

Signature Leadership Series

Hospitals in Pursuit of Excellence: A Compendium of Action Guides



July 2012

Dear Colleague:

We are pleased to release the 2012 edition of **Hospitals in Pursuit of Excellence: A Compendium of Implementation Guides**, 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.

As payment incentives continue to shift, health care leaders will need to continue to find ways to operate in the present volume-based environment while at the same time identify ways to successfully shift to a performance-based system that is focused on delivering value. Progressing from the first curve to the second will require that we focus on emerging approaches to clinical integration, care coordination, population health management and achieving financial sustainability. To deliver greater value through operational excellence and quality improvement, we will need to engage partners in new delivery and payment solutions and find new ways to leverage information technologies to improve performance.

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

- Learn ways to achieve **strategic cost transformation** to continue meeting community health care needs in the new delivery and payment environment from *A Guide to Strategic Cost Transformation in Hospitals and Health Systems*.
- Understand why organizations must pursue improved **care coordination strategies for dual eligibles and other vulnerable populations** in *Caring for Vulnerable Populations*.
- See what organizations are doing to advance **equity in care** in three critical areas -- increasing the collection of race, ethnicity, and language preference data; increasing cultural competency training for clinicians and support staff; and increasing diversity in governance and management – in *Eliminating Health Care Disparities: Implementing the Call to Action Using Lessons Learned*.
- Learn how to use **HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) data to effectively improve patient experience, quality and safety**, and to build a culture for HCAHPS success in *Health Care Leader Action Guide to Effectively Using HCAHPS*.
- Review survey results from more than 1,600 hospitals on their current **readiness to participate in an accountable care organization (ACO)** and use a tool to gauge your own organization's relative preparedness for ACO participation in *Hospital Readiness for Population-based Accountable Care*.

- Learn the definition of **population health** and discover strategies, including potential partnerships with other stakeholders, to improve the health of your organization's patient populations in *Managing Population Health: The Role of the Hospital*.
- Learn how to approach potential integration opportunities that may result in **changes in the ownership or control of hospitals** in a manner that protects the delivery of health care services in your communities but that recognizes your hospital's need to adapt in a changing environment in *Principles and Guidelines for Changes in Hospital Ownership*.
- Get details of a proposed framework to **improve perinatal safety** by eliminating elective deliveries before 39 weeks, including ways to measure progress and leading case examples, in *Improving Perinatal Safety*.
- Review results from a national survey of hospitals on the actions they are taking to **reduce health care disparities and promote diversity in leadership and governance**, in order to improve the quality of care that all patients, regardless of race or ethnicity, receive in *Diversity & Disparities: A Benchmark Study of U.S. Hospitals*.
- Learn about **must-do, priority strategies and core competencies that hospitals and care systems should establish** to remain successful in an era of sweeping change throughout the industry in *Hospitals and Care Systems of the Future*.

The compendium also includes executive summaries of several 2010 and 2011 guides that address such ongoing challenges as reducing inappropriate variation, employee health and wellness and reducing preventable mortality. You will also find our popular Research Synthesis Reports on bundled payment, medical homes and accountable care.

The AHA 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

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**Hospitals in Pursuit of Excellence: A Compendium of Action Guides
2012 Edition**

LIST OF REPORTS

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Caring for Vulnerable Populations

Diversity & Disparities: A Benchmark Study of U.S. Hospitals

Eliminating Health Care Disparities: Implementing the National Call to Action Using Lessons Learned

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Principles and Guidelines for Changes in Hospital Ownership

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**Guide to Strategic
Cost Transformation**



A Guide to Strategic Cost Transformation in Hospitals and Health Systems

March 2012

KaufmanHall

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HEALTH RESEARCH &
EDUCATIONAL TRUST
In Partnership with AHA

A Guide to Strategic Cost Transformation in Hospitals and Health Systems

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Executive Summary

Exacerbated by the U.S. deficit and other economic challenges, the rising cost of health care is a front-and-center issue nationwide for patients, employers, providers, and governmental and commercial payers alike. As health care moves to a value-based business model, health care payments will likely be constrained, while care efficiency, quality, outcomes, and access will be expected to improve. To continue meeting community health care needs in this new delivery and payment environment, hospital and health system leaders will need to think and act strategically about managing cost. *Strategic cost transformation* will be required.

In this guide, we propose that such transformation must occur along three pathways (see figure 1 on page 7): Pathway 1 involves reducing costs of current operations; pathway 2 involves reducing costs through restructuring businesses and service lines, among other elements; and pathway 3 involves reducing costs through clinical transformation. This guide focuses on specific elements of pathways 1 and 2.

Hospitals and health systems can lay the groundwork for strategic cost management by:

- » Ensuring that the CEO drives the strategic cost transformation process
- » Developing and implementing a strategic cost transformation master plan
- » Bolstering the organization's business platform and ensuring its full functioning at all levels
- » Creating and supporting cultural change

Cost management pathway (pathway 1): Cost management is an approach to significantly reshape and reduce cost by (1) improving planning and execution of current operations and (2) attacking overhead and non-value-added functions, overhead costs, and costs "flying below the radar." Cost management opportunities can best be achieved in organizations through:

1. Understanding your organization's readiness for cost management
2. Defining cost-reduction goals based on the organization's capital shortfall
3. Using internal and external benchmarks to identify possible sources of savings
4. Supplementing benchmark data with other data analyses
5. Understanding and focusing on the key drivers of staffing and productivity problems
6. Drilling down on staffing methods
7. Streamlining overhead functions
8. Ensuring that cost-reduction targets are integrated with organizational plans and budgets

Business restructuring pathway (pathway 2): Forward-thinking organizations, whether freestanding hospitals, multihospital systems, or other provider entities, are evaluating all aspects of their business in light of changing market conditions and requirements for future success under the new business model. They are asking, "What businesses and services are core to our mission and vision going forward?" and "Where can we most effectively invest our limited capital and human resources to meet the continuing health care needs in our communities?"

Eight action items can help hospital and health system executives and boards define the business strategies appropriate to their organizations, and the plan by which those strategies can be executed.

1. Start with an evaluation of your organization's strategic options.
2. Evaluate each business unit and service line to identify core elements.
3. Use a structured process to analyze the core businesses and services.
4. Implement a business/service line analysis framework.
5. Understand when and why service distribution planning will be needed.
6. Initiate the process of defining the most efficient and effective distribution of services.
7. Use a structured framework for service distribution planning.
8. Ensure a solid fact base for the service distribution plan.

Hospital and health system leaders have an opportunity to make a significant contribution to health care delivery in their communities by moving their organizations to a value-based business model, using the strategies of strategic cost transformation outlined here. The time to move is now.

Introduction

Due to factors including the federal and state budget deficits, rising health care costs, and the large percentage of gross domestic product consumed by health care spending, health care must focus on value. This value proposition, which is improved quality at lowest-possible cost, will not be undone.

Under health care's value-based business model, health care payments will be constrained, while care efficiency, quality, outcomes, and access will be expected to improve. At the same time, quality and cost will be much more transparent to patients and purchasers. Indicators will be closely monitored and reported in public forums.

To continue meeting community health care needs in the new delivery and payment environment, hospital and health system leaders will need to think and act strategically about managing cost. In this guide, we propose that this process—strategic cost transformation—will be required and that such transformation must occur along three pathways (see figure 1): Pathway 1 involves traditional cost management, namely reducing costs of current operations; pathway 2 involves reducing costs through restructuring businesses and service lines, among other elements; and pathway 3 involves reducing costs through clinical transformation.

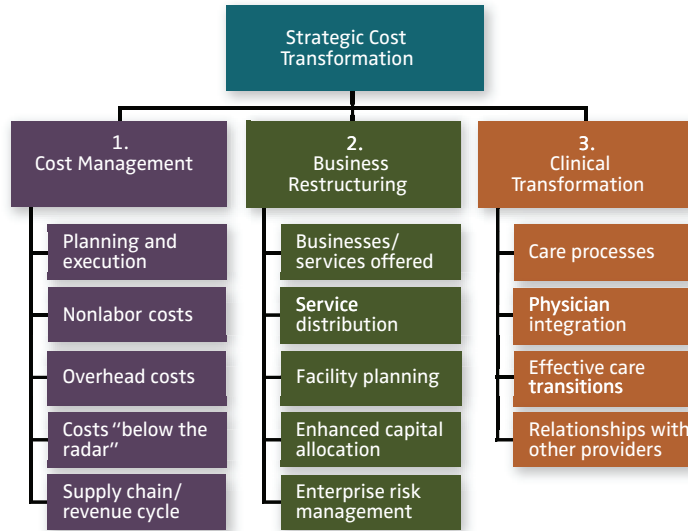
Most organizations have attacked or are currently attacking costs through pathway 1. But these savings may not be sufficient to achieve the overall cost reductions needed in the new environment. Furthermore, to ensure optimal long-term success, work occurring through pathway 1 must be carefully coordinated with work occurring through pathways 2 and 3. Some organizations have started to use pathway 2, business restructuring, as a means to reduce costs; but this work is much more difficult, and many organizations have not yet started it. Finally, though many providers talk about clinical transformation, many organizations have not started work in pathway 3, which takes the longest time to achieve but also has significant potential for true reduction of the cost of care.

This guide focuses on specific elements of:

- » Pathway 1. Cost management: Reducing costs of management operations, including planning and execution, nonlabor costs, overhead costs, and costs “flying below the radar”
- » Pathway 2. Business restructuring: Reshaping businesses and services offered and conducting service distribution planning

Future guides in this series will cover additional pathway elements.

Figure 1. Three Pathways for Strategic Cost Transformation



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

Laying the Groundwork

For health care management teams and boards, four strategies will be critical to achieving strategic cost transformation.

Strategy 1. Ensure that the CEO drives the strategic cost transformation process.

Removing costs to increase efficiency across an organization, while improving quality, will require sustained effort and attention at the highest level.

Strategy 2. Develop and implement a strategic cost transformation master plan.

The plan articulates the order and sequencing of pursuit and achievement of the cost-transformation pathways. While pursuit of all three pathways is likely required, it may be beyond a management team’s resources to pursue initiatives in all areas simultaneously. Some CEOs are very unsure of what they should do first. Many are diving into clinical integration and care-model change. Others are pursuing initiatives to enhance services or secure partnerships.

Or, if the hospital or health system is experiencing relatively stable financial performance, some CEOs are focusing on revenue or integration initiatives in lieu of cost reduction because they believe what is commonly cited in the literature that “the low-hanging fruit has already been picked.” This may not be the case.

Very few organizations seem to have the time and human and economic resources to pursue all pathways concurrently. The order of priority for cost transformation for any organization will vary based on its market, clinical resources and environment, and financial position. In addition, political will within the organization, the strength of its management and clinical teams, its culture of measurement and accountability, and other factors will play a significant role in whether and how strategic cost transformation proceeds. An objective evaluation of these characteristics is strongly recommended.

Strategy 3. Bolster the organization's business platform and ensure its full functioning at all levels.

The systems and technology required for monitoring and managing progress in delivering health care value, defined with cost and quality dimensions, must be put in place, functioning, and used effectively. Requirements include:

- » Corporate finance-based business systems and tools for business planning, financial planning, capital allocation and management, budgeting and cost control, and capital structure and risk management
- » Clinical information systems and tools

High-quality IT and clinical information tools must support the monitoring and management of performance under changing financial and care delivery arrangements. Clinical and business data must be integrate-able and integrated. Analytic capabilities and disciplined use of quantitative techniques are required.

Strategy 4. Create and support cultural change.

At the most fundamental and pervasive level, strategic cost transformation will require cultural change. Supported by the board of trustees, executive leaders must create a culture of results and accountability.

Executive communication of the strategic cost transformation plan to all stakeholder groups will be critical. Visionary leaders will recognize and enable active participation organizationwide. This will be key to sustaining the required changes. Major initiatives will need to be led in a way that is cognizant of the larger framework and the power of participation to drive meaningful change.

Leaders also must understand that, after 40-plus years, the mindset of the fee-for-service business model permeates organizations. Sustainable success within the new business model will require new forms of governance, organizational and management structure, and performance measurement that will alter the basic approach to care delivery. As described by Atul Gawande, M.D., new values and new attitudes will be needed to move from a sickness model, characterized by physician and hospital autonomy, to a wellness model, characterized by independence and team-centric care delivery.¹

Takeaways

- » Due to rising health care costs, the industry's value proposition—best-possible quality of care at lowest-possible price—will not be reversed.
- » Taking costs out of the health care system will require the sustained effort and attention of health care leadership teams and boards across multiple dimensions. The CEO must drive this process.
- » The strategic transformation of a hospital or health system's cost structure involves rigorous cost management to reduce costs of current operations, careful consideration of businesses and services offered (and the ability to make and implement tough decisions related to this), and clinical transformation through redesign of clinical operations and structure for maximum efficiency and effectiveness of the care delivery process.
- » In some organizations, the low-hanging fruit has *not* already "been picked."
- » The systems and technology required for monitoring and managing progress in delivering health care value, defined with cost and quality dimensions, must be put in place, functioning, and used effectively.
- » At the most fundamental and pervasive level, strategic cost transformation will require cultural change.

¹ Gawande, A. "The Real Reform of Healthcare." *Kaufman Hall Report*, Winter 2010.

Cost Management Opportunities

Cost management is an approach to significantly reshape and reduce cost by improving planning and execution of current operations, attacking overhead and non-value-added functions, and addressing the major strategic drivers of cost. Eight strategies can help hospital and health system executives achieve solid results.

Strategy 1. Understand your organization's readiness for strategic cost management.

Specific organizational competencies are required for success with strategic cost management. These include target setting and tracking; scope of cost-management focus; systems thinking; alignment between plans, targets, and financial performance; accountability and execution; management controls; operational planning; and overhead management. Detailed awareness of your organization's current level of preparedness is critical to effective planning. A cost management "readiness assessment," completed by an objective party and summarized based on a comparison with national performance, is recommended. Figure 2 provides a sample tool.

Figure 2. Sample Tool for Strategic Cost Management Readiness Assessment

	<i>Unprepared Hospital</i>	<i>Well-Prepared Hospital</i>
Target Setting and Tracking	Most departments look great in current productivity and budget reports, but hospital performance is lagging ✗	Aggressive cost-management targets
Scope of Cost Management	Focus of cost-management effort is fairly limited ✗	Extensive scope of cost-management effort addressing all major drivers
Systems Thinking	Focus exclusively on individual departments and silos ✗	Decision making driven by the "greater good"
Alignment	Total disconnect between plans, targets, and financial performance ✗	Schedules, staffing plans, targets, budget, financial needs aligned
Accountability and Execution	Highly creative and unending excuses are the norm ✗	Demanding culture with little room for excuses
Management Controls	Lots of workarounds for managers to get the staffing and resources that they want ✗	Strong controls on hiring and use of premium labor
Operational Planning	Managers told to cut cost with no evidence that fundamental changes are being made ✗	Structured process in place to drive changes in how work is done
Overhead Management	Overhead services and functions "fly below the radar" ✗	Mechanisms in place to rationalize overhead and corporate/system expenditures
Composite Position	Weak ✗	Strong

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

Strategy 2. Define cost-reduction goals based on the organization's capital shortfall.

An accurate analysis of the organization's capital position, as commonly prepared as part of an integrated strategic financial plan, enables organizations to identify their expected capital shortfall. In an era of flat-to-declining revenue, cost-reduction goals should be established to close as much of this capital shortfall as possible. The goals quantify the performance levels necessary to fund the organization's strategies and maintain its competitive financial performance. In this way, goals are connected directly to the organization's current financial position as well as its current and future strategic capital and other requirements.

All organizations should be thoroughly revisiting their integrated plan to examine the cumulative, projected impact of strategic initiatives and changes due to health care reform and the new business model. Projections of payment, volume, capital costs, capital investment needs, and other variables are changing and will likely continue to do so.

Strategy 3. Use internal and external benchmarks to identify possible sources of savings.

To define the sources and amount of possible savings, organizations can review historical trends, apply global and departmental benchmarks and peer department comparisons, and conduct supplementary drill-down data analyses.

Given operating characteristics that may be unique to the departments at any specific organization, there are limitations of, and sensitivity to, benchmarking. However, use of specific benchmarks, available within the organization or industry, is often entirely appropriate. Use of both internal and external benchmarks helps to build consensus within the organization around the level of cost reduction that may be available.

Strategy 4. Supplement benchmark data with other data analyses.

Other data analyses can be used to identify savings opportunities and validate cost-reduction estimates as realistic and achievable. A range of opportunities can be identified for each department using historical trends and budgeted performance, for example. While a department manager may not agree about the applicability of one benchmark source, use of three reference points will triangulate the savings and support the appropriateness of cost-reduction opportunities and targets.

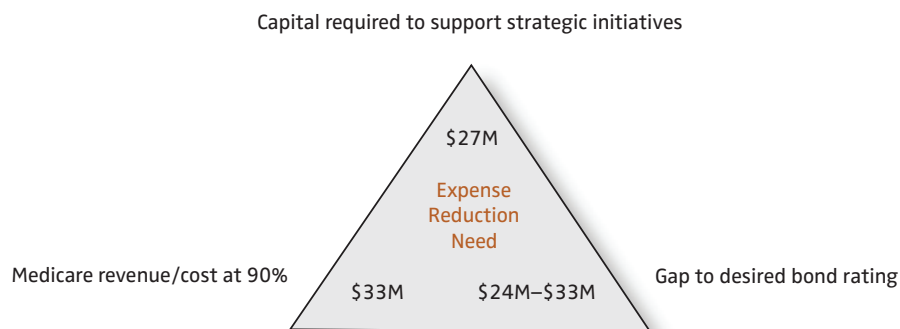
Example: A community hospital and a small multihospital system each used data from the following three separate analyses to quantify their expense reduction needs and opportunity:

- » The operating performance improvement that would be required to support their strategic capital needs
- » Cost reductions that would be required to bring the hospital or each facility within the organization to a 90 percent Medicare revenue-to-cost ratio (which was then extrapolated to Medicaid and commercial business)
- » Potential cost savings based on application of industry cost benchmarks (median ratios for health care bond ratings, as published by the rating agencies)

Figure 3 illustrates how triangulation of data from these three sources helped the health system to identify a preliminary expense-reduction target of \$30 million or more and the community hospital to identify a global cost-reduction target of \$7 million. Analyses related to each source quantified the level of improvement (i.e., cost reductions) needed to position the organizations to support a greater level of capital investment, enhance operating performance, and improve their balance sheets.

To achieve the target, the example health system identified staffing and productivity initiatives centered on the following: better alignment of staffing levels to patient demand; better targeting of workloads and assignments; reduced use of overtime and premium labor through cross-training; and reduced functional redundancies across the facilities. The hospital identified similar initiatives.

Figure 3. Understanding Cost-Reduction Needs



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

Strategy 5. Understand and focus on the key drivers of staffing and productivity problems.

The types of cost-reduction opportunities and their drivers vary by organization, but many of these are common to hospitals and health systems nationwide, independent of size (see sidebar 1). Staffing and productivity drivers should be a key focus, as labor costs often constitute more than half of an organization’s operating expenses.

Example: By addressing both cost structure (doing the right things) and cost management (doing things right), an independent community hospital identified 10 labor cost-reduction initiatives. Figure 4, a high-level mapping of the financial impact expected of these initiatives, can be used for all types of improvement opportunities.

In the cost-management domain, the “align staffing plans and schedules” initiative—number 1 in the graph—ensures that staff work schedules appropriately reflect patient and workload demands and staffing plans. This initiative can yield significant financial return and thus appears at the top of the high-impact quadrant for cost-management efforts.

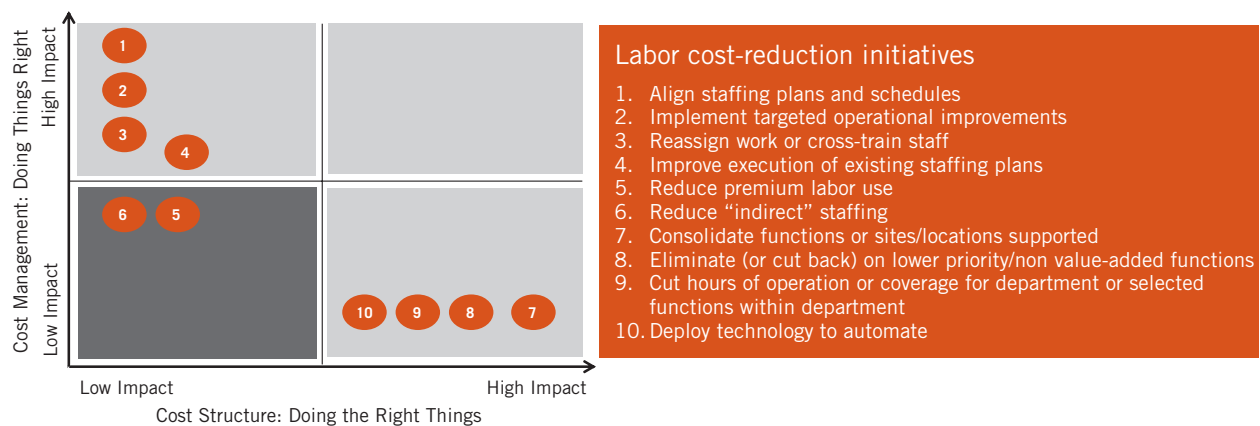
Cost-structure initiatives, such as “consolidate functions or the sites/ locations supported” (number 7 in the graph), also can be expected to yield a high return. Such initiatives could include, among other things, eliminating duplicative services in over-served markets and consolidating the number of satellite laboratory locations. Similarly, initiatives to “eliminate or cut back on lower priority/non-value-added functions”—number 8 in the graph—can provide considerable savings. A structural approach to scrutinize all work and functions for their cost/benefit “value” can be used, looking at both the importance of the functions and how well they are being performed.

Sidebar 1. Key Drivers of Staffing and Productivity Inefficiencies

- » Inadequate plans/ alignment
- » Poor execution of staffing plans
- » Inappropriate/unclear staffing roles, target workloads, and assignments
- » Service and functional redundancy/excess capacity
- » Insufficient management controls
- » Use of overtime/premium labor

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

Figure 4. Labor Cost-Structure and Cost-Management Opportunities



- Labor cost-reduction initiatives**
1. Align staffing plans and schedules
 2. Implement targeted operational improvements
 3. Reassign work or cross-train staff
 4. Improve execution of existing staffing plans
 5. Reduce premium labor use
 6. Reduce “indirect” staffing
 7. Consolidate functions or sites/locations supported
 8. Eliminate (or cut back) on lower priority/non value-added functions
 9. Cut hours of operation or coverage for department or selected functions within department
 10. Deploy technology to automate

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

Strategy 6. Drill down on staffing methods.

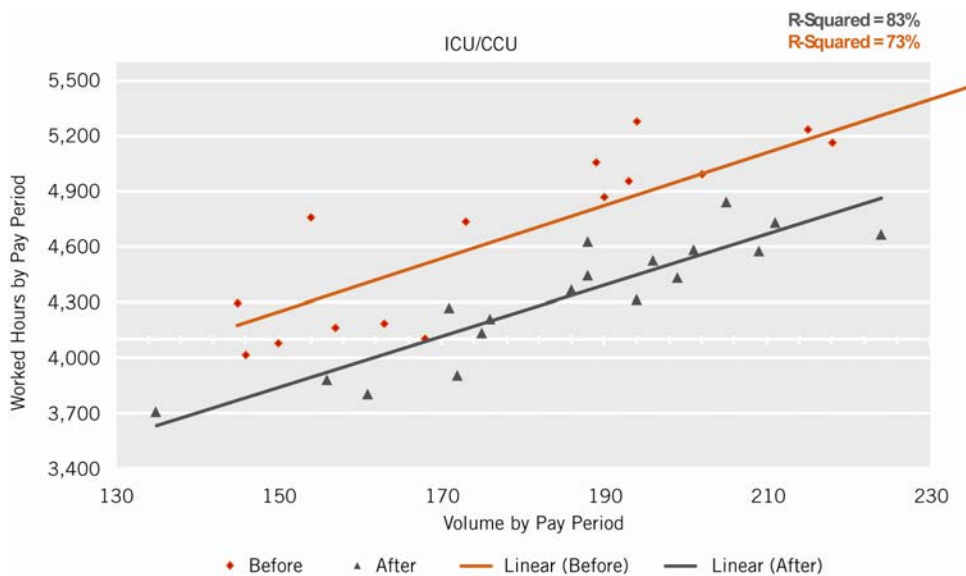
Poor alignment of staffing with patient volume, coupled with poor execution of existing staffing plans, can be among the more common contributors to high labor costs. While organizations may believe that their current staffing methods are highly effective in matching staffing and volume, such assumptions should be rigorously tested.

It may be possible to strengthen the relationship between staffing and patient demand. Staff schedules may not be geared to when patients arrive at the operating room or emergency department, for example. Planning for staff “flexing”—i.e., adjustment upward or downward with changes in volume—may not be occurring as expected. A close review of census-based staffing grids for inpatient units can reveal a less-than-ideal correlation between staffing and volume.

Figure 5 illustrates the results of a concerted effort by one hospital to more closely align staffing to demand in its intensive care and critical care units. The diamond-shaped points are the values for hours worked by pay period at specific patient-volume levels *before* alignment. The triangle-shaped points reflect staffing *after* focused alignment efforts were implemented. The effectiveness of this effort can be seen in the improved statistical alignment of staffing to demand as measured by the correlation (R-squared value), which increased to 83 percent from 73 percent.

Additionally, the data demonstrate the department’s ability to improve the efficiency of staffing at every volume level. This is illustrated by the fact that the black “after” line is lower at all points on the chart than the orange “before” line. This productivity improvement/staff alignment initiative saved the organization nearly 600 hours of staffing cost per pay period.

Figure 5. Aligning Staffing to Volume Demand



Note: The red line is performance before the initiative; the black line is performance after the initiative.

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

Strategy 7. Streamline overhead functions.

Opportunity exists in most multifacility organizations to achieve greater “system-ness” by eliminating redundancy of functions across facilities. Cost savings can be achieved through selective centralization or regionalization of administrative and/or overhead services and functions. These include human resources (HR), accounting and finance, revenue cycle, information technology, marketing, legal/risk management, and materials management, among others. Consolidation at the appropriate level can improve operations and yield large savings.

Example: Figure 6 illustrates how one health system reallocated HR functions, resulting in FTE savings of \$6 million. The system achieved such savings by reducing the duplication of HR services and reducing excess capacity. A large portion of the savings resulted from the health system’s decision to relocate several HR functions to regional or system-level offices.

A data-driven and objective evaluation of system services from a “total spend” perspective, regardless of where such services may currently reside, is highly recommended.

