced illness according to their wishes during their last two years of life.

What they did

As opposed to other general programs, Sharp's Transitions program is disease-specific, allowing for more evidence-based approaches. Currently managing the advanced illness progression for patients with heart failure, chronic obstructive pulmonary disorder and dementia, it is expanding capacity to stage IV cancer, cirrhosis and geriatric frailty syndrome in 2012.

Based on education, early symptom recognition and the creation of a road map to reach care goals, each patient in the program is designated a multidisciplinary care team consisting of a nurse, social worker, spiritual care counselor and the patient's physician. There are four pillars to Sharp's Transitions program:

- 1) Comprehensive home-based patient and family education;
- 2) Disease specific, evidence-based prognosis;
- 3) Proactive management of the caregiver to set realistic expectations on survival; and
- 4) Advance care planning with accurate descriptions of what treatments can provide.

These pillars are accomplished through both active management strategies (with each patient receiving an average of 10 home-based visits from mostly nurses and social workers annually) and maintenance approaches using telephone contact and nurse visits.

From June 2007 through December 2008, patients enrolled in the Transitions program experienced a 94 percent reduction in emergency department visits and hospitalizations as compared to pre-enrollment in the program. There was a 71 percent reduction in spending among this patient population. Transition patients are transferred to hospice 80 percent of the time. Nationally, 63 percent of congestive heart failure patients die in the hospital. Only three of the 109 program members died while admitted.

Keys to success

- Retain physician champions and other key stakeholders to engage support in development process
- Select one diagnosis and work through issues as each condition must be treated differently
- Think outside the four walls of the hospital
- Use a performance improvement framework to measure, monitor, evaluate and adapt program between disease states and over time.^{xxxvii}

Providing ambulatory palliative care to patients gives them options

Sutter Health serves patients in more than 100 Northern California cities. Sutter Health implemented the AIM program on a limited basis in 2009 to a group of patients who were already enrolled in home health care services through Sutter Health. In 2010, the program was expanded to patients with advanced illness in the Sacramento, Roseville and Davis metropolitan areas. More than 1,600 patients have participated in the program in the two-year period.

What they did

Sutter's AIM program is targeted at individuals in the last 12 months of their lives. Generally, these patients have at least 2 chronic conditions. The program is considered "ambulatory palliative care," and provides patients with an alternative to receiving care at the emergency department or hospital.

When the patient enters the program, at the hospital or from the community, they are assigned a care manager to serve as their main contact. Patients are also given a number they can call 24 hours a day, seven days a week. The AIM patient and care manager have a support network of a multidisciplinary team that consists of many health providers—physicians, nurses and home health professionals. Physicians are viewed as partners in providing care and are trained on what to look for in eligible patients. Nurses are specifically trained for the program to ensure care is given according to the patients' goals. Palliative care physicians oversee the clinical care of the AIM team and serve as an important liaison to the primary physicians. The first step is to have "the conversation" with patients regarding their care goals and preferences. These are then incorporated into Sutter's electronic health record. All providers have access to the health record and a patient may change his/her goals at any time. Patients are typically seen in the hospital, at home for 30 to 60 days and through office-based care with telemanagement.

Moving forward, the program wants to incorporate biomonitors to remotely track patient health status through key biometrics such as weight and blood pressure. The program works because it has a systems approach. Patients are referred from all areas of the system—40 percent from physician practices, 34 percent from the hospital, 20 percent from home health and hospice, and the remainder from other sources. Physician engagement is essential for the program's success. With a multidisciplinary team, the physician isn't the patient's only contact. Physicians are assisted by other experts skilled in tackling social, family and medical issues. AIM also helps provide better care to the patient in terms of symptom relief and quality of care.

Keys to success

- Physician engagement
- Team-based care that is protocol driven
- A board and system that supports a patient-centered care approach
- An integrated, system approach to care delivery.

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APPENDIX

Resources to improve AIM programs and services

1. AHA's Hospitals in Pursuit of Excellence
<http://www.hpoe.org>
2. AHA's Circle of Life
<http://www.aha.org/circleoflife>
3. Center to Advance Palliative Care
<http://www.capc.org>
4. Coalition to Transform Advanced Care
<http://www.advancedcarecoalition.org>
5. Institute for Healthcare Improvement's Conversation Project
<http://app.ihl.org/ittemp/ConversationProject/>
6. Joint Commission's Palliative Care Certificate Program
http://www.jointcommission.org/certification/palliative_care.aspx
7. National Comprehensive Cancer Network
http://www.nccn.org/professionals/physician_gls/f_guidelines.asp#supportive
8. National Consensus Project for Quality Palliative Care
<http://www.nationalconsensusproject.org>
9. National Hospice and Palliative Care Organization
<http://www.nhpco.org/templates/1/homepage.cfm>
10. National Quality Forum's Palliative Care Guidelines
http://www.qualityforum.org/Topics/Palliative_and_End-of-Life_Care.aspx
11. Respecting Choices
<http://respectingchoices.org>



Palliative Care Services: Solutions for Better Patient Care and Today's Health Care Delivery Challenges

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Accessible at: <http://www.hpoe.org/palliative-care-services>

For related resources, access *Advanced Illness Management*, a report from the 2012 AHA Committee on Performance Improvement, at <http://www.hpoe.org/resources/hpoehretaha-guides/800>

Contact: Hospitals in Pursuit of Excellence at hpoe@aha.org.

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Table of Contents

Executive Summary.....	3
Palliative Care: Definition and Impact.....	4
Growth in Hospital Palliative Care.....	4
Impact of Palliative Care.....	5
National Guidelines and Certification.....	6
Program Funding.....	6
Health Care Reform: The Role of Palliative Care in the Hospital.....	7
Improving Quality of Care and Reducing Readmissions.....	7
Case Example.....	7
Improving Quality of Care and Using Resources Wisely.....	8
Improving Quality of Care and Integrating Systems.....	8
Case Examples.....	9
Palliative Care Service Delivery.....	11
Consultation Service.....	11
Inpatient Units.....	12
Integration into the ICU and ED.....	12
Outpatient Care.....	12
Steps to Start or Expand Palliative Care Services.....	13
Conclusion.....	13
Appendix A: National Palliative Care Standards and Certification.....	14
Appendix B: Operational Features for Hospital Palliative Care Programs.....	15
Appendix C: Useful Metrics to Measure Impact and Value of Hospital Palliative Care.....	17
Appendix D: Palliative Care Screening Tool.....	18
References.....	19

Executive Summary

Palliative care specializes in taking care of patients with serious illness and focuses on providing relief from symptoms, pain and stress in order to improve the quality of life for patients and their families. The care is provided by an interdisciplinary team whose focus is:

- Assessment and treatment of a patient’s physical and emotional/spiritual distress
- Communication and decision making with patients and their families to establish achievable patient-centered goals of care
- Coordination of transitions of care and support for practical needs of patients and families

Palliative Care Services: Solutions for Better Patient Care and Today’s Health Care Delivery Challenges is designed to provide hospital and health care system leaders with the knowledge and resources necessary to understand the benefits and opportunities of providing high-quality palliative care services. Based on 20 years of clinical service development and research to understand the impact of hospital palliative care services, effective palliative care services can:

- Improve patient- and family-centered care and optimize quality of life
- Reduce avoidable patient suffering and distress from physical and psychological symptoms
- Reduce intensive care unit (ICU) length of stay for complex, seriously ill patients
- Improve discharge planning efficiency by rapid establishment of achievable patient-centered goals and care plans that meet these goals
- Reduce readmissions for patients with serious illness or multiple chronic conditions
- Improve both survival and quality of life in cancer patients co-managed with oncologists in the outpatient setting
- Prevent adverse events and lead to better outcomes, fewer readmissions and shorter hospital stays

Many hospitals and health care systems have recognized these benefits and are moving in a coordinated fashion to integrate palliative care principles and services. These services help meet national priorities of providing high-quality, patient-centered care and reducing readmissions and health care costs.

Important steps to ensure that hospitals are maximizing the potential of palliative care programs include:

- Convene a planning committee comprised of key hospital and health care system clinicians and administrative leaders
- Complete a needs assessment and align palliative care services with hospital and health care system priorities
- Review current priorities and identify those areas where palliative care services have been shown to improve outcomes
- Collect data to demonstrate the need for palliative care services and to use as baseline measures for performance improvement.
- Learn from peer institutions that are successfully integrating palliative care services into ICUs, emergency departments (EDs), hospitalist programs and outpatient services
- Develop a strategic plan and budget including new services, staffing and metrics to document program value

By viewing palliative care services as an essential component for co-management of the sickest and most complex patients served by U.S. hospitals—rather than only an “end-of-life” service line—leaders can improve the quality of care and quality of life for seriously ill patients and their families.

Palliative Care: Definition and Impact

Palliative care is the medical and nursing specialty focused on improving quality of life for seriously ill patients and their families. The following definition highlights how palliative care provides an added layer of support at the same time the patient is receiving all appropriate curative or disease-modifying treatments:

Palliative care is specialized medical care for people with serious illness. This type of care is focused on providing patients relief from the symptoms, pain and stress of a serious illness—whatever the diagnosis. The goal of palliative care is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses and other specialists who work with a patient’s other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.⁵

Palliative care should be delivered by a patient’s primary clinician(s) as a routine component of care, such as assessment and treatment of pain and other symptoms. These primary palliative care services should be expected from all clinicians caring for seriously ill patients.

Specialist palliative care services should be delivered by an interdisciplinary team that includes clinicians, social workers, spiritual counselors and others with special training and, if possible, with certification (see Appendix A). Services provided by a specialist palliative care team focus on:

- Assessment and treatment of a patient’s physical and emotional/spiritual distress, including pain, depression and shortness of breath, and of family burnout and exhaustion
- Communication and decision making with patients and their families to establish and then pursue medically achievable, patient-centered goals of care
- Coordination of transitions of care and support for practical needs of patients and families across care settings

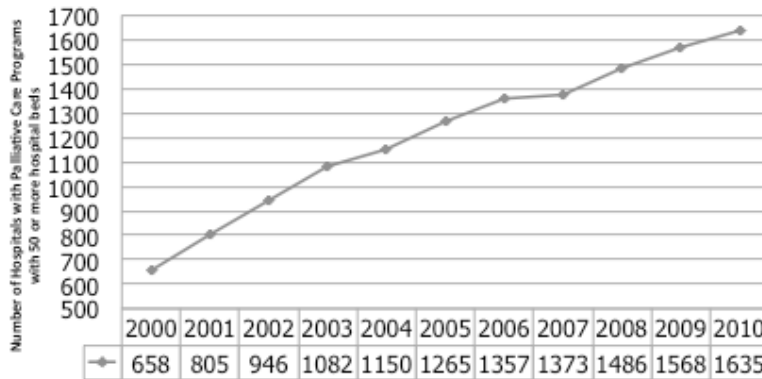
In addition, palliative care teams provide expert clinical consultation to colleagues, educate hospital staff and trainees and collect, measure and report program outcome data. Palliative care teams strive to integrate palliative care principles throughout the institution, seeking to align with mission and improve key quality outcomes.

Growth in Hospital Palliative Care

Availability of hospital-based palliative care services has increased rapidly in the United States during the last 10 years. More than 1,600 hospitals, 66 percent of those with 50 or more beds, reported on the 2010 American Hospital Association Annual Hospital Survey that they had a palliative care team.⁶ Nearly all of America’s larger hospitals with more than 250 beds reported having a palliative care team, an important resource given the concentration of serious and complex illnesses in these settings. See the graph “Prevalence of U.S. Hospital Palliative Care Programs 2000–2010” on page 5.

Prevalence of U.S. Hospital Palliative Care Programs 2000-2010

(50 or more hospital beds)



Source: 2002 to 2012 American Hospital Association Annual Hospital Surveys for FY 2000 to 2010; and Data from the Center to Advance Palliative Care's (CAPC) National Palliative Care Registry.™

Recent opinion polling revealed that palliative care is relatively unknown to the public and poorly understood by many health care providers.^{5,7} Many physicians misunderstand palliative care and wrongly conflate it with hospice or end-of-life care, a finding that calls for better training at all levels from medical school students to mid-career practitioners. And although consumers know relatively little about palliative care, once informed they become extremely positive about this type of care and want access to it.

The public opinion research showed that:

- 95 percent of consumers agree that it is important for patients with serious illness and their families to know about palliative care
- 92 percent of consumers say it is important that palliative care services be made available at all hospitals for patients with serious illness and their families⁵

Impact of Palliative Care

Palliative care programs consistently demonstrate improvement in patients' physical and psychosocial symptoms; in family caregiver well-being; and in patient, family and physician satisfaction.^{1,3,9-20} Palliative care teams identify and effectively treat distressing symptoms that have been shown to increase medical complications and hospitalization.^{1,21} Teams meet with patients to establish realistic care and treatment goals, support families in crisis and plan for safe transitions from the hospital to other care sites. These teams possess expertise in effectively communicating prognostic information and eliciting patient and family values and goals.

Recent studies have demonstrated that palliative care is associated with prolonged survival for some patient populations.^{9,22-24} Investigators suggest that palliative care helps decrease depression in patients, reduces hospitalizations and high-risk interventions and provides expert treatment of multiple, complex symptoms. It also helps enhance support for family caregivers, as patients are able to remain safely at home or in a setting of their choice.^{1,9}

National Guidelines and Certification

The National Consensus Project's *Clinical Practice Guidelines for Quality Palliative Care*, developed by a coalition of all major palliative care organizations in the United States, outlines the essential structural elements of palliative care.²⁵

These elements include:

- An interdisciplinary team with a physician, nurse, social worker, spiritual counselor, pharmacist, aide and volunteers
- Staffing ratios determined by the nature and size of the population to be served
- Staff who are trained, credentialed and/or certified in palliative care
- Access for patients and team responsiveness 24 hours a day, seven days a week

Formal guidelines and best practices for palliative care have been established through professional consensus and adapted by both the National Quality Forum (NQF) and The Joint Commission (TJC).

The NQF *National Framework and Preferred Practices for Palliative and Hospice Care Quality*²⁶ includes 38 preferred structural and quality practices and has been used to develop quality metrics for hospital palliative care services in the United States.²⁷⁻³⁰ An example of an NQF preferred practice is routine determination and documentation of patient and family goals of care using an advance care planning process that has been demonstrated to increase the likelihood that the care delivered matches patient- and family-centered goals and values. The Center to Advance Palliative Care (CAPC) reviewed the NCP's clinical practice guidelines and the NQF preferred practices and derived, through a national consensus process, a list of 12 program features essential for hospital palliative care programs (see Appendix B).²⁷

Building on these publications, in 2011 TJC began a new Advanced Certification Program for Palliative Care.³¹ Palliative care certification by TJC signifies that hospitals are committed to patient- and family-centered care that optimizes the quality of life for patients with serious illness and their families. Certification is based on clinical practice guidelines and national standards for delivering high-quality palliative care that emphasizes:

- A formal, organized palliative care program led by an interdisciplinary team whose members possess the requisite training and expertise
- Use of evidence-based guidelines or expert consensus to guide patient care
- Leadership endorsement and support of the program's goals for providing care, treatment and services
- A special focus on patient and family engagement
- Rigorous and continuous quality improvement efforts
- Processes that support the coordination of care and communication among all care settings and providers

Program Funding

Palliative care programs are funded through a diverse portfolio of resources including 1) fee-for-service billing for physician and advance practice nurse services, 2) direct hospital support and 3) philanthropy. Since the clinical work is largely cognitive and time intensive, it is poorly reimbursed relative to time invested and the billing for clinical services does not cover many of the program costs. The remaining funds are usually provided by the hospital in recognition of the ability of palliative care teams to "pay for themselves" by reducing high-cost, long-stay, inadequately reimbursed care that does not meet patient goals and values.³²⁻³⁴

Health Care Reform: The Role of Palliative Care in the Hospital

Providing high-quality palliative care can create opportunities and have a positive impact on key priority areas of health care reform and address some of the most important challenges that hospitals face such as:

- Improving quality
- Reducing variation in care
- Reducing avoidable readmissions
- Ensuring patient safety and satisfaction
- Addressing ICU overcrowding
- Planning for bundled payment systems⁸

Several leading U.S. health care systems have created palliative care programs that are achieving successful outcomes and improving quality of care by reducing readmissions, using resources wisely and integrating systems.

Improving Quality of Care and Reducing Readmissions

Patients with one or more serious or chronic conditions represent approximately 5 percent of the total patient population but account for more than half of health care costs. These patients are at the highest risk for adverse clinical outcomes, prolonged hospital stays, frequent care transitions and readmissions, and lower quality of care. Routine screening for unmet palliative care needs using checklists upon admission leads to timely and appropriately targeted involvement of palliative care teams. These teams can help prevent complications from hospitalization, symptom distress, miscommunication and fragmentation, and prolonged stays and also can reduce readmissions.³⁵

Inova Health System

At the largest hospital in the Inova Health System in Northern Virginia, patients receiving palliative care had lower readmission rates.³⁶ Using a palliative care screening tool (see Appendix D) and the V66.7 billing code for palliative care encounter as a tracking mechanism, analysis revealed a 30-day readmission rate of 5 percent to 8 percent for palliative care patients, compared to the benchmark of 20 percent among all Medicare fee-for-service patients.³⁶⁻³⁷

Inova Health System's approach demonstrated earlier "upstream" palliative care integration and reduction in avoidable hospitalization, achieved by assuring that care and treatment plans respected patient- and family-determined goals of care.

This example demonstrates the benefit of targeted and early palliative care team involvement as an effective strategy for reducing readmissions. The recommendations for leaders are:

- Ensure that palliative care specialists are part of any planning process to reduce readmissions
- Screen all hospitalized patients upon admission to identify those at highest risk for unmet palliative care needs, a population that is also at high risk for readmission³⁸
- Anticipate the growth in demand for both generalist and specialist palliative care services as a result of universal screening for palliative care needs
- Improve generalist palliative care knowledge and skills among all clinicians (e.g., physicians, nurses, social workers) with special attention to pain and symptom management and routine and timely communication with patients and families about achievable goals for medical care

Improving Quality of Care and Using Resources Wisely

Integration of palliative care services can help shift the physician and hospital culture toward achieving patient- and family-centered care goals. Well-articulated and broadly communicated goals improve care quality and, as a result, can reduce length of stay in the ICU or hospital. The shift comes about through expertly assessing and managing symptoms, establishing timely treatment goals, revising treatments to establish concordance with these goals and assuring full communication with all involved clinicians so that they are “on the same page” about the plan for care.

Studies have demonstrated when palliative care teams are involved, patients receive significantly better care due to medical treatments that are best tailored to the patients’ needs. This care may eliminate treatments that provide little benefit or that conflict with patients’ treatment wishes.

A study of eight hospitals in diverse regions and health care markets and with mature, adequately staffed and well-integrated palliative care programs demonstrated significant savings.³² The cost for palliative care patients was dramatically lower both for decedents (average of \$4,908 per admission) and for patients who survived (average of \$1,696 per admission) to hospital discharge compared to their nonpalliative care counterparts, driven in part by reduced ICU utilization. These findings have been replicated and are consistent across hospital types nationwide.

A similar study evaluated the impact of palliative care consultation on Medicaid patients at four New York state hospitals.³³ Palliative care consultation that clarified goals of care and relieved symptoms was associated with an average reduction of between \$4,000 to \$7,500 per hospitalization, compared to similar patients who did not receive palliative care consultation.³³ This study also revealed significant reduction in ICU and pharmacy costs when palliative care was provided.

Palliative care consultation promotes care that is well communicated to all involved clinicians both inside the hospital and out, is responsive to patient- and family-centered goals and priorities, and focuses on expert identification and treatment of patient and family symptoms.⁸

Improving Quality of Care and Integrating Systems

Accountable care organizations (ACOs) and patient-centered medical homes (PCMHs) will increase the demand for expertise in managing the sickest and costliest patients. Recognizing the enormous benefits of palliative care services to patients, families and the entire health care system, forward-looking health care organizations are integrating palliative care principles into the fabric of their institutions. See case examples from three health care systems on pages 9–10.

Banner Health

Banner Health started a palliative care program in 2010 at the system's flagship hospital, Banner Good Samaritan Medical Center (BGS), a 650-bed level-one trauma hospital. Within two years of implementation, palliative care became one of four focus areas for Banner Health's annual development Initiatives.

Key development steps include:

- Forming a palliative care advisory board charged with developing a systemwide palliative care clinical and business model to standardize and ensure access to high-quality palliative care across settings
- Formulating a systemwide definition and mission for palliative care services that focus on seriously ill patients of any age, diagnosis and illness stage
- Adopting a patient screening tool, developed through a national consensus process, to identify patients with unmet palliative care needs upon admission and daily during hospitalization³⁸
- Improving the continuity and quality of care by collaborating with clinical partners in outpatient clinics, long-term care facilities, home care and rural areas
- Integrating with the Banner Health Pioneer Accountable Care Organization program: This ACO has 50,000 members and is focusing efforts on improving care for the general population and for chronically ill, seriously ill and high-risk patients. Palliative care providers work closely with the ACO's leadership to identify and serve palliative care patients as a targeted high-risk group.

OSF HealthCare

OSF HealthCare consists of seven Midwest hospitals and medical centers, one long-term care facility, the OSF Medical Group, OSF Home Care Services and OSF Saint Francis, Inc., and two colleges of nursing. OSF HealthCare is a designated Pioneer Accountable Care Organization focusing on a patient-centered medical home model.

Palliative care and OSF's Advance Care Planning Model are linked to provide high-quality patient- and family-centered care. From their inception, these services received high-level support at the local and corporate levels. Palliative care and advance care planning team leaders are part of an executive strategy to ensure the best possible system integration. Variations in hospital size, services and population needs across the system guide specific characteristics and capacities for each facility's palliative care team. An operations council of clinical and nonclinical staff from all facilities works to promote systemwide palliative care and advance care planning services.³⁹

Palliative care is integral to the OSFHealthcare's ACO-PCMH demonstration project. Medical home case management staff identify high-risk patients using CMS risk-stratification methodology. The goal for the medical homes is to have at least 50 percent of all patients 65 years or older complete an advance directive and to have 100 percent of high-risk patients receive palliative care management.

North Shore-Long Island Jewish Health System

North Shore-Long Island Jewish (NSLIJ) Health System is a 15-hospital system serving the New York metropolitan area. Its initial palliative care program began in 2004 at North Shore University Hospital with two funded staff members. By 2012, the program grew to include three full-time physicians, two nurse practitioners, a 10-bed palliative care unit and four palliative medicine fellows. In March of 2012, North Shore University Hospital received The Joint Commission's Advanced Certification for Palliative Care.

Integration of palliative care services across the continuum aligns with NSLIJ Health System's strategic plan to improve care for patients with advanced and serious illness. In the system, 10 of 15 hospitals have palliative care services, and these services are also available in outpatient settings, nursing homes and home care. The health care system's Advanced Illness Coordinating Committee emphasizes patient- and family-centered care, highlighting the need for early and regular reassessment of goals and values. Ongoing educational initiatives include efforts aimed at improving cross-specialty generalist palliative care skills. NSLIJ is partnering with the Institute for Healthcare Improvement to develop new models of palliative care delivery across the health care continuum. These models have a stronger focus on home-based palliative care for seriously ill patients who continue to benefit from curative or life-prolonging treatments and who are not eligible for hospice.

Common features of successful palliative care systems integration include:

- System-level senior management and administrative support and strong commitment to palliative care as a key solution to pressing health system needs
- Recognition that palliative care outcomes are well aligned with current hospital priorities of quality improvement, risk and harm reduction, and patient- and family-centered care
- Recognition that palliative care is a simultaneous care co-management model, delivered at the same time as all other appropriate and beneficial medical therapies—and not limited to care at the end of life
- Commitment to data-driven guidance on quality and how to improve it, focusing on measurement of palliative care quality outcomes (e.g., symptom burden, concordance of care delivered with patient-determined goals, adverse events and costs)
- Emphasis on early and routine integration of palliative care into new health care models—bundled payments, ACOs, PCMHs—requiring high levels of care coordination
- Strong commitment to educational efforts to improve generalist palliative care skills for all staff
- Inclusion of palliative care program leaders in key strategic committees, helping to disseminate clear messaging on palliative care scope and service benefits
- Palliative care program growth based on evidence of quality and cost impact reflective of program value

Palliative Care Service Delivery

Consultation Service

Most hospitals begin providing palliative care services with a consultation service, either in selected units or across the entire hospital setting. A hospitalwide consultation service maximizes the potential for spread of palliative care principles and practices. The core members of the palliative care team include an advanced practice nurse, physician, social worker and chaplain. Other team members may include physician assistants, nurses and nurse assistants, massage/art/music therapists, case managers, psychologists, pharmacists and dietitians. Depending on hospital size and patient need, team members may be assigned to the palliative care service on a full-time or part-time basis. There is significant variation across sites in staffing models, reporting structures and staffing ratios.

The palliative care team manages referrals, triages additional services and coordinates discharge planning, while working in tandem with other hospital staff. In some hospitals, specially trained individuals work as “counselors” on the team, specifically for the purpose of facilitating and leading “family goal of care” meetings.⁴⁰ Because of the high level of medical complexity, assessment and decision making, an advanced practice nurse—clinical nurse specialist or nurse practitioner—is the preferred professional nursing position on a consultation team. Specialist palliative care certification is available for physicians, nurses (advanced practice nurse, RN and LPN/LVN/nursing assistants), social workers and chaplains (see Appendix A).

All teams determine which patient populations the consultation service will see and which populations are outside the team’s scope of expertise or program goals. For most teams, the core service population includes patients who have one or more serious or life-threatening illnesses and need specialist-level help with:

- pain and/or symptoms management;
- major medical decisions, requiring clarification of achievable medical care goals and personal goals of care;
- counseling and support for complex family dynamics; and/or
- disposition and management to meet intensive and demanding care needs.

A physician consultation order is required for billing. However, at many hospitals, any staff or family member may request a palliative care consultation. At some hospitals, consultations are suggested or initiated by preestablished criteria (e.g., pre-LVAD placement, pre-tracheotomy or PEG tube placement, prolonged ICU length of stay).⁴¹

Palliative care team members may be called upon to continue management of patients in the post-acute care setting, including serving as the attending physician for patients discharged with hospice services, providing outpatient follow-up or making palliative care home visits. Providing services across the continuum requires additional staff capacity to meet the demand for palliative care.

Estimating the expected consult volume is necessary to determine adequate staffing. New palliative care programs that are fully staffed typically will see 1 percent to 2 percent of total hospital admissions per year, while established programs may see up to 10 percent of admissions. All programs are encouraged to provide either in-person or telephonic coverage 24 hours, seven days a week, to meet both NQF preferred practices and TJC standards. Successful programs recognize that palliative care team members need dedicated time for nonclinical duties related to hospital staff education, quality improvement and system integration activities.

Inpatient Units

An inpatient palliative care unit is designed to provide specialist palliative care to patients who meet specific criteria. An inpatient unit can be helpful meeting hospital operational needs including:

- Providing consistency in care of the sickest patients needing palliative care specialty services
- Providing a more patient- and family-centered environment
- Improving ICU bed flow by reducing ICU length of stay
- Improving ED patient flow by rapid admission to a palliative care unit
- Serving as a focal point for palliative care education, research and philanthropy

Inpatient units can be either fixed-bed units, used solely for palliative care patients, or so-called “swing-bed” or “virtual” palliative care units, designated for either palliative care or general medical-surgical patients.

Common criteria for admitting patients to palliative care units are:

- Complex pain and symptom management needs
- Death imminent during the current hospitalization, especially for ICU patients
- Prolonged hospital or ICU stays with associated family confusion, mistrust or distress about achievable goals of care

The role of specialist palliative care clinicians for inpatient units is variable. In some units, palliative care physician specialists serve as attending physicians; in other units, they serve as consultants to the primary or attending physician, albeit typically with enhanced privileges (e.g., ability to write orders). Similarly, specialist palliative care nurses and social workers may be integral members of the inpatient unit staff or serve as consultants to the unit staff. Inpatient units where the palliative care providers have control over order writing can provide high-quality and resource-efficient care.⁴²

Integration into the ICU and ED

The ICU and the ED are sites that provide care for the sickest patients and where major decisions are made concerning appropriate levels of medical intervention. Increasingly, clinicians working at these sites are confronted with difficult in-the-moment decisions about using invasive high-technology measures when caring for patients with one or more chronic diseases and declining health despite the best that medical care has to offer. To help clinicians, patients and families, some ICUs and EDs are working in partnership with palliative care staff to develop collaborative practice models that seek to infuse palliative care principles and goal-setting practices into the daily care of patients and families. There are now several excellent models of collaborative care that result in measurable benefits to patients, families, clinicians and the hospital.⁴³ Through its Improving Palliative Care (IPAL) initiative, the Center to Advance Palliative Care has amassed tools and resources for the ICU and ED that can help spur such collaborative relationships.⁴⁴

Outpatient Care

Outpatient palliative care services are designed to improve the continuity of care for seriously ill patients outside the hospital setting. These services include outpatient clinics, home care and care provided by palliative care clinicians to patients at assisted living, long-term acute or chronic care facilities. The most common outpatient clinic arrangement is a co-management clinic, whereby palliative care clinicians see patients on a routine schedule within a host clinic, most commonly a cancer, pulmonary or cardiac clinic.⁴⁴ A 2010 report documented increased survival and quality of life for lung cancer patients co-managed from the point of diagnosis by oncologists and palliative care clinicians at Massachusetts General Hospital. This study has led to a major interest in developing conjoint oncology-palliative care clinics.⁴⁵

Steps to Start or Expand Palliative Care Services

Most hospitals and nearly all large and teaching hospitals in the United States report they have some type of palliative care services.⁶ These services may range from a part-time nurse with a relatively small number of cases referred by nursing or social services, to a large, well-integrated program with a full complement of interdisciplinary staff that provide consultation, inpatient and outpatient services. For hospitals planning to start or expand their palliative care services, *A Guide to Establishing a Hospital-Based Palliative Care Program*⁴⁶ provides step-by-step technical assistance and highlights these key tasks:

1. Convene a planning committee comprised of key hospital clinicians and administrators, including those from the departments of finance, quality improvement, nursing, medicine, discharge planning and social services.
2. Complete a needs assessment to understand a) gaps between current and ideal clinical care and b) local hospital and community resources that can be leveraged to support improved palliative care services.
3. Review current hospital priorities and identify those areas where palliative care services have been shown to improve outcomes (e.g., improving ICU and ED throughput, improving pain management and patient communication, reducing readmissions).
4. Collect meaningful data to a) demonstrate the need for improved services (e.g., pain management patient reports), b) define baseline measures for performance improvement (e.g., ICU length of stay, readmissions) and c) understand the potential impact of palliative care services.
5. Learn from peer institutions that are integrating palliative care services; make a site visit to another facility to see how palliative care inpatient units are organized or how an ICU is integrating palliative care principles to reduce length of stay.
6. Develop a strategic plan and budget including new services, staffing and metrics to document program value. The program budget should include the expected billing and philanthropic revenue as well as the cost avoidance enabled by preventing crises and delivering higher quality care.

Conclusion

Palliative care services are an essential tool for delivering high-quality, patient- and family-centered care. Through their demonstrated impact on improving quality and reducing readmissions and costs, palliative care teams can be aligned with and crucial to helping clinicians meet the needs of patients with the most serious and complex illnesses and their families.

Appendix A. National Palliative Care Standards and Certification

Advanced Certification—Hospitals

The Joint Commission Advanced Certification for Palliative Care Programs

http://www.jointcommission.org/certification/palliative_care.aspx

Cancer Program Accreditation

Commission on Cancer of the American College of Surgeons

<http://www.facs.org/cancerprogram/index.html>

National Comprehensive Cancer Network—Palliative Care Guidelines

http://www.nccn.org/professionals/physician_gls/f_guidelines.asp

Hospital Palliative Care Standards

- National Consensus Project
Clinical Practice Guidelines for Quality Palliative Care. 2nd ed.
<http://www.nationalconsensusproject.org/guideline.pdf>
- National Quality Forum
A National Framework and Preferred Practices for Palliative and Hospice Care Quality: A Consensus Report.
<http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=22041>
- Journal of Palliative Medicine
Operational Features for Hospital Palliative Care Programs: Consensus Recommendations
<http://online.liebertpub.com/doi/abs/10.1089/jpm.2008.0149?journalCode=jpm>
- Improving Palliative Care in the ICU
Defining Standards for ICU Palliative Care: A Brief Review from The IPAL-ICU Project
<http://ipal-live.capc.stackop.com/downloads/ipal-icu-defining-standards-for-icu-palliative-care.pdf>
- Improving Palliative Care in Emergency Medicine
<http://www.capc.org/ipal/ipal-em/monographs-and-publications>

Clinician Board Certification

- American Academy of Hospice and Palliative Medicine
American Board of Medical Specialties Physician Certification (MD)
<http://www.aahpm.org/certification/default/abms.html>
- American Academy of Hospice and Palliative Medicine
American Osteopathic Association Physician Certification (DO)
<http://www.aahpm.org/certification/default/do.html>
- National Board for Certification of Hospice and Palliative Nurses
Nurse Certification (Advance Practice Nurse, RN, LPN, Nursing Assistant, Program Administrator)
<http://www.nbchpn.org/>
- National Association of Social Workers, Certified Hospice and Palliative Social Worker
<http://www.socialworkers.org/credentials/credentials/chpsw.asp>

Appendix B. Operational Features for Hospital Palliative Care Programs: Consensus Recommendations ²⁷

Domain	Must Have	Should Have
1. Program Administration	Palliative care program staff integrated into the management structure of the hospital to ensure that program processes, outcomes and strategic planning are developed in consideration of hospital mission/goals.	Systems that integrate palliative care practices into the care of all seriously ill patients, not just those seen by the program.
2. Types of Services	A consultation service that is available to all hospital inpatients.	Resources for outpatient palliative care services, especially in hospitals with more than 300 beds. An inpatient palliative care geographic unit, especially in hospitals with more than 300 beds.
3. Availability	Monday–Friday inpatient consultation availability and 24/7 telephone support.	24/7 inpatient consultation availability, especially in hospitals with more than 300 beds.
4. Staffing	<p>Specific funding for a designated palliative care physician(s). All program physicians must be board certified in Hospice and Palliative Medicine (HPM) or committed to working toward board certification.</p> <hr/> <p>Specific funding for a designated palliative care nurse(s), with advance practice nursing preferred. All program nurses must be certified by the National Board for Certification of Hospice and Palliative Nursing (NBCHPN) or committed to working toward board certification.</p> <hr/> <p>Appropriately trained staff to provide mental health services.</p> <hr/> <p>Social worker(s) and chaplain(s) available to provide clinical care as part of an interdisciplinary team.</p> <hr/> <p>Administrative support (secretary/administrative assistant position) in hospitals with either more than 150 beds or a consult service with volume > 15 consults/month.</p>	
5. Measurement	<p>Operational metrics for all consultations.</p> <hr/> <p>Customer, clinical and financial metrics that are tracked either continuously or intermittently.</p>	

6. Quality Improvement	Quality improvement activities, continuous or intermittent, for a) pain, b) nonpain symptoms, c) psychosocial/spiritual distress and d) communication between health care providers and patients/surrogates.	
7. Marketing	Marketing materials and strategies appropriate for hospital staff, patients and families.	
8. Education	Palliative care educational resources for hospital physicians, nurses, social workers, chaplains, health professional trainees and any other staff the program feels are essential to fulfill its mission and goals.	
9. Bereavement Services	A bereavement policy and procedure that describes bereavement services provided to families of patients impacted by the palliative care program.	
10. Patient Identification		A working relationship with the appropriate departments to adopt palliative care screening criteria for patients in the emergency department, general med/surgical wards and intensive care units
11. Continuity of Care	<p>Policies and procedures that specify the manner in which transitions across care sites (e.g., hospital to home hospice) will be handled to ensure excellent communication between facilities.</p> <hr/> <p>A working relationship with one or more community hospice providers.</p>	
12. Staff Wellness	Policies and procedures that promote palliative care team wellness.	

Appendix C. Useful Metrics to Measure Impact and Value of Hospital Palliative Care

<p>Operational</p> <ul style="list-style-type: none"> • New consults/month & trend • Consult volume as % of hospital admissions • F/u visits seen; average daily census • Annual consults per clinical palliative care FTE • LOS pre- and post-consultation • Discharge status (to SNF, hospice, etc.) • Deaths as % of consults seen • % of hospital deaths seen by palliative care
<p>Staff Productivity</p> <ul style="list-style-type: none"> • Consults & f/u care by provider • Billed services by provider and for team • Hours of clinical time by provider (vs. budget) • Other team accomplishments for month
<p>Processes of care</p> <ul style="list-style-type: none"> • Mean & median response time (difference between time of consult requested and consult seen) • % time > target threshold (such as 24 hours) • % with documented communication with referring physician pre- and post-consult • % of consults meeting documentation standards for symptom management, goals of care discussions, transition management and family support
<p>Financial</p> <ul style="list-style-type: none"> • Monthly costs per consult (costs/volume) • Net billing revenue (overall and by consult) • % of patients in ICU w/ LOS >7 days prior to consult (example of a measure that matches a quality initiative with a likely financial impact) • % of consulted patients with readmissions • Annual “cost avoidance” impact
<p>Quality</p> <ul style="list-style-type: none"> • Symptom management impact • Patient/family satisfaction with care • Provider satisfaction with consultative services

Appendix D. Palliative Care Screening Tool (Inova)

This is not a part of the permanent medical record. © 2012 Inova Health System

Instructions

- Select all the triggers that apply to your patient
- Selection of two or more triggers indicates a positive screen
- Initial screen should be completed within 72 hours of admission
- Patient should be re-screened when transferred to a higher level of care unit due to declining clinical condition
- Patients in the ICUs should be re-screened on day 7
- If patient was previously enrolled in hospice, please contact the hospice provider automatically

General Palliative Care Domains

- Uncontrolled symptoms (dyspnea, nausea/vomiting, pain > 5/10) ≥ 24 hours
- Team/patient/family need help with complex decision making and determination of goals of care
- Patient (especially long-term care resident) with AND/DNAR orders

General Disease Category

- Second ED/hospital visit in the past 6 months for the same or similar diagnosis
- Age ≥ 70 years in the presence of two or more life-threatening comorbidities (ESRD, dementia, severe CHF) and declining functional status increasing dependence in ADLs

Specific Disease Category

- Advanced or end-stage organ disease (CHF, COPD, ESRD, ESLD, dementia, MS, ALS)
- Stage IV cancer with progression of disease despite treatment
- Considering PEG and/or tracheostomy placement with evidence of poor prognosis (advanced dementia)

ICU Category

- ICU stay of ≥ 7 days without evidence of improvement
- Second ICU admission during same hospital admission
- ICU admission from a nursing home in the setting of ≥ 2 chronic, life-limiting conditions
- Ventilator day # 6 or longer without evidence of improvement
- Glasgow score ≤ 5
- Multi-organ failure, involving ≥ 4 systems

Outcome of Screen and Discussion

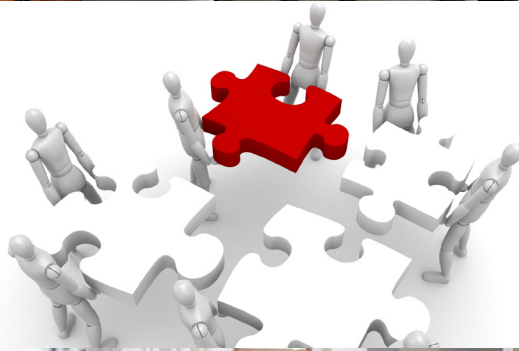
- ___ Screened but did not meet criteria for intervention
- ___ Screened, met criteria for intervention.
 - ___ Palliative Care consult initiated
 - ___ Palliative Care team already involved
 - ___ Hospice consult initiated
 - ___ Primary physician/team to provide primary palliative care (family meeting, goals of care and/or code status discussion, pain and symptom management, implementation of comfort measures)
 - ___ Primary physician/team believes that patient is expected to improve; current plan of care to continue
 - ___ Primary physician/team believes patient/family does not wish to discuss palliative care options at this time
 - ___ Other

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Advanced Illness Management Strategies:

Engaging the Community and a Ready, Willing and Able Workforce

Part 2

December 2012

A report from the AHA Committee on Performance Improvement:

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American Hospital Association

The Committee on Performance Improvement's first report in 2012, *Advanced Illness Management Strategies*, can be found at:

<http://www.aha.org/aim-strategies>

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The Committee on Performance Improvement's first report in 2012, *Advanced Illness Management Strategies*, can be found at: <http://www.aha.org/aim-strategies>

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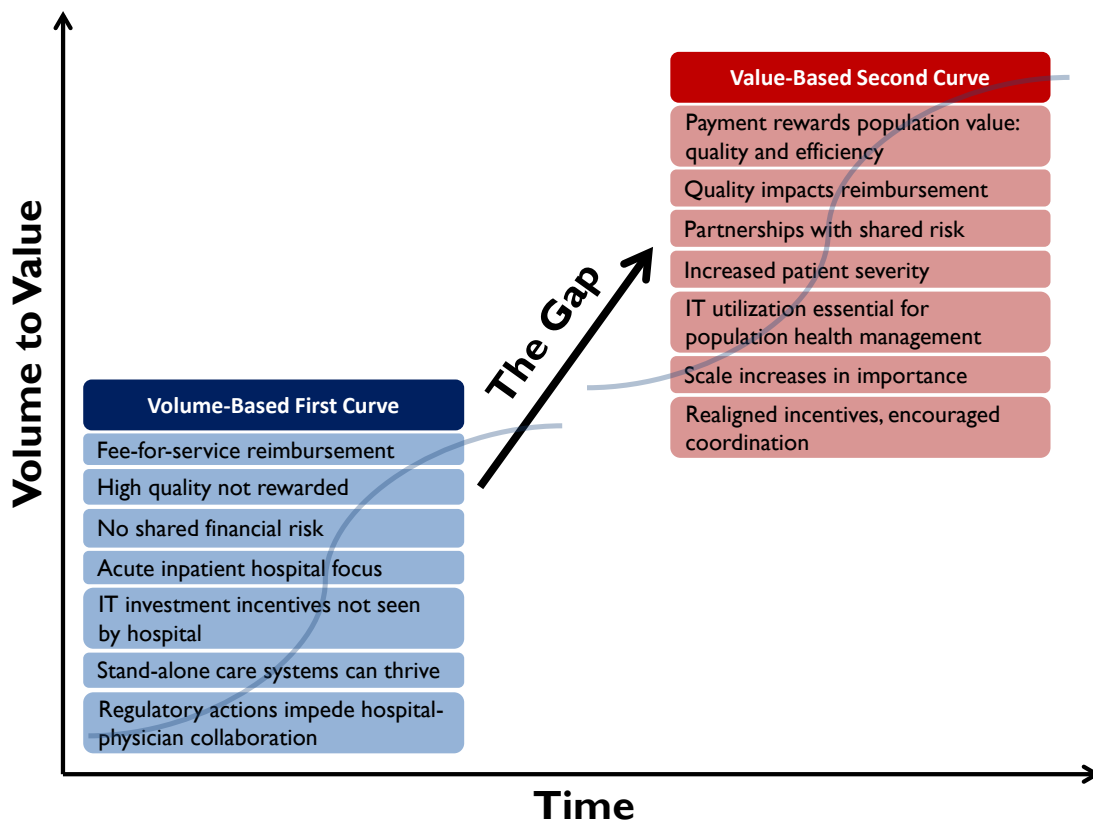
The Appendix identifies a number of valuable resources, including the accompanying August 2012 AHA Committee on Performance Improvement report, [Advanced Illness Management Strategies](http://www.aha.org/aim-strategies), found at <http://www.aha.org/aim-strategies> and AHA's Circle of Life Award found at www.aha.org/circleoflife.

Executive Summary

The American Hospital Association (AHA) Board's Committee on Performance Improvement (CPI) was created in 2010 to support performance improvement across the AHA membership and to align with the AHA's strategic platform, Hospitals in Pursuit of Excellence. The inaugural 2011 CPI report, *Hospitals and Care Systems of the Future* (found at: <http://www.aha.org/about/org/hospitals-care-systems-future.shtml>), conveyed that hospitals and health care systems in the United States are facing unparalleled pressures to change because of multiple and intersecting environmental forces—from the aging population to the unsustainable rise in health care spending as a percentage of national gross domestic product—that will transform health care delivery and financing from volume- to value-based payments over the next decade. These anticipated conditions are driving health care leaders to address the economic incentives that influence patient, provider and payer behavior.

Economic futurist, J. Ian Morrison, premised that as payment incentives shift, health care providers will go through a classic modification in their core models for business and service delivery. In his “first-curve-to-second-curve” framework, he defined the *first curve* as an economic paradigm driven by the volume of services provided and fee-for-service reimbursement while the *second curve* is concerned with value such as cost and quality of care necessary to produce desired health outcomes within a particular population. Conclusively, this framework illustrates that the most significant issue for hospitals and health care systems is establishing the transition rate from the two economic curves, which is referred to as *life in the gap*.

First Curve to Second Curve



Source: Hospitals and Care Systems of the Future Report, AHA CPI, September 2011, www.aha.org. Adapted from Ian Morrison, *The Second Curve*, Ballantine Books, 1996.

Managing Life in the Gap

Because progressing from the first curve to the second curve is a vital transition for hospitals, the first CPI report in 2012, *Advanced Illness Management Strategies* (found at <http://www.aha.org/aim-strategies>), focused on a particular approach that supports the imminent shift in business, care and service delivery models. The report geared its attention to **advanced illness management (AIM)** since hospitals are uniquely positioned to implement best practice strategies and integrate them into the normal continuum of care.

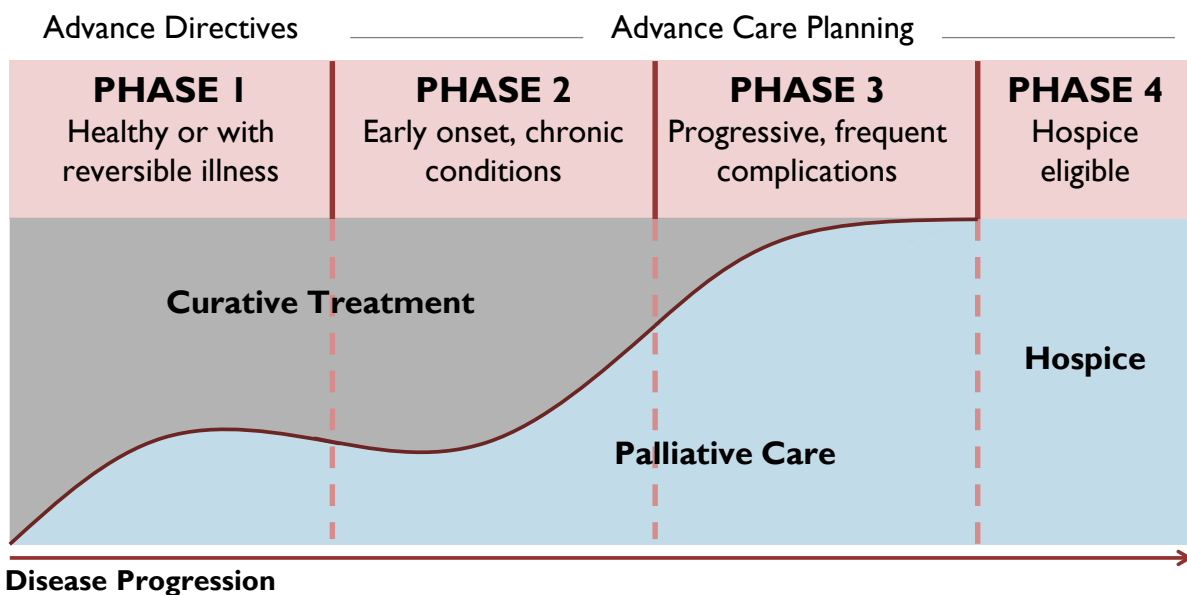
Why AIM?

The Coalition to Transform Advanced Care (C-TAC) defines advanced illness as one or more conditions serious enough that general health and functioning decline and treatments begin to lose their impact. Even though the trajectory of advanced illness leads to death, many studies show that well-developed AIM programs improve quality of life, lower utilization of clinical treatments and hospital admissions, increase patient and family satisfaction and reduce aggregate spending.

Three Key Strategies to AIM

The first CPI report framed AIM as a four-phase process—incorporating (1) advance directives, (2) advance care planning, (3) palliative care and (4) hospice care—and illustrated that integration of each segment results in successful initiatives. While hospitals have made significant strides incorporating these components, there are opportunities for improvement in both the number and coordination of AIM programs.

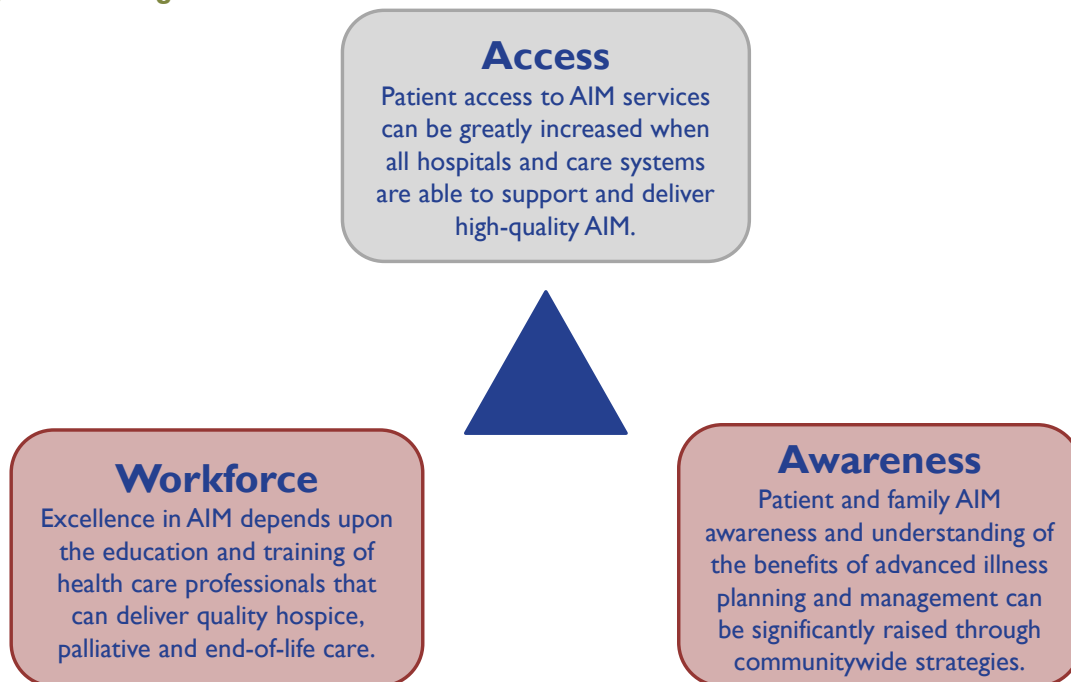
Phases of AIM



Source: AHA CPI analysis, 2012, with contributions from 2012 C-TAC data and 2011 Center to Advance Palliative Care data.

Three key strategies were also introduced in the push toward AIM's second-curve goals: *access*, *workforce* and *awareness*. They are connected and should be emphasized with equal value. When all strategies are at play, increasing demand from the public should be met by a supply of AIM structures, systems and services whose workforce can elicit informed end-of-life preferences and deliver consistently high-quality services with benefits that continue to expand community awareness, engagement and demand.

Three Key AIM Strategies



Source: AHA CPI, December 2012.

The [first CPI report](#) examined in depth how hospitals can increase **access** to AIM programs thereby changing the way medical services are utilized to improve outcomes and honor the wishes of patients and families. This second and follow-up report reviews the three key strategies and concentrates on two: patient and community **awareness** and engagement; and ready, willing and able **workforce**.

The "Strategy Implementation Checklist" table provides a list of salient implementation steps that can ensure success in each of the three strategies.

Table 1. Strategy Implementation Checklist

Strategy Implementation Checklist	
Access to AIM Services	
Patient access to AIM services can be greatly increased when an infrastructure of organizational services (1) is in place to deliver and support high-quality, coordinated, advanced illness care across settings and (2) is supported by the structure and incentives of public and private payment systems.	
	Develop a multidisciplinary care team with leadership buy-in
	Identify qualifying patients through evidence-based protocols
	Think beyond the traditional four walls of the hospital to promote AIM collaboration throughout the surrounding community
	Use a performance improvement framework to measure, monitor, evaluate and adapt the program between disease states and throughout time
Patient and Community Awareness and Engagement	
Communitywide strategies can significantly raise patient and family awareness in advanced illness planning and management.	
	Increase patient accessibility to information about end-of-life care by developing awareness and “conversation-readiness” among health care professionals; work with stakeholders on the importance of conversations, advance directives and early decision making; provide effective language assistance services; and address low health literacy
	Launch community development strategies that spread awareness of cultural diversity and support partnerships with local leaders and organizations that cater to the patient population’s demographics, education levels, culture and language
	Develop a workforce that embraces diversity to address the needs of patients and their families from different backgrounds and is equipped with the skills and knowledge necessary to support and guide those facing end of life
	Implement internal systems strategies such as collecting information on communication needs, tracking performance of patient engagement programs and ensuring that a strong advocate for patient-centered communication programs is present in the organization
Ready, Willing and Able Workforce	
The success of AIM programs is contingent upon the education and training of health care providers as the demand grows for managing multiple chronic conditions, as well as palliative and end-of-life care. There are not enough health care professionals who are ready, willing and able to manage advanced illness with patients and their families, and there is a constant need to engage in conversations and provide guidance to more expert resources.	
	Develop educational programs that offer ongoing training for health care professionals to learn the necessary skills and competencies to engage in sensitive conversations; train health care providers on the role and impact of spirituality in end-of-life care
	Use a multicultural guide/spiritual toolkit to support understanding and meeting diverse patient needs
	Launch collaborative strategies that create an environment for the multidisciplinary team to improve communication, leverage patient family advisory councils in communicating sensitive messages and provide or make available, to the palliative care workforce, comprehensive training in educating patients and their families during end-of-life care interactions
	Create a solid program infrastructure to sustain a successful palliative and end-of-life care program

Source: AHA CPI, 2012.

Introduction: Advanced Illness Management Strategies

This report explores two essential cornerstones for managing advanced illness: (1) patient and community awareness and engagement and (2) a health care workforce that is ready, willing and able to engage with patients and provide the spectrum of services that uphold dying comfortably and well. To begin, this report briefly recaps background information and defines terminologies associated with AIM, connecting content to an earlier companion report.

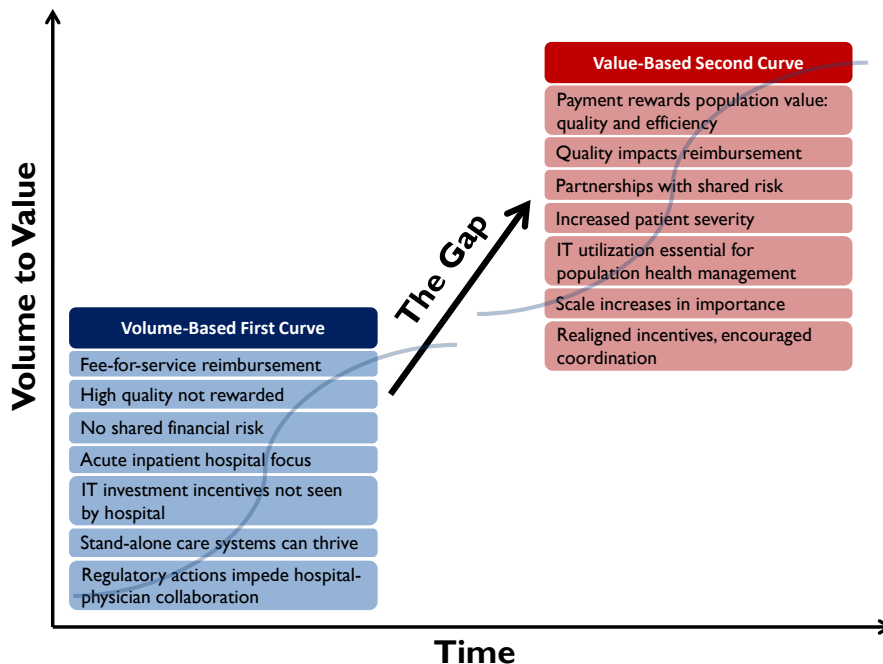
Terminology

According to Joanne Lynn, MD, director at Altarum Center for Elder Care and Advanced Illness, leaders in the care of frail elders and people with multiple chronic conditions or advanced or life-limiting illness are still exploring an appropriate language for serving those nearing the end of their lives. These and other overlapping terms are used to categorize the set of services needed for patients and families during the course of illness whose trajectory leads to death. For purposes of this report and its earlier companion,¹ AIM is being used as the overarching term. C-TAC has defined advanced illness as “occurring when one or more conditions become serious enough that general health and functioning decline, and treatments begin to lose their impact. This is a process that continues to the end of life.”²

Background

The AHA Board’s Committee on Performance Improvement (CPI) was created in 2010 to support performance improvement across the AHA membership to align with the AHA’s strategic platform, Hospitals in Pursuit of Excellence. Its inaugural 2011 report, *Hospitals and Care Systems of the Future*, is based upon economic futurist J. Ian Morrison’s “first-curve-to-second-curve” framework (Figure 1).³ It describes the shift in payment incentives that impact health care providers’ core business models for care and service delivery and demonstrates why progressing from the first curve to the second curve is a vital transition for hospitals.

Figure 1: First Curve to Second Curve



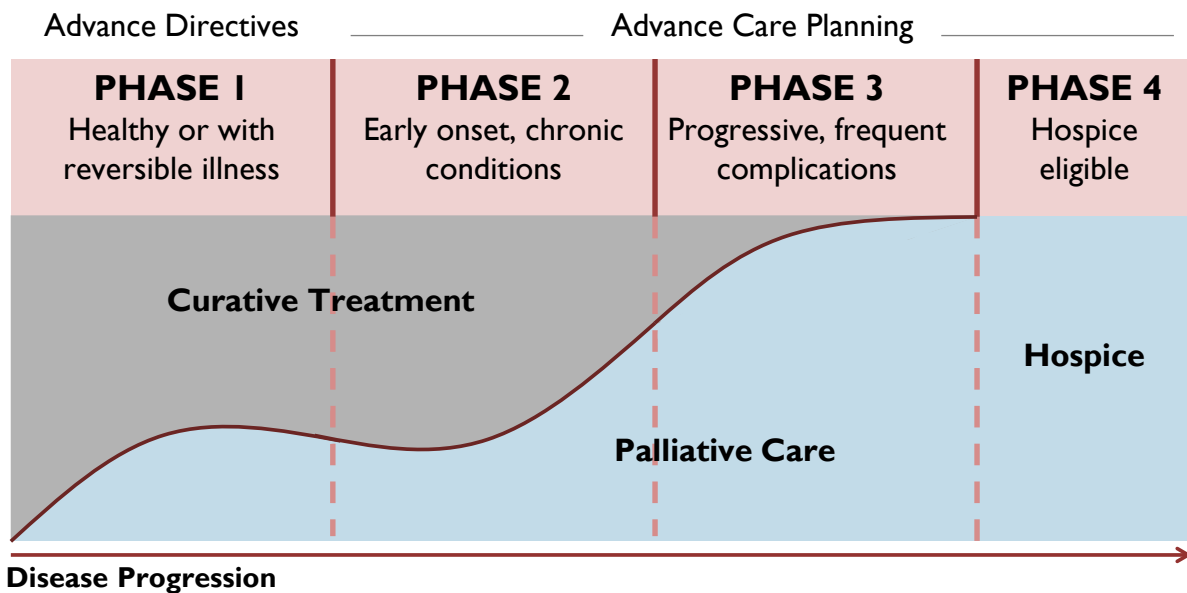
Source: Hospitals and Care Systems of the Future Report, AHA CPI, September 2011, www.aha.org. Adapted from Ian Morrison, *The Second Curve*, Ballantine Books, 1996.

In the August 2012 report, CPI focused on approaches to managing the transition period between the first-curve and second-curve economic markets, specifically in advanced illness management. Hospitals are uniquely positioned to implement best-practice strategies that integrate AIM into the normal continuum of care and ensure that the wishes of the patient and his or her family are carried out by the entire multidisciplinary team throughout disease progression.

Phases of AIM

There are four phases to AIM (Figure 2)—advance directives, advance care planning, palliative care and hospice care. Successful AIM programs integrate these phases into a continuum of care in which the treatment plan will increasingly be guided by the goals and decisions of the patient and family members, shifting from curative to palliative treatments and becoming more weighted toward psychosocial, relational and spiritual needs.

Figure 2: Phases of AIM



Source: AHA CPI analysis, 2012, with contributions from 2012 C-TAC data and 2011 Center to Advance Palliative Care data.

In the first phase, people are healthy and can recover from reversible illness. Those who stay ahead of the curve engage in advance care planning and have conversations with trusted friends and family members about their values and preferences should they become incapacitated. They document these conversations, sometimes in advance directives, and share or discuss their preferences with their health care provider(s), if they have the capacity and time. Some patients may already be well aware of their options, while others receive guidance from providers who will translate their preferences into available care options.

A person in the second phase typically has manageable, early or stable chronic condition(s) for which palliative care may begin to supplement disease treatment as part of maximizing quality of life. Palliative care relieves symptoms, complications of illness at any stage and side effects of medications or other treatments. It is independent of a prognosis and can be offered within or outside of a hospice structure and/or delivered at home, in a hospital, nursing home, residential hospice facility or other venues. While it is primarily focused on the alleviation of physical symptoms, palliative care encompasses social, emotional and spiritual needs and facilitates patient autonomy, access to information and choice.⁴

The second phase morphs into the third phase when the clinical condition (or conditions) continues to progress, producing more complications and placing increasing limits on the patient’s activities, independence and quality of life. The third phase then evolves into the final phase when a person is deemed hospice-eligible. This is to say that the patient has a prognosis of six months or less. Hospice services provide comprehensive biomedical, psychosocial and spiritual support to patients and family members through multidisciplinary teams (consisting of a physician, registered nurse, licensed practical nurse, social worker and spiritual counselor, to name a few) and provides bereavement support to the family during the year following death.⁵

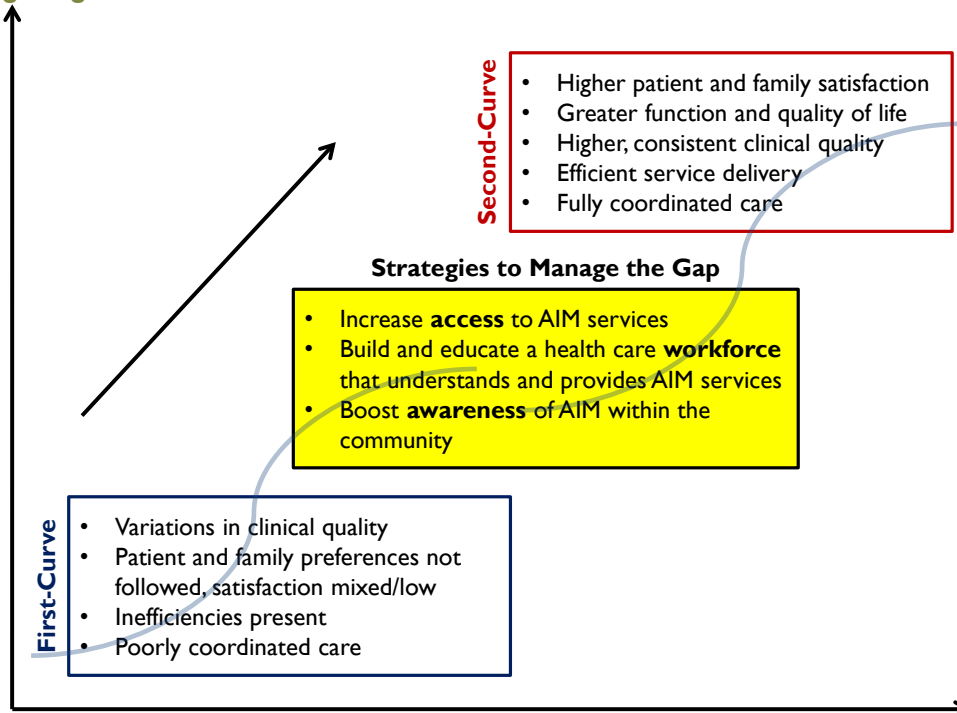
Goals and Strategies

AHA’s CPI identified four goals or outcomes of AIM:

- Better and more consistent clinical quality
- More efficient service delivery
- Full coordination of care throughout the continuum of care
- Higher patient and family satisfaction.

In 2012, CPI commissioned a pair of reports. The first report, *Advanced Management Illness Strategies*, framed AIM as a four-phase process to be addressed through three strategies (Figure 3)—**access**, **workforce** and **awareness**.⁶ It examined in depth how hospitals can increase **access** to AIM programs so that they may change the way medical services are utilized to improve outcomes and honor the wishes of patients and families at the end of life.