Figure 6. Integration of Systemwide Human Resource Functions

Human Resources Current Structure								
	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E	REGIONAL	SYSTEM	TOTAL
Current FTES	11.2	7.4	16.1	18.0	13.0	0.0	6.3	72.1
Organizational Development	X	X	X	X	X			
Human Resources Info Systems (HRIS)	X	X	X	X	X		X	
Employee Relations	X	X	X	X	X			
Benefits	X	X	X	X	X			
Compensation	X	X	X	X	X			
Employee Health	X	X	X		X			
Staff Training	X	X	X	X	X			
Labor Relations	X	X	X	X	X			
Employment Recruiting	X	X	X	X	X			
Workers' Compensation	X	X						
Human Resources Proposed Structure								
	Hospital A	Hospital B	Hospital C	Hospital D	Hospital E	REGIONAL	SYSTEM	TOTAL (1)
Recommended FTES	5.2	3.6	8.0	8.8	6.4	20.0	11.2	63.2
Organizational Development						X		
Human Resources Info Systems (HRIS)							X	
Employee Relations	X	X	X	X	X			
Benefits							X	
Compensation							X	
Employee Health						X		
Staff Training						X		
Labor Relations						X		
Employment Recruiting						X		
Workers' Compensation							X	
FTE Savings Due to Rationalization of H.R. Functions	6.0	3.8	8.1	9.2	6.6	-20.0	-4.9	8.9

Note: As evident from the many red boxes on the top portion of this illustration and the comparatively fewer boxes on the bottom portion, this organization was able to significantly reduce duplication of overhead HR functions.

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

Sidebar 2. Lessons from the Trenches

- » Targets *without* specific improvement initiatives will produce unsatisfactory cost savings.
- » Improvement initiatives *without* targets may enable or support various organizational priorities but will produce unsatisfactory cost savings.
- » Leaders must understand the political will or appetite to pursue cost reduction in traditionally sensitive areas before undertaking such a strategy.
- » Periodic “look backs” are helpful in evaluating how the organization’s cost structure has evolved and whether opportunities exist to use resources more effectively in support of mission and strategy.
- » Results must be tracked meticulously.

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

Strategy 8. Ensure that cost-reduction targets are integrated with organizational plans and budgets.

To realize cost reductions, the specific initiatives identified through the processes just described must be thoroughly integrated with the organization’s strategic financial plan, annual budget, and operating plan. Targets and reports must be aligned with financial statements so that the impact of initiatives is reflected in overall organizational performance. To ensure that progress toward specific goals can be monitored and measured, the initiatives also must be readily identifiable within these plans.

Additionally, productivity reporting systems and target metrics must integrate appropriately with the organization’s budget. Staffing plans with aligned staffing schedules should be reflected in the budget as well. If “disconnects” occur among any of these elements, cost efficiencies and reductions will be very difficult to achieve and will result in expenses that are higher than expected or warranted.

Target setting and achievement are critical leadership functions. But, targets alone are not sufficient. They must be monitored, readjusted, and reported upon departmentwide and/or organizationwide. The best results are achieved when targets are assigned to specific improvement initiatives and specific executives. Stretch targets must allow for “slippage” in planning and execution. Beware of an unwillingness to set targets! Sidebar 2 provides lessons from the trenches.

Takeaways

- » Detailed awareness of your organization’s current level of preparedness for strategic cost management is critical to effective planning.
- » In an era of flat-to-declining revenue, cost-reduction goals should be established to close as much of the organization’s capital shortfall as possible.
- » Staffing and productivity cost drivers should be a key focus, as labor costs often constitute more than half of an organization’s operating expenses.
- » To realize cost reductions, the specific savings initiatives identified by the organization must be specifically identified **and** integrated components of the strategic-financial plan, annual budget, and operating plan.

Strategic Businesses and Services and Their Distribution

Forward-thinking health care organizations, whether freestanding hospitals, multihospital systems, or other provider entities, are evaluating all aspects of their business in light of changing market conditions and requirements for future success under the new business model. They are asking, “What businesses and services are core to our mission and vision going forward?” and “Where can we most effectively invest our limited capital and human resources to meet the continuing health care needs in our communities?”

The costs involved in building competencies for the new business model, including tight physician integration, care-management infrastructure, a sophisticated health information technology platform, and partnerships across the care continuum, will be considerable for all organizations. For small community hospitals, it may not be possible to continue being “all things to all people.” Rather, community access to needed services may have to be accomplished through referral or partnership arrangements. Eight strategies can help hospital and health system executives and boards define the business strategies appropriate to their organizations and the plan by which those strategies can be executed.

Strategy 1. Start with an evaluation of your organization’s strategic options.

Identification and assessment of strategic options under alternative scenarios, supported by integrated strategic-financial planning related to these options, are more important than ever before in order to get to sustainable organizational positioning. Evolving incentives will force inefficiencies out of the broader health care system; those organizations unwilling or unable to make necessary strategic changes are at risk of being marginalized in their markets.

Strategy 2. Evaluate each business unit and service line to identify core elements.

Criteria for this evaluation should include, fit with strategic mission and vision in community or communities served, current market attractiveness, competitive landscape, current financial performance, and projected financial performance under new delivery and payment models. Sidebar 3 provides the key questions that health care boards and management teams must ask and answer.

Strategy 3. Use a structured process to analyze the core businesses and services.

Using a structured approach, the efficiency and effectiveness of each business and service should be evaluated, as should the organization’s ability to sustain the business or service’s relevance in a changing market (see figure 7).

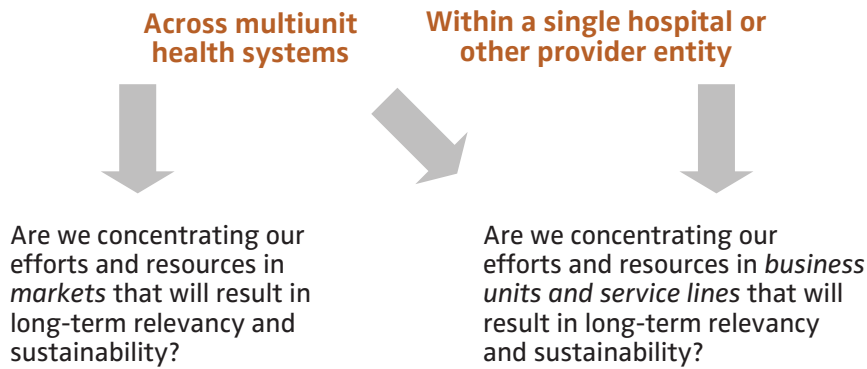
The multistep approach involves the following: articulating organizational goals; identifying the businesses and services for consideration; evaluating the geographic market; assessing each business/service within that market; identifying how services could be better distributed across the delivery system; formulating strategy for achieving more optimal distribution; preparing and evaluating volume and financial projections for individual businesses/services and the hospital or health system; making and implementing decisions for desired future delivery system.

Sidebar 3: Five Questions to Guide Leadership Thinking About Essential Businesses and Services

- » Is this an *essential* business/service that is required to deliver upon our mission?
- » Is this business/service fully integrated into the fabric of our organization and its care delivery model?
- » Will this business/service become more or less relevant as success requirements under reform and the new business model evolve?
- » Is our organization best positioned to own and operate this business/service or could another organization provide these services more effectively and efficiently for our community or communities through contractual and other relationships?
- » How can our resources be most effectively deployed to maintain and further advance our mission and strategic position?

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Figure 7. Approach to Assessing Businesses and Services



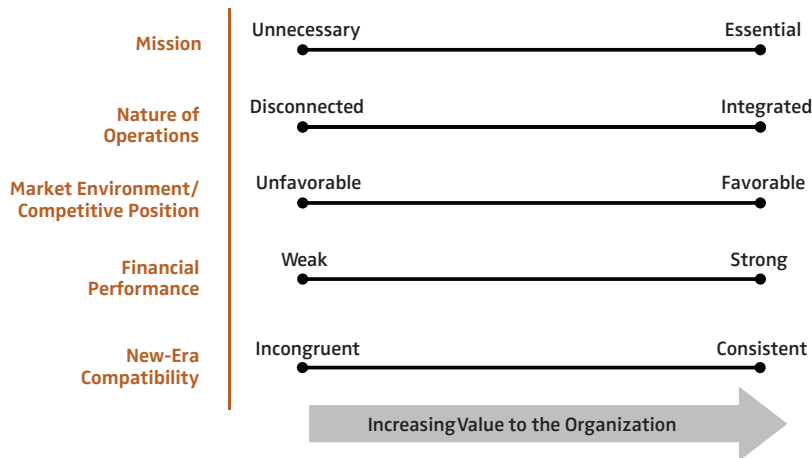
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Strategy 4. Implement a business/service line analysis framework.

The framework should consider mission, nature of operations, market environment/competitive position, financial performance, and compatibility with new-era needs and competencies (see figure 8). Appendix A includes a full description of each framework element.

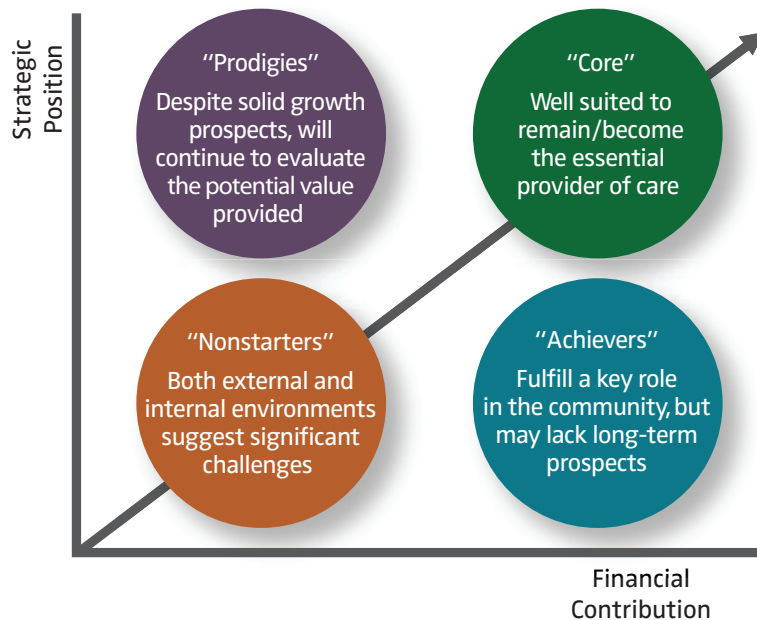
Ultimately, discussions related to an organization’s businesses and services must openly address total value of the business to determine if it is the best use of scarce resources available to meet community needs. Figure 9 provides an appropriate evaluation matrix, with four categories of businesses and services—core, achievers, nonstarters, and prodigies—as defined along strategic-position and financial-contribution axes. Tough decisions will need to be made and implemented by hospital and health system boards and executives teams.

Figure 8. Framework for Business/Service Analysis



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

Figure 9. Business/Service Evaluation Matrix



Source: Kaufman, Hall & Associates. Used with permission

Example: Given the significant capital investment requirements of the new business model, one academic medical center evaluated its options in the changing landscape. The evaluations started with the development of a financially oriented business plan for each service line and business unit currently owned and operated by the organization. The medical center owned a home health business and a reference laboratory business, among other entities.

Each business plan was supported by fact-based assumptions about volume, revenue, expense, and associated capital costs going forward. Sensitivity and scenario analyses were completed for the key drivers to understand the range of possible outcomes. Each plan was integrated into the organization’s long-term strategic financial plan in order to understand the impact of the businesses on the organization’s strategic and financial success going forward.

Home health business. The academic medical center needed access to high-quality post-acute care in order to manage patients’ health following discharge, thereby minimizing readmissions. But the economics of its home health business were difficult. Competition was intense in its market. The business was not profitable, and its losses were expected to increase. The medical center was concerned about its ability to sustain the business in the long run and provide the necessary capital and resources to maintain ongoing quality services. It decided to divest the home health business to one of the major players in the market, which could continue providing quality services more effectively and efficiently in the community. The divestiture would mitigate the medical center’s losses and enable the organization to redirect capital capacity to initiatives in its core competency and mission-driven areas.

Reference laboratory business. The academic medical center’s reference laboratory business, on the other hand, was very profitable, having been significantly capitalized over the years. But the business did not meet leadership’s criteria for core services, as identified through the key questions outlined in sidebar 3. Two large laboratory companies, which already provided services in the community, proposed to purchase the medical center’s business to increase their market penetration. The medical center decided to divest its reference lab business and use the proceeds to build its balance sheet in support of core strategic initiatives.

Sidebar 4. Critical Questions for Defining Your Organization's Position in the New Landscape

- » What services should we be offering in each location (and to what scope and scale), with consideration of the population's care needs and of access, cost, and quality objectives?
- » Are there services that we currently provide in multiple locations that could or should be concentrated at fewer sites (for example, specialty-based ambulatory services, resource-intensive services)?
- » Are there other services that require broader access (for example, primary care) and services that should be covered in lower-cost intensity settings?
- » If we were able to start fresh, what would be an optimal care delivery system across our inpatient and outpatient offerings?
- » How can we migrate from our current situation toward this more optimal system?

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Strategy 5. Understand when and why service distribution planning will be needed.

Service distribution planning is structural work that reshapes the programs and services offered by an organization across its geographic markets. Given the strategic and capital challenges posed by the new business model, such work will likely be required of many types of organizations and for many different reasons, including the following:

- » Community hospitals that wish to remain independent will need to redefine their service offerings, including inpatient and ambulatory sites, to maintain competitive performance.
- » Community hospitals that wish to partner with another community hospital to form a system or to join an existing health system will want to determine the fit of their business and service offerings.
- » As community hospitals partner with or join regional health systems, parent systems will need to integrate hospitals, outpatient facilities, and physician networks to deliver a coordinated system of care and gain scale efficiencies.
- » Before proceeding with transactions, partnering organizations will need to be certain of marketplace synergies for effective operations going forward.
- » Smaller multihospital community health systems will need to refine their service offerings to strengthen their market position.
- » Regional and super-regional systems will begin focusing beyond aggregation of providers to increase the efficiency and effectiveness of delivery system resources.

Service distribution planning is aimed at determining the appropriate level of care, access, and quality to achieve desired outcomes at a cost that considers the needs of patients and payers. At the same time, such planning aims to maximize capital capacity and to ensure that the organization remains financially competitive. The end product is a plan that drives improved operating performance through efficient care delivery across a geographic area, without compromising quality and outcomes, and often improving both.

Strategy 6. Initiate the process of defining the most efficient and effective distribution of services.

Health care executives and boards are now working to define their roles in local communities, to ensure that their organizations deliver value-based care, and to manage the transition. They are asking and answering critical questions that often require difficult decision making (see sidebar 4).

Given the speed with which health care is expected to change, delay in answering these questions increases the probability that markets will shift *around* organizations that are not redefining or refining their service distribution. As relationships between payers, physicians, hospitals, health systems, and other providers are secured in the new environment, organizations must have a clearly articulated service distribution strategy to remain relevant.

Additionally, inefficient service distribution stresses an organization's clinical, facility, technological, human, and capital resources, making the organization less viable as a value-based provider.

Strategy 7. Use a structured framework for service distribution planning.

Similar to the process used to evaluate and analyze the organization's core business and service offerings described earlier, the service distribution planning process should be a structured one, using a solid framework.

Educating the board, management, and physicians about why it is important to restructure the service delivery system provides the starting point. All key constituents need to understand the changes that are occurring in the environment and why this effort is essential to reposition the organization for sustained success. A clear and concise objective statement should be crafted and then reaffirmed on almost a continuous basis throughout the planning effort.

Strategy 8. Ensure a solid fact base for the service distribution plan.

A solid fact base provides a foundation that helps better contextualize barriers or challenging issues going forward. The fact base includes data related to the organization’s markets, strategic and financial positions, and the impact of current and possible future trends on those markets and positions. Within the planning framework, key realities and assumptions must be defined related to payment mechanisms, the competitive environment, physician market characteristics, and core competencies required for provider success (see figure 10).

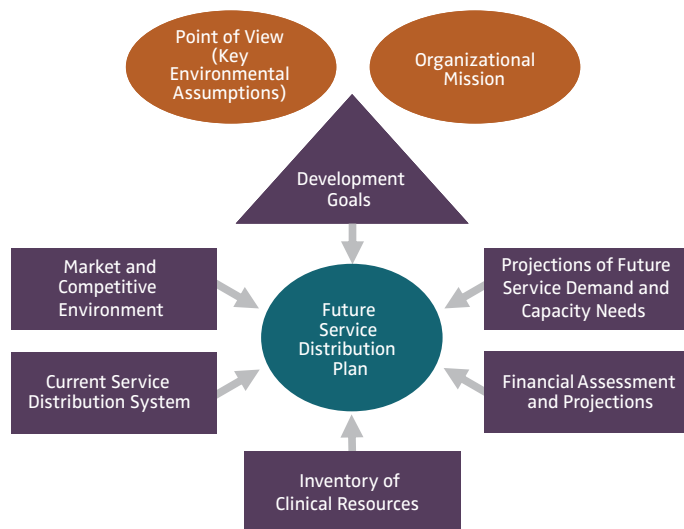
A comprehensive financial fact base must also be developed, quantifying the organization’s capital position, future financial position, and debt capacity. In the current uncertain environment, scenario modeling and sensitivity analyses are imperative in order to understand how changes in utilization, payment, capital, and other assumptions will impact future strategic and financial performance.

The final plan that is developed for the service delivery system, based on the above-described process, fully defines:

- » How the organization will serve the market
- » How each of the organization’s operations and service lines will relate to other operations and service lines
- » How clinical resources will be organized and deployed
- » The financial impact of the service distribution plan on the overall organization

Most organizations will not be able to be all things to all people. They will need to define and re-scope core community service offerings as appropriate to overall capital, management, and clinical resources.

Figure 10. Service Distribution Planning Framework

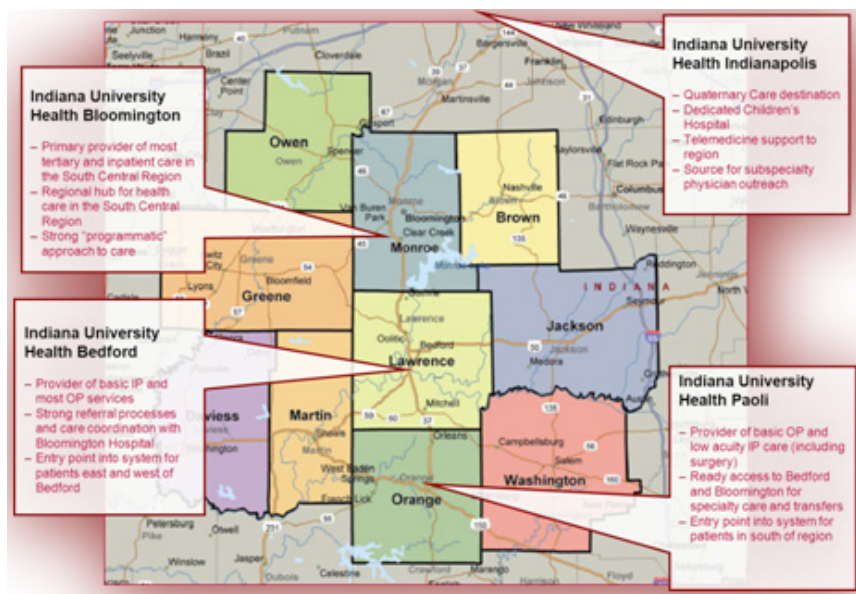


Source: Kaufman, Hall & Associates, Inc. Used with permission

Example: To effectively deliver high-value and high-quality patient care, i.e., the right care (at the appropriate level/scope) at the right locations, and at the right cost, Bloomington Hospital in Bloomington, Indiana, and Indiana University Health, headquartered in Indianapolis, initiated service distribution planning in connection with the affiliation of Bloomington Hospital with the IU Health system. The organizations wanted to have in place a regional service delivery plan that would optimize the delivery of the combined entity's services in South Central Indiana. A regional plan would enable the combined organization to serve patients as close to their homes as possible, improve referral processes and physician support, improve care coordination, enhance the quality of services being provided, and ensure a seamless care delivery system.

Figure 11 provides a high-level look at the strategic roles envisioned for entities within Bloomington Hospital and IU Health. By focusing and optimizing their combined geographic footprint once the affiliation was completed, Bloomington Hospital and IU Health ensured appropriate coverage to serve their service areas, without unnecessary saturation or overextension of clinical, human, or technological resources in ambulatory or inpatient settings. Appendix B provides additional information on this example.

Figure 11. A Service Distribution Plan for the South Central Indiana Region



Source: IU Health and Kaufman, Hall & Associates. Used with permission.

Takeaways

- » Forward-thinking health care organizations, whether freestanding hospitals, multihospital systems, or other provider entities, are evaluating all aspects of their business in light of changing market conditions and requirements for future success under the new business model. They are identifying core businesses and services using concrete criteria.
- » Hospitals and health systems should use a structured process and fact-based framework to analyze their core businesses and service lines. Discussions must openly address total value of each entity to determine if each is the best use of scarce resources.
- » Most organizations will not be able to be all things to all people. They will need to define and re-scope core community service offerings as appropriate to overall capital, management, clinical resources, and community need.
- » Tough decisions will need to be made and implemented by hospital and health system leadership.
- » Given the strategic and capital challenges posed by the new business model, service distribution planning will likely be required of many types of organizations and for many different reasons.
- » The end product of service distribution planning is a plan that drives improved operating performance through efficient care delivery across a geographic area without compromising quality and outcomes, and often improving both.

Concluding Comments

The transformation of U.S. health care to a very different delivery and payment system is underway. Proactive executives are moving forward aggressively to reshape and streamline their costs in anticipation of this new health care environment. Hospital and health systems leaders have an opportunity to make a significant contribution to health care delivery in their communities by moving their organizations toward value-based care, using the strategies of strategic cost transformation outlined here. The time to move is now.

Appendix A

Components of an Analysis Framework for Businesses and Service Lines

Essentiality of a business to an organization's mission

This element is exceedingly difficult to measure. As with most social goods, there is a nearly insatiable appetite for the services that hospitals and health systems provide for the benefit of their communities. Mission considerations include, among others: benefit provided to, and support provided by, the community; whether a void would be created if the business/services were not provided; and whether other organizations would appropriately fill that void.

Nature of operations

Considerations include: whether patients/customers flow across the businesses and services or whether the operations are detached and separate; the extent to which the business/service functions as a stand-alone operation (i.e., systems, management, funding of operations, utilization of shared services); the alignment of associated strategic requirements and financial incentives with the core operations of the organization; and the downstream or upstream implications of eliminating this business/service.

Market environment and competitive position

Considerations include: attractiveness and demand for this business/service; the key industry drivers and requirements for success of this business/service; the intensity of competition and the organization's ability to differentiate from others; and whether the organization has a competitive position that is relevant and sustainable in its market.

Financial performance

Considerations include: the historical financial performance of the business/service; the level of financial performance generally achieved within the industry for this type of business/service; future capital requirements and the level of performance that can be expected; the estimated valuation of the business/service; the impact divestiture would have on the overall credit profile and the financial position of the organization; and the impact development of a new business/service or acquisition would have on the credit profile/financial position of the organization.

New-era compatibility

Considerations include: whether the business/service supports longitudinal patient management across the continuum of care; whether this business/service creates or supports strong physician-hospital alignment; its impact on the organization's brand and image; whether this business/service has a material cost structure advantage or disadvantage relative to competitors; and whether the organization can be an essential provider of this business/service with sufficient scale of operation to succeed.

Appendix B

Example of Effective Distribution of Services at Indiana University Health

Objectives

To effectively deliver high-value, high-quality patient care, i.e., the right care (at the appropriate level/scope) at the right locations, and at the right cost, Bloomington Hospital in Bloomington, Indiana, and Indiana University Health, headquartered in Indianapolis, initiated service distribution planning in connection with the affiliation of Bloomington Hospital with the IU Health system.

The organizations wanted to have in place a regional service delivery plan prior to their integration in 2010 so that the delivery of services would be optimized once the affiliation was completed. A regional plan for South Central Indiana would enable the combined organization to serve patients as close to their homes as possible, improve referral processes and physician support, improve care coordination, enhance the quality of services being provided, and ensure a seamless care delivery system.

Processes

Bloomington Hospital and IU Health sought to gain a comprehensive understanding of their service areas, their strategic and financial positions, and the impact of current and possible future trends on those areas. A thorough fact base was developed for the two organizations. Key strategic analyses included a service delivery profile, physician and key clinician resource inventory, facilities assessment, competitive evaluation, and an internal performance profile.

For planning to be successful, a team-based approach was used. Board members, executives, physicians, and staff provided needed information and perspectives to help ensure success at the implementation stage. A facilitated committee structure proved effective. A thorough schedule of activities and a timeline kept the teams moving toward goals within a tight time frame.

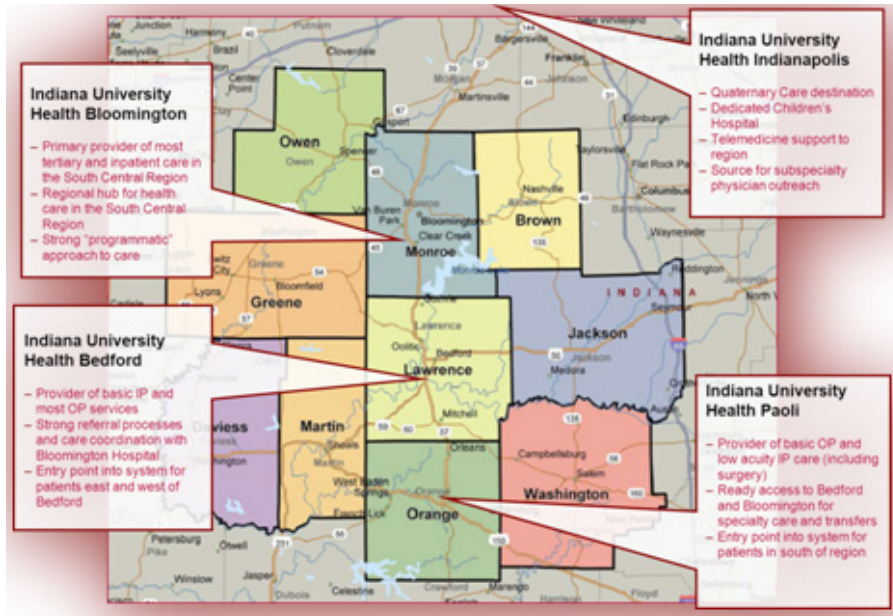
A management steering committee, whose members included systemwide leadership and executive management from each of the organization's hospitals or major facilities, provided oversight throughout the process.

At the conclusion of the planning process, the roles for each of the system's major hospitals and medical centers were as follows:

- » IU Health Bloomington (290 beds) would serve as the primary provider of most tertiary and inpatient care to the South Central Region.
- » IU Health Paoli (25 beds), formerly Bloomington Hospital Orange County, would provide basic outpatient and low-acuity inpatient care (including surgery) for patients in the southern portion of the region.
- » IU Health Bedford (25 beds), which was owned by IU Health prior to the merger, would provide routine inpatient and outpatient services for patients east and west of Bedford.
- » IU Health Indianapolis (2,000 beds) would provide sophisticated quaternary care throughout the region, including a dedicated Children's Hospital, telemedicine support, and subspecialty physician outreach.