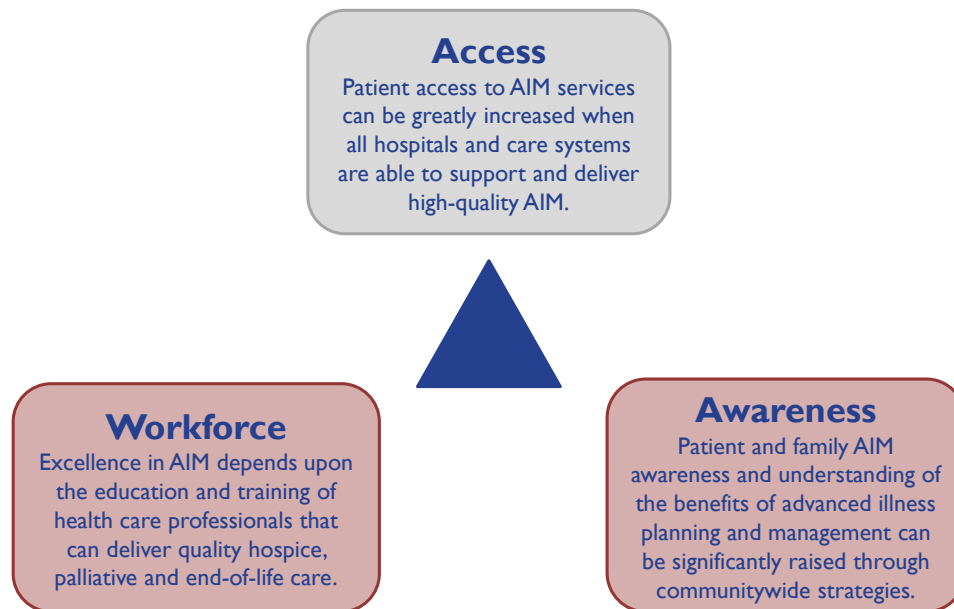
Figure 3: Navigating AIM



Source: AHA CPI analysis, 2012.

Following the CPI mandate to focus on the other two strategies (Figure 4)—**workforce** and **awareness**—this follow-up and second report expands and explains more precisely all three strategies, which could also be deemed cornerstones of late-life care.

Figure 4: Three Key AIM Strategies



Source: AHA CPI, 2012.

- **Access to AIM services:** An infrastructure of organizational services must be in place to deliver and support high-quality, coordinated advanced illness care across settings. Additionally, it must be supported by the structure and incentives of public and private payment systems.
- **Patient and community awareness and engagement:** To attain the best quality of life and support for psychosocial and spiritual needs, patients and family members should become aware of their options and understand the benefits of all phases of advanced illness planning and management. This will in turn drive the demand for AIM services.
- **Ready, willing and able workforce:** All health care professionals should be ready, willing and able to (1) have informed conversations with their patients about advanced illness and their evolving goals of care, (2) provide the basics of palliative care and (3) guide patients and families to more expert resources. Concurrently, the supply of ready, willing and able geriatricians, palliative care specialists and palliative care and hospice nurses must expand to meet the accelerating demand for managing chronic and often multiple conditions as well as palliative and end-of-life care.

When all three strategies are working synergistically (Figure 4), increasing demand from the public should be met by AIM structures, systems and services whose workforce can elicit informed end-of-life preferences and deliver consistently high-quality services with benefits that continue to expand community awareness, engagement and demand. The fourth and missing cornerstone in this dynamic—and the *sine qua non* of excellent late-life care and dying well—is the rethinking, reevaluation and restructuring of work that is needed to value and support family caregivers.

Expanding Patient and Community Awareness and Engagement Strategy

Most people want to die at home. Literally or metaphorically, the phrase encapsulates the imagery of “dying well” at home, comfortably surrounded by familiar people and things that evoke a lifetime of memories in an environment that can be more or less controlled and is the antithesis of the clutter, anonymity and intrusiveness of hospitals and nursing homes. Less than 25 percent of people die at home; most people die in institutions, where their symptoms are not managed well. Many are in pain. Some terminal illnesses are not painful, but most involve deteriorating mobility and uncomfortable, sometimes scary, sometimes serious complications. For example, limited movement and parchment skin make people vulnerable to pressure ulcers. Breathing and swallowing may become more difficult. Most of these symptoms can be prevented or alleviated, but often they are not. The staggering gap at the physical/biomedical level alone provides opportunities for radical improvement.

Whatever the venue, dying comfortably and well doesn’t just happen. Many factors contribute to end-of-life care, which requires the active involvement and participation of both health care providers and users. The former will need the necessary infrastructure of systems and supportive services designed to care for people as they become increasingly less able to tend to themselves. This includes palliative care units and hospices by which late-life care and complications are managed and overseen by a workforce skilled in providing this service. Meanwhile, the latter will need to engage and clearly articulate their needs so that providers can objectively translate and deliver the desired care. This involves becoming aware of the range of options for managing their symptoms and care and engaging with their late-life psychosocial, relational and spiritual needs and support.

Awareness is the first step in becoming informed of possibilities and options in end-of-life care. However, knowledge that palliative care units and/or hospice exists should not suffice. Appreciating the benefits and partnering with them sooner rather than later can make the utmost difference between “dying well” and “dying badly” and should be the draw to managing advanced illness and engaging with one’s mortality.

Sooner Rather than Later

When patients and families receive information about their prognosis, it affects their choices. Early discussion of and planning around end-of-life issues are linked to better outcomes for both patients and families. Advance care planning results in superior quality of life, increases the likelihood that individual wishes are followed, reduces hospitalization or admissions to the intensive care unit (ICU), and emotionally prepares families to better cope with the situation and the decision making involved in end-of-life care.^{7, 8, 9} Leaders in hospice and palliative medicine strongly recommend that hospitals make effective training programs widely available and professionals who care for people with complex and life-threatening conditions are trained and able to demonstrate competency in having such conversations.¹⁰

According to the National Hospice and Palliative Care Organization (NHPCO), in 2010, 75 percent of Americans did not even know that hospice care could be provided at home.¹¹ Although the percentage of patients with terminal illness who elect this service is steadily growing and the mean number of days their care is overseen by hospice is increasing, patients’ time in hospice care is still short: for a third of patients, it is a week or less.¹² One of the implications is that most of the care is physical and directed at managing the myriad symptoms that arise not only from the primary illness but also from bodily systems that are shutting down. As a result, many hospice patients and their families do not receive the full multidisciplinary benefits that come from partnering with hospice sooner rather than later.¹³

Developing Engagement

Friends and family members need to discuss, address and develop their preferences with health care providers and properly document them so that their wishes are likely to be carried out throughout the care continuum. Several efforts have been taken at the national and state levels to ensure that patient preferences are addressed. One example is Aging with Dignity, a nonprofit organization based in Tallahassee, Florida. This organization began to take steps at the national level to “affirm and safeguard the human dignity of individuals as they age” and “promote better care for those near the end of life.”¹⁴ In 1997, Aging with Dignity introduced to individuals in Florida, and later in other states, the “Five Wishes” document, which informs patients’ families and doctors (1) who can make decisions on their behalf in the event they are no longer able to do so, (2) preferences on medical treatment, (3) preferred comfort level, (4) how they want to be treated and (5) what they want their loved ones to know.¹⁵ Today, Aging with Dignity’s “Five Wishes” document meets legal requirements in 42 states.¹⁶

States, too, are taking the necessary steps to encourage people to complete advance directives and/or living wills. In 2011, the West Virginia state health insurance system, Public Employees Insurance Agency (PEIA), encouraged individuals to think about the kind of care they would prefer should they become seriously ill. PEIA offers a \$4 per month discount off the health insurance premium for signing a living will or medical power of attorney.¹⁷

The MOLST *Glossary of Terms* defines advance care planning as “an ongoing process of discussing and clarifying the current state of a person’s goals, values and preferences for future medical care. The discussion often, but not always, leads to the signing of documents known as advance directives.”¹⁸ In common parlance and practice, this planning process is frequently collapsed into documents (such as health care proxies and living wills as previously mentioned) that could take effect if the person becomes incapacitated.

Most people assume that completing advance directives and living wills takes care of things but this is not the case. Such documents typically deal with only very few options—DNR (do not resuscitate) or not, artificial nutrition or not—and cannot anticipate all the scenarios and decisions that could arise. These documents are frequently ignored or overridden by a family member or a physician. In some cases, the EMT is unaware of them or is being threatened with legal action by a family member if they abide by a DNR order. The MOLST (medical orders for life-sustaining treatment) and POLST (physician orders for life-sustaining treatment) responses in a growing number of states address these and other limitations of traditional advance directives. The six-year MOLST development and roll-out process in Massachusetts makes up an exemplary process. (See Case Study I.)

Written documents are only one aspect and outcome of advance planning. Ideally, people should stay ahead of the curve by having important conversations with trusted family members and friends to clarify their values and preferences regarding potential medical scenarios and end-of-life care. The goal of such conversations is to ensure that preferences are understood and to help those left behind make decisions on the patient’s behalf when the patient is no longer able to do so. The emotional toll on decision-makers when they don’t know what the patient wants can be monumental, and the anxiety and guilt around such decisions can have a lifelong effect.

For people who are able to have those kinds of conversations with friends and family and are aware of their options, they may need only to inform health care providers what they want and why. Others may need their wishes (e.g., to die at home) translated into what needs to be in place for them to be able to carry out those wishes, while providers may provide an educational and a facilitating role. However, many providers do not know how to have or initiate these conversations and may have difficulty receiving and translating the needs of their patients.

Work needs to be done both to stimulate conversations in informal or familial settings and develop capacity among health care professionals to initiate, elicit, receive and build on conversations with patients. Working “both sides of the street” is the aim of The Conversation Project (TCP). In partnership with the Institute for Healthcare Improvement (IHI), TCP develops awareness and engagement among individuals while developing “conversation-readiness” among providers. TCP works at the national and local levels to develop public and personal awareness

of options and possibilities for how patients end their days and tries to narrow or close the gap between what people say they want and what they get. (See Case Study 2.)

Conversations with friends, families and providers can and should continue throughout the care continuum so that people can confirm their wishes or change their minds. As complications, medications, consultations and hospitalizations accelerate and increase, it becomes more likely that patients and families need help navigating the system and becoming aware of the array of options that may be open to them. The compassionate care case management program at Aetna was designed with that objective. The program aims to improve quality of care for members, who are likely to live less than a year, and to support family caregivers with the help of experienced registered nurses who serve as guides and companions. Telephonic case management occurs after reviewing the member's case, patterns of claims and admissions and communication with the physician. (See Case Study 3.)

Other nonprofit organizations have emerged to further guide health care users. Respecting Choices, owned and operated by Gundersen Lutheran Medical Foundation in La Crosse, Wisconsin, designed a program that assists health care professionals guide patients and their families making an informed decision, allows health care plans to be properly documented and updates and ensures availability of these documentations when needed. The Respecting Choices model has demonstrated strong evidence of success and been internationally recognized and replicated. (See Case Study 4.)

Another example is C-TAC, an alliance of diverse organizations and individuals dedicated to transforming advanced illness care. This organization is working to improve the social, policy and health care system environment and norms for quality care, to ensure that patient choice and shared decision making drive care, to improve quality and to promote high levels of patient and family satisfaction. (See Case Study 5.)

Some hospitals are also changing their medical culture and providing optimal patient care by utilizing available resources and their current health care employees. One example is St. Joseph Mercy Oakland (SJMO), a community hospital and member organization of Trinity Health in Pontiac, Michigan. With the help of an interdisciplinary team already employed in the hospital, SJMO established a pain management and palliative care program that provides comprehensive services across the care continuum to individuals suffering from an illness and/or facing the end of life (See Case Study 6.)

Infrastructure of Systems and Supportive Services

Patient-centered communication is often described primarily as individual clinician-patient interactions.¹⁹ With the increasing diversity of the patient population, hospitals and health care systems can foster and encourage patient-centered communication by finding innovative ways to address cultural differences, linguistic barriers and varying literacy levels. This can include creating an infrastructure of systems and supportive services.

In a study conducted in eight hospitals by the American Medical Association's Ethical Force Program and the Health Research & Educational Trust (HRET), several recurring themes were identified as "promising practices" for hospitals and other health care systems to support patient-centered communication strategies:²⁰

- **Encourage passionate champions throughout the organization**
A passionate champion can serve as the most significant catalyst for change in launching patient-centered communication initiatives and guaranteeing their long-term sustainability.
- **Collect information to demonstrate needs**
Collecting information—e.g., in the form of surveys or interviews—to identify current gaps in communication will allow hospitals and health care systems to assess the needs of patients, staff and the community, which can then be transformed into programs and initiatives that will cater to the patient population.

- **Engage communities**
Planning community engagement initiatives requires acknowledging and understanding the demographics, education levels, culture and languages of the population being served. Engaged communities can provide an opportunity to share resources and information as well as work collaboratively and form partnerships.
- **Develop workforce diversity and communication skills**
Hospitals and health care systems must maintain or acquire a workforce that reflects and understands their diverse patient populations.
- **Involve patients every step of the way**
Patients must be educated about their health and care in a manner that they can comprehend.
- **Be aware of cultural diversity**
Cross-cultural communication is effective when hospitals and health care systems have a workforce that is culturally competent (explained in further detail later in this report), a welcoming environment, and interpreters who will conduct outreach in the community, assist patients in navigating the health system and facilitate cross-cultural discussions.
- **Provide effective language assistance services**
Studies show that qualified language interpreters can provide “better-quality care, order fewer unnecessary tests, and most likely decrease medical errors and the potential for lawsuits.”²¹ In addition, providing access to effective language assistance services empowers and enables patients who would not have been able to communicate in the common language to participate in their own care.²²
- **Be aware of low health literacy and use clear language**
Health care illiteracy can affect both English and non-English speaking patients, especially if they are facing a life-threatening illness and experiencing a lot of stress and discomfort. To engage patients in their care, staff must be able to detect signs of misunderstanding, avoid medical jargon and strive to communicate in clear and simple language.
- **Evaluate organizational performance over time**
To defend and demonstrate the value of patient-centered communication initiatives in hospital and health care system budgets, the initiatives must be continuously evaluated to show that they can have valuable impact on patient outcomes and deserve continuous funding.

Table 2. Hospital Strategies to Engage and Expand Patient and Community Awareness

Hospital Strategies to Engage and Expand Patient and Community Awareness	
Strategies to Increase Patient Accessibility to Information	
	Develop awareness and “conversation-readiness” among health care professionals providing care to patients with advanced illness. To create demand for AIM programs, health care professionals must be knowledgeable about services available to their patients and prepared to address them with tact.
	Work with stakeholders on the importance of conversations, advance directives, and early decision making in advanced illness management. Opening lines of communication provides an opportunity to discuss and identify all health care options for patients and their families to consider. Transparency of advance directives can also create accountability for all parties involved: patients, family members, health care providers, insurance companies, etc.
	Provide effective language assistance services. Translators can engage patients who would not have otherwise been able to converse due to language barriers.
	Address low health literacy. Patients can be engaged if they are given information that they can understand and comprehend. What is needed is an advocate who can facilitate patients in maneuvering the intricate health system.
Community Collaboration Strategies	
	Spread awareness of cultural diversity. Employing interpreters to carry out outreach programs outside the hospitals walls provides an opportunity to create visibility and network in the community.
	Develop community engagement programs. Developing community engagement initiatives that align with the current patient population’s demographics, education levels, culture and language will provide hospitals and health care systems an opportunity to share resources and work collaboratively with local leaders and organizations.
Workforce Development Strategies	
	Equip health care providers with the skills and knowledge necessary to provide support and guidance to patients and their families facing end-of-life care. Patients and family members often need assistance maneuvering the health care system. It is important to ensure that health services rendered throughout the care continuum are aligned with the patient’s and family’s wishes.
	Develop a diverse and skilled workforce that would cater to the patient population being served. Health care professionals who can culturally relate and converse with patients in their native languages can better address their needs and avoid misunderstanding.
Internal System Strategies	
	Have passionate champions for patient-centered communication programs. Any successful initiatives have a strong and passionate advocate who will see that the program is successfully launched and carried out to sustain in the long term.
	Collect information on communication needs. Identifying current gaps in patient engagement will allow hospitals to launch initiatives that strategically align with the needs of individuals, staff and the community.
	Track performance of patient engagement programs over time. To ensure the viability and fiscal solvency of patient engagement programs, hospitals and health care systems administrators and leaders must continuously measure their performance and impact on the patient population in order to demonstrate that the benefit outweighs the cost.

Source: AHA CPI, 2012.

Case Study 1

The Massachusetts MOLST Program

The MOLST (medical orders for life-sustaining treatment) and POLST (physician orders for life-sustaining treatment) concept began 20 years ago in Oregon, and initiatives of varying scope have now been developed in about 25 states. MOLST is a voluntary process and standardized form used to translate several life-sustaining treatment preferences of patients with advanced illness into valid medical orders that can be honored across all health care settings in Massachusetts. The form is filled out with and signed by a medical provider after discussing the patient's preferences and understanding of the potential risks and benefits of the interventions. The form guides emergency responders and surrogate decision-makers about what to do or not, if and when a situation arises.

Background

MOLST is not an advance directive; it is a medical order and the latter is a legal document. Using the form, a patient can opt in or out for various potentially life-sustaining treatments. The form travels with the patient and can be revoked or altered at any time. It is also valid in every health care setting—outpatient, emergency room, hospital unit, nursing home, rehabilitation facility, etc. Therefore, staff in all these areas requires training to be able to understand the document, how to respond to questions and where to find it in the medical record.

The premise of the MOLST form is that decisions are made following conversations between patient, family and providers, who help the patient understand the prognosis, possible symptoms or complications and potential benefits and risks of various life-sustaining interventions. For instance, resuscitation is rarely successful among frail elders because it may cause serious pain and discomfort and accelerate emotional disequilibrium. In contrast to advance directives, the MOLST form must be signed by the provider—a physician, nurse practitioner or physician's assistant—who will first discuss with patients and families the implications and benefits of their decision.

The format of the MOLST form is particularly significant for EMTs, whose input made a decisive impact on the content and organization of the first page. At a glance, the EMT can view the patient's preferences on four emergency procedures: resuscitation, intubation, ventilator and hospitalization. EMTs consider MOLST an improvement over other documentation tools. To date, EMT training on the document has been the most in depth of any group of health care providers.²³

What They Did

Those who have been working to improve end-of-life care recognized the need for a MOLST-type document and were keenly aware that the needs and wishes of those facing life-limiting illness have often not been expressed, communicated or documented. When such documentation was present, it was often unknown or unavailable to the EMT, the emergency room or other providers who must make medical decisions in the moment or are about how to treat someone who cannot communicate treatment preferences. Previously, Massachusetts' only advance directive was the health care proxy, which identified a surrogate decision-maker but did not circumstantiate the preferences of the person who entrusted that responsibility.

DNR forms deal with only one form of medical intervention. There has been “no standardized way for patients to express life-sustaining preferences in a way that can be readily understood and followed by members of the health care team in all settings of care.”²⁴ As a result, providers often feel compelled to provide life-saving/extending treatments that are unwanted by the patient, resulting in increased suffering and decreased quality of life.²⁵

In 2008, the Massachusetts Legislature mandated a MOLST demonstration project directed jointly by the Massachusetts Department of Public Health (DPH) and the Executive Office of Elder Affairs (OEA). From the outset, the approach was developed with the potential for statewide implementation. Therefore, the process was more comprehensive in Massachusetts than in many other states. A steering committee of diversely situated experts with a long history of having worked together was formed to improve end-of-life care at the state and national levels. It was co-chaired by both DPH and OEA staff in partnership with Commonwealth Medicine, the health care consulting arm of the University of Massachusetts Medical School in Worcester, to develop and manage the project.

Two years of iterative development of the MOLST form preceded pilot demonstrations in three nursing homes, two acute care hospitals, two hospices, a geriatric home visiting program and emergency medical services in the greater Worcester area. Based on that experience, conversations continued among multiple stakeholders, professional communities, lay communities, consumer groups, the staff, committee members and work groups to revise the form during the demonstration period prior to the two-year, statewide rollout in 2012.

During four years of development and testing, staff and committee members worked extensively with EMTs to revise the form. They worked with the Massachusetts Medical Society and boards of several health professions, overseen by the DPH. The developers had conversations with providers as well as individuals and groups who had been working on end-of-life care for many years. They also met with nurses, social workers, clergy, emergency responders and medical interpreters. The developers studied other MOLST/POLST forms and decided to broaden their scope. To do this, they held focus groups and worked with many consumer groups including members of the African-American, Latino and Vietnamese communities as well as people of all ages and abilities.

The developers acknowledged many of the concerns voiced by consumers such as: Would patients have adequate time to talk with the clinician? Why had the draft materials not made families more integral to the conversation? They learned from people with disabilities that the doctor spoke to the person who accompanied them rather than the patient. The developers also identified confusion among lay and professional groups about terminology and why both MOLST and proxies were needed. This concern later led to creating a glossary, written in a language that is clear and precise.²⁶ All the information gathered, from engaging a variety of groups, was incorporated into materials that were eventually developed to communicate MOLST and to design the program's website.

Results

The pilot results strongly recommended statewide expansion of MOLST, as did the 2010 report of the Expert Panel on End-of-Life Care under the State's Executive Office of Health and Human Services.²⁷ The goal was to reach every hospital, nursing home, home care agency, hospice as well as other health care entities that care for patients with advanced illness in Massachusetts, so they are aware of MOLST, participate in conference calls and use the implementation toolkit on the MOLST website.

Lessons Learned

From the demonstration sites, staff and work groups learned that:

- It is essential to have a MOLST champion in the institution where it is being introduced as well as the necessary administrative support for implementing the program.
- Each institution must develop policies and procedures so that staff is aware of the form's location, how to complete it and respond to questions and inquiries, and where it is entered in the medical records.
- A task force is needed to oversee the preparation, development, launch and phased implementation of MOLST.
- Health professionals require training, coaching and support during implementation.

With all the changes in health care, having well-versed officials and offices that stay involved during the implementation process has advantages. These participants can identify where and how to bring MOLST into new and emerging programs and organizations.

MOLST provided a tool for starting conversations between attending health care practitioners and their patients with advanced illness, which the state of Massachusetts had legislated for in August 2012. This legislation required conversations with patients regarding their prognosis, their legal rights to pain and symptom management and the "risks and benefits of the various options."²⁸

Massachusetts MOLST

(508) 856-5890

<http://molst-ma.org/>

Case Study 2

The Conversation Project

The Conversation Project (TCP) aims to create a movement that will make end-of-life discussions easier. In partnership with the Institute for Healthcare Improvement (IHI), TCP developed a forum for sharing stories, a marketing campaign, and resources for conversation starters and guides to help people who don't know where to begin end-of-life discussions.²⁹

Background

The concept behind TCP began to take shape after the death of founder Ellen Goodman's mother. Goodman is a Pulitzer Prize-winning syndicated journalist. Following her retirement in 2009, she started to formulate the idea of transforming health care by changing the way people die. Goodman, her colleagues, media, clergy and medical professionals discussed and shared stories and experiences about the culture of death in the United States and learned that more than half of Americans have not communicated how they want to spend the end of life. Prominent health care experts and leaders, Susan Block, MD, and Atul Gawande, MD, also affirmed that even baby boomers are ill prepared to face the death of their parents and their own aging.

The core purpose of TCP became to initiate and facilitate conversations as the first step in ensuring that people's end-of-life wishes are expressed and respected. Goodman believes that "the lever to begin this dramatic change is a willingness to talk as individuals, family members, and a culture about what we want when, as they say, the time comes."³⁰ TCP (1) provides a platform for sharing stories, (2) launches marketing campaigns to promote the conversation movement and (3) provides resources such as conversations starters and guides for those individuals who do not know how and where to begin end-of-life conversations.³¹

What They Did

During the 2009 IHI National Forum, Katherine Sebelius, U.S. Department of Health and Human Services Secretary, addressed to Maureen Bisognano, IHI CEO, the need to lead the charge on end-of-life issues. Today, IHI is a committed partner of TCP, sponsoring and providing TCP's office and activities.

IHI, through its client base of hospitals and clinicians, plans to build a medical community that is conversation-ready and able to fulfill the last wishes of patients facing the end of life. Meanwhile, TCP will work on the "demand" side of the equation, the public. It aims to create a movement that effects social and cultural change on the topics of death and dying. In addition, TCP aims to engage individuals in having conversations about what they want as their life draws to a close or if they are incapacitated. The partnership's premises are threefold:

1. *Reframing dialogue:* To reframe the public dialogue about death and dying in a way that people get what they want and wishes are both expressed and respected.
2. *Tapping readiness:* To tap into the readiness below the surface, creating safe space and permission, providing tools and scripts for how to begin and building critical mass for change. TCP will emphasize the deeper understandings flowing from the conversations rather than the documents. Some of the outcomes and clarifications that arise through conversation need to be documented, but the real meaning of "advance care planning" is the honest conversations among family members that can reveal surprises, foster deeper connections and collectively move dying "well," as defined by one's wishes, into the cultural mainstream.
3. *Creating demand:* For expressed wishes to be fulfilled, change is necessary in both the medical and broader social cultures. The medical culture is oriented to curing, heroics, technology and volume of

interventions. Therefore, TCP believes that change must come from outside the medical arena and originate from the public. While it is essential that physicians and nurses are trained how to initiate these conversations and respond to (rather than negate) patients who take the lead, the heart of the process lies with family and friends at home and not the medical office.

In September 2012, IHI announced it will be working with TCP and 10 pioneer sponsors who have committed sponsorship funds, resources and expertise to develop a “Conversation Ready” change package and with palliative care experts who will develop and communicate innovative ways to engage in difficult and sensitive conversations.³² The pioneer sponsors will first develop and pilot processes and tools that encourage people to express their wishes and engage in conversations with health care providers.³³ After one year of implementation, their change packages will be shared with the rest of the field.

The pioneer organizations are:³⁴

- Care New England Health System (Rhode Island)
- Contra Costa Regional Medical Center (California)
- Qulturum in the Jönköping County Council (Sweden)
- Mercy Health (Ohio)
- North Shore–Long Island Jewish Health System (New York)
- UPMC (Pennsylvania)

In August 2012, TCP launched its website and social and national media campaign. To create public awareness of the benefit of having end-of-life discussions, the website features a conversation starter kit and ways to tell stories. On the horizon is engaging employers who are beginning to realize the amount of time lost due to employee caregiving and the toll and impact on family caregivers such as depression, stress, post-traumatic stress disorder, physical illness and premature death. Employers are beginning to acknowledge the role of HR departments in providing resources and facilitating conversations.

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Case Study 3

Aetna Compassionate Care Program

The Compassionate Care Program (CCP) is a telephone case management program developed by Aetna. Designed to improve the quality of care for members who are likely to live less than a year, the program involves CCP case managers who serve as patient navigators and companions. Candidates are identified proactively through review of hospital admission records, medical history, pharmacy claims, referrals, etc.

Background

Aetna has long offered its members case management services staffed by registered nurse case managers. In 2004, it piloted the Compassionate Care Program (CCP) within a subset of Medicare Advantage and commercially insured members who were struggling with advanced illness. The key component of the new program was a specialized, telephonic case management program designed to improve quality of care for members and help support their family caregivers. CCP case managers serve as guides and companions for members who are likely to live less than a year. Potential candidates are identified proactively through reviews of hospital admissions, history of medical and pharmacy claims, predictive modeling, self-referrals and physician referrals.

For some of the commercially insured, a second program component of benefit liberalization was introduced. Hospice benefits were relaxed to 12 months and could be extended to 18 months, while conventional care could still be provided. Fifteen days per year of respite are now provided for family members. These benefit enhancements could not be offered to Medicare Advantage members without Centers for Medicare and Medicaid Services (CMS) permission. Aetna has proposed to CMS the same enhancements for its Medicare Advantage members at their own risk.

What They Did

After reviewing a member's case and pattern of claims and admissions, the case manager contacts the physician and then the member. Early calls assess the member's physical, familial, psychosocial and home situation. Individual care plans are built around these factors as well as the member's preferences. The case manager may educate patient and family members about the disease process, help them understand and create advance directives, navigate the system, coordinate medical care and benefits and connect them to resources that support both family caregivers and the patient. Caregiver support is a major aspect of the CCP. The case manager can help with pain, symptom and medication management as well as provide psychosocial support.

Aetna's case managers are experienced registered nurses. The CCP selects interpersonally gifted, clinically experienced case managers for four to five days of training in AIM and cultural attunement followed by two to three months of mentoring where they work side-by-side with a training case manager. Many of the CCP case managers have been cancer or hospice nurses and are already or soon to become subject matter experts or master trainers. According to a former team manager, turnover rate for this difficult but rewarding work is very low.

Case management teams include social workers who live in the same geographic territory as those they serve and are familiar with hospitals, physicians and social services in the area, making them better able to direct members to appropriate resources. Teams support each other, and regional teams take turns hosting the Schwartz Center Rounds, a platform that "allows caregivers from multiple disciplines to come together on a regular basis to discuss the most challenging emotional and social issues they face in caring for patients."³⁵

Results

A matched historic control was created for each of the following groups to test CCP: (1) commercially (non-Medicare) insured members that would receive specialized case management, (2) commercial members that would receive both case management and hospice benefit liberalization and (3) Medicare Advantage members that would receive case management.³⁶ The results of the pilot program were dramatic.

- Hospice election increased from 32 percent to 72 percent for the commercial case management group, and hospital days were reduced by 37 percent for the commercial case management group.³⁷
- Increased hospice election, 82 percent decrease in acute days, 88 percent decrease in intensive care days and 82 percent in emergency room utilization for the Medicare Advantage group.³⁸
- High satisfaction among members and their families.³⁹

Since the study was completed, Aetna has expanded CCP making it available to all medical members that are eligible for case management and making benefit liberalization a standard for commercially insured medical members.⁴⁰ In addition, the organization has proposed to CMS that it be permitted to liberalize the Medicare Advantage hospice benefit at its own financial risk.⁴¹

Over the years, Aetna has served 14,000 members through the CCP and not received a single complaint, despite the sensitive nature of the issues being addressed. Results continued to improve as case managers gained more experience in the area. As of 2011:⁴²

- Hospice election rate is 82 percent for Medicare Advantage members.
- Number of days in hospice has doubled, but the mean is still low at 36 days.
- 86 percent reduction in ICU days.
- 82 percent reduction in acute care/hospitalizations.

Lessons Learned

Randall Krakauer, MD, national Medicare medical director at Aetna and champion for the CCP, observed the greater impact to be made on Medicare members, some of whom are dual eligible. According to Dr. Krakauer, there is a greater opportunity to impact quality and costs in this group than those commercially insured because the former is more often associated with significant chronic illness. In addition, the Medicare population, a less affluent group, needs more assistance and will benefit more.

Aetna Compassionate Care Program

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<http://www.aetna.com/individuals-families-health-insurance/sas/compassionate-care/how-it-works.html>

Case Study 4

Respecting Choices in Gundersen Lutheran Medical Foundation

Respecting Choices is a nonprofit organization owned and operated by Gundersen Lutheran Medical Foundation in La Crosse, Wisconsin, part of the Gundersen Health System. The program has designed key elements to promote the adoption of advance care planning as an ongoing process of communication, integrated in the patient-centered care routine and staged to the individuals' state of health.⁴³

Background

In 1991, La Crosse, Wisconsin—composed of a mixed urban and rural population⁴⁴—conducted a random telephone survey of 304 adults and found that only 15 percent of its population reported having had some type of written advance directive.⁴⁵

Major health systems in La Crosse developed and implemented Respecting Choices as a collaborative, systematic and communitywide advance directive education program.⁴⁶ It was designed to assist patients and their families make informed decisions, properly document and update health plans and ensure that they are available to health care providers when needed.⁴⁷

In addition to helping patients and families complete advance directive documents, Respecting Choices is an evidence-based approach that provides a platform for thoughtful conversations with patients over time. The approach is not “one-size-fits-all” and was tailored to meet individual goals and values at a specific point in time.⁴⁸

What They Did

The premise of the program model is that a single document and discussion about health care plans cannot capture all possibilities. Effective advance care planning involves a process of communication that (1) allows individuals to understand their care options; (2) reflects the personal goals, values, religious and personal beliefs of individuals; and (3) supports conversations between individuals and physicians, health care agents and their family members.⁴⁹

Respecting Choices adopted three distinct stages of health when assisting individuals and families:⁵⁰

- **For healthy individuals**, it promotes basic planning. This includes creating a power of attorney with specific instructions for health care plans in the event that severe or permanent brain injury or disease occurs that could change treatment goals—shifting from prolonging life to providing comfort.
- **For individuals with progressive and advanced illness**, the program provides disease-specific planning, which includes specific instructions should a devastating complication arise from the illness, altering the goals of care.
- **For individuals facing end of life in the 12-month period**, it substantively opens communication about specific treatments documented on the POLST (physician orders for life-sustaining treatment) form.

Results

The Gundersen Health System along with other health care organizations in the La Crosse region have continued to monitor the outcomes of the program. Data collected in 2007 and 2008 on 400 deaths at all health organizations in La Crosse County over a seven-month period showed that:⁵¹

- Prevalence of care plans among adults who died in health care organizations in La Crosse County was 90 percent.

- Care plans were available in the medical records of health organizations in 99.4 percent of patients that died.
- 99 percent of the time, treatments provided were consistent with the care plans.
- 67 percent of individuals had a POLST form at the time of death.
- 96 percent of individuals had either an advance directive or POLST.

Because of the program's proven results and successful model, there are now more than 80 communities and organizations across the country that have launched Respecting Choices initiatives. In 2002, the program was presented for the first time in Heidelberg, Australia, attracting the attention of the Department of Health and Ageing and gaining political and media support.⁵² Today, the program has scaled up becoming the model for end-of-life care in all of Australia. The program now has expanded to Germany, Singapore and Spain. Respecting Choices has also provided consultation and education for Canadian Health Initiatives.

Large implementations are currently underway in the United States. These include Honoring Choices Minnesota, a project that includes the metropolitan area of Minneapolis and St. Paul convened by the Twin Cities Metro Medical Society; Honoring Choices Wisconsin, a project that will include the state of Wisconsin, convened by the Wisconsin Medical Society; and full implementation of all three stages of advance care planning by Kaiser Permanente of Northern California.

Lessons Learned

For Respecting Choices, living wills and advance directives merely scratch the surface and do not solve the underlying issues. The organization has placed great emphasis on the advance care planning process but also hopes to improve the health care delivery model by:⁵³

- Equipping health care professionals with the skills and competence to facilitate at each distinct stage of health.
- Creating a new role in health care such as the advance care planning facilitator. Advance care planning facilitators are typically health professionals, though they may include other professionals, who are trained using the standardized Respecting Choices curriculum. This curriculum is a blended learning approach that consists of online learning, role playing and coaching.
- Considering and designing new roles and responsibilities, which includes training staff at all levels and holding them accountable for their roles.
- Standardizing ways to document both the interactions of patients and plans that were created.
- Designing medical record systems, including EMRs, that ensure consistency of health care plans and maintenance of health records that are always available to providers. The medical record is also used to help guide the initiation of advance care planning conversations, document all types of care planning and provide a means of writing notes to track all advance care planning encounters.
- Ensuring all process and materials are subjected to evaluation and performance improvement.

The success of the program was also attributed to the support sought from health care leaders, professionals and the community. Local groups were engaged and included in the decision making prior to implementation of Respecting Choices. This type of community engagement established trust and garnered widespread support for the program.

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Case Study 5

The Coalition to Transform Advanced Care

The Coalition to Transform Advanced Care (C-TAC) is a national nonprofit, nonpartisan alliance of patient and consumer advocacy groups, health care professionals and providers, private sector stakeholders, faith-based organizations and health care payers. These groups have a shared vision that “all Americans with advanced illness, especially the sickest and most vulnerable, will receive comprehensive, high-quality, person-centered and family-centered care that is consistent with their goals and values and honors their dignity.”

Background

Patients and family caregivers facing the end of life are often not asked about the care that they want. With little support, they are left to navigate care settings, providers and fragmented information, creating physical, emotional and financial hardships on patients, families and caregivers.

High-performing systems are showing ways toward better care. Some of the most innovative health care providers in the United States have demonstrated that a coordinated, person-centered approach yields better care, greater satisfaction and lower costs.⁵⁴

Building on this experience, C-TAC provides resources, education and visibility aimed to deliver the appropriate care at the right place and time. The alliance is focused on key directives to empower consumers, change the health care delivery system, improve public and private policies, and enhance provider capacity. With a particular emphasis on faith-based and cultural perspectives, these directives are to:

- Identify, design and promote best-practice delivery models that ensure high-quality, coordinated care across all settings.
- Develop and disseminate innovative, interprofessional advanced care education to clinicians aimed at improving quality, shared decision making and medical care by cultivating respect, compassion and responsiveness in care delivery.
- Develop and advocate for federal and state legislative, regulatory, judicial and administrative policies as well as private policies to improve care for those with advanced illness.
- Undertake a nationwide campaign of public education and engagement to help patients and their families make more informed decisions and to support delivery system and policy change.

What They Did

C-TAC is aimed at increasing the percentage of Americans who engage in the advanced illness care planning processes. This participation will improve the social, policy and health system environment and norms for quality care, ensure that patient choice and shared decision making drive care, improve quality and promote high levels of patient and family satisfaction.

In the fall of 2012, as part of its public engagement strategy, C-TAC launched its website, which was designed to empower the public to make informed decisions about advanced illness care and provide high-quality resources. For example, the C-TAC website has published a consumer research brief, *Public Perceptions of Advanced Illness Care: How Can We Talk When There's No Shared Language?* which is updated regularly.

As part of its educational initiatives, C-TAC has also identified six core competencies and associated behaviors:

- **Advance care planning:** Facilitate nonbiased, objective discussions between an individual and health care proxy to ensure a better understanding of a person's wishes and goals; actively listen, using communication skills of exploration, summarizing, paraphrasing, validation and open-ended questions.
- **Care coordination:** Link patients with community resources to facilitate uninterrupted care and respond to social service needs; identify patients who are likely to need coordination, as well as the team members who will be responsible for coordinating care.
- **Person-centered care:** Conduct a full assessment prior to providing service; appropriately consider cultural needs; actively promote the well-being of the individual.
- **Communication:** Enable self-management and patient navigation; build and foster healing/therapeutic relationships; coordinate care with other clinicians, health care professionals and health-related agencies.
- **Interprofessional teamwork:** Monitor mutual performance; orient collectively; build the ability to adapt.
- **Clinician resilience:** Cultivate self-awareness; be able to accept personal limitations; maintain effective professional relationships.

By identifying and promoting best practices from across disciplines and diseases, C-TAC assesses existing evidence, increases utilization and applies innovation to advanced illness care such as:

- Developing messages using new and existing consumer research to reach segmented audiences and create strategies and concepts for each key segment and test and refine them.
- Building a website that will feature vetted, curated resources for the public and clinicians.
- Distributing messages via social media, story and editorial placement to motivate and empower consumers to make informed choices and call for and support change in the delivery system.
- Measuring performance and making refinements and adjustments. This includes tracking public perceptions and behavior, which involves establishing baselines, conducting periodic benchmark tracking surveys and adjusting channels and messages accordingly.

On the horizon, the C-TAC will create public support for policy reform to improve the social and health care system environment and improve norms for quality care. Public and clinician engagement will be integrated into C-TAC's clinical models initiative to ensure that patient choice and shared decision making drive care, improve quality, promote high levels of satisfaction and reduce costs.

Lessons Learned

C-TAC acknowledges that there is a growing body of evidence on the benefits of quality communication and shared decision making among patients, families and clinicians regarding advanced illness. However, clinicians still face challenges as they grapple with difficult questions such as what information to provide and how and when to share it with patients, families and fellow professionals.⁵⁵

While there are evidence-based tools and guides to improve communication and advance care planning, their adoption has not been widespread. Despite the existence of quality solutions, these resources can be hard to find. Some are fragmented, discipline- and disease-specific, and not as accessible or transparent. Much more work is needed in this area, and C-TAC aims to address these issues.

Coalition to Transform Advanced Care (C-TAC)

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Case Study 6

Mercy Supportive Care at St. Joseph Mercy Oakland

Mercy Supportive Care at St. Joseph Mercy Oakland (SJMO), a community hospital and member organization of Trinity Health in Pontiac, Michigan, is a pain management and palliative care program that provides individuals who suffer from an illness and/or are facing the end of life with comprehensive services across the care continuum. SJMO's motto is "dying well is only possible if everyone gets a chance...to live well until they die."⁵⁶

Background

SJMO's Mercy Supportive Care service changed the culture of pain management and palliative care through its multiple programs, services and infrastructure support. The team, led by board-certified palliative-care nurse practitioners in collaboration with an interdisciplinary team and a board-certified palliative care medical director, initiates contact with inpatients and follows a large percentage of them during transitions to hospice or outpatient care settings. Each month, the team provides 300–400 inpatient visits and discusses coordination of care plans during interdisciplinary team conferences.

To create infrastructure support, SJMO's Mercy Supportive Care provided educational training regarding pain management and palliative care programs for employees. To strengthen and foster the change in medical culture at SJMO, a curriculum on pain management, palliative care and ethics was developed for surgical and medical residents. Medical students and residents rotate throughout the pain and palliative care service lines. All medical students are required to participate in special simulations focused on pain management and palliative care scenarios. Meanwhile, nurses and pharmacists receive five hours of pain management education during new employee orientation, and many continue to retake the monthly course offerings.

What They Did

In 2005, SJMO's Mercy Supportive Care created the "No One Dies Alone" program to provide comfort and assistance to inpatients with few or no family members. The program recruits and trains volunteers to be at the patient's bedside at the end of life so that patients can die with dignity and comfort. Classes are offered at least twice a year to train new volunteers. To date, approximately 139 volunteers support the program. Since its inception, more than 554 patients received the service and over 11,779 hours were provided at the bedside. In an effort to expand this service, SJMO's Mercy Supportive Care mentored and assisted more than 85 hospitals to establish their own "No One Dies Alone" program. As a result, in 2010, SJMO received the Hospital Awards for Volunteer Excellence (HAVE) from the AHA for outstanding hospital-based volunteer programs.

Resources are provided to create a peaceful and healing environment for patients facing the end of life. SJMO's Mercy Supportive Care provides portable "comfort" carts for patients that contain a music player, soft listening CDs, homemade "love blankets," bereavement information, community resource booklets, religious books and other inspirational items. Other resources include the ability to conduct a life review; receive massage therapy, healing touch and aromatherapy sessions; and create hand casts of the dying patient for his or her family. Another therapy modality includes a harpist available to play music at the bedside. All of these resources create sacred and peaceful spaces for both patients and families.

Additional end-of-life support programs include the Emergency Department Service for grieving family members. A value-added component involves bereavement follow-ups for those that experienced the loss of a family member at the hospital. A unique miscarriage program was also implemented in the ambulatory surgery center, for mothers who underwent dilation and curettage after a miscarriage. This includes a naming ceremony, bereavement support, information on how to cope with early loss and outpatient perinatal loss support groups. Memorial services are held regularly for both infant and adult loss.

The outpatient palliative care component of the program has evolved over the years and features services such as case management, referrals to outpatient programs, home and hospice care. This service is available 24/7 and

serves as a support system for patients and their families. For example, the outpatient pain management and palliative care center provides the hospital with capabilities to care for complicated chronic pain patients and those facing the end of life within a clinical setting. The parish nurse outpatient service was also developed as a community outreach program. Parish nurses provide education while promoting community engagement and education of patients' rights within a pain management and palliative care setting. In addition, Mercy Supportive Care offers palliative care through the hospital's home care agency.

Results

The high volume of referrals, more than 4,200 patient visits annually, is a testament to the comprehensive services offered at SJMO's Mercy Supportive Care. Since 2001, palliative patients have consistently experienced reductions in pain scores, typically from 10 to 2. Data collected over the last 10 years indicates that more than 95 percent of families who experienced loss at SJMO also consistently reported in satisfaction surveys that they believe their loved one was comfortable at the end of life and felt supported.

Prior to the inception of SJMO's Mercy Supportive Care, resuscitation was attempted in 60 percent of patients who died at SJMO.⁵⁷ Since 2001, this has decreased to approximately 15 percent. This outcome demonstrates that patients and families are well-informed and able to express wishes to decline resuscitation efforts.

Another significant outcome demonstrates SJMO's ability to reduce the length of stay among palliative care patients in the ICU. While reduced length of stay in ICU was a favorable outcome of the program, the analysis justified Mercy Supportive Care as a financially viable and sustainable program. In 2003, the cost-per-case-per-day was \$600 less when palliative care services were involved. In 2011, using the Center to Advance Palliative Care impact calculator, SJMO data indicated that it was able to avoid \$920,000 in costs (based on volume).

The results at SJMO drew the attention of other community hospitals. Since 2005, Peg Nelson, director and nurse practitioner for pain and palliative services, reported that the program has been shared with more than 131 health care organizations, including competing hospitals. Many hospitals sent teams of administrators and clinical staff to observe SJMO'S program so that they might replicate them in their organizations.⁵⁸

In 2012, an important milestone occurred when the program received Joint Commission advanced palliative care certification, the first organization from the Trinity Health system and first of five hospitals in the United States to receive it.

Lessons Learned

The success of SJMO's Mercy Supportive Care can be attributed to the interdisciplinary team involved in the program. Nurse practitioners anchor the service and contact physicians and team members as appropriate.⁵⁹ Because the Mercy Supportive Care team includes pain and palliative care experts from both medicine and allied health occupations, it promotes staff interaction, communication, participation and program support.⁶⁰

While participation of the clinical team is crucial, the program also gained the support of hospital administrators and Trinity Health. All of them played an integral role in the success of Mercy Supportive Care, allowing SJMO to integrate services throughout the hospital rather than providing an isolated service.⁶¹

Mercy Supportive Care at St. Joseph Mercy Oakland

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Ready, Willing and Able Workforce Strategy

To launch successful AIM programs, hospitals and health care systems must have and foster or employ the necessary human capital that can deliver high-quality hospice, palliative and end-of-life care. This involves building a workforce with the knowledge, skills and competency to provide care to patients whose nature of illness leads to death. Health care professionals who are ready, willing and able are needed. But what exist now are serious and growing shortages of health care professionals, medical and nursing training programs that overlook the necessary skills to communicate with patients at end of life, a medical culture that too often regards death as a failure rather than as a natural part of life, and the slow and uneven journey of hospice and palliative medicine to become fully established among the specialties.

Shortages of Clinical Professionals

Baby boomers comprise a significant portion of the health care workforce. About 40 percent are doctors who are over 55 years of age, while one-third of the nursing workforce is over 50.⁶² When these baby boomers retire, there will be a significant shortfall of health care professionals. Coupled with these shortages, the health care community will also face challenges of meeting the needs of an aging cohort as one in five Americans will be over the age of 65 by 2030, according to the 2010 U.S. Census.⁶³

A task force appointed by the American Academy of Hospice and Palliative Medicine (AAHPM) in 2008 concluded that there is an acute shortage of hospice and palliative medicine physicians. Only about 4,400 hospice and palliative medicine physicians are currently practicing and most practice part-time; estimates of their full-time equivalents range from 1,700 to 3,300. If current programs were appropriately staffed, another 2,800 to 7,500 full-time employees would be needed, which translates to between 6,000 and 18,000 individual physicians who practice hospice and palliative medicine.⁶⁴

Aside from physician shortages in hospice and palliative medicine, the nursing shortage is also at crisis levels in the general field of health care. By 2025, it is projected that there will be more than 260,000 unfilled positions for registered nurses.⁶⁵ This shortage intensifies and makes more pronounced the already insufficient number of available nurses to provide care in hospice,⁶⁶ palliative and end-of-life care.⁶⁷ In fact, according to the 2008 *National Sample Survey of Registered Nurses*, only 3 percent of America's registered nurses (3.1 million) identified hospice as their clinical specialty area and 72 percent of them practice in nonhospital settings.⁶⁸

Medical School and Residency

American medical students and residents don't feel prepared to care for the dying, and statistics show that most aren't.⁶⁹ Based on self-reports from 1,455 fourth-year medical students in a major national study conducted in 2003, 296 residents and 287 faculty affiliated with a random sample of 62 accredited medical schools have seen only modest and uneven improvement in their preparation. Less than 20 percent of each group had coursework or rotation or were taught about end-of-life care in the past year. Additionally, only 30 percent of students were taught basic pain management while slightly more than 40 percent of each group did not consider meeting the psychosocial needs of dying patients to be a core clinical competency.

Conclusively, these and other findings suggest that American medical education and residency do a poor job of teaching the clinical aspects of end-of-life care and fail to recognize, let alone teach, the scope and skills of communicative competency required to work with the psychosocial needs of dying patients and their families. On the contrary, using a similar questionnaire, British medical students reported having more training and more experience in palliative care within a medical culture more favorably disposed to it.⁷⁰

Other data suggest that a major contributor to the deficiencies in American medical education is the “hidden curriculum”—mixed and implicit messages from residents and attending physicians that inform the local culture.⁷¹ The cultural milieu documented in the study indicated that end-of-life care is not a faculty competency or priority: residents are not introduced to issues of dying at home or hospice, complex communication issues are ignored, and emphasis is placed on high technology and curing, which reduces the meaning of impending death as being “nothing more we can do.” This concept to “prolong life” is imbued during medical school, suggesting that anything less is considered a failure to physicians. In fact, medical school educators are finding it difficult to teach about dying and death when they themselves were instilled with ideas that would be contrary to their professional oath to save lives.⁷²

The authors of the U.S. study called for structured, systemwide plans that include: (1) integrating palliative and end-of-life care into the curriculum; (2) requiring a rotation in palliative care, hospice and home care/death experience and continuing education for attending physicians; and (3) providing sustained observation and feedback (who is qualified to provide care?) on clinical and communication skills related to end-of-life care. The British study called for “creating robust academic palliative medicine departments to lead and support these advances.”⁷³

Susan Block, MD—a leader in developing hospice and palliative medicine and innovative educational programs and involved in the aforementioned studies—summarized that although there are still huge gaps in medical education, they are otherwise improving. She recounts that there is more integration of classroom-based training in palliative care, exposure to palliative care services, elective opportunities for students and residents, and culture change in some of the large teaching hospitals.

Nursing Programs

Unlike physicians who perhaps spend less than a few minutes per day with the patient, nurses on an 8-hour hospital or hospice shift spend more time on average with patients and their families.⁷⁴ This makes nursing the profession in the most immediate position to provide care, comfort and counsel to patients facing the end of life.⁷⁵

Although nurses are on the front lines, there is a large gap in the education and training of nurses providing end-of-life care. Both nursing and medical schools offer less than one-fifth of a full semester course on end-of-life topics^{76, 77} and when such electives were offered, they were taken only by a minority of students.⁷⁸ In 2005 and 2006, nursing and medical schools overwhelmingly reported having offered educational programs in end-of-life and bereavement issues with more than 90 percent of their students participating.⁷⁹ But despite this topic’s inclusion in the curriculum, an average of fewer than 15 hours was devoted to it.⁸⁰ This allotment merely exposes students rather than provides an in-depth understanding of the subject.

Medical and nursing schools are in a prime position to educate and provide quality training in end-of-life care. Most medical school deans are in favor of integrating end-of-life care into existing courses or clerkships, rather than as stand-alone programs, because segmenting this topic from the rest of the curriculum detracts from gaining better overall exposure on an important perspective.⁸¹

Other Health Care Professions in End-of-Life Care

There are other key players in end-of-life care. For example, social workers “have unique, in-depth knowledge of and expertise in working with ethnic, cultural, and economic diversity; family and support networks; multidimensional symptom management; bereavement; trauma and disaster relief; interdisciplinary practice; interventions across the life cycle; and system interventions that address the fragmentation, gaps, and insufficiency in health care.”⁸² Social workers offer a unique perspective to advanced illness management. But like physicians and nurses, there are also substantial gaps in their education in end-of-life care even though they are well-positioned to provide psychosocial support.⁸³

As another example, psychologists have the training and exposure to provide mental health treatment to those with major chronic illness.⁸⁴ They bring a unique asset to the field because of their ability “to conduct psychological assessments, build teams, evaluate programs and facilitate communication among the variety of players involved—patients and loved ones, patients and medical staff.”⁸⁵ Not only are they able to provide prescription management and ensure treatment compliance, they are also able to offer pain management to patients using expertise in techniques such as clinical imagery and biofeedback.⁸⁶ There is a high demand for psychologists in advanced illness care, but like the aforementioned health care professionals, they are also scarce.⁸⁷ Nevertheless, the psychological practice is expanding and embracing end-of-life care.

This report highlights several health care professionals in end-of-life care, but the intent is not to overlook other key contributors in the field. These include case managers, dietitians, pharmacists, complementary therapists, caregivers and certified nursing assistants (CNA). All play an integral role in advanced illness management.

An Emerging Recognized Field

Between 1996 and 2006, the American Board of Hospice and Palliative Medicine (ABHPM) certified hospice and palliative medicine physicians. However, ABHPM was not recognized by the American Board of Medical Specialties (ABMS). In 2006, ABMS recognized palliative medicine as a subspecialty of 10 participating boards. Dale Lupu, one of the leaders in this 10-year effort, noted that specialty recognition is a path for codifying knowledge and skills into the curriculum, residencies and fellowships.⁸⁸ Although voluntary, ABMS recognition “is used by the government, health care systems and insurers as evidence of high standards.”⁸⁹

In conjunction with the 10 participating boards, the Accreditation Council for Graduate and Medical Education (ACGME) immediately began the process of accrediting hospice and palliative medicine fellowship training. However, the American Academy of Hospice and Palliative Medicine (AAHPM) task force criticized ACGME’s palliative care requirements for nonpalliative residencies and fellowships as minimal and vague, and the requirements of the Liaison Committee on Medical Education for undergraduate palliative education as shallow.⁹⁰

Changing the Approach

Ninety percent of the American public identified advanced illness care as a top priority for the health care system while 86 percent wanted a public discussion about it.⁹¹ There is consensus to change the current approach of advanced illness care, but a common language is still needed to bridge the communication gap among consumers, health professionals, members of the media and policymakers.

Core competencies for specialists have been put forward and are posted on the AAHPM website.⁹² Basic palliative competencies for nonspecialists are being designed (currently for internists and family physicians). The developers are aiming to define 12 competencies in several domains such as pain and symptom management, psychosocial support, spiritual support and communications.

Foundation: Communicating and Understanding

Empathic, skillful communication is at the heart of palliative and hospice care. Both patients and families have better outcomes when a physician is skilled in communication. “Physician ability to identify and respond to emotion and to effectively share prognostic information” is correlated with better outcomes for both patients and families.⁹³ Proactively intervening to manage symptoms and having family meetings can reduce ICU days and improve bereavement outcomes. “Empathic communication, skillful discussion of prognosis, and effective shared decision making are core elements of quality care in the ICU, represent basic competencies for the ICU physician, and should be emphasized in future educational and clinical interventions.”⁹⁴

Breaking the Bad News: The Prognosis

Critical care nurses and physicians describe communicating a prognosis as “painting a picture” so that families can visualize, comprehend, anticipate and prepare for potential responses including death.⁹⁵ There are two ways of delivering a prognosis: informal and formal communications. For the former, conversations typically occur during medical rounds, when family members are in proximity.⁹⁶ These are often spontaneous and brief.⁹⁷ Meanwhile, the latter occurs when significant negative prognostic information becomes available and needs to be broached to both the patient and the family for the first time.⁹⁸ Research data suggests that the difference between the two forms of prognosis delivery is that ambiguity, expression of hope, and uncertainty are absent in formal communications.⁹⁹

Both critical-care physicians and nurses perceive that it is the physician’s responsibility and role to communicate prognostic information.¹⁰⁰ Even though nurses possess intimate knowledge about patients and their families as a result of their proximity and constant interaction at the bedside, there are “unspoken boundaries” precluded from their domain of practice.¹⁰¹ In a study conducted to shed light on the actual prognostic communication of nurses, physicians did not solicit information from them during a family conference.¹⁰² Despite nurses’ interest in taking part in these conversations, it is plausible that physicians did not want their participation for fear of inconsistent messages being delivered to the family that could confuse or provide a sense of hope and, most of all, detract from aligning and understanding the prognosis and goals for care.¹⁰³

While medical culture does not foster shared responsibility in delivering a patient’s prognosis, communication between physicians and nurses regarding end of life will have a positive impact on quality of care. In fact, active participation of nurses has found to have improved both patient outcomes and nurse satisfaction.¹⁰⁴

During an end-of-life care conference, the decision-making responsibility shifts from the provider to the patient and family. This suggests the reluctance of the former to assume the moral burden for death.¹⁰⁵ In fact, during these conversations, physicians greatly emphasize the statement “you need to decide” or “you need to make the decision.”¹⁰⁶ Despite this shift, providers and other knowledgeable sources still need to translate personal wishes into services and structures through which personal preferences can be met. They will need to acknowledge important dimensions of life including spirituality and cultural diversity of health care users to successfully deliver the appropriate care.

Spiritual Sensitivity

A life-threatening diagnosis has a profound effect on people. Questions relating to identity and self-worth begin to emerge as patients seek to find the ultimate meaning of their lives.¹⁰⁷ Therefore, understanding the role of spirituality in AIM is just as important as adopting a caring attitude and disposition. While sometimes synonymous with religion, spirituality as a broader concept is “the aspect of humanity that refers to the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred.”¹⁰⁸

Religious and nonreligious adults overwhelmingly expressed reclaiming and reasserting the spiritual dimensions when faced with death.¹⁰⁹ For this reason, it would be advantageous for health care providers to familiarize with the patient’s spirituality in AIM because (1) it may be a factor in the patient’s understanding of the disease, (2) religious convictions may affect health care decision making, (3) it may be a patient need and a vital coping strategy and (4) it is integral to the entirety of patient care.

As a partner in the therapeutic relationship, “a skillful, caring and compassionate health care professional can be an important anchor in which the patient can find solace and strength to move through distress to peace and acceptance.”¹¹⁰ Of 456 patients surveyed, two-thirds felt that physicians should be aware of their religious or spiritual beliefs while 50 percent desired for spiritual interaction with their physicians in a near-death scenario.¹¹¹

Unfortunately, health care providers are having difficulty defining spiritual care from psychosocial or psychological and emotional care.¹¹² For example, nurses revealed in a spirituality survey the need for clarification in drawing personal and professional boundaries, support in dealing with this issues and guidance and education.¹¹³

To educate health care providers and other caregivers as they provide care and support to patients with advanced illness, programs like the Sacred Art of Living Center (SALC) for spiritual formation, established by Mary and Richard Groves, have emerged. This center offers a workshop for caregivers that acknowledges and incorporates spirituality in clinical care. The two-day workshop, Sacred Art of Living and Dying, provides training and certification programs for health care providers, hospice professionals, faith community leaders and the general public for spirituality in end-of-life care. Program participants explore universal patterns of spiritual and emotional suffering and are taught time-tested ways to relieve them, based upon ancient wisdom traditions with respect to contemporary clinical research. (See Case Study 7.)

Cultural Competence

Although non-Hispanic whites are still the largest race and ethnic group in the United States (64 percent of the population), their growth is much slower (1 percent) in comparison to other races such as Hispanics and Asians, which have relatively higher levels of immigration.¹¹⁴ About one-third of the U.S. population is now comprised of ethnic minorities.¹¹⁵ With this type of racial distribution, it is evident that people will differ in values and beliefs, including preferences about end-of-life care.

Having cultural competence can better equip health care professionals in addressing sensitive matters to patients and their families. This type of competence includes acknowledging diverse attitudes and cultural practices when translating the wishes of patients and their families facing the end of life. According to Searight and Gafford (2005), there are at least three interrelated dimensions to the differences in beliefs and values of racial groups: “communication of ‘bad news,’ locus of decision making, and attitudes toward advance directives and end-of-life care.”¹¹⁶ Below are examples of data that highlight the preferences of various racial backgrounds:

- Asian Americans, Hispanic Americans and African Americans are less likely to complete advance directives.¹¹⁷ For example, about two-thirds of older white patients completed advance directives in comparison to only one-third of older black patients.¹¹⁸
- A majority of Arab Americans indicated a preference to be cared for by family members rather than enter a nursing home.¹¹⁹
- African Americans expressed preference to receive care in nursing homes and hospitals.¹²⁰
- Non-Hispanic whites preferred to die at home but did not believe that end-of-life care was their family’s responsibility; therefore they were open to the idea of hospice care, hospitals and nursing homes.¹²¹
- Both Hispanic and African American men wanted minimal medical intervention while women in both ethnic groups wanted more extensive intervention at the end of life.¹²²

Recognizing and understanding the different racial preferences should not be the only factor in determining how health care professionals approach and deliver care to patients nearing the end of life. It is also important to avoid generalizing and making assumptions based on appearances. While some people maybe be born to a particular culture, they may not necessarily identify with that group and sometimes may identify with more than one.¹²³ Cultural competence should begin with acquiring general knowledge and leaving room for open communication to prevent stereotyping.¹²⁴

Guidelines and Standards

More than 70 percent of large (200+ beds) hospitals report having a palliative care program.¹²⁵ During the past decade, several national forums have drawn upon a broad range of thought and practice leaders to develop a

consensus about guidelines, standards and metrics for palliative care.¹²⁶

- *Clinical Practice Guidelines for Quality Palliative Care* from the National Consensus Project for Quality Palliative Care (NCP 2004; updated 2009) outlines eight domains for palliative care programs: structure and processes, physical, psychological, social, spiritual, cultural, ethical and legal, and care of the imminently dying.
- In 2006, the National Quality Forum (NQF) published *National Framework and Preferred Practices for Palliative and Hospice Care Quality* that identified 38 preferred practices, based on NCP's work, which form the basis for quality metrics.
- In 2008 and 2009, the Center to Advance Palliative Care (CAPC) convened a consensus development process among leaders in the field and published a three-part series of recommendations with additional operational details.

CAPC's first set of 22 recommendations is separated into "must-haves" and "should-haves" in 12 domains. All the groups agree that key "must-have" elements of a palliative care program should include:

- an interdisciplinary clinical team (physician, nurse, social worker, spiritual counselor, others);
- staff trained, credentialed and/or certified in palliative care;
- 24/7 access and responsiveness.¹²⁷

Academic Programs in Palliative Care

In a 2010 position paper, the AAHPM task force of experts drew upon the clinical guidelines work of NCP, NQF and CAPC to develop a set of recommendations to help palliative care faculty and their department chairs, deans and other stakeholders build an administrative and educational infrastructure for viable, high-quality, academic, palliative care programs.

Establishing a new specialty is always difficult, but the task force pointed out why hospice and palliative medicine has distinguishing features that make it particularly challenging: interdisciplinary staffing across multiple settings and the enormous time commitment it requires. Palliative medicine therefore calls for new thinking about organizational structure and how to measure "staffing productivity, compensation incentives, and administrative support."¹²⁸

Palliative care is delivered by interdisciplinary teams. In addition to the team's core members, multiple medical specialists are often involved, as well as nutritionists, physical therapists, occupational therapists and other professionals. Although this teamwork and coordination fit well with health care quality and safety improvement movements, administratively it means multiple reporting lines and financial challenges. Some services are covered by the bed rate and some not at all. Even for reimbursable services, reimbursement rates are inadequate because so much time is expended. Palliative medicine clinicians usually report to administrative leaders whose experience with hospice and palliative medicine is limited.¹²⁹

Clinical care delivery issues—expectations of productivity, incentive plans, billing, business planning, and required interdisciplinary collaboration with other colleagues from other health care disciplines—may also be different from other fields. Colleagues in other specialties or administrative leaders may not appreciate the need for very long consultations, frequent family meetings, the interdisciplinary nature of the work, and the significant emotional impact this work can have on faculty.¹³⁰

Because palliative medicine is taught, investigated and practiced across multiple settings, integrating the diverse continuum of care may be unfamiliar to administrative leaders, resulting in the "underestimation of both the tremendous potential and the unique support needs of a comprehensive palliative care continuum of care."¹³¹

Palliative care also requires substantial investments of time in communication, coordination and ensuring 24/7 continuity across settings. Therefore, conventional productivity expectations and metrics are not a good fit. Palliative care revolves around communicating with and supporting patient and family members, exploring alternatives and negotiating wrenching decisions and bereavement care after death. The scope of care is much broader than biomedical, and the intensity of emotions, decisions, crises and emergencies draws energy and time. “Many consultations are urgent or emergent in nature and must be completed in a timely manner. Palliative medicine specialists require rapid access to disciplines, such as social services, pastoral care, rehabilitation, nutrition, counseling, and advanced practice nursing.”¹³² Care must be coordinated around interacting clinical conditions in a weakening body, across disciplines and settings and with community-based agencies.

Because of the complexities involved in developing and managing palliative care programs, the Harvard Medical School Center for Palliative Care (HMS CPC) was established by Drs. Susan D. Block and J. Andrew Billings to serve as a national and international resource for the best practices in palliative care education. The program fosters health care leadership and supports palliative educational programs aimed to alleviate suffering and enhance the care of patients and their families facing severe and life-threatening illness. HMS CPC offers three continuing education opportunities to physicians, nurses and other health care professionals. (See Case Study 8.)

To develop balance between curative treatments and reduce suffering from chronic or life-limiting illness, the Education on Palliative and End-of-Life Care (EPEC) was established. This comprehensive training program is aimed at educating physicians on the clinical competencies required to provide quality and compassionate care to patients facing the end of life.¹³³ Based on adult education theory, the program uses interactive techniques and application of social science principles to change social expectations and behavioral norms. To disseminate its curriculum, EPEC uses the “train-the-trainer” approach to increase physician knowledge. (See Case Study 9.)

Much like the EPEC train-the-trainer approach, there are national educational initiatives that improve palliative care for other health care professionals. End-of-Life Nursing Education Consortium (ELNEC), for example, is aimed at educating nurses to improve end-of-life care.¹³⁴ ELNEC provides palliative care training to undergraduate and graduate nursing faculty, continuing education providers, staff development educators, specialty nurses in pediatrics, oncology, critical care and geriatrics and other nurses.¹³⁵ With a curriculum that focuses on the core topics of end-of-life care, participants teach what they have learned to nursing students and practicing nurses. Since this program was established, trainers have trained more than 390,000 nurses and other health care providers.¹³⁶

Table 3. Hospital Strategies to Create a Ready, Willing and Able Workforce

Hospital Strategies to Create a Ready, Willing and Able Workforce	
Educational Strategies	
	Offer ongoing training for health care professionals to learn the necessary skills and competencies to engage in sensitive conversations with patients facing advanced illness.
	Educate and train health care providers on the role and impact of spirituality in end-of-life care. There is a high demand for acknowledging and incorporating spirituality in health care, especially among patients nearing the end of life.
Toolkits for Multidisciplinary Teams	
	Develop a multicultural guide. Used to assess the cultural beliefs and values of patients and their families, this tool should include questionnaires that clarify preferences for end-of-life care with respect to diversity. The goal is to assist health care professionals in their conversations and interactions with patients and their families. (Examples are Multicultural Care: A Clinician’s Guide to Cultural Competence published by the American Psychological Association and A Toolkit for Serving Diverse Communities by the U.S. Administration on Aging.)
	Develop a spiritual toolkit. This tool should complement the multicultural guide. The objective is to delve beyond racial differences—such as the cultural and religious nuances involved—and assist health care professionals in providing care with awareness and sensitivity to the dimensions of life and imminent death. (An example is A Dictionary of Patients’ Spiritual & Cultural Values for Health Care Professionals developed by the HealthCare Chaplaincy.)
Collaborative Strategies	
	Create a collaborative environment for the multidisciplinary team to improve communication during end-of-life care. Providing a venue for health care professionals to share ideas and to communicate can increase accountability and maintain consistency of information, thereby impacting the delivery of information.
	Leverage patient-family advisory councils that would mobilize in communicating the message. Advisory councils can be a significant ally in helping patients and their families arrive to a consensus on a health care decision.
	Provide or make available, to the palliative care workforce, comprehensive training in educating patients and their families during health care interactions. The scope of end-of-life care extends beyond the traditional clinical aspect. Health care professionals must integrate a holistic approach in their practice, such as social balance.
Organization and Leadership Strategies	
	Create a solid leadership foundation and program infrastructure to sustain a successful palliative and end-of-life care program. For palliative and end-of-life care programs to thrive, hospitals must acknowledge the value of the continuing education of their leadership, who will not only impart knowledge to the rest of the team but also develop and launch successful AIM initiatives.

Source: AHA CPI, 2012.

Case Study 7

Sacred Art of Living Center

The Sacred Art of Living Center (SALC) for spiritual formation in Bend, Oregon, was cofounded by Mary Groves and Richard Groves, a pastoral counselor and hospice chaplain. Since 1997, they have offered programs for spiritual formation for caregivers.

Background

The flagship workshop-retreat series of SALC, the Sacred Art of Living and Dying (SALD), is the nation's first comprehensive training and certification program for spirituality in end-of-life care. This program explores universal patterns of spiritual and emotional suffering and time-tested ways to relieve them based upon ancient wisdom traditions and contemporary clinical research.

The SALD program series is offered throughout the United States and Canada and in more than 15 countries. Since its inception, more than 30,000 participants have attended, ranging from health care providers and hospice professionals to faith community leaders, from all spiritual traditions and including the general public. The program has drawn 15 percent medical doctors, 22 percent nurses, 21 percent mental health professionals, 19 percent chaplains/clergy and 22 percent of the general public.

What They Did

The SALD program series is taught in seminaries of all faith traditions,¹³⁷ and its nondenominational approach is designed to respect the spiritual path of every participant regardless of religious affiliation. This two-day program is divided into four units: understanding, diagnosing, healing and transforming spiritual pain. Each unit is an interactive learning experience and incorporates a blend of best practices, instruction, personal reflection, hands-on experience, multimedia presentation and creative rituals from great wisdom traditions all over the world. The aim is to train participants to become “contemplative caregivers.”

Unit 1: Understanding Spiritual Pain

Participants learn about the rich cultural history and clinically sound practices for detecting and alleviating spiritual and emotional distress at the end of life. Caregivers learn valuable models for addressing death anxiety as the most critical issue for the dying person.

Unit 2: Diagnosing Spiritual Pain

Participants study in depth the time-tested primary diagnoses of spiritual pain: forgiveness, relatedness, meaning and hope. They examine the relationship between ethical and religious-based decision making and enhance their ability to recognize and celebrate the final gifts of growth and transformation revealed at the end of life.

Unit 3: Healing Spiritual Pain

Participants are mentored in a wide range of creative and effective psychospiritual tools for end-of-life care. The spectrum of practices includes art and music therapies, guided imagery, coma work and prescriptive ritual tailored to the spiritual belief of each patient. Holistic therapies are drawn from the world's great spiritual traditions and applied with contemporary scientific skills.

Unit 4: Transforming Spiritual Pain

Based on lessons that the experience of dying teaches the living, this retreat format allows for ample reflection on the meaning of end-of-life ministry. Exercises include meditation, life-priorities evaluation and self-care skills for maintaining a centered, professional presence.

Results

The workshop-retreat series received accolades from multiple health care providers and institutions, religious leaders and authors in the United States and internationally. Mother Theresa of Calcutta described the work as necessary because it takes more than medicine to alleviate human suffering. The San Diego Hospice and Institute of Palliative Medicine lauded the holistic approach of the workshop-retreat series for having introduced a common language for all caregivers in naming and responding to spiritual suffering.

Based on more than 30,000 participant evaluations, the program received ratings of 94 percent to 98 percent in overall program experience, practical usefulness of the series, meeting program goals and objectives, applicability for clinical practice and usefulness for personal/spiritual development.

Lessons Learned

Various factors contributed to the success of the SALD program including:

- Offering a holistic model for healing drawn from great wisdom traditions with respect to contemporary science and depth psychology
- Teaching clinically proven practices
- Presenting a universal language for caregiving not available in most professional training
- Offering a learning model that addresses suffering and loss in transformative ways

Sacred Art of Living

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Case Study 8

Harvard Medical School Center for Palliative Care

The Harvard Medical School Center for Palliative Care (HMS CPC) in Cambridge, Massachusetts, was established by Susan D. Block, MD, and J. Andrew Billings, MD, with the sponsorship of the Robert Wood Johnson Foundation. The center serves as a national and international resource for best practices in palliative care education.

Background

HMS CPC fosters health care leadership and supports palliative care educational programs aimed to alleviate suffering and enhance the care of patients and their families who are facing severe and life-threatening illness.

What They Did

HMS CPC offers three continuing education opportunities to physicians, nurses and other health care professionals: Palliative Care Education and Practice (PCEP), Practical Aspects of Palliative Care (PAPC) and Palliative Care for Hospitalists and Intensivists (PCFHI).

Palliative Care Education and Practice (PCEP)

The field of palliative care is rapidly growing, but leaders in clinical care and education are greatly outweighed by the current supply.¹³⁸ In addition, there are major gaps in physician competence and confidence for providing palliative care. More senior physicians tend to overestimate their palliative care competence¹³⁹ while few faculty members feel prepared to teach end-of-life issues.

To bridge this gap, PCEP, in partnership with the Dana-Farber Cancer Institute, Department of Psychosocial Oncology and Palliative Care (DPOPC), was established “to contribute in the training of leaders and educators who can train the next generation of clinicians, and lead new programs to improve access to palliative care services.”¹⁴⁰

PCEP is a two-week faculty development program for physicians and nurse educators who want to gain expertise in clinical practice, teaching comprehensive and interdisciplinary palliative care and leading and managing palliative care initiatives in their institutions. The educational offering is divided into two segments. The first part is a week-long on-site training followed by a six-month distance-learning component, which supports participants developing a project in their own institutions. The second part is another week of continued experiential learning and training focused on communication, teaching methods, teamwork and leadership.

Practical Aspects of Palliative Care (PAPC)

PAPC is a two-and-a-half-day educational offering that provides basic and advanced palliative care competencies for physicians, nurses, allied health professionals and chaplains who work with patients and families facing advanced illness. The annual review course explores cultural issues, communication, prognostication, bereavement, management of various nononcological conditions, special needs of patients at various stages of the life cycle and ethical, legal and practical issues in the advanced illness setting. The program is designed to address “the assessment and management of physical, psychological, social, spiritual, and existential sources of suffering experienced by patients and their families.”¹⁴¹

Palliative Care for Hospitalists and Intensivists (PCFHI)

PCFHI is an educational offering geared toward palliative care specialists who are providing inpatient care for life-threatening illnesses. Since there is a significant number of hospital-based specialists who are in need of training in AIM, this course provides clinicians with the skills and competencies necessary to offer high-quality care to patients nearing the end of life.

Results

The PCEP course was highly effective in meeting its goal of training clinical leaders in palliative care. Ninety percent of program participants reported launching palliative care initiatives and attributed this success to their participation in PCEP.¹⁴² Participants also described the course as “transformative.”¹⁴³ Program surveys demonstrated a change in the program participant’s teaching approach and practice in caring for patients facing advanced illness after completing the program.¹⁴⁴

Lessons Learned

The success of PCEP is attributed to:¹⁴⁵

- Curriculum design and pedagogy that was based on the adult learning theory.
- Distance-learning component, during the six-month interim that catered to the schedule of busy clinician participants.
- Small group sessions and distance learning that were skillfully used in a complementary manner.
- Encouraging participants to expand beyond personal development to address problems of organizational change and systems-based practice.

Harvard Medical School Center for Palliative Care

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<http://www.hms.harvard.edu/pallcare/>

Case Study 9

Education in Palliative and End-of-life Care

Education on Palliative and End-of-Life Care (EPEC) is a comprehensive training program aimed at educating physicians on the clinical competencies required to provide quality and compassionate care to patients facing the end of life.¹⁴⁶

Background

In 1997, the Institute for Ethics of the American Medical Association and the Robert Wood Johnson Foundation developed Education on Palliative and End-of-Life Care (EPEC), a comprehensive training program aimed at educating physicians on the core competencies of palliative care.¹⁴⁷

The program's curriculum is "based on adult education theory that emphasizes interactive techniques and the application of social science principles that can lead to changes in social expectations and behavioral norms."¹⁴⁸ To disseminate the curriculum, EPEC uses the "train-the-trainer" approach to increase physician knowledge. The program is structured so course participants can teach others what they have learned in their own institutions.¹⁴⁹

What They Did

To educate physicians on the clinical competencies necessary to provide quality and compassionate care to patients with life-limiting illness, EPEC identified specific goals. First is defining the skills required for end-of-life care.¹⁵⁰ The project staff and 56-member advisory group, consisting of leaders in end-of-life care and education, established the educational needs that the program would address, and the principles that they identified guided the development of the EPEC curriculum. These principles are:¹⁵¹

- The program would be built around the palliative care framework that is to cure, prolong life or have total focus of care.
- The content would include expert opinions about the core competencies of the general practicing physician.
- The program design would cover the entire scope of end-of-life care and address general physician education in comprehensive materials.

The EPEC curriculum that was later developed addresses the medical education gap and teaches critical communication skills essential for end-of-life conversation.¹⁵² It also teaches fundamental skills in ethical decision making, palliative care, pain and symptom management, and other end-of-life issues.^{153, 154, 155} Today, the EPEC curriculum provides a combination of didactic sessions, video presentations, interactive discussions, and practice exercises.¹⁵⁶ The program also offers various versions of its curriculum adapted for specialties such as oncology, emergency medicine, and the care of veterans.¹⁵⁷

EPEC's second goal is to use the train-the-trainer approach to disseminate its curriculum.¹⁵⁸ This model involves educating a cadre of physician or EPEC trainers who will teach what they have learned to a second tier of practicing physicians.^{159, 160} This strategy was adopted under the premises that the educational materials will be useful to those who want to teach others and trainers will utilize them when teaching.¹⁶¹ For example, EPEC distributes to participants slides, videos, and teaching tips and encourages their liberal use with appropriate acknowledgment.^{162, 163}

Results

Studies show that 90 percent of EPEC trainers were actively using its curriculum to teach others.¹⁶⁴ It is estimated that from a sample of 184 initial trainers, they taught 120,000 other professionals.¹⁶⁵ As of 2012, EPEC reports there are more than 2,000 trainers in the United States and 16 other countries.¹⁶⁶ Based on this information, reports estimate that the EPEC curriculum has reached more than 1 million end-learners.¹⁶⁷

Because of its successes, EPEC extended its model and collaborated with various partners to adapt the curriculum to the needs of various and specific populations. This expansion led to programs such as A Progressive Palliative Care Education Curriculum for the Care of African Americans at Life's End (APPEAL), EPEC-Roman Catholic, EPEC-Caregiver and EPEC-India.¹⁶⁸ In addition, to expand the scope and range of palliative care, EPEC and its partners introduced adaptations of the original curriculum into new settings and broadened the definitions to include the entire spectrum of illness.¹⁶⁹ Examples of medical specialty partners include EPEC-Oncology, EPEC-Emergency Medicine and EPEC-Geriatrics/Long-term Care.¹⁷⁰

Lessons Learned

Since its inception, EPEC has solicited feedback from participants to augment its program.¹⁷¹ For example, following development of the curriculum, four regional conferences were held in Phoenix, Atlanta, Boston and Chicago in 1999.¹⁷² In 1999, EPEC educational materials were presented as a working draft to 271 participants who were offered an opportunity to constructively criticize and provide feedback on the program.¹⁷³ A process evaluation was also conducted in the last three field testing sites involving 195 participants.¹⁷⁴ At the end of each workshop module, participants were asked to evaluate the relevance of the topic, effectiveness of the teaching tools and learning objectives of the module.¹⁷⁵ Results show that an overwhelming majority agreed or strongly agreed that (1) the module topics were clinically relevant to the care of patients facing the end of life, (2) EPEC highlighted important concepts, a clear indication of excellent coverage of the topic, and (3) educational materials such as slides and trigger tapes were clear and useful in learning the curriculum.¹⁷⁶

With thousands attending its programs each year, EPEC is continuously finding ways to improve and update its curriculum to meet the needs and goals of future participants and address the growing and evolving educational demands of physicians.

Education on Palliative and End-of-Life Care (EPEC)

(312) 503-3087

<http://www.epec.net/>

Appendix

Resources to improve AIM programs and services:

1. AHA's Committee on Performance Improvement report: *Advanced Illness Management Strategies* (August 2012)
<http://www.aha.org/aim-strategies>
2. Health Research & Educational Trust/Center to Advance Palliative Care guide: *Palliative Care Services: Solutions for Better Patient Care and Today's Health Care Delivery Changes* (November 2012)
<http://www.hpoe.org/resources/hpoehretaha-guides/1148>
3. AHA's Hospitals in Pursuit of Excellence
<http://www.hpoe.org>
4. AHA's Circle of Life Award
<http://www.aha.org/circleoflife>
5. Center to Advance Palliative Care
<http://www.capc.org>
6. Coalition to Transform Advanced Care
<http://thectac.org/>
7. Institute for Healthcare Improvement's Conversation Project
<http://theconversationproject.org/>
8. Joint Commission's Palliative Care Certificate Program
http://www.jointcommission.org/certification/palliative_care.aspx
9. National Comprehensive Cancer Network
http://www.nccn.org/professionals/physician_gls/f_guidelines.asp#supportive
10. National Consensus Project for Quality Palliative Care
<http://www.nationalconsensusproject.org>
11. National Hospice and Palliative Care Organization
<http://www.nhpco.org/templates/1/homepage.cfm>
12. National Quality Forum's Palliative Care Guidelines
http://www.qualityforum.org/Topics/Palliative_and_End-of-Life_Care.aspx
13. Respecting Choices
<http://respectingchoices.org>

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A Guide to Physician Integration Models for Sustainable Success

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HEALTH RESEARCH &
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A GUIDE TO PHYSICIAN INTEGRATION MODELS FOR SUSTAINABLE SUCCESS

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CONTENTS

Executive Summary

Introduction

Laying the Groundwork for Successful Integration

- Strategy 1. Understand the forces affecting physicians; design strategic offerings to meet the needs of local physicians.
- Strategy 2. Understand the hospital or health system's specific capabilities and infrastructure in the context of the communities served.
Example: A Hospital Assesses the Feasibility of Clinical Integration.
- Strategy 3. Ground physician-integration efforts on a well-defined strategic financial plan with sufficient resources and performance targets.
Example: A Health System Builds a Viable Physician Strategy within Capital Constraints.
- Strategy 4. Ensure strong physician participation, leadership and governance.
Example: A Regional Medical Center Develops a Clinically Integrated Care Delivery Model through Physician Collaboration.

Integration Options

- Customer Service Programs
 - Technology ProgramsStrategy 5. Use technology to connect with physicians.
- Contractual Ventures
 - Professional Services Arrangement
 - Physician-Hospital Organization
 - Comanagement Agreement
 - Management Services Organization
 - Clinical Integration Program (compliant with regulations)
Example: An Integrated Delivery System Develops a Clinical Integration Network.Strategy 6. Ensure objective assessment of organizational readiness for value-based care transformation efforts, including a formal clinical integration program.
- Joint Venture/Shared Equity Arrangements
- Physician Employment/Practice Acquisition
 - Alternative StructuresStrategy 7. Use a disciplined, integrated approach to practice acquisition and employment.
Strategy 8. Document and communicate the level of financial commitment required to employ physicians.
Strategy 9. Before employing physicians, model alternative compensation arrangements.
Strategy 10. Structure effective and sustainable compensation programs for employed physicians.
Example: A University Health System Manages the Value Equation.
Strategy 11. Manage employed physicians to achieve goals.

Evaluation of Physician Integration Options

- Strategy 12. Use a structured process to ensure creation of a sustainable venture and consistency over time.

Concluding Comments

Executive Summary

As health care delivery and financing shifts from a volume-based to a value-based business model, provider success will be achieved through offering services with the best possible quality, outcomes and access for the lowest possible cost across the continuum of patient care services and sites.

Improved alignment between hospitals and physicians will be essential to changing the way care is delivered, enhancing patient and physician satisfaction and improving each element of the value equation—quality, outcomes, cost and access.

Because physicians are responsible for driving the clinical care of patients, their incentives must be based on value and aligned with those of hospitals and health systems. Properly structured hospital-physician ventures reduce duplication of assets in communities and overall costs to payers, employers and patients. Such ventures also improve quality, access and satisfaction, reduce inappropriate clinical variation (which reduces quality and increases costs), and increase operating and capital efficiency.

A Guide to Physician Integration Models for Sustainable Success describes the groundwork and prerequisites required for successful hospital-physician integration and offers an overview of integration models currently deployed at hospitals and health systems nationwide. These models include customer service offerings, contractual ventures, joint venture/shared equity arrangements and employment/practice acquisition models. This guide also presents key considerations involved in implementing the models and sustaining their success, and offers 12 strategies to guide the integration efforts. These are:

1. Understand the forces affecting physicians; design strategic offerings to meet the needs of local physicians.
2. Understand the hospital or health system's specific capabilities and infrastructure in the context of the communities served.
3. Ground physician-integration efforts on a well-defined strategic financial plan with sufficient resources and performance targets.
4. Ensure strong physician participation, leadership and governance.
5. Use technology to connect with physicians.
6. Ensure objective assessment of organizational readiness for value-based care transformation efforts, including a formal clinical integration program.
7. Use a disciplined, integrated approach to practice acquisition and employment.
8. Document and communicate the level of financial commitment required to employ physicians.
9. Before employing physicians, model alternative compensation arrangements.
10. Structure effective and sustainable compensation programs for employed physicians.
11. Manage employed physicians to achieve goals.
12. Use a structured process to ensure creation of a sustainable venture and consistency over time.

This guide provides examples of physician-integration initiatives at organizations of different types and sizes, including a hospital, health system, regional medical center, integrated delivery system and university health system.

For the purpose of this report, "clinical integration" will refer to a formal clinical integration program or network that is compliant with Federal Trade Commission and Department of Justice laws, rules and regulations.

Introduction

Hospitals and health systems are facing an increasingly challenging environment as health care delivery and financing begins to shift from a volume-based to a value-based business model. Under the new model, provider success will be accomplished by offering services with the best possible quality, outcomes and access for the lowest possible cost across the continuum of patient care services and sites.

Both care delivery models and payment systems will change. The episodic approach to care, characterized by one physician directly caring for each patient, in one facility for each individual care “event,” will be replaced by a team-based longitudinal approach across multiple facilities and sites, including the patient’s home.

Under the value-based model, provider payment will be tied to results for quality, access and efficiency. When threshold performance levels are met, providers will benefit from shared saving. When threshold performance levels are not met, hospitals and physicians will be at risk for reduced payment, no payment or exclusion from a network.

Improved alignment between hospitals and physicians is essential to changing the way care is delivered, enhancing patient and physician satisfaction and improving each element of the value equation—quality, outcomes, cost and access. Because physicians are responsible for driving the clinical care of patients, their incentives must be based on value and aligned with those of hospitals and health systems. Properly structured hospital-physician ventures can reduce costs and duplication of assets in communities, improve quality, access, and satisfaction, and increase operating and capital efficiency.

Organizations must prepare for the future value-based health care system while ensuring sustainable performance under the current payment and delivery model. This requires the participation and coordination of all stakeholders across the care continuum and the close management of key indicators. Transition success will be determined by organizational readiness, culture, operating capabilities, infrastructure and leadership.

Organizations need to manage the transition appropriately. Value-based contracting arrangements should be secured only when organizations can demonstrate their value-driving capacity and when their infrastructure can support the needed changes. Arrangements secured too late into the performance-building process may result in payers not partnering financially in these efforts because results have been fully demonstrated without their involvement.

This guide offers an overview of physician integration models currently deployed at hospitals and health systems. These models include a wide array of programs, covering customer service offerings, contractual ventures, joint venture/shared equity arrangements and employment/practice acquisition models. The legal, taxation and regulatory issues surrounding hospital-physician integration are complex and changing. This guide does not intend to provide recommendations in these areas; providers should seek expert advice.

In summary, the guide:

- Describes the groundwork required for successful hospital-physician integration;
- Presents key considerations involved in implementing these models and sustaining their success;
- Offers 12 strategies to guide integration efforts; and
- Provides examples of hospital-physician integration initiatives at organizations of different types and sizes, including a hospital, health system, regional medical center, integrated delivery system and university health system.

Your comments and questions are always welcomed at hpoe@aha.org.

Laying the Groundwork for Successful Integration

To achieve a hospital-physician integration strategy that is sustainable for both parties, hospitals and health systems must lay the needed groundwork of knowledge, capabilities, infrastructure, resources, performance targets and physician participation. Implementation of the first four strategies lays that groundwork.

Strategy 1. Understand the forces affecting physicians; design strategic offerings to meet the needs of local physicians.

Many physicians in private practice have been struggling during recent years due to flat or declining revenue and increasing expenses in benefit costs, malpractice insurance rates and rapidly escalating technology requirements to support an electronic health record. These factors have put substantial pressure on physician and practice income. Additionally, uncertainty about the viability of private practices, the shift from a volume- to value-based business model and the advent of a new generation of physicians who have different work and lifestyle expectations are creating additional pressures.

As a result, physicians are exploring alternate ways of working with hospitals and health systems. Since 2000, hospital employment of physicians has increased 32 percent, with 17.3 percent of all physicians now directly employed by hospitals or health systems.¹ Physicians are exploring arrangements with other partners, such as payers, independent practice associations and large multispecialty practices.

To meet the needs of physicians, hospitals and health systems should be designing strategic offerings based on their organizational capabilities and local service area characteristics (as described in the next section). Based on observations in working with hospitals and health systems nationwide, organizations making more rapid progress with physician integration offer multiple points of entry. The path to physician integration typically is through a pluralistic model, with three key alternative offerings:

1. *Independent physician programs*: Hospitals develop and refine programs to support and align with physicians who wish to remain independent.
2. *Employed physician programs*: Hospitals and health systems acquire and organize primary care and multispecialty practices around driving high quality health care.
3. *Clinically integrated networks or accountable care organizations*: These include both employed and independent physicians, who are aligned through formal clinical integration programs and other value-based integration options, such as the Medicare Shared Savings Program.

Strategies related to these offerings may be proactively pursued or may occur reactively in response to physician approaches. Flexibility must be demonstrated to accomplish organizational goals while accommodating physician needs. Figure 1 is a matrix of alignment options.

¹ AHA Hospital Statistics: 2012 Edition, based on 2010 data.

Figure 1. Alignment Options

Integration Alignment Matrix

Proactive	<ul style="list-style-type: none"> • Employment • Physician JVs • Risk Sharing • Clinical Integration 	<ul style="list-style-type: none"> • Technology • Customer Relationship Management • Referring MD • Contracting
Reactive	<ul style="list-style-type: none"> • Employment • Physician JVs • Pay for Performance/Comanagement 	<ul style="list-style-type: none"> • Management Services Organization • Recruitment
	Partner/Employ	Customer Service

Source: Kaufman, Hall & Associates, Inc. Used with permission.

Strategy 2. Understand the hospital or health system’s specific capabilities and infrastructure in the context of the communities served.

Two major variables are critical in understanding an organization’s ability to develop specific physician-integration strategies.

The first variable is the service area, including the patient-population characteristics, local and national payers and the nature of the competitive environment. Hospitals and health systems should understand the mix of payers and how this mix is expected to evolve over the next decade. Additionally, they need to consider how innovative the existing payers are. Just as different providers have differing capabilities to execute new strategies, different payers have different appetites and capabilities for collaboration and innovation in supporting changes in care delivery under the new business model.

The second variable relates to the provider organizations themselves. Integration and alignment programs need to be based on a well-informed and objective assessment of the hospital’s or health system’s core capabilities and operating competencies in both acute and ambulatory settings. Care coordination across a variety of acute, ambulatory and post-acute settings is important as organizations begin to manage a population’s health.

To effectively offer services in a value-based environment, some form of integration with employed and private practice physicians is a core competency. Whether or not an organization chooses to pursue a formal clinical integration program, the organization should be developing the required infrastructure and competencies to support a broader approach to managing care across the continuum. Five core areas can be the focus: provider alignment, care delivery, information technology, data management/analytics and payment management (Table 1).

Table 1. The Core Capabilities of Value-Based Care Delivery

Provider Alignment	Care Delivery	Information Technology	Data Mgmt./Analytics	Payment Management
<ul style="list-style-type: none"> • Governance • Organizational structure • Foundational primary care • Primary care/ specialist communication • Network development and management • Contracting • Clinical collaboration forums 	<ul style="list-style-type: none"> • Prevention and wellness initiatives • Evidence-based protocols • Care transition initiatives • Patient health tools • Health management support 	<ul style="list-style-type: none"> • Patient registry • Electronic medical record • Computerized physician order entry (CPOE) • Case management workflow tools • Decision support • Provider portal • Billing/claims • Contracting • Health information exchanges 	<ul style="list-style-type: none"> • Patient/condition identification • Clinical outcomes • Quality reporting • Utilization reporting • Movement toward data standardization 	<ul style="list-style-type: none"> • Patient attribution • Incentive distribution/ funds flow

Source: Kaufman, Hall & Associates, Inc. Used with permission.

Example: A Hospital Assesses the Feasibility of Clinical Integration

Hospital X is a 500+bed independent hospital located on a coast with a fragmented service area, serving a population insured through many different payers. The hospital identified the need to prepare itself for value-based reimbursement models through development of a clinically integrated network of physicians. The leadership team believed the organization was at risk both of being marginalized and of a diminished ability to remain independent in a region experiencing increasing consolidation.

Hospital X assessed the feasibility of developing a formal clinical integration program. The first step was to obtain a data-based understanding of its specific capabilities and infrastructure in the context of local service area conditions.

The assessment identified key characteristics of Hospital X’s provider/physician service area. These included the following:

- Highly competitive, yet fragmented, service area with strong specialist representation;
- Strong physician preference for private practice;
- Limited coordination of care transitions among providers;
- Active discussions in the service area related to narrowing of provider networks; and
- Room for improvement across the service area from both a cost and quality perspective.

To further assess the feasibility of formal clinical integration, a clear value proposition was identified for each stakeholder, including member physicians, Hospital X and the community. To engage physicians in the program, a value proposition was developed

for each physician segment, including private practice physicians, hospital-employed physicians, academic physicians and employed foundation physicians. Elements of value for physicians included:

- Access to reasonable payment rates;
- Ability to maintain current levels of productivity;
- Coordination and alignment of care;
- Involvement in administrative efforts to impact care delivery;
- Access to information technology solutions;
- Practice promotion and branding;
- Reduction in practice overhead costs; and
- Access to performance data and benchmarks.

However, these elements were highly specific to the service area. For example, physicians in growing, well-reimbursed areas had very different drivers than physicians in flat or shrinking areas where new entrants increased the competition.

Hospital X took a close look at each of the attributes driving feasibility for value-based care delivery (Table 2) and rated its level of preparedness for an ACO, a formal clinical integration program, or risk-based contracting as compared with key characteristics of well-prepared organizations. From this study, the organization identified performance dimensions that needed to be strengthened or partners already accomplished in selected dimensions with which collaborative arrangements could be secured.

Table 2. Feasibility Dimensions for Value-Based Care Delivery Transformation

Performance Dimensions	Key Characteristics of Most Prepared
Service Area–Intrinsic	Service area characteristics and overall composition (e.g., size, scale, demographics, economics) support and enhance fee-for-service–based clinical integration initiatives.
Differentiation	Clinical integration provides differentiating value to community, enabling value-based innovation and initiatives.
Organizational Capacity	Institutional quality infrastructure is robust and scalable. Financial and capital capacity supports ongoing and strategic investment in the organization.
Value Proposition	Clear, discernible, and communicable value propositions exist for all major stakeholders, including primary care and specialty physicians, hospitals, the community and payers.
Physician Alignment	A highly aligned medical staff is characterized by shared goals, outcomes-based contractual arrangements and significant planning input. Physicians are adequately represented in organizational governance.
Physician-Change Awareness	Providers are highly aware of the transformational change occurring across the healthcare landscape, including timing and operating pressures associated with this change.
Culture of Collaboration	A high degree of collaboration exists; care transitions are highly coordinated among primary care physicians, specialists, post-acute care, and other components of the system of care.
Technology	High level of EHR adoption by community physicians exists. There is also sophisticated utilization of these systems to advance quality initiatives and capabilities.

Source: Kaufman, Hall & Associates, Inc. Used with permission.

This approach helped Hospital X's leadership team understand that service-area elements were unfavorable for a formal clinical integration program and that becoming an ACO through participation in the Medicare Shared Savings Program could build physician alignment and advance the value-based transformation with less risk.

Strategy 3. Ground physician-integration efforts on a well-defined strategic financial plan with sufficient resources and performance targets.

To pursue a pluralistic physician strategy with private practice, clinically integrated and employed physicians, hospitals and health systems must develop a well-defined strategic financial plan that identifies the specific strategies and quantifies the direct and indirect revenue, cost and performance targets of each alternative.

Most hospitals and health systems have limited resources; therefore, it is important to ensure that capital spending needs and operating performance levels of physician strategies are identified and quantified before a commitment is made. Organizations should focus financial and human resources on options that support the quality targets, service lines, geographic access cost efficiencies and other goals in their communities. Goals must align appropriately with local service area drivers. Integrated strategic financial planning will enable the organization to determine the level of financial commitment versus the level of operating improvement offered by specific strategies, both separately and in combination. Capital allocation plans must balance the need for growth, quality and access across physician strategies.

Initiatives that require significant amounts of capital include: recruitment, employment, practice acquisitions, technology, physician joint ventures and other asset-based ventures. Market-based planning is required to quantify the impact of these initiatives on volumes, revenues, expenses, investment in fixed assets and working capital and downstream contribution margin. Solid analytics, using proven planning tools, help leadership assess the required level of investment relative to the risk.

Few hospitals and health systems can afford employing a majority of their independent physicians without a negative financial impact on the overall operating and capital position. Transaction costs, operating costs and transitional capital expenditures tend to be higher than anticipated (Table 3).

Table 3. Example of Estimated Capital Impact per Employed Physician

	Primary Care MD		High-Cost Specialist	
	Year 0	Year 1	Year 0	Year 1
Purchase Price	\$75,000		\$150,000	
Transaction, Tail and Bonuses	\$65,000		\$100,000	
Net Working Capital		\$100,000		\$150,000
Capital Expenditures		\$50,000		\$100,000
Capitalization of Op. Leases*	\$250,000		\$300,000	
Capitalization of Losses†	\$400,000		\$600,000	
Typical Impact	\$790,000	\$150,000	\$1,150,000	\$250,000

* Capitalization of operating leases assumed for 10 years upon acquisition and based only on equipment leases.

† Annual operating losses multiplied by 4.

Source: Kaufman, Hall & Associates, Inc. Used with permission.

To adequately develop and deploy a strategy and to ensure that limited capital resources are optimized with independent physicians, organizations should segment their medical staff into a number of distinct cohorts. These include foundational, loyalist, splitter, occasional user, referring non-admitting and non-users. Table 4 defines each cohort. Integration plans should address the needs of these unique groups of physicians in the context of organizational capabilities and service area characteristics.

Table 4. Distinct Cohorts of Independent Physicians

Cohort	Definition
Foundational	<ul style="list-style-type: none"> Loyal, highly active physicians who drive quality and a disproportionate amount of revenue and volume to the hospital; typically anchor a particular service line.
Loyalists	<ul style="list-style-type: none"> Physicians who admit 70 to 100% of their inpatients to the hospital; may or may not be foundational practices.
Splitters	<ul style="list-style-type: none"> Physicians who admit to multiple facilities but admit 20 to 70% of their inpatients to the hospital.
Occasional Users	<ul style="list-style-type: none"> Physicians who admit less than 20% of their inpatients to the hospital. Barriers to securing their admissions are usually significant.
Referring Non-admitting	<ul style="list-style-type: none"> Upstream referral sources who may direct sizable volume (usually to a specific specialty or subspecialty), usually from outside the service area. In the future, these physicians may represent a potential source of new business or a loss of existing business.
Non-users	<ul style="list-style-type: none"> Physicians who do not use the organization’s facilities and are still independent. As current situations evolve, these physicians could represent growth opportunities.

Source: Kaufman, Hall & Associates, Inc. Used with permission.

Developing a three-to-five year plan will ensure that the proper level of resources (financial and human) exist to support the successful implementation of the strategy. In general, when working with physicians, organizations have only one chance to “get it right,” after which their credibility with physicians will be diminished.

Example: A Health System Builds a Viable Physician Strategy within Capital Constraints

Health System X developed a comprehensive and proactive strategy for physician integration across its network of employed and independent physicians. Located in a competitive service area, Health System X has three acute care hospitals and other health facilities. More than 1,000 independent physicians are part of its medical staff and many other physicians refer patients to the system’s hospitals. When it started planning, Health System X employed less than 50 primary care physicians and a similar number of specialists.

Although a limited amount of practice-acquisition activity had been observed in the system’s communities up to that point, competitive threats were on the horizon. Specialty and primary care physicians were starting to align with large academic medical centers and several area health systems.

While Health System X’s financial performance was strong, capital constraints were a strategic reality. The capital capacity to acquire large numbers of primary and specialty practices simultaneously was not available. Estimated capital impact of practice acquisition, before the impact of operating losses, averaged \$500,000+ per physician. The organization, therefore, wanted to create models that would align physician and health system needs in a rapidly changing environment and accomplish this goal within financial capabilities.

Health System X wanted to offer physicians multiple options for aligning with the system—from improved physician support functions to employment. The health system also wished to create a replicable practice-acquisition program that clearly defined the process to acquire physicians, and a process to quickly evaluate and define the future operational and financial commitments to support physician initiatives.

Beyond the employment model, Health System X evaluated the following options.

- Service-based contracting model—This option would create a management service organization that would support employed and independent physicians, offering services such as billing, medical malpractice, group purchasing and others “a la carte.”
- Quality-/performance-driven contracting model—Under this option, the health system would partner with physicians through a traditional physician hospital organization, a clinical integration program or an ACO, to jointly contract with payers and employers to provide health care services with performance-based incentives related to quality, access and cost management.
- Loosely or highly integrated technology alignment—This option would offer physicians easier use of technology-enabled services or development of systems, interfaces and processes that tightly integrate clinical quality information and outcomes data—through EHRs, CPOE systems and picture archiving and communication systems.
- Customer service model—This option would offer a physician concierge program, office coordinators and other high-touch services.

Health System X evaluated each strategy for how well it: 1) supported organizational and physician needs; and 2) stayed within the investment guidelines (Figure 2). The system pursued a multi-pronged approach.

Figure 2. Evaluation of Physician Strategies across Strategic and Financial Dimensions

	Employment	Contractual		Technology Alignment		High-Touch Customer Service
		Service-Based Model	Quality-Driven Contracting	Loosely Integrated	Highly Integrated	
Foundational Loyalists	High	Moderate	High	Low	High	Low
Foundational Splitters	High	Moderate	High	Low	High	Low
Loyalists	Moderate	Moderate	High	Low	High	Low
Splitters	Moderate	Moderate	High	Low	High	Low
Occasional Users	Low	Moderate	High	Low	High	Low
Referring Non-admitting	Low	Moderate	High	Low	High	Low
Estimated Capital Requirements	High	Low	High	Mod	High	Low
Degree of Alignment	High	Low	Mod – High	Low	Mod – High	Low
Degree of Differentiation	High	Low	Mod – High	Low	High	Mod
Estimated Coverage (Preliminary)						
Headcount	25%	10%	75%	90%	90%	100%
Volume	50%	10%	95%	95%	95%	100%

Level of Alignment with Strategic Goals: High Moderate Low

Source: Kaufman, Hall & Associates, Inc. Used with permission.

Strategy 4. Ensure strong physician participation, leadership and governance.

Physician involvement at all levels of the organization must be supported by executive leadership and the board of trustees. Clinical and administrative physician leaders should be included in planning and development of new networks, operating models and other integration initiatives. Value-based health care is not possible without physician leadership. Physicians drive the design/redesign of clinical care delivery within this model. Both boards and executive teams should empower physician leaders with the authority to drive change, recognizing their vital role in the value equation. Leading health systems that are moving to a value-based system consistently mention physician leadership and participation as key differentiating factors.

At this time, most organizations do not have adequate physician representation at the executive leadership and board levels. Currently, physicians comprise less than 30 percent of senior leadership teams (senior vice president and higher) in 88 percent of organizations; 36 percent of organizations report no physicians on the senior leadership team.²

Example: A Regional Medical Center Develops a Clinically Integrated Care Delivery Model through Physician Collaboration

An independent 220-bed regional medical center in the Midwest, serving residents in 10+ counties, updated its strategic financial plan to identify and quantify a set of initiatives to achieve success under the value-based business model. New projections of reform and new era-related volumes, expenses and capital expenditures were added to baseline financial projections to study the impact of changes on hospital profitability, liquidity and debt capacity.

An assessment of the plan indicated six critical factors for future success:

- Maintaining a consistent revenue base—Maximizing the number of lives and managing the care of those lives were critical.
- High quality at the absolute lowest cost—The ability to drive strong operational performance while delivering high quality care would be a key element driving financial performance in a model predicated on achieving maximum efficiencies.
- Physician integration—Effective physician engagement and alignment would enable the center to move to a population health management model; physician leadership would be required around key initiatives, from clinical integration to regional growth planning.
- Access to capital and talent—These attributes would support investment needs and clinical and non-clinical resources.
- Effective infrastructure—IT facilities and equipment would allow users to achieve the required performance.
- A sustainable competitive position—Partnerships with regional employers, programs, physicians, facilities and infrastructure would provide the center with a sustainable competitive advantage/differentiation in its community.

At the commencement of planning, the center's specialty medical staff was largely in private practice; primary care physicians were mostly employed. Leaders recognized the ability to effectively and efficiently integrate care with physician collaboration would be critical to driving improvement in quality and outcomes. The organization committed to establishing a clinical-integration platform for the region.

² HealthLeaders Media Industry Survey, Feb. 2012.

To plan and develop a comprehensive and functional clinically integrated care delivery model, the center's key leaders and representatives from the critical stakeholder groups were engaged. These groups included physicians, staff, administrators and board members. The participation of physicians on the board provided needed input. Physicians could also educate the board on the magnitude of change being recommended and the critical nature of holding "the professionals" accountable for leading the organization during planning and implementation. Clinical leaders were involved early and throughout the process. Active participation of senior leadership demonstrated the center's commitment to clinical integration as an immediate organizational priority.

A specific group of physicians was identified to lead the efforts. The group included service-line representatives and quality and thought leaders who participated on a steering committee. This committee's worked to:

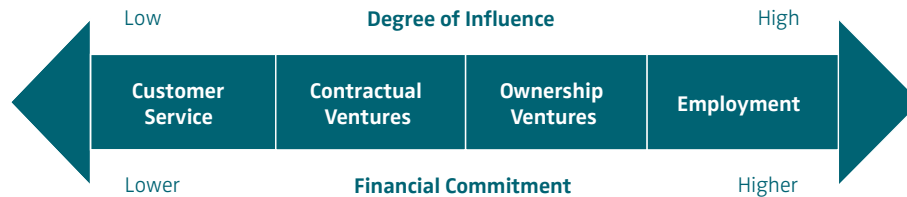
- Identify and define contracting goals, structures and mechanisms; quality goals; timetable to initial implementation date; role of existing physician contracting structures; proposed organizational structure; and a proposed governance model.
- Review business models used at other organizations and select an optimal business model, defining key operating statistics and requirements.
- Develop a business plan and business case for a clinical integration program, including start-up costs and ongoing capital requirements; utilization and quality impacts; clinical infrastructure requirements; technology requirements; care management requirements; reimbursement impacts; identification of required services to purchase or operationalize; reporting requirements; patient and physician satisfaction measurement requirements; physician payment mechanism; and high-level financial projections.

Based on the committee's work, the management team and board reached a decision to proceed with the clinical integration program as defined in the business plan.

Integration Options

In today's environment, hospitals and health systems have four primary physician-alignment options: customer service programs, contractual ventures, joint-ownership ventures and employment. As indicated in Figure 3, these options range from a lower financial commitment and degree of integration influence (customer service option) to a higher degree of integration influence and financial commitment (employment option). A description of each option follows.

Figure 3. Spectrum of Integration Options along Influence and Financial-Commitment Dimensions



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Customer Service Programs

These programs provide support and services to physicians in technology, revenue cycle, medical malpractice insurance, training, co-marketing programs and other administrative support services. The focus is on improving independent physician practice performance and satisfaction, while aligning physician goals with hospital and health system goals.

Hospitals and health systems are focusing on overall improvements in physician customer service, creating new and innovative programs to enhance physician experience across all aspects of operating performance. These initiatives are technology dependent, specifically electronic medical records (EMRs). An EMR is a computer system composed of multiple, integrated applications that enable clinicians to order, document and store patient information. The term electronic health record is sometimes, and incorrectly, used interchangeably. In contrast, an EHR is patient health information from multiple care delivery organizations' EMRs, comprising a patient-centric, longitudinal view of a patient's encounters with health care providers. An EHR may also include electronic data from payers, pharmacy benefits managers and patients.

Technology Programs

Technology has been and will continue to be one of the most successful tools to engage physicians with hospitals and health systems. The provision of incentives by the Centers for Medicare & Medicaid Services for "meaningful use" of EMR technology has provided further stimulus to physician-hospital alignment efforts, since most physicians in private practice are challenged to qualify for these incentives without involvement of a hospital or health system at some level.

The relaxation of Stark Laws has allowed hospitals to subsidize up to 85 percent of the cost of an EHR or EMR system for community physician practices. Many hospitals are finding that equipping community physicians with the hospital's EHR system is an attractive option for both parties—a means to improve patient care and align goals at a significantly lower cost than employing physicians.

The success of an organization’s physician-integration efforts is substantially contingent on the effectiveness and reach of its clinical systems. Value-based care requires functional clinical systems that provide interoperability between ambulatory and acute settings. Physicians will not want to use more than one EMR platform; therefore, the race among hospitals to “own physicians’ desktops” and link ambulatory and acute care is intensifying.

To accelerate the integration of technology platforms between hospitals and physicians, organizations must ensure thorough technology planning that defines user requirements at the physician level and engages physicians early in the process. A technology oversight committee with representatives from all constituencies is recommended. This committee can set target service-level agreements with vendors and partners before implementation occurs.

To ensure the success of technology programs, hospitals must also:

- Limit the required level of physician investment of both capital and time;
- Emphasize physician training by providing appropriate and versatile training in EMR use, such as on-site coaching, as well as classroom time;
- Enable multiple access points across all sites of practice (office, hospital, home, etc.); and
- Measure success through satisfaction surveys and physician adoption rates.

Strategy 5. Use technology to connect with physicians.

The options for leveraging technology across the physician enterprise—employed and independent physicians—require interoperability across the spectrum of physician activities—clinical, business and customer service domains. Table 5 presents some of the many options to leverage technology within a physician enterprise.

Table 5. Examples of Technology Used to Connect with Physicians

Clinical	Business	Customer Service
<ul style="list-style-type: none"> • Clinical systems <ul style="list-style-type: none"> – Comprehensive – A la carte + EHR + Results reporting + Pharmacy + Patient alerts • Clinical education 	<ul style="list-style-type: none"> • Scheduling • Registration • Data integration • Contracting/contract management • Management Service Organization (MSO) • Electronic consent programs 	<ul style="list-style-type: none"> • E-mail • Telephony • Customer relationship management (CRM) program • Referring physicians support systems • Call centers

Source: Kaufman, Hall & Associates, Inc. Used with permission.

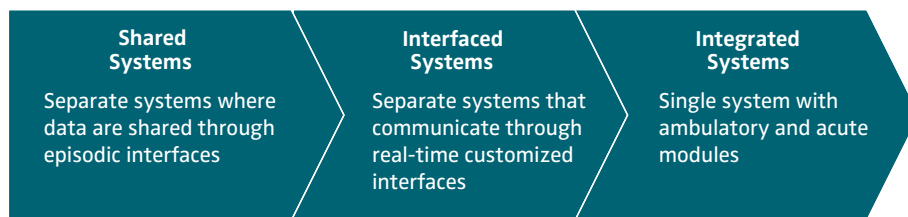
For physicians to use and interface with hospital/health system technology, the following criteria must typically be met:

- It takes the same or less time than their current technology or offers a significant advantage in another area when it requires more time.
- It does not require more than one user interface.
- It requires a low-to-moderate level of investment.
- It allows two-way information flow between the physician and hospital/health system.

- It eliminates duplication of work effort.
- It supports or improves existing workflow.
- It is proven technology—not an “alpha” or “beta” version of developmental technology.

Ultimately, from the physician perspective, technology that facilitates the practice of medicine provides access to relevant information to allow effective decision making. The choice of systems, whether shared, interfaced or integrated, will affect the depth and quality of information available, and the degree of workflow integration that can be supported. The point of clinical technology is to enable and improve clinical workflow. The more it does so, the more successful adoption efforts will be, and the more connectivity that can be achieved (Figure 4).

Figure 4. Progression of Technology Connectivity



Source: Kaufman, Hall & Associates, Inc. Used with permission.

Physician input, preferably physician leadership input, must be obtained before selecting and implementing technology that affects physicians. Understanding what it will take to gain physician support and participation is critical. Long-term technology alignment is predicated on end-user functionality of the technology, not its technical architecture or price. With technology ventures that involve physicians, it is imperative to under commit and over deliver. Some recent technology applications have been disruptive to daily physician practice operations and have materially underachieved relative to promised performance levels. Early and educated engagement of practicing physicians will mitigate this risk. Service-level agreements and technology support are crucial for physicians’ long-term commitment to a hospital or health system’s technology initiatives.

Contractual Ventures

These alignment options involve developing a contract or series of contracts with a physician or physician group(s) to either purchase services from them or provide services to them.

Most contractual ventures are entered into to improve efficiency. Ventures can range from programs such as *pay-for-performance initiatives* to *comprehensive management services organizations*. They have a limited scope and traditionally have been short-term, focused initiatives, with a half-life of about two or three years. Typically, such contractual ventures are a useful starting point for aligning incentives, building trust and establishing the basic performance requirements for a transformation to value-based care. Expectations must be managed to ensure that physicians understand that the programs are transitional and not sustainable in the long term due to the rapidly changing health care environment.

Contracting arrangements can be developed in a number of different ways:

Professional Services Arrangement. A PSA is the most common direct contractual arrangement between hospitals and hospital-based physicians or physician groups for professional services provided by the physicians, including radiology, pathology and anesthesiology.

Physician-Hospital Organization. A PHO is a legal entity formed by a hospital and one or more physicians or physician groups for the purpose of negotiating and obtaining contracts with insurance plans and employers. Historically, most PHOs have been “messenger models,” meaning that a payer submits fee schedules to an agent or third party, who transmits this schedule to the network physicians. Each physician can decide individually whether to accept or reject that fee schedule. The messenger or agency communicates the decisions to the payer, who then contracts with the physicians who have accepted the terms.³ There are numerous variations of this model and many PHOs are evolving into clinical integration programs.

Comanagement Agreement. A comanagement agreement involves a contractual agreement between a hospital and management services company (typically a new company) or a group of individual physicians. The latter agree to perform clinical and management services with specific improvement targets in exchange for a predetermined fee. Under a comanagement arrangement, the hospital enters into a contractual arrangement with a new company or a group of physicians individually. The new company or physician group agrees to provide defined services to the hospital for a set price for a limited period of time.

Other considerations include the following:

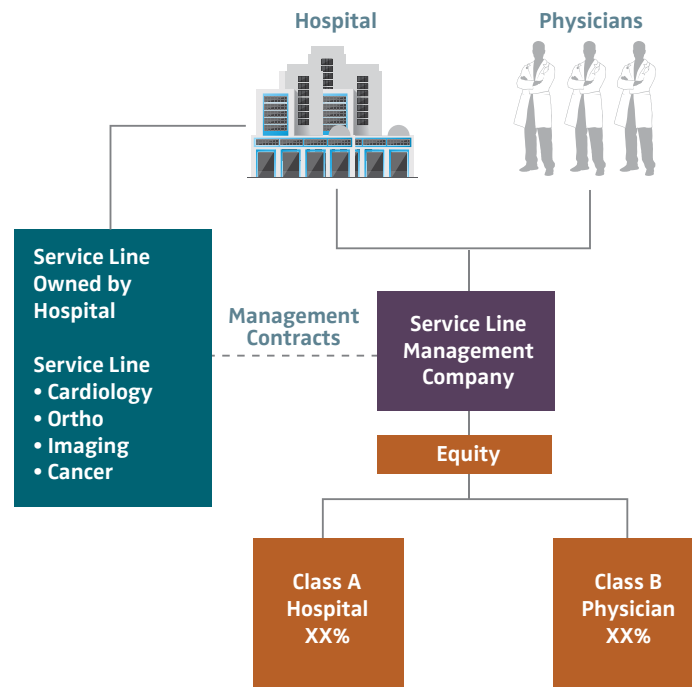
- The new company includes both physicians and professional management. It may include physicians from a single practice or from multiple practices.
- There are defined deliverables and performance levels. These contracts include service-level agreements tied to specific quality, operating and financial goals that form the basis for renewal or extension of the agreements.
- Comanagement agreements can be as simple as assisting the hospital in developing a new program or care center or can be as extensive as managing an entire service line or ambulatory service venture.
- Limited, if any, capital investment is typically required of physicians.
- These arrangements can be set up as management services agreements or as consulting engagements.
- Equity return rates can only be earned if material levels of equity are at risk for nonperformance; otherwise, payments must be tied to work effort.
- Such agreements have a limited applicability across clinical services.
- The arrangement must be well-defined with a high degree of specificity.
- Duties must require the involvement of physicians.
- The overall required level of work effort and the individual hours incurred by each physician must be reasonable.
- The imputed or actual rate per hour must meet standards for fair market value.
- Contemporaneous time reporting must be maintained.

³ Ross, D.: *Physician IPAS: Messenger Model*. FTC/DOJ Health Care Hearings. www.ftc.gov/ogc/healthcarehearings/docs/030925douglasross.pdf (accessed Aug. 21, 2012).

Comanagement is a relatively quick and proven method for hospital-physician collaboration. It usually takes about 90 to 120 days to establish the program, draft the documents and commence operations—a time frame which is much shorter than with other approaches. Figure 5 illustrates the typical comanagement structure.

Comanagement arrangements continue to draw increased regulatory scrutiny, so expert counsel should be sought to ensure legal and regulatory compliance.

Figure 5. Example Comanagement Structure



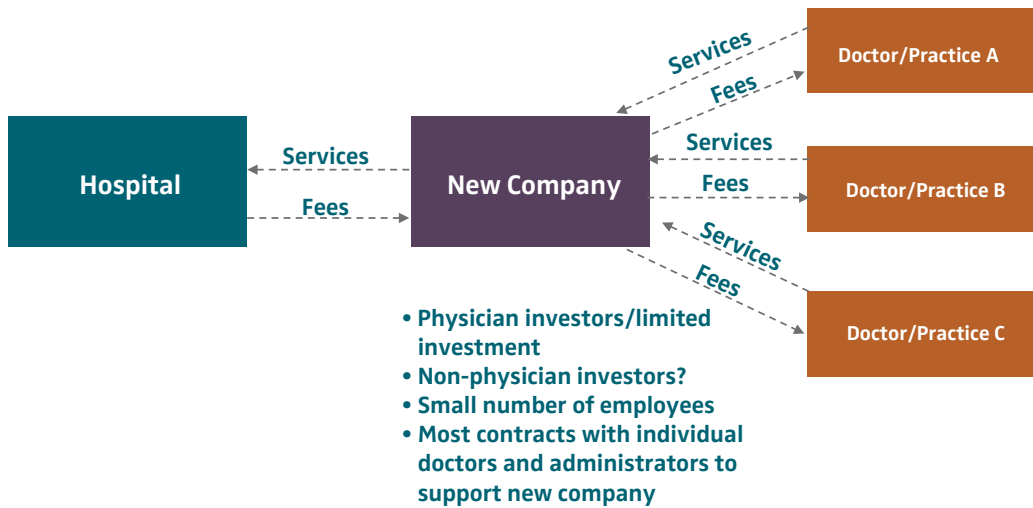
Source: Kaufman, Hall & Associates, Inc. Used with permission.

Management Services Organization. Under an MSO, the hospital or health system forms a new division or company, (“Newco”), for the purpose of managing a defined set of activities for the members of their medical staff. MSOs have gained popularity, especially in the areas of clinical technologies and physician revenue cycle, where significant investment in infrastructure can be spread by health care organizations across a larger physician base.

The Newco would typically include both physicians and management professionals and would provide the agreed-upon services at an amount equal to or less than the current cost level for the independent physicians. These agreements usually include service-level standards for key financial, service and quality indicators.

MSOs can be used in the management of any physician specialty or ambulatory venture where physicians seek assistance in lowering their cost structure. Figure 6 illustrates the typical MSO structure.

Figure 6. Example of the Structure of a Management Services Organization



Source: Kaufman, Hall & Associates, Inc. Used with permission.

Clinical Integration Program. CI programs involve collaboration between private practice and employed physicians and hospitals to increase quality and efficiency of patient care and allow for joint contracting with fee-for-service health plans on this basis, subject to review by the regulatory agencies.

While this concept has generally been understood for many decades, clarity about the official definition is critical. Antitrust laws generally prohibit doctors and hospitals from negotiating jointly with health insurers. And, because financial collaboration between non-employed providers (physicians in private practice), hospitals and insurers often involves contractual agreements, clinical integration programs have been—and are now—the subject of Federal Trade Commission and U.S. Department of Justice scrutiny related to possible anticompetitive practices.

The following is a list of key components of regulatory-compliant clinical integration programs:

1. Collaboration between hospitals and both employed and private practice physicians. Typically, CI programs require the participation and support of a significant proportion of an organization's medical staff.
2. Purposeful agreement to measurably improve the quality and efficiency of care, access, clinical outcomes, utilization and other defined factors.
3. Use of evidence-based practices and data-driven performance improvement, supported by IT tools to accomplish the goals itemized in #2.
4. Some form of intervention to address program/network members who do not meet performance expectations.

Antitrust laws forbid collective negotiations unless the involved parties are either truly clinically integrated (as defined above) or financially integrated. Financial integration occurs when the hospital owns all of the participating physician practices and employs the doctors, or through financial risk sharing. Therefore, clinical integration requirements apply only to fee-for-service contracting arrangements with commercial payers and not to risk-based contracting models or government payers, such as Medicare or Medicaid.

Sidebar 1. Is Your Clinical Integration Program Allowed by the FTC and DOJ?

An affirmative response to each of these questions could indicate that your clinical integration program is likely to be allowed by the FTC and DOJ, but legal counsel is required.

- Is joint contracting with fee-for-service health plans “reasonably necessary” to achieve the efficiencies of a CI program? Proving clinical integration (i.e., demonstrating higher performance through coordination and measurement) without joint-contracting negotiations will show that the hospital does not need the joint-contracting arrangement to drive the increased alignment.
- Does the CI program consist of authentic initiatives that include specific metrics and processes actually undertaken by the network, involving all physicians in the contracting network and applying to the physicians’ practice patterns for fee-for-service patients?
- Will each physician in the network have five to 10 measures that apply specifically to his or her practice?
- Is the program likely to achieve improvements in health care quality and efficiency?
- Are there significant penalties (such as network removal) for physicians who do not perform?
- Can physicians participating at any level explain the program’s aims and objectives?

Source: Kaufman, Hall & Associates, Inc. Used with permission.

An affirmative response to each of the questions in sidebar 1 could indicate that the hospital-physician CI program is likely to pass the acid test for clinical integration, as allowed by the agencies. However, being clinically integrated is not an automatic or complete exemption from antitrust challenges; it merely removes one from automatic, or “per se” violation of the rules. The program or network could still be subject to antitrust action on the basis of the “rule of reason” if it has consolidated significant pricing power in its service area without demonstrating value in quality and efficiency. Due to the complexity of legal and regulatory requirements, retaining expert legal counsel is a key part of building a clinical integration program.

Clinical integration is only one route toward developing the capabilities that will enable success in a value-based payment system. The elements outlined in Tables 1 and 2 determine whether it is feasible for an organization to start with clinical integration, as opposed to the Medicare Shared Savings program or risk-based contracting arrangements. Early CI programs have enabled hospitals, physician networks and other providers to collectively negotiate with managed care companies and health plans to improve the quality and efficiency of care.

Continued growth of clinical integration is expected in many areas of the country, because it provides physicians and hospitals, in appropriate circumstances, with a powerful business and clinical strategy to succeed in the new era of value-based care. However, due to the significant infrastructure and care delivery requirements of a formal clinical integration program, many organizations are not well positioned to pursue such FTC-compliant programs at this time. An objective evaluation of the key factors in Table 2 will position systems to choose the appropriate path forward in a value-based system and maximize the return on a significant investment.

Example: An Integrated Delivery System Develops a Clinical Integration Network

The example integrated delivery system is a seven-hospital organization with a 1,000+ physician medical group, 2,000+ affiliated independent physicians and a health plan with more than 500,000 enrollees. With intense competitive pressures in its region, the IDS developed a CI program that enabled it to proactively respond to changing service area dynamics and drive value-based care delivery.

The IDS aimed to improve quality, enhance access, lower costs, achieve clear first-mover advantage, improve stakeholder (physician and patient) satisfaction and improve its performance in a value-based reimbursement environment.

The network’s goal was to assess and transform the practice patterns of participating physicians to create a high degree of cooperation among its physicians, thereby controlling costs and improving quality. The IDS transformed care delivery by:

- Enabling primary care physicians to serve as the coordinator of the delivery network;
- Using approaches similar to a medical home model;
- Ensuring a patient-centric EHR accessible by all stakeholders; and
- Providing health management functions throughout the network.

The IDS identified specific drivers of cost reduction in each of three categories: decreased demand for medical services; decreased episodic cost for medical services; and a decreased administrative cost structure. Table 6 presents key physician participation terms deemed critical to achieving the network’s goals.

Table 6. Criteria for Participation in a System’s Clinical Integration Network

Participation Criteria	2012 Requirements
Adopt and adhere to physician-developed standards to improve quality and efficiency	<ul style="list-style-type: none"> • Work towards the goals and metrics targets identified by the Clinical Integration Committee of the IDS network • Evaluate and share clinical processes to reach targets as appropriate
Agree to be measured and share information to facilitate measurement	<ul style="list-style-type: none"> • Share clinical and business data as appropriate • Permit a network-selected data aggregator tool to collect the data for performance measurement
Collaborate with network participants to improve performance	<ul style="list-style-type: none"> • Participate in and contribute to regional clinical management forums and/or network workgroups to review performance, share clinical processes, and make recommendations to improve care delivery
Promote, refer to, and communicate with network participants appropriately and effectively	<ul style="list-style-type: none"> • Work effectively with other network participants • Refer patients within the network when appropriate and in accordance with patient preference
Adopt technology offered and/or recommended by the network, including high-speed internet access, E-prescribing, disease registry, and data exchange tools	<ul style="list-style-type: none"> • Maintain high-speed internet access • E-prescribing • Use a disease registry • Begin migration to connectivity solutions that will allow sharing of clinical information
Maintain medical staff membership in good standing at an IDS hospital or credentials according to an IDS-affiliated hospital standards	<ul style="list-style-type: none"> • Maintain medical staff membership in good standing at an IDS hospital or credentials according to IDS-affiliated hospital standards

The clinical integration network/program went “live” after an 18-month development and design process. Table 7 summarizes the initial 100+ clinical physician performance metrics for year one. With nearly 1,500 physicians in the network, including nearly 300 private physicians, the IDS has contracted with its first group, the IDS employee pool, which has approximately 25,000+ covered lives.

Table 7. Physician Performance Program Metrics, Year 1

Metric Source/ Type	Number of Metrics by Source/Type	Target	Threshold
PQRI	45	Improvement goal of 10%	One standard deviation
HEDIS	9	75 th percentile	25 th percentile
SCIP/CORE	28	90 th percentile	One standard deviation
Incidence	1	None	One
Administrative	3	Met requirement	Did not meet requirement
Other	18	–	–

The key success factors expected to contribute to the IDS network’s success going forward include:

- Service area relevance;
- Building and maintaining the right physician network with the right criteria;
- Strong physician governance and leadership across multiple physician constituencies;
- Strong practice management base capabilities (e.g., revenue cycle, contracting, physician compensation models)
- Transparency and engagement with physicians at all levels;
- Financial incentives tied to volume and quality of care;
- Significant investment in technology to enable all partnered physicians to operate on a common platform, either directly or through a health information exchange; and
- Strict adherence to quality guidelines.

Strategy 6. Ensure objective assessment of organizational readiness for value-based care transformation efforts, including a formal clinical integration program.

Before committing to investment in the design, development and implementation of a formal CI program, hospitals and health systems need to understand the feasibility of the CI approach for their unique service area and their internal capabilities and culture. They should also understand and quantify the requirements for investment in people, processes and technology needed to yield value in serving a defined population and to identify the barriers to implementation.

Organizations can benefit from a feasibility assessment, since it will identify the functions and capabilities that will be needed to compete in evolving reimbursement environments. This assessment, which typically takes two to three months to complete, provides the hospital or health system with a comprehensive fact base and an understanding of the potential opportunities to advance the organization’s value-based agenda. The assessment also helps define opportunities for the organization to participate in value-based initiatives with government and/or commercial payers.

The assessment should include both qualitative and quantitative analyses, covering the elements identified in Sidebar 2. This process requires engagement of key stakeholders—including physicians, payers, employers, patients and the hospital or health system—in defining the value proposition for each element. The process should also include development of a high-level business case for each integration initiative, including a CI program, with identification of the gaps in the organization’s current capabilities and financial modeling related to the opportunity.

Joint Venture/Shared Equity Arrangements

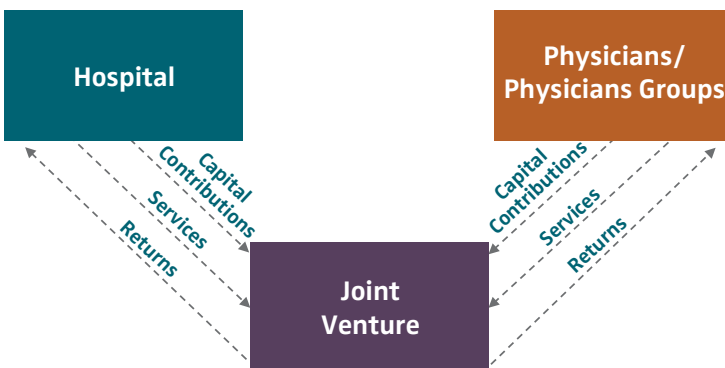
These arrangements involve a short or long-term agreement with risk and benefit sharing between a hospital or health system and one or more physician groups or individual physicians to form and operate a common enterprise (Figure 7). Returns are distributed based upon the proportionate investment of both parties.

Typically, ambulatory surgery centers, imaging facilities, endoscopy centers, urgent care centers and other outpatient diagnostic and treatment facilities are involved. Such facilities may be started by physicians or by the hospital/health system. Due to declining payment rates for care received in ambulatory settings, many of the physician-owned entities are now seeking hospital participation in joint ventures as a partial exit strategy for the physician investors.

Ownership distribution between the hospital or health system and the physicians has a big impact on payment levels and is one of the most significant issues with joint-venture equity structuring. Financial integration or sharing does not assure clinical integration, as most ambulatory joint ventures are still predicated on maximizing volumes and revenues.

For-profit operators are increasingly being introduced as a third class of investors to improve margins and operating efficiencies and to function as an independent buffer between physician and hospital interests.