Figure 1 provides a high-level look at the strategic roles envisioned for entities within Bloomington Hospital and IU Health.

Figure 1. A Service Distribution Plan for the South Central Indiana Region



Source: IU Health and Kaufman, Hall & Associates. Used with permission.

Clinical task forces, comprised of key physician and administrative leaders representing each service line and clinical site, served as the core planning groups for service lines. Through an iterative facilitated process, they developed preliminary plans defining which services will be offered at which sites and to what scale, considering both existing and potential new locations.

A *facility planning task force* reviewed facility priorities and investment needs and provided direction on how the investments should be prioritized. The team based its recommendations on the volume/capacity, operating impacts, and associated capital requirements of specific strategies or initiatives identified by the other teams, for example, ambulatory services joint ventures, inpatient programs, and others.

Based on the work accomplished by the teams, the financial impact of the regional strategic plan on the combined organization was assessed. The resulting service distribution plan included: definition of the service delivery system; service area, program/service, physician, operating, and other strategies; facility impacts; organizational structure and implementation considerations; and financial goals.

Outcomes

By focusing and optimizing their geographic footprint, Bloomington Hospital and IU Health ensured appropriate coverage to serve their service areas, without unnecessary saturation or overextension of clinical, human, or technological resources in ambulatory or inpatient settings.

For example, Bloomington Hospital Orange County (in Paoli) would focus on basic outpatient and low-acuity inpatient care, while Bedford Regional Medical Center, 20-plus miles north of Paoli, could also offer more complex treatments in a few selected areas. This would allow patients in surrounding counties to receive certain care locally, rather than having to drive 20 or more miles further north to Bloomington Hospital. By providing a more sophisticated level of selected services at one of its small hospitals, the system could also avoid operating an underperforming program at each of the locations.

IU Health Indianapolis and Bloomington Hospital were able to complement each other's services. A coronary artery bypass graft surgery program, which had been in place at Bloomington Hospital since the mid-1990s, would continue at that site, reserving the quaternary Indianapolis-based hospital for the most complex, critical heart cases requiring the highest level of clinical and technological sophistication. The cardiovascular surgery group at IU Health Indianapolis was able to help Bloomington Hospital by placing two full-time surgeons at Bloomington Hospital, as and when needed by that hospital.

This plan enabled the higher-cost Indianapolis hospital to avoid overbuilding its facilities to accommodate volume that actually required a lower level of sophistication. The plan totally reshaped the way the organization was looking at plans for major facility renovations, enabling the organization to make the best possible use of scarce capital and clinical resources.

**Caring for
Vulnerable Populations**



Caring for Vulnerable Populations



A Report of the AHA Committee on Research:

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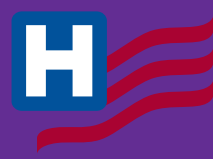
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Executive Summary

Purpose

The American Hospital Association's Committee on Research (COR) annually studies a topic in depth to provide the hospital field with relevant recommendations for advancing health care. **In 2011, the AHA COR examined emerging practices in effectively coordinating care for vulnerable populations.** Since the breadth of the vulnerable population is large, the committee focused its initial efforts on the dual eligible population as a subset. While the alignment of financial incentives to provide care to this population will evolve at the federal, state, and local policy levels, hospitals are well positioned to address the system, provider, and patient opportunities to provide high-quality care. This report summarizes the literature, highlights best practices, and makes recommendations for the field on important elements that should be included in any organized program to coordinate care for dual eligibles or any other vulnerable population.

Background

Approximately 9.2 million Medicaid beneficiaries are dual eligibles—low-income seniors and younger persons with disabilities who are enrolled in both the Medicare and Medicaid programs. Dual eligibles are among the sickest and poorest individuals, and they must navigate both government programs to access necessary services, relying on Medicaid to pay Medicare premiums and cost sharing to cover critical benefits not covered by Medicare. Fifty-five percent of this population has an annual income below \$10,000, and the same subset is three times more likely than the rest of the Medicare population to be disabled and have higher rates of diabetes, pulmonary disease, stroke, mental disorders, and Alzheimer's disease. Although they represent a relatively small percentage of the overall Medicare and Medicaid populations, 16 percent and 15 percent respectively, dual eligibles account for \$300 billion (approximately one-third) of annual spending between the two programs.

Currently, care for dual eligibles is fragmented, lacking management and coordination at the program level. Different eligibility and coverage rules in Medicare and Medicaid contribute to these difficulties. The current system lacks sufficient care coordination for the comprehensive services this population needs, which inhibits access to critical services and encourages cost shifting between providers and payers. All of these factors adversely affect this population's quality of care and health outcomes, in addition to contributing to Medicare and Medicaid spending challenges.

Policymakers and providers have recognized the challenges associated with caring for dual eligibles, and some care coordination models have developed. The currently implemented options for coordinated payment and care at the federal, state, and provider levels can be grouped into three broad categories: (1) Special Needs Plan, (2) Program of All-Inclusive Care for the Elderly, and (3) Medicaid Managed Care. While the selections offer several opportunities for integration, they have failed to expand beyond modest penetration, reaching less than 20 percent of the overall dual eligible population. Only 2 percent of duals actually participate in a fully coordinated plan.

Policy Developments

The Affordable Care Act established two new federal entities—the Federal Coordinated Health Care Office and the Center for Medicare and Medicaid Innovation—that will both be involved in efforts to study and improve care for dual eligible beneficiaries. Developing and overseeing large-scale pilot projects, states will still take time to institute full care-coordination programs. All this creates a tremendous opportunity for hospitals to take the lead in developing integrated delivery programs for the dual eligible population.

Best Practice Recommendations

The COR reviewed the literature and spoke to experts in the field to identify a set of promising practices that can be implemented by hospitals to improve care coordination. Not mutually exclusive, the core elements detailed in the table below represent foundational essentials that may be combined in various arrangements depending on each organization’s population, infrastructure capabilities, and ideal outcomes. Detailed metrics are provided in this report, which focus on utilization, cost, quality/outcomes, and satisfaction. These metrics will also vary by organizational initiative.

Core Elements		Description
1	Complete Comprehensive Assessment and Reassessment	Complete patient evaluation upon entrance to the program as well as regularly scheduled assessments to adjust care plans to evolving patient needs
2	Conduct Periodic Visits	Include periodic visits (in person, by telephone, or via internet) with the patient and his/her family and caregivers at home, complementing regularly scheduled medical care
3	Implement Protocol-Based Planning	Evaluate and employ evidence-based protocols to manage common conditions affecting geriatric and other vulnerable populations, reducing unwarranted provider variation
4	Incorporate Person-Centered Care Principles and Practices	Place the individual and those affiliated (family members, other informal caregivers, client advocates, and peers) at the center of all planning decisions to achieve better results and promote self-direction
5	Utilize Team-Based Care Management Centered on Primary Care	Coordinate medical, behavioral, and long-term support services through the work of a multidisciplinary, accountable, and communicative care team. Integrate primary care physicians as the core of the care team, supporting and collaborating with the multidisciplinary group
6	Facilitate Data Sharing and Integrated Information Systems	Provide mechanisms and create the necessary data-sharing arrangements to collect, store, integrate, analyze, and report data in a timely manner to promote care coordination
7	Align Financial Incentives	Organize financial arrangements and potential savings to encourage cooperation and alignment across the continuum of care
8	Develop Network and Community Partnerships	Expand beyond the hospital and encourage relationships with nursing homes and long-term care providers, public health departments, community centers, and other organizations to improve care coordination and transition
9	Provide Non-Health Care Services	Provide nonclinical services such as transportation to appointments to assist patients in receiving needed care and living healthier lives
10	Offer Home-Based Care	Incorporate timely, patient- and family-centric, home-based care options
11	Organize Center-Based Day Care	Form or partner with a program that utilizes a center-based day care model
12	Incorporate Cultural Competency and Equity of Care Standards	Develop care teams with awareness of the individual’s cultural perspective and language fluency, and hold them accountable for quality metrics aimed at reducing incidences of care disparities

Introduction

“The moral test of a government is how it treats those who are at the dawn of life, the children; those who are in the twilight of life, the aged; and those who are in the shadow of life, the sick, the needy, and the handicapped.” – Hubert Humphrey, 1977

Importance

Sixty million Americans currently obtain coverage through state-based Medicaid programs. These individuals come from lower socioeconomic backgrounds and pose unique care coordination challenges. They disproportionately face chronic diseases and challenges to access health care as compared to the overall population. Even when care is provided, the complexity of the patients often prevents application of appropriate care standards. More than 9 million Medicaid beneficiaries are also enrolled in Medicare. While a small percentage of the overall Medicare and Medicaid population, this group accounts for almost \$300 billion in spending, or one-third of the overall annual government health care expenditure.¹ When compared to other Medicare beneficiaries, these dual eligibles are more likely to have multiple chronic physical conditions and mental disorders, posing further challenges to care coordination and access to appropriate care.

Further expounding the challenge, the Affordable Care Act (ACA) will expand Medicaid and the Children’s Health Insurance Program (CHIP) to an additional 16 million Americans by 2014, a portion of which will be dual eligibles.² Additionally, 49 states have, at least to some degree, a balanced budget amendment, and as states continue to face debt crises, Medicaid funding may be cut. Realizing the significance of the impact of this unique group, ACA created the Federal Coordinated Health Care Office, which is charged with improving integration between the two government payers, ideally increasing the quality of care provided. **While payment coordination is being organized at various policy levels, hospitals should capitalize on their unique position to address the system, provider, and individual level barriers to the provision of high quality care, implementing effective population-specific programs.**

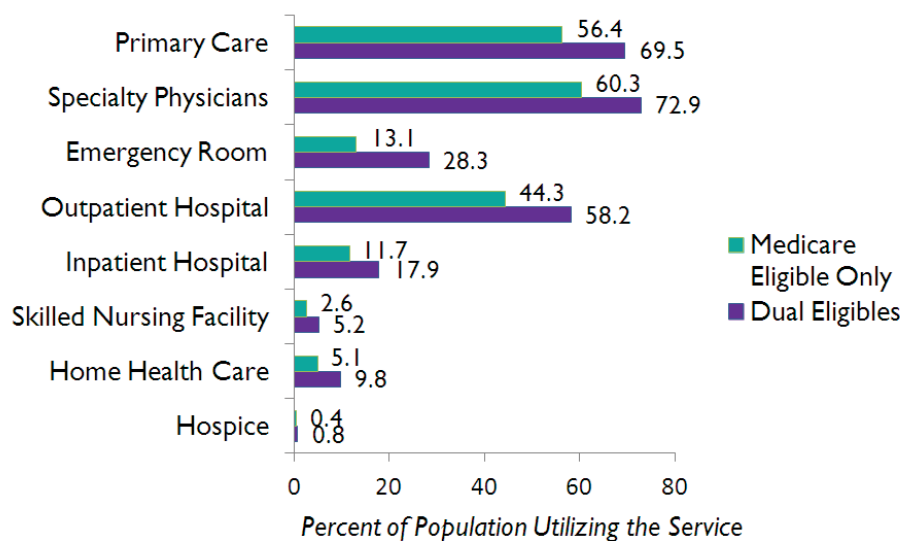
Who Is a Dual Eligible?

About 6 in 10 (5.5 million) dual eligibles are 65 and over, and more than one-third (3.4 million) are younger individuals with disabilities.³ Compared to other Medicare beneficiaries, dual eligibles are sicker, poorer, and more likely to have chronic health conditions which require institutional care. Most dual eligibles have very low incomes: 55 percent have annual income below \$10,000 compared to 6 percent of all other Medicare beneficiaries. In particular, dual eligibles are:

- 15 percent more likely to have a cognitive or mental impairment compared to non-dually eligible Medicare beneficiaries⁴
- Likely to have a limitation in at least one activity of daily living that would require attendant care (approximately 60 percent)⁵
- Three times more likely to be disabled⁶
- 50 percent more likely to have diabetes
- 600 percent more likely to reside in a nursing facility
- 250 percent more likely to have Alzheimer’s disease⁷
- Only 25 percent receive a mammogram every two years, as compared with 40 percent of Medicare beneficiaries⁸
- 162 times more likely to face schizophrenia⁹

The varying and extensive physical and mental health comorbidities increase care complexity, making health care service use extremely high among this population and care coordination particularly challenging. The following chart details the high service use among the dual population.

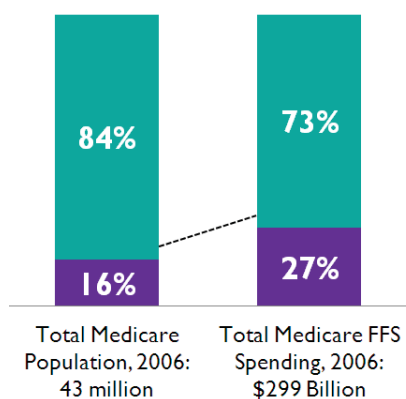
Health Service Use Among Dual Eligibles as Compared to the Medicare Population



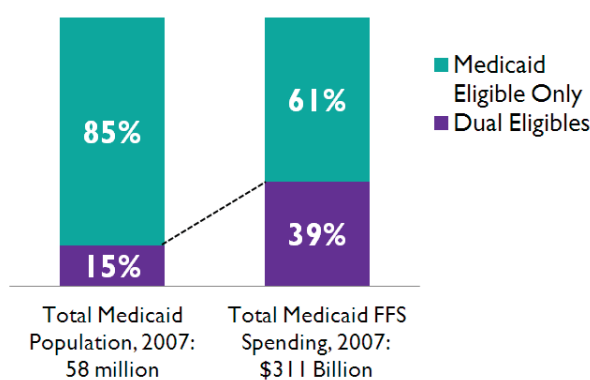
Kasper, Judy, Molly O'Malley, and Barbara Lyons. "Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending." Kaiser Commission on Medicaid and the Uninsured, <http://www.kff.org/medicaid/8081.cfm>, July, 2010.

Due to their poorer health status and greater service needs, particularly for high-cost services such as inpatient and nursing home care, dual eligibles are the most expensive population within both the Medicare and Medicaid programs. Annual mean per person spending for all dual eligibles was \$19,400 with Medicaid covering slightly more than half of the spending (56 percent). Spending per person with more than one mental or cognitive condition increased to approximately \$38,500.¹⁰ Although they are a relatively small percentage of the overall Medicare and Medicaid populations, they account for almost one-third of overall Medicare and Medicaid spending. This distortion is displayed in the charts below.

Dual Eligibles as a Share of Medicare Population and Medicare Spending, 2006



Dual Eligibles as a Share of Medicaid Population and Medicaid Spending, 2007



Source: Kaiser Family Foundation, "The Role of Medicare for the People Dually Eligible for Medicare and Medicaid," January 2011. <http://www.kff.org/medicare/upload/8138.pdf>

How do Coverage and Payment Policies Function for Dual Eligibles?

The current distribution of financial costs and the management of dual eligibles across Medicare and Medicaid require the coordination of two programs with different coverage and payment parameters. For this population, Medicare generally covers acute care services while Medicaid may reimburse for different combinations of Medicare premiums, cost sharing, and long-term care services, depending on the beneficiary.

Despite the obvious need for coordination between the two organizations, the administrative complexity has encouraged few dual eligibles to participate in coordinated care models and even fewer in integrated programs that align Medicare and Medicaid. Legally, the government payers are structured to operate as two separate programs, and their interaction is complicated by 50 separate state Medicaid policies.

Financially, the current policy creates incentives to shift costs to the other payer, often hindering efforts to improve quality, increase access, and coordinate care. State-run Medicaid plans have little incentive to improve coverage on long-term and supplemental services for duals—which ideally would reduce hospitalizations, readmissions, and unnecessary ED visits—because potential savings would accrue primarily to Medicare. Better discharge planning under Medicare could help avoid a lengthy Medicaid-reimbursed nursing home stay, but without program coordination, there is no incentive for Medicare to support this endeavor.

As such, dual eligibles are forced to navigate a system with two sets of payers and benefits. This fragmentation results in unnecessary, duplicative, and missed services. Integrating Medicare and Medicaid services can ensure that dual eligible beneficiaries receive the right care in the right setting. Coordinated care through aligned financial incentives potentially offers one seamless set of benefits and providers, high-quality care, and less confusion. For state and federal policymakers, coordinated care can potentially reduce fragmentation, increase flexibility in the types of services provided, enhance budget predictability, align incentives, and control the costs of caring for this population.

Existing Service Delivery Models

Existing efforts to integrate the health care of dual eligibles at the federal and state level demonstrate both the promise and perils of such programs. The current widespread options can be grouped into three broad categories, which are summarized and then compared in the following chart. These plans are not mutually exclusive, and states have adopted a combination to suit their population's needs as well as to cover both Medicare- and Medicaid-reimbursed services. While some states have introduced other integrated models, they are not included due to the limited number of beneficiaries.

- 1) Special Needs Plan (SNP):** SNPs are specialized Medicare Advantage Plans that receive capitated premiums to pay for traditional and nontraditional Medicare-covered services. New and expanding SNPs are now required to contract with the state to provide some Medicaid coordination.
- 2) Program of All-Inclusive Care for the Elderly (PACE):** PACE is a fully integrated, provider-based managed care plan, incorporating all Medicare and Medicaid primary and acute services, in addition to long-term health care. PACE providers assume full financial risk for participants without limits on quantity, period, or scope of services.¹¹
- 3) Medicaid Managed Care (MMC):** MMC models vary widely and include both fee-for-service (FFS) arrangements with additional payment to further care coordination and risk-based models, which provide one capitated payment to cover all services.¹²

Program	Financing	Population	Care Coordination
SNP	Risk-adjusted, capitated payments to provide Medicare Part A and B services and some degree of Medicaid services depending on the plan ¹³	298 plans serving more than 1,000,000 beneficiaries ¹⁴	<p>Opportunities</p> <ul style="list-style-type: none"> • Patient ease with one plan • Greater budget predictability • Multidisciplinary care team <p>Barriers</p> <ul style="list-style-type: none"> • No proven care improvement • Varying degree of Medicaid coordination
PACE	Separate Medicare and Medicaid capitated benefit at an agreed-upon per member per month rate	71 sites nationally, serving approximately 23,000 participants ¹⁵	<p>Opportunities</p> <ul style="list-style-type: none"> • Fully integrated funding stream • Established quality measures • Medical and nonmedical capabilities <p>Barriers</p> <ul style="list-style-type: none"> • Sufficient up-front capital required¹⁶ • High administration and workforce costs • Centered on one physical location
MMC	Some plans maintain FFS with an additional payment for coordination, and others utilize a capitated model	Approximately 2.5 million beneficiaries ¹²	<p>Opportunities</p> <ul style="list-style-type: none"> • Incremental step toward risk sharing • Improved care coordination <p>Barriers</p> <ul style="list-style-type: none"> • FFS disincentives remain • No set design standard • Some exclusion of long-term care and behavioral health benefits

While the plans depicted above offer several opportunities for integration, truly aligned plans have failed to expand to more than 2 percent of the overall dual eligible population (not including non-Medicaid affiliated SNPs) for a variety of reasons including but not limited to¹⁷:

- Traditional beneficiary resistance to capitation models
- Ineffective communication around the voluntary programs
- Increasing opportunities for adverse selection
- Differences between state and federal requirements that complicate plan development
- Variation between state Medicaid regulations, making it difficult to replicate plans between states
- Disparity among the dual eligible population within geographic areas, making it harder to develop one comprehensive plan
- Large start-up costs, additional administrative staffing

While the information below provides a summary, more details about each of the current models can be found in [Appendix A](#).

Policy Developments

The disproportionately high-cost and low-quality outcomes associated with the dual eligible population brought them to the attention of health care policymakers. The promise of a 2014 Medicaid expansion combined with potential Medicare and Medicaid reimbursement reductions—Congressional action and state balanced budgets, respectively—further highlight the need for action to increase care coordination to improve quality and reduce costs.

ACA offers new opportunities for states and the federal government to align Medicare and Medicaid to establish more efficient, better coordinated care for dual eligibles. The Centers for Medicare and Medicaid Services has two new avenues for improving care. The Federal Coordinated Health Care Office, established through Section 2602 of ACA, will study and analyze the best methods to integrate benefits under the Medicare and Medicaid programs and improve coordination between the federal government and the states for dual eligibles.¹⁸

The Center for Medicare and Medicaid Innovation (CMMI) will test innovative payment and service delivery models to improve quality and reduce unnecessary costs. In April 2011, CMS announced the 15 states that were selected to receive up to \$1 million to design a delivery system and payment model to improve coordination across primary, acute, behavioral health, and long-term support systems for dual eligibles.¹⁹ Three months later, CMMI announced the pilot testing of two different shared saving models to improve care for this same population: 1) a state, CMS, and health plan will enter into a three-way contract that distributes a prospective blended payment to the managed care plan for providing coordinated care or 2) a state and CMS enter into an agreement that makes the state eligible to benefit from savings resulting from managed FFS initiatives.^{20,21} * The programs vary by state and county, as participating entities have varied the programs based on geographic and population demographics.

What Should Hospitals Do?

In the current hospital economic climate, it is necessary for financial incentives to be aligned, and this will be addressed legislatively at the federal, state, and even local levels. The pilot projects are taking large leaps forward in coordinating care at the payer level. Even if successful, these plans will take several years to expand beyond the current pilot format. And while integration at the payer level facilitates care coordination, it does not guarantee the same intensity among providers. Additionally, coordinated payments for this population demand that organizations improve quality, transitions, and efficiency. While hospitals have made considerable strides in caring for vulnerable populations, both onsite and through partnerships with other institutions, true care coordination remains a challenge.

Improved infrastructure, integration, and collaborative relationships are the keys to providing better care for vulnerable populations beyond the fragmented arrangements reinforced by the current FFS programs. With the ACA Medicaid and CHIP coverage expansion by 2014, combined with a potential reduction in Medicaid payment rates, **hospitals have the opportunity to address the patient, provider, and system barriers that have impeded the progress toward improved care coordination and a positive impact on the quality of care and cost for the vulnerable populations they serve.**

**The states currently involved in these demonstrations (although they may have to change specifics after the July 2011 shared savings models) include: California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington, and Wisconsin.*

Promising Models and Program Elements

There is wide variation within the dual eligible population. Less than 18 percent of duals (approximately 1.6 million) account for more than 70 percent of all health care spending.²² To further complicate the matter, there also is wide geographic variation in dual eligibles as a share of the overall Medicare population—from 11 percent in Montana to 37 percent in Maine.²³ (It is important to note that these numbers and ratios will change when Medicaid is expanded in 2014.)

It is not realistic or financially feasible for every organization to develop comprehensive care coordination plans solely for the dual eligible population. However, dual eligibles have similarities with other populations that require a high intensity of inpatient and outpatient medical and social services. **The committee believes that strategies to improve care for dual eligibles and other vulnerable populations also have spillover benefits for patients with chronic conditions, regardless of payer type.** Therefore all facilities should consider the models presented on the following pages.

Each hospital and health care system must match its community's needs and demographics with the appropriate model. As the case studies illustrate, some programs are more comprehensive while others focus on specific points within the care continuum. Some programs require a significant amount of up-front funding and others do not. However, the majority of programs enforce improved communication and data exchange across care transitions.

The following pages will detail 12 core elements of successful programs for care management of vulnerable populations. While each case study is focused on one element, these programs typically include a large majority of the elements. The table below displays each profiled program as well as their adherence to the core elements as described on the following page. **Appendix B** provides full case studies on the programs at various institutions that improve care coordination and transitions for complex, vulnerable populations. Additionally, more resources are available on the Hospitals in Pursuit of Excellence Web site at www.hpoe.org.

Core Elements within each Care Management Program

		Element Number											
		1	2	3	4	5	6	7	8	9	10	11	12
Case Study	Johns Hopkins Health System	X	X	X	X	X	•	X	X	X	X	X	X
	Wishard Health Services	X	X	X	X	X	X	X	X	•	X	•	X
	Holy Cross Hospital	X	n/a	X	X	X	•	n/a	•	n/a	n/a	n/a	•
	SSM St. Mary's Health Center	X	X	X	X	X	X	•	•	•	n/a	n/a	•
	AtlantiCare	X	X	X	X	X	X	X	X	X	n/a	n/a	X
	Aurora Health Care	X	n/a	X	X	X	X	X	n/a	•	n/a	n/a	•
	Commonwealth Care Alliance	X	X	X	X	X	X	X	X	X	X	•	•
	Montefiore Medical Center	X	•	X	X	X	X	X	X	•	X	•	•
	Fairview Health Services	X	X	X	X	X	X	X	X	X	n/a	n/a	X
	Summa Health System	X	n/a	X	n/a	X	X	X	X	•	n/a	n/a	•

X - Included within program

n/a - Not included due to structure/purpose of program

• - Not included or not emphasized in utilized resources

Core Elements		Description
1	Complete Comprehensive Assessment and Reassessment	Complete patient evaluation upon entrance to the program as well as regularly scheduled assessments to adjust care plans to evolving patient needs
2	Conduct Periodic Visits	Include periodic visits (in person, by telephone, or via internet) with the patient and his/her family and caregivers in their own home, complementing regularly scheduled medical care
3	Implement Protocol-Based Planning	Evaluate and employ evidence-based protocols to manage common conditions affecting geriatric and other vulnerable populations, reducing unwarranted provider variation
4	Incorporate Person-Centered Care Principles and Practices	Place the individual and those affiliated (family members, other informal caregivers, client advocates, and peers) at the center of all planning decisions to achieve better results and promote self-direction
5	Utilize Team-Based Care Management Centered on Primary Care	Coordinate medical, behavioral, and long-term support services through the work of a multidisciplinary, accountable, and communicative care team. Integrate primary care physicians as the core of the care team, supporting and collaborating with the multidisciplinary group
6	Facilitate Data Sharing and Integrated Information Systems	Provide mechanisms and create the necessary data-sharing arrangements to collect, store, integrate, analyze, and report data in a timely manner to promote care coordination
7	Align Financial Incentives	Organize financial arrangements and potential savings to encourage cooperation and alignment across the continuum of care
8	Develop Network and Community Partnerships	Expand beyond the hospital and encourage relationships with nursing homes and long-term care providers, public health departments, community centers, and other organizations to improve care coordination and transition
9	Provide Non-Health Care Services	Provide nonclinical services such as transportation to appointments to assist patients in receiving needed care and living healthier lives
10	Offer Home-Based Care	Incorporate timely, patient- and family-centric, home-based care options
11	Organize Center-Based Day Care	Form or partner with a program that utilizes a center-based day care model
12	Incorporate Cultural Competency and Equity of Care Standards	Develop care teams with awareness of the individual's cultural perspective and language fluency, and hold them accountable for quality metrics aimed at reducing incidences of care disparities

Program Metrics

The following pages provide descriptions of the core elements present in successful care programs. It is often complicated to measure success of these programs, especially in the short term. Overcoming the patient, provider, and system-level barriers requires patience. Additionally, the applicable metrics will depend on the program implemented. The chart below details different metrics that organizations can utilize to measure their progress in program implementation. Organizations must realistically apply these metrics to their own situation.