Figure 7. Sample Model of a Joint Venture



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Before initiating joint venture discussions and setting physician expectations, organizations must assess the goals of the joint venture and determine whether these are strategically aligned with organizational goals. Key questions to be answered include:

- Does this venture support the organization's strategy?
- If the joint venture is a reactive response to service area pressures or requests for partnership from physicians, has leadership assessed other options?
- Is the organization setting a precedent with requests for joint ventures with physician-owned facilities?

Sidebar 2. Elements of a Value-Driven Feasibility Assessment

- Physician and administrative leadership interviews
- Focus group with local payers, employers and patients
- Service area assessment and demand analysis
- Geographic reach, service mix and physician capacity gap analysis
- Utilization, revenue and cost opportunity analysis
- Definition of key program requirements and organizational gaps
- Infrastructure and capabilities gap analysis
- Recommendations of priority focus areas
- Development of a high-level action plan for program development and implementation

Source: Kaufman, Hall & Associates, Inc. Used with permission.

- Will the first joint venture lead to many more, and, if so, is that desirable?
- How will payers and patients view this venture?
- How flexible are the governance requirements?
- If the organization doesn't pursue this venture, will it cause a "gap" in its physician coverage (e.g. loss of orthopedics or radiology)?
- What will the financial impact of the joint venture be on existing operations?
- Will the joint venture be sustainable over the long term or is this just a short-term solution to an immediate situation?

Before pursuing any joint venture, an impact analysis must be performed to determine the effect of the new venture on existing organizational performance. This ensures that the new venture does not dilute existing performance levels. Legal and regulatory issues are complex; again, expert counsel is required.

Physician Employment/Practice Acquisition

Many hospitals and health systems are employing physicians to secure physician loyalty, increase service volumes (under the current fee-for-service system) and achieve the ability to provide integrated, high-quality and cost-efficient care across a larger care continuum under a value-based delivery system. Practice acquisition activity is much greater now than in prior years. In particular, specialty practice acquisitions are growing rapidly, occurring at or exceeding levels experienced in the mid-1990s.

Physician employment may take many different forms, including:

- Direct employment by the hospital;
- Employment by a wholly owned tax-exempt subsidiary;
- Employment by a wholly owned taxable entity;
- Employment by an independent or joint-ventured entity; and
- Employment by an independent, financially aligned foundation.

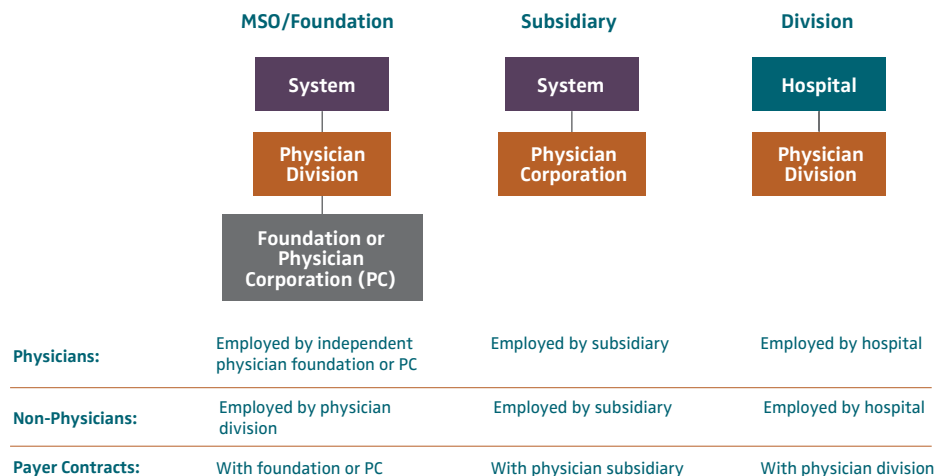
Hospitals are structuring practice acquisitions in a very straightforward way, as compared with the arrangements that were consummated during the 1990s. Asset-purchase agreements are the dominant purchase structure due to tax implications and liability issues; virtually no equity deals are being pursued. Goodwill payments are rare; some payment for defined intangibles occurs occasionally (for example, medical records, work in process), typically to assist physicians in paying taxes and medical malpractice insurance tail costs. Due to Medicare rules, accounts receivable typically are not acquired but are addressed under a custodial arrangement in the asset-purchase agreement. Three- to five-year employment agreements are being offered to physicians, with the specific compensation metrics re-indexed quarterly or annually based on productivity and market changes. Signing or retention bonuses are occasionally paid as part of initial consideration. Non-compete provisions are still prevalent.

Alternative Structures

Figure 8 illustrates three basic models for physician employment. An organization's selection of a specific model should be based on its integration strategy. Key considerations that will impact the organization's financial and operating performance

based on the model selected include: wage and benefit structure; flexibility in retirement packages; non-physician/ambulatory wage scale; parity pay (W-2 vs. K-1); medical malpractice; degree of control/influence in admissions and utilization; technology implications; funding implications; and contracting.

Figure 8. Alternative Models for Physician Employment



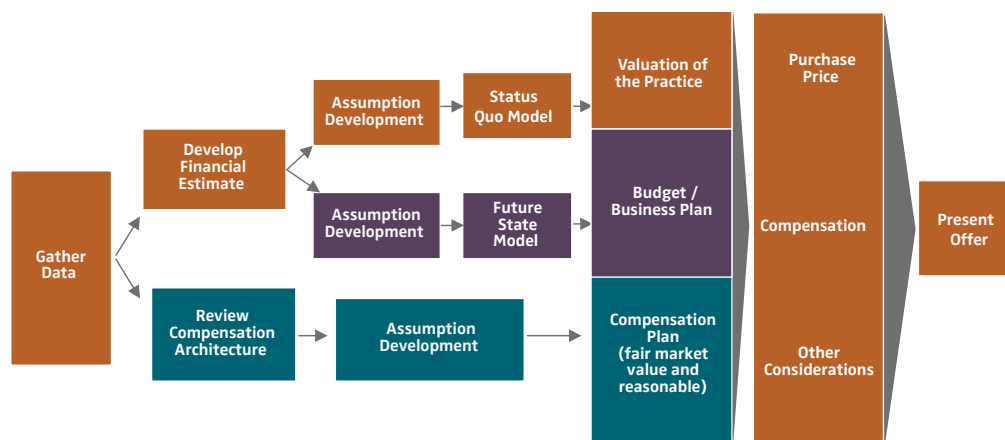
Source: Kaufman, Hall & Associates, Inc. Used with permission.

Whichever model is pursued, solid information technology capabilities are required to effectively manage practices and to monitor ongoing performance across many domains. Physician acquisitions and employment do not guarantee meaningful integration and alignment. Clinical and financial incentives must be aligned, and shared goals must be established and achieved. Implementation of strategies seven through 11 is recommended.

Strategy 7. Use a disciplined, integrated approach to practice acquisition and employment.

A formal acquisition program is required for large organizations, and a disciplined process is required for all organizations. A disciplined approach to practice acquisition includes standardized activities that are completed at all stages of an acquisition, from the preliminary screen to the final due diligence (Figure 9).

Figure 9. Steps in a Disciplined Approach to Practice Acquisitions



Source: Kaufman, Hall & Associates, Inc. Used with permission.

Given the current competitive environment around physician alignment and the tsunami of physician employment programs, hospitals and health systems need to take a long-term perspective regarding strategic goals and avoid reacting to immediate market pressures. Many organizations indicate that the most difficult issue with physician acquisition and recruitment is having the discipline to say “no” to physicians who approach the system seeking employment, when their employment is not in the organization’s best interest.

Use of a high-level screening tool to assist in making an early determination of “go” or “no go” is recommended. Specific parameters for practice acquisitions should include:

- Specific specialties and geographic coverage goals in the context of organizational and service line priorities;
- Existing volumes and potential incremental volumes associated with proposed acquisition;
- Baseline quality metrics used for selection;
- Baseline financial performance requirements;
- Strategic fit and sustainability analysis; and
- Cultural fit with the hospital or health system.

Recruitment efforts and acquisition plans must be incorporated in the organization’s strategic and financial planning assumptions. When communicating about practice acquisitions and employment with the hospital’s board, the bond rating agencies and other capital market participants, the management team should focus on the impact to the organization’s income statement and balance sheet.

Long-term strategy with physician acquisition/employment must be front and center, as the shorter-term results may require sustained investments and funding of losses. Again, the legal and regulatory issues are complex; expert legal counsel is required.

Strategy 8. Document and communicate the level of financial commitment required to employ physicians.

Planning, budgeting and forecasting enables hospitals and health systems to thoroughly understand the level of ongoing financial commitment required of physician employment. These activities are not discretionary, but mandatory. Currently, too many organizations are underestimating the ongoing level of operating losses that their employed physicians will generate. Rating agencies, boards and leadership teams do not like surprises or variances. As acquisition plans are developed, annual budgets prepared, and long-term plans developed, detailed plans must produce realistic estimates that are attainable and for which management and physicians can be held accountable.

When a hospital acquires an independent physician practice, such change in ownership will almost always create an operating loss with the practice, even when productivity and compensation are held constant. Direct operating cost differentials that cause this loss typically include items such as more comprehensive non-physician employee wage and benefit programs, significantly large investment in technology, strategic investments in facility upgrades and higher medical malpractice coverage requirements. These additional costs are part of “doing business” for organizations that employ physicians. Costs need to be managed, but it is almost impossible to reduce these losses to a breakeven performance level.

Indirect or allocated costs can have a significant negative impact on practice performance. Such costs are typically outside the direct control of practice management and the physicians. Therefore, when developing budgets and assigning accountabilities, these costs can be presented below the operating-line level for managerial or non-generally accepted accounting principles purposes. Such items need to be reviewed and negotiated but typically are not part of physician and management incentive programs.

Strategy 9. Before employing physicians, model alternative compensation arrangements.

Compensation modeling enables management to understand the financial impact of alternative compensation frameworks before practices are acquired or compensation agreements are signed or renewed. Modeling also allows physicians to see the impact of proposed changes to their compensation before the changes occur.

Based on the results of this modeling, physicians and management can pursue compensation frameworks or “architectures” that best meet physician and hospital quality, access, service and financial goals. Detailed compensation modeling can be integrated directly into budgeting, reporting and planning activities, making adjustments as changes occur in service areas.

Physician compensation should be tied to productivity, quality, service, cost-effectiveness, access and other strategic goals, as described in the next section, and must provide physicians a fair and stable income. Different compensation arrangements are required for mid-level providers, urgent care providers, hospitalists and hospital-based physicians. These arrangements must recognize the role the provider is playing and the differing variables that are within and beyond their control.

Strategy 10. Structure effective and sustainable compensation programs for employed physicians.

Developing an effective physician compensation framework/architecture is the single most important factor driving the future performance of a hospital’s physician enterprise.

An efficient compensation design follows key principles that support organizational goals and provide physicians a fair and stable income. The most important principle is to develop consistent compensation standards and metrics and to apply these consistently across physicians, locations and specialties. Standards should cover work effort/productivity, quality, cost-effectiveness and patient access, and should support of the organization’s strategic objectives.

Another important principle in designing physician compensation programs is finding the right balance of the key metrics. Clinical work effort often represents up to 95 percent of community physicians’ work effort. So, while the industry is expected to evolve to a value-based payment system, productivity still needs to be the main factor driving compensation and the primary metric for incentive-based compensation programs. Quality, access and strategic alignment thresholds should be incorporated, but to a lesser extent. If only quality, service, patient satisfaction and other non-productivity goals are used, a measurable decline in access may occur. Recent experience demonstrates that even in a value-based care model, productivity metrics must be used or patient access measures will deteriorate. If access falls, then both quality and patient satisfaction can suffer. In a value-based care environment, productivity weighting may still need to be in the range of 50 to 70 percent, depending upon the organization’s service characteristics.

Productivity-based methods of structuring compensation programs include:

- Compensation per work relative value units (wRVUs);
- Compensation as a percentage of gross charges;
- Compensation as a percentage of net collections;
- Compensation per encounter; and
- Compensation based on panel size or panel-size equivalencies.

Of these alternatives, paying compensation per wRVU is the preferred method for a number of reasons: it is directly linked to the patient-activity level maintained by the physician and is neutral relative to patient payer mix; it is highly correlated to reimbursement for the services provided; and it is flexible enough to allow “shadow wRVUs” that can compensate physicians for items such as achievement of quality goals, support of strategic initiatives, excess travel time to cover outlying sites, participation in administrative functions, or whatever other work efforts the organization deems important.

As part of a compensation-per-wRVU framework, most leading organizations are also including quality, access, cost-effectiveness and service and patient satisfactions scores as variables that drive physician compensation. Typically, a total compensation per wRVU is set and then a portion of that total is allocated to the non-productivity metrics but is paid out on a per-wRVU basis. This requires the physicians to meet productivity goals and quality and other service-driven metrics at the same time. In general, quality is positively correlated with volume, so linking them in the compensation system makes sense.

Employment compensation agreements need to be structured competitively in a manner that is sustainable over the long term. Short-term agreements, which lead to major renegotiations after only a few years, create unnecessary conflict for the hospital or health system and the physician involved by increasing the frequency of the required renegotiations. Two- to three-year initial agreements with “evergreen” or automatic renewals are recommended. Typically the compensation metrics would be predetermined for the initial period and then would be adjusted based upon their relationship to other predetermined drivers of practice performance. If the metrics varied outside predetermined ranges, both parties would be required to renegotiate the compensation architecture.

In many successful health systems, a physician compensation committee is a standing committee that meets on an ongoing basis, not just during renegotiations. Goals related to quality, access, cost, service and other metrics are continually reviewed to determine if the goals offer the best-possible way to align the health system and physician goals.

Example: A University Health System Manages the Value Equation

As part of its clinical integration program, a university health system established a value management committee, with responsibility for defining:

- Quality and other value metrics related to infrastructure incentives, improved outcomes, improved quality and reduced clinical costs; and
- Clinical initiatives to drive value.

The selection of quality and other value metrics established consistency among all payers and a foundation for incentive payments. The committee started with a small number of metrics that were identified and approved by physicians with collective input from employers, physicians and payers. The number of metrics will grow and be reviewed annually. The university health system examined more than 400 clinical metrics from sources including:

- Other hospitals and health systems;
- Regulatory and accreditation agencies: meaningful use objective measures, Agency for Healthcare Research and Quality measures, proposed ACO measures, CMS core measures and value-based purchasing guidelines; and
- Internal sources (e.g., metrics in organizational balanced scorecards).

The rigorous evaluation process examined cultural feasibility (i.e., the likelihood of acceptance, receptivity to process change and credibility) and technical feasibility (i.e., the ability to collect the data and produce credible results). Through this process, the university health system selected 112 metrics to implement in its first program year.

Measurement is a key ingredient of managing value, but also necessary are appropriate resources and planning related to clinical initiatives that make performance targets achievable. The university health system defined three major clinical programs related to managing value across the continuum of care—managing chronic disease, improving generic prescribing and reducing overall hospital days—and defined specific and detailed plans to implement comprehensive programs in each area.

Strategy 11. Manage employed physicians to achieve goals.

Hospitals and health systems with high-performing physician enterprises actively track and monitor the performance of their employed physicians, using both internal and published benchmarks to identify and address performance strengths and weaknesses. Indicators for employed physicians should focus on financial performance, quality, outcomes, service, patient satisfaction, cost and other operational metrics. Indicators must be specific, measurable, attainable, relevant and time bound. They also must be reviewed on a frequent and ongoing basis.

On the revenue side, two areas require particularly close performance monitoring, review and proactive intervention when needed.

- *Physician revenue cycle performance.* This must be a top priority if the organization is committed to physician employment. If the organization cannot effectively manage the physician revenue cycle, the organization should outsource this function to a proven firm that can improve collection metrics and reduce collection costs.
- *Treatment of technical revenues post acquisition.* There are regulatory reasons that technical revenues cannot tie directly to physician compensation. However, many organizations shift technical revenues from the practice to the hospital to reflect the fact that the revenues are being billed at hospital rates. This creates a large revenue loss for the practice, even though the practice is creating value for the hospital. To hold physicians accountable to benchmark performance levels based on survey data, these revenues should remain in the practice at least at the operating reporting level before being removed during consolidation.

Cost-effectiveness will be a key issue in a value-based business environment. Figure 10 illustrates a simple performance dashboard that serves as an important practice management reporting tool. This dashboard allows individual physicians, practice administrators and organizational leadership to track productivity, staffing efficiency, revenue and expenses by physician, site or in total. The level of detail is indicative of what is required. Prompt identification of areas of underperformance and the development of concrete improvement strategies better enable the organization to attain performance targets.

Figure 10. Physician Practice Budget Dashboard by Region

Physician Network			
Budget Summary for Region 1			
FY2012 Budget			
	FY10	FY11 PROJ	FY12 BUD
Physician Productivity			
Physician FTEs	0.00	0.00	0.00
Mid-Level Provider FTEs	0.00	0.00	0.00
Total Provider FTEs	0.00	0.00	0.00
Office Visits (IP and OP)	000,000	000,000	000,000
% Growth		0%	0%
Office Visits per Provider	0,000	0,000	0,000
Office Visits per Day per Provider	0	0	0
Staff Efficiency			
Staff FTEs (exclude Mid-Level Prov.)	0.00	0.00	0.00
Ratio of Staff FTEs to Provider FTEs	0.00	0.00	0.00
Office Visits per Staff FTE	0,000.00	0,000.00	0,000.00
Average Hourly Wage	0.00	0.00	0.00
% Increase Average Hourly Wage		0.00%	0.00%
Revenue Analysis			
Net Patient Revenue per Visit	0.00	0.00	0.00
% Increase per Visit		0%	0%
Net Revenue per Provider	0	0	0
Expense Analysis			
Non-Provider Expense per Provider	0	0	0
% Increase		0%	0%
Rent Expense/Provider	0	0	0
Operating Expense per Visit	0.00	0.00	0.00

Source: Kaufman, Hall & Associates, Inc. Used with permission.

Evaluation of Physician Integration Options

Evaluation of physician integration options involves a thorough and fact-based analysis of the community-based advantages, capital requirements, operating impact and quality implications of each option. Hospitals and health systems must be able to answer the question, “What are the costs and impacts of each option in the integration continuum, from customer service arrangements to practice acquisitions and employment?” Ultimately, the alignment models encouraged by payers, employers and patients require a transformational change in the health care business model from facility-based silos to systems-level thinking.

Whatever the form of integration, the litmus test for an approach’s effectiveness will be its ability to align hospital and physician goals related to utilization, cost, service, access and quality, while maintaining or increasing the level of physician and patient satisfaction. Without achieving target levels of physician and patient satisfaction, none of these options are sustainable.

Ultimately, an organization’s arrangements with physicians must provide the platform for organizational growth. Many hospitals and health systems are responding reactively to

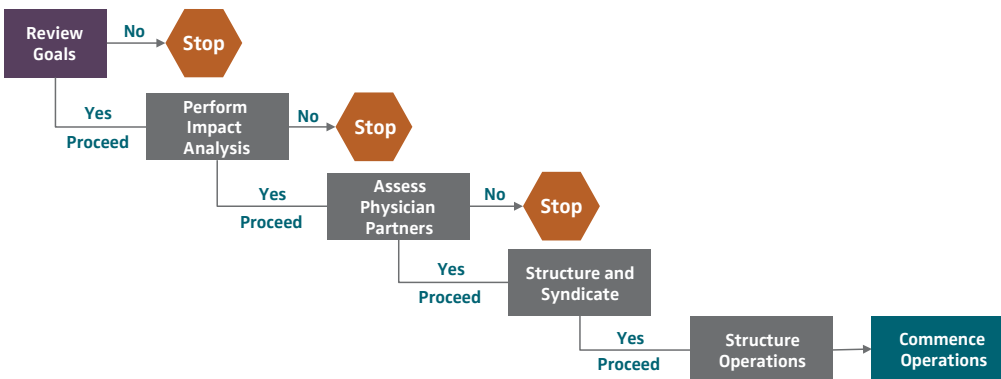
integration options as they evolve. But a better approach is to proactively identify, evaluate and select physician-integration options that represent a win/win opportunity—meeting physicians’ needs while positioning the overall organization for success. Timing is often critical. Nationally, the trend is service areas that moved from experiencing little physician practice consolidation to being fully “in play” in a matter of months.

Regulatory and compliance issues are numerous, so hospitals need to be knowledgeable and guided by legal counsel in these areas.

Strategy 12. Use a structured process to ensure creation of a sustainable venture and consistency over time.

As described in the previous section for physician-employment opportunities, hospitals and health systems should use a comprehensive process to ensure that they are creating a sustainable venture that is aligned with their “go-forward” strategy. Figure 11 illustrates this process.

Figure 11. Process for Creating Sustainable Integration



Source: Kaufman, Hall & Associates, Inc. Used with permission.

Review goals: Before initiating collaborative discussions and setting physician expectations, the organization must review its strategic goals and determine how or if the venture would support such goals.

Perform an impact analysis: An impact analysis quantifies the effect the collaboration would have on existing and proposed operations, financial performance, patient access, tax status, contracting and a host of other factors. One of three outcomes are possible from the perspective of physicians, the hospital or the patient: 1) the collaboration creates value; 2) the collaboration preserves value, meaning that the collaboration may be a needed defensive strategy to maintain the current level of value; or 3) the collaboration erodes value, which indicates that the collaboration should never be pursued, even if it meets one or more tactical goals.

Assess physician partners: Selecting the right physician partners has the biggest impact on creating value and driving quality. Key questions that must be addressed include: Is the arrangement with individual physicians or with a group or legal entity? If it is with a physician group, does the entire group meet the organization’s quality expectations? What will be the competitive response from non-participating physicians? How will the organization build in succession plans, future offerings and other considerations with relatively modest initial capitalization requirements? What will be the specific change to acute operations (e.g., volumes, payer mix, charity care) based on the specific physician partners? How will the organization handle different physician groups (e.g. faculty practice plans versus voluntary physicians)?

Structure and syndicate the venture and operations: This phase typically has two concurrent work streams, which include structuring the venture and operations and syndicating the venture, as appropriate. As described previously, there are numerous ways to structure a partnership. To create value for all stakeholders, operations must be structured for optimal efficiency and should include physicians in key leadership roles. Appropriate for shared joint-equity arrangements, the goal of syndicating a venture is to attract physicians as equity investors at a price that ensures viability of the venture and meets regulatory requirements but does not create too great a financial hurdle for interested physicians.

Commence operations: This phase requires start-up planning and implementation that is as thorough and seamless as possible. Continuous monitoring of progress toward meeting strategic financial goals and development of plans to address performance shortfalls are critical.

Concluding Comments

Hospitals and health systems must achieve effective hospital-physician alignment to remain competitively positioned. There is no one integration plan that works for all organizations or all physicians. Service areas and physician needs are diverse, so hospitals and health systems must be prepared to offer multiple engagement options, serving multiple physician constituencies.

Models selected for use must align organizational and physician goals related to improved quality, efficiency and access within the constraints of current organizational capital resources. Finding a sustainable balance of strategic and clinical needs, capital constraints, operation capabilities and management competencies is critical.

The organizations most likely to gain and retain close integration with physicians have common attributes that include deep management expertise, shared hospital-physician leadership and a well-developed integration infrastructure. Health care boards and executives should be taking purposeful steps to align their organizations with physicians for sustainable success under a very different care and payment system going forward. Organizations whose leaders act early to build these attributes based on solid planning and monitoring are poised for future success in their communities.

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About Kaufman, Hall & Associates, Inc.

Founded in 1985, Kaufman, Hall & Associates, Inc. is an independent management consulting firm, providing services and software to hospitals, health systems and other health care organizations nationwide.

The firm provides strategic advisory services; physician advisory services; financial advisory services to debt transactions; strategic, financial and capital planning services; capital allocation design and implementation services; and merger, acquisition, joint venture, real estate and divestiture advisory services.

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American Hospital
Association



Engaging Health Care Users: *A Framework for Healthy Individuals and Communities*




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Table of Contents

Executive Summary.....	4
Introduction.....	9
Framework for Engaging Health Care Users.....	13
Strategies for Engaging Health Care Users.....	15
Case Studies: Engaging Health Care Users.....	18
Strategies at the Community Level.....	19
Strategies at the Organization Level.....	27
Strategies at the Health Care Team Level.....	33
Strategies at the Individual Level.....	41
The Future of Health Care User Engagement.....	43
Appendix: Center for Advancing Health Engagement Behavior Framework.....	46
Resources.....	48
Endnotes.....	49

Executive Summary

The mission statement of virtually every hospital in the United States is to improve the health of individuals and communities. This is evident in the manifestation of the Triple Aim for the U.S. health care system, a framework developed by the Institute for Healthcare Improvement. This framework includes three dimensions: improve the health of the population (our communities), improve the individual care experience and reduce or control the per capita cost of health care.

The American Hospital Association (AHA) in its framework for health reform, Health for Life, embraces the need to engage patients and families and contemplates the role of hospitals and health care systems in improving the total health of the population and community they are serving. Within this context, in 2012 the AHA Committee on Research decided to focus on patient and family engagement. This subject has taken on increasing importance with the growing recognition that actively engaging health care users in their care can improve outcomes and reduce health care costs. To adequately embrace the AHA's mission to improve the health of people and communities, hospitals must become more “activist” in their orientation and move “upstream”—that is, they must do more to engage patients earlier in the disease process.

Individual interactions with patients are the fundamental means by which hospitals and health care systems can improve the health of the patients and communities they serve. This two-way interaction requires health care providers to understand how they might present health matters to optimize the patient and family experience.

What Is Health Care User Engagement?

There are many definitions of “health care user engagement.” To focus this work, the strategies and framework included in this guide will be built around this definition: **“a set of behaviors by health professionals, a set of organizational policies and procedures and a set of individual and collective mindsets and cultural philosophies that foster both the inclusion of patients and family members as active members of the health care team and encourage collaborative partnerships with patients and families, providers and communities.”**¹ In this report, “health care users” is the term used to denote all those who use health care services, though “consumer” and “customer” are also used frequently.

Framework for Engaging Health Care Users

Achieving “Health for Life” is a team effort that requires actions from key players within the health care system to develop a culture that supports patient and family engagement. The Framework for Engaging Health Care Users diagram presents a continuum for engagement from information sharing to partnerships, with entry points for user engagement occurring at different levels of the health care system.²

Framework for Engaging Health Care Users



Source: AHA COR, 2013.

Strategies for Engaging Health Care Users

As hospitals and health care systems begin to play more of an activist role with their patients and communities and move upstream to intervene earlier in disease states, there are several barriers to acknowledgment and consider. These are:

- Current volume-based reimbursement system that does not offer significant funding upfront toward health engagement initiatives
- Ambiguity surrounding the definition of health care user engagement and the large number of diverse strategies that hospitals can employ to achieve desired results
- Current professional culture and norms that intimidate patients in approaching their health care providers
- Low health literacy levels among patients
- Lack of measurement tools to assess where a patient is along the engagement continuum and how well an organization is doing in engaging health care users

Hospitals and health care systems can employ an array of strategies to increase consumer engagement at different levels of the health care system. See the table on page 6 for examples.

Examples of Health Care User Engagement Strategies

Health Care System	Examples of Engagement Strategies
Community	<ul style="list-style-type: none"> • Providing health education and health literacy classes • Providing healthy cooking and physical education classes • Using patient navigators and peers to provide support • Making local policy changes that promote healthier lifestyles (e.g., eliminating sugary drinks from school cafeterias)
Organization	<ul style="list-style-type: none"> • Using volunteers or patient advocates to support care • Involving patients and families in patient and family advisory councils, governance and other committees • Removing restrictions on visiting policies for families • Opening access to medical records • Using email and social media technology (e.g., Facebook, Twitter)
Health Care Team	<ul style="list-style-type: none"> • Using bedside change-of-shift reports • Involving patients and families in multidisciplinary rounds • Using patient- and family-activated rapid response • Providing shared decision-making tools • Using patient teach-back • Using clinic-based multidisciplinary care teams
Individual	<ul style="list-style-type: none"> • Seeking health information and knowledge • Adhering to treatment plans and medication regimens • Participating in shared decision making • Using online personal health records • Engaging in wellness activities

Source: AHA COR, 2013.

The case studies in this report present approaches that hospitals and health care systems have already taken to engage health care users as active participants in their care.

Community Level

- **Griffin Hospital** worked with nursing homes and home health agencies to standardize protocols and patient education materials to reduce readmissions. As a result, their readmissions fell from 15 percent to 7 percent during the course of the project.
- **Cambridge Health Alliance** worked with school nurses and families to improve asthma outcomes in children. Because of this, admissions for pediatric asthma fell by 45 percent and pediatric emergency department visits fell by 50 percent in seven years. The return on investment for the program is \$4 for every \$1 invested.
- **Methodist Le Bonheur Healthcare** partnered with the Congregational Health Network, a faith-based group, to improve care transitions. An analysis of 473 CHN participants found that their mortality rate was nearly one-half of the rate for nonenrolled patients with similar characteristics.
- **Southcentral Foundation** and **Kaiser Permanente**, both owned and managed by the customers they serve, are examples of a total health model.

Organization Level

- **Georgia Health Sciences Health System** partnered with patients and families in all aspects of the health care system's operations. Patient and family advisors were instrumental in providing input on key operational and strategic decisions including anesthesia staffing, medication dispensing, patient handoffs, patient and family rounding, patient safety and the design of new services. As a result, in a three-year period, patient satisfaction scores increased and medication errors declined.
- Health care systems are also finding ways to engage their own workforce to become more involved in their overall health and care. **Saint Elizabeth's Medical Center, Bellin Health System** and **Sentara Healthcare** developed and established employee health and wellness programs that provide monetary incentives to encourage participation. These initiatives contributed to either reduction or slower growth of health care spending, while still improving the health and well-being of program participants.

Health Care Team Level

- **Cincinnati Children's Hospital Medical Center** and **Helen DeVos Children's Hospital** focused on patients, families and the health care team when designing and implementing an approach for patient- and family-centered rounds. At Helen DeVos Children's Hospital, nursing units raised their patient satisfaction scores from below the 50th percentile to greater than the 90th percentile on a consistent basis.
- **Emory Healthcare** had patient and family advisors contribute to the development of protocols for conducting bedside change-of-shift reports and serve as instructors in training front-line staff. Patient satisfaction increased with overall nursing care augmenting from the 41st to 78th percentile on the Press Ganey survey. Quality outcomes also improved; hospital-acquired pressure ulcers decreased from 8.15 percent to 2.5 percent.
- **Informed Medical Decisions Foundation** supported research projects on shared decision making at primary and specialty care demonstration sites across the country.
- **Atlantic Health System** set flexible visiting hours. The system not only received strong support from internal staff to continue the open visitation policy but also increased patient satisfaction scores.
- **Geisinger Health System** established a medical home model, ProvenHealth Navigator, designed to reduce downstream costs—which occur later in the disease process—from the highest acuity by moving resources upstream or earlier in the disease process. It improved health coordination, enhanced patient access to primary care providers and provided more effective and efficient disease and case management. Over time, the program also reduced costs.

Individual Level

- **Howard University Hospital** provided diabetes patients with access to personal health records to assist them in monitoring a range of clinical indicators pertinent to diabetic health. As a result, hemoglobin A1c levels fell by approximately 13 percent for patients participating in the program compared to an increase in levels for those not participating.
- **Ryhov Hospital** provided training for patients interested in managing their own dialysis. The 52 percent of renal patients who are on self-dialysis had fewer side effects and lower infection rates.

The Future of Health Care User Engagement

While there is tremendous need to bridge the gap among consumers, health care professionals and policymakers to increase health care user engagement, there is also a collective awareness for change. Impressive health care user engagement initiatives and best practices are found in many health care systems across the country. Engaging users in health care is essential for transformation of the care system.

It requires a collaborative partnership and relationship among all stakeholders, including patients, families, communities, providers and other individuals involved in the industry.

The health care system is adapting to the ever-changing needs and demands of health care users. As the health care system evolves and user engagement matures, it creates opportunities to dramatically improve health care delivery. Many promising technologies and practices are being tested and many are yet to be discovered.

This report discusses many issues related to health care user engagement, but other emerging areas deserve appropriate attention. Though not discussed in as much detail in this report, these other topic areas are likely to have some significance in the future of health care user engagement, but they require further research to address questions surrounding them. These topic areas include:

- Consideration and integration of behavioral health and mental health as they relate to engagement at all four levels—the community, organization, team and individual
- Role of health plans as significant stakeholders in the engagement process
- Role of employers as drivers for creating a culture of health
- Emergence of new technologies that will facilitate patient, family and provider interactions; health education; treatments and overall engagement
- Role of social media as a means to enhance communication and networking with individuals and communities

Engaging patients, families and communities has the potential to be a “game changer” in the transformation of the health care system in the United States. Hospitals and health care systems can serve as laboratories for developing, testing, learning and disseminating new engagement practices. The impact of this type of engagement and the role that hospitals can play in leading this transformative element of system redesign in their own communities are foundational for achieving the Triple Aim in health care.

Introduction

The mission statement of virtually every U.S. hospital is to improve the health of individuals and communities. According to the World Health Organization, “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”³ The Triple Aim for the U.S. health care system, a framework developed by the Institute for Healthcare Improvement, is to improve the health of the population (our communities), improve the individual care experience and reduce the per capita cost of health care.

The AHA framework for health care reform, Health for Life, embraces many of these core tenets. The Health for Life’s pillars—“Best Information,” “Highest Quality Care,” “Most Efficient, Affordable Care” and “Focus on Wellness”—encompass engaging patients and families and contemplate the hospital’s role in the larger sphere of improving the total health of the population and community being served. This expanded focus requires hospitals and health care systems to (1) move beyond the acute-care in-hospital management of episodes of illnesses, (2) encourage larger and longitudinal contact with people in their communities to maximize the health of each person and (3) create a better, safer, more efficient and affordable health care system.

It is important to understand that health care accounts for a small share of the factors determining the health of individuals and, by extension, the community. Genetic and demographic factors, socioeconomic status, education and lifestyle choices are overwhelmingly more important health determinants. Hospitals and health care systems often see patients far “downstream,” or late in the disease state of the population they serve. These health care organizations treat patients whose health status is determined by environmental, genetic and lifestyle choices beyond their control. To adequately embrace the AHA’s mission to improve the health of communities and individuals, hospitals must become more “activist” in their orientation and move “upstream”—that is, they must do more to engage patients earlier in the disease process.

The fundamental means by which hospitals and health care systems can affect the health of individuals and the communities they serve is through interactions with each patient. This two-way interaction requires health care providers to understand how they might diplomatically address health matters to optimize the experience and health of patients and their families. And patients have to understand a provider’s recommended course of action and follow the prescribed therapies and lifestyle changes. Attaining the optimal result for all parties involved is contingent on maintaining the delicate balance for recommended action and information uptake between the health care organization and patients. Unfortunately, most patient interactions fail to achieve this optimal result.

To understand this dynamic and examine ways that hospitals and health care systems can address these issues, the 2012 AHA Committee on Research focused on the topic of patient and family engagement. This report summarizes the literature on the rationale for health care user engagement, recommends actions that organizations should consider when developing initiatives to increase health care user engagement and highlights promising strategies found across hospital and health care system facilities.

What Is Health Care User Engagement?

Health care user engagement is a broad concept. Many definitions place it in the context of patient-centered care, one of the six aims for improvement outlined in the 2001 Institute of Medicine’s *Crossing the Quality Chasm: A New Health Care System for the 21st Century* and a central concept of the Triple Aim. For the IOM, patient-centered care is “providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions.” (“Patient-centered care” and “person-centered care” are the most commonly used terms, and this report will use “patient-centered.”)

National leadership organizations define health care user engagement in the context of patient-centered care in various ways. The Institute for Patient- and Family-Centered Care highlights bringing patient and family perspectives into the design and delivery of care with an emphasis on dignity and respect, information sharing, participation and collaboration.⁴ The Commonwealth Fund defines seven attributes of patient-centered care including access to care, patient engagement in care, information systems, care coordination, integrated and comprehensive team care, patient-centered care surveys and publicly available information.⁵ Planetree describes patient engagement as a model in which health care providers partner with patients and families to identify and satisfy the full range of patient needs and preferences. Staff dedicated to meeting the physical, emotional and spiritual needs of patients is a key element of this model.⁶ The Center for Advancing Health defines patient-centered care as “actions individuals must take to obtain the greatest benefit from the health care services available to them.”⁷ The CFAH focuses on more than 40 behaviors of individuals to become more engaged rather than on behaviors of providers or policies of organizations. These behaviors are grouped into 10 categories and together make up the “Engagement Behavior Framework” (See Appendix).⁸ Despite differences across these definitions, patient and family engagement is universally viewed as the mechanism to achieve patient- and family-centered care.

This guide will build its framework and strategies around **“a set of behaviors by health professionals, a set of organizational policies and procedures and a set of individual and collective mindsets and cultural philosophies that foster both the inclusion of patients and family members as active members of the health care team and encourage collaborative partnerships with patients and families, providers and communities.”**⁹ This definition, adapted from the Agency for Healthcare Research and Quality’s *Guide to Patient and Family Engagement: Environmental Scan Report*, shares many of the elements associated with definitions from other organizations. The definition also provides clarity of purpose for hospitals and health care systems to develop and implement strategies that support patient and family engagement.

Why Health Care User Engagement?

Improving overall health in the United States requires active participation from all segments of the population: policymakers, public health agencies, providers, payers and health care users. A tremendous opportunity to improve health lies in optimizing health care user engagement because 40 percent of all deaths in the United States are attributed to personal behavior.¹⁰

Studies have also shown that on average only half of adult patients receive the recommended care¹¹ according to best practices, and the results for children are similar.¹² There are myriad reasons for this gap including the fragmentation of the current health care system, the payment system that rewards volume instead of value and a care delivery system that historically has been designed without input and involvement from the individuals that the system serves.^{13, 14}

More and more researchers, policymakers, patients and providers are embracing health care user engagement as an important factor to improve quality and outcomes when providing care. Engaged health

care users are more likely to comply with their treatment and prevention plans and less likely to engage in unhealthy behaviors, and they have fewer emergency department visits and hospitalizations.¹⁵ Additionally when patients and families are involved, hospitals and health care systems have an opportunity to improve quality and reduce medical errors, health care-associated infections and readmissions.¹⁶

Other forces in the health care environment are creating momentum for change. The increasing rates of chronic disease, changing patient demographics, advances in medical technology, greater use of smart phones and the Internet, new models of health care delivery (e.g., patient-centered medical homes and accountable care organizations) and emerging value-based payment systems—all these forces are pressing organizations to take a more proactive role and approach to patient engagement. This expansion includes seeking ways to better engage patients in shared decision making and self-management behaviors and involving the community in supporting care. These components are critical strategies as the population ages and management of chronic diseases becomes the norm.

Progression of Health Care User Involvement

As providers' practices have evolved, health care markets have developed and the identities and functions of health care system stakeholders have changed, patient roles also have changed. Below are several forces that have progressively expanded the patient's role in health care delivery.¹⁷

Informed Consent

Early in the 20th century, judicial courts began to recognize the right of patient self-determination. These courts laid the foundation for today's informed consent doctrine requiring physicians to obtain consent for treatment after disclosing factors such as the patient's diagnosis, the proposed treatment's nature and purpose, treatment risks and treatment alternatives.

This type of information transfer brings the patient's knowledge base closer to that of the physician's, making the health care provider and user relationship less hierarchical and providing the patient with an opportunity to direct his or her care path.

Beyond Consent: Patient-Centered Care

Like the commitment to informed consent, patient-centeredness requires informed patient participation in decision making and care that caters to the patient's needs and preferences. It requires more active involvement than just the grant or denial of consent. In patient-centered care, patients exercise greater autonomy.

There are six core attributes of patient-centered care:¹⁸

1. Education and shared knowledge
2. Involvement of family and friends
3. Collaboration and team management
4. Sensitivity to nonmedical and spiritual dimensions of care
5. Respect for patient needs and preferences
6. Free flow and accessibility of information

Barriers to Health Care User Engagement

As health care leaders move to embrace health care user engagement, they have encountered and will continue to face considerable barriers. The current volume-based reimbursement system does not offer significant upfront funding toward these initiatives because savings and outcome improvements are typically realized later. Additionally, the ambiguity surrounding the definition of health care user engagement and the large number of diverse strategies that hospitals can employ to achieve desired results—from medical home models to nutrition classes and shared decision making—make it challenging to identify which aspects of engagement represent the best opportunities for investment, especially with limited time and resources.

Barriers to change can be attitudinal and related to professional culture and norms, with older providers tending to be more paternalistic in their approach. The “physician knows best” culture is at odds with the tenets of patient-centeredness. Many patients are often overwhelmed when faced with navigating the health care system and can be intimidated by health care professionals. These patients believe they lack the necessary skills to seek out information and effectively use the information once they receive it. For example, an online survey asked 1,340 adults how they would want to be involved in their own treatment if they were patients suffering from heart disease. Only one in seven respondents was willing to bring up a disagreement with the physician if the physician’s recommendation clashed with their own treatment preference.¹⁹

Motivational factors can also play an important role. In a recent meta-analysis of the literature conducted by Ng et al., when patients perceive respect for their autonomy in the health care setting, they experience better physical and emotional health.²⁰ Poor health literacy skills are a huge barrier and associated with increased hospitalizations and emergency department use, poor medication adherence and low screening and immunization rates. The relationship between health literacy and health outcomes is particularly true for the elderly. Additionally, studies show that health literacy may also be inversely associated with health care disparities.²¹

Another significant obstacle is the lack of measurement tools to assess where a patient is along the engagement continuum and how well an organization is doing in engaging health care users. This is changing with the development of the Patient Activation Measure by Judith Hibbard, for use with chronic disease patients.²² Hospitals are also starting to think about using available patient-reported outcome measures along with patient experience and quality-of-care measures to gain a better idea of the quality of care they are providing. Patient-reported outcome measures assess health, functional status and quality of life from the patient’s perspective and can be an important tool in engaging patients in their care.

Despite these challenges, hospital and health care system leaders are recognizing the importance of patient engagement in increasing quality and safety, developing care coordination activities, advancing preventive services, expanding access and improving patient experience scores. Some of the financial incentives are not yet fully aligned, but specific and considerable efforts to engage health care users in the current volume-based payment systems will be critical in the future value-based market.

Framework for Engaging Health Care Users

Achieving “Health for Life” is a team effort that requires actions from key players within the health care system in developing a culture that supports patient and family engagement. Hospital leaders and clinical providers will need to create a culture that brings the patient and family perspective into the design and delivery of care programs and practices. Individuals (patients and families) will need the necessary knowledge and skills to become more involved in their care. Meanwhile, the broader community will need to align policies and programs that are responsive to patient and family needs and support engagement efforts. As care shifts away from acute, episodic care to chronic disease management, hospitals will have to expand their focus beyond the inpatient setting, create mutual relationships and think more broadly and creatively with different stakeholders when developing strategies for health care user engagement.

The Framework for Engaging Health Care Users in Figure 1 shows how health care organizations can actively engage with health care users. This framework presents a continuum for engagement from information sharing to partnerships, with entry points for user engagement occurring at different levels of the health care system.²³ Strategies within each of the different entry points can be mutually reinforcing and should encourage collaborative partnerships across each level of the health care system.

Figure 1: Framework for Engaging Health Care Users



Source: AHA COR, 2013.

At the **individual level**, the focus is on patients and families and includes strategies to increase their skills, knowledge and understanding of what to expect when receiving care. For example, some hospitals provide patients with informational packets upon admission and have educational resource centers available for access. Other hospitals assign transition coaches to help patients and families understand discharge instructions and prepare questions for their physicians during a follow-up visit. There are also facilities that provide patients with pocket guides to aid in their conversations with physicians. Additionally, other hospitals combine technology with techniques such as coaching or mentoring to prepare patients to become more actively involved in their care.²⁴ These and other strategies allow patients to take ownership of their care. With more information and guidance, patients can make better, well-informed decisions and even augment a physician's care plan to reflect personal preferences and individual values.

At the **health care team level**, point-of-care strategies can be implemented such as patient and family rounds, patient and family involvement in bedside change-of-shift reports, patient- and family-activated rapid response, and open charting. The Center for Advancing Health has developed a "Patient-Clinician Pact," which includes a list of responsibilities for patients paired with a set of responsibilities for clinicians grouped around "sharing information, shared decision making and responsibility for care."²⁵ The CFAH also suggests developing an information pamphlet for patients giving them the "rules of engagement" for the physician's office or clinic. This pamphlet can include instructions for the type of information that patients should bring with them to each appointment (e.g., medication list, recent test results) and the procedures for making office appointments and where to go for care when the office is closed. A similar type of instructional pamphlet could be developed for patients at hospital discharge or at other points of transition or entry into the health care system. Strategies at this level allow patients to participate in the system and play a role in health care units. As a result, patients and their providers build a shared understanding of expectations when seeking and receiving care.

At the **organization level**, hospitals and health care systems can encourage partnerships with patients and families by involving them in program planning and development, patient safety, and quality improvement processes by establishing patient and family advisory councils and including them on quality improvement and other hospital management and committees. The ultimate goal is to integrate the patient and family perspective into all aspects of hospital operations. To do this, a culture that is conducive and supportive of patient and family engagement is required. Some hospitals define behaviors associated with patient-centered care and incorporate them into staff position descriptions and provide role-playing opportunities during new employee orientation, thus incorporating patient-centered concepts into daily practice. Other hospitals have asked patients and families to serve as faculty members when training staff on patient-centered concepts and provide opportunities for students to shadow patients and their families to understand what they are experiencing when they visit the hospital. Strategies at the organizational level provide patients and families the opportunity to influence health care systems and integrate perspectives from their experiences.

At the **community level**, hospitals can also expand their focus beyond the facility by providing care to patients in the home, partnering with the community on care transitions and finding opportunities to improve community health overall. Hospitals are working with schools, faith-based organizations and other community partners to provide screenings, health education and wellness programs. Some hospitals are trying novel approaches such as using peer mentors to improve and manage chronic conditions like diabetes.²⁶ Hospitals are also collaborating with professional associations, nonprofit organizations and community members to deliver information and engage health care users on issues such as patient safety and health reform. Aside from hospitals, states are taking steps to increase public health engagement. Open board meetings are occurring throughout the United States. Massachusetts, for example, posts notices of upcoming meetings from its Department of Public Health website.²⁷ At this level, health care systems take an activist role and move their level of disease intervention "upstream." Through early detection and engagement, health care users are more cognizant of their well-being.

Strategies for Engaging Health Care Users

Strategies to increase health care user engagement at different levels of the health care system are listed in Table 1. Hospitals and care systems may not be able to pursue all these strategies, but even small steps in one of the areas can yield beneficial results. The four levels of the health care system detailed in the table are community, organization (governance, executive leadership, management, and clinical), health care team (bedside, inpatient unit, exam room, home) and individuals (patients and families). Each of the strategies involves implementing different programs, both big and small, that can increase health care user engagement.

Table 1: Examples of Patient and Family Engagement Strategies

Health Care System	Description	Examples of Engagement Strategies
Community	Communities have an important role to play in supporting residents living with chronic disease. A growing number of hospitals and health systems are partnering with community health centers and public health agencies to involve the community in engaging in healthier behaviors and self-management activities.	<ul style="list-style-type: none"> • Providing health education and health literacy classes • Providing healthy cooking and physical education classes • Using patient navigators and peers to provide support • Making local policy changes that promote healthier lifestyles (e.g., eliminating sugary drinks from school cafeterias)
Organization	Health care organizations can implement many programs and changes in care delivery to engage patients throughout the continuum of care and involve them in improving quality and the patient experience.	<ul style="list-style-type: none"> • Using volunteers or patient advocates to support care • Involving patients and families in patient and family advisory councils, governance and other committees • Removing restrictions on visiting policies for families • Opening access to medical records • Using email and social media technology (e.g., Facebook, Twitter)
Health Care Team	The growing incidence of chronic disease combined with an expanded patient base has placed more responsibility onto clinicians practicing both inside and outside of the hospital. Clinicians must work with each other and with patients to design individual care plans to achieve better outcomes.	<ul style="list-style-type: none"> • Using bedside change-of-shift reports • Involving patients and families in multidisciplinary rounds • Using patient- and family-activated rapid response • Providing shared decision-making tools • Using patient teach-back • Using clinic-based multidisciplinary care teams

Health Care System	Description	Examples of Engagement Strategies
Individual (Patients and Families)	Clinical advances have the ability to improve the quality of life for the majority of patients. To receive the full benefit, patients must actively manage their conditions to help prevent complications. For example, new HIV/AIDS drugs extend life, but patients must maintain the necessary regimens for success.	<ul style="list-style-type: none"> • Seeking health information and knowledge • Adhering to treatment plans and medication regimens • Participating in shared decision making • Using online personal health records • Engaging in wellness activities

Getting Started: Implementing Organizational Change

An organization’s culture—its norms, values, beliefs and behaviors—influences its capacity to pursue and adopt patient engagement strategies. Changing culture to support health care user engagement is a long-term and interactive process that begins with strong leadership. Leaders set the tone by actively building awareness of the importance of this issue and visibly supporting this core value. Conducting an assessment to understand where the organization is in its journey to engage patients and families is one way to identify opportunities and build awareness. Several tools are available in the literature to use in conducting this assessment. Here are examples of questions to consider:

- Does the hospital have an active patient and family advisory council?
- Do patients or families serve on the hospital’s quality improvement project teams?
- Does the hospital have open visiting hours?

Learning from patients and families that use services is key to the assessment process. Although hospitals leaders can examine their Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) results to enhance understanding of how patients view their current experiences, this should not suffice. Hospitals should supplement the survey approach by asking patients and families questions about their recent visit or hospitalization. Some hospital leaders begin with patient focus groups and ask them to discuss their recent experience, or leaders round on patient floors. Patient stories can be a powerful tool for determining gaps and identifying opportunities of where to begin. Other strategies include having leaders begin each hospital meeting with a “mission” moment by reading a letter from a patient or relaying a story. Whatever approach is used, scrutinizing the care experience through the patient’s perspective is important.

Once an overall assessment is complete, hospitals can begin to take steps necessary to target strategies for engagement. One-size-fits-all passive strategies will not be as successful to support patient and family engagement as tailored, individually focused activities. Important insights can be gained from understanding the factors that are outside the control of health care organizations but relate to the hospital patient population (e.g., demographics, education level, socioeconomic status, housing conditions and neighborhood violence). These factors should also be considered when developing strategies and programs for engagement. With this knowledge, hospitals will be in a better position to develop effective programs to encourage behavior change.

Steps to Engage Health Care Consumers

A health care organization can approach health care user engagement by first knowing its own patients well—as individuals and population subgroups. Patient information can be collected and segmented by disease status, age, gender, geographic region, socioeconomic status, race, ethnicity, language preference, etc. This process of identifying the patient population ensures that information and programs provided are appropriate for the individuals and community served by the hospital.

Organizations must identify the results they hope to achieve before developing patient and family engagement programs. Having a clear vision for a proposed change can provide a road map for success. This requires an understanding of patient and family engagement, its importance and the behaviors that foster it.²⁸ Strategy for change begins with a strong leader, particularly someone who will advocate and participate in a visible way to move the initiative forward. Health care stakeholders also should actively listen and incorporate ideas suggested by the target patient population.

As when implementing any new initiative, changes in the workforce should be expected and addressed. Educating health care providers about the availability of these new programs and encouraging participation in ways that foster patient engagement are essential for success, particularly in understanding and acknowledging the different challenges at the patient level including cultural differences, socioeconomic status, language barriers and literacy levels, issues of noncompliance and lifestyle choices. Actively including clinical providers, health care staff and patients and their families in the planning and implementation process will help get buy-in and mutual support for change.

Communication is a two-way process and involves asking and listening by both sides. This two-way process ensures that hospital and clinical providers are addressing the concerns of patients and families, who also need to be reached through mediums and language that they prefer and can comprehend.

Once the appropriate programs have been implemented, they must be supported and sustained to achieve the best health outcomes. Too often, new programs are developed without outlining the shared set of expectations for both patients and providers. Therefore, infrastructure to support the initiative, such as ongoing training, providing internal incentives for participation and incorporating necessary improvements in a continuous manner, is essential.

Organizations must consistently measure outcomes at the individual level and in aggregate to monitor progress and make adjustments as needed. Progress should be monitored, whenever possible from the patient's perspective, and include measures of patient-reported outcomes along with measures of patient experience and clinical quality.

Case Studies: Engaging Health Care Users

The remaining sections of this report present various health care user engagement strategies that have been deployed at health care organizations throughout the United States, either independently or through external partnerships. These initiatives illustrate how patient and family engagement strategies can focus on populations large and small, and on frequent hospital users and those who need more preventive screening and support to change health behaviors. The initiatives also demonstrate how health care users have responded to engagement efforts. Results show that patients and families have a strong interest and willingness to be more actively involved in their health and care.

While some of these health care user engagement initiatives require large investments, successful, proven results can still be achieved for those that do not. Some of the strategies are more widespread than others and have already demonstrated specific benefits; other strategies will take more time to gain prevalence yet are still effective. Some initiatives are focused on a single site of care while others overlap sites. In addition, many health care user engagement initiatives have expanded to involve the community and the larger field of public health. Case studies are organized according to the Framework for Engaging Health Care Users (page 13) and include strategies for engagement at different levels of the health care system.

Community Level

- Customer-owned Model of Care at Southcentral Foundation
- The Congregational Health Network at Methodist Le Bonheur Healthcare
- Collaborative Effort to Reduce Readmissions at Griffin Hospital
- Public Health Partnership at Cambridge Health Alliance
- Total Community Health at Kaiser Permanente

Organization Level

- Organizational Level Partnerships at Georgia Health Sciences Health System
- Total Health Model at Bellin Health System
- Mission: Health at Sentara Healthcare
- WellnessWorks at Saint Elizabeth's Medical Center

Health Care Team Level

- Patient- and Family-Centered Rounds at Cincinnati Children's Hospital Medical Center
- Patient- and Family-Centered Rounds at Helen DeVos Children's Hospital
- Shared Decision Making at Informed Medical Decisions Foundation
- Bedside Change-of-Shift Reporting at Emory Healthcare
- Flexible Visiting Hours at Atlantic Health System
- ProvenHealth Navigation at Geisinger Health System

Individual Level

- Use of Personal Health Records at Howard University Hospital
- Patient-Driven Care at Ryhov Hospital

Strategies at the Community Level

To successfully engage health care consumers across the care system, hospitals are turning to nonclinical participants—employees and volunteers—to improve care outcomes. Hospitals are also pursuing partnerships with communities and public health entities to support patient and family self-management skills, participation in wellness activities and changes in local policies.

Customer-owned Model of Care at Southcentral Foundation

Southcentral Foundation

Southcentral Foundation (SCF) is a nonprofit health care organization owned by the Alaska Native people and located in Anchorage, Alaska. This customer-owned system of care, called the SCF Nuka System of Care, provides a range of medical, dental, behavioral and complementary medicine, traditional healing, home-based services and education. SCF, together with the Alaska Native Tribal Health Consortium, jointly owns the Alaska Native Medical Center, which includes a 150-bed hospital providing acute, inpatient and specialty care

Background

Before SCF transitioned to a customer-owned system, care was fragmented, patient satisfaction was poor and staff turnover was high. Alaska Native leaders decided to create a customer-owned system of care built on the values of Alaska Native people.

Intervention

SCF underwent a whole system transformation after moving from the Indian Health Service to a customer-owned system of care. Every aspect of the care system is designed by the customer-owners. The board of directors is made up of all customer-owners, and 54 percent of the workforce is customer-owners. In addition, a variety of approaches are utilized to listen to customer-owners—such as surveys and focus groups—and the feedback is incorporated into care delivery. A multidisciplinary team, called an Integrated Care Team (ICT) at SCF, consists of a primary care provider, a certified medical assistant, a full-time RN, case manager, an administrative assistant providing care coordination support, and a behaviorist. The ICT works together with a panel of customer-owners who have chosen their own primary care provider, and customer-owners develop a relationship with their chosen team.

SCF removes barriers to care by giving customer-owners access to the team's direct phone numbers and also encouraging email communication. If a problem cannot be handled over the telephone or by email, customer-owners get a same-day appointment with the appropriate member of the ICT.

Key elements of the system's success are the recruitment process and training and orienting staff to this approach. SCF conducts group interviews, uses behavioral interviewing techniques and makes same-day hiring decisions as often as possible. New hires have an extensive orientation and onboarding process that includes information about the customer-owner philosophy of care and the culture of the Alaska Native people. Front-desk employees receive additional training before beginning their positions and participate in a six-month mentoring process. All employees are trained in quality improvement. Clinical staff work in teams and are encouraged to work to their highest skill level.

Results

Since the implementation of this system, positive results have been achieved in utilization, customer-owner and employee satisfaction, and clinical quality outcomes.

Lessons Learned

Staff can initially be uncomfortable with the shifting of responsibilities created by encouraging the clinical team to work to the top of its level. Carefully screening and matching new employees with the right team, making sure that employees are trained in their new roles and providing them with appropriate supervision are all important factors in a successful transition.^{29, 30}

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The Congregational Health Network at Methodist Le Bonheur Healthcare

Congregational Health Network

The Congregational Health Network (CHN) is a partnership between Methodist Le Bonheur Healthcare and almost 400 churches in Memphis, Tennessee. CHN is designed to maintain a smooth transition from inpatient hospital admission to home.

Background

The African-American population in Memphis had a higher readmission rate than the rest of the population. Traditionally, this population had lower levels of support after discharge, and the church remained a powerful organization within the community. The health care system employs the equivalent of nine full-time employees at CHN, and more than 500 volunteers participate as well.

Intervention

CHN provides health education to parishioners and assigns parishioners as liaisons should any congregant need hospital care. Congregants that choose to be enrolled in CHN are flagged by the health care system's electronic health record upon hospital admission. A hospital-employed navigator meets with the flagged patient to establish his or her needs once discharged and then works with the affiliated congregation's volunteer health liaison to arrange post-discharge services and facilitate the transition back into the home. The church volunteer provides education and comfort to the patient.

The health care system approached each of the member churches to form a partnership. Participating CHNs are assigned according to level of involvement. Level of involvement by churches ranges from being a good health role model to a congregation with enrollees that participate in data analysis and help with further program development. Additionally, the health care system supports the liaisons, who communicate directly with patients to encourage program enrollment.

Results

More than 12,000 congregants from approximately 400 churches have signed up to be members of the program. CHN seeks regular input from church partners and also analyzes data to ensure ongoing progress and potential improvement. An analysis of 473 CHN participants found that the mortality rate was nearly one-half of the rate for nonenrolled patients with similar characteristics. The same study found that CHN members had lower health care charges than nonparticipants, lower inpatient utilization and higher patient satisfaction with the health care system.³¹

[Congregational Health Network at Methodist Le Bonheur Healthcare](#)

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Collaborative Effort to Reduce Readmissions at Griffin Hospital

Griffin Hospital

Griffin Hospital is a 160-bed acute care community hospital located in Derby, Connecticut. It is the flagship hospital for Planetree, Inc., an organization that promotes patient-centered care.

Background

Griffin Hospital examined its readmissions and determined that there were too many readmissions for patients with congestive heart failure. Hospital leaders realized they needed to extend their patient-centered model of care into the community and partner with long-term care organizations to do so. Leaders began by reaching out to nursing homes and home health facilities to gain a better understanding of each organization's role and the factors contributing to readmissions. Through this process, the hospital learned that (1) patients were getting too much sodium in their diets, a factor in many readmissions for CHF, (2) there were neither consistent programs for home care services after discharge nor follow-up with primary care and cardiac physicians and (3) each organization used different teaching tools and protocols.

Intervention

The hospital invited skilled nursing facilities and home health agencies to join a collaborative effort to reduce readmissions. This collaborative, Valley Gateway to Health, implemented a shared model of care transitions with standardized teaching tools and protocols for patients and providers.

Patients with CHF who arrive at the emergency department are seen by a multidisciplinary team consisting of a cardiologist, nutritionist, case manager and pharmacist. Each team member meets with the patient prior to discharge and ensures that the patient understands medical prescriptions, diet plans and exercise needs and recognizes which symptoms require a call to the cardiologist or primary care physician. An outpatient CHF clinic provides intravenous medications since many nursing homes are not licensed to do so in their facilities. The hospital follows up with patients and nursing homes weekly for one month after discharge. Physicians learn how to provide information at discharge in ways that patients can understand. The teach-back program was implemented, using a brochure developed by the University of North Carolina. The brochure provides information on actions patients can take to prevent readmissions. Nursing homes and home health facilities use the same brochure so that patients receive a consistent message.

Results

CHF readmissions fell from 15 percent to 7 percent during the course of the project. From 2010 through 2011, the internal heart to heart failure readmissions decreased from 13.2 percent to 8.6 percent, and heart failure to any readmission decreased from 30.2 percent to 23 percent.³²

Lessons Learned

The CHF population is largely elderly, so it is important to identify members of a patient's support system and educate them as well.³³

[Griffin Hospital
http://www.griffinhealth.org/](http://www.griffinhealth.org/)

Public Health Partnership at Cambridge Health Alliance

Cambridge Health Alliance

Cambridge Health Alliance (CHA) is an integrated health system located in Cambridge, Massachusetts. It includes three hospitals, 12 primary care practices, and specialty centers. CHA also provides public health services to the city of Cambridge.

Background

CHA implemented several public health community programs to address pediatric asthma, obesity and chronic disease management. First, the Childhood Asthma Program involves a collaboration of CHA with pediatricians, school nurses and local public health departments. Second, CHA developed a centralized complex care management team that interacts with patients extensively in the community. Third, CHA's Institute for Community Health and the Cambridge Health Department partnered to prevent obesity.

Interventions

Asthma: A web-based registry for pediatric patients was developed. The information is shared with parents and, with parental permission, school nurses, emergency departments, primary care physicians and community health workers. The registry tracks treatments and outcomes and provides decision support prompts. Children are grouped according to asthma severity. The care team works with patients to develop an asthma action plan and provides education. CHA also provides school-based peer support groups and has developed online tools and resources to support patients and families. Additionally, a nurse and community health worker from the Cambridge Health Department Healthy Homes project conducts home visits to assess environmental triggers and help asthma-proof the home.

Centralized care: The centralized complex care management program provides a multidisciplinary team of nurses, community health workers and social workers to engage high-risk and chronically ill patients in care and help them with a variety of clinically and nonclinically related tasks, such as transportation, housing and child care. These tasks may sound simple, but they are often very difficult for this population and can mean the difference between a well-managed disease and significant complications.

Obesity: CHA has long supported obesity prevention in the community through its partnerships with the Institute for Community Health, city leadership and local health and school departments. Community liaisons work with community organizations to develop programming and support policy change, while volunteer health advisors provide education on diabetes prevention at community events and local churches.

Results

Asthma: From 2002 to 2009, admissions for pediatric asthma fell by 45 percent, and pediatric emergency department visits fell by 50 percent. The return on investment (ROI) has been \$4 for every \$1 invested in the program.

Centralized care: The centralized complex care management program has generated a 5:1 ROI over its first six months of operation.

Obesity: In Cambridge, the proportion of children with healthy weight improved from 61 percent in 2004 to 62.4 percent in 2007, and the overall prevalence of obesity among a cohort of monitored children decreased by 2.2 percentage points ($p < 0.05$) from 20.2 percent to 18 percent. From 2004 to 2007, almost a quarter (24 percent) of children who were obese dropped to the overweight category, while 40 percent of children who were overweight moved into the healthy weight category.

Lessons Learned

Asthma: The asthma registry helps the care team be more proactive with managing asthma and helps to coordinate care. It also equips providers with data to identify and measure how well they are managing asthma patients. Having access to this type of data was extremely motivating for physicians.³⁴

Centralized care: The centralized complex care management team has reached out to patients in the communities where they live by using insurance and provider EMR data to target the highest risk patients. These patients are already incurring the highest health care costs or are predicted to have the highest costs.

Obesity: To curtail the obesity epidemic at the community level, strong relationships with community organizations, public health agencies, schools and city planners are required.

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Total Community Health at Kaiser Permanente

Kaiser Permanente

Kaiser Permanente is a health care provider and nonprofit health plan that serves more than 9 million members in nine states and the District of Columbia.

Background

At the core of Kaiser Permanente's mission is focusing on the continuum of health and not just health care. What hasn't always been central is explicitly talking about that full continuum. That shift was driven by comprehensive brand research asking members and nonmembers what was important to them. Their responses had very little to do with medical care; rather, they focused on relationships, levels of safety and security, and feelings of well-being. Kaiser Permanente leadership recognized the value of communicating how total health is not just the absence of illness but also a positive state that involves mind, body and spirit. To deliver on that promise, Kaiser Permanente deepened its commitment to extend beyond the medical setting to what is happening in the homes, neighborhoods and communities of the people it serves.

Intervention

To facilitate the journey to total health, Kaiser Permanente supports all aspects of a person's well-being and examines every aspect of the organization to determine how it contributes in a positive way to total health. Kaiser Permanente has created programs in both the clinic and the community to support the full continuum of health for members. Exercise as a Vital Sign is an innovative effort in which patients are asked about their level of physical activity and responses are recorded in the electronic health record. If fitness levels are low, patients are counseled on strategies for increasing activity, particularly by walking 30 minutes a day, five days a week.³⁵ For 25 years, Kaiser Permanente's Educational Theatre Program³⁶ has used live theater, music and dance productions to teach children and adults about healthy eating, physical activity and self-esteem. Environmental stewardship is also an important part of the total health philosophy, and the organization has committed to reducing greenhouse gas emissions and increasing how much locally produced, pesticide-free food it buys in all of its facilities.

Additionally, Kaiser Permanente continues to invest in Community Health Initiatives/Healthy Eating Active Living partnerships, which were first launched in 2004 and focus on prevention of obesity and its related diseases through improved healthy food choices and support for physical activity.

Results

The Community Health Initiatives have expanded from just three communities eight years ago to more than 40 locales today, supported by a cumulative investment of more than \$236 million. In addition, Kaiser Permanente has been a partner for high-profile health initiatives such as "The Weight of the Nation," the documentary and initiative targeting obesity in America; the Let's Move! initiative Michelle Obama kicked off to end childhood obesity within a generation; and the Partnership for a Healthier America, through which Kaiser Permanente committed publicly to offer healthier hospital food.

Lessons Learned

According to Kaiser Permanente, the most important lesson is that health systems don't have to "do it all" as they evolve into a health provider that extends care beyond the clinical setting. Looking at health through the model of the whole person—mind, body and spirit—removes the artificial distinction of community engagement as "nice to have" and instead positions it as an indispensable part of the organization's care model. A second key lesson is that health systems don't have to go it alone. Kaiser Permanente has advanced numerous community-based services by partnering with subject experts and organizations that benefit from Kaiser Permanente's resources and expertise. Kaiser Permanente was able to create a culture in which people look to health organizations not just for care, but as trusted partners in all facets of total health.

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Strategies at the Organization Level

Engaging patients and families at the organizational level provides an opportunity to integrate patient and family perspectives into all aspects of the care delivery process. Therefore, a culture that is conducive and supportive of engagement is essential at the organizational level. The 2011 AHA Long-Range Policy Committee Report, [A Call to Action: Creating a Culture of Health](#), highlights current health and wellness practices that hospitals have already established within their workforce. The report also provides examples of promising strategies and how-to recommendations to the field as health care organizations serve as drivers for change toward healthier communities.

Organizational Level Partnerships at Georgia Health Sciences Health System

Georgia Health Sciences Health System

Georgia Health Sciences Health System is located in Augusta, Georgia. The health care system consists of a 478-bed medical center, more than 80 outpatient practice sites, a critical care center and a 154-bed Children's Medical Center.

Background

The Georgia Health Sciences Medical Center and Children's Medical Center began a patient- and family-centered journey in the 1990s when families expressed interest in being more involved with care for their children in intensive care units. Parents began meeting regularly with ICU clinicians to discuss issues and provide feedback about the care. With the building of a new Children's Medical Center, there was an opportunity to involve patients and families in its design.

Intervention

Beginning with the pediatric units, a steering committee was established. Training sessions were held for staff and families to learn how to work together. A visioning retreat was held for hospital leaders to define core values and family-centered concepts, and priorities were identified and agreed upon. A family-centered services committee, which included staff and families, was formed to identify ways to integrate these concepts and strategies into all aspects of the hospital's operations. In the late 1990s, a strategic plan was developed to implement patient- and family-centered care throughout the organization. The position of Director of Family Services Development was created, and the hospital hired the mother of a child with special health care needs to make sure that patient and family perspectives were represented in all aspects of the care experience. Patient and family engagement was then spread to the adult campus.

To support this work, all new staff members received orientation on patient- and family-centered care and the role of patient and family advisors. Patient-centered behaviors were defined and included in position descriptions, performance evaluations and annual reviews.

Results

More than 200 patients and family advisors participate in advisory councils and hospital committees, including the children's advisory committee, Kids' ART (Architectural and Recreational Team), which gives recommendations to make the facilities more children friendly. Practice areas and affiliated ambulatory clinics also have a family advisory council. These patient and family advisors have provided input on key operational and strategic decisions including anesthesia staffing, medication dispensing, patient handoffs, patient and family rounding, patient safety and the design of new services. For example, patient and family advisors provided guidance for the design of the Neuroscience Center for Excellence, a patient care unit for stroke patients and individuals undergoing brain surgery. The new unit was designed with the goal of engaging families in care. In a three-year period, patient satisfaction scores increased and

medication errors declined. In addition, patient and family advisors serve as faculty to the Health Sciences University.

Lessons Learned

Senior leadership is key as leaders need to model the behaviors of patient- and family-centered care and continually find ways to encourage patient and family involvement.^{37, 38, 39}

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Total Health Model at Bellin Health System

Bellin Health System

Bellin Health System is a nonprofit integrated health care delivery system based in Green Bay, Wisconsin. It has two hospitals, located in Wisconsin and Michigan.⁴⁰

Background

Annual health care spending at Bellin Health System reached \$10 million in 2002, and that figure was projected to increase by \$3 million the following year.⁴¹ To slow this rise, Bellin Health System searched for innovative ways to reduce costs, while still improving availability and quality of care. The health care system developed and implemented the Total Health Model for its own workforce. Over the years, Bellin Health System slowed the growth of spending per employee through vigorous efforts aimed at improving efficiency.⁴²

Intervention

There are several components to the Total Health Model. The Bellin Health System: (1) uses health risks assessments and analysis of claims and productivity data to gain a better understanding of the health care needs of its employees, (2) offers comprehensive resources to help employees make sustainable lifestyle and behavior changes, such as providing health coaches, nutritionists, fitness experts, educational programs and support groups—all aligned with a primary care physician and medical home, (3) offers customized work solutions such as job matching, health and wellness services, ergonomics, workplace design, rehabilitation and case management and (4) provides a comprehensive navigation platform to guide patients and ensure they receive the appropriate level of care.⁴³

Results

Since 2002, the cost of employee health coverage at Bellin has not increased.⁴⁴ An estimated \$10 million savings in employee health costs was also projected over a five-year period.⁴⁵

The success of the Total Health Model drew other organizations to follow. Several medium-sized companies contracted Bellin Health System to establish clinics at their workplace so that minor ailments and injuries among employees are managed before they become serious.⁴⁶ This type of prevention and promotion of healthy living has had a tremendous fiscal impact on organizations that adopted them. The Fincantieri Marine Group, for example, was able to reduce total health care spending by \$2 million even though its workforce has expanded.⁴⁷ Similarly, Northeast Wisconsin Technical College estimates saving about half a million dollars per year, and the Foth Companies are saving a quarter of a million dollars per year. In some places, the model is slowing down health care spending. At LaForce Inc., spending grew less than 2 percent on average annually over the last four years.⁴⁸

Lessons Learned

Engaging and investing in the health of employees, with their active participation, can have a significant impact on both parties: Employers benefit from reduced health care costs and spending while employees benefit from quality care and improved health and well-being.

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Mission: Health at Sentara Healthcare

Sentara Healthcare

Sentara Healthcare is a nonprofit health care system headquartered in Norfolk, Virginia. It consists of 10 acute care hospitals and operates more than 100 sites in Virginia and North Carolina.⁴⁹ Sentara Healthcare has 3,680 medical providers and three medical groups with 618 providers.⁵⁰

Background

Sentara Healthcare found that 20 percent of employees were responsible for 80 percent of the organization's health care costs.⁵¹ Refusing to continually increase insurance co-payments and premiums among its employees, health care leaders at Sentara explored innovative ways to cut costs.⁵²

Intervention

In 2008, Sentara Healthcare in partnership with Optima Health—a sector of the former and its insurance carrier—established Mission: Health, an incentive-based wellness and disease management program. The program was developed to manage health care costs for more than 11,200 benefit-eligible employees in both the Virginia and North Carolina locations.⁵³ Nearly 80 percent of Sentara's employees participate in Mission: Health.⁵⁴

Employees complete a voluntary health profile that measures their risk factors. Those identified as low-risk receive more than \$500 in annual premium reductions while those considered high-risk are given an opportunity to earn the award by partnering with a health coach.⁵⁵ Additional incentives are also available to employees with targeted chronic diseases such as diabetes, coronary artery disease or congestive heart failure, or those who are pregnant. They are awarded an extra \$450 if they partner with diseases managers who monitor their medications, check-ups and other crucial health activities.⁵⁶

Results

Both employers and employees benefit from the program. During the first year, not only did employees receive monetary rewards, 85 percent of participants who were identified as high-risk and monitored in the program maintained or improved their critical health risks.⁵⁷

In 2010, Sentara Healthcare saved \$3.4 million in health care costs.⁵⁸ According to Michael M. Dudley, president and CEO of Optima Health, for every dollar spent to reward employees, the organization saved \$6.⁵⁹ In a more recent study, Sentara saved more than \$4 million in medical costs and sustained significant return on investment.⁶⁰ In addition, for every dollar invested in the program, Sentara saved \$2.70.⁶¹

Lessons Learned

The Mission: Health program at Sentara Healthcare demonstrates that investing in workforce wellness is beneficial to employees and employer. The wellness incentive program engages employees to maintain or improve their health through monetary rewards while helping employers reduce health care spending and adapt to rising costs.

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WellnessWorks at Saint Elizabeth's Medical Center

Saint Elizabeth's Medical Center

Saint Elizabeth's Medical Center, part of Ministry Health Care, is a 25-bed critical access hospital located in Wabasha, Minnesota.

Background

In 2003, Saint Elizabeth's Medical Center built a robust program, WellnessWorks, which includes a variety of wellness offerings for staff and family members. Its objectives were to create a culture of wellness, address high claims of utilization and serve as an example to the community.⁶²

Seeing great value in workforce wellness, Saint Elizabeth's Medical Center began campaigning for similar programs in the community.⁶³ The medical center started collaborating with local businesses to provide wellness screening for their employees.⁶⁴

Intervention

The wellness program at Saint Elizabeth's Medical Center encouraged employee participation in activities that promote physical exertion and improve nutrition. This later expanded to a more robust initiative that includes an on-site family wellness center, biometric screening/health risk assessment, clinical consultation/coaching, tobacco cessation and nicotine replacement products, LEARN Healthy Lifestyle series, Medication Therapy Management, chronic disease management programs, healthy cafeteria options and an abundance of wellness education, activities and resources.⁶⁵

In transforming the culture of health at Saint Elizabeth's Medical Center, the comprehensive wellness program catered to the needs of both high- and low-risk employees. In fact, it offered varying levels of participation based on health status and physical ability, ensuring a broad range of engagement in the workplace.

Many offerings of WellnessWorks are either free or discounted. In addition, the program provides monetary incentives to further encourage staff and family participation. For example, employees receive a \$50 reward for completing an annual physical, a yearly dental checkup, a flu shot and a biometric screening/consultation. They may also earn up to \$200 for completing tiered exercise and nutritional requirements.

Results

Over time, participation rates grew and health status improved among individuals in the program. Early in 2011, Saint Elizabeth's Medical Center reported that more than 60 percent of its workforce is participating in on-site wellness programs and activities.⁶⁶ Many employees are also adopting healthy habits and reducing risk factors.⁶⁷ Over a five-year period, participants experienced 67 percent reduction in high-risk total cholesterol, 36 percent reduction in high-risk LDL cholesterol and 56 percent reduction in pre-diabetes.⁶⁸

As the largest employer in the community, Saint Elizabeth's Medical has made its wellness efforts a paradigm for improving overall community health. The medical center is reaching out to local businesses, schools and other community organizations to share resources and knowledge.

Lessons Learned

Financial constraints make it challenging for Saint Elizabeth's Medical Center to hire staff dedicated to coordinating the wellness program. As a result, wellness committee members took on various roles. Wellness committee members emphasize that gaining administrative support, integrating wellness

initiatives into the strategic plan and continually enhancing and improving services through employee feedback are necessary to retaining participation.⁶⁹

Saint Elizabeth's Medical Center is a small, rural medical center, and it struggled to sustain cost savings since a small number of large claims—one or two—can have a significant impact on its small group market.⁷⁰ Through WellnessWorks, Saint Elizabeth's Medical Center found that it can reduce or at least maintain health care costs. According to Jim Root, vice president of human resources, investing in wellness can benefit the medical center up to \$6 in savings for every dollar spent in claims, absenteeism and lost productivity.⁷¹

[Saint Elizabeth's Medical Center](#)

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Strategies at the Health Care Team Level

Throughout the care continuum, clinicians have the most face time with health care consumers and are in the unique position to expand engagement strategies. Hospitals and health care systems should institute policies that encourage clinician-patient partnerships and increase patient involvement in their own care planning. Promising mechanisms include bedside rounding, bedside change-of-shift reports, patient- and family-activated rapid response teams, and medication reconciliation.

Patient- and Family-Centered Rounds at Cincinnati Children's Hospital Medical Center

Cincinnati Children's Hospital Medical Center

Cincinnati Children's Hospital Medical Center (CCHMC) is an academic teaching hospital with 577 beds. In 2001, the institution began the Robert Wood Johnson Foundation's Pursuing Perfection initiative, which includes the development of an interdisciplinary group of patients and parents to redesign patient-centered care delivery.

Background

Families were historically not included in rounding or in supporting the providers who conducted rounds. Families did not witness the decision-making process for future treatments and rarely participated as a result.

Intervention

Family representatives suggested that parents attend teaching rounds to improve communication. CCHMC did not perfect the model right away, but started with smaller changes to the rounding system to improve communication and analyze results. Families were interviewed throughout the trial implementation to describe their experiences, and changes were incorporated as necessary. CCHMC also instituted a patient and family experience committee to address unsolicited patient and family concerns. The goal was to address concerns as they happened, such as a delay in the operating room schedule, and while the family was still in the hospital so staff could strengthen the lines of communication and mitigate negative perceptions and feedback as much as possible. The intervention focused on the entire inpatient population at CCHMC.

The bundle of interventions that comprise family-centered care at CCHMC includes (1) determining patient preference for family-centered rounds, (2) using a patient/family preference card, (3) standardizing the format for rounds that solicit parent concerns, (4) developing a plan of care for each patient, such as preparing daily goals and listing them on a board in the patient's room as well as the electronic medical record and (4) agreeing on discharge criteria in a manner that the family can comprehend. An important focus is that the nurse who is caring for the patient is in the room during the rounds. In this family-centered model, patients and families are benefiting from providers who are available to answer questions and concerns.

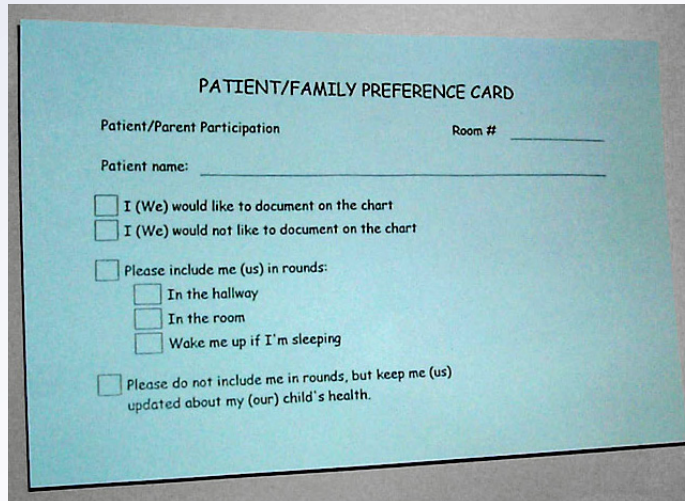
Results

CCHMC monitored feedback from all involved parties: nurses, residents, attending physicians and families. The process evolved based on this feedback, and within one year, family-focused teaching rounds were standard throughout the organization. CCHMC monitored patient and family satisfaction scores as well as anecdotal information from providers participating in the rounds to see where changes could be made.

Lessons Learned

Families determine their preferred rounding process when their child is admitted (see sample card in Figure 2), with staff explaining the process and opportunities for their participation. Initially, patients and families were given cards upon admission to indicate their rounding preference. Realizing that patient and family perspectives related to rounding may change during the course of the hospital stay, many inpatient units now offer patients and families the opportunity every day to participate in the rounding process.

Figure 2: Sample Blue (Patient/Family Preference) Card



PATIENT/FAMILY PREFERENCE CARD

Patient/Parent Participation Room # _____

Patient name: _____

I (We) would like to document on the chart

I (We) would not like to document on the chart

Please include me (us) in rounds:

- In the hallway
- In the room
- Wake me up if I'm sleeping

Please do not include me in rounds, but keep me (us) updated about my (our) child's health.

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Patient- and Family-Centered Rounds at Helen DeVos Children's Hospital

Helen DeVos Children's Hospital

Helen DeVos Children's Hospital is a 212-bed children's hospital located in Grand Rapids, Michigan. The hospital examined its patient rounding process and decided it needed to become more family-centered.

Background

Hospital leaders wanted the multidisciplinary team to engage the family and the patient and involve them in the decision-making process as well as help them participate in clinical readiness for discharge.

Intervention

The hospital completely revised its procedure for rounding to include the patient and family as active participants in the day's care plan. The family became the center of the rounding process. The team now utilizes the families' input, values the information they provide and asks them to actively participate in making the care plan. The team prepares families for rounding. The staff advises families in advance about the size of the care team that will be rounding, describes what to expect and encourages them to ask questions and voice concerns. When families miss rounding, the care team attempts to return later in the day to keep the family engaged.

Results

Patient and family rounds help empower families to have a trusting relationship with the health care team, increase their understanding of the care plan and create a safer culture for patient, family and staff. Since implementing family-centered rounds, nursing units have raised their patient satisfaction scores from below the 50th percentile to greater than the 90th percentile on a consistent basis. Although family-centered rounds may not be the only reason for these higher scores, families have responded positively about their involvement in rounds and feel better prepared for discharge.

Lessons Learned

It is important for staff to remember that the patient's family knows the patient best and the team must have an open mind when making a plan of care. Families are very willing to tell the team that something is not the best choice, particularly in cases involving children with complex medical needs. Utilizing what the patient and family have to say and putting them at the forefront of decision making are paramount. Changing the rounding process was a new experience for the hospital's health care team. In the past, rounds were medically driven and included a lot of medical terminology that patients and families did not understand.

The team no longer uses medical jargon during rounds but instead tries to talk in a way that patients can understand. Medical education now occurs outside of the patient's room. This has been a culture shift for the team as well as the patients and families involved.⁷²

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Shared Decision Making at Informed Medical Decisions Foundation

Informed Medical Decisions Foundation

Informed Medical Decisions Foundation (IMDF), founded in 1989 and based in Boston, Massachusetts, is a nonprofit organization working to advance research, policy and clinical models to ensure that patients understand their health care choices and have the information and support to make sound medical decisions.

Background

IMDF supports research projects on shared decision making at both primary and specialty care demonstration sites across the United States. In addition, IMDF: (1) facilitates a learning community, (2) provides patient surveys to help evaluate decision aids and their impacts, (3) provides access to a secure online data warehouse to capture patient survey data and (4) performs data analyses on survey process measures.⁷³

Currently, there are 10 demonstration sites representing a wide geography of rural and urban areas: a nationwide Breast Cancer Initiative, Dartmouth-Hitchcock Medical Center, MaineHealth, Massachusetts General Hospital, Mercy Clinics, Inc., Oregon Rural Practice-based Research Network, Palo Alto Medical Foundation, Stillwater Medical Group, University of California San Francisco Breast Care Center, and University of North Carolina at Chapel Hill. Each site consists of a variety of provider organizations serving a diverse patient population. Some sites are affiliated with large academic medical centers, and others are affiliated with independent community practices.

From the demonstration sites, a learning collaborative was formed. IMDF facilitated monthly calls so that members of the group could share implementation strategies—ideas, challenges and successes—on shared decision making. These teleconferences provide a platform for learning how to overcome barriers to successful implementation in real world clinical settings.

Intervention

IMDF has developed several tools to facilitate the shared decision-making model at its demonstration sites. The decision aids are presented in the form of text, graphics, video, personal stories, and more. These tools provide patients with information about a specific condition, evidence organized around a specific decision, charts and graphs, and other tools, in an unbiased manner. The tools are aimed at encouraging patients to understand evidence in the context of their own goals and engage in decision making with their physicians. IMDF recognizes the need for physicians to put shared decision making into action and is in the process of creating a usable provider tool for clinicians. IMDF now offers six steps of shared decision making that are focused on provider actions: (1) invite patients to participate, (2) present all available options in simple, easy-to-understand language, (3) provide information on benefits and risks, (4) assist patients in evaluating options based on their goals/concerns, (5) facilitate deliberation and decision making and (6) assist with decision making.

Results

According to the 2007 National Survey of Medical Decisions, participants who had made medical decisions reported talking more about why they might want to have a medical treatment than about why not to have the treatment. The findings suggest that patients are not getting balanced information about treatment options during discussions with providers.⁷⁴

In 2011, a study published online by the Cochrane Database of Systematic Reviews examined the impact of decision aids. From 86 trials in six countries of 34 different types of decisions, the study found that decision aid tools led to greater knowledge, higher accuracy in risk perceptions, lower decisional

conflicts, higher participation in the decision making and fewer individuals that were undecided about their care.⁷⁵ In another implementation project that introduced the tools for some health conditions with treatment decisions that were also highly sensitive to patients' and physicians' preferences, decision aids were linked to reduced rates of elective surgery and lower costs.⁷⁶ At Group Health, where this research was conducted, there were 26 percent fewer hip replacement surgeries, 38 percent fewer knee replacements and 12 percent to 21 percent lower costs over a six-month period.⁷⁷

Lessons Learned

To make informed decisions, patients must have adequate knowledge and understanding of issues related to their care.⁷⁸ Essential elements to support shared decision making include improving knowledge about the risks, benefits and characteristics of medical procedures; and incorporating patients' values and preferences into the decisions.

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Bedside Change-of-Shift Reporting at Emory Healthcare

Emory Healthcare

Emory Healthcare, a large academic teaching system in Atlanta, deployed a patient- and family-centered care transformation model in 2008.

Background

In partnership with patients and their families, Emory nursing staff created a set of evidence-based guidelines on items nurses should discuss during shift changes at the bedside. Conducting change-of-shift reports at the bedside provides another opportunity for patients and families to become involved in the care team and participate in the mutual sharing of information to ensure that patient, family and team priorities are identified.

Intervention

The goal of Emory's bedside change-of-shift reporting is to engage patients and their families as partners in goal setting, treatment decisions and education. Patient and family advisors helped develop and test the protocols with nurses. Outcome analysis revealed that patient satisfaction improved so much in intensive care units that bedside shift reporting was implemented throughout all acute care areas at four of the Emory hospitals. Patient and family advisors served as instructors to train all front-line clinical staff on the new initiative. Nurses received ongoing training and feedback when necessary and helped train new units that adopted the policy.

Results

Patient satisfaction increased. Press Ganey satisfaction scores for overall nursing care increased from the 41st percentile to 78th percentile, and patients' ratings of how well nurses kept them informed increased from the 43rd to 80th percentile. While these increases cannot solely be attributed to the bedside change-of-shift reports, a 2011 survey of the Emory nursing staff showed that the measure of overall partnership was highest in units that used bedside shift reports. Quality outcomes also improved. Hospital-acquired pressure ulcers decreased from 8.15 percent to 2.5 percent, and patient falls decreased from 3.24 to 2.85 per 1,000 patient days.

Lessons Learned

Bedside change-of-shift reporting enhanced the engagement of staff with patients and families.

Emory Healthcare
<http://www.emoryhealthcare.org/>

Flexible Visiting Hours at Atlantic Health System

Atlantic Health System

Atlantic Health System, New Jersey, owns and operates Morristown Medical Center, Overlook Medical Center, and Newton Medical Center. The three hospitals combined have 1,308 beds and more than 2,750 affiliated physicians. They provide a wide array of services and specialty areas including advanced cardiovascular care, pediatric medical and surgical specialties, neurology, orthopedics and sports medicine.

Background

To further encourage patient and family engagement, visiting hour restrictions were eliminated at three New Jersey hospitals in the Atlantic Health System: Morristown Medical Center, Goryeb Children's Hospital, and Atlantic Rehabilitation Institute. The open visitation policy was crafted with input from administration, nursing, medical staff, trustees, security, and patients and families.

Intervention

The new policy allowed for two visitors to be with a patient if both the patient and the floor nurse agreed that having visitors did not present any problems at that particular time. In the first five months of the open visitation policy, approximately 10,000 visitors came to the hospitals during the previously restricted time frames.

Results

Patient satisfaction scores at the hospitals increased. An internal staff survey showed strong support for continuing the open visitation policy.

Lessons Learned

Initial results from implementing the open visitation policy have been positive overall. With careful planning and policy implementation, the participating medical centers avoided much of the staff resistance toward unrestricted visiting hours.

(As of January 2013, a peer-reviewed journal article about Atlantic Health System's flexible visiting hours is pending.)

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ProvenHealth Navigation at Geisinger Health System

Geisinger Health System

Geisinger Health System is an integrated health services organization that serves more than 2.6 million residents in 44 counties in both central and northeastern Pennsylvania.

Background

With the care delivery system changing, Geisinger Health System began looking for ways to improve patient outcomes, quality of service and value of care. The organization's community practice service line—doctor's offices within the health care system—met and examined its structure and started discussing ways to provide higher value care to members and patients.⁷⁹ As a result, in 2006, Geisinger Health System and Geisinger Health Plan developed and established a medical home model, creating ProvenHealth Navigator.

ProvenHealth Navigator was designed to reduce downstream costs from the highest acuity by moving resources upstream.⁸⁰ In particular, more services are rendered in primary care as the starting point of the chain of care delivery. Successful upstream efforts are expected to reduce inpatient care costs and unnecessary duplication of service.⁸¹

Intervention

The medical home model is built upon a five-point framework: patient-centered primary care, integrated population management, medical neighborhood, quality outcomes and value-based reimbursement.⁸² With this framework, ProvenHealth Navigator “wraps a bundle of services around the patient and family and addresses healthy behaviors, disease prevention and disease management.”⁸³ These services include 24/7 phone access to a nurse care manager, same-day appointments and a primary-care office staff that facilitates access to community resources and helps patients understand medications and prescription coverage—all of which help decrease unnecessary hospitalizations.⁸⁴

Results

Geisinger's medical home model improved care coordination, enhanced patient access to primary care providers and provided more effective and efficient disease and case management. Additionally, studies show that ProvenHealth Navigator reduced costs over time. From November 2007 to December 2010, Geisinger's estimated total cumulative savings was 7.1 percent (based on the model that accounts for the prescription drug coverage interaction effects) and 4.3 percent (based on the model that does not account for the interaction effects).⁸⁵

Lessons Learned

Although it takes time to reap benefits from the redesign of care, cost savings are achievable.⁸⁶

[ProvenHealth at Geisinger Health](#)

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Strategies at the Individual Level

With the growth of health information technology and the use of social media, health care organizations are testing promising approaches to engage directly with individual patients to support information sharing, shared decision making and self-care. In some instances, individual patients are driving this change.

Use of Personal Health Records at Howard University Hospital

Howard University Hospital

Howard University Hospital is a private, nonprofit teaching hospital located in Washington, D.C.

Background

Fragmented care and changes in insurance plans, especially for the Medicaid population, prompted the leadership of Howard University Hospital to develop a program that gives patients access to an electronic personal health record and improves continuity of care.

Intervention

Howard University Hospital provided patients in its diabetes program with a free electronic personal health record (PHR), linked to the electronic medical record, to help them monitor a range of clinical indicators important to a diabetic's health, including blood sugar and weight. Clinicians are also able to check how their patients are doing and follow up with them between visits. Patients are invited to enroll in the program and get assistance setting up the PHR, with training and ongoing support.

Results

The program increased patient engagement, especially for patients with Medicaid insurance. Hemoglobin A1c levels fell by approximately 13 percent for patients participating in the program, compared to an increase in levels for those not participating.

Lessons Learned

Patients are more apt to use the program if clinicians use the data during visits with their patients. In addition, it is important to remove any barriers for use by patients, including making it easy for them to obtain passwords.

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Patient-Driven Care at Ryhov Hospital

Ryhov Hospital

Ryhov Hospital is a county hospital in Jönköping, Sweden, with a dialysis unit for patients with renal disease.

Background

Ryhov Hospital transitioned more than 52 percent of its traditional peritoneal and hemodialysis patients to a self-management program for patients undergoing dialysis. This change in approach was driven by a single patient seeking to take charge of his own care and improve his quality of life.

Intervention

A patient on dialysis at the hospital asked to learn how to perform self-dialysis. In response to this request, a nurse at Ryhov Hospital taught the patient how to use the dialysis machine, interpret lab values and document his care at the dialysis protocol. Shortly afterward, the patient was managing his own dialysis and experiencing fewer side effects of the treatment, such as nausea, edema and hypotension. The patient and the nursing staff took this success to the next level and began training other dialysis patients interested in self-dialysis. Patients document their blood pressure, weight, dryweight, blood flow, dialysis flow, symptoms, amount of water drawn, etc. on a report form, and the doctor or nurse enters their information in the record system.

Results

Currently 52 percent of Ryhov Hospital's dialysis patients are on self-dialysis. With the reduction in side effects from self-dialysis, patients have dialysis more often and infection rates have declined.

Lessons Learned

Responding to the preferences of patients and engaging them as full partners in care can result in better outcomes, fewer complications and increased patient and caregiver satisfaction.⁸⁷

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The Future of Health Care User Engagement

While there is a tremendous need to bridge the gap between consumers, health professionals and policymakers to increase health care user engagement, the case studies in this report demonstrate a collective awareness for change. Many hospitals and health care systems across the United States and in other countries have deployed engagement initiatives and implemented best practices with impressive results. Engaging consumers in health care is essential for transformation of the care system. As the case studies illustrate, health care user engagement requires a collaborative partnership and relationship among all stakeholders, including patients, families, communities, providers and other individuals involved in the health care industry.

The health care system is adapting to the ever-changing needs and demands of health care users. As the health care system evolves and user engagement matures, opportunities are created to dramatically improve health care delivery. Many promising technologies and practices are being tested, and many are yet to be discovered.

This report discusses many issues related to health care user engagement, but other emerging areas deserve appropriate attention. Though not discussed in as much detail in this report, these other topic areas are likely to have some significance in the future of health care user engagement, but they require further research to address questions surrounding them. These topic areas include:

- Consideration and integration of behavioral health and mental health as it relates to engagement at all four levels—community, organization, team and individual
- Health plans and their role as significant stakeholders in the engagement process
- Role of employers as drivers for creating a culture of health
- Current and emerging technologies that will facilitate patient, family and provider interactions; health education; treatments and overall engagement
- Social media and its role as a means to enhance communication and networking with individual and communities

Integration of Behavioral Health and Mental Health

Many health care professionals believe that people with serious mental illnesses have such impaired judgment or delusional beliefs that they cannot participate in making decisions about their own care and treatment.⁸⁸ Studies illustrate that many and perhaps most individuals with mental illnesses and their families can and want to participate in the decision making.^{89,90}

Several strategies that cater to the needs and wishes of mental health care users have been developed and implemented. One study demonstrated that integrated care programs that place a mental health specialist in primary care settings have higher levels of patient engagement and comparable clinical results and overall costs.⁹¹

Experts in the integration of primary care and behavioral health have emphasized the importance of a “warm handoff.” “Warm handoff” is the transition from the primary care provider to the behavioral health consultant. The PCP activates and engages patients with special needs by personally introducing them to the behavioral counselor to establish an initial rapport. As a result, this process increases the likelihood that the patient engages in behavioral health treatment.⁹²

Consumer-Centered Health Plans

In the past, health plans have taken a one-size-fits-all approach—that is, a provider-centered strategy to communicate information to individuals.⁹³ But over the years, health plans have begun to recognize the value of improving patient engagement, acknowledging that “increased compliance helps them save money and that the investment in reaching consumers the right way is more than offset by improving levels of engagement.”⁹⁴

In an effort to move away from this one-size-fits-all approach, some health plans are using the Patient Activation Measure (PAM) developed by Judith Hibbard, DrPH, a professor of health policy at the University of Oregon. The 13-question survey evaluates patients’ levels of engagement and measures their knowledge, skills, beliefs and confidence in managing their own health and care.⁹⁵ Using this measure, health plans are able to partner with and meet their members where they are on the engagement spectrum, helping them become better managers of their own health and effective health care users.

Among those already using the Patient Activation Measure is Medica, a regional health plan in Minneapolis with more than 1.6 million members.⁹⁶ Medica has reported saving \$19 to \$22 per month from each member in comparison with costs for the controls.⁹⁷ Regence BlueCross BlueShield, which has 2.2 million members in Oregon, Utah, Idaho and parts of Washington, also plans to use PAM later this year.⁹⁸ According to Ralph Prows, MD, chief medical officer at Regence BlueCross BlueShield, the organization is interested in using PAM as a yardstick for its programs, tools and techniques to measure and evaluate how patients are engaging with their doctors.⁹⁹

Other efforts are also underway to engage health care users in controlling health care costs. Some health plans are providing financial rewards to members who are choosing low-cost providers. Both Harvard Pilgrim Health Care and at least three plans affiliated with Anthem have implemented monetary incentives to draw the attention of members.¹⁰⁰ As a result, the SaveOn program of HPHC increased the volume of its most cost-efficient providers while the Compass SmartShopper program of Anthem was able to target high-volume elective procedures.¹⁰¹

Consumer-centered health plans demonstrate that engagement is a two-way stream that benefits both health care users and providers. With financial incentives, as seen in HPHC and the Anthem network, health care users become active participants in their care by being cognizant of the services they are receiving. By engaging members, health plans are able to control spending while rewarding members.

Culture of Health: Employer Wellness Programs

According to the Value-Based Health Care Baseline Benchmarking Survey, “a majority of multiemployer funds and public employers have realized the importance of sponsoring health management initiatives such as wellness and disease management programs that are at the core of a value-based health care system.”¹⁰² In the next two years, the survey projected that both multiemployer funds and public employer sectors will likely increase their emphasis on these areas because, when implemented together, wellness programs improve the health of employees, enhance their quality of life and lead to a culture of health within their organizations.¹⁰³

Because public and private sector employers have unique characteristics, their strategies must be tailored according to the different barriers in their organizations. Among these challenges are dispersed worker populations and the lack of employee engagement and sufficient financial incentives.¹⁰⁴ But despite challenges, these organizations are not only realizing the need to change but also are increasing their focus on value-based health care.¹⁰⁵

Emerging and Present Technology

Telemedicine

With technology expanding, some health care providers are now using online applications to interact with patients. Examples are Skype and California LiveVisit, a web-based telemedicine application that offers a secure platform for face-to-face and patient-to-provider visits. These video chat services are convenient for both health care users and providers because they allow for quick check-ins and follow-ups. This type of distant interaction encourages patients to stay at home while in recovery rather than spread contagious diseases, if any. In addition, providers, especially specialty physicians, are able to reach out and provide consultations to patients in a distant or remote location.

Online Patient Records

In a study—involving 105 physicians and 13,564 patients—conducted at Beth Israel Deaconess Medical Center, Geisinger Health System, and Harborview Medical Center, researchers found that patients were enthusiastic when provided access to their doctors' notes via a secure Internet portal.¹⁰⁶ A large majority of individuals accessed some or all of their doctors' notes and almost 90 percent believed that having this access would affect their decisions when seeking future care.¹⁰⁷ The Web proved to be an effective platform to expand transparency of medical records to patients. At the study's completion, 99 percent of patients at all three hospitals continued to access their visit notes, and none of the participating physicians elected to end this practice.

Online Health Resources

Not only does the Internet contain a plethora of information, it also serves as a valuable resource for engaging health care users. WebMD, for example, is a rich repository of health and science information. It provides patients with reliable medical knowledge that was previously unavailable to them, mainly due to their inability to acquire or discuss the information with a provider. Additionally, the website allows for active participation among health care users, through online blogging with research scientists and medical and public health experts.

Patient Engagement Systems

To engage patients, some hospitals are using televisions at the bedside to deliver information pertaining to their individual care. This practice has resulted in better patient outcomes, efficiency in the workflow of health care professionals and other hospital staff, and improved scores in patient satisfaction surveys.¹⁰⁸

Several hospitals and health care systems are now using patient engagement systems. LodgeNet's interactive e-suite system at NorthShore University HealthSystem allows patients to view preoperative videos at home, see their daily schedule when in the hospital and review home care instructions after discharge.¹⁰⁹ PCHI is an interactive TV channel designed to answer common questions and reduce anxiety during treatment for patients in Phoenix Children's Hospital.¹¹⁰ CareNavigator at Skylight Health Care Systems reinforces direct clinical care and has been a significant tool in reducing the amount of time nurses spend educating their patients.¹¹¹ GetWellNetwork, an interactive patient care system used at the University of Minnesota Amplatz Children's Hospital, engages patients by overlaying content on top of whatever channel the patient is watching, so they can respond quickly and easily to automated prompts.¹¹²

Collaboratively engaging patients, families and communities has the potential to be a “game changer” in the transformation of the health care system in our country. Hospitals and health care systems can serve as laboratories for developing, testing, learning and disseminating new engagement practices. The impact of the practice of health care user engagement and the role that hospitals can play in leading this transformative element of system redesign in their own communities are foundational for achieving the Triple Aim in health care.

Appendix: Center for Advancing Health Engagement Behavior Framework

1. Find Safe, Decent Care

- Find provider(s) who meet personal criteria (e.g., performance, cost, geographic access, personal style), will take new patients and accept personal insurance
- Use available comparative performance information (including cost data) to identify prospective providers
- Establish a relationship with a health care professional or group
- Use available comparative performance information (including cost data) to identify prospective health care facilities
- Seek and use the appropriate health care setting when professional attention is required

2. Communicate with Health Care Professionals

- Prepare in advance of outpatient and inpatient contact a list of questions/issues for discussion with the health care professional
- Bring list of all current medications (including supplements and alternative products) and be prepared to discuss their benefits and side effects
- Report accurately on the history and current status of physical and mental symptoms
- Ask questions when any explanations or next steps are not clear and express any concerns about recommendations or care experiences

3. Organize Health Care

- Make appointments; inquire about no-show policies; arrive on time
- Assess whether facility can accommodate unique needs (e.g., physical navigation, hearing or visual impairment, translation services) and arrange for assistance
- Bring documentation of health insurance coverage
- Bring another person to assist patient if frail, confused, unable to move around or unable to remember the conversation with the provider
- Bring a summary of medical history, current health status and recent test results to visits as appropriate
- Ensure that relevant medical information is conveyed between providers and institutions
- Obtain all test results and appointment records and maintain personal health record

4. Pay for Health Care

- Compare insurance coverage options, match to personal values, needs and preferences, and select coverage
- Gather and submit relevant eligibility documentation if applying for or seeking to maintain public insurance (e.g., Medicaid, Medicare, SCHIP), compare coverage options if applicable, match to patient's own values, needs and preferences, and select coverage
- Before seeking treatment: ascertain cost, benefit coverage restrictions and incentives such as mental health benefits limitations, pre-certification requirements, access restrictions to specialists or adjunct health providers, variables in co-pays for specific types of care or providers
- Maintain or adjust coverage in the event of unemployment, eligibility or family status changes (i.e., change of job, marriage, divorce, birth of child)
- Maintain all receipts for drugs, devices and services; submit any documentation of services and/or payments upon request or as needed for third-party payers (e.g., private insurance, medical/flexible health savings accounts or public payers) and submit payment; negotiate schedule and amount if necessary

5. Make Good Treatment Decisions

- Gather additional expert opinions on any serious diagnosis prior to beginning any course of treatment
- Ask about the evidence for the efficacy of recommended treatment options (risks and benefits)
- Evaluate treatment options
- Negotiate a treatment plan with the provider(s)

6. Participate in Treatment

- Learn about any newly prescribed medications and devices including possible side effects or interactions with existing medications and devices
- Fill or refill prescriptions on time, monitor medication effectiveness and consult with prescribing clinician before discontinuing use
- Maintain devices
- Evaluate and receive recommended diagnostic/follow-up tests in discussion with health care providers
- Monitor symptoms/condition including danger signs that require urgent attention (e.g., for diabetes—monitor glucose regularly, check feet; for depression—provide medication and/or counseling and monitor symptoms; for hypertension—measure blood pressure regularly, maintain blood pressure diary)

7. Promote Health

- Set priorities for changing behavior to optimize health and prevent disease and act on them
- Identify and secure services that support changing behavior to maximize health and functioning and maintain those changes over time
- Manage symptoms by following treatment plans, including diet, exercise and substance use, agreed upon by the patient and his or her provider

8. Get Preventive Health Care

- Evaluate recommend screening tests in discussion with health care provider
- Act on referrals for early detection screenings (e.g., breast cancer, colon cancer) and follow up on positive findings
- Get recommended vaccines and participate in community-offered screening/wellness activities as appropriate

9. Plan for the End of Life

- Complete advance directives and medical power of attorney, file with personal/home records
- Discuss with/deliver to family physician and other health care providers, appropriate family and/or significant others
- Review documents annually; update and distribute as needed

10. Seek Health Knowledge

- Assess personal risks for poor health, disease and injury and seek knowledge about maintaining health and caring for one's self
- If diagnosed with a chronic disease, understand the condition(s), the risks and benefits of treatment options and personal behavior change(s) by seeking opportunities to improve health/disease knowledge
- Know personal health targets (e.g., target blood pressure) and what to do to meet them

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Metrics for the Second Curve of Health Care

April 2013

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Resources: For information related to health care delivery transformation, visit www.hpoe.org.

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Table of Contents

Executive Summary.....	3
Introduction.....	4
Strategy One: Aligning Hospitals, Physicians and Other Providers Across the Continuum of Care.....	8
Strategy Two: Utilizing Evidence-Based Practices to Improve Quality and Patient Safety.....	10
Strategy Three: Improving Efficiency through Productivity and Financial Management.....	12
Strategy Four: Developing Integrated Information Systems.....	14
Measuring the Six Other Must-Do Strategies.....	16
Conclusion.....	17
Endnotes.....	18

Executive Summary

In 2011, the AHA Board Committee on Performance Improvement (CPI) identified ten must-do strategies for the hospital field to implement in order to survive and thrive in the transforming health care system. These strategies were identified in the groundbreaking report, *Hospitals and Care Systems of the Future*, found at <http://www.aha.org/about/org/hospitals-care-systems-future.shtml>.

Building off of health care futurist Ian Morrison’s first curve to second curve shift, CPI identified characteristics of the first curve (the volume-based curve) and the second curve (the value-based curve). Of the ten must-do strategies, four were identified as major priorities for health care leaders. “Metrics for the Second Curve of Health Care” expands on those strategies, focusing on the four imperative strategies:

1. Aligning hospitals, physicians and other clinical providers across the continuum of care
2. Utilizing evidence-based practices to improve quality and patient safety
3. Improving efficiency through productivity and financial management
4. Developing integrated information systems

In addition, there is another report hospitals and health care systems can use to self-assess and provide a road map on the first curve to second curve transition at <http://www.hpoe.org/future-roadmap-1to4>.

Table 1: Second Curve Evaluation Metrics (applicable to the hospital or the health care system)

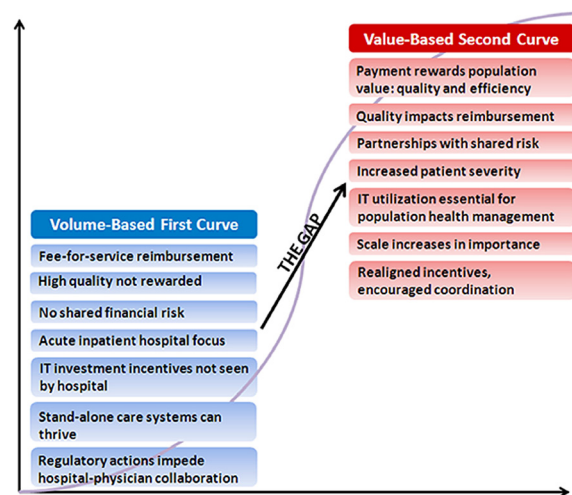
Strategy One: Aligning Hospitals, Physicians and Other Clinical Providers Across the Continuum of Care
<i>Percentage of aligned and engaged physicians</i>
<i>Percentage of physician and other clinical provider contracts containing performance and efficiency incentives aligned with ACO-type incentives</i>
<i>Availability of non-acute services</i>
<i>Distribution of shared savings/performance bonuses/gains to aligned physicians and clinicians</i>
<i>Number of covered lives accountable for population health (e.g., ACO/patient-centered medical homes)</i>
<i>Percentage of clinicians in leadership</i>
Strategy Two: Utilizing Evidence-Based Practices to Improve Quality and Patient Safety
<i>Effective measurement and management of care transitions</i>
<i>Management of utilization variation</i>
<i>Reducing preventable admissions, readmissions, ED visits, complications and mortality</i>
<i>Active patient engagement in design and improvement</i>
Strategy Three: Improving Efficiency through Productivity and Financial Management
<i>Expense-per-episode of care</i>
<i>Shared savings, financial gains or risk-bearing arrangements from performance-based contracts</i>
<i>Targeted cost-reduction and risk-management goals</i>
<i>Management to Medicare payment levels</i>
Strategy Four: Developing Integrated Information Systems
<i>Integrated data warehouse</i>
<i>Lag time between analysis and availability of results</i>
<i>Understanding of population disease patterns</i>
<i>Use of electronic health information across the continuum of care and community</i>
<i>Real-time information exchange</i>

Source: AHA, 2013.

Introduction

Hospitals and health care systems face common challenges in transitioning to a health care delivery system characterized by value-based payment focused on outcomes, population health management and a patient-centered, coordinated care-delivery approach. As hospitals and health care systems shift from the volume-based first curve to the value-based second curve, they must transform their business and health care delivery models to balance quality, cost, patient preferences and health status to achieve real value and outcomes.¹ Hospitals and health care systems that are moving to the second curve use performance metrics to identify clinical, financial, cultural and process improvements; incorporate appropriate incentives; and evaluate results. The AHA *Hospitals and Care Systems of the Future* report from 2011 (found at <http://www.aha.org/about/org/hospitals-care-systems-future.shtml>) outlined 10 must-do strategies, with four high-priority strategies required to be successful in the transformation from the first curve to the second curve.

Figure 1: First Curve to Second Curve



Source: Adapted from Ian Morrison, 2011.

This guide builds on the first report further detailing each of the four high-priority strategies and creating specific metrics to evaluate progress toward the next generation of essential hospital management competencies. Table 2 outlines the second curve evaluation metrics for the four high-priority strategies. The four high-priority strategies detailed in this report (bolded) and the additional six must-do strategies are:

- 1. Aligning hospitals, physicians and other clinical providers across the continuum of care**
- 2. Utilizing evidence-based practices to improve quality and patient safety**
- 3. Improving efficiency through productivity and financial management**
- 4. Developing integrated information systems**
5. Joining and growing integrated provider networks and care systems
6. Educating and engaging employees and physicians to create leaders
7. Strengthening finances to facilitate reinvestment and innovation
8. Partnering with payers
9. Advancing an organization through scenario-based strategic, financial and operational planning
10. Seeking population health improvement through pursuit of the “Triple Aim”

Table 2: Second Curve Evaluation Metrics (applicable to the hospital or the health care system)

Strategy One: Aligning Hospitals, Physicians and Other Clinical Providers Across the Continuum of Care	
<i>Percentage of aligned and engaged physicians</i>	
All affiliated physicians are aligned across all dimensions (structural relationships, financial interdependence, culture, strategic collaboration).	
All affiliated and employed physicians are engaged, collaborative and participative in all major strategic initiatives.	
Physician engagement survey data has been analyzed and improvement actions have been implemented with positive results.	
Recruiting and contracting include an assessment of cultural fit as well as a formalized “compact” or code of conduct with mutually agreed on behaviors, values and mission for all physicians.	
<i>Percentage of physician and other clinical provider contracts containing performance and efficiency incentives aligned with ACO-type incentives</i>	
Significant level of reimbursement risk associated with new payment models (bundled payments, two-sided shared savings with both upside and downside risk, or capitation payments).	
Participating in an ACO or PCMH model across a significant population, utilizing value-based incentives.	
All payment contracts, payment and compensation models are linked to performance results.	
<i>Availability of non-acute services</i>	
Full spectrum of ownership, partnership or affiliation of health care services available to patients.	
<i>Distribution of shared savings/performance bonuses/gains to aligned physicians and clinicians</i>	
All clinicians’ performance is measured and they receive benchmark data on performance against peers.	
Most clinicians share financial risk and rewards linked to performance, and many have received distributions of shared savings or performance bonuses.	
<i>Number of covered lives accountable for population health (e.g., ACO/patient-centered medical homes)</i>	
Active participation in a population health management initiative (e.g., chronic disease management, prevention) for a defined population.	
Able to measure the attributable population for health management initiatives and a sizable population is enrolled.	
<i>Percentage of clinicians in leadership</i>	
Active clinical representation at the leadership or governance level (30 percent or above).	
Physicians and nurse executives are leading development of strategic transformation initiatives.	
Strategy Two: Utilizing Evidence-Based Practices to Improve Quality and Patient Safety	
<i>Effective measurement and management of care transitions</i>	
Fully implemented clinical integration strategy across the entire continuum of care to ensure seamless transitions and clear handoffs.	
Fully implemented use of multidisciplinary teams, case managers, health coaches and nurse care coordinators for chronic disease cases and follow-up care after transitions.	
Measurement of all care transition data elements. Data is used to implement and evaluate interventions that improve transitions.	
<i>Management of utilization variation</i>	
Regular measurement and analysis of utilization variances, steps employed to address variation and intervention effectiveness analyzed on a regular basis.	
Providing completely transparent, physician-specific reports on utilization variation.	
Regular use of evidence-based care pathways and/or standardized clinical protocols on a systemwide basis for at least 60 percent of patients.	

<i>Reducing preventable admissions, readmissions, ED visits, complications and mortality</i>
Regular tracking and reporting on all relevant patient safety and quality measures.
Data commonly used to improve patient safety and quality, with positive results observed.
<i>Active patient engagement in design and improvement</i>
Regular use of patient-engagement strategies such as shared decision-making aids, shift-change reports at the bedside, patient and family advisory councils and health and wellness programs.
Regular measurement or reporting on patient and family engagement, with positive results.
Strategy Three: Improving Efficiency through Productivity and Financial Management
<i>Expense-per-episode of care</i>
Tracking expense-per-episode data across every care setting and a broad range of episodes to understand the true cost of care for each episode of care.
<i>Shared savings, financial gains or risk-bearing arrangements from performance-based contracts</i>
Measuring, managing, modeling and predicting risk using a broad set of historical data across multiple data sources (e.g., clinical and cost metrics, acute and non-acute settings).
Implementing a financial risk-bearing arrangement for a specific population (either as a payer or in partnership with a payer).
<i>Targeted cost-reduction and risk-management goals</i>
Implemented targeted cost-reduction or risk-management goals for the organization.
Instituted process re-engineering and/or continuous quality-improvement initiatives broadly across the organization and demonstrated measurable results.
<i>Management to Medicare payment levels</i>
Projected financial impact of managing to future Medicare payment levels for the entire organization; cost cuts to successfully manage at that payment level for all patients.
Strategy Four: Developing Integrated Information Systems
<i>Integrated data warehouse</i>
Fully integrated and interoperable data warehouse, incorporating multiple data types for all care settings (clinical, financial, demographic, patient experience, participating and non-participating providers).
<i>Lag time between analysis and availability of results</i>
Real-time availability for all data and reports through an easy-to-use interface, based on user needs.
Advanced data-mining capabilities with the ability to provide real-time insights to support clinical and business decisions across the population.
Advanced capabilities for prospective and predictive modeling to support clinical and business decisions across the population.
Ability to measure and demonstrate value and results, based on comprehensive data across the care continuum (both acute and non-acute care).
<i>Understanding of population disease patterns</i>
Robust data warehouse, including disease registries and population disease patterns to identify high-risk patients and determine intervention opportunities.
Thorough population data warehouse that measures the impact of population health interventions.
<i>Use of electronic health information across the continuum of care and community</i>
Fully integrated data warehouse with advanced data mining capabilities that provides real-time information in order to identify effective health interventions and the impact on the population.
<i>Real-time information exchange</i>
Full participation in a health information exchange and utilizing the data for quality improvement, population health interventions and results measurement.

Source: AHA, 2013.

Metrics for the Second Curve of Health Care enables hospital leaders to evaluate current position and progress along the continuum toward meeting second-curve metrics. It also provides organizations (or organizations in affiliation with other partners) with guidance on measures to help them assess potential gaps and provide a road map for planning future improvements. Additionally, the AHA, through its performance improvement strategy, *Hospitals in Pursuit of Excellence*, develops educational resources, including best practices, to help hospitals and health care systems bridge any gaps and successfully navigate the transformation to the second curve.

The time frame for transitioning to the second curve may be dependent on each hospital's or health care system's marketplace, but significant transformation across the health care field is expected to occur in the next three to five years. Some markets are moving more quickly toward the second curve, based on payer, competitor and other market pressures; others are moving more slowly.

Moving too quickly could have a negative impact on margin or other operations as organizations shift from volume-based reimbursement approaches to value-based payment approaches. The speed of transformation also is dependent on the organization's resources or the resources provided through the organization's partnerships or affiliations. However, this report provides direction to prepare for future capability development (either individually or with a partner/affiliation). Regardless of the market or where the health care organization falls on this continuum, it is important to strive for quality improvement, increased efficiency and IT capability development in order to move to a value-based care approach.

Strategy One: Aligning Hospitals, Physicians and Other Providers Across the Continuum of Care

It is increasingly important to align, engage and integrate providers into the organization. Second-curve hospitals and health care systems have clear physician/provider performance measures tied to payment incentives. Increasingly, provider contracts are incorporating performance rewards that are aligned with accountable care organization-type incentives. These incentives focus on quality, efficiency, patient experience, care coordination, population health management, patient safety and at-risk population care. Hospitals that form Medicare ACOs operate under a different set of rules and legal restraints than private sector ACOs, including antitrust laws, information privacy and security concerns and insurance regulation with the assumption of risk.

Successful alignment includes the availability and integration of non-acute services. Non-acute services include chronic disease management, preventive medicine, outpatient services, rehabilitation care, behavioral health and long-term care. As a result, alignment with multidisciplinary teams, including acute care and non-acute care providers, and non-clinical staff is necessary. When successful alignment occurs across the care continuum, all responsible parties are accountable and work under a care system with a patient-centered approach that rewards performance.²

One approach to improve provider alignment is strengthening providers' strategic relationships with hospitals and health care systems. Physicians are seeking employment and other affiliations with hospitals and health care systems due to the ever-increasing administrative costs, regulatory burdens and the difficulty of remaining a financially viable independent practice.³ Additionally, as health care organizations move to provide care to populations across the entire continuum, they are seeking stronger relationships with primary care and non-acute care providers. To increase engagement, hospitals and health care systems also are increasing the number of clinicians in leadership positions.

Table 3 provides six evaluation categories, or criteria, that hospital or health care systems can use to track progress toward the first high-priority strategy. Accompanying each criterion are detailed metrics that hospitals and health care systems can use to evaluate their progression from the first curve to the second curve.

Table 3: Evaluation Metrics for Strategy One (applicable to the hospital or the health care system)

First Curve 1.0 Transitioning in the Gap Second Curve 2.0		
<i>Percentage of aligned and engaged physicians</i>		
Limited structural physician alignment that exists through relationships (ownership, partnership, affiliation) or other collaboration.	Moderate degree of physician alignment with some financial interdependence, structural relationships or collaboration on strategic initiatives.	All affiliated physicians are aligned across all dimensions (structural relationships, financial interdependence, culture, strategic collaboration).
Minimal level of engagement and collaboration among affiliated and employed physicians on strategic initiatives.	Moderate degree of engagement and collaboration among affiliated and employed physicians on strategic initiatives.	All affiliated and employed physicians are engaged, collaborative and participative in all major strategic initiatives.
Physicians have not been surveyed on engagement.	Physician engagement survey data has been analyzed ; however, no corrective actions have been implemented.	Physician engagement survey data has been analyzed and improvement actions have been implemented with positive results.
Physician recruitment and contracting process do not include assessment or formalized agreement on cultural/mission fit.	Recruitment and contracting process for all physicians includes a cultural fit assessment and some degree of formal code of conduct linked to behavior and mission.	Recruiting and contracting include an assessment of cultural fit as well as a formalized " compact " or code of conduct with mutually agreed on behaviors, values and mission for all physicians.

<i>Percentage of physician and other clinical provider contracts with performance and efficiency incentives aligned with ACO-type incentives</i>		
No initiation of new payment models based on performance or value.	Moderate degree of payment models or moderate risk models (bundled payments, shared savings and capitation payments).	Significant level of reimbursement risk associated with new payment models (bundled payments, two-sided shared savings with both upside and downside risk, or capitation payments).
No participation in or exploration in adopting an ACO or patient-centered medical home model (PCMH).	Participating in a pilot ACO or PCMH program.	Participating in an ACO or PCMH model across a significant population, utilizing value-based incentives.
No payment contracts, payment models or compensation linked to performance measures.	Some contracts, payment models and compensation tied to performance rewards related to quality, efficiency and patient experience.	All payment contracts, payment and compensation models are linked to performance results.
<i>Availability of non-acute services</i>		
No partnership, ownership or affiliation to offer non-acute care services.	Some ownership, partnership or affiliation to offer selected aspects of non-acute care.	Full spectrum of ownership, partnership or affiliation of health care services available to patients.
<i>Distribution of shared savings/performance bonuses/gains to aligned physicians and clinicians</i>		
Clinicians' performance measures are not tracked or reported .	Some clinicians' performances are measured and they receive benchmark data on performance against peers.	All clinicians' performances are measured and they receive benchmark data on performance against peers.
Limited portion of clinicians receive a distribution of shared savings or incentive rewards linked to performance.	Selected clinicians receive a distribution of shared savings or incentive rewards linked to performance	Most clinicians share financial risk and rewards linked to performance, and many have received distributions of shared savings or performance bonuses.
<i>Number of covered lives accountable for population health (e.g., ACO/patient-centered medical homes)</i>		
No patients participate in population health management or ACO initiatives.	Pilot programs on a population health management are available to patients.	Active participation in a population health management initiative (e.g., chronic disease management, prevention) for a defined population.
No ability to determine the attributable population for health management initiatives.	Limited ability to determine the attributable population for health management initiatives.	Able to measure the attributable population for health management initiatives and a sizable population is enrolled.
<i>Percentage of clinicians in leadership</i>		
Limited clinical representation at the leadership or governance level (10 percent or less).	Stronger clinical representation at the leadership or governance level (10 to 30 percent).	Active clinical representation at the leadership or governance level (30 percent or above).
Physicians and nurse executives have limited roles in development of strategic transformation initiatives.	Physicians and nurse executives are involved to a moderate degree in leading development of strategic transformation initiatives.	Physicians and nurse executives are leading development of strategic transformation initiatives.

Source: AHA, 2013.

Strategy Two: Utilizing Evidence-Based Practices to Improve Quality and Patient Safety

Measurement of quality and safety improvement initiatives is critical for hospitals and health care systems moving to the second curve. New value-based models tie quality metrics to payment, encouraging hospitals and health care systems to use evidence-based practices and increase the organization's accountability for high-quality outcomes. Although many systems conduct measurement and data collection on utilization variation and quality issues, they need to intensify data analysis to identify performance improvement opportunities across the care continuum, develop standardized care processes, implement evidence-based protocols and train staff on clinical quality-improvement methods.

Collecting data on care transitions, readmissions, preventable admissions, mortality and other quality metrics allows health care organizations to identify variations in care, providing opportunities for clinical quality or process improvement. Evidence-based practices guide quality-improvement interventions and hospitals can utilize a variety of different performance improvement methods, such as Lean, Six Sigma, and Baldrige. Data from multiple sources, including patients and families, are necessary to identify and evaluate improvement interventions. Patient and family engagement in decision making is critical to generate positive health outcomes and increased satisfaction. Table 4 addresses specific metrics to evaluate readiness and achieve success on the second high-priority strategy.

Table 4: Evaluation Metrics for Strategy Two (applicable to the hospital or the health care system)

First Curve 1.0 → Transitioning in the Gap → Second Curve 2.0		
<i>Effective measurement and management of care transitions</i>		
Limited patient education and coordination after discharge.	Moderate degree of patient outreach and follow-up after care transition; some care coordination tools used to manage care transitions	Fully implemented clinical integration strategy across the entire continuum of care to ensure seamless transitions and clear handoffs.
No use of team-based approaches or case managers for chronic disease management or follow-up for at-risk patients after discharge.	Limited use of multidisciplinary teams, case managers or nurse care coordinators for chronic disease cases and follow-up care.	Fully implemented use of multidisciplinary teams, case managers, health coaches and nurse care coordinators for chronic disease cases and follow-up care after transitions.
Limited measurement of care transition data.	Some measurement of care transition data; no analysis conducted on the results.	Measurement of all care transition data elements. Data is used to implement and evaluate interventions that improve transitions.
<i>Management of utilization variation</i>		
No measurement of utilization variation; no processes to minimize variation.	Relatively consistent measurement and analysis; limited action to address variation.	Regular measurement and analysis of utilization variances occur, steps are employed to address variation and intervention effectiveness is analyzed on a regular basis.
Limited reporting on utilization variation with limited transparency or physician specificity.	Utilization variation reports created with moderate transparency or physician specificity.	Provides completely transparent, physician-specific reports on utilization variation.
No evidence-based practices or protocols to standardize care practices.	Some use of data-driven analysis to reduce variation in clinical practice and identify opportunities for standardization.	Regular use of evidence-based care pathways and/or standardized clinical protocols on a systemwide basis for at least 60 percent of patients.

<i>Reducing preventable admissions, readmissions, ED visits, complications and mortality</i>		
No comprehensive tracking of patient safety or quality metrics.	Limited tracking of patient safety or quality measures; some analysis of results.	Regular tracking and reporting on all relevant patient safety and quality measures.
No review process on quality performance for any care settings.	Simple review process on quality performance in certain care settings.	Data commonly used to improve patient safety and quality, with positive results observed.
<i>Active patient engagement in design and improvement</i>		
Provides various sources of patient education and information, but lacking a comprehensive patient engagement strategy.	Uses various patient surveys; no in-depth analysis or connection to engagement strategies is made.	Regular use of patient-engagement strategies such as shared decision-making aids, shift-change reports at the bedside, patient and family advisory councils and health and wellness programs.
No regular measurement or reporting on patient and family engagement.	Some regular measurement or reporting on patient and family engagement, with limited results.	Regular measurement or reporting on patient and family engagement, with positive results.

Source: AHA, 2013.

Strategy Three: Improving Efficiency through Productivity and Financial Management

In the transforming health care environment, health care systems face an ever-increasing demand for efficiency in productivity, care delivery and financial management. As commercial payers reduce volume-based reimbursement levels, health care systems have a reduced ability to offset government payments and uncompensated care. As a result, health care organizations need to enhance their financial management capabilities to understand the true cost of care (per episode as well as on a per member, per month basis), focus on targeted cost-reduction goals, begin managing to Medicare payment levels throughout the entire organization, as well as demonstrate value and performance results.

As payment models shift to the value-based second curve, health care systems must manage in the curve gap to remain financially healthy. It is increasingly important for health care leaders to implement strategic cost-management approaches and focus on financial planning efforts while the payment system moves from volume- to value-based contracts. Leaders need to evaluate the implications of new payment models, tracking shared savings and financial gains from these performance-based contracts. These contracts can range from simple shared-savings models with upside risk to the health system, to two-sided shared savings (both upside and downside risk), partial or global capitation and bundled payments.⁴ These value-based arrangements call for cost reduction while improving care quality and patient-engagement outcomes.⁵

As payers seek ways to bend the cost curve and increasingly use Medicare payment levels as a benchmark, hospitals are pressured to improve efficiency and cost effectiveness. According to “Managing to the Medicare Margin,” produced by Sg2 consulting group (<http://www.youtube.com/watch?v=uZdNeaBDwLA>), hospitals and health care systems will have to reduce costs by 13.9 percent if Medicare covered every patient. In order to prepare for these cost-reduction strategies hospitals need to prepare for Medicare-based payment levels. Reviewing internal and external benchmarks against operating budgets can assist in identifying specific cost-reduction goals. Financial management also must involve increased productivity through continuous process improvement, clinical care standardization and the elimination of variation in patient procedures.⁶ Table 5 charts the evaluation metrics associated with strategy three.

Table 5: Evaluation Metrics for Strategy Three (applicable to the hospital or the health care system)

First Curve 1.0 → Transitioning in the Gap → Second Curve 2.0		
Expense-per-episode of care		
No tracking of expense-per-episode of care in any setting.	Tracks expense-per-episode data in selected care settings or certain episodes.	Tracks expense-per-episode data across every care setting and a broad range of episodes to understand the true cost of care for each episode of care.
Shared savings, financial gains or risk-bearing arrangements from performance-based contracts		
Lacks data or financial risk modeling tools resulting in limited ability to manage or measure risk.	Moderate ability to manage and measure risk (limited data collection, limited data analytics or limited ability to accept risk payment arrangements).	Measures, manages, models and predicts risk using a broad set of historical data across multiple data sources (e.g., clinical and cost metrics, acute and non-acute settings).
No financial risk (either as a payer or in partnership with a payer).	Evaluating a financial risk-bearing arrangement for a specific population (either as a payer or in partnership with a payer).	Implementing a financial risk-bearing arrangement for a specific population (either as a payer or in partnership with a payer).

<i>Targeted cost-reduction and risk management goals</i>		
No targeted cost-reduction or risk-management goals for the organization.	Created targeted cost-reduction or risk-management goals for specific services or departments.	Implemented targeted cost-reduction or risk-management goals for the organization.
No process or continuous quality-improvement interventions incorporated (Lean, Six Sigma, etc.).	Initiated process or quality-improvement interventions and captured initial data on the interventions.	Instituted process re-engineering and/or continuous quality-improvement initiatives broadly across the organization and demonstrated measurable results.
<i>Management to Medicare payment levels</i>		
No projections on the financial impact of managing to future Medicare payment levels.	Projected financial impact of managing to future Medicare payment levels for a limited scope of care settings.	Projected financial impact of managing to future Medicare payment levels for the entire organization; cost cuts to successfully manage at that payment level for all patients.