Utilization	
Depending on the attributed patient population, some of these metrics may see increased or decreased numbers. For example, for patients who never received appropriate treatments, the number of labs ordered should increase, but improved care coordination for the most complex patients should reduce the number of ordered labs.	
Examples of program measures: <ul style="list-style-type: none">• Number of emergency department visits• Number of hospital admissions• Number of preventable readmissions	<ul style="list-style-type: none">• Number of surgical procedures• Number of labs and tests ordered• Number of missed appointments• Hospital length of stay• Electronic health record meaningful use
Quality/Outcomes	
While all organizations strive for improved quality and outcome metrics, the desired measures will vary based on patient population. The programs centered on older and more complex patients should achieve improved quality of life; for younger patients, clinical outcomes will be a more important focus.	
Examples of program measures: <ul style="list-style-type: none">• Length of survival• Assessing Care of Vulnerable Elders (ACOVE) measures• SF-36 questionnaire or similar scale	<ul style="list-style-type: none">• ADL improvement• Hospital Compare – process of care measures• Mortality• Medication compliance
Cost	
Measuring cost is complicated for these programs. While it is desired for total cost of care to remain constant or decrease, in the beginning programs may see a shift in spending from inpatient and post-acute care to primary, home, and preventive care.	
Examples of program measures: <ul style="list-style-type: none">• Total cost of care• Cost per inpatient hospital stay• Cost of specialty care visits• Cost of primary care visits	<ul style="list-style-type: none">• Mental health care spending• Durable medical equipment costs• Non-health care service spending• Cost of employed care coordinators• Home health care costs
Satisfaction	
Care coordination programs must monitor satisfaction among all customers: patients, their families, and affiliated providers.	
Examples of program measures: <ul style="list-style-type: none">• Patient satisfaction in all settings – inpatient (HCAHPS), ambulatory, nursing home• Affiliated partner satisfaction	<ul style="list-style-type: none">• Provider satisfaction (employed and affiliated)• Patient satisfaction• Patient family/caregiver satisfaction

Element #1: Complete Comprehensive Assessment and Reassessment

Facing a specific but variable population of complex patients confronting multiple chronic diseases, it is essential to enroll the right patient in the right care plan at the right time. Therefore, all programs must institute a comprehensive assessment to identify potential medical and psychosocial supports that each beneficiary may need, and utilize that information to develop an individualized care plan. Additionally, while frequent visits should give providers the opportunity to recognize patient needs, all of the comprehensive programs include reassessments at least annually, to evaluate any change in the beneficiary's clinical or social status. For complex patients, one acute event has the potential to drastically modify the frequency or type of necessary services to maintain, if not improve, daily function.

Hopkins ElderPlus, Johns Hopkins Health System *Baltimore, MD*

Background: Hopkins ElderPlus is the PACE program of Johns Hopkins Health System, providing all primary, acute, and long-term services and supports (LTSS) under integrated Medicare and Medicaid financing to approximately 150 beneficiaries.

What they did: To ensure that Hopkins is accepting the appropriate patients into the program, PACE participants must fit the following eligibility requirements: 55 years old, certified by the state to need nursing home care, able to live safely in the community at time of enrollment, and residing in a PACE service area. Upon initial pass, each beneficiary goes through an intensive medical, social, and behavioral assessment to determine which services are needed. The multidisciplinary staff—including everyone from physicians to housekeeping aides and social workers—holds a quarterly intake and assessment meeting for each participant, offering insights into how the participant is doing, identifying any problems, flagging potential future issues, and discussing how to improve care moving forward.

Financing: As with all PACE programs, Hopkins receives a separate Medicare and Medicaid capitated benefit on a per member per month rate (PMPM), and all necessary services are coordinated within that amount.

Results: Evaluations of the PACE model show successful outcomes in several areas including health and functional status, quality of life, length of survival (4.2 years) and service satisfaction. In spite of increased beneficiary complexity, the PACE program's readmission rates are similar to those of the overall Medicare population. The state of Virginia calculated that their PACE program costs them approximately \$4,200 less per year compared to the cost for a person receiving Medicaid services at home or in a nursing facility.^{24,25}

Element #2: Conduct Periodic Visits

Care plans typically center on physician-based medical appointments. However, ongoing visits between providers of all levels, patients, and their families are a crucial complement to scheduled medical care, to evaluate patient progress and any need for changes in the beneficiary's care. Programs deploy these visits in a variety of ways: face-to-face meetings at the patient's home or day center (depending on the program), via telephone, or through other remote, virtual technologies. These nonclinically focused visits can help beneficiaries and their caregivers address issues and unmet needs, such as overcoming difficulties obtaining medications, reducing household safety hazards, getting to required appointments, setting up more clinical home visits, or arranging other caregivers.

Geriatric Resources for Assessment and Care of Elders, Wishard Health Services

Indianapolis, IN

Background: Geriatric Resources for Assessment and Care of Elders (GRACE) is an integrated care model targeting the senior population facing multiple chronic conditions. A partnership between Indiana University and other local facilities, the program is centered on a community-based health center, leveraging the expertise of a geriatric interdisciplinary team for designing individual, patient-specific, care protocols. The initiative reached nearly 1,000 patients by 2007.

What they did: The program is designed with an understanding that integration of medical and social care, in addition to repetition in clinical and support visits, constitutes essential care for patients with functional limitations. Comprehensive patient assessments, along with ongoing communication and evaluation, aid in developing the ideal care plan. These periodic visits will vary by patient but generally include:

- A comprehensive in-home assessment by nurse practitioner and social worker
- A second in-home visit to review the individualized care plan with the patient and his or her family and to discuss logistics
- Patient contact by phone at least once a month by GRACE coordinators
- Home visits after a hospitalization or ED visit

Financing: Physicians are reimbursed on the typical FFS schedule, and hospitals are reimbursed based on Medicare diagnosis-related-groups. Working with Indiana University, the group secured a large amount of funding from a variety of local and national organizations to cover the additional cost (approximately \$105 PMPM).

Results: A randomized control trial found a positive impact on both quality and cost. In a group with incomes 200 percent of the federal poverty level, high-risk patients had fewer ED visits, inpatient hospitalizations, and readmissions. Satisfaction was higher among GRACE patients and participating providers than the control groups. Finally, the improved quality and reduced number of acute hospitalizations saved approximately \$1,500 per patient by the second year of program implementation.^{26,27,28}

Element #3: Implement Protocol-Based Care Planning

Care transition and coordination are difficult processes for vulnerable populations, as they need a number of specialty-trained providers who also have experience caring for patients with multiple chronic diseases. While this patient population does have variable medical and social needs, aggregate data analysis allows for effective protocols for both clinical care and processes. These protocols may differ by site of care and program design, but they have the potential to reduce variation, increase quality, and avoid unnecessary costs. Each program should also deploy protocols to scan for behavioral issues. If not cared for properly, complex patients with behavioral health issues may double medical claims cost.

Holy Cross Hospital Geriatric Emergency Department *Silver Spring, MD*

Background: Holy Cross is a 450-bed, not-for-profit teaching hospital located just north of Washington, DC. Part of Trinity Health, Holy Cross established the first geriatric ED (GED) in the country, which treats patients 65 and older with acute, but not life-threatening, issues.

What they did: Patients are first triaged in the main ED and then appropriate candidates are sent to the department located immediately adjacent. All GED staff receive specialized training in common health issues facing the geriatric population, allowing for quicker diagnosis and standardized treatment protocols. For example, any patient who is on five or more medications is immediately scheduled for a polypharmacy referral. A pharmacist reviews the identified drugs and doses to determine if an undesired interaction occurred or may occur in the future. Once a patient is stabilized, nurses screen for cognitive loss, depression, and alcohol or drug abuse in addition to fall evaluation and neglect.

Financing: The Holy Cross geriatric ED is still reimbursed in a FFS system with DRG payment upon admission. Trinity subsidized the development of the specialized center at a cost of less than \$200,000.

Results: Ninety-eight percent of patients rated their ED care as “excellent.” One-ninth of the patients were prescribed five or more medications, and through the pharmacist referral, 20 percent of that population was identified as taking inappropriate medications or doses. Inpatient volume increased, signifying appropriate admissions, and return ED visits within 72 hours decreased to 3 percent.^{29,30,31}

BOOST Program at SSM Saint Mary’s Health Center *Saint Louis, MO*

Background: Better Outcomes for Older Adults through Safe Transitions (BOOST) is a discharge-focused program from the Society of Hospital Medicine.

What they did: Following BOOST protocols based on aggregate data analysis, patients are “BOOST-ed” upon admission, their charts flagged, and names added to a unit white board so that all providers can track each patient’s care. A nurse and physician make patient rounds together prior to discharge, and use the “teach-back” technique. With teach-back, patients restate the instructions they receive to care for themselves after they leave inpatient care, so providers can gauge and correct any misunderstandings. Upon discharge, all important points of patient information such as diagnosis, tests performed, medication prescribed, and future appointments are captured in a patient-friendly, one-page document.

Financing: Organizations are reimbursed by DRG or FFS, depending on the payer. The BOOST toolkit is available from the Society of Hospital Medicine.

Results: BOOST programs have found lower numbers of unnecessary readmissions (12 percent to 7 percent), reduced preventable ED visits, and increased patient satisfaction (from 52 percent to 68 percent).^{32,33}

Element #4: Incorporate Person-Centered Care Principles and Practices

The success of a program depends on patient involvement which includes adhering to prescribed medication rituals, complying with fall prevention protocols, eating a healthy diet, and keeping all necessary medical appointments. Satisfied patients are much more likely to stay involved in their care plan, and therefore each program needs to put the individual, and his or her family if applicable, at the center of the care team. All of the care models should include several mechanisms to engage patients and their families. This should include self-educational, easy-to-read materials that take into account the low health literacy levels of some patients and their families.

AtlantiCare Special Care Center *Atlantic City, NJ*

Background: The Special Care Center (SCC) is a primary care center serving about 1,000 patients, established in conjunction with large employers in the Atlantic City area. This care coordination program is specially designed for patients with a chronic illness such as heart disease, diabetes, hypertension, obesity, asthma, or emphysema.

What they did: SCC put the patient and his or her family first in total clinic design. The following practices have improved patient compliance and satisfaction:

- Each patient is assigned a nonclinical health coach to help him or her proactively manage his care and navigate the health system. Health coaches make contact with each of their patients at least once every two weeks.
- New patients receive a one-hour appointment with a physician, and existing patients receive 30-minute physician appointments.
- Each member of the interdisciplinary care team shares 24-hour call coverage so that patients can contact someone at any time when issues arise. Data capabilities allow the team to access patient charts from home and refer patients to the ED if necessary.
- All patients are guaranteed same-day sick visits.
- Patients have access to group education on a variety of issues, which are segmented by type of condition and provided in several languages.
- All patients who need a sick visit will receive a follow-up call from their health coach within 24 hours of leaving the physician's office.
- Patients have no copayments for physician visits or prescriptions filled at the on-site pharmacy, which encourages patients to get their prescriptions there and allows the care team to monitor adherence.

Financing: The original funding came through a partnership with HEREIU Fund—a large multi-employer trust fund for service workers at hotels, restaurants, and casinos—and AtlantiCare employees. Initially budgeted globally with costs shared by the fund and health system, the risk moved to an adjusted PMPM for subsequent payers.

Results: Initial results show improved clinical incomes and significantly lower treatment costs. According to analysis conducted between 2008 and 2009, patients experienced 41 percent fewer inpatient admissions, 48 percent fewer ED visits, 25 percent fewer surgical procedures, and improved outcomes in pharmaceutical adherence, quality indicators, and generic medication use. Spending on primary care visits, prescription drugs, labs, and testing all increased. It is assumed that these increases are a result of higher compliance, and the program still produced a first-year savings of 28 percent of total net spending for the highest-risk patients.^{34,35,36}

Element #5: Utilize Team-Based Care Management Centered on Primary Care

All programs designed for dual eligibles and other vulnerable populations must incorporate a multidisciplinary care team that can cross the boundaries between medical, behavioral, and long-term supports and services needs. All care models should include a primary care physician as an integral part of the care team, working in support with the interdisciplinary group. This comprehensive provider network must fit the needs of the target population and support an overall model for care coordination. Success depends not only on the number and type of providers involved but also on how well providers communicate to put the health of the patient before anything else. Improving patient transitions between these providers will prevent potential errors that may decrease quality and outcomes and increase costs. While team composition will vary based on the target population and its demands, these integrated groups often include nurses, nurse practitioners, medical assistants, social workers, primary care physicians, specialty physicians, home-based nurse aides, hospitalists, geriatricians, care coordinators/navigators, and psychologists or psychiatrists. Hospitals must engage primary care physicians to change the way they operate. Also, organizations have noted that success necessitates a workforce environment in which all licensed practitioners are able to utilize their clinical skills.

The Acute Care for Elders Tracker at Aurora Health Care *Milwaukee, WI*

Background: Aurora Health Care is a not-for-profit, integrated delivery system consisting of 15 hospitals, 155 clinics, and 1600 employed physicians throughout Wisconsin. To improve care for their most complex patients in areas where they may not have physicians trained in geriatrics, they installed the Acute Care for Elders Tracker (ACE). Following the traditional ACE regulations, this computerized tool is designed to improve care for hospitalized elderly patients.

What they did: The ACE tracker provides the multidisciplinary care teams with real-time information on each patient's health risks based on retrospective and aggregate analysis, and allows the teams to customize treatment plans. To facilitate the individualized care plans, the teams use e-Geriatrician, which utilizes teleconferencing so geriatricians can consult with staff at hospitals that do not have someone board-certified in this specific area. The team meets for 30 minutes a day, five days a week to review the ACE tracker report on each patient, develop a plan, or make necessary modifications. The team overseeing the inpatient care and attending these meetings includes clinical nurse specialists, social workers, pharmacists, physical therapists, and occupational therapists. Geriatricians attend the meeting twice a week. If the hospital in question does not have a geriatrician, one from another Aurora facility will participate twice a week via teleconference.

Financing: Aurora receives no additional funding beyond traditional DRG or FFS reimbursement (depending on payer). Additionally, for participating organizations without a geriatrician on staff, Aurora reimburses the physician an additional hourly rate for joining ACE team meetings via teleconference twice a week.

Results: Initial published data shows that the percentage of patients receiving urinary catheters decreased from 26.2 percent to 20.1 percent, and the share of patients receiving physical therapy consultations has risen from 27 percent to 39.1 percent. These changes are attributed to the regular, multidisciplinary team meetings designed to improve care plans.³⁷

Element #5: Utilize Team-Based Care Management Centered on Primary Care (Continued)

Commonwealth Care Alliance *Massachusetts*

Background: Commonwealth Care Alliance (CCA), which functions as part capitated health plan and part provider, developed a Senior Care Options Program for low-income, dually eligible beneficiaries. Analysis of health care in Massachusetts found that primary care for vulnerable and complex populations was inadequate, discontinuous, and unengaged with the patients it was designed to serve.

What they did: Through the Senior Care Options plan, enrollees are provided with a primary care team made up of a physician, nurse practitioner, and geriatric specialist who work at the beneficiary's primary care clinic. They created a new system of multidisciplinary primary care that includes the following components:

- Comprehensive assessments instead of medical histories
- Individualized care plans with behavioral health integrated into primary care services
- A team trained to go beyond medical services to address poverty alleviation issues
- Capacity for home visits and transfer of clinical decision to the home or other care settings
- Team approach with the nurse, nurse practitioner, behavioral health, team social worker, and primary care physician cooperating in a horizontal rather than vertical relationship
- A well-established hospital and institutional network to complement primary care referrals

Financing: First started as a demonstration program, CCA relies on a risk-adjusted premium paid separately from both Medicare and Medicaid. Providing primary care themselves, the plan contracts at agreed-upon rates (typically Medicare reimbursement) for specialty and inpatient care.

Results: Even with a more complex population, hospital utilization is significantly lower for both nursing home certifiable and ambulatory CCA beneficiaries (1,634 and 511 hospital days per 1000 population respectively) as compared with traditional Medicare fee-for-service beneficiaries (2,620 risk adjusted hospital days per 1,000 population). For enrolled CCA patients who are nursing home certifiable and living in the community, 46 percent fewer become long-term nursing home residents. These are indicators of both increased quality and long-term cost reduction.^{38,39}

Element #6: Facilitate Data Sharing and Integrated Information Systems

Dual eligibles tend to utilize both inpatient and outpatient services intensively, especially those who have more than one chronic condition. Increased patient utilization from various clinicians, combined with poor communication between the providers, leads to fragmentation and unnecessary duplication of efforts. Using a combination of robust data sharing and an electronic communication system guarantees continuous access to services and promotes care coordination across settings. To further promote the adoption of best practices across programs, data on service utilization is shared on a regular and timely basis, including measurement of person-level outcomes and identification of high-utilization members that need increased attention. Integrated information technology systems facilitate this exchange of health information between and among physicians, case managers, and other health professionals.

CMO, The Care Management Company, at Montefiore Medical Center Bronx, NY

Background: Montefiore Medical Center is a large, academic medical center in New York City that has created a large integrated system for its population of primarily low-income patients. CMO, The Care Management Company, is a for-profit subsidiary of the medical center, and it receives capitated payments for about 140,000 patients to provide medical and behavioral care management in addition to traditional health plan administrative functions.

What they did: CMO shares and analyzes its data through an integrated information technology system that includes several attributes for success. All providers within the Montefiore Medical Center and its outpatient locations have access to the same electronic health record system. They utilize a data warehouse called Clinical Looking Glass to measure quality of care and identify areas for improvement for this specific patient population. CMO uses the clinical data, along with claims data, to identify patients who would benefit from its extensive level of care coordination, which other networks do not provide. Care managers look closely at ED visits, as frequent trips can be an early sign of ongoing, complex problems. CMO also participates in the Bronx Regional Health Information Organization, which contains data on more than 1 million patients. CMO can utilize the data to check on its patients' interactions with Bronx health providers other than Montefiore. CMO is able to mine both provider claims and cost data to understand where care can be improved. All patients have access to an online personal health record to monitor their own care progress. For more complex patients, caregivers have permission to access information from the personal health record.^{40,41,42}

Financing: Responsible for medical and behavioral care management along with other administrative functions, CMO receives a capitated payment from the payers reimbursing the Montefiore Integrated Provider Association.

Element #7: Align Financial Incentives

Designing clinical and financial models that align incentives and foster collaborative partnerships is not simple, but such design has a huge impact on the program's success in care coordination. The payment arrangements previously described—PACE, Medicaid managed care models, and Special Needs Plans—all facilitate a distinct type of reimbursement that should incentivize providers to improve care coordination and quality while reducing inefficiencies and cost. Fragmentation can be addressed through blended funding for programs and shared gains and risk agreements. Aligning economic incentives is a large challenge and will require a collaborative environment in which all parties see themselves as partners and not competitors.

Fairview Partners, Fairview Health Services *Red Wing, MN*

Background: Fairview Partners is a subsidiary of Fairview Health Services, an integrated health system of six acute care hospitals and affiliated physicians. With the goals of improving care delivery, promoting integration, and improving customer satisfaction and clinical outcomes, Fairview Partners offers comprehensive care management for seniors living in assisted living sites, long-term care centers, and in their own homes.

What they did/ Financing: Fairview Partners receives a PMPM reimbursement to provide comprehensive care for all services that fall under the program's authority. The net income is distributed to all participants in the partnerships. Fairview Partners assumes full operational responsibility for the continuum of care. The flexibility in the PMPM payments affords Fairview Partners the ability to allocate the funds to meet specific patient needs. To make this model operable and successful, Fairview Partners had to understand and analyze the surrounding area's demographics.⁴³

Element #8: Develop Network and Community Partnerships

It is neither realistic nor financially feasible for every organization to develop comprehensive programs for dual eligibles that cover the entire care continuum. However, this population still demands a large number of services to be delivered beyond the four walls of an acute-care hospital. In response, market innovators are turning to other community providers, ranging from health centers and adult day care centers, to long-term care facilities and agencies on aging, to improve care coordination and care transitions. These arrangements cannot only be financially based; they must be built on a mutual understanding that improving care coordination will improve the quality of care provided.

The Care Coordination Network at Summa Health System Akron, OH

Background: Summa Health System serves a five-county region in northeast Ohio, including seven owned, affiliated, and joint-venture hospitals, a regional network of ambulatory care centers, and a multispecialty group of more than 240 employed physicians.

What they did: Summa started the Care Coordination Network to help address the longstanding concern for improved patient coordination with the long-term care facilities in the surrounding counties. The network was established to improve access for Summa patients needing post-acute beds, facilitate the transfer of patients across the continuum, and optimize the combined expertise of providers to achieve the desired clinical outcomes. After contacting all of the area's skilled nursing facilities (SNFs) to gauge their interest, Summa worked with representatives from 28 SNFs, several EMS/ambulance service companies, and the local agency on aging to create a task force that has three main objectives:

1. Standardize the SNF referral process, including evidence-based guidelines for determining patient needs and a reference tool for discussing options with patients.
2. Create a clinical and educational subcommittee to address priority areas for improving care transitions.
3. Design and then evaluate various outcome measures to monitor members and overall network performance to encourage development of best-practice tools.

Financing: This program does not require much additional funding beyond some administrative costs, and it was subsidized by Summa with in-kind donations from the participating SNFs.

Results: This partnership increased the visibility of the area SNFs to hospital case workers and improved the overall sense of understanding and collaboration between the parties. The streamlined processes and protocols improved the transitions between the facilities. For example, there are fewer broken appointments, and scheduling compliance has improved for same-day surgery and outpatient testing for post-acute patients. Previously, many patients would arrive with incomplete paperwork, and adherence now has increased significantly.^{44,45}

Additional Model Core Elements

Vulnerable populations face a wide range of medical and social issues, which may not be covered by the majority of programs. Over 60 percent of dual eligibles have a limitation in at least one activity of daily living, increasing the likelihood they will need assistance beyond the scope of traditional Medicare reimbursement. Best-practice programs directly include or partner with other institutions to provide specialized benefits for this population. These initiatives make it easier for patients to delay nursing-home residential care. At a national level, the AARP Public Policy Institute reported that Medicaid expenditures could assist nearly three seniors in home and community-based services for the same cost of providing care to one person in a residential facility. Additionally, a similar report detailed that more than 87 percent of this population would like to remain in their own homes.⁴⁶ Detailed in the table below, these elements also are integrated throughout the case studies on prior pages.

9	Provide Non-Health Care Services	Programs that encompass a wider range of social and medical conditions have been including more non-health care services ranging from transportation to appointments to assistance with cleaning and grocery shopping.
10	Provide Home-Based Care	The comprehensive plans typically begin with a home-based clinical assessment. Additionally, medical office-based care is often complemented with home-based visits to increase the frequency of patient-provider contact. Data show these services improve patient satisfaction and compliance.
11	Organize Center-Based Day Care	Hopkins ElderPlus and GRACE provide center-based care. While both institutions run these with the PMPM payment received through state and federal funding, the program development required large upfront costs. The benefit of these institutions is that they provide duals with the ability to remain in their own homes and communities for a longer period of time. Additionally, providers can observe their patients every day, improving coordination of necessary clinical and psychosocial visits and medication compliance.
12	Incorporate Cultural Competency and Equity of Care Standards	Dual eligibles are more than twice as likely to be members of racial and ethnic minorities as traditional Medicare beneficiaries (42 percent as compared to 16 percent). Therefore, all care models should consider developing care teams that are aware of the cultural norms and language fluency of their hospital's populations. This may range from holding educational groups in several languages to holding teams accountable for reducing health disparities.

Supporting Evidence from Key References

Background: The Need to Focus on Duals

Evidence: Illustrates the roles of Medicare and Medicaid in providing care for the dual population, detailing traits of the group and providing statistics on spending trends.

Jacobson, Gretchen et al. The Role of Medicare for the People Dually Eligible for Medicare and Medicaid. The Kaiser Family Foundation Program on Medicare Policy. January 2011.

Evidence: Describes the number and characteristics of potentially preventable admissions and readmissions among dual eligibles.

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Evidence: Analyzes the characteristics of dual eligibles, their service utilization, and associated costs.

The SCAN Foundation. *DataBrief Series*. September 2010-January 2011. (Available at www.TheSCAN-Foundation.org)

Evidence: Explores the contradictory incentives present within the Medicare and Medicaid programs to coordinate long-term care for the dual eligible population.

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Evidence: Displays through statistical analysis that organizations must develop interventions for smaller, more defined patient populations in order to see improved care coordination at a higher quality with lower cost.

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Feder, Judy et al. Refocusing Responsibility for Dual Eligibles: Why Medicare should Take the Lead. Robert Wood Johnson Foundation. October, 2011.

Support for State- and Payer-Coordinated Plans

Evidence: Expresses the need and potential benefits of coordination and integration among Medicare and Medicaid programs for dual eligibles.

Medicare Payment Advisory Commission. Coordinating Care for Dual-Eligible Beneficiaries. *Report to Congress: Aligning Incentives in Medicare*. June 2011.

Special Needs Plans

Evidence: Describes the impetus for Special Needs Plans, their effectiveness, and opportunities for expansion.

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Evidence: Details the central elements of the PACE program and its effectiveness in practice.

Gadsby, Laura. PACE-Program of All-Include Care for the Elderly. *Age in Action*. Volume 22. Number 4. Fall 2007.

Shared Savings Plans

Evidence: Provides a general overview of shared savings plans as well as characteristics of effective arrangements

Bailit, Michael et al. Key Design Elements of Shared-Savings Payment Arrangements. *The Commonwealth Fund*. Vol. 20. August 2011. (Available on www.commonwealthfund.org)

States as Coordinated Entities

Evidence: Details the 15 state design contracts funded by CMS to integrate Medicare and Medicaid benefits for dual eligibles.

The Kaiser Commission on Medicaid and the Uninsured. Proposed Models to Integrate Medicare and Medicaid Benefits for Dual Eligibles: A look at the 15 State Design Contracts Funded by CMS. *The Kaiser Family Foundation*. August 2011.

Focus on Care Coordination for Improved Care Quality

Evidence: Constructs the rationale for integrated care and identifies key obstacles to integration.

Bella, Melanie et al. Encouraging Integrated Care for Dual Eligibles. *Center for Health Care Strategies, Inc.* July 2009.

Evidence: Describes the benefits of care and transition coordination at the state and organizational level.