Source: AHA, 2013.



Strategy Four: Developing Integrated Information Systems

In order to achieve these must-do strategies, hospitals and health care systems need to develop integrated information systems that incorporate multiple, disparate data sources across the care continuum. An integrated IT system should include a comprehensive data warehouse with clinical, financial, demographic and patient satisfaction data. Integrated information systems enable connectivity across providers and a complete view of patients' health histories at the point of care, resulting in better clinical decision making.

The performance of second-curve hospitals and health systems is dependent on advanced analytics and timely business intelligence capabilities that provide real-time decision support. Analytical capabilities, such as data mining, are critical to provide data and trends for real-time decision support. These capabilities also can help decrease administrative overhead, reduce duplicative tests or treatments, decrease medication errors and improve coordination of care across settings.⁷

Health care organizations moving to the second curve must have the ability to analyze and leverage data to evaluate quality-improvement interventions, predict financial risk, make informed business decisions, manage population health and assess process improvement performance results. Data registries and health information exchanges allow providers to access historical and robust data across a larger population base. Table 6 provides the evaluation metrics to assess progress toward meeting strategy four.

Table 6: Evaluation Metrics for Strategy Four (applicable to the hospital or the health care system)

First Curve 1.0  Transitioning in the Gap  Second Curve 2.0		
<i>Integrated data warehouse</i>		
No data integration across continuum of care.	Possesses a data warehouse with a limited amount of data sources (e.g., acute care and some non-acute care data).	Fully integrated and interoperable data warehouse, incorporating multiple data types for all care settings (clinical, financial, demographic, patient experience, participating and non-participating providers).
<i>Lag time between analysis and availability of results</i>		
Data analysis and reporting not widely available or easily accessible.	Limited amount of standard reports on key performance measures available.	Real-time availability to all data and reports through an easy-to-use interface, based on user needs.
No data-mining capabilities.	Limited data-mining capabilities on a subset of data or for certain delivery settings.	Advanced data-mining capabilities with the ability to provide real-time insights to support clinical and business decisions across the population.
No predictive modeling capabilities.	Limited predictive modeling capabilities on a subset of data or for certain delivery settings.	Advanced capabilities for prospective and predictive modeling to support clinical and business decisions across the population.
No ability to measure or demonstrate value and results.	Limited ability to measure and demonstrate value and results.	Ability to measure and demonstrate value and results based on comprehensive data across the care continuum (both acute and non-acute care).

<i>Understanding of population disease patterns</i>		
No examination of population disease patterns.	Limited examination of population disease patterns (e.g., focus on certain diseases or targeted population groups).	Robust data warehouse, including disease registries and population disease patterns to identify high-risk patients and determine intervention opportunities.
No ability to identify high-risk/high-utilization patients.	Limited ability to identify high-risk/high-utilization patients and conduct interventions.	Thorough population data warehouse that measures the impact of population health interventions.
<i>Use of electronic health information across the continuum of care and community</i>		
Limited electronic health information, limited interoperability between systems.	Most health information is available electronically, 80 percent of patient information is in a certified EHR, some interoperability exists between systems and limited population health data is included.	Fully integrated data warehouse with advanced data mining capabilities that provides real-time information in order to identify effective health interventions and the impact on the population.
<i>Real-time information exchange</i>		
No participation in a regional or other type of health exchange.	Partial participation in a regional or other type of health exchange.	Full participation in a health information exchange and utilizing the data for quality improvement, population health interventions and results measurement.

Source: AHA, 2013.

Measuring the Six Other Must-Do Strategies

Future guides will focus on the additional six strategies and provide specific metrics. As a starting point, Table 7 outlines the additional strategies. Commonalities exist across these six strategies and the four high-priority strategies, so metrics associated with one strategy may be relevant for evaluating other strategies.

Table 7: Potential Metrics for Strategies Five through Ten

Strategy Five: Joining and Growing Integrated Provider Networks and Care Systems
Care arrangements and redesigned workforces that increase integration
Primary-care service arrangements that increase coordination across the continuum of care
Post-acute care services and integration with acute-care providers
Working with partners and other organizations on integrated care delivery
Structural ownership, partnership or affiliation arrangements that enable integrated care delivery
Alignment of clinical staff and other workforce to the organization's mission, vision, values and strategic priorities
Strategy Six: Educating and Engaging Employees and Physicians to Create Leaders
Formal leadership education program for employees, physicians and other clinicians
Formal leadership development and mentoring opportunities within the organization
Engagement of the employee population on culture and key strategic improvement initiatives
Strategy Seven: Strengthening Finances to Facilitate Reinvestment and Innovation
Identification and access to necessary capital finances for innovation initiatives
Quality-improvement initiatives tied to financial goals
Strategy Eight: Partnering with Payers
Contracts with payers aligning risk and reward
Contracts and partnerships with different payers on new initiatives to transform delivery or financing of care (commercial, regional, government, self-insured employers, etc.)
Contracts including clinical quality, patient experience/satisfaction, cost/efficiency and second-generation value indicators
Strategy Nine: Advancing an Organization through Scenario-Based Strategic, Financial and Operational Planning
Incorporation of flexible, systematic strategic planning with financial and operational capabilities
Incorporation of scenario-based planning including risk assumptions
Strategy Ten: Seeking Population Health Improvement through Pursuit of the "Triple Aim"
Implementation of the Institute for Healthcare Improvement's Triple Aim initiative
Development of population health programs
Tracking and measurement of population health management initiatives relative to evidence-based practices

Source: AHA, 2013.

Conclusion

For hospitals and health care systems to meet the second-curve challenges, leaders must create and measure organized processes. The second curve will require value, integration, the ability to meet patient expectations and clinician engagement on all levels. Although the four high-priority strategies outline different aspects of the care delivery system, all of the strategies address the shift toward value-based care delivery, with special consideration for managing in the gap. Using these metrics, leaders can evaluate progress in meeting the challenges of a dynamic, evolving health care environment. This guide will help leaders manage in the gap while payment models continue to evolve to a value-based system.

Endnotes

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Second Curve Road Map for Health Care

April 2013

HRET
HEALTH RESEARCH &
EDUCATIONAL TRUST
In Partnership with AHA

Online survey tool accessible at:
<http://www.hpoe.org/future-roadmap-1to4>

Resources: For information related to health care delivery transformation, visit www.hpoe.org.

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Contact: hpoe@aha.org or (877) 243-0027

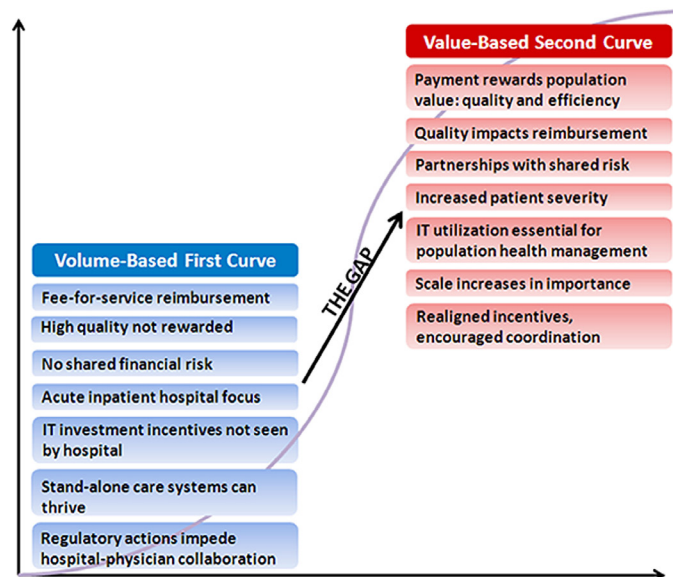
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Second Curve Road Map for Health Care

Hospitals and health care systems face common challenges in transitioning to a health care delivery system characterized by value-based payment focused on outcomes, population health management and a patient-centered, coordinated care delivery approach. In 2011, the AHA *Hospitals and Care Systems of the Future* report (found at <http://www.aha.org/about/org/hospitals-care-systems-future.shtml>) identified ten must-do strategies for the hospital field to implement in order to survive and thrive in the transforming health care system.

Building off of health care futurist Ian Morrison's first curve to second curve shift, the AHA identified characteristics of the first curve (the volume-based curve) and the second curve (the value-based curve). The 2011 report outlined 10 must-do strategies, with four high-priority strategies required to be successful in the transformation from the first curve to the second curve. Hospitals and health care systems that are moving to the second curve use performance metrics to identify clinical, financial, cultural and process improvements; incorporate appropriate incentives; and evaluate results. In 2013, the American Hospital Association further defined the performance metrics for these 10 must-do strategies in the report, *Metrics for the Second Curve of Health Care* (found at <http://www.hpoe.org/future-metrics-lto4>).

Figure 1: First Curve to Second Curve



Source: Adapted from Ian Morrison, 2011.

This road map builds on both the 2011 and 2013 AHA reports to further detail each of the four high-priority strategies and create more specific metrics to evaluate progress toward the next generation of essential hospital management competencies. It will help you assess your hospital's progress in the transition from the volume-based first curve to the value-based second curve.

Completing the *Second Curve Road Map for Health Care* will enable hospital leaders to determine their current position and progress along the continuum toward meeting the second curve metrics. This information can provide your organization with guidance on the metrics that will be important for health care systems of the future, will enable you to assess potential gaps and provide a road map for planning future improvements within your hospital (or in affiliation with other partners).

The time frame for transitioning to the second curve will depend on your marketplace, but significant transformation across the health care field is expected to occur over the next three to five years. Some markets are moving more quickly toward the second curve, based on payer, competitor and other market pressures; others are moving more slowly. Moving too quickly could have a negative impact on margin or other operations as your organization shifts from volume-based reimbursement approaches to value-based payment approaches. Regardless of your market or where your health care organization falls on this continuum, it is important to strive for quality improvement and increased efficiency, while preparing for value-based payment approaches.

The AHA will use the collected data to identify operational gaps and create educational resources, including best practices and guides, to help hospitals and health care systems bridge these gaps.

Metrics for the four high-priority strategies below (bolded) are detailed in the *Metrics for the Second Curve of Health Care* report and this road map. Several preliminary metrics are also included for the additional six must-do strategies. The 10 must-do strategies are:

- 1. Aligning hospitals, physicians and other clinical providers across the continuum of care**
- 2. Utilizing evidence-based practices to improve quality and patient safety**
- 3. Improving efficiency through productivity and financial management**
- 4. Developing integrated information systems**
5. Joining and growing integrated provider networks and care systems
6. Educating and engaging employees and physicians to create leaders
7. Strengthening finances to facilitate reinvestment and innovation
8. Partnering with payers
9. Advancing an organization through scenario-based strategic, financial and operational planning
10. Seeking population health improvement through pursuit of the “Triple Aim”

While completing this assessment, please refer to the 2011 [Hospitals and Care Systems of the Future](#) and 2013 [Metrics for the Second Curve of Health Care](#) reports, as each report explains metrics for the high-priority, must-do strategies for transitioning to the second curve. In addition, the 2013 report contains tables for each of the four high-priority strategies with metrics showing a general range of capabilities, which can help determine your current position and guide your answers.

You should respond to the survey questions on behalf of your hospital and where it is **currently positioned** on these metrics. If you are a leader of a hospital that is also part of a larger health care system, you may answer either from the perspective of your hospital or from the perspective of your health care system, but please indicate in the “Background Demographics” section from which perspective you are responding (hospital versus health care system level).

To take the survey online and to submit your data to AHA [click here](http://www.hpoe.org/future-road-map-1to4) (<http://www.hpoe.org/future-road-map-1to4>). If you have any questions, please contact Thomas Duffy, Hospitals in Pursuit of Excellence program manager, at tduffy2@aha.org.

Instructions

The assessment has five sections. The first four sections are focused on the four highest priorities or must-do strategies. The fifth section includes evaluation metrics for six other important strategies for shifting to the second curve.

For each strategy, evaluation statements (or metrics) are provided to assess your hospital’s current position. For example:

1) All of our hospital’s or health care system’s physicians are completely aligned across the entire care delivery spectrum, regardless of organizational structure (physicians could be employed, privileged, affiliated or contracted).

Not Applicable	No agreement	Minimal agreement	Moderate agreement	Strong agreement	Complete agreement
N/A	0	1	2	3	4
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

To complete the assessment, please answer all questions using a score of 0 to 4, or N/A, indicating your level of agreement with each statement. The assessment’s total score range is 0 to 340 points, with higher scores indicating further progression toward second curve capabilities. At the end of the survey, your scores will be totaled and you will see a summary of your results compared to these categories:

- 0 – 136 = Limited transition toward the second curve
- 137 – 238 = Moderate transition toward the second curve; currently managing in the “gap”
- 239 – 340 = Generally operating in the second curve

When evaluating each statement in the survey, please refer to the scoring scale below. Indicate the degree to which you agree with each statement using a score of 0–4.

- 0 = no agreement
- 1 = minimal agreement
- 2 = moderate agreement
- 3 = strong agreement
- 4 = complete agreement

Background Demographics

Demographic Information	
Hospital name	
City	
State	
Bed size	
If part of a larger system, are you responding on behalf of your hospital or your larger health care system?	
<ul style="list-style-type: none"> Please check one: <input type="checkbox"/> Hospital or <input type="checkbox"/> Health care system 	

Strategy One: Aligning Hospitals, Physicians and Other Clinical Providers Across the Continuum of Care

Statement	Score (0–4 or N/A)
Scoring Scale: 0 = no agreement, 1 = minimal agreement, 2 = moderate agreement, 3 = strong agreement, 4 = complete agreement	
<i>Percentage of aligned and engaged physicians</i>	
1. All of our hospital’s or health care system’s physicians are completely aligned across the entire care delivery spectrum, regardless of organizational structure (physicians could be employed, privileged, affiliated or contracted).	
2. We are developing new physician alignment relationship strategies (e.g., physician-hospital organizations, clinical co-management, ACOs, employment or joint ventures).	
3. All of our physicians have financial interdependence with the hospital (i.e., joint financial success or risk is dependent on both the hospital and the physicians).	
4. All physicians affiliated or employed with our hospital are aligned with (and are champions for) our mission, vision and culture.	
5. All physicians affiliated or employed with our hospital are highly engaged, collaborative and participative in all major strategic initiatives.	
6. Improvements in physician engagement have been made that incorporate results from analysis of physician engagement survey data.	
7. Our physician recruiting efforts assess cultural fit including expected behaviors, values and mission (for all employed, privileged, contracted and affiliated physicians).	
8. Our physician contracts include a formalized “compact” or code of conduct with mutually agreed on behaviors, values and mission for all physicians (employed, privileged, contracted and affiliated).	
<i>Percentage of physician and other clinical provider contracts containing performance and efficiency incentives aligned with ACO-type incentives</i>	
9. We have a significant level of reimbursement risk associated with a bundled payment through a <u>commercial health plan</u> .	
10. We have a significant level of reimbursement risk associated with a bundled payment initiative through <u>Medicaid</u> .	
11. We have a significant level of reimbursement risk associated with a bundled payment initiative through <u>Medicare</u> .	

Statement	Score (0–4 or N/A)
Scoring Scale: 0 = no agreement, 1 = minimal agreement, 2 = moderate agreement, 3 = strong agreement, 4 = complete agreement	
12. Our hospital or health care system has or is developing affiliated, accredited medical homes with <u>Medicare</u> .	
13. Our hospital or health care system has or is developing affiliated, accredited medical homes with <u>Medicaid</u> .	
14. Our hospital or health care system has or is developing affiliated, accredited medical homes with a <u>commercial ACO</u> .	
15. All of our hospital’s or health care system’s payment contracts, payment models and compensation are linked to performance results (e.g., clinical outcomes, value-based care).	
16. We have implemented new payment models for <u>acute care</u> such as bundled payments, two-sided shared savings, partial or global capitation payments.	
17. We have implemented new payment models for <u>non-acute care</u> such as bundled payments, two-sided shared savings, partial or global capitation payments.	
<i>Availability of non-acute services</i>	
18. We have a full spectrum of health care services available across both acute and non-acute care (through ownership, partnerships or other affiliations).	
19. We are developing nontraditional partnerships to provide non-acute care for the population (e.g., payers, employers, community organizations, post-acute care affiliations).	
<i>Distribution of shared savings/performance bonuses/gains to aligned physicians and clinicians</i>	
20. We measure all clinical providers on performance results.	
21. We report feedback on physicians’ and other clinical providers’ performance against peers and benchmarks.	
22. All clinical providers across the entire spectrum of care share financial risk and rewards linked to performance.	
23. A large portion of our clinical providers have received a distribution of shared savings or performance incentives.	
<i>Number of covered lives accountable for population health (e.g., ACO/patient-centered medical homes)</i>	
24. Our hospital or health care system is participating actively in population health management initiatives for a defined population in <u>chronic disease management</u> .	
25. Our hospital or health care system is participating actively in population health management initiatives for a defined population in <u>prevention and wellness programs</u> .	
26. Our hospital or health care system is participating actively in population health management initiatives for a defined population in <u>dental care</u> .	
27. Our hospital or health care system has or is determining the threshold population size for participation in a medical home.	
28. We are able to measure the attributable population to be included in health management initiatives.	
29. A significant percentage of our hospital’s or health care system’s income and/or patients are covered by population health models such as ACOs or patient-centered medical homes.	

Statement	Score (0–4 or N/A)
<i>Percentage of clinicians in leadership</i>	
30. 30 percent or more of our hospital's or health care system's leadership roles (in active management positions) are filled by clinicians (e.g., physicians or nurse executives).	
31. A significant percentage of our hospital's or health care system's governance roles are filled by clinicians (e.g., physicians or nurse executives).	
32. Clinicians are leading the implementation of strategic, transformation initiatives through other organizational leadership positions (e.g., committee leadership).	
STRATEGY ONE SCORE	

Strategy Two: Utilizing Evidence-Based Practices to Improve Quality and Patient Safety

Statement	Score (0–4 or N/A)
Scoring Scale: 0 = no agreement, 1 = minimal agreement, 2 = moderate agreement, 3 = strong agreement, 4 = complete agreement	
<i>Effective measurement and management of care transitions</i>	
33. We have a fully implemented clinical strategy across the entire continuum of care to ensure seamless transitions and clear handoffs of responsibility.	
34. We utilize a multidisciplinary, team-based approach to ensure care coordination.	
35. We have fully implemented the use of case managers, health coaches and nurse care coordinators for chronic disease cases and follow-up care after transitions.	
36. We analyze all care transition data elements to evaluate the effectiveness of care transitions.	
37. All patient transitions are handled appropriately so transitions are safe and complete, have excellent communication and information exchange, and no one loses sight of the patient during the process.	
38. We implement interventions based on care transition data results to improve the care transition process.	
<i>Management of utilization variation</i>	
39. We regularly measure, analyze and report on utilization variances.	
40. We evaluate the impact of evidence-based interventions.	
41. We identify specific physician results in a transparent manner when reporting on utilization variations.	
42. We reliably use evidence-based care pathways and/or standardized clinical protocols on a systemwide basis for at least 60 percent of patients.	
<i>Reducing preventable admissions, readmissions, ED visits, complications and mortality</i>	
43. We regularly report on all relevant data points on patient safety and quality (e.g., preventable admissions, readmissions, ED visits, mortality rates, complications, infections, falls).	
44. Based on timely patient safety and quality data analysis, we implement quality improvement interventions.	
45. We have observed positive results from our interventions to improve patient safety.	

46. We have implemented new chronic disease management care delivery initiatives to prevent future hospitalizations (e.g., proactive coaching to help change lifestyle behaviors, training on team-based disease management, working with nontraditional partners and community organizations).	
<i>Active patient engagement in design and improvement</i>	
47. We regularly use patient engagement strategies such as shared decision-making aids, shift-change reports at the bedside, patient and family advisory councils, motivational interviewing and/or health and wellness programs.	
48. We regularly measure and report on patient and family engagement.	
49. We have experienced an increase in patient and family engagement, including the effectiveness, use and uptake of our patient-centered strategies and tools.	
STRATEGY TWO SCORE	

Strategy Three: Improving Efficiency through Productivity and Financial Management

Statement	Score (0–4 or N/A)
Scoring Scale: 0 = no agreement, 1 = minimal agreement, 2 = moderate agreement, 3 = strong agreement, 4 = complete agreement	
<i>Expense-per-episode of care</i>	
50. We track expense-per-episode data across every care setting and across a broad range of episodes.	
51. We analyze our expense-per-episode data to understand the true cost of care for entire episodes.	
<i>Shared savings or financial gains from performance-based contracts</i>	
52. We measure, manage, model and predict risk using a broad set of historical data across multiple data sources (e.g., clinical and cost metrics, acute and non-acute settings).	
53. We have implemented a financial risk-bearing arrangement for a specific population (either as a payer or in partnership with a payer).	
54. We assess our ability to achieve long-term financial sustainability and scope required to succeed in value-based performance contracting (e.g., evaluating opportunities to achieve economies of scale through consolidation or joint ventures, or participating in affiliations/partnerships for virtual integration).	
<i>Targeted cost-reduction and risk-management goals</i>	
55. We have implemented targeted <u>cost-reduction</u> goals for the organization.	
56. We have implemented targeted <u>risk-management</u> goals for the organization.	
57. We have instituted process re-engineering and/or continuous quality improvement initiatives broadly across the organization (e.g., Lean/Six Sigma, Baldrige).	
58. We demonstrated measurable results from our process re-engineering or continuous quality improvement initiatives.	
<i>Management to Medicare payment levels</i>	
59. We currently project financial impact of managing to future Medicare payment levels for the entire organization.	

60. We have cut costs to successfully manage at future Medicare payment levels for all patients.	
STRATEGY THREE SCORE	

Strategy Four: Developing Integrated Information Systems

Statement	Score (0–4 or N/A)
Scoring Scale: 0 = no agreement, 1 = minimal agreement, 2 = moderate agreement, 3 = strong agreement, 4 = complete agreement	
<i>Integrated data warehouse</i>	
61. We have a fully integrated data warehouse, incorporating multiple data types for all care settings (clinical, financial, demographic, patient experience, participating and nonparticipating providers).	
62. We have a fully interoperable data warehouse, enabling seamless interface, connectivity and data exchange across multiple systems (acute and non-acute providers, participating and non-participating providers).	
<i>Lag time between analysis and availability of results</i>	
63. Our hospital or health care system provides real-time availability for all data and reports through an easy-to-use interface, based on user needs.	
64. We have advanced data-mining capabilities with the ability to provide real-time insights to support clinical and business decisions across the population.	
65. We conduct prospective/predictive modeling to support clinical and business decisions across the population.	
66. We have the ability to measure and demonstrate value and results/outcomes based on comprehensive data across the care continuum (both acute and non-acute care).	
<i>Understanding of population disease patterns</i>	
67. Our hospital or health care system possesses a robust data warehouse, including disease registries and population disease patterns to identify high-risk patients.	
68. We utilize a population health data warehouse to identify intervention opportunities and develop appropriate care programs.	
69. We have a thorough population health data warehouse that measures the impact of population health interventions.	
<i>Use of electronic health information across the continuum of care and community</i>	
70. Our hospital or health care system has a fully functioning electronic health record across all settings of care.	
<i>Real-time information exchange</i>	
71. Our hospital or health care system fully participates in a health information exchange.	
72. We utilize health information exchange data for quality improvement, population health interventions and results measurement.	
STRATEGY FOUR SCORE	

Additional Must-Do Strategies

Statement	Score (0–4 or N/A)
Scoring Scale: 0 = no agreement, 1 = minimal agreement, 2 = moderate agreement, 3 = strong agreement, 4 = complete agreement	
73. We have fully developed relationships with primary care services, post-acute services and other care organizations for fully integrated, coordinated care delivery across the entire care spectrum.	
74. We have a formal leadership education and/or development program for staff (employees, physicians and other clinicians).	
75. We engage staff on the organization’s mission, vision and strategic priorities through education, communication and involvement in planning sessions.	
76. We have <u>identified</u> both short-term and long-term financial needs for IT capital projects and other innovation initiatives.	
77. We have <u>accessed</u> the short-term and long-term capital required for IT projects and other innovation initiatives.	
78. Our hospital or health care system has or is developing new types of contracts with payers focused on <u>care delivery transformation</u> .	
79. Our hospital or health care system has or is developing new types of contracts with payers focused on <u>value-based financing approaches</u> .	
80. Our hospital or health care system has or is developing new types of contracts with payers focused on <u>population health management</u> .	
81. Our hospital or health care system has or is developing new types of contracts with payers focused on <u>patient engagement and experience</u> .	
82. Most of our contracts with commercial health plans include <u>clinical quality indicators</u> .	
83. Most of our contracts with commercial health plans include <u>patient experience indicators</u> .	
84. Most of our contracts with commercial health plans include <u>efficiency performance indicators</u> .	
85. Our hospital or health care system regularly utilizes scenario-based planning along various dimensions and incorporates risk assumptions.	
ADDITIONAL STRATEGY SECTION SCORE	

TOTAL ROAD MAP SCORE	
-----------------------------	--

- 0 – 136 = Limited transition toward the second curve
- 137 – 238 = Moderate transition toward the second curve; currently managing in the “gap”
- 239 – 340 = Generally operating in the second curve

Any additional comments?

If you would like to complete the online version of the survey and submit your answers to AHA [click here \(http://www.hpoe.org/future-roadmap-1to4\)](http://www.hpoe.org/future-roadmap-1to4).

Signature Leadership Series
Focus on Population Health



The Role of Small and Rural Hospitals and Care Systems in Effective Population Health Partnerships

June 2013

Resources: For information related to health care delivery transformation, visit www.hpoe.org.

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Table of Contents

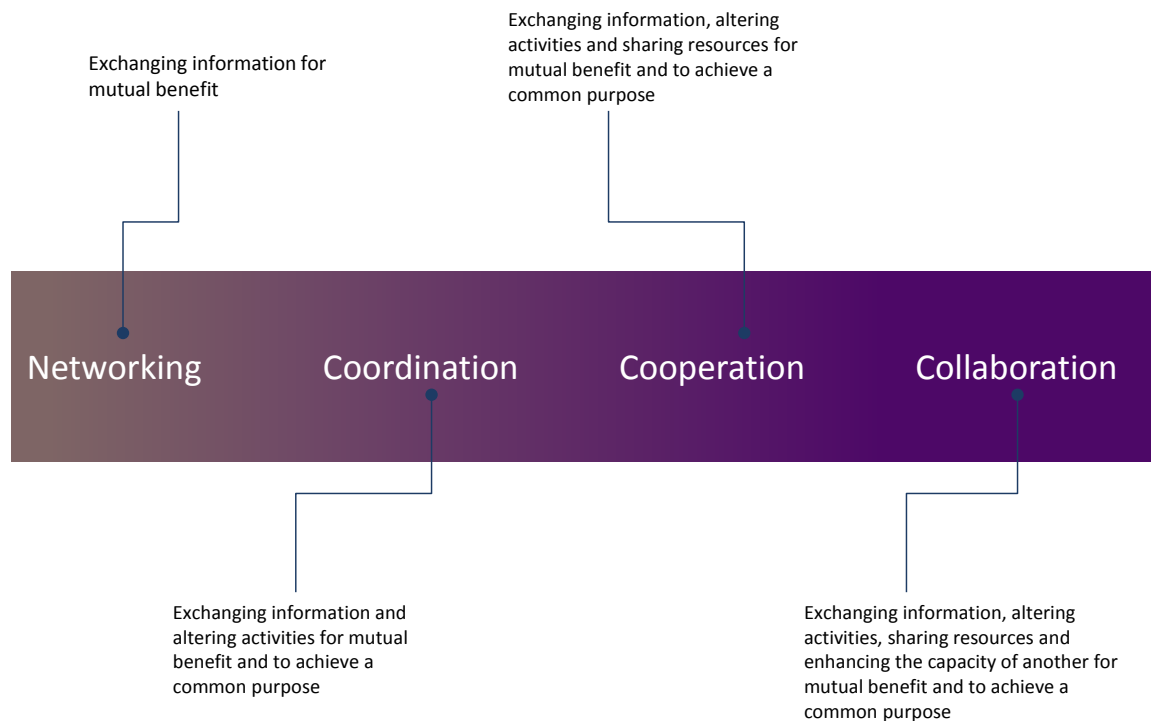
Executive Summary.....	3
Introduction.....	6
Population Health Definition.....	6
Challenges and Opportunities.....	8
Developing an Effective Partnership	10
Strategies for Creating Effective Population Health Partnerships.....	11
Potential Partners and Resources.....	12
Types of Partnerships.....	13
Developing a Collaboration.....	14
Conclusion.....	17
Case Study: New Ulm Medical Center, Minnesota.....	18
Case Study: Wrangell Alaska Medical Center.....	20
Case Study: Mt. Ascutney Hospital and Health Center, Windsor, Vermont	21
Case Study: Yuma Hospital District, Colorado.....	22
Case Study: Cheyenne Regional Medical Center, Wyoming.....	23
Resources.....	24
Endnotes.....	25

Executive Summary

Rising health care costs and greater demand for quality outcomes have led to a shift toward value-based payment models focused on better population health management. These market dynamics, along with new care delivery models and payment reform, are challenging hospitals and health care systems to develop population health approaches focused on prevention, improved chronic disease management and wellness activities. Hospitals and care systems that engage the community prepare themselves to meet these opportunities. Each type of hospital or care system—academic medical center, integrated health system, independent hospital, and small and rural hospital—engages the local community by providing resources, sharing knowledge and developing relationships and skills to manage its challenges and leverage its advantages.

To become an effective population health manager, a hospital must create effective partnerships. This guide describes how small and rural hospitals and care systems can develop effective population health partnerships that balance the challenges and opportunities encountered in providing health management. Hospitals and care systems can use one of several types of partnerships, as described in Figure 1.

Figure 1. Types of Population Health Partnerships



Source: Adapted from Robert Pestronk's *Collaborating for Healthy Communities* and Arthur T. Himmelman's *Collaboration for a Change: Definitions, Decision-making Models, Roles and Collaboration Process Guide*, 2013.¹

Additionally, by using a checklist and a defined framework for population health partnerships, small and rural hospitals and care systems can work to form strong, well-structured relationships with community partners (see Figures 2 and 3).

Figure 2: Population Health Partnership Checklist

Leadership and Governance Roles	
	All primary and secondary partners have developed a decision-making model (committee structure, board, coalition and community infrastructure).
	Agreement has included representation and composition of leadership and governance group.
	Specific partner skills and competencies are aligned to the roles and responsibilities in the decision-making process.
	Partners have agreed on the program’s mission and vision.
Program Resources	
	Partners have identified all anticipated resources required for the program in the agreement and have developed a process to identify future resources.
	Specific partner-related resources are determined.
	A schedule for the release of resources is included in the agreement.
Program Development and Implementation	
	Analysis of the population health status and/or assessment of community health needs is conducted with participation or input from all partners.
	Key trends and factors influencing health status outcomes are evaluated and prioritized, with input from key partners.
	Interventions and programs to improve population health status are developed collaboratively.
Program Communication	
	Partner communication methods (internally and externally) are defined, including meetings scheduled.
	Messages and branding used in communications are coordinated.
	Communication methods for each partner are identified and developed to allow information to be quickly disseminated to the community.
Care Delivery/Coordination Approach	
	Primary patient tracking mechanisms are identified.
	Each partner’s role within the care delivery process is clearly defined.
	Biometric and other health-related data points that will serve as measurement tools for the population health program are identified.
Information Collection, Storage, Sharing and Utilization	
	How program data is collected, stored and shared between partners is predetermined.
	Methods and partner responsibilities for utilizing data to measure the impact of the program are identified.
	Any technology or data sources that are integrated to enable program success are identified (if applicable).

Source: American Hospital Association, 2013.

Figure 3: Framework for Defined Population Health Partner Roles

	Small and Rural Hospital or Care System	Community Organization(s)
Leadership and Governance	<ul style="list-style-type: none"> • Provide clinical expertise to the partnership • Assist in strategic planning for all population health programs • Work with all partners to create mission and vision statements 	<ul style="list-style-type: none"> • Work with all partners to create mission and vision statements • Identify community leaders to coordinate with the small and rural hospital or care system • Assist in strategic planning for all population health programs
Program Resources	<ul style="list-style-type: none"> • Provide full-time employees (FTEs) for administrative purposes • Establish health center locations for health program 	<ul style="list-style-type: none"> • Identify existing resources such as facilities, data or technology systems, communication vehicles or other capabilities that can be used for health programs • Identify community volunteers to assist the FTEs
Program Development and Implementation	<ul style="list-style-type: none"> • Coordinate with urban health centers to identify additional resources • Determine priority trends from a hospital perspective 	<ul style="list-style-type: none"> • Analyze community health needs and assessment results to determine community perspective on possible health interventions • Determine priority trends from a community perspective
Program Communication	<ul style="list-style-type: none"> • Survey the community on health needs • Create a broad marketing campaign for the program • Create a broad communication plan for all partners 	<ul style="list-style-type: none"> • Create targeted marketing campaigns for specific populations in the community • Create a communication plan for all community partners
Care Delivery/Coordination Approach	<ul style="list-style-type: none"> • Outline patient handoffs • Outline administration of care for population health programs 	<ul style="list-style-type: none"> • Identify potential community sites for care delivery • Coordinate resources from community partners
Information Collection, Storage, Sharing and Utilization	<ul style="list-style-type: none"> • Provide IT data storage for all program data • Provide data-mining expertise to the program 	<ul style="list-style-type: none"> • Assist in data collection for the active population health programs

Source: American Hospital Association, 2013.

Introduction

Rising health care costs, increasing prevalence of chronic disease, an aging population, greater demand for quality outcomes and the recent passage of the Affordable Care Act have led to a shift toward value-based payment models focused on better population health management. New care delivery models such as accountable care organizations (ACOs) and patient-centered medical homes (PCMHs), as well as new payment models such as capitation, global payments and bundled payments, are emerging to improve quality, manage costs and improve the health status of defined populations.

These market dynamics are driving a shift toward population health approaches that are focused on prevention, improved chronic disease management and wellness activities. Population health models often include financial risk management elements by incorporating both upstream and downstream costs of care delivery. Additionally, population health models encourage responsibility among health care providers to provide continuous care delivery across larger populations—essentially providing total health solutions to patients across the continuum of care.

Population health management approaches are focused on understanding the health needs of the community, measuring and evaluating health status, and developing collaborative programs that will improve health outcomes. As a result, health care and community leaders are driving this shift toward population health management by focusing on assessment, prevention, wellness, chronic disease management and other initiatives to benefit the community. To address multiple health issues and improve the overall health status of the population, population health programs are becoming more complex and having greater reach.

Expansive and complex health programs necessitate an evolving role for hospitals and care systems, as well as greater integration with a variety of community organizations and other partners. Merging the resources and skills of hospitals and health care systems with community partners is essential for the integration and expansion of health management programs. Together, hospitals and care systems and their partners can create targeted population health programs that engage and communicate with the patient population and ultimately increase efficiency and quality of health care and improve health status in the community.

Population Health Definition

As defined in the 2012 American Hospital Association report, *Managing Population Health: The Hospital's Role* (available at http://www.hpoe.org/Reports-HPOE/managing_population_health.pdf), and amended in this report, population health can serve as a strategic platform to improve the health outcomes of a defined group of people, with a focus on three correlated stages:

1. Identification and analysis of the distribution of specific health statuses and outcomes within a population.
2. Identification and evaluation of factors that cause the current outcomes distribution.
3. Identification and implementation of interventions that may modify the factors to improve health outcomes.²

Population health resides at the intersection of three distinct health care mechanisms (see Figure 4). Improving population health requires effective initiatives to: (1) increase the prevalence of evidence-based preventive health services and preventive health behaviors, (2) improve care quality and patient safety and (3) advance care coordination across the health care continuum.

Figure 4. Mechanisms to Improve Population Health



Source: American Hospital Association, 2012.

Each type of hospital or care system—academic medical center, integrated health system, independent hospital, and small and rural hospital—engages the local community by providing resources, sharing knowledge and developing relationships and skills to manage its challenges and leverage its advantages. Each partner’s role depends on organizational capabilities and market dynamics. Furthermore, some general challenges, opportunities and roles within the population health management process exist, based on the type of hospital or care system involved, which influence the success of any population health strategy.

Small and rural hospitals and care systems face unique challenges and opportunities in providing health care services, as outlined in the 2011 AHA report *The Opportunities and Challenges for Rural Hospitals in an Era of Health Reform* (available at <http://www.aha.org/research/reports/tw/11apr-tw-rural.pdf>). Typically, classification for small or rural hospitals is based on whether the hospital meets at least one of the following criteria: has 100 or fewer beds, has 4,000 or fewer admissions or is located outside a metropolitan area.

Many of these hospitals or care systems are one of the largest employers in their area, so they have a greater impact on their communities. For example, a hospital’s internal wellness program focused on its employees could have significant, positive outcomes in a community of 5,000 residents where the hospital employs 400 residents or 8 percent of the population (not including families). Small and rural hospitals and care systems also face distinct challenges and opportunities that influence their relationships within the community. In some aspects, the role played by small and rural hospitals and care systems in working with community partners on population health differs from that of other types of hospitals and care systems.

This guide describes the role of small and rural hospitals and care systems in building and sustaining effective population health partnerships that balance the challenges and opportunities encountered. Implementing a successful population health initiative requires an organized effort in which all partners understand the roles and limitations they bring to the partnership. Hospitals and care systems highlighted in this guide’s case studies used a strategic framework to construct working relationships with their community partners and create successful population health programs.

Challenges and Opportunities

Rural communities share common challenges that influence the health status of residents. The resources required to manage a population health program also create challenges for small and rural hospitals and care systems. Identifying and adjusting to market and organizational dynamics improve the impact of population health programs. Building on the 2011 AHA report, Figure 5 highlights the challenges that small and rural hospitals and care systems face in population health management, related to population demographics and health, financial pressure, inadequate infrastructure and data, lack of scale and limited staffing.³

Figure 5. Population Health Management Challenges for Small and Rural Hospitals and Care Systems

Population Demographics and Health	Financial Pressure	Inadequate Infrastructure and Data	Lack of Scale and Limited Staffing
<ul style="list-style-type: none"> • 23 percent of the U.S. population lives in a rural area. • 19.8 percent of the rural population is over the age of 65. • 16.6 percent of the rural population lives in poverty. • Almost half of rural residents report at least one major chronic illness, including higher prevalence of diabetes mellitus, respiratory infections, obesity and heart disease. • Patients must travel farther for medical care. • Patient engagement in medical care is lower due to societal factors. 	<ul style="list-style-type: none"> • Nearly half of rural hospitals have 25 or fewer beds. • Rural hospitals make up half of the total number of hospitals but represent 12 percent of spending on hospital care. • 56 percent of gross revenue for rural hospitals comes from outpatient services. • Nearly 60 percent of revenues are from Medicare and Medicaid. • Medicare and Medicaid are the primary payers, covering 31 percent of the rural population. • 25 percent of rural residents under the age of 25 are uninsured. 	<ul style="list-style-type: none"> • Small and rural hospitals and care systems lag behind urban health centers in demonstrating meaningful use for health information technology. • Integrated technology and informatics capabilities often lack the ability to measure population health status. 	<ul style="list-style-type: none"> • Small and rural hospitals and care systems have challenges in becoming an accountable care organization or organizing a patient-centered medical home, due to limited scale. • Less able to recruit skilled and experienced health care workers. • Without sufficient volume for certain medical procedures, rural hospitals are unable to meet certain quality standards or have adequate/accurate data, which can affect reimbursement.

Source: American Hospital Association, 2013.

Offsetting these challenges, small and rural hospitals and care systems have several opportunities that other types of hospitals and care systems do not necessarily possess. By managing challenges and leveraging opportunities, small and rural hospitals and care systems can work with their communities to influence the population's health by adopting specialized population health programs that create positive health outcomes. The impact of these programs can be significant due to the strength of the relationship between the community and hospital. Building on the 2011 AHA report, Figure 6 highlights opportunities for small and rural hospitals and care systems in population health management, related to strong community and patient relationships, integration of services, and federal financial assistance.⁴

Figure 6. Population Health Management Opportunities for Small and Rural Hospitals and Care Systems

Strong Community and Patient Relationships	Integration of Services	Federal Financial Assistance
<ul style="list-style-type: none"> • One of the largest employers in their community, creates a stronger brand and perception. • Residents have a limited number of health care options, resulting in long-term relationships. • Hospitals use community residents for their workforce, increasing employment. • Working with urban health centers and larger health systems, small and rural hospitals offset costs and gaps in resources. 	<ul style="list-style-type: none"> • Increased use of electronic tools and technology, including the use of telemedicine. • Partnering with other local health providers for care delivery (home health, prevention and post-acute care). 	<ul style="list-style-type: none"> • Becoming a critical access hospital (CAH) provides opportunity for additional funding (as of September 2010, 1,328, or 26.5 percent, of rural hospitals are CAHs). • Graduate medical education redistribution of unused residency slots gives priority to rural training tracks.

Source: American Hospital Association, 2013.

A survey conducted by the Association for Community Health Improvement in 2012 identified several other factors that influence small and rural hospitals' and care system's population health programs. The survey had 1,198 responses total, with 336 from rural hospitals (see Figure 7).

Figure 7. ACHI 2012 Survey Findings

<ul style="list-style-type: none"> • Rural hospitals and care systems are more likely than urban hospitals to run their population health programs through the administration executive office (22.3 percent of the time for rural versus 9.8 percent for urban). • Rural hospitals and care systems have fewer full-time employees dedicated to population health programs (3.6 FTEs for a small and rural hospital and care system versus 11 FTEs for an urban health center). • Rural hospitals and care systems have fewer established partnerships on average than urban health centers (7.8 partnerships for small and rural hospitals and care systems versus 9.2 partnerships for urban health centers). • Rural hospitals and care systems have fewer programs for heart/lung/diabetes than urban health centers (60 percent for small and rural hospitals and care systems versus 73.2 percent for urban health centers). • Rural hospitals and care systems have fewer community clinics compared to urban health centers (66 percent for small and rural hospitals and care systems versus 73.9 percent for urban health centers).

Source: American Hospital Association, 2013.

Developing an Effective Partnership

Before building a complex and expansive population health program, the small and rural hospital or care system must establish a successful working relationship with the community for population health initiatives. This foundation allows the health care organization to develop more complex health management models such as a patient-centered medical home (PCMH) or an accountable care organization (ACO). To begin the relationship, a small and rural hospital and care system should:

1. Conduct a community health needs assessment with the local public health department
2. Work with the community to synthesize the assessment results
3. Identify potential community partners that are aligned with the population health mission or objectives
4. Form one or more partnerships to address health issues in the community

Before starting any population health program, the hospital or care system typically undertakes the community health needs assessment with the local public health department. The assessment is a process that describes the health of local people by identifying major risk factors and necessary health interventions. Working together, the hospital or care system and the public health department set out to assess and catalog the various health issues for the community and establish criteria to prioritize the identified health issues. The community often assists in data collection for the health needs assessment.

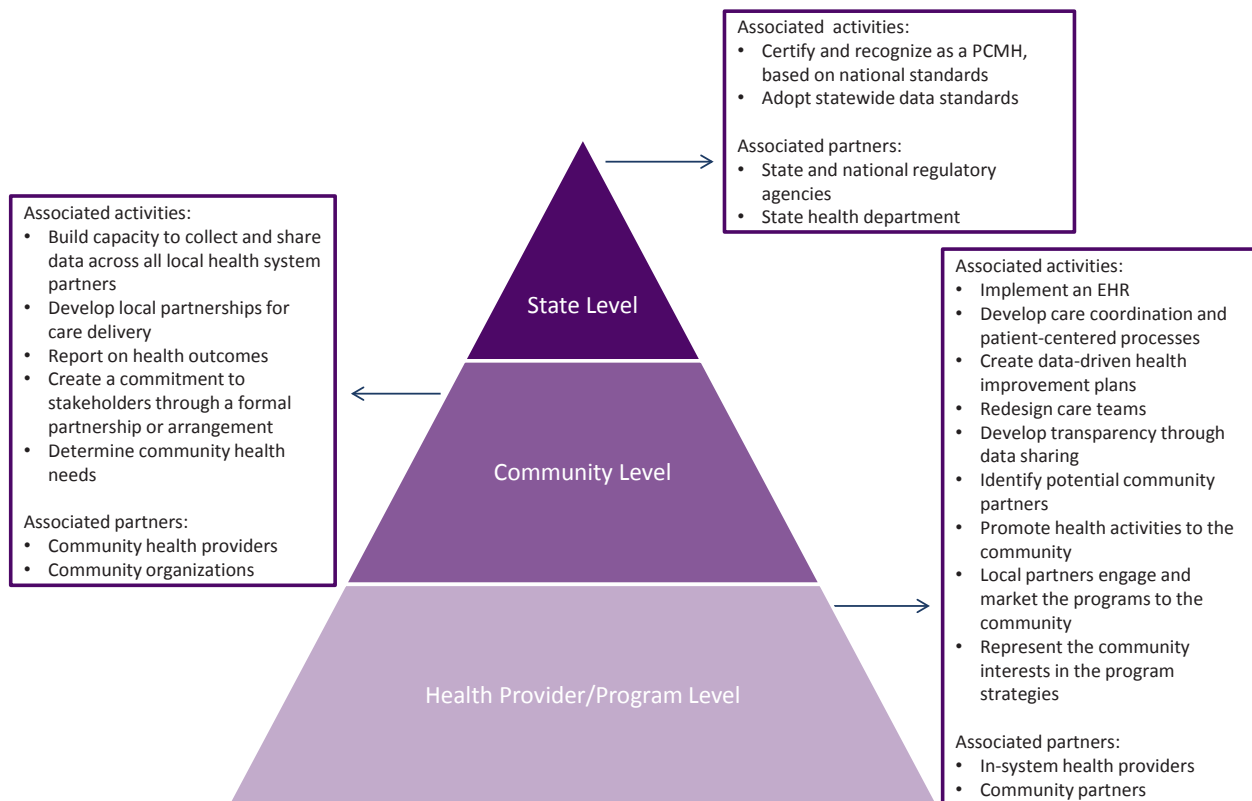
Once the data has been collected from the assessment process, a strategic planning session should be held with stakeholders to help identify and agree on high-priority initiatives. For more information on conducting the assessment, access the [Association for Community Health Improvement's Assessment Toolkit](http://www.assesstoolkit.org/) at <http://www.assesstoolkit.org/>.

In ACO and PCMH models, the population may be defined more narrowly than the larger community. ACOs and PCMHs may include specific patient populations, which are defined by Medicare, Medicaid, a commercial insurance payer or even the hospital's own employee population. These types of models also require extensive partnerships at the local level.

As part of an ACO or PCMH, small and rural hospitals and care systems may seek partnerships in the local community to measure health status; educate, communicate with and engage patients; and implement wellness or chronic disease management programs. However, in a rural and small hospital setting, population health management through an ACO or PCMH also may require partnerships or affiliations with larger hospitals and health care systems, to provide health care across the entire care continuum.

Figure 8 illustrates a possible framework for developing a PCMH. Each level—health provider/program, community and state—has associated activities and partners. As the hospital and community explore the creation of a PCMH, it is important to identify all potential partners and their specific roles within the PCMH.

Figure 8. Framework for Development of a Patient-Centered Medical Home



Source: American Hospital Association, 2013.

Strategies for Creating Effective Population Health Partnerships

Forming a lasting and meaningful relationship with the community is critical for a functioning population health partnership. Hospital leaders should be aware of existing strategies and tactics (see Figure 9). Identifying and employing strategies that will be most effective working with the local community help ensure success.

Figure 9. Strategies for Creating an Effective Population Health Partnership

- Encourage hospital leaders to serve on community boards
- Provide community representation on hospital boards
- Survey the community on the effectiveness of the partnership
- Provide financial support to community groups
- Develop joint ventures with the community
- Provide outreach to the community to attract local volunteers
- Share health data with the community
- Develop a shared mission and vision for community health
- Analyze patient feedback on population health programs
- Develop focus groups that are comprised of members of the local community to gauge reactions and opinions on various population health initiatives
- Partner with other local health providers for care delivery (home health, prevention, post-acute care)

Source: American Hospital Association, 2013.

Potential Partners and Resources

Demographic challenges and resource limitations can impede the success of population health programs coordinated by small and rural hospitals and care systems. At the same time, the success of a population health program is built around the partnership between the small and rural health care organization and the community it serves. To deliver lasting impact on a community, collaboration is necessary. Engaging the community through local organizations provides the greatest chance for success. Some examples of community organizations that could be included are:

- Local public health departments
- Local health care providers
- Local businesses and chambers of commerce
- Community organizations, such as churches, libraries, educational institutions
- Local and national charities
- Health care payers
- Other government or municipal agencies (e.g., police, fire)
- Urban health centers
- Financial institutions
- Media
- Other not-for-profit groups

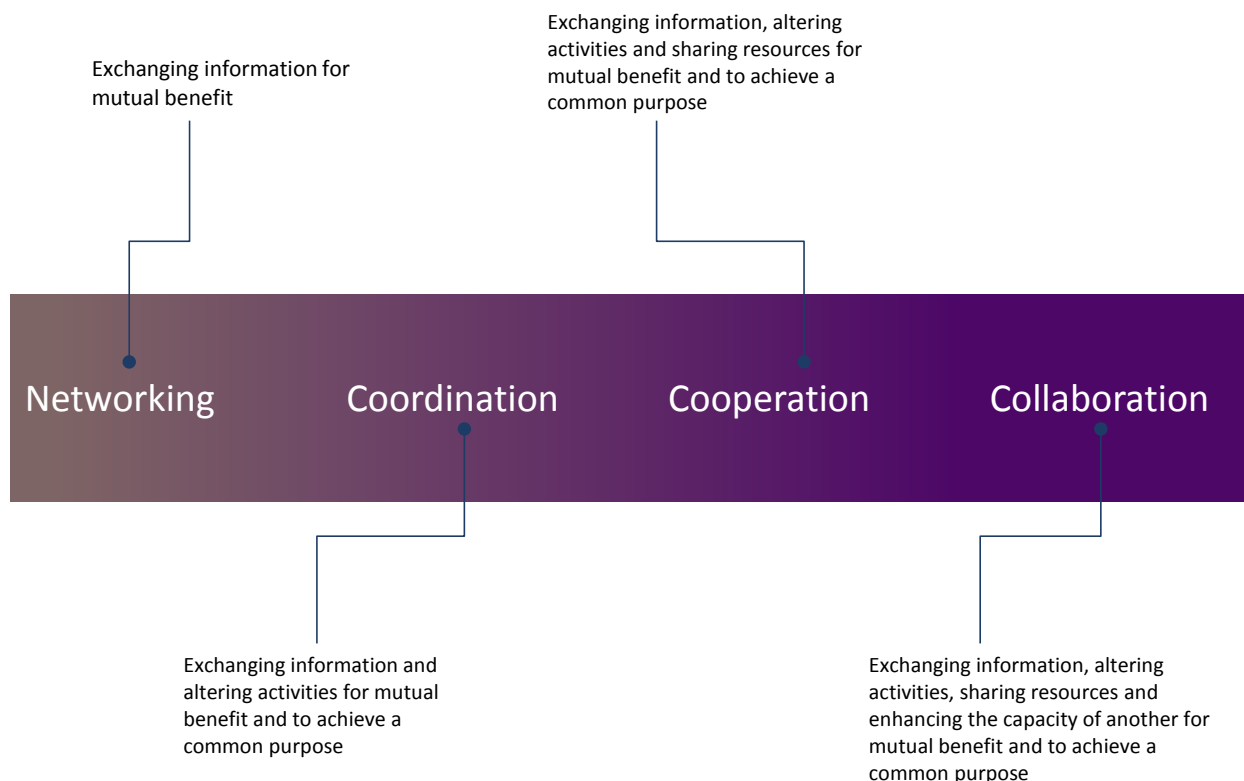
By engaging these types of organizations, small and rural hospitals and care systems can coordinate and disseminate community resources to improve the community's health. Community partners provide skills and resources, including:

- Marketing assistance to the community
- Logistical support, including meeting space, staff and volunteers
- Community-specific services such as translators
- Care delivery assistance
- Access to or support for health data via a disease registry or data storage
- Access to funding mechanisms (or provision of capital) for infrastructure and corporate initiatives

Types of Partnerships

The vetting process for potential partners should be strategic, selective and complementary of existing and necessary skill sets; otherwise, the partnership can become unmanageable. The depth of the interactions between the partners characterizes the relationships that form between the hospital and community. The types of relationships that exist between these partners fall into four main categories: networking, coordination, cooperation and collaboration (see Figure 10).

Figure 10. Types of Population Health Partnerships



Source: Adapted from Robert Pestronk's *Collaborating for Healthy Communities* and Arthur T. Himmelman's *Collaboration for a Change: Definitions, Decision-making Models, Roles and Collaboration Process Guide*, 2013.

Networking. Partners utilize a networking approach to exchange health information for mutual benefit; however, there is no shared vision and mission, no sharing of resources and no coordination of programs. Examples of networking partnerships are health information exchanges and disease registries. Organizations involved with these types of partnerships are providing data to each other—in this case, a third party—for the mutual benefit of data analysis and comparison. However, each organization that participates in these partnerships has a different mission, vision and purpose to its program. For example, a diabetes prevention program and a population health program for mental health each can be part of a health information exchange but have no other connection.

Coordination. Partners exchange information, and separate programs are coordinated to create a greater impact on the health issue. The programs are not merged into one entity, do not share resources, and have no singular mission and vision. Coordination partnerships involve multiple organizations that are running health programs and desire to work with each other to create a greater health impact. For example, several organizations that are administering obesity prevention programs may meet to share information and plan certain activities with each other, to offset gaps in their programming and have a larger impact. However, each program is separate and possesses a different mission and vision statement.

Cooperation. Partners exchange information and share resources between the programs. This information exchange and sharing of resources alters the program’s operations, necessitating a common vision and mission. Although the programs share a common purpose, they are still operated by separate organizations. Cooperation partnerships involve multiple organizations running similar health programs and sharing resources and information to create an even larger health impact. A cooperation partnership is distinct from a coordination partnership in that all partners are actively sharing information and resources, suggesting a high level of collaboration. In addition, all the separate programs share a common mission and vision to allow for greater information flow and resource sharing.

Collaboration. Partners exchange information, share resources, possess one singular mission and vision statement and have merged the separate programs into a more formalized operational model. This new unified organization gives each partner representation on a new board for program operations and decision making on the direction of the group. The most advanced type of partnership, the collaboration partnership is found in a PCMH or ACO, as the hospital and its partners share a common mission and vision organized as one greater entity that manages the operations. In this type of organization, with a single mission and vision, the partners have established a new organizational framework that can include a new board representing all partners.

Regardless of the partnership type, partner organizations are charged with marshaling their resources to address the population health issue. However, more advanced partnerships have greater success sharing resources, are committed to a common mission and vision and include cross-representation across the hospital and within the community partner organizations. These factors are critical to the success and impact of the population health program because both the community and the hospital or care system must own the solution for the health issue.

Developing a Collaboration

Collaboration between the hospital or care system with the community is a critical factor in making a significant impact with a population health program. The success of a population health program hinges not only on proper role identification and full role ownership but also on a clear agreement between each partner to ensure a proper governance structure and resource contributions.

As hospitals and care systems and communities form collaborations, all partners achieve success by following a comprehensive organizational framework. Advancing an organizations framework between partners relies on detailing:

- Leadership and governance roles
- Program resources (e.g., time, staff, facility space, technology, etc.)
- Program development and implementation
- Program communication
- Care delivery approach
- Information collection, storage, sharing and utilization

Figure 11 provides a checklist for partners to ensure that any potential agreement between all the partners addresses the various organizational elements necessary to creating a successful population health program.

Figure 11: Population Health Partnership Checklist

Leadership and Governance Roles	
	All primary and secondary partners have developed a decision-making model (committee structure, board, coalition and community infrastructure).
	Agreement has included representation and composition of leadership and governance group.
	Specific partner skills and competencies are aligned to the roles and responsibilities in the decision-making process.
	Partners have agreed on the program's mission and vision.
Program Resources	
	Partners have identified all anticipated resources required for the program in the agreement and have developed a process to identify future resources.
	Specific partner-related resources are determined.
	A schedule for the release of resources is included in the agreement.
Program Development and Implementation	
	Analysis of the population health status and/or assessment of community health needs is conducted with participation or input from all partners.
	Key trends and factors influencing health status outcomes are evaluated and prioritized, with input from key partners.
	Interventions and programs to improve population health status are developed collaboratively.
Program Communication	
	Partner communication methods (internally and externally) are defined, including meetings scheduled.
	Messages and branding used in communications are coordinated.
	Communication methods for each partner are identified and developed to allow information to be quickly disseminated to the community.
Care Delivery/Coordination Approach	
	Primary patient tracking mechanisms are identified.
	Each partner's role within the care delivery process is clearly defined.
	Biometric and other health-related data points that will serve as measurement tools for the population health program are identified.
Information Collection, Storage, Sharing and Utilization	
	How program data is collected, stored and shared between partners is predetermined.
	Methods and partner responsibilities for utilizing data to measure the impact of the program are identified.
	Any technology or data sources that are integrated to enable program success are identified (if applicable).

Source: American Hospital Association, 2013.

Clearly defined roles allow partners to identify required resources and skills, which ultimately leads to successful implementation of population health programs. Depending on the type of partnership, some of these roles can overlap. Figure 12 provides a framework that outlines each partner’s roles.

Figure 12: Framework for Defined Population Health Partner Roles

	Small and Rural Hospital or Care System	Community Organization
Leadership and Governance	<ul style="list-style-type: none"> • Provide clinical expertise to the partnership • Assist in strategic planning for all population health programs • Work with all partners to create mission and vision statements 	<ul style="list-style-type: none"> • Work with all partners to create mission and vision statements • Identify community leaders to coordinate with the small and rural hospital • Assist in strategic planning for all population health programs
Program Resources	<ul style="list-style-type: none"> • Provide full-time employees (FTEs) for administrative purposes • Establish health center locations for health program 	<ul style="list-style-type: none"> • Identify existing resources such as facilities, data or technology systems, communication vehicles or other capabilities that can be used for health programs • Identify community volunteers to assist the FTEs
Program Development and Implementation	<ul style="list-style-type: none"> • Coordinate with urban health centers to identify additional resources • Determine priority trends from a hospital perspective 	<ul style="list-style-type: none"> • Analyze community health needs and assessment results to determine community perspective on possible health interventions • Determine priority trends from a community perspective
Program Communication	<ul style="list-style-type: none"> • Survey the community on health needs • Create a broad marketing campaign for the program • Create a broad communication plan for all partners 	<ul style="list-style-type: none"> • Create targeted marketing campaigns for specific populations in the community • Create a communication plan for all community partners
Care Delivery/Coordination Approach	<ul style="list-style-type: none"> • Outline patient handoffs • Outline administration of care for population health programs 	<ul style="list-style-type: none"> • Identify potential community sites for care delivery • Coordinate resources from community partners
Information Collection, Storage, Sharing and Utilization	<ul style="list-style-type: none"> • Provide IT data storage for all program data • Provide data-mining expertise to the program 	<ul style="list-style-type: none"> • Assist in data collection for the active population health programs

Source: American Hospital Association, 2013.

Conclusion

Although small and rural hospitals and care systems face several challenges—such as treating more patients who are older, have at least one major chronic disease and live in poverty; overcoming geographic limitations; and facing many financial pressures—they also have distinct opportunities. Small and rural hospitals and care systems can leverage strong relationships with their community and patients and with urban health centers and increase integration of services with other local health providers.

Small and rural hospitals and care systems that build partnerships with the communities they serve can have a significant positive influence on population health. Partnerships allow communities to create flexible and customized population health programs. Effective partnerships can be developed by conducting a community health needs assessment and employing the strategies and organizational framework outlined in this guide. Through networking, coordination, cooperation or collaboration, small and rural hospitals or care systems and partner organizations can marshal their resources to create successful community health initiatives and improve population health.

Case Study: New Ulm Medical Center, Minnesota

Background: New Ulm Medical Center (NUMC) is a critical access hospital that is part of Allina Health, a not-for-profit health care system that includes more than 90 clinics, 11 hospitals, 15 pharmacies, specialty care centers and specialty medical services. NUMC is located in New Ulm, Minnesota, a town of 13,500 residents. Key to NUMC's population health focus and rural health model is its strategic foundation, which includes an integrated health care team, electronic health record, coordinated clinical service lines and community health engagement.

In the mid-2000s, New Ulm government and business leaders identified health and wellness as a top priority. In 2006, New Ulm achieved "Governor's Fit City" status in recognition of the city's commitment to improve the health of its residents by encouraging physical activity. The community was approached in 2008 to see if it would be interested in improving health and preventing heart attacks through Hearts Beat Back: The Heart of New Ulm Project (HONU). Throughout all of the project's activities, the commitment and engagement of the entire community have been critical.

Interventions: In 2008, Allina Health collaborated with the Minneapolis Heart Institute Foundation to launch the Heart of New Ulm project. HONU is designed to reduce the number of heart attacks that occur in the New Ulm area over a 10-year period. The project aims to help residents make lifestyle changes to reduce their risk for heart attack, such as getting more physically active, making healthier eating choices, maintaining a healthy weight, managing stress and quitting smoking. HONU applies evidence-based practices in the community, health care, worksites and environment. To help plan and promote health initiatives, a 36-member steering committee includes representatives from a broad, multisector base, such as local employers, the City of New Ulm, Chamber of Commerce, churches, school district, local colleges, NUMC, Brown County Public Health and the general community.

Project interventions include worksite wellness programs and consultations with local businesses; tobacco control policy work; restaurant, convenience and grocery store programs; physician continuing medical education; free community heart health screenings; and community educational programs and health challenges. To help NUMC patients who are at high risk for heart disease or who have diabetes or heart disease, a free phone-coaching program is provided. Individuals are proactively invited to participate based on data from their EHR, as well as referrals from NUMC's primary care providers. The program provides patients with supplemental education and support between regular office visits with their primary care provider. The community provides an enthusiastic group of volunteers. Numerous local employers and their employees have embraced worksite wellness initiatives, local schools have developed opportunities to improve wellness for their staff as well as students, and local produce farmers are working to provide more delicious fruits and vegetables to the community.

Results: HONU has had considerable success in improving community health. Comparing data from community heart screenings held in 2009 and 2011, the project has recorded an increase in healthy lifestyle behaviors. Changes include:

- Increase in the number of people eating five or more fruits and vegetables per day from 19 percent to 33 percent
- Improvement in the number of people taking daily aspirin from 32 percent to 40 percent
- Increase in the percent of people getting 150 minutes a week of moderate exercise from 67 percent to 77 percent

Data trends from EHR data—which represents between 75 percent and 81 percent of the population in the 40 to 79 age group—show solid improvements in biometric risk factors:

- Decrease in the percent of residents with high blood pressure from nearly 21 percent to less than 18 percent
- Decrease in the percent of residents with high cholesterol from nearly 11 percent to less than 9 percent
- Decrease in the percent of residents with high triglycerides from nearly 34 percent to just under 32 percent

Lessons Learned: Community buy-in and a sense of ownership from the onset are critical. Throughout all of the project's activities, the commitment and engagement of the entire community have been important. By using the EHR as the primary population surveillance tool, project planners can target population segments and disease risk levels with the goal of identifying, implementing and tracking interventions. Strong support from physicians and the health care team is critical, as they play a key role in advocating for HONU's services and contribute significantly to improving the health of patients in the community.

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Case Study: Wrangell Alaska Medical Center

Background: Wrangell Medical Center (WMC) is located in Wrangell, Alaska, a town of 2,300 residents. The city and borough of Wrangell own WMC, which employs 65 full-time employees with an annual budget of \$8.8 million. WMC care services include an eight-bed acute unit, a 14-bed long-term care unit, emergency department, lab, physical therapy, home health and specialty clinics. Only accessible by airplane or boat, Wrangell has geographical limitations, and WMC is the sole health care provider for the community and one of the largest employers.

Intervention #1: Recognizing the economic and social challenges of the community and the need for qualified nursing assistants, WMC created the Rural Health Careers Initiative, in partnership with the local educational system that promotes the program to students. The program's purpose is to provide clinical education and training to students interested in becoming a certified nursing assistant. Students receive mentoring and financial assistance to take the year-long course. WMC pays 100 percent of the cost for its employees.

Results: To date, the program has trained more than 200 students, with more than \$250,000 saved in education costs. WMC also employs the majority of students who complete and pass the state certification exam.

Challenges: Increasing the community's interest in the program remains an ongoing challenge for WMC, along with enhanced prescreening for acceptance. Before using an in-depth screening process, potential students not eligible to take the state certification exam were being accepted. Additional training methods, including hands-on training, also became necessary to increase the educational performance of the students.

Intervention #2: To further educate and engage the community, WMC provides an annual community health fair that more than one-third of the community attends. One of WMC's longest running health programs, the fair has seen considerable growth over the years, with more than 60 vendors in health, social services and education. The local community supports the health fair by partnering with WMC for promotion, assistance with registration and recruitment.

Results: With the significant growth of the health fair, numerous success stories have originated from the health screenings. The fair has reached its capacity on the number of vendors and continues to reach a high percentage of the population.

Challenges: WMC is faced with a growing space issue for the fair due to the demand of vendor participation. Currently, the fair has reached its vendor capacity, and vendors are limited in the types of educational displays. As the fair has grown, WMC staff members have increased responsibilities in coordinating and managing the fair, often outside their normal job duties.

Strategies and Tactics Used: Building on strong volunteerism in the community, WMC provides internal staff to run both the community health fair and the Rural Health Careers Initiative. WMC engages local businesses, including two grocery stores, to assist in registration and marketing for the community health fair. In the past, WMC has used schools and other state agencies to inform potential applicants of the career program.