Craig, Catherine et al. *Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs*. IHI innovation Series white paper. Cambridge, Massachusetts: Institute for Health-care Improvement; 2011. (Available on www.IHI.org)

Evidence: Articulates the need for improved comprehensive primary care for elderly patients with multiple chronic conditions.

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Davenport, Karen et al. *The "Dual Eligible" Opportunity*. *Center for American Progress*. December 2010. (Available at www.americanprogress.org).

Evidence: Details actions that can improve health system delivery for the elderly and disabled population.

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Diversity & Disparities: A Benchmark Study of U.S. Hospitals

<http://www.hpoe.org/diversity-disparities>



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Executive Summary

- In 2011, the Institute for Diversity in Health Management, an affiliate of the American Hospital Association (AHA), commissioned the Health Research & Educational Trust (HRET) of the AHA to conduct a national survey of hospitals to determine the actions that hospitals are taking to reduce health care disparities and promote diversity in leadership and governance. Additional funding was made possible from the ARAMARK Charitable Fund at the Vanguard Charitable Endowment Program, Health Forum and HRET.
- The survey results offer a snapshot of some common strategies used to improve the quality of care that hospitals provide to all patients, regardless of race or ethnicity.



Executive Summary (cont.)

- 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.
- This overview provides data to help the health care field focus attention on areas that will have the most impact and establish a benchmark to gauge hospitals' progress in the coming years.



3

Survey Methods

- Data for this project were collected through a national survey of hospitals mailed to the CEOs of 5,756 institutions, which represented all U.S. registered hospitals at the time of the survey.
- The response rate was 16% (924 hospitals), with the sample generally representative of all hospitals.
- All data are self-reported.



4

Collection and Use of REAL Data

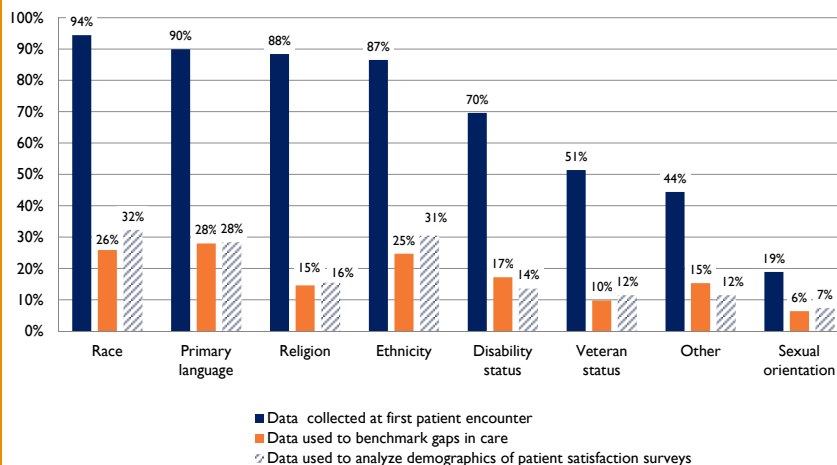
- Overall, hospitals appear to be actively **collecting** patient demographic data, including:
 - race (94%);
 - ethnicity (87%); and
 - primary language (90%).
- Use** of REAL is just beginning.
 - Data used to benchmark gaps in care for:
 - race (26%);
 - ethnicity (25%); and
 - primary language (28%).



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Collection and Use of REAL Data (cont. I)

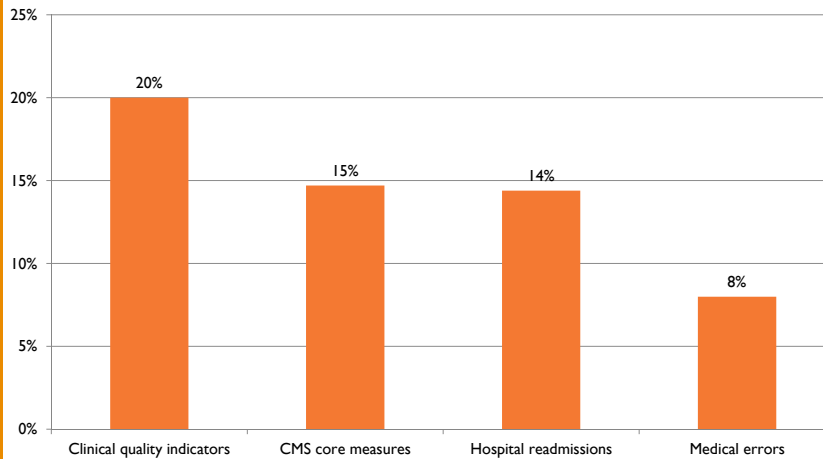
Collection and Use of Patient Demographic Data



6

Collection and Use of REAL Data (cont. 2)

Hospitals' Analysis of Data by Race/Ethnicity to Identify Patterns

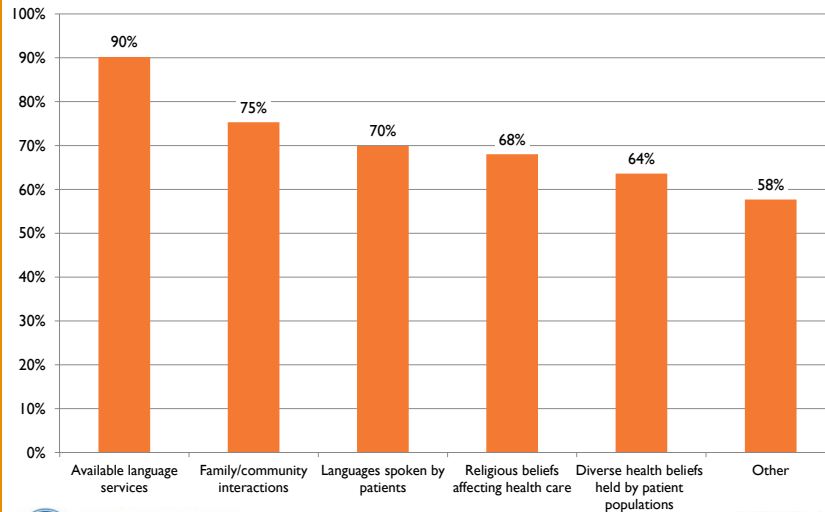


Cultural Competency Training

- 81% 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.
- 61% of hospitals require all employees to attend diversity training.

Cultural Competency Training (cont. I)

Cultural Content Areas Included in Hospital Orientation

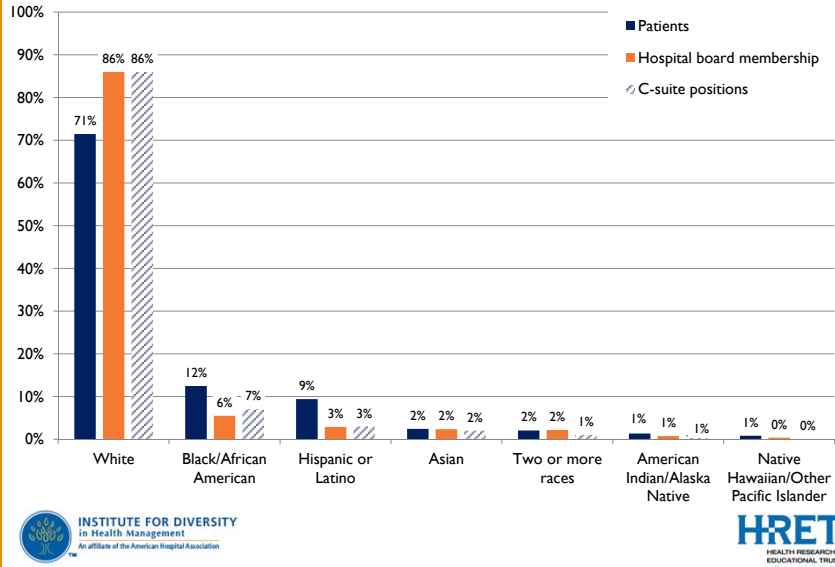


Leadership and Governance

- Although minorities represent a reported 29% of patients nationally, they comprise only:
 - 14% of hospital board members;
 - an average of 14% of executive leadership positions; and
 - 15% of first- and mid-level management positions.

Leadership and Governance (cont. 1)

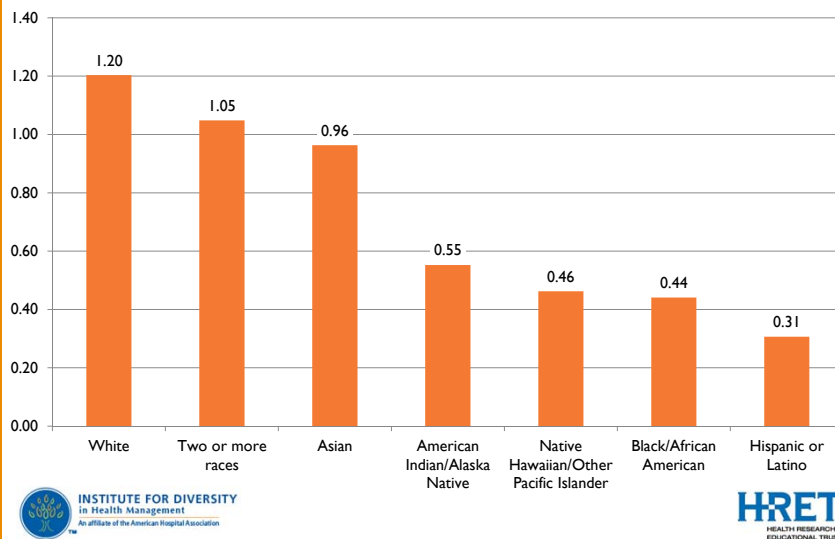
Minority Representation in Hospital Leadership and Governance



11

Leadership and Governance (cont. 2)

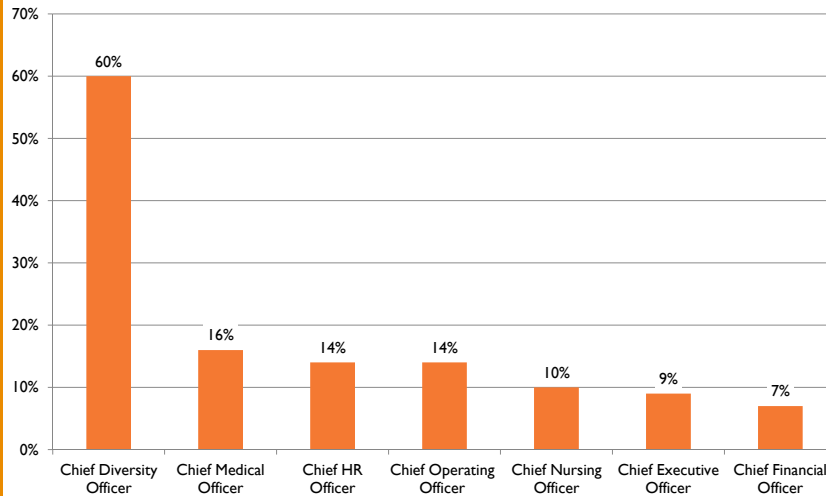
Ratio of Board Representation to Patient Population
(A group is underrepresented if the value is less than one.)



12

Leadership and Governance (cont. 3)

Minority Representation in Executive Leadership Positions



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Summary Findings

- Collection of all REAL data – 77%
- Use of all REAL data to benchmark gaps in care – 18%
- Cultural competency training – 45% train in all five cultural competency areas (languages spoken by patients, available language services, diverse health beliefs held by patient populations, religious beliefs affecting health care, and family/community interactions)
- Diversity in governance – 14% minority
- Diversity in management – 15% minority

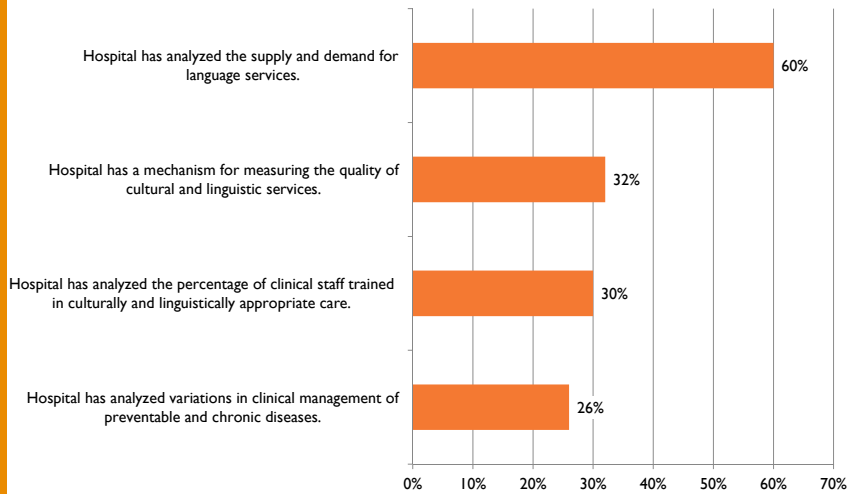
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Appendix A: Data Utilization

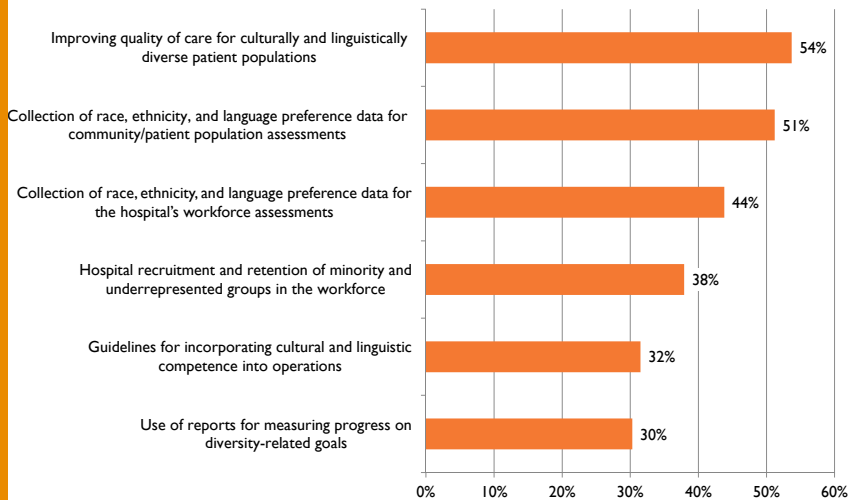
Hospitals' Utilization of Data to Address Health Care Disparities



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Appendix B: Strategic Goals

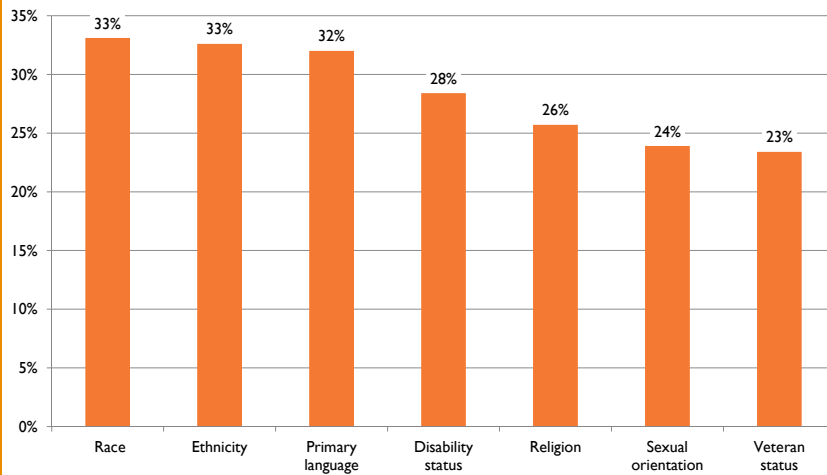
Inclusion of Goals within Hospitals' Strategic Plans



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Appendix C: Strategic Goals

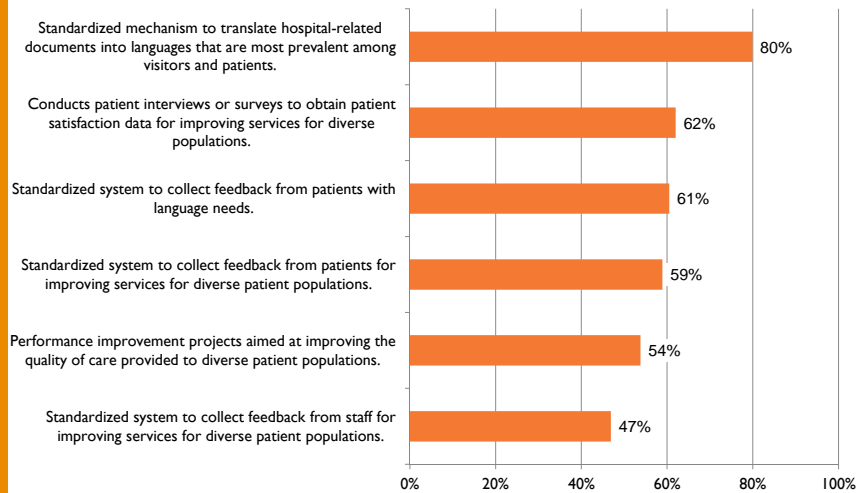
Percentage of Hospitals Using Patient Characteristics Data to Establish a Disparities Reduction Goal



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Appendix D: Reducing Disparities

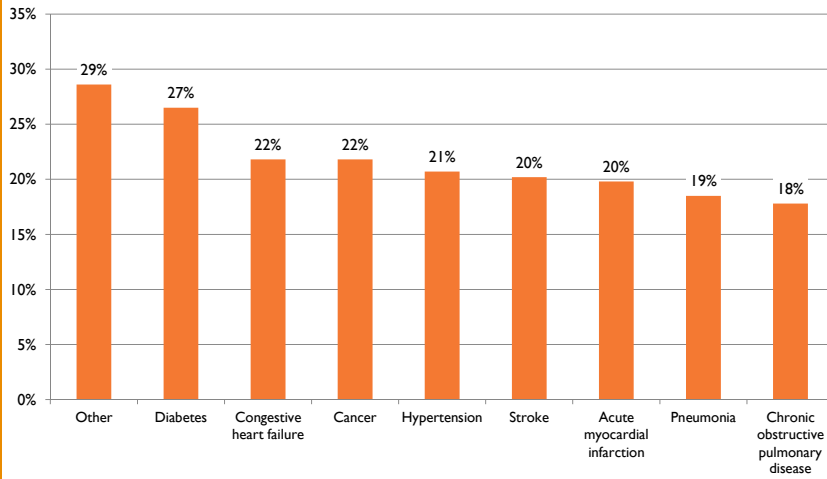
Hospitals' Efforts to Reduce Racial/Ethnic Health Care Disparities



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Appendix E: Reducing Disparities

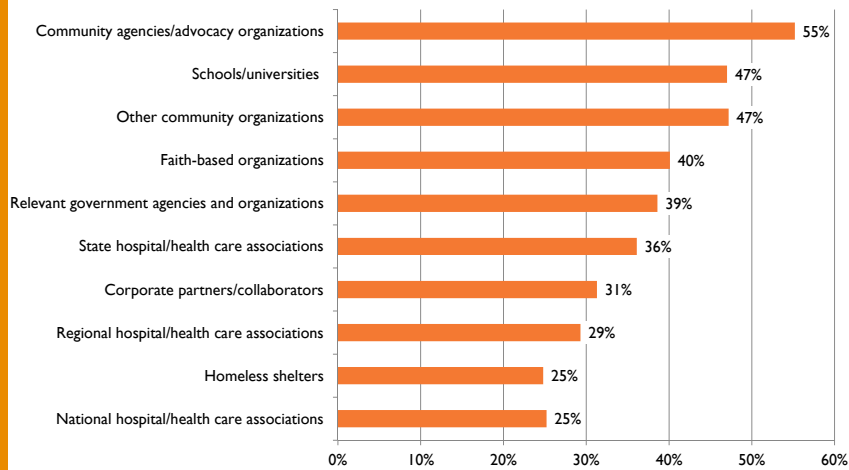
Disease-Specific Interventions Planned or Implemented by Hospitals to Reduce Racial/Ethnic Disparities



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Appendix F: Reducing Disparities

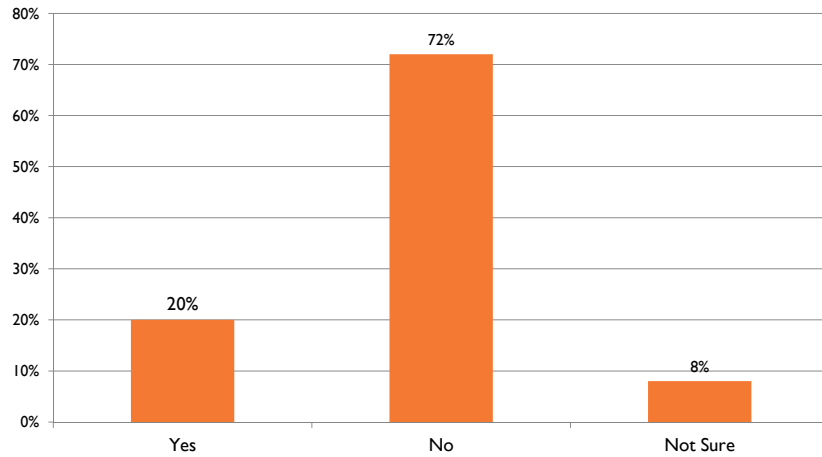
Hospitals' Collaboration with External Organizations to Reduce Disparities



20

Appendix G: Reducing Disparities

Does Your Organization Have a Community-based Diversity Advisory Council or Committee?



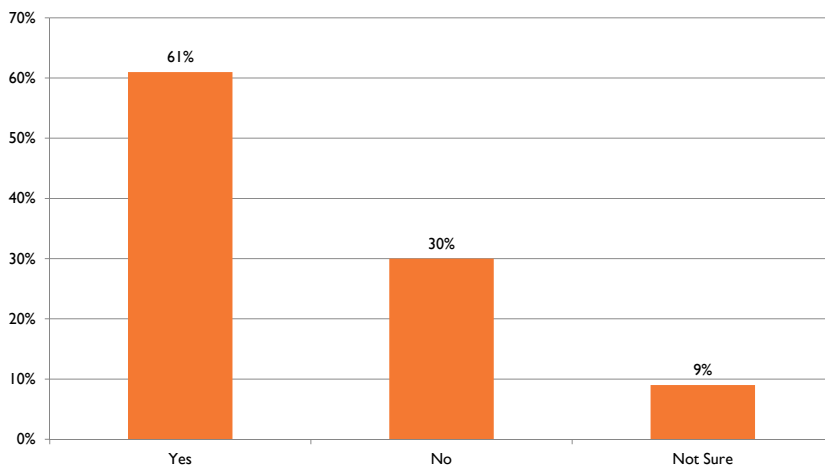
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Appendix H: Cultural Competency

Has Your Hospital Conducted an Assessment of the Racial and Ethnic Demographics of Your Community in the Past Three Years?



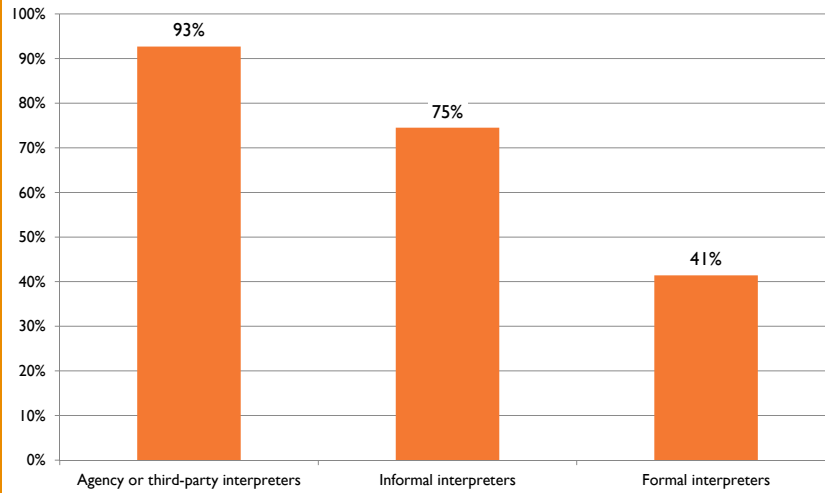
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Appendix I: Cultural Competency

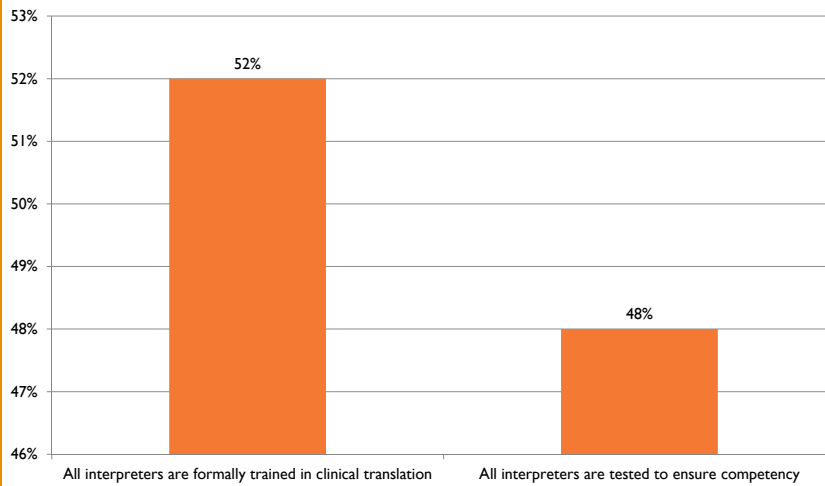
Types of Interpreters Used by Hospitals



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Appendix J: Cultural Competency

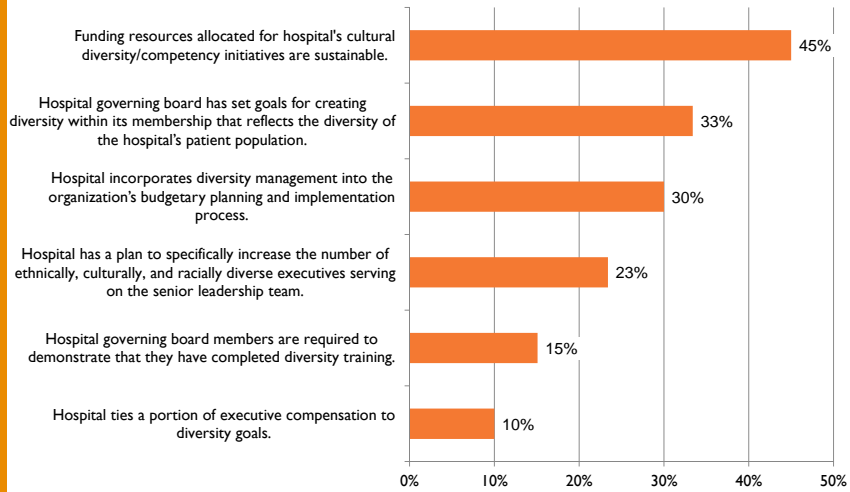
Hospitals' Verification of Interpreter Quality



24

Appendix K: Leadership

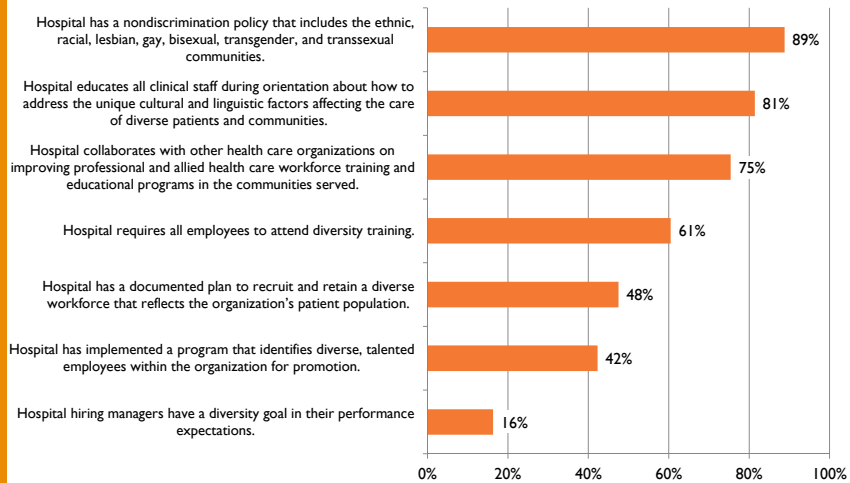
Hospitals' Leadership Goals



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Appendix L: Diversity Management

Percentage of Hospitals Participating in Diversity Improvement Plans



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**Eliminating Health
Care Disparities**

Equity of Care

February 2012



Eliminating Health Care Disparities: Implementing the National Call to Action Using Lessons Learned



Eliminating Health Care Disparities: Implementing the National Call to Action Using Lessons Learned

Suggested Citation

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Accessible at: <http://www.hpoe.org/resources-and-tools/185000138>

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Executive Summary

Achieving health care equity and eliminating health care disparities are a top goal of hospitals and health systems. Health care equity has become an important discussion nationally as policymakers aim to improve quality of care while lowering costs through a variety of changes to existing incentives. Recognizing that there are areas for improvement is a first step, but it must be followed by actionable strategies to make sustainable improvements.

The American Hospital Association, Association of American Medical Colleges, American College of Healthcare Executives, Catholic Health Association of the United States, and National Association of Public Hospitals and Health Systems have launched a call to action to eliminate health care disparities. The goals of the group are to (1) increase the collection of race, ethnicity, and language (REAL) preference data to facilitate its increased use, (2) increase cultural competency training for clinicians and support staff, and (3) increase diversity in governance and management.

These three goals represent realistic and fact-based approaches to eliminate disparities in care. Through consistent and reliable data collection, hospitals and systems can understand the characteristics of the communities they serve, identify differences in care, target quality improvement activities, and track progress. Training in cultural competency will increase clinician and staff awareness and help hospitals and systems ensure that patients receive high-quality, individualized care. Greater diversity in hospital leadership positions will ensure that hospitals and health systems reflect diversity in the communities they serve and provide valuable perspective for improvements.

This guide looks at nine hospitals and health systems and summarizes each organization's key successes toward achieving one of the three goals. The case examples offer a snapshot of some best practices and lessons learned for other hospitals and systems working to make improvements.

Introduction

The United States is becoming more diverse demographically, with racial and ethnic minorities projected to become the majority of the U.S. population by 2042¹. Nearly 47 million people—18 percent of the U.S. population—speak a language other than English at home². There is evidence that the health care system is not meeting the needs of the changing communities it serves, contributing to disparities in care. Research shows that disparities in health care can lead to increased medical errors, prolonged length of stays, avoidable hospitalizations and readmissions, and over- and under-utilization of procedures³. While this issue is not new to health care leaders, there is now legislation in place that has the potential to address some of the underlying issues that lead to disparities in care.

The Affordable Care Act not only enacted comprehensive health care reform but also addressed health care disparities in critical ways. Included in the final law are provisions that increase access to and the affordability of care in underserved populations, develop community-based strategies to eliminate local barriers to health care, and improve both the diversity of the health care workforce and its competency in treating patients from different cultural and linguistic backgrounds⁴.

The American Hospital Association, the Association of American Medical Colleges, American College of Healthcare Executives, Catholic Health Association of the United States, and National Association of Public Hospitals and Health Systems, as part of a national call to action, have defined three goals for hospitals and health systems to eliminate health care disparities. These goals focus on data collection and use, cultural competency training, and leadership diversity. This guide is not intended to be definitive or representative of all types of hospitals and approaches. The purpose is to highlight best practices and lessons learned from several organizations that have implemented strategies to improve their performance in one of these three areas.

While each of these organizations have taken different approaches to improve REAL data collection, increase cultural competency, or increase leadership diversity, the strategies they have implemented share three success factors. First, the organizations have indicated that leadership buy-in, both administrative and clinical, is essential if any of these improvement efforts are to be implemented and sustained. Second, consistent and recurrent training of clinicians and staff involved in the improvement efforts can help to reinforce behaviors and implementation of new processes. Finally, organizations sustained improvements when initiatives to eliminate disparities were incorporated into their overall quality improvement and strategic plans.

As demonstrated by the variety of improvement efforts in the case studies that follow, there is more than one way for an organization to improve equity of care delivery. In addition, specific strategies will be highly dependent upon the local demographics. However, all of these organizations have made a commitment to align more closely with their increasingly diverse communities and to improve the overall quality of care they deliver and the satisfaction of patients they serve.

Increasing Collection and Use of REAL Data

Most hospitals collect demographic information containing components of race, ethnicity, and primary language data, but the quality and entirety of this data is not consistent. The purpose of collecting REAL data is to learn the exact demographic makeup of the communities served, determine what disparities in care exist, decide how the hospital can allocate resources to improve access to health services, and target quality improvement activities. Most hospitals believe they provide care equally to all patients, but only by collecting REAL data can this be quantified.

At some hospitals and systems, data collection is handled by front-line and registration staff who may enter the information based on sight, educated guesses, or secondary sources such as identification documents. The recommended method is for hospitals to ask patients to self-declare their information either by entering the data themselves or through a structured interview during patient registration. Hospitals have used extensive training to motivate and encourage staff to adopt new data collection protocols. In addition, emphasizing the importance of collecting accurate REAL data for overall quality improvement helps organizations overcome any initial resistance from staff. Most hospitals use scripts and role-playing during training sessions to mitigate any concerns that staff may have about asking patients for personal information. Scripts address how staff can ask questions and handle problems that may arise during conversations with patients.

REAL data can be used for strategic planning and quality improvement purposes. A hospital can more appropriately allocate resources if it can identify where disparities exist within the communities served and where there is a need to improve access to appropriate services. For example, increasing access points to primary care in underserved communities can provide essential preventive services that may improve overall outcomes, efficiency, and patient satisfaction. Data collected for these purposes needs to be consistent and reliable in order to create a concrete business case for deploying resources and to achieve buy-in from senior and clinical leaders.

Finally, to ensure that data collection is efficient and accurate, organizations should use a multidisciplinary team of individuals to develop the collection process. Involving the registration staff, IT, quality department, and hospital leadership is important to ensure that the data collected aligns with the organization's quality goals, is compatible with existing IT platforms, and alerts stakeholders of the impetus for improvements.

Case Study: Updating EMRs to Include REAL Data

San Mateo Medical Center, San Mateo, California

Overview: San Mateo Medical Center has collected demographic data for many years. But due to a cumbersome framework for collection as required under state and federal guidelines, and inefficient screening practices, the data has been unreliable and not very useful to the hospital's quality and leadership teams. Furthermore, they knew that integrating REAL data into the organization's electronic medical record (EMR) would require a costly upgrade to the existing IT system.

Actions: San Mateo Medical Center is using recommendations from the California Health Care Safety Net Institute to simplify and focus its data collection practices. For example, although the number of race categories is dictated by federal reporting guidelines, the ethnicity categories were expanded to reflect the diversity of its specific patient communities. The medical center also created a multidisciplinary team, including managers from the IT department, health information management, quality department staff, and training supervisors for the clerical staff to oversee and coordinate the changes. With the support of executive management, the REAL data project was included as a goal in the package of Delivery System Reform Incentive Payments (DSRIP) for the medical center's Medicaid waiver, which rewards hospitals for improving quality performance. This advancement will also allow the medical center to eventually load REAL data directly into the EMR.

Results: Although the full changes will not go live until mid-January, patients will soon be able to self-report their ethnicity, language, and race from a preselected, abbreviated list of categories created by the hospital and aligned with community demographics. Patient registration team members will then input the data into the EMR. The medical center is beta testing the new system with its quality team to incorporate this information and ensure the right data is collected. One goal of the changes is the availability of REAL data to identify and address potential disparities for at least 90 percent of patients encountered by late 2012⁵.

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Case Study: Analyzing REAL Data to Improve Quality of Care

University of Mississippi Medical Center, Jackson, Mississippi

Overview: University of Mississippi Medical Center wanted to improve the way it collected REAL data and better understand the demographics of the communities that the medical center served. In addition, UMMC wanted to use REAL data to analyze and identify opportunities to improve clinical outcomes for its diverse patient communities.

Actions: UMMC created a Healthcare Disparities Council with 40 members, including interpreters, administrators, nurses, physicians, and members of the registration staff. The council reports to the hospital leadership. Four subgroups support the council's efforts and focus on health literacy, patient access and experience of care, education and awareness, and quality for diverse populations. The council has focused its efforts on several performance improvement initiatives.

One success story has been UMMC's involvement in Expecting Success: Excellence in Cardiac Care, a program of the Robert Wood Johnson Foundation aimed at improving quality of cardiac care for African-American and Hispanic patients by improving care for all patients⁶. During the program, UMMC adopted standardized protocols to collect REAL data, including using standard categories for race, ethnicity, and language data. In addition, staff was trained to interview patients to ask for this information. UMMC used the REAL data to provide monthly reports on care performance measures, stratified by patient race, ethnicity, and primary language. The medical center also tracked core measures of care for patients who had a heart attack or heart failure. Through this effort, UMMC was able to demonstrate how simple, standard collection methods of REAL data can help improve overall patient quality.

Results: Participating in the RWJF project yielded several positive outcomes for UMMC. First, the number of patients receiving all core measures of care for heart attack and heart failure increased from 74 percent to 82 percent in two years⁷. UMMC also realized that heart attack patients need help to better control and self-manage their disease post-hospitalization. As a result, the medical center established an outpatient heart failure management clinic, led by a nurse practitioner who helps patients manage their disease after leaving the hospital. Approximately one year after the clinic opened its doors, the readmission rate for the clinic's patients was 0 percent.

Today the Healthcare Disparities Quality Subcommittee supporting the Healthcare Disparities Council has created an equity scorecard that specifically monitors performance in cardiac care. The scorecards are updated and reviewed quarterly to identify areas for improvement in caring for diverse populations.

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Case Study: Beyond REAL Data - Community Actions to Improve Diabetes Care and Outcomes

Baylor Health Care System, Dallas, Texas

Overview: The Baylor Health Care System Office of Health Equity (OHE) aims to reduce variation in health care access, health care delivery, and health outcomes among its diverse patient populations. For example, diabetes is a severe epidemic in the state of Texas and also more than twice as likely to occur in minority populations. REAL outpatient diabetes management data analysis indicated the presence of disparities in diabetes management within the primary care practices employed by Baylor Health Care System (BHCS). As a first step in reducing diabetes care disparities, BHCS recognized an opportunity to develop a community-based self-management diabetes education and advocacy intervention, reducing the burden on clinicians while improving diabetes disease control disparities. This low-cost, patient-centered self-management education program was designed to support patient needs with less expensive community health workers, functioning as diabetes health promoters. The OHE developed the Diabetes Equity Project (DEP), with funding from a Merck Company Foundation grant, with the goal of reducing observed disparities in diabetes care and outcomes in the predominately Hispanic, medically underserved communities around BHCS.

Actions: Hispanics with diabetes experience a 50 to 100 percent higher burden of diabetes-related illness and mortality than non-Hispanics⁸. The DEP was designed to improve access to preventive care and diabetes management programs. DEP was deployed in five community charity clinics and makes use of community health workers who receive extensive training in diabetes care and management, enabling them to serve as a bridge between patients and providers. Patients are referred to the DEP from both community and private practice clinics, following emergency room visits and hospitalizations related to uncontrolled diabetes. The DEP seeks to be responsive to patient-reported needs like education, communication and respect, removal of financial constraints, and access to medication and transportation by (1) placing an emphasis on community health worker recruitment and training; (2) building on existing community infrastructure through partnerships with local clinics; (3) integrating the community health workers' role into a health care system's care coordination strategy; and (4) developing an electronic diabetes registry that tracks patient metrics and facilitates disease management communication between community health workers and primary care clinicians.

Results: Enrollment in the Diabetes Equity Project began at the end of September 2009 and, within the first 18 months of the rolling enrollment, had 806 patients in the program. A preliminary analysis of the first year of results revealed a statistically significant drop in HgbA1c value from a baseline of 8.7 percent to 7.4 percent. Patient satisfaction surveys revealed that over 98 percent of participants indicated the highest level of satisfaction with the care they received. The program performance suggests that the long-term value of the program is that sustainable diabetes control can be achieved for participants who have previously experienced poor control by augmenting "usual care" with community health worker-led patient education and advocacy. The next step in the BHCS diabetes management disparity improvement journey will be to apply the community-based success to a group of private practice clinic patients experiencing care management disparities.

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Creating a Culturally Competent Organization

Cultural competency in health care describes the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring health care delivery to meet patients' social, cultural, and linguistic needs. Ultimately, cultural competency is recognized as an essential means of reducing racial and ethnic disparities in health care. 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 regarding their health status. While this is challenging to do for all patients, for diverse patient populations it can be even more difficult due to deficits in English-language proficiency and health care literacy, and cultural differences in communication styles.

It is therefore imperative that hospitals not only understand the diverse communities they serve but also prepare their physicians and staff to interact with patients of diverse backgrounds to increase patient engagement and education. The first step in the process is to use REAL data to identify which diverse populations the hospital is serving. Next, organizations need to identify how to develop appropriate training to increase staff members' and clinicians' abilities to accurately and consistently communicate with patients.

Translation services are a foundational element used by hospitals to bridge gaps in communication with diverse populations. Some hospitals in communities with large numbers of non-English speaking patients have chosen to employ bilingual and bicultural staff. In addition, many hospitals have developed programs to build upon the bilingual skills that their clinicians and staff may already have. Although staff or clinicians may be bilingual, unless they are adept at translating medical terms and procedures, important messages regarding care delivery can be missed, which will impact outcomes.

Finally, hospitals and systems can better understand diverse cultures by seeking advice from individuals and groups in the communities they serve. These constituencies can help hospitals develop educational materials, improve access to services for patients, and increase health care literacy. Community groups such as religious organizations or schools can help hospitals understand how best to interact and communicate with various cultures.

Case Study: Improving Cultural and Linguistic Competency of Health Care Providers and Staff

Adventist HealthCare, Rockville, Maryland

Overview: Adventist HealthCare created the Center on Health Disparities to reduce and eliminate disparities in health status and health care access, treatment, quality, and outcomes throughout the communities served by its system. The center is organized into three focus areas: cultural competence education and training, health disparities research, and health care services partnerships. To ensure the provision of culturally competent, patient-centered health care, the center provides education and training on cultural awareness and cross-cultural communication to health care providers and staff within the Adventist system and at partner organizations. An advisory board composed of representatives from health care, academia, local governments, and community-based organizations provides guidance to the center on its activities.

Actions: The Center on Health Disparities emphasizes organizational and health professional cultural and linguistic competency in several ways. First, the center's staff conducts organizational cultural competence assessments to determine how well hospitals are meeting the needs of their patients and creates strategic plans for leadership to improve health equity. At presentations and in-services and through web-based training to promote patient-centered care, physicians and other health care providers and staff learn about culturally appropriate and effective communication techniques to care for diverse populations. In addition, to ensure that patients receive linguistically appropriate services, the center offers programs such as the Qualified Bilingual Staff Training (QBS) Program. The purpose of this three-day program is to assess language proficiency and train bilingual staff to provide proper foreign language interpretation for patients who speak little or no English. Health care providers and staff learn proper medical interpreting skills to facilitate effective communication during cross-cultural encounters and improve the organization's ability to provide culturally and linguistically appropriate care and services.

Results: With an increased focus on cultural and linguistic competency, the Center on Health Disparities has helped patients better navigate the health care system and improved the care they receive. For example, patients are now more thoroughly screened at registration, and offered language assistance from a hospital-provided language interpreter or a qualified bilingual staff member, when needed.

Since 2007, the center has held 19 QBS training sessions and trained more than 400 providers and staff to provide language access services to non-English speaking patients. The center also has developed and disseminated annual reports at local conferences to bring community stakeholders together and share best practices and community interventions to improve cultural competency and enhance patient experience.

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Case Study: Providing Education and Training to Improve Cultural Competency

Children's Mercy Hospitals & Clinics, Kansas City, Missouri

Overview: The patient population at Children's Mercy Hospitals & Clinics has become more diverse as the Kansas City metropolitan area population has changed demographically. In addition to collecting REAL data, Children's Mercy emphasizes educating and training all staff on diversity and inclusion issues and providing more in-depth cultural competency and language training for front-line admissions staff as well as clinicians. Work on diversity and equity issues at the hospital is guided by an Office of Equity and Diversity and an Equity and Diversity Council composed of staff members at all organizational levels¹¹.

Actions: The hospital's Office of Equity and Diversity (OED) is working with the Service Excellence Steering Committee to implement an organization-wide strategy on diversity, inclusion, service excellence, and cultural competence. Between 2008 and 2010, more than 6,000 employees at Children's Mercy completed a required course entitled "Honoring Diversity." New employees now complete the training online. In addition, Spanish-speaking admissions staff can enroll in a Spanish proficiency assessment program. Participants who complete and pass a testing process then receive a pay differential. Testing is repeated annually to ensure ongoing competency. The hospital's Equity and Diversity Council is exploring an organization-wide rollout of this competency assessment process. Children's Mercy offers other Spanish language courses to health care workers, all with the aim of providing better care for Spanish-speaking patients and families.

At the hospital's Pediatric Care Center, at least a quarter of the 45,000 visits each year are for Spanish-speaking families. In response, Dr. John Cowden created the CHICOS Clinic (Clinica Hispana de Cuidados de Salud). This program trains select pediatric residents with moderate or better Spanish proficiency to complete a bilingual cross-culture care curriculum as part of their primary care training¹². Residents speak Spanish with patients with an interpreter in the room as a "safety net," and a bilingual attending doctor provides role modeling and coaching. The program's goal is to develop certifiably bilingual and culturally sensitive clinicians.

Results: Equity and diversity have become part of the culture of safety and service excellence at Children's Mercy. The organizational structure created in the OED and its partner council has provided stability and strategy for wide-ranging improvement activities. New hospital standards for assuring language competency and excellent communication have resulted in critical conversations about how patients have been treated in the past and a vision for more equitable care moving forward.

Participation in the CHICOS Clinic has increased to 11 residents, from 3 the first year. Overall at Children's Mercy Hospital, feedback from patients and the community has been impressive, and patient satisfaction has increased. Physicians and other health care workers enjoy the improved ability to interact with and treat patients. Many patients previously lacked an access point for care, partly due to language barriers, but they now can receive individualized care and improved access to follow-up treatments due to improved communication. In addition, the OED is planning an organization-wide cultural competency assessment to evaluate its current strengths and weaknesses and assist in developing future programming.

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Case Study: Integrating Cultural Competency into Population Health Initiatives

New York-Presbyterian Hospital, New York, New York

Overview: New York-Presbyterian Hospital's Columbia University Medical Center campus serves a predominately Hispanic community with high rates of asthma, diabetes, heart disease, and depression¹³. Recognizing that health disparities and gaps in care coordination existed in this community, NYP developed a strategy to improve clinical care coordination, increase cultural competency among providers, and introduce integrated information systems across sites of care.

Actions: NYP established the Regional Health Collaborative to improve care coordination and cultural competency through four main strategies: (1) implementation of seven National Committee for Quality Assurance designated patient-centered medical homes focused on diabetes, CHF, asthma, and depression, (2) centralization of call center functions such as scheduling, test results, and follow-up information for all seven sites, (3) employment of bilingual and bicultural community health workers and navigators in the medical homes and emergency departments, and (4) implementation of a four-hour training program to build a workforce that can better address linguistic, cultural, and health literacy needs of the community. Physicians also receive training with patient-based cross-cultural care, which assists with cultural competency and communication with patients and families. This training helps physicians become more aware of their patients' perspectives in addition to their own¹⁴.

Results: As of May 2011, approximately 600 employees have received cultural competency training¹⁵. The collaborative has helped decrease the number of emergency department visits for ambulatory care - sensitive conditions by 9.2 percent.

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Increasing Diversity in Governance and Management

Many hospitals and health systems recognize that they need to increase the diversity of their senior leadership and board to reflect the diversity of the communities they serve. But many hospitals have encountered difficulties recruiting and retaining qualified candidates to their facilities. The pool of qualified candidates can be small. Some hospitals have successfully implemented complementary strategies related to recruitment, retention, and “candidate pipeline development.”

As a first step, hospitals need to develop a formal recruiting strategy that targets qualified candidates and establishes metrics that can be used to monitor the number of minority or underrepresented candidates who apply and advance through the hiring process. A long-term solution is to expand the number of leadership candidates within a community. To encourage more minorities to pursue a career in health care, hospitals have formed partnerships with local schools and universities and offered internships, held educational fairs, and awarded scholarships—all to highlight the benefits and value of working at a hospital.

Retention and succession planning are also important components for increasing diversity in governance and senior management. Improving cultural competency within the organization and providing mentorship programs to support new employees and potential candidates can enhance efforts to recruit and retain culturally diverse candidates. The changes required to establish a successful recruiting and retention program will require changes across several internal departments. Support and acknowledgment by the board and senior leadership team are required, and incorporating diversity efforts as part of an organization's strategic mission is critical.

Case Study: Setting Goals to Increase Diversity in Leadership

Barnes-Jewish Hospital, St. Louis, Missouri

Overview: Barnes-Jewish Hospital created the Center for Diversity and Cultural Competence in 2006. One of the center's goals is to ensure that the professional, management, and senior leadership team reflects the diverse community it serves.

Actions: A diversity council, which reports to the hospital's executive council and board, was established in 2007. The diversity council's recommendation to meet the goal of recruiting and retaining 25 percent or more individuals from diverse backgrounds in professional and management positions was approved and incorporated into the strategic goals of Barnes-Jewish Hospital. As a result, specific metrics were established to track the number of underrepresented minorities who currently hold professional and management level positions through recruiting efforts and promotions, or who are emerging into leadership roles. To ensure a diverse pool of qualified candidates, new hiring processes were implemented, such as engaging a consultant with expertise in diversity recruiting, using certified diversity internet recruiters, utilizing minority search firms, recruiting through community organizations, and social networking. Outcomes are reported on a dashboard, enabling the executive leadership, board, management, and staff at large to monitor progress in reaching this goal. Understanding how many minorities apply and interview for an open position allows the council to develop strategies for recruitment, retention, and succession planning.

Results: Barnes-Jewish Hospital conducts an annual employee engagement survey. Diversity scores on this survey increased by a statistically significant percentage, raising the overall employee engagement score to 82 points from 2008 to 2010. The diversity component of the employee engagement survey reflected an overall improvement in areas such as respect and support of a diverse workplace, and efforts by the organization to become more diverse. Recruitment, promotion, and retention of staff from diverse backgrounds in professional and management positions increased from 10 percent in 2006 to 18 percent in 2011. Although it acknowledges there is more work to be done, Barnes-Jewish Hospital has implemented a framework for measuring progress and the tools to implement changes.

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Case Study: Establishing a Process to Increase Diversity in Recruitment Initiatives

Greenville Hospital System University Medical Center, Greenville, South Carolina

Overview: The diversity of the leadership team—director level and above—at Greenville Hospital System University Medical Center (GHS) lagged in comparison to the diversity of the workforce and the communities it served. In addition, there was no consistent method for hiring members of the leadership team, and no metrics were in place to measure progress on recruitment and retention.

Actions: The leadership search and selection process was overhauled, and a new method of hiring employees at the director level and above was put in place. For each leadership team vacancy, a diverse search and selection committee was established to develop a diverse pool of highly qualified candidates. The committee also is responsible for recommending the top two candidates to the hiring manager. Michael Riordan, GHS's CEO, established as one of his five personal goals to focus on having at least one racial or ethnic minority in the final round of onsite interviews for leadership team positions. To ensure that GHS's leadership understood the rationale for this focus on diversity, GHS worked with Furman University, also in Greenville, to send key leaders at GHS through a five-month educational program designed to train existing local leaders in diversity and its importance to an organization.

Results: The first year after implementation of the new process, 70 percent of leadership team appointments were from underrepresented groups, and 50 percent were racial and ethnic minorities¹⁶.

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Case Study: Building a Pipeline to Increase Diversity Recruitment

University Hospitals, Cleveland, Ohio

Overview: To address the changing demographics of its patient community and provide equitable care, University Hospitals' senior leadership created a Diversity Council that includes physicians, nurses, administrators, and nonclinical staff. The Diversity Council's mission is to ensure that diversity and inclusion are an integral part of University Hospitals' culture. The council focuses on three main goals: (1) ensuring a multicultural group of administrative leaders, (2) recruiting and retaining a talented pool of minority faculty and other health care professionals, and (3) building partnerships with minority- and family-owned businesses in the Cleveland area.

Actions: Specific initiatives have been established to recruit and retain a diverse group of leaders and physicians at UH. The David Satcher Clerkship, established in 1991, annually hosts 10 to 15 fourth-year minority medical students who will be seeking residencies. This clerkship offers hands-on exposure to career opportunities in an urban academic medical center. Using a grant from the Joan C. Edwards Charitable Foundation, UH and Case Western Reserve University School of Medicine have established a multifaceted outreach program to encourage promising students at John Hay High School to pursue careers as physician-scientists. For this initiative each year, eight paid summer internships are offered to underserved and underrepresented students, and laboratory-based work-study positions are available at UH Case Medical Center during the academic year for CWRU undergraduate medical students.

UH also provides job shadowing opportunities for 40 students and a half-day class, Introduction to Business and Finance Careers in Health Care, for 100 students at John Hay High School. Ten students from Central Catholic High School and Shaw High School receive 16 hours of career exposure to health careers during the summer. UH also supports Future Connections, a mentoring program that links 10 Central Catholic students with mentors in health care and other professions. For the most promising students at John Hay High School, another program provides scholarships that cover all tuition and fees for undergraduate and medical school. The Minority House Staff Organization was created to support residents and fellows throughout their education, by involving them in community service projects, mentoring minority medical students, and assisting recruitment to UH.