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Case Study: Mt. Ascutney Hospital and Health Center Windsor, Vermont

Background: Mt. Ascutney Hospital and Health Center (MAHHC), located in Windsor, Vermont, is a 25-bed critical access hospital that includes a 10-bed rehabilitation unit and 25-bed nursing facility. Serving a local population of 21,000 people, the center offers a variety of care services, including outpatient primary and specialty care, acute care, transitional care and rehabilitative services. The per capita income is \$21,936, with 54 percent of children living below the poverty level.

Intervention: Collaborating with the community, MAHHC formed a community health infrastructure, and the community and hospital worked together to close the fragmented and decentralized care services. The infrastructure has established several programs including the Mt. Ascutney Hospital Community Health Foundation, the Windsor Area Community Partnership, the Windsor Connection Resource Center, Patch Team Services, the Mt. Ascutney Prevention Partnership and the Windsor Area Drug Task Force. Community partners provide in-kind support including volunteers and administrative logistics.

Results: Through various initiatives of the community infrastructure, 14 major health promotions were managed, and communication and organization were improved among the various partners. A total of 3,248 individuals have received assistance in social services, and numerous antidrug programs have been introduced.

Lessons Learned: A systematic and organized framework that existed within the community health infrastructure allowed community partners to increase their impact on the community. The infrastructure provided an organized framework for the partners in determining how resources were allocated to meet the community health issues. Hospital leaders effectively coordinated and managed resources for these programs.

Challenges: MAHHC faced skepticism and mistrust from community partners over the control and management of the programs. Several segments of the community became concerned that they were losing their area of control.

Tactics and Strategies: To manage the challenges, MAHHC worked on building trust and allowing community partners to receive a large portion of the credit. MAHHC also decentralized grant funds to the community partners and celebrated every program success.

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Case Study: Yuma Hospital District, Colorado

Background: Yuma District Hospital, located in Yuma, Colorado, is a facility that houses acute inpatient health services, including 12 acute care beds, two labor/delivery/post-partum beds, surgical services and 24-hour emergency services. The hospital also has two provider-based rural health clinics, one of which is co-located in the hospital facility.

Intervention: Yuma District Hospital began work four years ago with several safety net clinics in Colorado to transform into a patient-centered medical home (PCMH). Selected by the Colorado Community Health Network to take part in a five-year demonstration project initiated and funded by Qualis Health in Washington State, the Commonwealth Fund, and the MacColl Center for Health Care Innovation at the Group Health Research Institute, these safety-net clinics focused on helping primary care safety-net sites become high-performing PCMHs. Through this initiative, the Colorado Community Health Network, a group consisting mostly of federally qualified health centers, provided technical assistance for these clinics to become PCMHs. Staff have spent three years working with consultants to get the Yuma clinics certified as a PCMHs. Yuma has developed provider teams and a process for assigning patients to those teams, and Yuma's IT department has been actively involved in creating new ways to track and monitor patients.

Because of the hospital's and clinic's efforts to adopt the PCMH model, Yuma Hospital District was invited to participate in the Medicaid Regional Care Coordination Organization managed by Colorado Access. Participating members of the PCMHs receive \$2 per member per month, plus another \$1 per member per month if the following goals are met: reductions in 30-day readmissions, ED visits and high-cost imaging. If the region's goals are not met, partners do not receive the additional incentive payment. Yuma will continue to be reimbursed on a fee-for-service basis for medical care provided to Medicaid patients. PCMH services include only patient care management.

Yuma patients require behavioral and social support, which they receive from a nearby health and social service agency, the North Colorado Health Alliance. A community service organization handles the nonmedical elements that influence health, like behavioral health care, arranging for transportation and helping with financial management. The alliance supplies a staff member to assist Yuma in accessing these resources.

Challenges: Similar to other rural towns, Yuma previously had physicians that served the community on an ongoing basis. Changing to the PCMH model removed the traditional model of physician service and created a care transition system where a patient may see multiple physicians. Switching to this new model created some community dissatisfaction as patients' traditional relationship with their physician was interrupted.

Results: Introducing the medical home process helped in developing communication systems to improve patient hand-offs and data access. A huge advantage of being part of the PCMH is access to the wealth of data available to help with patient care management. After reviewing the data, Yuma identified a pool of high-risk people who could benefit from patient care management. Contracting with the North Colorado Health Alliance gives the organization access to nonclinical services that have a significant impact on the health of the patient.

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Case Study: Cheyenne Regional Medical Center Wyoming

Background: Cheyenne Regional Medical Center (CRMC) consists of 206 beds, making the facility Wyoming's largest health care system with a total of 168 physicians and 1,850 employees. CRMC serves a patient population characterized as follows: 22.6 percent of the patients lack health insurance, more than 20 percent of the patients smoke and 24.3 percent of the adults are obese.

Intervention: Cheyenne Regional created the Cheyenne Health and Wellness Center (CHWC) in 2005 in South Cheyenne. CHWC partners with local community organizations including businesses, schools and child care facilities to provide general primary medical care, dental/vision services, flu shots/immunizations, diagnostic testing/screening, well-child visits, in-house pharmacy, translation services (English/Spanish), health education, family planning, pregnancy testing and referral, work/school physicals and case management. CHWC serves more than 5,000 patients annually, and 70 percent of patients have family income below 100 percent of the federal poverty level. Wanting to engage more proactively with patients with chronic disease, CHWC created Wyoming's first patient-centered medical home (PCMH) with the aim to improve access to care, help patients manage their symptoms, reduce acute events and improve patients' health outcomes.

Results: In year two, the PCMH has shown significant improvement for patients struggling with access to health care services and with high incidence of chronic disease, including:

- Overall, patient population size increased by 17.5 percent; over 5,000 patients served to-date.
- Breast cancer screening was improved to 41 percent (from 13 percent in 2011).
- Pneumococcal vaccination for the age target population improved to 19 percent (from 10 percent in 2011).
- Female patients receiving a Pap test increased to 68 percent (from 19 percent in 2011).
- BMI is now captured and recorded for 100 percent of the patients at the time of their visit.
- The average cost per clinic visit decreased by 20.84 percent.

Challenges: As CHWC evolved, the partners found it necessary to address quality improvement issues to streamline operations such as patient tracking and monitoring, clinical management and reporting.

Strategies and Tactics Used: CHWC has implemented a series of PDSA (Plan-Do-Study-Act) cycles of quality improvement to streamline the operations, the clinical management and the quality reporting processes in support of the PCMH transformation work. As a result, the team has successfully implemented chronic disease management programs, developed a streamlined process of medical referrals, increased access to care including same-day appointment availability and doubled the number of successful prescription assistance applications. The clinic had significantly reduced operating costs and increased revenues.

Lessons Learned: The safety-net PCMH is evolving into a more formal learning model, which includes the transformation of process and culture.

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Signature Leadership Series

Becoming a Culturally Competent Health Care Organization

June 2013

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Becoming a Culturally Competent Health Care Organization

Background

This guide is part of a continuing series that will support hospitals and care systems as they work to reduce health care disparities and promote diversity in health care governance and leadership. Becoming a culturally competent health care organization is a critical component in reducing health care disparities. A recent survey by the Institute for Diversity in Health Management, an affiliate of the American Hospital Association, found that 81 percent of hospitals educate all clinical staff during orientation about how to address the unique cultural and linguistic factors affecting the care of diverse patients and communities, and 61 percent of hospitals require all employees to attend diversity training. This is a positive start, but more work needs to be done in this area.

In 2011, the American College of Healthcare Executives, American Hospital Association, Association of American Medical Colleges, Catholic Health Association of the United States, and National Association of Public Hospitals and Health Systems stood together in a call to action to eliminate health care disparities. Our focus is on increasing the collection of race, ethnicity and language preference data; increasing cultural competency training; and increasing diversity in governance and leadership.

As national partners, we are committed to these focus areas and will support quality improvement in health care through shared best practices and resources. Ensuring that all hospitals prepare their clinicians and staff to meet the care needs of all patients is an important component of an overall effort to improve equitable care and a goal of the call to action.

Introduction

Cultural competence in health care describes the ability to provide care to patients with diverse values, beliefs and behaviors, including tailoring health care delivery to meet patients' social, cultural and linguistic needs¹. A key component to new care delivery models, such as patient-centered medical homes and accountable care organizations, is the ability to engage and educate patients about their health status. While doing this is challenging with all patients, for diverse patient populations it can be even more difficult due to language barriers, health literacy gap, and cultural differences in communication styles.

It is imperative that hospitals and health care systems understand not only the diverse patients and communities they serve but also the benefits of becoming a culturally competent organization. Hospitals and care systems must prepare their clinicians and staff to interact with patients of diverse backgrounds to increase patient engagement and education and to help eliminate racial and ethnic disparities in care. To improve understanding of diverse cultures, hospitals and care systems should seek advice from individuals and groups in the communities they serve. These constituencies can help hospitals and care systems develop educational materials, increase patient access to services and improve health care literacy.

In 2013, the Office of Minority Health, U.S. Department of Health and Human Services, issued enhanced National Culturally and Linguistically Appropriate Services (CLAS) Standards in Health and Health Care, and a blueprint with guidance and strategies to help implement them. This first update to the standards since their initial release in 2000 expands upon the concepts of culture to reflect new developments and trends, and focuses on leadership and governance as drivers of culturally competent health care and health care equity². More information on CLAS Standards is available at the end of this guide.

Benefits of Cultural Competence

Cultural competence in a hospital or care system produces numerous benefits for the organization, patients and community. Organizations that are culturally competent have improved health outcomes, increased respect and mutual understanding from patients, and increased participation from the local community³. Additionally, organizations that are culturally competent may have lower costs and fewer care disparities⁴.

Figure 1. Benefits of Becoming a Culturally Competent Health Care Organization

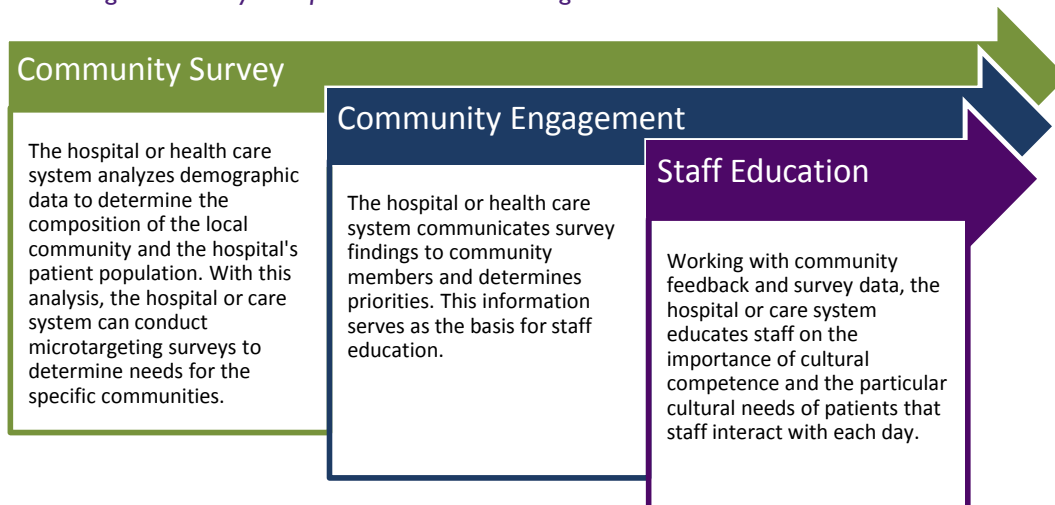
Social Benefits	Health Benefits	Business Benefits
<ul style="list-style-type: none">• Increases mutual respect and understanding between patient and organization• Increases trust• Promotes inclusion of all community members• Increases community participation and involvement in health issues• Assists patients and families in their care• Promotes patient and family responsibilities for health	<ul style="list-style-type: none">• Improves patient data collection• Increases preventive care by patients• Reduces care disparities in the patient population• Increases cost savings from a reduction in medical errors, number of treatments and legal costs• Reduces the number of missed medical visits	<ul style="list-style-type: none">• Incorporates different perspectives, ideas and strategies into the decision-making process• Decreases barriers that slow progress• Moves toward meeting legal and regulatory guidelines• Improves efficiency of care services• Increases the market share of the organization

Source: American Hospital Association, 2013.

Steps to Becoming a Culturally Competent Organization

Before a health care organization becomes culturally competent, leaders must understand the local community and the role the organization plays within the community. Steps to becoming culturally competent include (1) analyzing data and microtargeting surveys to improve service for the local community, (2) communicating survey findings to determine priorities and (3) educating staff and aligning programming and resources to meet community needs. Figure 2 highlights the process involved for a health care organization to become culturally competent.

Figure 2. *Becoming a Culturally Competent Health Care Organization*

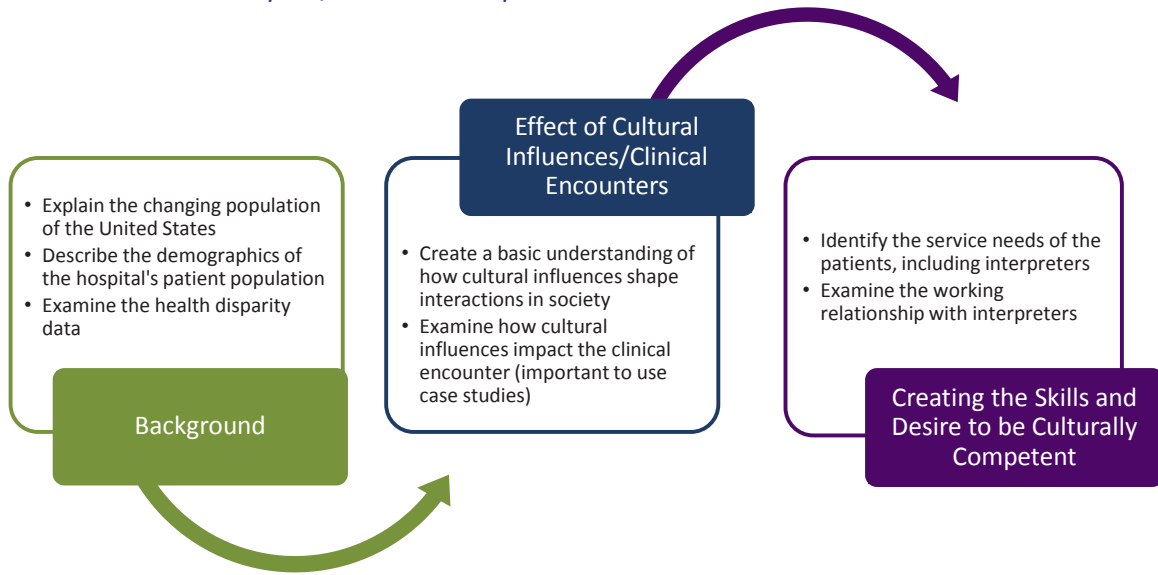


Source: American Hospital Association, 2013.

Educational Principles for Cultural Competence

Becoming a culturally competent organization requires a thorough understanding of the principles that characterize cultural competence (see Figure 3). First, staff needs to understand the factors that are pushing hospitals and care systems to become culturally competent. Hospital staff also needs to recognize and understand the cultural and clinical dynamics in interactions with patients. Becoming culturally competent involves developing and acquiring the skills needed to identify and assist patients from diverse cultures. With the necessary skills and mindset, staff can quickly identify the services required by a patient, thereby increasing positive health outcomes.

Figure 3. Educational Principles for Cultural Competence

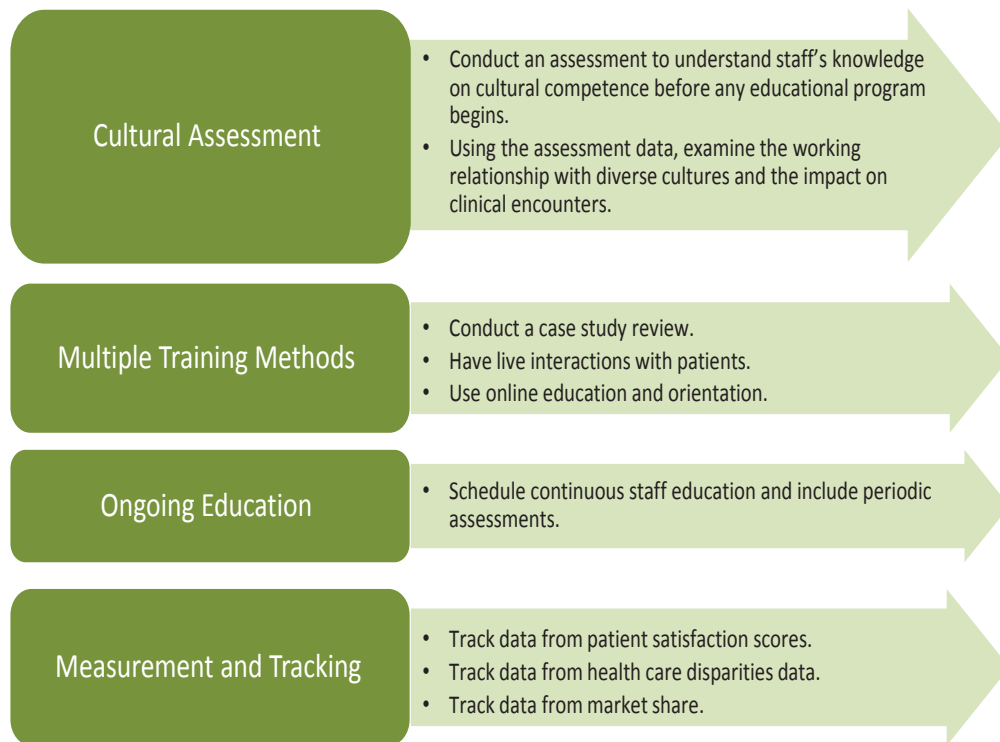


Source: American Hospital Association, 2013.

Staff Education for Cultural Competence

An effective educational or training program for cultural competence correlates with a lasting awareness and understanding by hospital staff. Although there are several approaches to educate staff, a successful educational program includes (1) cultural assessment, (2) multiple training methods, (3) ongoing education and (4) measurement and tracking (see Figure 4).

Figure 4. Staff Education for Cultural Competence



Source: American Hospital Association, 2013.

Conclusion

Hospitals and care systems must prepare their clinicians and staff to interact with patients of diverse backgrounds to increase patient engagement and education and to help eliminate racial and ethnic disparities in care. Cultural competence is needed to provide care to patients with diverse values, beliefs and behaviors. Hospitals and care systems, as part of their mission, are eager to reduce variations in care and are using a variety of efforts to train staff to become culturally competent.

Hospitals and care systems first must understand the benefits of cultural competence and the diverse patients and communities they serve. The steps to becoming culturally competent begin with understanding the background of the community and patient population, the effect that cultural influences have on care delivery, and the skills needed by clinicians and staff. Effective educational programs and training for hospital staff include a cultural assessment, multiple training methods, ongoing teaching, and measurement and tracking. Culturally competent health care organizations have improved patient outcomes, increased respect and mutual understanding from patients, and increased participation from the local community.

Case Example: Advocate Lutheran General Hospital, Chicago, Illinois

Background: One of the largest hospitals in the Chicago area, Advocate Lutheran General is a 645-bed teaching and research hospital. To become a culturally competent organization, Advocate Lutheran focused on improving its staff's cultural awareness and enhancing the organization's connection to local ethnic communities the hospital served. Challenges that the organization encountered included the staff's lack of knowledge about different cultures, language barriers, and socioeconomic and ethnic barriers.

Interventions: To develop a robust educational program to train hospital staff, Advocate Lutheran analyzed local demographic data and patient data to determine the ethnic composition of the individuals being served. Based on this analysis, education on the importance and implications of cultural competence was added to new employee orientation. Additionally, the hospital CEO meets with new employees to discuss the organization's cultural competence initiatives.

The hospital also formed a diversity group made up of staff members who organize cultural awareness days. These cultural awareness events allow hospital staff to interact with individuals from different cultures that are represented in the greater community served by the hospital. To engage local ethnic communities, Advocate Lutheran surveyed the community to determine potential barriers and opportunities for providing care to the South Asian population. In response, the hospital established a South Asian Cardiovascular Center, the first cardiovascular center in the Midwest that aims to educate, screen, prevent, and treat South Asians for their high risk of cardiac disease.

Results: Although its cultural competence initiatives are still being expanded, Advocate Lutheran has seen progress in providing culturally competent care to its ethnically diverse patient population. Patients needing special care to accommodate their ethnic beliefs or practices are being identified more quickly as a result of the increased cultural competence of hospital staff.

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Case Example: Lutheran Medical Center, Brooklyn, New York

Background: Lutheran Medical Center, part of Lutheran HealthCare, is a 468-bed acute care hospital and trauma center. Serving an extremely diverse community in Brooklyn, Lutheran Medical Center estimates its patients and staff members speak about 73 languages and celebrate 30 different ethnic holidays.

Interventions: Embracing the wide variety of cultures in the community, Lutheran Medical Center developed the resources necessary to become culturally competent. A cultural competence department was created with a cultural initiatives coordinator and vice president of cultural competence. Patient relations staff includes multilingual and multicultural individuals. The medical center also uses community liaisons and cultural advisory committees to reach out to the community. Care delivery forms and hospital signage are translated into the five primary languages spoken in the community. Hospital staff and medical residents are required to receive cultural competence training. Lutheran Medical Center created a Chinese unit within its health system to address specific cultural issues for Chinese patients.

Results: Lutheran Medical Center tracks the impact of its cultural competence programs through bed occupancy and the number of patients from the local community. Many patients seen at the hospital are from the local community, and with growth in the ethnic and religious groups in the area, the hospital is consistently occupied to capacity. Patient satisfaction scores indicate high satisfaction with health care delivery.

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- 2 U.S. Department of Health and Human Services: Office of Minority Health. (2013, May). *The national CLAS standards*. Washington DC. US Department of Health and Human Services: Office of Minority Health.
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- 4 Ibid.

National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard:

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership, and Workforce:

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance:

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability:

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.



Checklists to Improve Patient Safety

June 2013



Resources: For information related to patient safety and quality, visit www.hpoe.org, <http://www.cynosurehealth.org/> and <http://www.hret-hen.org/>.

Suggested Citation: Health Research & Educational Trust. (2013, June). *Checklists to improve patient safety*. Chicago: IL. Illinois. Health Research & Educational Trust, Accessed at www.hpoe.org.

Accessible at: <http://www.hpoe.org/checklists-improve-patient-safety>

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Checklists to Improve Patient Safety

Why a Checklist?

To improve patient safety and quality outcomes, health care professionals are using multiple methods to reduce patient harm and eliminate medical errors. One method being implemented more and more is the checklist. In his book “The Checklist Manifesto,” Atul Gawande, MD, analyzes the positive impact of checklists used in many fields, including health care, to handle “the volume and complexity of what we know.”

Know-how and sophistication have increased remarkably across almost all our realms of endeavor, and as a result so has our struggle to deliver on them....Avoidable failures are common and persistent, not to mention demoralizing and frustrating, across many fields—from medicine to finance, business to government. And the reason is increasingly evident: the volume and complexity of what we know has exceeded our individual ability to deliver its benefits correctly, safely, or reliably. Knowledge has both saved us and burdened us. (Gawande, 2010)

The development and use of checklists in health care has increased. In 2010, a HealthLeaders Media Industry Survey reported that 88.8 percent of quality leaders use checklists to prevent errors in hospital operating rooms. It is important to note that the effectiveness of a checklist depends on its quality and thoroughness, acceptance and compliance by staff, and a strong culture of safety in the organization.

Types of Checklists

Developing the structure and content of a checklist starts with identifying its purpose or goal. Table 1 outlines several types of checklists and their uses in a medical environment.

Table 1. Types of Checklists

Type of Checklist	Description	Example
Laundry list	Items, tasks or criteria are grouped into related categories with no particular order.	Medical equipment checklist
Sequential or weakly sequential checklist	The grouping, order and overall flow of the items, tasks or criteria are relevant in order to obtain a valid outcome.	Procedure checklist (equipment must be gathered before procedure begins)
Iterative checklist	Items, tasks or criteria on the checklist require repeated passes or review in order to obtain valid results, as early checkpoints may be altered by results entered in later checkpoints.	Continued rechecking of the pulse and blood pressure in checklists for adult cardiopulmonary resuscitation
Diagnostic checklist	Items, tasks or criteria on the checklist are formatted based on a “flowchart” model with the ultimate goal of drawing broad conclusions.	Clinical algorithms
Criteria of merit checklist	Commonly used for evaluative purposes, in which the order, categorization and flow of information are paramount for the objectivity and reliability of the conclusions drawn.	Checklist for diagnosis of brain death

Source: Modified from Development of medical checklists for improved quality of patient care, *International Journal for Quality in Health Care*, 2008.

Benefits of Checklists in Health Care

Checklists used in the medical setting can promote process improvement and increase patient safety. Implementing a formalized process reduces errors caused by lack of information and inconsistent procedures. Checklists have improved processes for hospital discharges and patient transfers as well as for patient care in intensive care and trauma units. Along with improving patient safety, checklists create a greater sense of confidence that the process is completed accurately and thoroughly.

Checklists can have a significant positive impact on health outcomes, including reducing mortality, complications, injuries and other patient harm. Working with the World Health Organization, Gawande examined how a surgical safety checklist was implemented and tested in eight hospitals worldwide. With this checklist, major post-surgical complications at the hospitals fell 36 percent and deaths decreased by 47 percent.

Checklists for Improving Patient Care

The Partnership for Patients Hospital Engagement Networks are designed to improve patient care across 10 areas of patient harm through the implementation and dissemination of best practices in clinical quality. This guide includes checklists, developed by Cynosure Health, for these 10 areas:

1. Adverse drug events (ADEs)
2. Catheter-associated urinary tract infections (CAUTIs)
3. Central line-associated blood stream infections (CLABSIs)
4. Early elective deliveries (EEDs)
5. Injuries from falls and immobility
6. Hospital-acquired pressure ulcers (HAPUs)
7. Preventable readmissions
8. Surgical site infections (SSIs)
9. Ventilator-associated pneumonias (VAPs) and ventilator-associated events (VAEs)
10. Venous thromboembolisms (VTEs)

To prevent process breakdowns due to human factors, each checklist identifies the top 10 evidence-based interventions that health care organizations can implement and test to reduce harm. The AHA/HRET Hospital Engagement Network (HEN) supports each checklist topic with a change package that can be accessed at www.HRET-HEN.org. The change packages provide guidance for implementing best practices, including suggested aim statements, lists of change ideas and tools, detailed steps and driver diagrams. These diagrams map the process to implement each intervention.

Through the AHA/HRET HEN, quality improvement leaders and their teams are encouraged to use the checklists to determine which key interventions they can test as part of their Plan-Do-Study-Act process. HEN staff reviews the interventions during site visits with state hospital association leaders and hospitals. With these tools, hospital improvement teams can identify and adopt the process change, assign staff responsibility and record a target date for completion.

These checklists will assist hospitals and health care systems in their efforts to prevent inpatient harm and reduce preventable readmissions, which are the end goals of the Partnership for Patients initiative.

Checklist I: Adverse Drug Events Top 10 Checklist

Top 10 Evidence-Based Interventions				
Process Change	In place	Not done	Will adopt	Notes (Responsible & By When?)
Identify “look-alike, sound-alike” medications and create a mechanism to reduce errors (e.g., different locations, labels, alternate packaging)				
Standardize concentrations and minimize dosing options when feasible				
Set dosing limits for insulin and narcotics				
Use low-molecular-weight heparin or other agents instead of unfractionated heparin whenever clinically appropriate				
Use alerts to avoid multiple prescriptions of narcotics/sedatives				
Require new insulin orders when patient is transitioned from parenteral to enteral nutrition				
Reduce sliding scale variation (or eliminate sliding scales)				
Minimize or eliminate pharmacist or nurse distraction during the medication fulfillment/administration process				
Use data/information from alerts and overrides to redesign standardized processes				
Coordinate meal and insulin times				

Checklist 2: Catheter-Associated Urinary Tract Infections Top 10 Checklist

Top 10 Evidence-Based Interventions				
Process Change	In place	Not done	Will adopt	Notes (Responsible & By When?)
Adopt insertion criteria				
Ensure sterile technique (including hand hygiene, soap and water perineal care prior to insertion, and appropriate-sized catheter) is used (i.e., through evaluating staff competency and performing observation audits)				
Incorporate daily review of line necessity into workflow, such as charge nurse rounds, electronic health care record prompt (e.g., take advantage of habits and patterns rather than create a new form)				
Do not change indwelling urinary catheters routinely				
Ensure appropriate care and maintenance—closed system, perineal hygiene done routinely, keep urine flowing (no kinks, bag lower than bladder), regular emptying, use of securement device				
Include RNs, MDs, nurse aids, PT, OT, transport, etc. in efforts to reduce CAUTI; they all have a role in care, maintenance and discontinuation of the catheter				
Engage emergency department and surgical services (and other invasive procedure areas where urinary catheters might be inserted) in adopting insertion criteria and insertion technique				
Use other tools, such as underpads that provide a quick-drying surface and wick moisture away, toileting schedule, and purposeful rounding (good alignment here with falls and HAPU prevention) to manage incontinence				
Involve patient and family so they understand the risks associated with a urinary catheter				
Establish CAUTI as a top priority by making CAUTI data transparent				

Checklist 3: Central Line-Associated Blood Stream Infections Top 10 Checklist

Top 10 Evidence-Based Interventions				
Process Change	In place	Not done	Will adopt	Notes (Responsible & By When?)
Implement insertion bundle: procedural pause, hand hygiene, aseptic technique for insertion and care, site selection of subclavian (preferred), internal jugular (acceptable) and avoidance of femoral vein in adults, maximal sterile precautions, skin prep with 2% chlorhexidine				
Implement “stop the line” approach to insertion bundle; if there is an observed violation of infection control practices (maximal sterile barrier precautions, break in sterile technique), line placement should stop and the violation corrected				
Implement insertion checklist to help with compliance and monitoring				
Incorporate daily review of line necessity into workflow, such as charge nurse rounds, electronic health care record prompt				
Adopt maintenance bundle of dressing changes (every 7 days for transparent) line changes, and IV fluid changes; incorporate into daily assessment and review. Can be part of charge nurse checklist along with the daily review of line necessity				
Use a chlorhexidine-impregnated sponge dressing				
Use 2% chlorhexidine-impregnated cloths for daily skin cleansing				
Do not routinely replace CVCs, PICCs, hemodialysis catheters or pulmonary artery catheters				
Use a sutureless securement device				
Use ultrasound guidance to place lines if this technology is available				

Checklist 4: Early Elective Deliveries Top 10 Checklist

Top 10 Evidence-Based Interventions				
Process Change	In place	Not done	Will adopt	Notes (Responsible & By When?)
Educate hospital governing board about the dangers of early elective delivery and the hospital's role in prevention				
Use prenatal classes as an opportunity to educate patients about the dangers of early elective delivery and the hospital's policy				
Find a physician willing to champion the effort to reduce early elective delivery. This physician does NOT have to be an obstetrician; a neonatologist or pediatrician can be very successful in this role				
When writing a hard-stop policy, have physicians and hospital leaders involved from the start				
Ensure the hard-stop policy is very prescriptive (stating the exact steps to be taken, and by whom, in the chain of command when an elective delivery is being scheduled that does not meet criteria determined by the medical staff)				
Use policies, scheduling forms, educational materials and data collection tools that are already created and available publicly from the March of Dimes or California Maternal Quality Care Collaborative				
Display data as concurrently as possible for all stakeholders				
Review all early elective deliveries in the past 12 months to determine if any were admitted to NICU; use those stories as motivation				
Pick one system for determining gestational age in hospital policy and stick to it; the "line in the sand" is key to success				
Do not get stuck in developing the policy by trying to be so prescriptive that any possible medical indication is mentioned. Let the policy allow for medical judgment and a rate of less than 3% as a goal instead of zero				

Checklist 5: Injuries from Falls and Immobility Top 10 Checklist

Top 10 Evidence-Based Interventions				
Process Change	In place	Not done	Will adopt	Notes (Responsible & By When?)
Conduct fall and injury risk assessment upon admission				
Reassess risk daily and with changes in patient condition				
Implement patient-specific intervention to prevent falls and injury				
Communicate risk across the team; use handoff forms, visual cues, huddles				
Round every 1 to 2 hours for high-risk patients; address needs (e.g., 3Ps: pain, potty, position-pressure). Combine with other tasks (vital signs)				
Individualize interventions. Use non-skid floor mats, hip protectors, individualized toileting schedule; adjust frequency of rounds				
Review medications (by pharmacist); avoid unnecessary hypnotics, sedatives				
Incorporate multidisciplinary input for falls prevention from PT, OT, MD, RN and PharmD				
Include patients, families and caregivers in efforts to prevent falls. Educate regarding fall prevention measures; stay with patient				
Hold post-fall huddles immediately after event; analyze how and why; implement change to prevent other falls				

Checklist 6: Hospital-Acquired Pressure Ulcers Top 10 Checklist

Top 10 Evidence-Based Interventions				
Process Change	In place	Not done	Will adopt	Notes (Responsible & By When?)
Implement head-to-toe skin evaluation and risk assessment tool; assess the skin and risks within 4 hours of admission; risk and skin assessment should be age appropriate				
Develop and implement an individualized plan of care based on skin and risk assessment				
Assess skin and risk at least daily and incorporate into other routine assessments				
Avoid skin wetness by protecting and moisturizing as needed; use underpads that provide a quick-drying surface and wick away moisture; use topical agents that hydrate the skin and form a moisture barrier to reduce skin damage				
Set specific time frames or create reminder systems to reposition patient, such as hourly or every- two-hours rounding with a purpose (the 3 P's: pain, potty, position-pressure). This aligns nicely with fall prevention				
Monitor weight, nutrition and hydration status; for high-risk patients, generate an automatic registered dietician consult.				
Use special beds, mattresses, and foam wedges to redistribute pressure (pillows should only be used for limbs)				
Cover operating room tables with special overlay mattresses for long cases (greater than 4 hours; some hospitals choose cases greater than 2 hours) and high-risk patients.				
Use breathable glide sheets and/or lifting devices to prevent shear and friction				
Involve licensed and unlicensed staff, i.e., RNs, LVNs and nurse aides, in HAPU reduction efforts such as rounding with a purpose				

Checklist 7: Preventable Readmissions Top 10 Checklist

Top 10 Evidence-Based Interventions				
Process Change	In place	Not done	Will adopt	Notes (Responsible & By When?)
Conduct enhanced admission assessment of discharge needs and begin discharge planning at admission				
Conduct formal risk of readmission assessment. Align interventions to patient's needs and risk stratification level				
Perform accurate medication reconciliation at admission, at any change in level of care and at discharge				
Provide patient education that is culturally sensitive, incorporates health literacy concepts and includes information on diagnosis and symptom management, medications and post-discharge care needs				
Identify primary caregiver, if not the patient, and include him/her in education and discharge planning				
Use teach-back to validate patient and caregiver's understanding				
Send discharge summary and after-hospital care plan to primary care provider within 24 to 48 hours of discharge				
Collaborate with post-acute care and community-based providers including skilled nursing facilities, rehabilitation facilities, long-term acute care hospitals, home care agencies, palliative care teams, hospice, medical homes, and pharmacists				
Before discharge, schedule follow-up medical appointments and post-discharge tests / labs. For patients without a primary care physician, work with health plans, Medicaid agencies and other safety-net programs to identify and link patient to a PCP				
Conduct post-discharge follow-up calls within 48 hours of discharge; reinforce components of after-hospital care plan using teach-back and identify any unmet needs, such as access to medication, transportation to follow-up appointments, etc.				

Checklist 8: Surgical Site Infections Top 10 Checklist

Top 10 Evidence-Based Interventions				
Process Change	In place	Not done	Will adopt	Notes (Responsible & By When?)
Develop and follow standardized order sets for each surgical procedure to include antibiotic name, timing of administration, weight-based dose, re-dosing (for longer procedures) and discontinuation				
Ensure preoperative skin antisepsis, such as basic soap and water shower; use chlorhexidine gluconate showers				
Develop standardized perioperative skin antiseptic practices utilizing the most appropriate skin antiseptic for the type of surgery performed				
Develop a standardized procedure to assure normothermia by warming ALL surgical patients				
Develop and implement protocol to optimize glucose control in ALL surgical patients				
Develop protocol to screen and/or decolonize selected patients with <i>Staphylococcus aureus</i>				
Adhere to established guidelines (e.g., HICPAC, AORN) to ensure basic aseptic technique (e.g., traffic control, attire) is adhered to uniformly				
Establish a culture of safety that provides an environment of open and safe communication among the surgical team				
Establish system so surgical site infection data is analyzed and shared				
Develop a protocol to provide guidance on blood transfusion practices, as a unit of packed red blood cells should be considered a transplant/immune modulator and has been linked to a higher risk of SSIs				

Checklist 9: Ventilator-Associated Pneumonias and Ventilator-Associated Events Top 10 Checklist

Top 10 Evidence-Based Interventions				
Process Change	In place	Not done	Will adopt	Notes (Responsible & By When?)
Include all elements of the bundle in charge nurse rounds and nurse-to-charge-nurse reports				
Multidisciplinary approach is key: RN and RT staff can work together to ensure bundle items such as HOB, SAT/SBT and oral care are done according to recommendations				
Elevate head of the bed to between 30–45 degrees (use visual cues, designate one person to check for HOB every one to two hours, involve family)				
Conduct routine oral care every 2 hours with antiseptic mouthwash and chlorhexidine 0.12% every 12 hours (create visual cues, partner with respiratory therapy in performing oral care by making it a joint RN and RT function). Make the above oral care part of the ventilator order set as an automatic order that requires the MD to actively exclude it				
Include peptic ulcer disease prophylaxis on ICU admission and ventilator order sets as an automatic order that requires the MD to actively exclude it				
Include venous thromboembolism (VTE) prophylaxis on ICU admission and ventilator order sets as an automatic order that would require the MD to actively exclude it				
Spontaneous awakening and breathing trials (SAT/SBT): designate one time of day for the SAT and SBT to be attempted				
Coordinate SAT and SBT to maximize weaning opportunities when patient sedation is minimal; coordinate between nursing and respiratory therapy to manage SAT and SBT; perform daily assessments of readiness to wean and extubate				
Include SAT and SBT in the nurse-to-nurse handoffs, nurse-to-charge-nurse reports, and charge-nurse-to-charge-nurse reports.				
Delirium management: sedation should be goal oriented; provide a daily reduction of removal of sedative support; administer sedation as ordered by the physician according to a scale such as the Richmond Agitation Sedation Scale				

Checklist 10: Venous Thromboembolisms Top 10 Checklist

Top 10 Evidence-Based Interventions				
Process Change	In place	Not done	Will adopt	Notes (Responsible & By When?)
Adopt a VTE risk assessment screening tool, such as the three-bucket tool from UCSD				
Assess every patient upon admission of his/her risk for VTE using the VTE risk assessment screening tool (instead of just for certain diagnoses or procedures)				
Adopt a standardized risk-linked menu of choices for prophylaxis				
Develop standard written order sets that link the risk assessment to the choice of prophylaxis				
Use protocols for dosing and monitoring when using unfractionated heparin				
Use pharmacists as key real-time decision support for protocols and when patients have contraindications to chemical intervention				
Make prophylaxis ordering an opt-out process instead of an opt-in				
Find the stories of patients who have fallen through the cracks and ended up with a hospital-acquired VTE/PE. Use these stories as motivation to make the assessment process “real”				
Give nurses the same tools you give doctors; doctors get a hard-stop CPOE process for ordering, so work with IT department to identify VTE at-risk patients in the EHR for risk assessments				
If assessments are not being done reliably, consider changing roles: physicians may do the assessment instead of nurses, pharmacists may do assessments through trigger tools, etc.				

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Value-Based Contracting

July 2013

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Resources: For more information related to value-based contracting, visit www.hpoe.org and www.kaufmanhall.com

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Table of Contents

EXECUTIVE SUMMARY	3
INTRODUCTION	4
FOUNDATIONAL REQUIREMENTS	5
Shared Goals and Incentives	5
Strong Leadership and Governance	5
The Unified Persistence of a Value Mindset	5
ASSESSMENT AND PREPARATION	6
Desired Future Position	7
Delivery Service Area and System Infrastructure, Resources, and Contract Scope	8
Types of Arrangements	9
Capacity to Carry Risk	11
Types of Risk	12
Strategy and Contracting Plan	13
Time Frame for Transitioning and How to “Mind the Gap”	15
FINANCIAL AND OPERATIONAL CONSIDERATIONS	16
Capital Requirements	16
Unit Costing and Tracking	17
Financial/Actuarial Assessment and Planning	18
Contracting Capabilities	19
Data Infrastructure and IT	19
EVALUATING A CONTRACT	20
Initial Questions	21
Responsibilities and Risk	21
Financial Impact	22
Credit Risk	24
IMPLEMENTATION SUCCESS FACTORS	24
Physician Engagement	24
Transparency and Accountability	25
Performance Measurement and Improvement	25
CONCLUSION	27
RESOURCES	28
ENDNOTES	29
ABOUT THE AUTHORS	31

Executive Summary

Health care is experiencing dramatic change as the nation's delivery system transitions to a value-based system from the fee-for-service approach that has been in place for the past half century. In the evolving business model, hospitals, health care systems, physician groups, and other health care providers¹ will take on more risk, and be responsible for delivering defined services to a specific population at a predetermined price and quality level. New care delivery networks and value-based arrangements are emerging in communities nationwide. While the pace of change varies in different communities, health care organizations must be proactive or risk being left behind.

The transformation in how providers deliver and are paid for services is, and will continue to be, challenging. The terms of value-based contracts are significantly different than the fee-for-service arrangements. *Value-Based Contracting* provides a primer for hospitals and health care systems as they begin the move to value-based contracting arrangements.

The guide commences with an examination of the foundational requirements for success with value-based arrangements: shared goals and incentives, strong leadership and governance, and a value mindset organization-wide. These factors ensure that organizations are able to learn how to operate in a value-based environment, and maintain strategic flexibility as markets and stakeholders change.

In assessing and preparing for value-based contracting, health care organizations must evaluate the feasibility of their desired position in the new delivery environment, and their preparedness to assume risk under value-based arrangements. Some vital questions hospitals and health care system leaders must ask of their organizations include: What is our desired service area and what infrastructure, resources, and contracting scope are required to meet the population health needs in that service area? What types of arrangements can we or should we participate in? How much risk and what types of risk can we carry? What is our plan for risk contracting and how do we develop this plan? How quickly should we move to value-based contracts and how do we "mind the gap" during the transition?

There are numerous financial and operational considerations for health care providers entering into value-based care. These include capital requirements, unit costing and tracking (which will drive the evaluation of performance under a value-based contract), financial/actuarial assessment and planning, and contracting capabilities (expertise and strength of contracting relationships). A strong data infrastructure and expertise also will be required in order for providers to meet quality targets and proactively, effectively, and efficiently manage the care of a specific patient population under a value-based contract.

Evaluating a specific value-based contract requires weighing the potential benefits and risks related to the organization's capabilities and resources, the financial impact, and credit risk. Three factors that are absolute "must haves" for successful implementation of value-based contracting are: physician engagement, transparency and accountability, and performance measurement and improvement.

The transition to the new care delivery model will vary by market, and likely will extend over a period of 10 years or more. As hospitals, health care systems, and other providers evaluate their changing roles, they must recognize that preparing for value-based contracts will require planning, new skills, and a new approach to health care delivery. Taking measured, incremental steps will increase the chances of success for organizations in the face of a shifting health care environment. At the same time, it is important not to wait too long. Participation is essential to realizing the goal of improving quality and efficiency through value-based arrangements, which ultimately will benefit providers, employers, payers, and patients alike.

Introduction

Value-Based Contracting provides guidance for hospitals and health care systems that are considering value-based contracting arrangements.

“Value” is generally understood to be defined as the result of quality divided by cost, or the health outcomes achieved per dollar spent.² Value-based contracting involves payment or reimbursement based on indicators of value, such as patient health outcomes, efficiency, and quality. This is distinct from volume or fee-for-service based contracting, which involves payment for every unit of service delivered, often without terms related to outcomes, quality, or cost performance.

In the emerging new care delivery model, under the terms of a value-based arrangement, hospitals, health care systems, physicians groups, and other health care providers will be responsible for delivering defined services to a specific population at a predetermined price and quality level. This development has significant strategic and financial implications for health care organizations, as described in this guide.

Managing a population’s health, or “population health management,” involves proactively identifying and assessing those at risk of developing disease, preemptively managing those with chronic disease, and implementing broad-based interventions in early stages of disease to avoid or reduce cost and improve health. This approach requires broadening the scope, environments, and capabilities in which health care organizations must operate in order to be a successful “population health manager.” It also involves developing the right strategies for specific population segments to maximize wellness and minimize illness.

The transformation in how hospitals, health care systems, and other health care providers deliver and are paid for services is, and will continue to be, challenging. The terms of value-based contracts are significantly different than the fee-for-service arrangements in place for the past half century in the United States.

Challenges notwithstanding, progressive health care leaders who understand the value imperative are moving their organizations forward, shifting their business from fee-for-service to performance-based risk arrangements. The anticipated benefits to all stakeholders—patients, health care providers, payers, employers, and the community—include alignment of compensation with quality and outcomes, improved administrative and care-delivery efficiencies, and better quality, outcomes, and access to care.

Value-based contracting will be critical to the ability of health care organizations to establish themselves as essential in their markets. The current level of their involvement in such contracting varies widely. But non-participation is no longer an option anywhere for health care organizations wishing to preserve clinical and financial integrity in their communities. Achieving the Triple Aim objectives of better health, improved care, and lower cost—as described by the Institute for Healthcare Improvement—is a national imperative.

By providing specific guidance related to assessment, and financial, operational, and implementation issues, this guide aims to speed the process for providers. While the primary audience is hospitals and health care systems, much of the information provided is applicable to other types of health care providers, such as physicians, physician groups, and nursing facilities. Its scope is introductory, purposefully focusing on readiness issues, while leaving specific implementation elements or legal issues (for which qualified legal advice should be sought) to other sources.

Foundational Requirements

For value-based contracting, a good starting place is foundational requirements. To be successful with the transition to value-based arrangements, hospitals and health care systems must have underpinning from three sources:

- Shared goals and incentives
- Strong leadership and governance
- The unified persistence of a value mindset

Shared Goals and Incentives

Stakeholders participating in value-based contracting should share goals and incentives for effective health care payment and delivery. Sidebar 1 outlines one expert's definition of necessary goals. Although it may be difficult and take significant time to do, achieving these goals and establishing aligned incentive systems could remedy many of the problems and concerns about current payment systems.

Strong Leadership and Governance

Strong executive, physician, and board leadership call for a unified vision and focus, as well as transparent accountability for the quality and efficiency of delivered care. Such leadership can:

- Clearly articulate the organization's strategy and direction
- Align physician and hospital goals and objectives
- Proactively guide the organization through the delivery and payment-model transformation
- Establish a shared culture with effective multidisciplinary teams

The Unified Persistence of a Value Mindset

A value mindset recognizes the following:

- In risk arrangements, utilization creates expense, not revenue, and hospitals and health care systems become viewed as cost centers.
- Improving outcomes and costs under value-based contracts requires a different incentive system, as well as new management and reporting structures.

Sidebar 1. Goals for Effective Value-Based Health Care Payment Systems

Payment systems should:

1. Enable and encourage hospitals and health care systems to deliver accepted procedures of care to patients in a high-quality, efficient, and patient-centered manner.
2. Support and encourage hospitals and health care systems to invest, innovate, and take other actions that lead to improvements in efficiency, quality, and patient outcomes and/or reduced costs.
3. Make hospitals and health care systems responsible for quality and costs within their control, but not for quality or costs outside of their control.
4. Support and encourage coordination of care among multiple health care organizations, and discourage hospitals and health care systems from shifting costs to other organizations without explicit agreements to do so.
5. Encourage patient choices that improve adherence to recommended care processes and improve outcomes, thus reducing the costs of care.
6. Minimize the administrative costs for hospitals and health care systems in complying with payment system requirements.
7. Align different payers' standards and methods of payment to avoid unnecessary differences in incentives for hospitals and health care systems.

Payment systems should not:

1. Encourage or reward overtreatment, use of unnecessarily expensive services, unnecessary hospitalization or readmission, provision of services with poor patient outcomes, inefficient service delivery, or choices about preference-sensitive services that are not compatible with patient desires.
2. Reward hospitals and health care systems for undertreatment of patients, or for the exclusion of patients with serious conditions or multiple risk factors.
3. Reward hospital and health care system errors or adverse events.
4. Reward short-term cost reductions at the expense of long-term cost reductions, or increase indirect costs (such as the cost of lost time from work or other activities by an individual while receiving health care services) in order to reduce direct costs (the spending by a hospital or health care system for immediate services).
5. Encourage hospitals and health care systems to reduce costs for one payer by increasing costs for other payers, unless the changes bring payments more in line with costs for both payers.

Source: Miller, H.D.: Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform. The Commonwealth Fund, Sept. 2007. Used with permission.

Sidebar 2. Moving Up the Risk Continuum: Challenges for Hospitals and Health Care Systems

- Health care networks and distribution of care are fragmented, siloed, and inefficient.
- Clinical outcomes often are unmanaged; poorly performing health care providers are not held accountable.
- Compensation is not aligned with quality of care.
- The regulatory environment is not conducive to integrated delivery models.
- Facility infrastructure does not align with the new era of health care delivery.
- Many health care organizations have not been successful in past pursuit of risk; lessons learned should be applied to avoid repeat use of models proven unsustainable in the past.

Source: Kaufman, Hall & Associates, Inc.

- Hospitals, health care systems, physicians, and other health care providers must work collaboratively to develop new systems to track and manage the care of patients, particularly those with chronic illness.
- Health care organizations must operate as efficiently as possible in providing evidence-based services.
- Evidence-based services should be provided to all patients, regardless of the payer or payer agreements.

Health care organizations that learn how to operate in a value-based environment will gain critical experience that provides strategic flexibility over time as markets and stakeholders change. The process will be neither quick nor easy, so commitment to the long haul is vital. Initial investments in value-based care and risk contracts will be significant, and efficiencies will not be immediate. But it is far better to lead change than to await its impact.

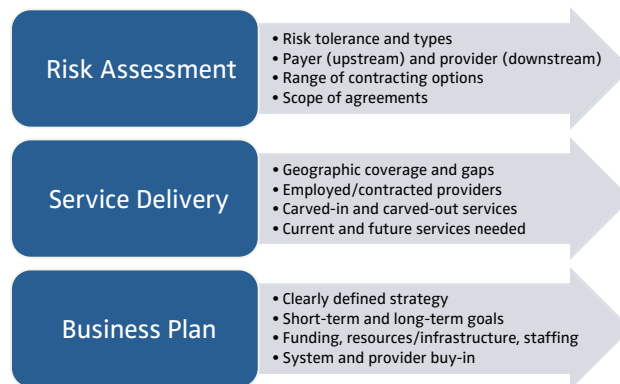
Moving up the risk continuum presents hospitals and health care systems with significant challenges related to changing the “sick care” model to a true “health care” model (see Sidebar 2). Organizational assessment and preparation, covered in the next section, facilitate the structural and behavioral changes needed for success as the “next generation” of payment arrangements emerge.

Assessment and Preparation

To assess and prepare for value-based contracts, hospitals and health care systems should conduct an iterative evaluation of risk and strategic financial performance. Factors organizations should consider in evaluating performance within the context of their desired position in the new delivery environment include the population covered, services to be offered, capabilities, existing delivery model, relationships of other providers in the community (i.e., non-acute or continuum-of-care providers), and alternative payment arrangements (as described later). The end result of this iterative process is a solid business plan that presents a clear strategy for value-based contracting and the key financial and operational considerations going forward (see Figure 1). Such considerations are covered in separate sections that follow.

In developing a contracting strategy and plan, hospitals and health care systems must have meaningful and collaborative dialogue with the desired payers. Overcoming past differences and working together will facilitate a win-win for both parties moving forward with a new contract.

Figure 1. What Is Needed to Assess and Prepare



Source: Kaufman, Hall and Associates, Inc.

Hospitals and health care systems can proactively develop a value-based contracting plan and start implementing this plan.

Desired Future Position

To assess the organization’s ability to participate in value-based care delivery and build a viable plan, hospitals and health care systems should ask, “What role do we want to play in a care delivery network?” As risk contracting and providing care that is “accountable” across value dimensions increase nationwide, different categories of providers are emerging and likely will continue to emerge. The categories will reflect the health care organizations’ ability to incur risk in managing a population’s health, extending from no risk to the ability to assume full capitated, or “cap” risk.

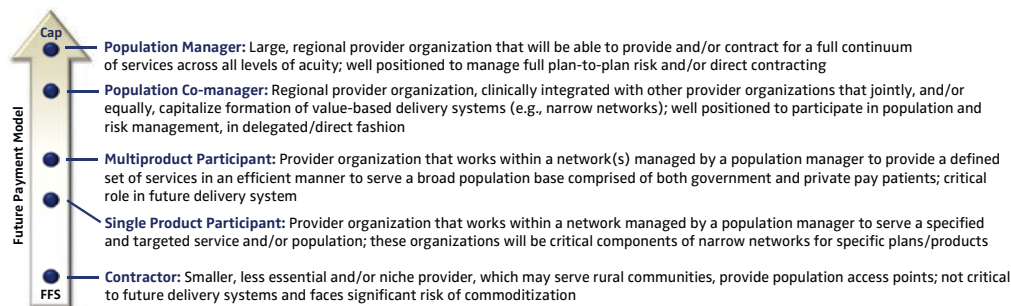
Some large health care systems will be functioning as regional “population health managers,” defined as organizations providing and/or contracting for a full continuum of services across all acuity levels for regional populations. At the other end of the spectrum, some hospitals—such as critical access hospitals, small and rural hospitals, and post-acute care facilities—will provide specified services to target populations under contract, working within networks that are managed by larger entities functioning as population health managers. Other roles in between will be assumed by other organizations as outlined in Figure 2.

The health care organization’s desired position within this framework must be firmly grounded on its strategic financial condition, and its organizational and leadership competencies. Only a small proportion of health care organizations today have the geographic reach, scope of services, scale, and risk-management expertise to truly manage the care of a large population. However, many providers—including large physician practices, hospitals and health care systems—are working aggressively to reposition themselves to do so through virtual affiliations or more formalized, integrated delivery structures.

Boards and management teams of every hospital and health care system need to determine which category of provider they are seeking to become under the value-based model. Success factors are different for each organization type, and resource issues are significant.

For example, health care providers working under contract (“contracted providers” or “contractors”) with another provider to deliver specified services will need high quality, predictable outcomes, low cost, and efficient information exchange with the contracting population health manager. Population health managers will need to offer an integrated delivery system, with health care providers accessible across the delivery continuum (from preventive services to hospice). This will require a sophisticated care management infrastructure, advanced information technology and analytics, network development and management expertise, and interface and connectivity to all stakeholders, as appropriate.

Figure 2. Categories of Hospitals and Health Care Systems Under a Value-Based Model



Source: Kaufman, Hall & Associates, Inc.

Delivery Service Area and System Infrastructure, Resources, and Contract Scope

Hospital and health care system leaders must define the desired service area and assess whether they currently have, or can build or purchase, the delivery infrastructure required to participate in value-based contracts for the covered population. Critical considerations include identifying the target population, the services used, and services needed in the future. The question is, "Given our resources, which service area and how large a population do we believe we can effectively manage?"

Health care organizations must accurately assess their geographic coverage capabilities, defining the "right" population and the organization's ability to meet that population's health needs under a contracting arrangement (Figure 3). Contracting will differ by location and by the presence or absence of participating payers. Many different payers exist in most markets, with broad categories including: Medicare; Medicaid; county and other public programs; commercial insurers (operating nationally, regionally, or locally, and including Medicare Advantage programs); self-insured employers (often working through a third-party administrator); and self-pay individuals.

To participate in contracts in some regions, organizations will need considerable scale and geographic coverage with a range of care-continuum providers, either through ownership or partnerships. In other areas, more limited service delivery may be possible. Scale will be required to diversify risk in many areas of the country. Many small and mid-size organizations—including critical access or rural hospitals—may need to pursue risk-contracting strategies through strategic partnership arrangements with other organizations.

Figure 3. Defining and Managing the Optimal Populations Are Key



Source: Kaufman, Hall & Associates, Inc.

Additional questions to be answered include:

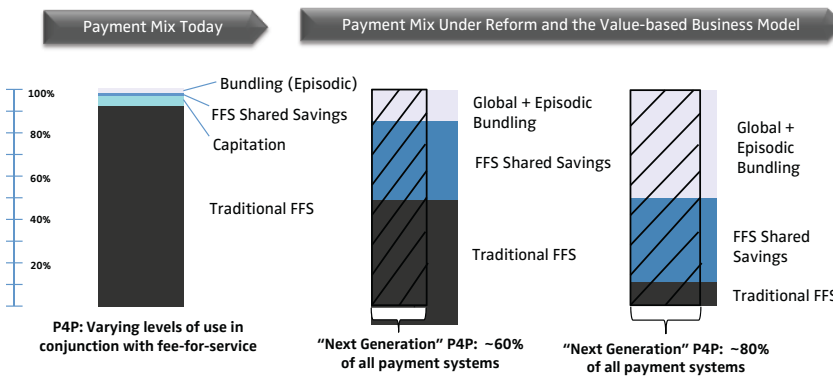
- How strong are our relationships with payers and employers? What defensible value proposition can we proactively bring to them in contracting arrangements?
- How strong are our relationships with primary care physicians, specialists, and other health care providers? Do we have a physician network with contractual arrangements that provide incentives to effectively and efficiently manage the care of a defined population?
- Do we need to employ or own the providers (for example, physician practices, home care) or can we contract or make partnership arrangements for their services?
- Which clinical services would we want included ("carved in") or excluded ("carved out") in contracts?
- How can the number of patients who seek out-of-network and out-of-area services be minimized, when allowed by state and federal regulations?

The strength of the organization's value proposition will hinge on the strength of the proposed primary care network and its geographic and service line coverage. It also will depend on whether the organization has the requisite infrastructure to allow for data sharing with patients, payers, and other providers (more on this later). Payers must be convinced that the organization's care delivery platform will lead to lower costs and better outcomes.

Types of Arrangements

As payment transitions to a value-based system, a hybrid of payment mechanisms is emerging, incrementally shifting the mix from fee-for-service to value-based (Figure 4).

Figure 4. Expected Shift in Payment Mix



Note: Projections are "in the aggregate" and not market-specific
 Sources: Payment system "mix" extrapolated from *Managed Care Digest Series*, *HMO-PPO Digest* (23rd edition) and review of for-profit, publicly traded managed care 2009 10Ks.

One size will not fit all. A wide range of value-based payment alternatives already are in operation nationwide and are expected to increase as payers, purchasers, hospitals, health care systems, and other types of providers gain experience.

Although payer initiative is more common, providers or employers may be the parties proposing the contracts. Some organizations and companies are establishing their own health plans, or entering into existing plans and assuming insurance risk. Contract opportunities are regional or localized in nature. Regional or national insurers are not and likely will not offer arrangements in all communities or to all providers.

National payers have begun to take a position that shared-risk arrangements are the only way to drive results. Such arrangements have upside potential, but they also have downside potential if performance doesn't meet expectations. In early-stage value-based arrangements, both upside gains and downside risks are usually "bracketed" to give reasonable protection to both sides. Risk-based contracting involves some expansion of potential downside financial risk for the cost of care, through bundling of payments, varying degrees of capitation, or full assumption of both administrative and clinical costs (e.g., a system-owned health plan).

Variations in possible payment arrangements abound, and organizations need to assess which types of contracts are appropriate. For example, a multi-provider bundling of payment for an episode of care might or might not extend beyond hospital discharge. A hospital or home health bundled payment would provide one fee for the combined inpatient and home health services for an episode of care, as well as related physician services. Organizations would need contracts with those providers and expertise in administering those contracts.

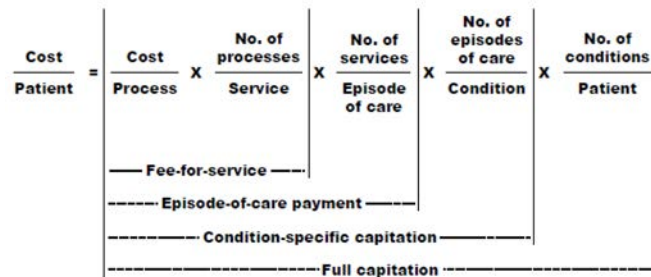
Under "health condition-specific capitation," one fee would be paid to cover all services rendered by all providers for a defined condition, either on a one-time basis for short-term conditions, or on a regular, periodic basis for longer-term conditions,

such as chronic diseases. In this case, the hospital or health care system should determine the scope of services that the organization can provide and with whom it will need to partner if pursuing a capitated contract.

As noted by one expert, “Any given provider may face significantly different incentives and disincentives for the care of patients with similar conditions, depending on which payer is paying for a patient’s care.”³ Figure 5 shows the variables contributing to care cost and which of these variables the provider could be at risk for under alternative payment systems.

Each of the payment systems inherently creates incentives and disincentives for the provider and payer, with systems on the left side of Figure 5 having risks of higher costs for the payer and overtreatment of patients, while those on the right side shift the risks of costs to health care providers, thereby creating risks of undertreatment of patients, as described by Harold Miller.⁴ Various contractual controls and incentives can be developed to counteract the risks, but the organization must be cognizant of its risk tolerance, as described later in this guide.

Figure 5. Variables for Provider Risk Under Alternative Payment Systems

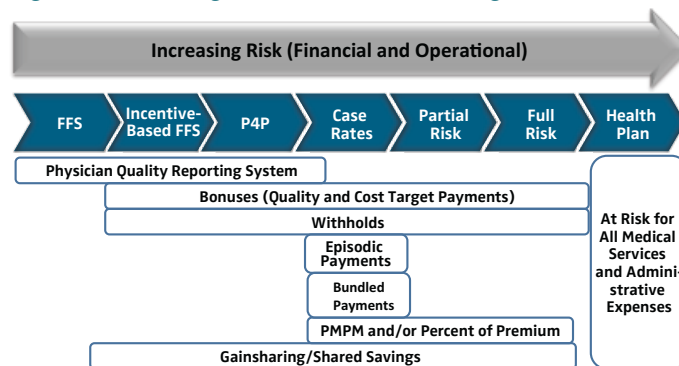


Source: Miller, H.D.: *Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform*. The Commonwealth Fund, Sept. 2007. Used with permission.

Risk-sharing arrangements may not be available in all regions, but most areas will have a variety of incentive options. It is possible to get into value-based contracting under the current fee-for-service model through pay-for-performance and other upside incentive-enhanced arrangements.

If sufficient time and payer willingness exist for an incremental transition, hospitals and health care systems can start with programs with upside risk only, or those heavily weighted to upside risk, and then move up the risk continuum as they gain experience and build infrastructure (see Figure 6). Sidebar 3 includes definitions of basic types of value-based arrangements.

Figure 6. The Range of Value-Based Arrangements on the Risk Continuum



Source: Kaufman, Hall & Associates, Inc.

Capacity to Carry Risk

Leaders of health care organizations should assess the organizational tolerance for risk. In the value contracting context, risk is incurred through acceptance of a fixed dollar amount in exchange for the partial or total care of an identified patient population at a specified quality level, as defined through a contract. Risk represents the uncertainty about whether, after incurring the care-provision costs, the organization will have a net gain or net loss from this arrangement. Tolerance reflects the organization's capacity to "carry" the risk without endangering its strategic, operational, or financial performance, or a combination thereof, to an extent defined by the organization. Different organizations will have varying capacity and tolerance for risk.

Value-based models are designed to shift "performance risk" for care quality and costs to health care providers, who ultimately control the costs and quality of care, and away from insurers or payers, who have limited control over these factors. Insurers or payers traditionally assume "insurance risk," namely the risk that a patient will need services or a greater level of services than projected.

Providers will assume *downside* financial risk for not meeting targeted population health measures, for costs above expenditure benchmarks, and for not meeting quality thresholds. Conversely, *upside* financial incentives will accrue when providers exceed the population health measures, achieve a lower cost of care than target levels, and exceed quality thresholds.

Upside-only risk models may carry downside risk too if the agreed-upon fixed-payment amount (the base rate) is lower than the provider received or receives under other payment arrangements. Upside incentives will be paid if the provider meets or exceeds goals, as defined, but uncertainty exists related to whether the provider can accomplish this. If not, the result will be lower overall payments than experienced under other arrangements. Payments might come from a commercial or government payer, a self-insured employer, or another health care organization. If the latter, this organization would be accepting and managing risk as a partial or full-spectrum delivery network under population care arrangements with payers.

Research-based quantification of the amount of risk assumed by hospitals and health care systems at this point in time is lacking. But in early 2013, Moody's Investors Service introduced new indicators to capture the changing payment and care models.⁵ One of the indicators asks organizations to report

Sidebar 3. In-Brief Definitions: Types of Value-Based Arrangements

Pay-for-performance—Hospitals, health care systems, physicians, or other providers receive bonus payments or have a portion of their pay withheld based on whether they meet preset performance targets. Targets may relate to quality, cost effectiveness, efficiency of care, or other factors.

Physician Quality Reporting System—PQRS involves a Medicare payment bonus paid once a year based on previous time period completion and submission of PQRS initiative measures.