In addition, to ensure a multicultural group of administrative leaders, UH created the Edgar B. Jackson Jr., MD, Endowed Chair for Clinical Excellence and Diversity. The physician appointed to this permanent position has the opportunity to mentor and serve as a role model for minority medical students and post-graduate trainees, recruit diverse physicians, and lead a systemwide effort to reduce health disparities in Northeast Ohio. UH also grows the number of diverse physicians by conducting the Minority Faculty Development Award Program, the KeyBank Faculty and Administrative Fellowship Program, and Timothy Stephens Fellows Program.

Results: More than 200 medical students from more than 40 different medical schools have participated in the David Satcher Clerkship. All of UH's diversity initiatives have helped to double the percentage of African-American physicians on UH's faculty. Today about 6 percent to 9 percent of doctors in residence are underrepresented minorities, up from 1.8 percent in 1991¹⁷.

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Leader Expectations

Increase Collection and Use of REAL Data:

- Develop consistent processes to collect REAL data. Ask patients to self-report their information, or train staff using scripts to have appropriate discussions regarding patients' cultural and language preferences during the registration process.
- Go beyond collection of REAL data—use the data to improve performance. REAL data can be used to develop targeted interventions to improve quality of care for diverse patients with specific conditions (e.g., improving cardiac care for African-American males) and can help create the case for building access to services in underserved communities.

Create Culturally Competent Organizations:

- Leverage the diversity of the existing workforce. Provide additional training opportunities for bilingual staff to improve their abilities to communicate medical information and education to patients.
- In addition to training all staff on cultural competency, look for opportunities to employ bicultural clinical and administrative staff to improve education, care delivery, and ultimately, outcomes.

Increase Leadership Diversity:

- Set measurable goals for increasing the percentage of diverse candidates who interview for and fill positions in leadership and governance.
- Look for opportunities to support minority students pursuing careers in medicine, science, and health care administration in local communities.
- Provide mentorship programs to help support the careers of up-and-coming minority clinical and administrative leaders.

Conclusion

Disparities in health care impact all hospitals and health systems. Finding and implementing solutions should be an ongoing effort and part of a national dialogue. Although hospitals have long promoted equity in care, eliminating health care disparities has increasingly focused on quality improvement. Hospitals and health systems, as part of their mission, are eager to correct inappropriate variations in care.

Additional Resources

Resource	Description	Address
American Hospital Association	To help the hospital field improve the care provided to minorities and eliminate disparities in care, the AHA has convened the Equity of Care Committee. The group examines and provides guidance on how hospitals can help eliminate disparities in care.	http://www.aha.org/advocacy-issues/disparities/index.shtml
Association of American Medical Colleges	The AAMC's commitment to diversity includes embracing a broader definition of "diversity" and supporting our members' diversity and inclusion efforts.	https://www.aamc.org/initiatives/diversity/
American College of Healthcare Executives	The American College of Healthcare Executives has undertaken a number of initiatives to further diversity within ACHE and the health care management field.	http://www.ache.org/policy/diversity_resources.cfm
Catholic Health Association of the United States	The Catholic Health Association and the Catholic health care ministry are committed to the importance of diversity—both in the workforce and in meeting the needs of diverse patients—and to ending health disparities.	http://www.chausa.org/Diversity_and_Health_Disparities.aspx
Catholic Health Care's Response to Disparities	CHA has collected stories on member programs that showcase creative and collaborative approaches to decrease disparities.	http://www.chausa.org/Pages/Our_Work/Diversity_and_Disparities/Disparities_Resources/Response_to_Disparities/
Equity of Care	This site was created to help hospitals, health systems, clinicians, and staff improve the quality of care for every patient. Through free resources, shared best practices, and national collaborative efforts, Equity of Care is leading the health field on a clear path to eliminate disparities.	www.equityofcare.org
Hospitals in Pursuit of Excellence	This website provides evidence-based guides for hospital quality improvement efforts aimed at reducing disparities.	http://www.hpoe.org/topic-areas/health-care-equity.shtml
HRET Disparities Toolkit	The HRET Disparities Toolkit is a web-based tool that provides hospitals, health systems, clinics, and health plans with information and resources for systematically collecting race, ethnicity, and primary language data from patients.	www.hretdisparities.org
Institute for Diversity in Health Management	The Institute for Diversity is committed to expanding health care leadership opportunities for ethnically, culturally, and racially diverse individuals.	www.diversityconnection.org
Minority Trustee Candidate Registry	An online registry of candidates from diverse backgrounds who are interested in serving on the board of their local hospital or health system.	http://www.americangovernance.com/americangovernance/candidatesProgram/index.jsp?fll=SI%3f
National Association of Public Hospitals and Health Systems	More than half of public hospital patients are racial and ethnic minorities, and a majority of patients are uninsured or qualify for Medicaid. The NAPH works to investigate and disseminate promising practices to achieve health equity.	http://www.naph.org/Main-Menu-Category/Our-Work/Health-Care-Disparities.aspx

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**Action Guide to
Using HCAHPS**



Health Care Leader Action Guide to Effectively Using HCAHPS

March 2012



Resources: For information related to the patient experience, visit www.hpoe.org.

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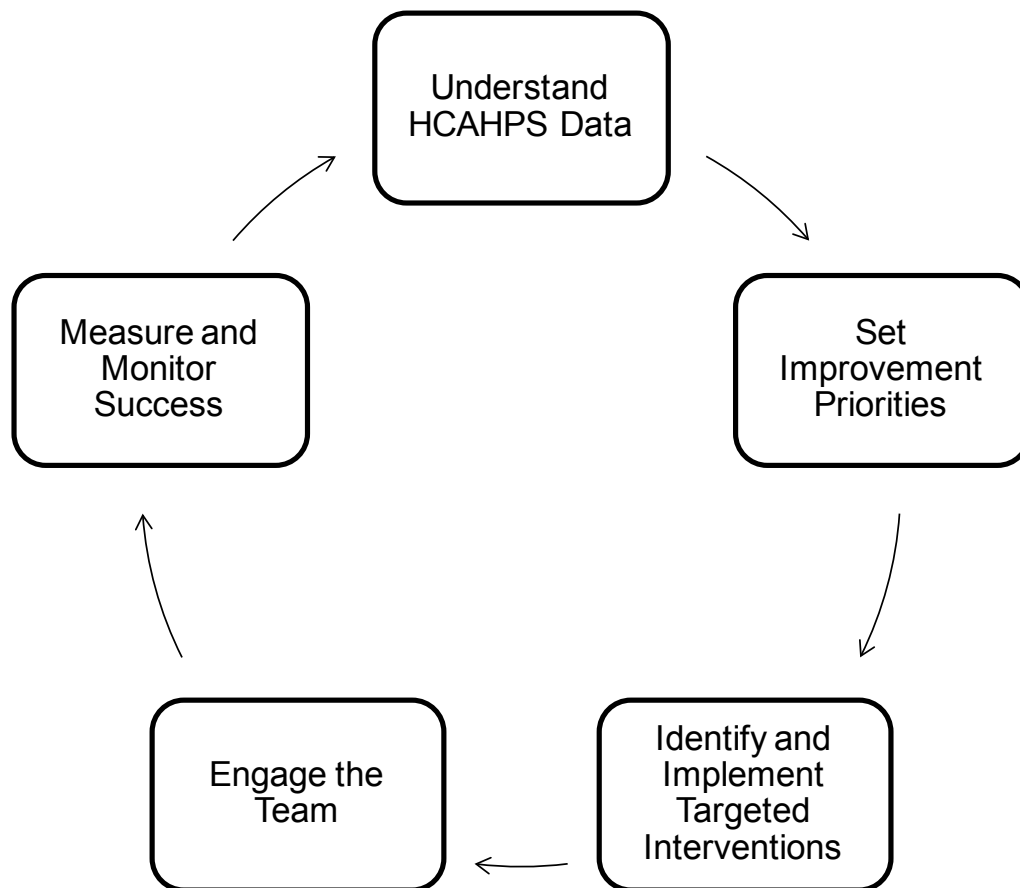
Executive Summary

Recent research has demonstrated that an exceptional patient experience correlates with improved clinical quality, reduced readmissions and improved mortality. HCAHPS is a tool that can be used to help organizations improve the patient experience, and may have a related effect on clinical quality. With the implementation of value-based purchasing beginning with October 1, 2012 discharges, HCAHPS performance will also have an impact on financial goals.

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:

1. Understand HCAHPS data
2. Set improvement priorities
3. Identify and implement targeted interventions
4. Engage the team
5. Measure and monitor success

The appendix includes links to white papers and case studies that can help health care leaders better understand the HCAHPS survey and identify and successfully implement strategies for improvement.



Introduction

Since the first public reporting of Hospital Consumer Assessment of Healthcare Providers and Systems data by the Centers for Medicare & Medicaid Services in March 2008, HCAHPS data has increasingly gained the attention of hospital leaders. For the first time, hospitals can compare themselves against all U.S. hospitals; and the public can see these data.

**How Can (you)
Always Help Patients
(and providers) Succeed**

Using the HCAHPS data effectively can help health care leaders position their organizations and patients for success.

As pay-for-reporting incentives evolve into pay-for-performance incentives, the need to excel on the survey evolves from a competitive differentiation strategy to a financial imperative and a way to improve quality and patient safety. A study of HCAHPS data published in *New England Journal of Medicine* found that hospitals in the top quartile of HCAHPS ratings performed better than those in the bottom quartile, with respect to the care that patients received for acute myocardial infarction and pneumonia.¹

The HCAHPS survey is a tool that, when used correctly, can help hospital leaders identify how to effectively meet their patients' needs. The CMS HCAHPS website (www.hcahpsonline.org) reports that more than 7,500 patient complete the survey each day. Vast numbers of patients are willingly sharing their perspectives, but many providers are finding it challenging to use this information effectively. With HCAHPS

scores accounting for 30 percent of a hospital's value-based purchasing score, effectively applying this data to improve performance has become even more important.

Hospital leaders need to understand how HCAHPS data should be used in context with other information about organizational performance. There are several cultural elements necessary to build a firm foundation for HCAHPS success. Once these foundational elements have been considered, hospital leaders can use the following 5-step approach to improve the patient experience, quality and safety:

1. Understand HCAHPS data
2. Set improvement priorities
3. Identify and implement targeted interventions
4. Engage the team
5. Measure and monitor success

HCAHPS survey is a powerful tool

To understand the data and maximize its value, it should be used in conjunction with other information that provides a complete picture of the patient and staff experience in the organization.

Putting HCAHPS Data in Context

Hospital leaders should use the survey as a tool to strengthen patient relationships and improve care. However, similar to other tools, the data must be applied wisely in order to be effective. The survey should not be the organization's only way of obtaining information about the patient experience. Nor is it intended to be a comprehensive assessment of everything that is important to patients.

To get the most value out of the data, it should be considered in conjunction with other organizational metrics related not only to the patient experience, but also to the staff experience. To establish its relevance with clinicians, survey data should be an integral part of hospitals' quality and safety improvement efforts, rather than simply a measure of customer service. Improving HCAHPS scores should not be viewed as a separate task, but rather within the context of a broader focus.

Getting a Broader Perspective of the Patient Experience

Hospitals routinely obtain a wide variety of information from patients and families. Common sources of patient/family perspectives include: follow-up phone calls after discharge; patient compliments and

¹ Ashish K. Jha, MD, E. John Orav, Jie Zheng, Arnold M. Epstein, MD, (2008). Patients' perception of hospital care in the United States, *New England Journal of Medicine*, 359, 1921-1931

complaints; patient and family advisory councils; patient satisfaction survey comments; letters; and focus groups. The information obtained from these sources should be combined with HCAHPS data to provide a complete picture of the patient experience, highlighting areas of strength and opportunities for improvement.

Consideration of the Staff Experience

Improving the patient experience also depends on the quality of the staff experience. In one study, higher HCAHPS scores were associated with a higher quality nurse work environment and higher nurse-to-patient ratios.² Leaders need to consider data from staff comments and surveys, such as the Agency for Healthcare Research and Quality's Survey of Patient Safety Culture (see appendix).

Making the Connection to Quality and Safety

In the past, it was common for hospitals to view the HCAHPS survey as a customer-service indicator that was not related to clinical outcomes. Research is demonstrating, however, that although patients may not have the ability to judge all clinical aspects of their care, their perceptions do reflect important aspects of quality and safety. A few recent studies highlight opportunities for hospital leaders to integrate their HCAHPS improvement work with other quality and patient safety initiatives.

- » **Readmissions:** Most hospital leaders regularly scrutinize the organization's performance on clinical process measures as part of their efforts to avoid preventable readmissions. However, research has shown that the HCAHPS questions related to discharge information, overall rating and willingness to recommend are associated with lower 30-day risk-standardized hospital readmission rates after adjusting for clinical quality.³
- » **Mortality:** In a prior study on acute myocardial infarction, several of the same researchers involved in the readmissions study (reference above) found that even after controlling for hospitals' clinical performance, "higher hospital-level patient satisfaction scores were independently associated with lower hospital inpatient mortality rates." In fact, the researchers found that a one-quartile change in patient satisfaction was associated with an effect on mortality equivalent to a one-quartile change in clinical guideline adherence. Although this study was based on a survey other than HCAHPS, it highlights the relationship between the patient experience and clinical outcomes.⁴
- » **Other Measures:** Another study evaluating the relationship between HCAHPS and other common quality and safety measures found that "there were consistent relationships between patient experiences and technical quality as measured by the measures used in the HQA program, and complication rates as measured by the AHRQ Patient Safety Indicators."⁵

Setting the Stage for Success by Building a Firm Foundation

Although many organizations focus their HCAHPS improvement strategies on identifying discrete interventions targeting a specific HCAHPS domain, research indicates that HCAHPS success is related to building a culture of patient-centered care. For example, a recent survey found that organizations that scored both exceptionally and poorly on questions related to overall rating and willingness to recommend had implemented many of the same interventions, indicating that making the improvements specific to the domains were not enough to achieve success.

2 Kutney-Lee, A., McHugh, M. D., Sloane, D. M., Cimiotti, J.P., Flynn, L., Neff, D.F., Aiken, L.H. (2009) Nursing: A key to patient satisfaction, *Health Affairs*, 28(4) w669-w677

3 Boulding W., Glickman S.W., Manary M.P., Schulman K.A., Staelin R., (2011). Relationship between patient satisfaction with inpatient care and hospital readmission within 30 days. *American Journal of Managed Care*, 17(1), 41-48.

4 Glickman S.W., Boulding W., Manary M., Staelin R., Roe M.T., Wolosin R.J., Ohman E.M., Peterson E.D., Schulman K.A., (2010) Patient satisfaction and its relationship with clinical quality and inpatient mortality in acute myocardial infarction. *Circulation: Cardiovascular Quality and Outcomes*, 3(2), 188-195

5 Isaac T., Zaslavsky A.M., Cleary P.D., Landon B.E., (2010) The relationship between patients' perception of care and measures of hospital quality and safety, *Health Services Research*, 45(4), 1024-1040

Common Characteristics of High-Performing HCAHPS Organizations

<p>Leadership</p> <p>Senior leaders are visible and lead by example:</p> <ul style="list-style-type: none"> » Leaders make rounds and speak with patients, families and staff » Leaders clearly communicate a vision and plan for integrating patient-centered care into daily operations <p>Clinicians are engaged in improvement efforts and visibly support patient-centered care</p> <p>Patient experience is integrated and aligned with other organizational priorities, including quality and safety</p> <p>A dedicated champion is in place to support patient-centered care</p>	<p>Partnership with Patients and Family</p> <p>Patients and families are treated as partners at every level</p> <p>The organization engages in dialogue with patients and families on a routine basis using methods other than the HCAHPS survey, including:</p> <ul style="list-style-type: none"> » Regular rounding with patients to solicit their perspectives » Patient and family advisors » Focus groups » Post-discharge phone calls » Organizations identify and respond to patients' individual needs
<p>Engaged Workforce</p> <p>Staff members are recruited for patient-centered values and job descriptions, including patient-centered description of responsibilities</p> <p>Orientation and ongoing training reinforce patient-centered tools and skills</p> <p>Patient-centered care is rewarded and celebrated</p> <p>Caregivers are supported when challenging situations arise with patients/families:</p> <p>Staff are actively involved in designing patient-centered care processes</p> <p>Accountability and incentives support patient-centered care</p>	<p>Performance Improvement Focus</p> <p>Patient-experience metrics are on the organization's balanced scorecard</p> <p>Patient experience is systematically evaluated and feedback is provided to staff</p> <p>Data is analyzed to enable organizational learning from high-performing units</p> <p>Performance goals are established</p> <p>An improvement methodology is used</p> <p>Tools, training and support for using data effectively for improvement</p> <p>Staff are encouraged to suggest and pilot improvement ideas</p>

Sources: Shaller, D., *Patient-centered care: What does it take?*, The Commonwealth Fund, October 2007., Luxford, Karen, Safran, Dana Gelb, Delbanco, Tom (2011) Promoting patient-centered care: A qualitative study of facilitators and barriers in healthcare organizations with a reputation for improving the patient experience. *International Journal for Quality in Health Care*, 23(5) 510—515., Shaller, D., Darby, C., *High-performing patient and family-centered academic medical centers: Cross-site summary of six case studies.*, Picker Institute 2009., Balik B, Conway J, Zipperer L, Watson J.

The paper discovered that high-HCAHPS-performing organizations had several traits in common. Overall, interventions were implemented in an effective manner that engaged staff at all levels, focused on organizational culture, reflected effective partnerships with patients and clinicians and were supported by a commitment of leadership time.⁶

This study is consistent with prior research which showed that patient-centered organizations share many common characteristics, including committed leadership, partnerships with patients and families and an engaged workforce, as well as effective performance measurement and reporting. Additionally, a literature review shows that high-performing organizations make sure that patient-centered care isn't

⁶ The Beryl Institute, *The four cornerstones of an exceptional patient experience: focus, accountability, engagement, and commitment*, September/October 2010.

just a temporary program, but a core component of the organization’s culture, even reflected in many organization’s mission statements. HCAHPS success is dependent upon creating a firm foundation for patient-centered care that is built on strong leadership, effective partnerships with patients and families, an engaged workforce and a focus on performance improvement.

Step I: Understand HCAHPS Data

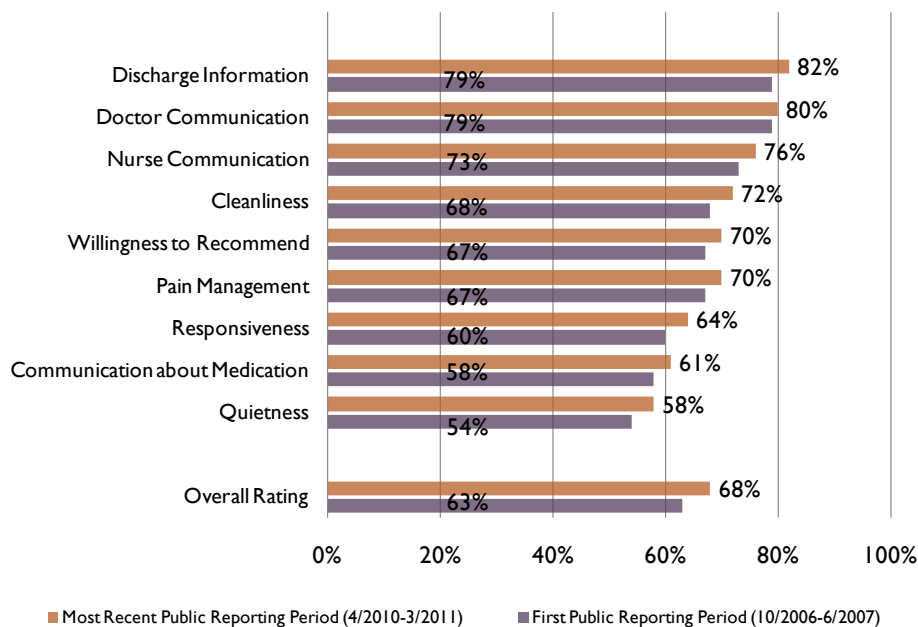
Understanding HCAHPS data requires knowing more than an organization’s current performance on the 10 publicly reported HCAHPS indicators. Behind those numbers is a wealth of information that leaders need to understand and use to guide improvement efforts. Besides the current performance, leaders should pay particular attention to trending, benchmarking and unit analysis. Further, leaders should pay attention to bottom-box performance—the least positive response category on the HCAHPS survey. They should examine if the organization has a higher percentage than the national bottom-box score; this will help set priorities.

Trending

An HCAHPS score reflects how an organization performed during a particular time period. To understand what that data means operationally, it is important to consider historical performance. Trending against prior performance provides leaders with insight into whether performance is improving, holding steady or worsening. Leaders should then take appropriate action, such as celebrating improvement, acknowledging consistency or correcting negative changes. Trending can also be used to evaluate the impact of any HCAHPS improvement strategies implemented by the organization and to decide which strategies should be replicated throughout the organization.

Nationally, HCAHPS scores have improved in all categories. Between the first public reporting period (reflecting October 2006 to June 2007 discharges) and the current public reporting period (reflecting April 2010 to March 2011 discharges), top-box performance has improved in each of the 10 publicly reported HCAHPS metrics from one to five percentage points. Top box refers to the most positive response for each HCAHPS question (see table 1).

Table 1: Average Top Box Scores



Source: Summary of HCAHPS Survey Results. www.hcahpsonline.org/HCAHPS_Executive_Insight. Public reporting periods, CMS, Baltimore, Page accessed 2/17/12

Notably, although top-box performance in all categories has improved, the comparative performance ranking by question has stayed the same with discharge information having the highest score of 82 percent, followed by doctor communication at 80 percent. Communication about medications and quietness have the lowest scores of 61 percent and 58 percent respectively. Ironically, discharge information is both a high- and low-performing category. Since the only answer choices for this category are “yes or no,” it has the highest top-box score and one of the highest bottom-box scores.

Benchmarking

In addition to examining historical and trending performance, understanding HCAHPS requires a comparison of the hospital’s performance to other hospitals. Public reporting and value-based-purchasing performance are based on comparison to national benchmarks that are comprised of all the hospitals reporting HCAHPS data. Additionally, hospitals may create their own benchmarks using vendor or publicly reported data. For example, some hospitals benchmark their performance against hospitals in the same state or against other hospitals of the same type (e.g., academic medical centers or hospitals of a similar size).

Benchmarks should be selected with care, as they typically become the reference point for evaluating progress and setting organizational goals. For instance, if percentiles are used as a benchmark, leaders should realize that this benchmark can vary substantially based on the performance of other hospitals, even if the organization’s performance has not changed. In addition, performance in a benchmarking group is often tightly clustered, so a different answer on a few surveys can result in dramatic swings in percentiles that do not accurately reflect changes in organizational performance. When significant changes in percentiles are not related to changes in performance, as reflected in top-box scores, they can mislead leaders and frustrate teams who see the performance apparently declining when in fact it has not changed. To get a more complete picture of organizational performance, percentile benchmarks should be viewed in conjunction with actual top-box performance scores.

There are many ways to use the HCAHPS data to highlight opportunities for improvement. Leaders should ensure that the data are used in a way that is credible and actionable.

Unit Analysis

Although HCAHPS performance is publicly reported as a set of numbers reflecting the performance of the hospital as a whole, many hospitals also generate internal reports demonstrating the performance of individual units or departments. Analyzing HCAHPS performance on a unit level allows hospital leaders to determine which units are creating a better patient experience and to learn from those units. Leaders should familiarize themselves, not only with their overall scores, but with the unit scores. Analyzing organization-wide and unit-based data will provide more detail to what is working and not working in particular areas.

However, leaders should exercise caution in making comparisons between units that do not have a sufficient sample size for the data to reliably reflect performance. For example, it is not reliable to compare a 100 percent top-box score on a unit where four patients were surveyed to a unit with a score of 90 percent where 100 patients returned surveys. The data based on only four patients is not reliable and will vary dramatically based on who is surveyed. One patient having a different experience would drop the first unit’s score from 100 to 75 percent. On the Hospital Compare website, CMS encourages viewers to exercise caution when looking at data that reflects less than 25 completed surveys per quarter (100 per year).

Bottom-Box Performance

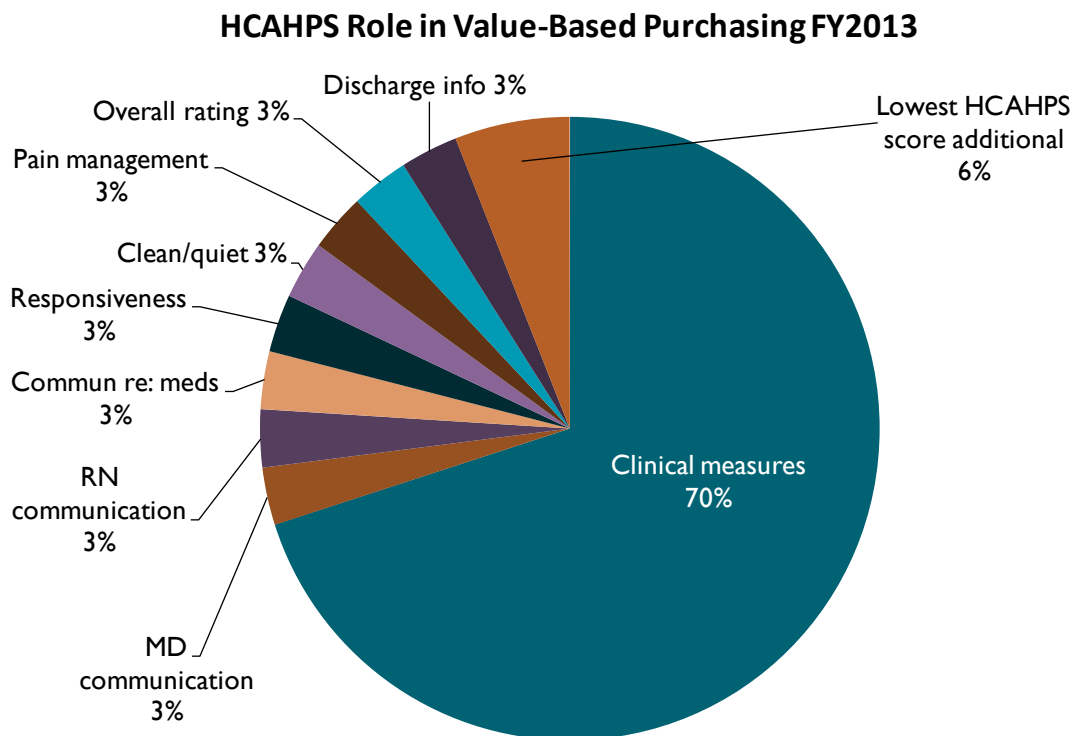
Although most hospitals focus on their HCAHPS top-box scores since those are the scores that are used for value-based purchasing and public reporting, reviewing bottom-box scores can provide valuable information for setting improvement priorities and measuring progress. CMS publishes the bottom-box scores on a quarterly basis. In reviewing HCAHPS data, leaders should consider whether there are any areas in which a larger percentage of patients are giving the organization bottom-box scores than the

national 50th percentile bottom-box scores published by CMS, as this could identify areas that should be a high priority.