Case rates (also known as episode-of-care payment or bundled payments)—Under these arrangements, providers are paid a fixed amount for services required by a patient during an entire care episode. For example, a provider may be paid a set amount for all care associated with treating a stroke patient. Payments are based on the estimated costs of care associated with a specific condition and determined annually or within a set time frame, such as from the time a stroke patient is admitted to the hospital to when he or she is discharged, or 30 days after hospital discharge.

Gainsharing—Gainsharing is a management system or approach that promotes a higher level of performance through the involvement and participation of physicians or other providers. As performance improves, financial gains are shared. Improved performance yields greater compensation, in turn promoting continuous improvement through a reinforcing cycle.

Shared savings—Shared savings is a payment strategy that offers incentives for providers to reduce health care spending for a defined patient population by offering them a percentage of net savings realized as a result of their efforts.

Capitation contracts—Under capitation contracts, providers administer the contract and assume risk for contractually defined services. These contracts can be structured in many ways. Providers can receive a set amount per patient per month, or periodically receive a predetermined percentage of the premiums that patients pay to insurers. Providers are able to keep any savings if costs are below the capitated amounts, but are responsible for any cost overruns. Global capitation payments cover all patient services, while partial global capitation payments cover only a specified portion of services. The entity contracting with the payer must have downstream network contracts. Cost savings, after administrative fees, can be distributed per contract agreement.

Source: Kaufman, Hall & Associates, Inc.

the percentage of net patient revenue that is “risk-based,” which will include the traditional forms of risk-based payment, such as per-member, per-month capitation, and emerging models, such as bundled payment and pay-for-performance. These data will help capture how quickly hospitals and health care systems whose debt is rated by Moody’s are moving into value-based arrangements.

Types of Risk

Assessment of risk tolerance needs to be based on an understanding of how much and what type of risk the organization can and should incur. Four sources of risk are inherent in value-based contracting: strategic and operating; actuarial or insurance; financial/asset and liability; and comprehensive.

Strategic and operating risk involves the organization’s ability to successfully execute its contracting plan into the future. Organizations wishing to provide—either directly or through managed relationships—a full continuum of services across all service lines and levels of acuity will need deep financial resources and a robust risk-management infrastructure. The ability to generate sufficient capital and to effectively manage the allocation of risk will be critically important to all organizations participating in a care delivery network.

Risk related to potential care-continuum partners should be considered as part of strategic and operating risk. The contracting entity usually assumes risk for its network partners and out-of-area services. Robust data are needed prior to contracting to ensure that the amount paid will cover these services. Risk incurred by potential partners will impact the contracting provider. For example, hospitals and health care systems that contract with physicians or laboratories will assume their downside risk unless the arrangements involve subcapitation, with contracted physicians and labs also at risk.

Actuarial or “insurance” risk involves the organization’s ability to properly estimate use rates and costs for serving a defined population, and to mitigate risk of inaccurate projections through specific initiatives. Also important is the ability to meet capital reserve requirements for assuming risk, as described later in this guide. Only a limited number of organizations currently have the scale and resources to absorb this level of risk, so any organization considering taking on actuarial risk should seek expert advice.

Financial/asset and liability risk is incurred due to the significant capital that is required to build physician networks, enhance technology, develop care-management infrastructure, and maintain minimum cash reserves. All of these uses divert capital capacity from supporting the “traditional” business or funding other strategic initiatives. Health care organizations will be at risk for capital allocation decision-making that does not enhance long-term competitive or financial performance. This impact is capable of altering—perhaps profoundly—the organization’s financial risk profile.

Capital commitments to population health arrangements also restrict the organization’s flexibility with capital structure decision-making, i.e., asset and liability management. Because the health care organization is assuming considerable new market and operating risks, it may be unable to tolerate capital structure-related risks that would lower the cost of capital and enhance earnings under other circumstances. Over time, this may stress the organization’s current credit rating or outlook, as provided by the rating agencies.

Comprehensive risk represents vertical risk, or how the component risks described here might combine in ways that create substantially more risk than the parts might suggest. Such total risk can undermine the health care organization’s strategies, market position, financial performance, and ultimately, its ability to serve its communities. If the three risks are not properly balanced, the organization is strategically vulnerable due to the resulting limits on its financial flexibility and, potentially, its inability to respond to realized risk or to provide financial support for its strategic needs.

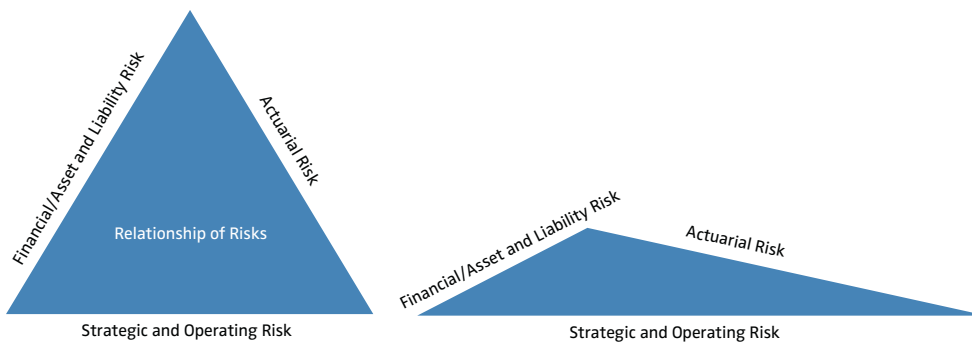
Health care executives and board members must understand how their organizations' single and comprehensive risk profiles are matched—or not—with the ability to handle that risk. The key to success becomes finding the balance point.⁶

Like the sides of a triangle, all risks are linked and interdependent. The total comprehensive risk that reasonably can be assumed by an organization is finite at any moment in time, but variable as internal and external circumstances change. Once an organization quantifies the level of total risk it is able to support, an increase in any side of the triangle (single type of risk) will and should proportionately reduce the length of other sides. Unless the organization wishes to increase its total risk by increasing the triangle's perimeter, total risk thus remains constant and balanced.

The left triangle in Figure 7 depicts a situation in which all major risk components are equal. The right triangle depicts a scenario in which there has been a significant increase in the organization's strategic and operating risk. In this instance, to keep its total risk profile constant, the organization has had to significantly decrease its financial/asset and liability risks.

The risks involved in implementing a health care organization's strategies will be high during the next decade. When, with whom, and how to start managing population health and assuming performance-based risk contracts are important questions with critical implications to the total risk assumed by hospitals and health care systems. Top-down management of risk, with executive buy-in and commitment at all levels, is required.

Figure 7. Comprehensive Risk: The Relationship of Risks



Source: Kaufman, Hall & Associates, Inc.

Strategy and Contracting Plan

A fact-based, corporate-finance approach is recommended for answering the questions in each of the previous sections. Answers to these questions will identify the feasibility of the organization's desired future state, and also identify strategies that might be needed to achieve it.

The corporate financing approach, well-documented in a number of publications,⁷ involves the following steps:

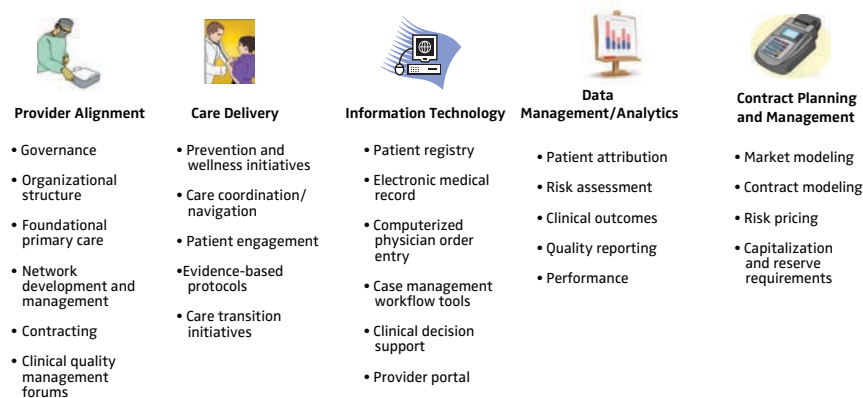
- Quantify the organization's capital position through an analyses of risk position, and sources and uses of capital, as described earlier.
- Determine its capital constraint (i.e., the net capital available for spending within a designated period of time) and risk constraint (i.e., the level of total risk the organization can carry, given organizational risk tolerance).
- Identify available debt capacity (i.e., the amount of debt an organization is capable of supporting within a particular desired credit profile).
- Assess the risk profile and available hedging resources, such as working capital and contingent payments.
- Conduct sensitivity analyses around the magnitude of possible financial impacts of defined risks, occurring singly and in combination.

In short, the objective is to build a comprehensive catalogue of the health care organization's risk-bearing capacity, and identify how that capacity can best be deployed against the array of risks the organization would assume by pursuing financial, strategic, or operating returns. These analyses will indicate the organization's ability to assume risk, including risk related to contracting arrangements. If that ability is limited, partnership arrangements may be needed and appropriate.

A health care organization's risk-contracting strategy should be a part of its comprehensive business plan. This provides the documentation and analysis necessary for valid capital decision-making related to risk contracting and the scope of feasible population health management.

Hospitals and health care systems need to be thoughtful and realistic about the skills and infrastructure needed to manage different types of payment arrangements under population health management. Figure 8 outlines critical elements of readiness for organizations assuming full risk as population health managers.

Figure 8. Organizational Abilities Required for Population Health Management



Source: Kaufman, Hall & Associates, Inc.

Relationships are changing rapidly. Value-driven contracts will fundamentally transform how many hospitals conduct their business with physicians, other health care organizations, and payers. Many health care organizations have no prior experience with risk-based contracting. External advisors can help ensure organizations consider all important factors in developing a plan, and evaluate their capabilities in a broader context of the regional and national markets. The assessment and planning process can take between two to six months, depending on the complexity of contracting arrangements in the specific region, and the organization assuming performance or risk-based agreements.

Hospitals' or other providers' entry into new agreements and how they position themselves on the risk contracting and population health management continuum depend on two key elements:

- What the hospital, health care system or other provider brings to the table in terms of current clinical capabilities, culture, IT infrastructure, and financial capability to understand and manage the future risk involved with a population's health management. This includes the degree to which the organization has a population health management or total continuum of care viewpoint rather than a singular viewpoint (i.e., hospital or ambulatory), and its fortitude to make quality of care and financial decisions independently of their impact on a singular network component.
- The payers present in the market, which will affect the speed of movement and the options available to hospitals, health care systems, and other providers. In some

markets, risk contracting is limited. In other markets, payers are actively negotiating value-based arrangements that allow hospitals and health care systems to assume increased risk, and give them greater control or influence over benefit design and administration when they do so. This depends on specific state- or employer-defined benefit levels and scopes. When insurers offer risk contracts, the provider entering into the contract must administer the benefits per defined scopes in the state, or as defined by self-insured or fully insured employers (it cannot change the benefits).

Hospitals and health care systems that are contracting with a payer will want to ensure that, as they move to the right on the risk continuum, they are responsible for managing medical services risk, including claims payment, and referral management and authorization, but not premium collection or bad debt. This should remain under the insurer's purview until the hospital or health care system assumes full risk with a health plan of its own.

Health care organizations that currently have strong population health management capabilities and infrastructure will bring to the table a solid value proposition for contractual arrangements with payers and self-insured employers. Hospitals and health care systems that don't yet have the requirements outlined in the first bullet point above (and illustrated in Figure 8) can begin building these processes and infrastructure, and developing new collaborative partnerships with payers.

Hospitals and health care systems should explore all available options, whether that means developing the required capabilities alone, or seeking partners to achieve the goal of increased risk management, reward, and the delivery of higher-quality, cost-effective care.

Assuming risk will have other implications that will need to be explored. From a financial reporting perspective, assuming risk contracts will require changes to the way the organization recognizes revenue and accrues liabilities over time. The cash and financial impact of these accruals could significantly impact the organization's financial performance and should be incorporated into planning activities.

Time Frame for Transitioning and How to "Mind the Gap"

The current macroeconomic environment, including federal and state budget pressures, presents significant challenges for hospitals and health care systems. Health care organization revenues will be under considerable pressure as payment mechanisms migrate toward value-based approaches. Use rates for inpatient and certain hospital outpatient services are declining already in many areas of the United States, and this trend is expected to continue.⁸

In this environment, a key issue in front of every hospital and health care system is how quickly to move to value-based arrangements. Current trends will reshape health care's business model from a volume- to a value-based one, with the transition extending over a period of 10 years or more. Hospitals and health care systems should understand the impact and start the move to value-based arrangements now, if they haven't already done so. Improving quality and efficiency through value-based arrangements is the right thing to do. As the market for health care services continues to shrink, continuing to compete on volumes and rate will be a riskier strategy than shifting to value-based arrangements.

The speed of the shift will vary by market. Variables affecting the rate of change include payers, employers, health care organizations, physicians, and other providers (and their degree of integration). The demographics, health needs, and other characteristics of the population also will have an impact. The transition in payment rates and structures to pursue value-based care will affect hospital and health care system performance, decreasing margins in the short term.

Robust, disciplined financial planning is required to quantify the health care organization's

path to optimize performance as it transitions payment from volume to value. The foundation for best practice financial planning is the corporate finance-based approach outlined in the previous section. Components of this approach include analyses related to:

- Credit position
- Overall capital position that defines profitability targets to meet the organization's needs for long-term strategic positioning
- Capital requirements (both routine capital committed into the next 5 to 10 years, and capital required to accomplish strategic goals)
- Debt capacity
- Minimum cash position required given future reimbursement challenges, competitive threats, and capital demand

In all, these analyses will provide a comprehensive view of the organization's current capital position and the performance levels required to support its strategic requirements.

Based on these analyses, the hospital or health care system should develop baseline financial projections using assumptions related to volumes, reimbursement (Medicare, Medicaid, and commercial payers), salary expense, non-salary expense, capital spending, and investment income. From that base, scenario analyses are essential to quantify the effect on margin and liquidity of changing assumptions and new initiatives that represent key variables. These variables may include expense reduction efforts, increased physician alignment (to enhance primary care and/or specialist base), and restructuring of reimbursement arrangements from fee-for-service to value-based.

The resulting plan can be used to identify the strategic and financial implications of these key variables singly or in combination. As the health care organization moves forward with its new initiatives, the plan should be revisited regularly to measure success or lack thereof, adjust to changing market realities, and ensure that the organization maintains its desired level of financial performance.

Financial and Operational Considerations

Financial and operational considerations should be inexorably linked. Each of the topics covered in this section is critical to achieving sustainable financial performance in value-based arrangements.

One operational consideration that should be addressed here first is that organizations seeking to develop their own health plans will need to be licensed and, possibly, accredited. Accreditation bodies include the National Committee for Quality Assurance, Accreditation Association for Ambulatory Health Care, and URAC (formerly known as the Utilization Review Accreditation Commission).

Capital Requirements

Significant investment of capital—both financial and human—is required for entering into risk-based arrangements. As mentioned earlier, the health care organization's capital and financial performance is greatly affected by the cost of building physician networks, enhancing technology, developing care-management infrastructure, and maintaining cash reserves. Hospitals and health care systems must maintain enough capital to fund their strategic needs, while meeting operating costs and maintaining the liquidity required for financial performance targets.

Capital reserve requirements, which will vary by contract, include regulatory reserves and financial reserves.

- *Regulatory reserves* may be required by states or the federal government. Their size will depend on the specific health insurance contract and the level of risk involved.

-
- **Financial reserves** offset an organization's future operating exposure to contract-based risk, such as higher-than-anticipated costs. These reserves generally need to be in place to meet the terms of the contract. Hospitals, health care systems, and other providers that make global contracting arrangements, for example, must meet minimum "statutory" capital requirements. These are defined as the organization's liquid assets that can be converted to cash quickly, thus ensuring sufficient capital to pay ongoing claims.⁹ Payers that make partial risk arrangements with health care organizations also may require access to financial reserves, a line of credit, or both.

Organizations also may have debt covenants that require excess reserves and specific audit requirements to book those reserves. Reserves can significantly affect access to capital and its cost due to implications relative to debt covenants (e.g., liquidity requirements). If an organization's use of capital reserves diminishes its liquidity to the point of triggering debt covenants, its credit rating may be at risk. A lower credit rating increases the cost of capital for the organization going forward.

As part of statutory reporting requirements, organizations must be calculating, monitoring, and recording a new class of liability known as Incurred But Not Recognized (IBNR). IBNR exists under fixed or capitated payments and is a claim against the organization's payment streams when services have been provided but the contracting entity has not yet received the claims information.

State commissioners or departments of insurance also typically promulgate state statutory requirements. Many states require statutory reserves only if providers are taking on insurance risk, but providers still should maintain IBNR records. Depending upon the timing of the fixed payments to the health care organization, the organization's auditor may require reserves and accruals to recognize the fixed payments due to the organization.

The American Academy of Actuaries¹⁰ and the National Association of Insurance Commissioners¹¹ publish reserve standards for health plans. Organizations should seek expert advice in this area as regulations and requirements are complex.

Unit Costing and Tracking

Data on unit and case cost for all services for which the hospital or health care system will be at risk will drive the evaluation of the health care organization's performance under a value-based contract. The availability and accuracy of such data are of utmost importance. Tracking ensures that costs are managed, given quality and outcome targets.

Hospitals and health care systems must know their current cost of care, as well as the care costs of partners that will be sharing risk. A quick response to high-cost "outlier activity" will be required to meet expected financial targets. But hospitals and health care systems currently may not have their own cost data, as actual per-unit or per-case costs have not been tracked under the existing diagnosis-related group-based payment system. Additionally, hospitals and health care systems typically have had difficulty capturing and accessing data on outpatient costs.

Payers currently have the most complete cost picture. While this information traditionally has not been shared, the situation is changing for the better. As of June 2013, 16 states have established or are establishing all-payer claims databases, with the purpose of promoting the uniformity and availability of health care data.¹²

Many hospitals and health care systems will need to acquire more robust, cost-accounting systems that allocate costs—either directly or through a proven and established formula—to the products and services provided. This will require many decisions about what data to capture and how to capture them.

Sidebar 4. Actuarial Considerations with Risk Contracting

Contractual payment model:

- Model types, such as global capitation, shared savings, and incentive plans
- Model considerations, such as period of time, benchmarks/targets, one- or two-sided risk, phase-in of payment model
- Enterprisewide management of contractual arrangements

Cost-measurement considerations:

- Define costs
- Define members, such as minimum enrollment and attribution logic
- Risk adjustment, including model choice, calibration to other contractual parameters, provider coding patterns

Savings calculation considerations:

- Where is the health care organization today? (Consider level of current medical management/care coordination, availability of comparative analytics, IT infrastructure, culture for change)
- Where does the health care organization want to go? (What changes are included in the plan? Has the organization set targets or goals?)
- How long will the health care organization take to get there? (What are the upfront costs? When will savings from the initiatives materialize? Will there be savings offsets?)

Source: Presentation by David A. Neiman, FSA, MAAA: *Actuarial Implications of Accountable Care Organizations & Patient-Centered Medical Homes*. Society of Actuaries, Oct. 2012. Used with permission.

Hospitals and health care systems will want to establish a baseline of cost and utilization data for the organization itself and any of its partnering providers participating in a risk contract. Developing financial scenarios for a risk contract and ongoing cost and volume tracking will be critical. For example, with bundled payment arrangements for episodes of care, different types of defined episodes will have different distributions of costs by service type. An American Hospital Association¹³ publication notes that the 30-day fixed costs of a “major joint” episode (DRG 471) was comprised of initial hospital costs of approximately 51 percent, physician services of 12 percent, post-acute care of 32.6 percent, readmission-related expenses of 3 percent, and “other” costs of 1.5 percent. These data suggest possible savings opportunities through initiatives designed to reduce post-acute care for major joint replacement patients.

Organizations without accurate information about costs across the episode are “at risk of either overpricing the bundle, making it less attractive to purchasers, or underpricing the bundle, exposing the organization to financial risk,” according to the Healthcare Financial Management Association.¹⁴

Financial/Actuarial Assessment and Planning

Actuaries use mathematics, statistics, and financial theory to study the risk of uncertain future events, such as hurricanes or health care utilization. They evaluate the likelihood of those events, and design creative ways to reduce such likelihood and decrease the impact of adverse events that do occur.¹⁵ Most actuaries work in the insurance industry and determine how much an insurer should charge for insurance, taking into account the specific region’s demographics, costs, utilization patterns and expectations, and other factors.

Although hospitals and health care systems have financial planning staff, they typically do not have actuaries on staff. Depending on their level of involvement in risk contracting, hospitals and health care systems may need to contract for these services or recruit the talent to complete the financial statements at the chief financial officer and audit level. Relevant actuarial issues for health care organizations considering risk contracts are numerous, including the number of patients covered by the contract, risk adjustment, cost, pricing, benefit design, the required upside and downside payment, and stop-loss insurance and reinsurance. All of these issues are interrelated, so they must be assessed together to ensure that the total cost of the services provided does not exceed the payment offered for those services.

For example, the risk inherent in providing care to a specific population depends on its size, with larger panels generally representing lower risk. But even large populations, such as Medicare beneficiaries and commercially insured patients, will have very different utilization patterns, representing significantly different risk to contracting organizations.

If contracting in a competitive market, payer pricing may be constrained, and richer benefits (which cost more to provide) may be necessary. A close look at the cost of each benefit—who will be providing it, the appropriate infrastructure, and the expected payment—is important. Every variable in the equation must be accounted for, as closely as possible. Pricing and payment must be competitive to enter and survive in a market.

To mitigate risk, hospitals and health care systems should ensure that they do not enter full-risk arrangements until they have the capabilities to do so. Risk mitigation strategies include purchasing stop-loss insurance, which provides financial coverage for care delivery costs that exceed a maximum threshold amount, and incorporating maximum cost structures into contracts. Sidebar 4 outlines actuarial assessment and planning considerations.

Contracting Capabilities

Organizations should consider two important issues related to contracting capabilities: contracting expertise and strength of relationships. The current know-how within many hospitals and health care systems for contracting under risk arrangements and administering contracts may not be sufficient. Health care organizations will most likely need new skills and capabilities due to both the overall complexity of contracts, and the critical nature of financial and operational considerations (see Sidebar 5).

On the front end, individuals negotiating risk contracts will need solid financial and analytic skills to know what constitutes the right contract and the right terms, and whether the organization has the resources and infrastructure in place to deliver on those terms. Analytic expertise exists across health care, but an executive of a major health care system notes, “It’s hiding in silos,” including payer organizations, care-management organizations, traditional hospital-system organizations, and physician enterprises.¹⁶ To be successful, hospitals and health care systems will need to obtain contracting expertise from other areas. Employment or advisory arrangements may be appropriate.

Individuals with leadership, analytic, and performance-management expertise will be needed for “governance” of contractual arrangements. Such governance includes high-quality program management and administration, which are achieved through a clear delineation of roles and responsibilities across all stakeholders. Program governance answers questions about who will provide which services and the specific targets under which each hospital or health care system will operate. During the life of a contract, the contract must be managed proactively, with routine tracking of progress related to benchmarks and targets, and developing and implementing course corrections as necessary.

Governance also includes strong “upstream” relationships with payers and “downstream” relationships with physicians and other providers covered under the contract or subcontracting arrangements. The quality of these relationships will largely determine contracting capabilities. If relationships are weak, the health care organization’s leaders should figure out why and what they can do to remedy the situation. Relationships will need to be collaborative under the value-based model.

Data Infrastructure and IT

Data sharing between payer and provider is essential to tracking organizational performance of key measures under value-based contracts. Multiple types of data will be needed, including claims data, transactional information, and data available through the electronic medical record system.

Payers have robust actuarial, benefit, and contract departments, as well as the ability to provide claims data independent of where the patient receives care. But payers’ use of multiple processes and systems to validate, route, and report on their transaction activity still can result in “a spaghetti-like environment that is plagued with inconsistent

Sidebar 5. Skills Required for Risk Contracting

- Actuarial expertise/insurance risk management
- Networking and contracting strategies
- Predictive modeling
- Aggregation and analysis of claims and EHR data for population-level intelligence
- Advanced data management capabilities
- Physician-level reward systems
- Operation of analytic software for performance measurement
- Analysis of disease registries for practice variation reduction opportunities

Sources: Mechanic, R., and Zinner, D.E.: “Many Large Medical Groups Will Need to Acquire New Skills and Tools to be Ready for Payment Reform.” *Health Affairs* 31(9): 1984-1992, Sept. 2012; Morrissey, J.: “Data Driven.” *Hospitals & Health Networks*, Feb. 2013.

processing and fragmented visibility into transaction activity.”¹⁷ More insurance companies share data now, and technology capabilities to enable that sharing are improving rapidly.

Hospitals and physician practices historically have had access only to data on their own patients, with no broader view of what is happening in their communities. But the ability to proactively manage the care of a specific patient population requires a much more expansive level of data. All risk-based contracts secured by hospitals and health care systems should grant access to data from payers and other health care providers on the populations to be served. Ready access to timely data from all care providers and payers helps providers to measure and track performance, and to frame their clinical programs and protocols. Data sources include inpatient and outpatient claims, medical records, pharmacy, and lab and test results.

Moreover, to effectively and efficiently manage the care of a patient population, hospitals and health care systems must have sophisticated analytics, informatics, and predictive modeling capabilities related to overall population health and high-risk subsets. Modeling enables organizations to more accurately identify and target specific populations for health-related interventions. Health care organizations can initiate pilot programs, track results, and revise programs, as needed.

Additionally, with drill-down analytics by clinician, location, and date, health care organizations can quickly respond to any variance below targeted performance standards. Real-time data that are patient-centric and available at the point of care facilitate quick remedies to non-optimal performance.

Health care organizations that subcontract with other providers must routinely share data and analyses with partnering entities to ensure transparency in measuring subcontractor performance. Reports generated by the entity's IT system and related to specific performance metrics should be submitted on a regular basis to the leadership team and other appropriate internal departments or program supervisors.

Many hospitals and health care systems are finding ways to collect and use more data to manage population health risk. For example, Advocate Health Care in Illinois is developing data-driven predictive models to enhance patient care across the care continuum. The health care system is partnering with an IT vendor to build a cloud-based platform that will integrate all of Advocate's data silos, including claims, and inpatient, outpatient, and home care EMR-based information.¹⁸

“We're aligning all data so that the index of analysis is not the episode of care but the patient and his or her entire longitudinal history,” notes Advocate's vice president of clinical transformation.¹⁹ The goal is to use advanced analytics and models to predict when a patient is likely to develop a complication, or be admitted or readmitted. Advocate then aims to embed tools in the organization's workflow at the point of care so that information is actionable and improves care delivery.

Other data infrastructure and IT considerations include billing and coding capabilities. Billing and coding capabilities must be robust, with systemwide consistency and timeliness. New contracts may bring new coding requirements, with payers or providers at risk if the coding is done incorrectly, so education in proper coding techniques may be needed.

Evaluating a Contract

Big-picture evaluation of value-based contracts involves identifying and weighing the potential pros and cons based on the health care organization's current capabilities and resources. This is true whether the organization is evaluating a contract proposed by a payer, or developing contractual elements to propose to a payer or employer. Potential benefits should include: effective population health management through coordination of care, with improved care quality at the lowest-possible cost; a bottom-line impact that is

sustainable into the future; facilitation of a closer partnership with physicians in the community; lower administrative and operating expenses; and a model to use for contractual arrangements with other payers.

Initial Questions

To evaluate a specific contract, initial questions to answer include:

- What population will be covered by this contract?
 - If an existing contract covers this population, what level of profitability does it achieve?
- What infrastructure elements are required for successful management of this population (primary care and specialty physicians, allied health professionals, facilities, staff, technology support, and more)? Clarifying questions that can help in this evaluation include:
 - What are the inpatient and outpatient utilization patterns for this population?
 - What employer groups are included in the enrolled population?
 - What is the population’s expected distribution by age and sex? (key to usage rates)
 - What has been the historical growth of the proposed population? (slow growth rates offer more predictability, which helps to reduce risk)
 - What other demographic factors should be considered? (e.g., income, ethnicity, crime rates)
- What utilization do we project for this population going forward under our management?
- What expenses do we project for this population going forward under our management?
- Will accepting this contract in any way interfere with the organization’s ability to work with other providers, payers, and employers in the market?

Responsibilities and Risk

Under value-based contracts, hospitals, health care systems, and other providers typically will receive a set sum from the payer, and then they distribute that money to partnering or participating providers both inside and outside the organization. This arrangement requires a clear delineation of services covered under the agreements and of entities responsible for risk for each service. Distribution methodologies should be outlined in advance for agreements with the payer and partnering providers.

Sidebar 6 provides principles to guide the equitable and effective distribution of risk among collaborating organizations during this process.

With sound payment methodologies, hospital or health care system payments from payers are aligned with partnering providers, meaning that each benefit financially as they achieve common value-based goals. The parameters, terms, and conditions of the contract should be flexible and negotiable.

The Integrated Healthcare Association, a California-based nonprofit representing health plans, physician groups, and hospitals, developed a coded version of the Division of Financial Responsibility framework. The DOFR defines which party is financially responsible for services rendered, and is used as a reference document to support contract administration and claims payment. The DOFR gives providers and payers a starting point for negotiating capitated payment arrangements with Medicaid managed care plans,

Sidebar 6. Three Guiding Principles of Risk Distribution

- Establish a structure that rewards providers who are successful in efficiently managing the provision of quality care; incentivize cost-efficient and high-quality care across all collaborating health care organizations.
- Distribute risk equitably and transparently across participating health care organizations, to the extent possible.
- Although payment methodologies often have multiple structures, as much as possible, ensure that payments to physicians and other collaborating health care organizations are consistent with the overall payment structure of the contract.

Source: Kaufman, Hall & Associates, Inc.

commercial Health Maintenance Organizations/Point-of-Service plans and Medicare Advantage populations. It offers a standard set of service categories with associated codes to help “manage” any redefinition of the DOFR, commonly called “DOFR creep.”

The initial assessment of organizational capabilities should guide the hospital or health care system to potential services and the assumption of risk related to them. The scope of risk contracts can include:

- Primary care services only
- All professional services
- All organizational services
- Both professional and organizational services (global or full risk)

Items commonly negotiated in risk contracts include how to handle out-of-area care and high-cost, high-risk items, such as transplants, which may be “carved in” or “carved out” according to different arrangements between contracting entities.

The proposed payment arrangements with both the payer and partnering providers must be sound. Financial expertise is required to determine soundness, by taking a full look at the level of risk involved given the elements outlined in Sidebar 4. Individuals with financial expertise will advise on whether stop-loss, risk limits, and “risk corridors” might be needed to protect the organization’s financial position.

Financial Impact

Evaluating the bottom-line impact of any individual contract is an iterative process that starts by calculating the percentage of the health care organization’s inpatient and outpatient revenues associated with the proposed contract by service line. This is based on identification of the services included in the agreement. Revenue calculations vary by type of contract, with “new math” involved with each.

For *shared savings contracts with upside only* arrangements, hospitals and health care systems are incentivized to decrease service units while meeting quality requirements. Revenues include a “savings” payment for efficiencies and the agreed-upon price multiplied by the service units provided. Savings depend on the providers’ ability to control volume and mix. To achieve a net gain, providers must lower variable expenses and service units, and the share of savings generated must offset the lower revenues from the decreased number of service units.



For *shared savings contracts with upside and downside* arrangements, which introduce risk, providers again are incentivized to decrease service units while meeting quality requirements. Revenues include a savings payment for efficiencies, or a deduction for a lack thereof, and the agreed-upon price multiplied by the service units provided. Savings or losses depend on the providers’ ability to control volume and mix. To achieve a net gain, providers must lower variable expenses and service units, and the share of savings generated must offset the lower revenues from the decreased number of service units. Providers unable to lower the cost of providing care will experience loss of revenue.



For *capitation contracts*, providers receive fixed revenues on a per-member, per-month basis to pay all costs of providing specified care. Higher utilization by the covered population results in lower profits and higher losses. To achieve a gain, providers must keep expenses and utilization at the targeted levels.



Scenario modeling is essential to evaluate how a contract would work under various operating assumptions or various levels of risk. Many health care organizations can start the modeling by comparing current contracts to proposed shared-savings or risk-based contracts, adding scenarios to evaluate the financial results, as required. Sidebar 7 provides an example of scenario modeling for a hospital considering a full capitation contract.

Sidebar 7. Scenario Modeling Example

A hospital evaluated a capitated contract for inpatient and outpatient facility services for a large Medicaid population in its primary and secondary service area. The following options were compared to continuing with the current fee-for-service contract under a rate reduction:

- A. Assuming capitated risk for outpatient services only
- B. Assuming full capitated risk for inpatient and outpatient services for a small member pool
- C. Assuming full capitated risk for inpatient and outpatient services for the proposed larger patient population

Scenario modeling was conducted, using a number of variables related to operating assumptions, including enrollment growth, expenses, and capital funding for inpatient and outpatient facilities. Also included were adjustments to utilization patterns and cost structure, contract and risk assumptions (such as downside limits), and projected annual revenue funding and expenses for the risk pools.

Figure 9 presents the overall results for the “best” contract scenario. This was identified as Scenario A, taking full risk for outpatient facility services only. The “worst” contract arrangement is Scenario B, assuming full risk for a small member pool. The projected potential losses under Scenarios B and C are significant, so key lessons learned from the modeling are:

- Incorporate as many internal and external data in the analyses as possible
- Make the decision to move forward, or not, based on a detailed financial analysis

Figure 9. Sample Financial Scenario Analysis Results

	Current Fiscal Year	Projected Year 1		
		Scenario A	Scenario B	Scenario C
TOTAL – I/P and O/P Expenses - PMPM	\$88.36	\$26.61	\$79.52	\$79.52
TOTAL – I/P and O/P Risk Expenses	\$53,018,029	\$18,623,912	\$57,651,653	\$57,651,653
TOTAL RISK POOL SURPLUS / (LOSS)	\$(7,518,029)	\$1,376,088	\$(7,051,653)	\$(7,051,653)
TOTAL RISK POOL SURPLUS / (LOSS) PMPM	\$(12.53)	\$1.97	\$(9.73)	\$(9.73)
Full Risk Pool Margin	\$(16.5%)	6.9%	(13.9%)	(13.9%)
Profit/(Loss) Summary – Full Risk		\$(13,092,087)	\$(21,519,828)	\$(21,519,828)
Profit/(Loss) Summary – Fee-for-Service	\$(10,404,774)	\$(14,468,174)	\$(14,468,174)	\$(14,468,174)
Variance		\$1,376,088	\$(7,051,653)	\$(7,051,653)
Downside Risk Projection Provisions				
Risk Pool Up/Downside Split (Health Plan / Primary Hospital)		\$688,044	\$(7,051,653)	\$(3,525,827)
Risk Pool – Downside Limit Threshold – Only if Negative		\$-	\$(5,060,000)	\$(2,530,000)
Profit / (Loss) – Full Risk		\$(13,780,130)	\$(19,528,174)	\$(16,998,174)
Variance		\$688,044	\$(5,060,000)	\$(2,530,000)



Source: Kaufman, Hall & Associates, Inc.

Credit Risk

Based on such modeling, health care organizations should assess how the expected financial performance of a contract affects the organization's current credit rating. Maintaining a solid credit rating is critical as it ensures the organization's ability to access affordable capital in the debt markets.

Doing so requires a close look at the balance sheet, including operating margins, and days-cash-on-hand and cash-to-debt ratios. Because payment arrangements are expected to put continuing pressure on hospital and health care system balance sheets, Moody's Investors Service is beginning to closely examine how hospitals and health care systems are reimbursed and how payer mix is changing. For example, the agency now is asking for data on reimbursement methods, including traditional capitation, DRG, percent of charges, fee schedule, per diem, and risk-based or other.²⁰

Moving incrementally toward managing risk is recommended, and gainsharing options can be a good way to start improvement efforts. But at the same time, the proportion of revenue affected has to be enough to motivate behavior change. Stephen M. Shortell, PhD, MPH, dean of the University of California, Berkeley, School of Public Health, observes: "When 30 percent of your business is in a non-fee-for-service model, your structure starts to change."²¹ This change will vary by organization and area of the country, but significant progress is still needed in moving toward value-based arrangements.

Implementation Success Factors

Three factors are absolute "musts" for implementation success with value-based contracting:

- Physician engagement
- Transparency and accountability
- Performance measurement and improvement

Physician Engagement

Fully engaging physicians by offering alternatives that align their clinical and financial interests with those of the hospital or health care system is required for success with value-based contracts.

Most hospitals and health care systems will need to support a pluralistic integration or alignment model that addresses the different interests of physician groups. Not all physicians will want to be employed, and most hospitals and health care systems likely will not have the capital to employ all the physicians they need. Options available for engaging physicians who wish to remain independent include offering support for business systems, management, or IT. Examples of contracting options are joint ventures, physician-hospital organizations, and management service organizations.

Depending on the population to be covered under an agreement, many hospitals and health care systems are likely to need to invest in primary care practices, midlevel providers, and IT support for such providers. This investment will enable the practices to become patient-centered medical homes or similar models, as care delivery shifts in emphasis from inpatient care to primary care.

Physician leadership in redesigning the delivery system to meet value objectives will be critical. Most health care organizations today don't have a high proportion of physicians in executive leadership roles or in key positions on board committees. This will have to change. Creating a leadership structure that is responsible for coordinating the many affiliated independent physician practices is recommended.

Transparency and Accountability

Transparency and accountability are essential components of any contracting arrangement. The goal should be to align financial interests of contracting parties with quality, efficiency, and other performance targets.

Transparency in engaging physicians under contracting arrangements can make or break efforts to secure their participation. As noted by the American Medical Association in contracting guidance to physicians,²² physicians need to be given complete, accurate, and transparent information concerning all important contract items, such as the assigning of responsibilities and timing of payments.

A well-defined process for clearly delineating and communicating responsibilities keeps all stakeholders accountable. Organizations should communicate with participating providers about what information they are collecting and when and how they will report that information back to stakeholders. Participating providers must know how they are performing and where to make improvements to meet performance targets and incentivized goals.

Spurred by consumers who want information on their smart phones 24/7/365, health care pricing and quality data are moving to transparency with lightning speed. Resources like the Joint Commission's Quality Check website,²³ Medicare's "Hospital Compare" website,²⁴ The LeapFrog Group,²⁵ and the Dartmouth Atlas of Health Care,²⁶ as well as tools developed by payers and employers, enable consumers to do organization-specific searches that aid their decision making about health care providers.

Performance Measurement and Improvement

Value is measured through a combination of quality, cost efficiency, and patient satisfaction indicators. To achieve sustainable performance improvement with value-based care under new payment arrangements, hospitals and health care systems will be required to measure, report, and improve care processes. To determine whether performance has improved across Triple Aim dimensions, health care stakeholders nationwide are wrestling with the questions:

- How do we measure value?
- What measures of value should be linked to payment and other contractual incentives to improve population health, experience of care, and costs?

So far, the array of answers is confounding. Payers are using different measures, even with a particular patient population or contract type, such as bundled payment.

Multiple entities disseminate measures. Commonly used indicators include Medicare quality measures,²⁷ Healthcare Effectiveness Data and Information Set (HEDIS) measures from the National Committee for Quality Assurance, and National Quality Forum measures.²⁸ NQF has endorsed approximately 700 measures that are included in its Quality Positioning System database.²⁹

As health care delivery moves toward a value-based approach, hospitals will need to provide data on numerous care measures to federal and state agencies, private payers, and a variety of accrediting bodies. Sidebar 8 provides the American Hospital Association's guidance related to measures.

Sidebar 8. Selection and Use of Measures with Value-Based Contracts

It is important that the measures selected for reporting programs and value-based contracting meet rigorous standards. The National Quality Forum is a consensus standards organization for health care that convenes multistakeholder committees to review measures, and decide whether those measures are suitable for endorsement. NQF's endorsement criteria are intended to determine whether measures are important, feasible to collect, usable for improvement, and reliably generate accurate performance results.

The American Hospital Association, in general, believes that measures selected for public reporting programs, and for value-based contracts, should be NQF endorsed. However, it is important that such measures are applied in a manner consistent with how the measures are specified and tested. For example, a measure specified for use in nursing homes may not be well-suited for a hospital value-based contract and program. Similarly, if a measure is specified for use with an all-payer data source, it may not generate accurate performance scores with Medicare-only data.

Source: The American Hospital Association

The state of performance measurement and its role in moving payment from volume to value are of interest to numerous policy experts. Robert Berenson, MD, of the Urban Institute, cites the following challenges:³⁰

- Current measurement approaches must rely on existing data sources, which for the most part have been administrative claims rather than true clinical information.
- Major gaps exist in the current clinical measurement sets; few measures address accuracy of diagnosis, surgical success rates, appropriateness of diagnostic and procedural interventions, or skill in managing patients with complex care needs.
- Most of the focus has been on the quality numerator; there is controversy about whether costs (the denominator) can be accurately measured and how to incorporate cost assessment into any value index.
- Current value-based payment with pay-for-reporting and pay-for-performance initiatives do not recognize that value can be improved not only by enhancing how well particular services are provided, but also by improving the kind and mix of services that beneficiaries are receiving.

Advancing performance measurement, and assisting providers and payers in selecting and implementing effective measures, must be national priorities. A report from the RAND Corporation,³¹ which was based on the review of 90 different payment models, indicates that the following measures are key to value-based reform:

- Outcome measures
- Care coordination measures
- Patient engagement measures
- Organizational capability measures
- Composite measures
- Efficiency measures
- Disparity measures

The Institute for Healthcare Improvement's *A Guide to Measuring the Triple Aim* provides a menu of suggested measures for the Triple Aim dimensions and outlines key measurement principles including:³²

- The need for a defined population (as the denominator of population health)
- The need for data over time, which distinguishes between common cause variation (always present and inherent in all processes) and special cause variation (intermittently present, arising from causes that are not part of the system, as designed)³³
- The need to distinguish between outcome and process measures, and between population and project measures
- The value of benchmark or comparison data

Identifying the right measures and then linking them to the right payment involve difficult processes, such as attributing a patient's health outcomes to a specific provider and adjusting risk to account for patient populations with different risk factors, demographics, and health conditions.³⁴ According to Miller, "Since different payment systems create different kinds of incentives and disincentives, no single set of quality measures and payment adjustments will be appropriate for all payment (systems)."³⁵

The measures used and the extent of their use will vary depending on the contract. Hospitals and health care systems must have knowledge of and confidence in their ability to meet the required standards of selected measures. In negotiating contracts, providers should remember that measures often are negotiable and should be regularly reviewed and updated. Detailed analyses of which measures should be linked to what type of payment, and to what extent incentives and disincentives should be put in place, are beyond this publication's scope but are important issues for hospitals and health care systems.

Conclusion

Health care delivery is experiencing dramatic change. Roles and lines for hospitals and health care systems, payers, employers, and other stakeholders are blurring. Every stakeholder is or will be affected. Payers and providers will learn to work together in developing and implementing value-based contracts. If they are not proactive, providers may be forced into an unfavorable contract, or be excluded from the narrow and tiered networks that are being formed nationwide. Inaction is not an option.

Preparing for value-based contracts will require planning, new skills, and a new approach to health care delivery. Without a true partnership between hospitals and health care systems, physicians, other providers, and payers, the likelihood of long-term success with risk contracts will be limited. Achieving the right timing in the volume-to-value transition will involve a delicate but critical balancing act. Strong health care leaders with a value mindset will help their organizations make a successful transformation.

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Endnotes

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About the Authors

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Ms. Ryan is active in the Chicago Managed Care community as the past president and current chief operating officer of the Managed Healthcare Providers Association.

Ms. Ryan received a BS from the University of Michigan.

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Founded in 1985, Kaufman, Hall & Associates, Inc. is an independent management consulting firm, providing services and software to hospitals, health care systems, and other health care organizations nationwide.

The firm provides strategic advisory services; physician advisory services; financial advisory services to debt transactions; strategic, financial and capital planning services; capital allocation design and implementation services; and merger, acquisition, joint venture, real estate and divestiture advisory services.

In addition, Kaufman Hall developed and markets the ENUFF Software Suite® of strategic and financial management products. Kaufman Hall serves its clients from offices in Chicago, Atlanta, Boston, Los Angeles, and New York. For more information, visit kaufmanhall.com.

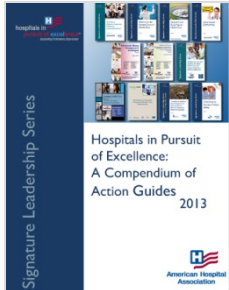
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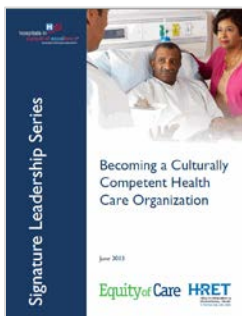
2013 Hospitals in Pursuit of Excellence: A Compendium of Implementation Guides – July 2013

The compendium is a collection of action-oriented resources that can help design and implement strategies that will assist in delivering care that is safe, timely, equitable, effective, efficient and patient-centered.



Value-Based Contracting – July 2013

The nation's health care system is undergoing dramatic change as the country shifts to a value-based business model. The pace of the transition varies by market, but hospitals, health care systems, and other providers must be proactive. This Hospitals in Pursuit of Excellence guide provides specific guidance related to assessment, and financial, operational and implementation issues organizations should examine as they consider value-based contracting arrangements.



Becoming a Culturally Competent Health Care Organization – June 2013

It is imperative hospitals and health care systems not only understand the diverse patients and communities they serve but the benefits of becoming a culturally competent organization. This guide describes the benefits, steps and educational techniques of becoming a culturally competent health care organization.

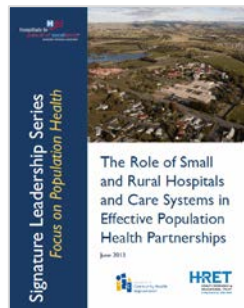
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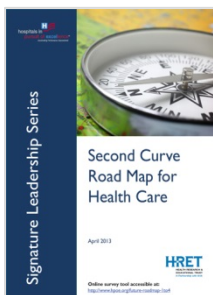
[Checklists to Improve Patient Safety](#) – June 2013

To improve patient safety and quality outcomes, health care professionals are using multiple methods to reduce patient harm and eliminate medical errors. One method being implemented more and more is the checklist. This Hospitals in Pursuit of Excellence guide includes a checklist, developed by Cynosure Health, for each of the 10 areas in The Partnership for Patients Hospital Engagement Network.



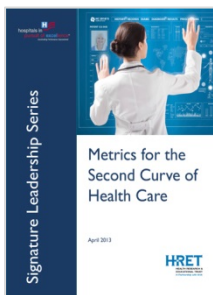
[The Role of Small and Rural Hospitals and Care Systems in Effective Population Health Partnerships](#) – June 2013

To become an effective population health manager, a hospital must create effective partnerships. This guide describes how small and rural hospitals and care systems can develop effective population health partnerships that balance the challenges and opportunities encountered in providing health management.



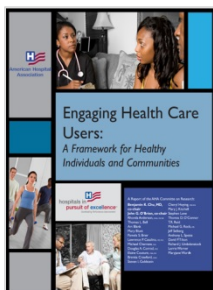
[Second Curve Road Map for Health Care](#) – April 2013

This road map is intended to assist leaders trying to implement major strategies and assess their progress on meeting the second curve that is explained in the Metrics for the Second Curve of Health Care report.



[Metrics for the Second Curve of Health Care](#) – April 2013

Building off of health care futurist Ian Morrison's first curve to second curve shift, CPI identified characteristics of the first curve (the volume-based curve) and the second curve (the value-based curve). Of the ten must-do strategies, four were identified as major priorities for health care leaders and are expanded on in this guide.



[Engaging Health Care Users: A Framework for Healthy Individuals and Communities](#) – January 2013

This guide focuses on actively engaging health care users to improve outcomes and reduce health care costs. This report introduces a continuum for engagement from information sharing to partnerships and recommends entry points for user engagement occurring at different levels of the health care system. Aimed to help hospitals and health care systems become more "activist" in their orientation and move "upstream"—that is, to do more to engage patients and intervene earlier in the disease states.

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[Advanced Illness Management Strategies: Engaging the Community and a Ready, Willing and Able Workforce Part 2](#) – December 2012

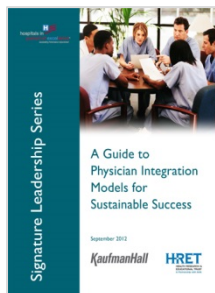
This report expands upon part 1 and explains all three strategies and focuses on patient and community **awareness** and engagement and a ready, willing and able **workforce**. The first CPI report released August 2012, *Advanced Illness Management Strategies Part 1*, examined in depth how hospitals can increase **access** to AIM programs. To access this report <http://www.aha.org/aim-strategies>



[Palliative Care Services: Solutions for Better Patient Care and Today's Health Care Delivery Challenges](#)

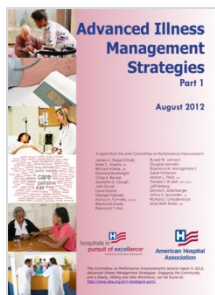
November 2012

Palliative care specializes in taking care of patients with serious illness and focuses on providing relief from symptoms, pain and stress in order to improve the quality of life for patients and their families.



[A Guide to Physician Integration Models for Sustainable Success](#) – September 2012

This guide is authored by Kaufman Hall executives, describes the groundwork and prerequisites required for successful hospital-physician integration. It provides an overview of integration models currently deployed at hospitals and health systems nationwide and offers 12 strategies hospitals and health systems will find useful in navigating the physician-integration pathway. Also included are examples of physician integration initiatives at organizations of different types and sizes, including a hospital, health system, regional medical center, integrated delivery system and university health system.



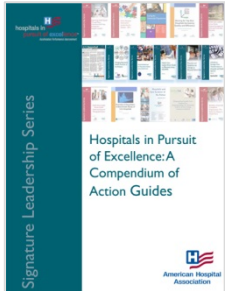
[Advanced Illness Management Strategies](#) - August 2012

Effectively integrating AIM into the continuum of care will position the hospital and health system to manage the gap between the first and second curve and support the transition to the second-curve business, care and service delivery model.



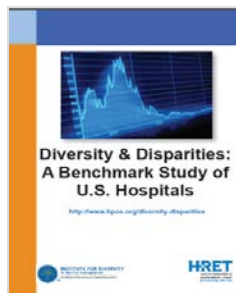
[The Commonwealth Fund Issue Brief - Hospitals on the Path to Accountable Care: Highlights from a 2011 National Survey of Hospital Readiness to Participate in an Accountable Care Organization](#) – August 2012

Accountable care organizations (ACOs) are forming in communities across the country. In ACOs, health care providers take responsibility for a defined patient population, coordinate their care across settings, and are held jointly accountable for the quality and cost of care.



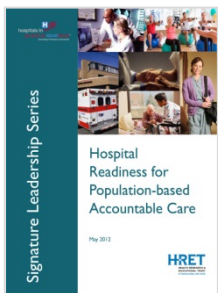
[2012 Hospitals in Pursuit of Excellence: A Compendium of Implementation Guides](#) – July 2012

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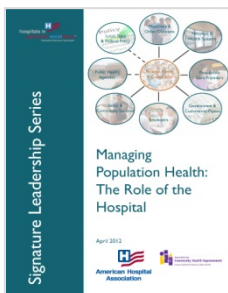
[Diversity and Disparities: A Benchmark Study of U.S. Hospitals](#) – June 2012

This chartpack offers a snapshot of some common strategies used to improve the quality of care that hospitals provide to all patients, regardless of race or ethnicity. The survey results highlight that, while more work needs to be done, advancements are being made in key areas that can promote equitable care, such as collecting demographic data, providing cultural competency training, and increasing diversity in leadership and governance.



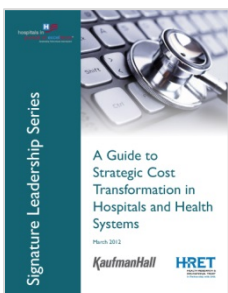
[Hospital Readiness for Population-based Accountable Care](#) – May 2012

This report provides hospital leaders with a snapshot of hospitals' current readiness to participate in an ACO, as well as a tool with which to gauge their own organizations' relative preparedness for ACO participation.



[Managing Population Health: The Role of the Hospital](#) – April 2012

To meet patient needs in the current market, hospitals have traditionally focused their efforts on caring for individuals and personalizing care for each person admitted to their facility. Common community health initiatives, such as mobile vans and health screening and education fairs, are sometimes delivered apart from an overall strategy or impact analysis. However, external forces to simultaneously reduce cost, improve quality, and implement value-based payment programs command that organizations examine how to manage the health of their patient populations to improve outcomes.

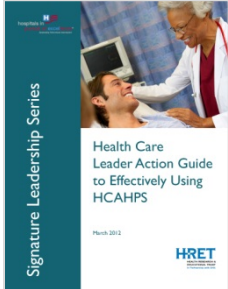


[A Guide to Strategic Cost Transformation in Hospitals and Health Systems](#) – March 2012

As health care moves to a value-based business model, health care payments will likely be reduced, while care efficiency, quality, outcomes and access will be expected to improve. To continue meeting community health care needs in the new delivery and payment environment, hospitals and health system leaders need to think strategically about managing cost.

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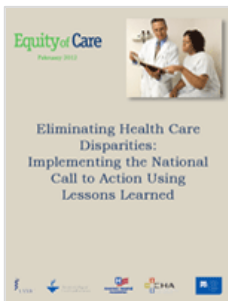
[Health Care Leaders Action Guide to Effectively Using HCAHPS](#) – March 2012

This guide describes how HCAHPS data should be used in context with other information about organizational performance. It highlights cultural elements necessary to build a firm foundation for HCAHPS success. Once these foundational elements have been considered, the guide outlines a 5-step approach to using HCAHPS effectively to improve the patient experience, quality and safety.



[Improving Perinatal Safety](#) – February 2012

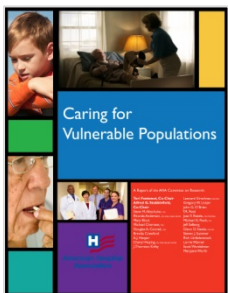
Early elective deliveries have been proven to increase the risk of adverse health outcomes post delivery for both mother and child. As a result, many hospitals and health systems are trying to eliminate elective deliveries before 39 weeks. This guide provides a framework for the quality improvement project, metrics to measure progress and leading case examples.



[Eliminating Health Care Disparities: Implementing the National Call to Action Using Lessons Learned](#)

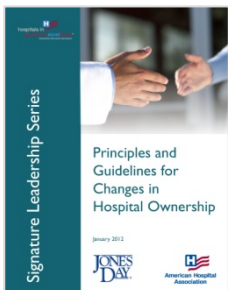
February 2012

This guide looks at nine hospitals and health systems and summarizes each organization's key successes toward providing equity in care in one of the three areas: increasing the collection of race, ethnicity, and language preference data, increasing cultural competency training for clinicians and support staff, or increasing diversity in governance and management.



[Caring for Vulnerable Populations](#) – January 2012

In 2011, The AHA Committee on Research examined emerging hospital-centered practices in effective care coordination for vulnerable populations, focusing the examples on the critical "dual eligible" population – individuals eligible for both Medicare and Medicaid. The report explores the necessity for organizations to pursue improved care coordination strategies for dual eligibles and other vulnerable populations.

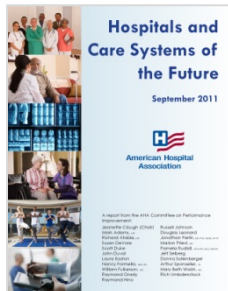


[Principles and Guidelines for Changes in Hospital Ownership](#) – January 2012

Market forces are driving renewed interest in integration that may result in changes in the ownership or control of hospitals, such as through mergers with or acquisitions by other hospitals, the formation of integrated delivery networks or the development of accountable care organizations.

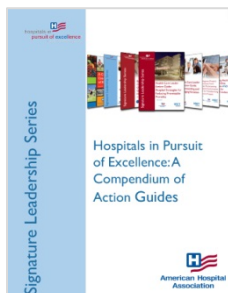
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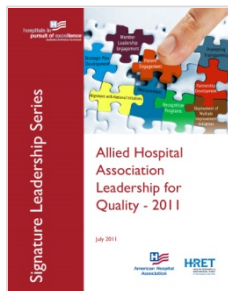
[Hospitals and Care Systems of the Future](#) – September 2011

Analyzing the results of exploratory interviews, this inaugural publication from AHA's Committee on Performance Improvement identifies must-do, priority strategies and core competencies that hospitals and care systems should establish to remain successful in this era of sweeping change throughout the industry.



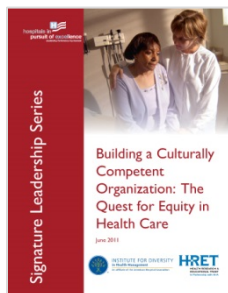
[2011 Hospitals in Pursuit of Excellence: A Compendium of Implementation Guides](#) – July 2011

The compendium includes the latest HPOE guides on equity, variation, health and wellness, patient safety, and financing. Together with the AHA's recent series of Research Synthesis Reports and the executive summaries of the 2010 HPOE guides, this collection provides a wealth of resources that can help you design and implement the strategies that will take your organization to the next level of performance and achieve new heights in delivering care that is safe, timely, equitable, effective, efficient and patient-centered.



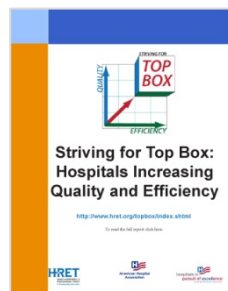
[Allied Hospital Association Leadership for Quality](#) – July 2011

Using examples from the applicants for the American Hospital Association's inaugural Dick Davidson Quality Milestone Award for Allied Association Leadership, this guide describes the common elements of implementing successful performance improvement initiatives among hospitals and health systems.



[Building a Culturally Competent Organization: The Quest for Equity in Health Care](#) – June 2011

This guide explores how hospitals and health systems can increase their cultural competency in order to provide care that is respectful of patients' diverse values, beliefs and behaviors.

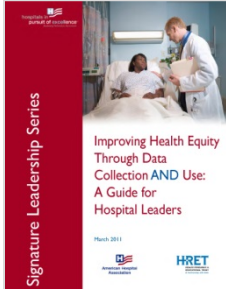


[Striving for Top Box: Hospitals Increasing Quality and Efficiency](#) – April 2011

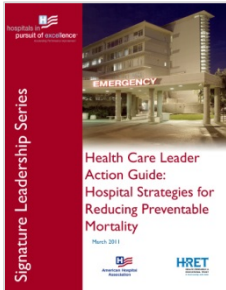
This guide was created to share best practices and key lessons from innovative organizations on a variety of topics including care coordination, health and wellness, equity of care, and new payment and care delivery models.

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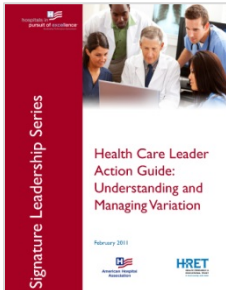
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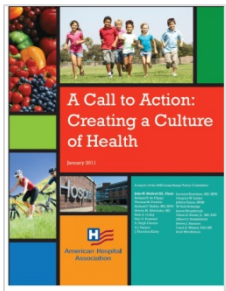
[Improving Health Equity Through Data Collection AND Use: A Guide for Hospital Leaders](#) – March 2011
This guide explores key strategies that hospitals have adopted to collect race, ethnicity, and primary language data about their patients and use the data in efforts to overcome disparities in care.



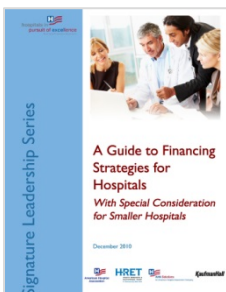
[A Health Care Leader Action Guide: Hospital Strategies for Reducing Preventable Mortality](#) – February 2011
This guide is designed to assist hospital leaders in improving quality and performance by outlining eight steps for reducing preventable mortality.



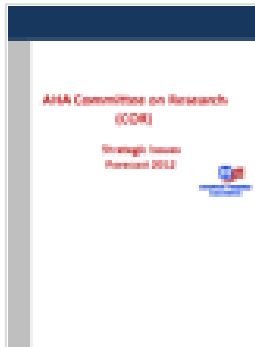
[A Health Care Leader Action Guide: Understanding and Managing Variation](#) – February 2011
The guide includes practical steps to understanding and managing variation and a list of best practices and case studies as examples and resources for hospital leaders to use for implementing key interventions.



[Call to Action: Creating a Culture of Health](#) – January 2011
This comprehensive report highlights current practices that hospitals use today with their own employees, gives examples of promising practices, and provides how-to recommendations to the field to be leaders of health in their communities.



[A Guide to Financing Strategies for Hospitals - With Special Consideration for Smaller Hospitals](#) – December 2010
This guide explores seven strategies that can help hospitals achieve the best possible capital access.



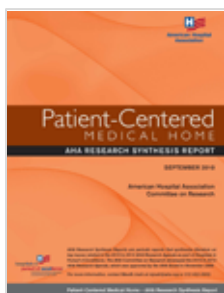
[AHA Committee on Research: Strategic Issue Forecast Report](#) – November 2010

The purpose of the Strategic Issues Forecast 2015 is to look beyond the 2010-2012 AHA Research Agenda and to focus on long-term strategic issues affecting hospitals and health systems in the 2011 to 2015 horizon. By doing so, the Strategic Issues Forecast 2015 is meant to help drive transformation in health care.



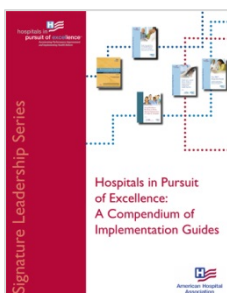
[Hand Hygiene Project: Best Practices from Hospitals Participating in the Joint Commission Center for Transforming Healthcare Project](#) – November 2010

This multi-case study describes how eight hospitals used Lean Six Sigma to examine and improve work processes and identify causes and targeted solutions for failure to clean hands.



[AHA Research Synthesis Report: Patient-Centered Medical Home \(PCMH\)](#) – September 2010

This synthesis report presents an overview of the Patient-Centered Medical Home (PCMH), including key features, discussion of federal, state, and private sector medical home models, and considerations for hospitals interested in developing a PCMH.



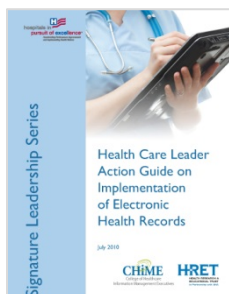
[2010 Hospitals in Pursuit of Excellence: A Compendium of Implementation Guides](#) – July 2010

This compendium of guides, reports, and toolkits provides a wealth of actionable resources to help you design and implement strategies as you take your hospital to the next level of performance and address the challenges and opportunities of implementing health care reform.



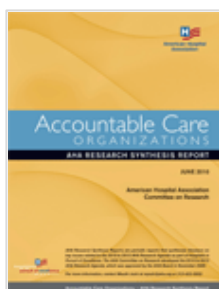
[Early Learnings from the Bundled Payment Acute Care Episode Demonstration Project](#) – July 2010

An overview and summary of lessons learned from the CMS Acute Care Episode Demonstration Project, which tested the effect of bundling Part A and B payments for episodes of care improve coordination, quality and efficiency of care.



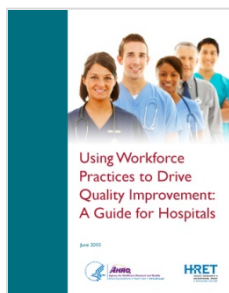
[Health Care Leader Action Guide on Implementation of Electronic Health Records](#) – July 2010

This report provides a roadmap to help senior executives develop a strategy to use EHRs that advances the organization's ability to deliver care that is safer, effective and efficient.



[AHA Research Synthesis Report: Accountable Care Organizations](#) – June 2010

This guide presents ideas to consider in developing an ACO and reviews the key competencies that are needed in order to be an accountable ACO.



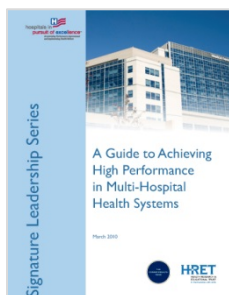
[Using Workforce Practices to Drive Quality Improvement: A Guide for Hospitals](#) – June 2010

This guide provides practical advice on workforce practices that hospitals can adopt to develop a high-performing workforce that can deliver safe, high quality and efficient health care.



[AHA Research Synthesis Report: Bundled Payment](#) – March 2010

The report presents an overview of bundled payment, including evidence of its impact in the public and private sector, as well as questions that must be considered.

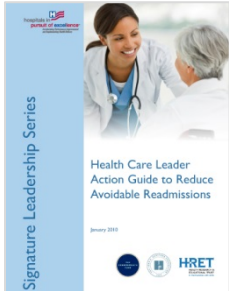


[A Guide to Achieving High Performance in Multi-Hospital Health Systems](#) – March 2010

The guide provides numerous tools that leaders can use to help drive performance improvement regardless of whether they are part of a health system; the lessons are transferrable to all hospitals.

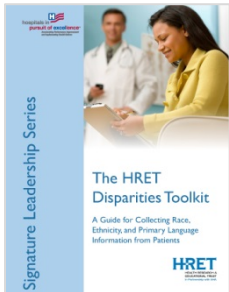
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[Health Care Leader Action Guide to Reduce Avoidable Readmissions](#) – January 2010

This guide helps hospital leaders assess, prioritize, implement and monitor strategies to reduce avoidable readmissions during hospitalization, as well as at discharge and post-discharge.



[HRET Disparities Toolkit](#) – updated in 2010

This toolkit provides a comprehensive approach to the collection of race, ethnicity and primary language data and offers guidance on how to improve quality of care and reduce health disparities.

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