Step 2: Set Improvement Priorities

Once hospital leaders have an understanding of the HCAHPS data within the organizational context, the next step is to identify improvement priorities. Other than willingness to recommend, performance on all other HCAHPS metrics is incorporated into value-based purchasing. In fiscal year 2013, HCAHPS performance accounts for 30 percent of a hospital's value-based purchasing payments, with clinical measures accounting for the other 70 percent. Because of the financial component, hospital leaders should pursue multiple improvement initiatives simultaneously. A focused approach to improvement will help to align efforts and contribute to success.

When identifying HCAHPS improvement priorities, health care leaders should consider the value-based-purchasing implications of the performance and the correlations between HCAHPS measures in conjunction with the opportunities for improvement identified by other feedback from patients, families and staff.



Value-Based Purchasing Implications

In identifying improvement priorities, one key factor to consider is how the hospital's performance will affect payments under the value-based purchasing program. In the fiscal year 2013 value-based purchasing system, there are three ways to obtain points:

- » *Achievement or Improvement:* The hospital achieves a certain level of performance compared to national performance during the baseline period (up to 10 points per measure) OR the hospital improves performance compared to its own performance during the baseline measurement period (up to 9 points per measure)
- » *Consistency:* The hospital's lowest HCAHPS measure compared to national performance during the baseline period (up to 20 points)

Hospitals can earn up to 100 points total on HCAHPS:

- » 80 points are available by using the greater of the achievement or improvement threshold for each measure; and
- » 20 consistency points are available for exceeding the national median during the benchmark period for all HCAHPS dimensions.

The hospital’s lowest HCAHPS score has a disproportionate weight to the others—30 of the 100 HCAHPS value-based-purchasing points are based on that one measure.

In setting HCAHPS improvement priorities, leaders should consider which improvements are likely to have the most financial value. If the HCAHPS category in which the organization performs the least well is less than the national 50th percentile for that measure (See middle column of table below), that area will likely have a significant impact on value-based-purchasing performance and should be identified as a priority.

HCAHPS Category	“Top Box” Minimum Score Required for:		
	Any Consistency Points (Minimum)	Any Achievement/Full Consistency Points on Lowest HCAHPS Measure (Achievement Threshold - 50 th percentile)	Maximum Achievement Points (Benchmark - mean of top decile)
Nurse Communication	38.98	75.18	84.70
Doctor Communication	51.51	79.42	88.95
Responsiveness	30.25	61.82	77.69
Pain Management	34.76	68.75	77.90
Communication about Medicines	29.27	59.28	70.42
Clean/Quiet	36.88	62.80	77.64
Discharge Information	50.47	81.93	89.09
Overall Rating	29.32	66.02	85.52

Source: Federal Register, 76 (88) 2001.

Correlations

CMS publishes an annual correlations table that demonstrates how the HCAHPS metrics relate to one another. When setting improvement priorities, health care leaders should consider how improvement in one area is likely to affect performance in other areas. For example, the current CMS analysis demonstrates that the three strongest drivers of overall rating are nurse communication, pain management and responsiveness.

The impact of HCAHPS performance on value-based purchasing, especially the disproportionate weighting of the lowest HCAHPS dimension, should be considered in setting priorities.

In addition to considering the CMS correlations table, those hospitals using survey-vendor questions in combination with HCAHPS questions should consider any analysis provided by their vendors on questions that correlate with HCAHPS performance. Examination of these drivers, such as questions about the courtesy and respect of hospital personnel, help hospital leaders understand what is driving HCAHPS performance. They can then create specific action plans to improve the patient experience.

Although lessons can be learned from other organizations' experiences, many insights can be gained internally by comparing unit performance, identifying differences, learning from prior experiences and soliciting and respecting frontline wisdom.

Organization- and Unit-Specific Priorities

Just as an understanding of HCAHPS performance requires an examination of both individual, unit and the organizational performance, leaders should consider setting organization- and unit-specific improvement priorities. For example, if nurse communication is identified as an organization priority, and there are a few units with exemplary nurse communication scores, those units should have the ability to select a different priority for their improvement work. Priorities should be integrated and aligned with other organizational priorities and developed in conjunction with input from staff.

Step 3: Identify and Implement Targeted Interventions

After identifying priority areas for improving the patient experience, organizations should determine performance-improvement interventions. Choosing interventions should involve a combination of external and internal review.

External Review

In selecting improvement interventions, leaders should consider the successful practices that other organizations have implemented. Many published case studies (summarized in the appendix) describe what organizations have done to improve HCAHPS performance. Organizations should review successful and unsuccessful process and common characteristics of hospitals that have already improved their HCAHPS performance. Simply deciding to adopt a practice is not enough. Careful attention must be paid to how to do it consistently and effectively in each organization.

Since HCAHPS is a relatively new survey, additional research and case studies are being released on a regular basis. Leaders should monitor emerging developments, such as through the Agency for Healthcare Research and Quality's Innovation Exchange (www.innovations.ahrq.gov) and the AHA's Hospitals in Pursuit of Excellence (www.hpoe.org) which regularly profiles organizations implementing innovative practices to improve the patient experience. Promising practices identified by existing articles and case studies include:

- » Leadership rounding
- » Hourly nurse rounding
- » Bedside change of shift reporting
- » Patient and family advisory councils
- » Post-discharge phone calls
- » Project RED (**Re**Engineering hospital **D**ischarge)
- » Sleep aids (e.g. headphones, ear plugs, soothing sound generators)
- » Patient-friendly daily medication schedule and teaching cards on common new medications
- » Communication tools for patients/families during their stay (e.g. notepads, white boards)

Internal Review

In selecting improvement interventions, leaders should actively tap into the expertise within their own hospital (or, if applicable, within the other hospitals in their system). Leaders should familiarize themselves with the differences in practices between high- and low-performing units in the priority area to determine if there are unit-based innovative practices that could be replicated throughout the organization. Team trades, where a staff member from a high-performing unit exchanges places with a colleague in a low-performing unit for a few hours, can be an effective way of identifying the differences between the units.

Understanding Organizational History

Leaders also should familiarize themselves with what interventions have previously been attempted in the organization, both successful and unsuccessful interventions. For example, if hourly rounding was started and then stopped, it is important for leaders to understand the barriers that impeded successful implementation and to determine how to avoid them in future implementation.

Step 4: Engage the Team

HCAHPS success depends not only understanding the data, but on engaging and motivating the right team. Each team member, clinical and non-clinical, must understand what their role is in creating an ideal experience for patients and should be provided with the appropriate tools and training to support their work.

Involving Patients, Families and Frontline Staff in Improvement

Patients, families and frontline staff provide invaluable perspectives on HCAHPS improvement. Hospital-improvement teams should include patients, families and frontline staff working together to understand the patient experience and offering ideas to improve it. Rather than attempting to implement an intervention across the entire hospital at one time, it is often a better strategy to implement an intervention on one unit. Starting small enables the team to address barriers on a more manageable scale. Plans tend to be more developed, more realistic and more successful when moved to full hospital implementation. In addition, if the intervention does not have the desired effect of improving the patient experience, it can be modified or discontinued before too many resources and too much time are invested. Starting

How you approach HCAHPS improvement is important. Provide your team with the necessary skills and resources. Create a shared vision.

small also makes it possible for organizations to build momentum by engaging staff. For example, one hospital team worked on reducing noise levels and implemented every suggestion made by frontline staff, even if it was only piloted by one nurse with one patient on one shift. Engaging a multidisciplinary team in the improvement process and acting on staff ideas can build enthusiasm for the work.

Providing Appropriate Tools and Training

Using data effectively is not a skill that is intuitive for all, so it is essential to offer appropriate tools and training to promote effective use of the HCAHPS data. For example, Duke University Hospital (Durham, N.C.) has created a Patient Satisfac-

tion University for managers, directors and other staff to train them on patient satisfaction data. In many organizations, HCAHPS data is unwittingly misused by managers who are trying hard to improve the patient experience, but lack the necessary foundational knowledge of how to use data effectively. Common data mistakes include making comparisons with sample sizes that are too small to be reliable, isolating individual patient comments to use in performance reviews and overreacting to changes in percentiles that do not reflect changes in actual organizational performance. These common errors can discourage team members and impede HCAHPS improvement.

Motivation and Communication

Understanding what motivates individual members of the team is critical to success. Some team members may be motivated by value-based purchasing implications, but others may lose enthusiasm if finances seem to be the primary driver for improvement. Frontline clinical staff may be motivated by connecting the patient experience to quality and safety. One hospital found that physicians' interest in patient satisfaction reports increased when the hospital demonstrated the relationship between satisfaction, complaints and malpractice.

Communicating both the goal and the strategic vision behind the goal is important. Every staff member should know what is expected of them. Leaders need to make a clear connection for staff to understand how daily tasks contribute to creating an optimum patient experience. All departments, such as pharmacy and environmental services, have a direct bearing on several of the HCAHPS questions. Although improving HCAHPS performance is a desired outcome, successful patient-centered organizations often articulate a broader vision for patient-centered care. As one leader from a high-performing hospital noted, don't focus on the scores; focus on tasks that affect the scores.

Reports utilizing HCAHPS data should be designed to enable staff members to quickly understand the organization's current performance, how the data are trending and the improvement priorities and strategies. Communication about improvement techniques is an essential, but often forgotten task. Many organizations broadly disseminate the HCAHPS data without sharing information about improvement

strategies. Further, many organizations don't create opportunities for improvement discussions. Effective HCAHPS improvement work requires a coordinated effort to address the opportunities for improvement identified by the data; simply disseminating the data is not an effective way to spur change.

Step 5: Measure and Monitor Success

Use of HCAHPS measures should be embedded into the organization's overall quality improvement program. Each improvement cycle should include ongoing measuring and monitoring for success. The impact of patient-experience interventions can be measured by using HCAHPS data, along with other organizational metrics related to the patient experience, quality and safety. Staff metrics may provide valuable insights into what aspects of patient-experience-improvement initiatives are working and what aspects should be refined or abandoned.

Leaders should ensure that managers are provided with appropriate tools and training to improve quality using a rigorous well-designed process, rather than a scattershot approach. There are many methods for quality improvement, such as the Plan-Do-Study-Act or Six Sigma methods. Many of the case examples listed in the appendix illustrate the multitude of performance-improvement methodologies. Leaders should determine what quality improvement methodology will be used to improve HCAHPS performance and provide managers with guidance and support in using the methodology. Organizations are famous for planning and implementing performance improvements, and forgetting to follow through after the initial implementation. An ongoing systematic approach to evaluation is one way to ensure that successful practices will be disseminated broadly throughout the organization. Further, given limited time and resources, knowing what to stop doing is sometimes as important as knowing what to implement.

An ongoing measurement and monitoring system helps maintain momentum by giving you valuable information about what to start doing on a more widespread basis, as well as what to stop doing because it is not effective.

Maintaining Momentum

Improving the patient experience is a never-ending process and maintaining momentum is important, both for organizations that have achieved exceptional HCAHPS success, and those still in pursuit of such success. For an organization that achieved its HCAHPS goals, it can be easy to fall back into old routines and fail to sustain the successful interventions. Leaders must motivate staff to continue to focus on the patient. They need to recognize and reward patient-centered behaviors rather than shift focus to other priorities.

Not every attempted intervention will be successful in improving the patient experience or HCAHPS scores. For those organizations that have not yet achieved their goals, it is important for leaders to recognize effort as well as success. Teams that have invested time and energy in testing interventions should be acknowledged for the work they have put into improving the patient experience. Even if the goal has not yet been achieved, progress toward the goal should be celebrated.

Appendix of HCAHPS Improvement Resources

Resource	Summary	Link
HCAHPS Online	CMS website for all HCAHPS information, including announcements, data analysis and quality assurance guidelines.	http://www.hcahpsonline.org
REPORTS		
Patient-Centered Care: What Does It Take?	Identifies seven key organizational factors that contribute to patient-centered care.	http://www.commonwealthfund.org/Publications/Fund-Reports/2007/Oct/Patient-Centered-Care--What-Does-It-Take.aspx
The State of Patient Experience In American Hospitals	Benchmarking study based on a survey of 800 health care executives. It identifies organization's top priorities in addressing the patient experience, key components of organizations' patient experience efforts, drivers of success, roadblocks and prevalence of incentives.	http://www.theberylinstitute.org/?page=PEBENCHMARKING
High-Performing Patient and Family-Centered Academic Medical Centers: Cross-Site Summary of Six Case Studies	Identifies six elements of sustainable culture change supporting patient and family-centered care.	http://174.120.202.186/~pickerin/wp-content/uploads/2010/06/Picker_Report_final.pdf
Achieving an Exceptional Patient and Family Experience of Inpatient Hospital Care	Identifies five primary drivers and 15 secondary drivers of patient and family experience. Includes descriptions of exemplar organizations reflecting each primary driver.	http://www.ihl.org/knowledge/Pages/IHIWhitePapers/AchievingExceptionalPatientFamilyExperienceInpatientHospitalCareWhitePaper.aspx
The Four Cornerstones of an Exceptional Patient Experience: Focus, Accountability, Engagement and Commitment	Study comparing top- and bottom-performers on HCAHPS survey. The report also outlines seven components to building an effective service culture.	Executive summary available at http://www.theberylinstitute.org/resource/resmgr/White_Paper_Exec_Summ/The_Beryl_Institute_-_4_Corn.pdf (full report available for purchase)
Advancing Effective Communication, Cultural Competence and Patient- and Family-Centered Care: A Roadmap for Hospitals	Joint Commission recommendations on how to improve care in various components of the care continuum: <ul style="list-style-type: none"> » Admission » Assessment » Treatment » End-of-life care » Discharge and transfer » Organization readiness 	http://www.jointcommission.org/assets/1/6/roadmapforhospitalsfinal-version727.pdf

Resource	Summary	Link
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DATA ANALYSIS

	CMS provides several types of HCAHPS data analyses:	
HCAHPS Online	<ul style="list-style-type: none"> » Survey results by state » HCAHPS percentiles HCAHPS patient-level correlations » HCAHPS hospital characteristics chart 	http://www.hcahponline.org/SummaryAnalyses.aspx
Hospital Compare	Hospitals can download the entire HCAHPS dataset and run their own analyses.	http://www.medicare.gov/download/downloadadb.asp
Why Not the Best	Leaders can run comparative HCAHPS reports filtered by characteristics such as state, bed size and type of hospital and can add multiple national benchmarks.	http://www.whynotthebest.org/reports (log-in required)

CASE STUDIES

	Summarizes HCAHPS performance improvement strategies based on six case studies of top-performing hospitals. Hospitals include:	
Case Study Series on Hospital Patient Experience Measures: Improvement Strategies of Top-Performing Hospitals	<ul style="list-style-type: none"> » Parkwest Medical Center (Knoxville, Tenn.) » Duke University Hospital (Durham, N.C.) » Valley Hospital (Ridgewood, N.J.) » Hutcheson Medical Center (Fort Oglethorpe, Ga.) » Munson Medical Center (Traverse City, Mich.) » Brigham and Women’s Hospital (Boston) 	www.whynotthebest.org/uploads/download/47
Patient-Centered Hospital Redesign Leads to Low Infection Rates, Higher Patient Satisfaction, More Admissions, and Other Benefits	Griffin Hospital (Derby, Conn.) facility redesign that contributed to HCAHPS success.	http://www.innovations.ahrq.gov/content.aspx?id=2301
Patient- and Family-Centered Care Initiative is Associated with High Patient Satisfaction and Positive Outcomes for Total Joint Replacement Patients	Magee-Womens Hospital of UPMC’s (Pittsburgh) patient-centered care methodology and practice, which resulted in exemplary HCAHPS score. Detailed additional resources related to the program are available at https://www.cahps.ahrq.gov/Quality-Improvement/~media/Files/Quality%20Improvement/GoGuide.pdf	http://www.innovations.ahrq.gov/content.aspx?id=1764

Resource	Summary	Link
Implementing Clinical Nurse Leader Role Improves Core Measures Performance, Patient and Physician Satisfaction and Reduces Nurse Turnover	St. Lucie Medical Center's (Port St. Lucie, Fla.) experience in creating a new position of clinical nurse leader.	http://www.innovations.ahrq.gov/content.aspx?id=2566
Hourly Nurse Rounds Help to Reduce Falls, Pressure Ulcers, and Call Light Use and Contribute to Rise in Patient Satisfaction	Implementation of hourly nurse rounding by Memorial Health System (Springfield, Ill.).	http://innovations.ahrq.gov/content.aspx?id=3204
Active Solicitation of Patient Feedback and Engagement of Employees in Customer Service Significantly Increases Patient Satisfaction	Poudre Valley Health System's (Fort Collins, Colo.) approach to engaging patients, families and employees.	http://innovations.ahrq.gov/content.aspx?id=2890
Standardized Shift-Change Process Optimizes Time for Transfer of Patient Care Responsibility, Leads to High Levels of Nurse and Patient Satisfaction	The implementation of Nurse Knowledge Exchange Plus—a 6-step process for nurse shift changes that includes bedside reporting, in Kaiser Permanente hospitals (Oakland, Cal.). Detailed additional resources related to the NKEplus program are available at http://xnet.kp.org/innovationconsultancy/nkeplus.html	http://www.innovations.ahrq.gov/content.aspx?id=1803
Transforming Care at the Bedside through Reduction of Noise	St. Francis Hospital's (Englewood, Colo.) successful efforts to improve their quiet at night HCAHPS performance through a multi-faceted approach to reducing noise.	http://www.theberylinstitute.org/?page=CASE0720112
Improving Medication Communication	NCH Healthcare System's (Naples, Fla.) success in improving medication communication through a 4-step process.	https://theberylinstitute.site-ym.com/?page=CASE112010
Increasing Satisfaction by Providing Headphones and Ear Plugs to Patients	Inova Alexandria Hospital's (Alexandria, Va.) significant improvement on the HCAHPS quiet at night scores after implementing a program to provide headphones and ear plugs to patients.	http://www.rwjf.org/qualityequality/product.jsp?id=30271
Memorial Healthcare System: Patient-Friendly Daily Medication Schedule	Memorial Healthcare System's (Hollywood, Fla.) implementation of a patient-friendly daily medication schedule.	http://www.naph.org/Homepage-Sections/Explore/Innovations/Patient-Safety-Innovations/Memorial-Healthcare-Patient-Safety-Innovation.aspx
TOOLS		
CAHPS Improvement Guide and Other CAHPS Resources	AHRQ's website includes the CAHPS improvement guide, presentations from the CAHPS user group meetings and videos.	https://www.cahps.ahrq.gov/Quality-Improvement.aspx

Resource	Summary	Link
Project RED (Reengineering Hospital Discharge)	A curriculum designed to improve the discharge.	http://www.ahrq.gov/qual/projectred/
TeamSTEPPS	A curriculum designed to improve teamwork and communication.	http://teamstepps.ahrq.gov/
Patient-Centered Care Improvement Guide	This guide contains tools to improve patient-centered care. Appendix A is a cross-walk of patient-centered strategies for HCAHPS improvement categorized by domain.	http://www.patient-centeredcare.org/index.html
Institute for Patient- and Family-Centered Care	This website provides tools to assist organizations in becoming more patient- and family-centered, including assessments, presentations from successful organizations and guides.	http://www.ipfcc.org/
Surveys on Patient Safety Culture	Patient safety culture assessment tools for hospitals, nursing homes and ambulatory outpatient medical offices.	http://www.ahrq.gov/qual/patient-safetyculture

**Hospitals and Care
Systems of the Future**



Hospitals and Care Systems of the Future

September 2011



American Hospital Association

A report from the AHA Committee on Performance Improvement:

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To access the appendices and presentation slides for this report visit:

<http://www.aha.org/about/org/hospitals-care-systems-future.shtml>

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Executive Summary

Purpose

The AHA Board Committee on Performance Improvement (CPI) was created in 2010 to provide guidance to the American Hospital Association (AHA) in supporting performance improvement across the membership, including further development of the AHA’s strategic platform, Hospitals in Pursuit of Excellence (HPOE).

In the current environment, hospitals need to focus their efforts on performance initiatives that will remain crucial in the long term. As such, the Committee’s initial project centers on the role of the “hospital of the future.” With economic, demographic, and regulatory changes occurring throughout the health care industry, the Committee’s report serves to synthesize best practice strategies for the next decade and potential transition paths to reach the desired future models of care delivery.

This report will mobilize hospital senior leadership teams to consider the strategies they must deploy throughout their individual organizations to adapt and succeed in the future. Change will occur; what will vary is each organization’s path to embrace the future. To accomplish its goal, the CPI project team conducted interviews with an initial sample of leaders from hospitals and health care systems throughout the country, and then with multiple AHA member constituency groups and policy boards. The Committee aggregated the results to outline actionable strategies and core competencies for hospitals to pursue.

Background

Hospitals and health systems in the United States face unparalleled pressures to change in the future. Industry experts have projected that multiple, intersecting environmental forces will drive the transformation of health care delivery and financing from volume-based to value-based payments over the next decade. These influences include everything from the aging population to the unsustainable rise in health care spending as a percentage of national gross domestic product.

Economic futurist Ian Morrison believes that as the payment incentives shift, health care providers will go through a classic modification in their core models for business and service delivery. He refers to the volume-based environment hospitals currently face as the *first curve* and the future value-based market dynamic as the *second curve*. Progressing from the *first curve* to the *second curve* is a vital transition for hospitals. This is analogous to having one foot on the dock and one foot on the boat—at the right point, the management of that shift is essential to future success. Within this environmental context, the report is structured as a first step in an ongoing dialogue with the hospital community for identifying and implementing key strategies, tactics, and measures that hospitals may employ for success.

Recommendations

This report groups the findings into four major sections:

1. **Must-do strategies accompanied by case studies profiling hospitals who have taken on those challenges;**
2. **Second-curve metrics to aid in measuring success of the implemented strategies;**
3. **Organizational core competencies that should be mastered; and**
4. **Self-assessment questions to assist in understanding how well the competencies have been achieved.**

Must-Do Strategies

Ten must-do strategies were identified for the hospital field to implement; however, the first four were identified as major priorities.

1. Aligning hospitals, physicians, and other providers across the continuum of care
2. Utilizing evidenced-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”

Additionally, it was noted that organizational culture is an essential foundation to the success of the strategy execution. A culture of performance improvement, accountability, and high-performance focus is critical to enhancing the organization’s ability to implement strategies successfully. The right culture will enable the transformation to the hospital and care system of the future.

In this report, each of the major strategies is accompanied by at least one example from a hospital-based best practice. In addition to being described on the page itself, all of the case studies are available at <http://www.hpoe.org>.

Second-Curve Metrics

Second-curve metrics are identified to assist in measuring the success of the top four priority strategies.

Aligning hospitals, physicians, and other providers across the continuum of care

- Number of “aligned and engaged” physicians
- Percentage of physician and provider contracts with quality and efficiency incentives aligned with ACO-type incentives
- Availability of nonacute services
- Distribution of shared savings/performance bonuses/gains to aligned physicians and clinicians
- Number of covered lives accountable for population health—e.g., ACO/medical home-covered lives
- Number of providers in leadership

Utilizing evidenced-based practices to improve quality and patient safety

- Effective measurement and management of care transitions
- Management of utilization variation
- Preventable admissions, readmissions, ED visits, and mortality
- Reliable patient care processes
- Active patient engagement in design and improvement

Improving efficiency through productivity and financial management

- Expense per episode of care
- Shared savings or financial gains from performance-based contracts
- Targeted cost reduction goals
- Management to Medicare margin

Developing integrated information systems

- Integrated data warehouse
- Lag time between analysis and availability of results
- Understanding of population disease patterns
- Use of health information across the continuum of care and community
- Real-time information exchange
- Active use of patient health records

Core Organizational Competencies

Organizations that are beginning to implement the must-do strategies will seek to achieve competency in several areas of care delivery and organizational management. Similar to the strategies, these competencies are intrinsically connected and aligned.

1. Design and implementation of patient-centered, integrated care
2. Creation of accountable governance and leadership
3. Strategic planning in an unstable environment
4. Internal and external collaboration
5. Financial stewardship and enterprise risk management
6. Engagement of employees' full potential
7. Collection and utilization of electronic data for performance improvement

Self-Assessment Competency Questions

For an organization to track how successful it has been in establishing the core organizational competencies, the following set of questions can serve as a guide for self-assessment.

Design and implementation of patient-centered, integrated care

- Have we developed a clear and compelling approach to clinician alignment and integration?
- Are we developing sufficient capabilities to measure, manage, and improve the quality and efficiency of patient care across the continuum of care?
- How are we rapidly assimilating best practices into clinical medicine?
- What is our role in improving overall population health?

Creation of accountable governance and leadership

- Does the board drive the organizational strategy for moving toward the second curve while assessing the balance of risks and rewards?
- Does the board have an explicit succession planning process in place to ensure the selection and development of leaders with the right attributes?
- Does physician/clinician engagement in governance and management activities reflect their emerging roles as economic and clinical partners?
- Does the board have the appropriate competencies for executing the must-do strategies?
- Is there transparency in the communication of patient outcomes, financial results, and community benefit to the community?

Strategic planning in an unstable environment

- Do we have a clear/compelling vision for the second curve?
- Do we have a plan and timeline for moving toward the second curve of value-based care delivery, as compared to current financial incentives?
- What is the necessary mix of inpatient beds, ambulatory facilities, physicians, midlevel providers, and emerging technologies to meet future demand?
- What size and scale of our organization will be sustainable in the future?
- Should our organization explore new strategic partnerships? What type of organization best meets our needs while still fitting with our mission?
- Are we utilizing scenario-based planning techniques to monitor key changes in our assumptions and making necessary adjustments?
- Do we assess the health needs of the community we serve? Do we also identify potential partners to improve access to necessary care?

Internal and external collaboration

- Have we examined our mission to determine if we can financially sustain high quality in all of the services we currently provide?
- How well are we developing trust within our organization?
- What is our desired culture? Does it value collaboration, accountability, transparency, excellence, patient focus, and similar core values?
- Are our leaders “role models” for a collaborative culture?
- Are we considered a valuable partner to physicians and other organizations within the community?
- Do we know our partners well enough?

Financial stewardship and enterprise risk management

- Do we have a capital investment plan for testing strategic activities in payment pilot projects and health management strategies (e.g., service line management, population health, use of health information technologies)?
- Can we measure revenues and expenses by each clinical service?
- Are we utilizing an annual enterprise risk management assessment?
- Have we identified long-term financial goals and a plan to get there?

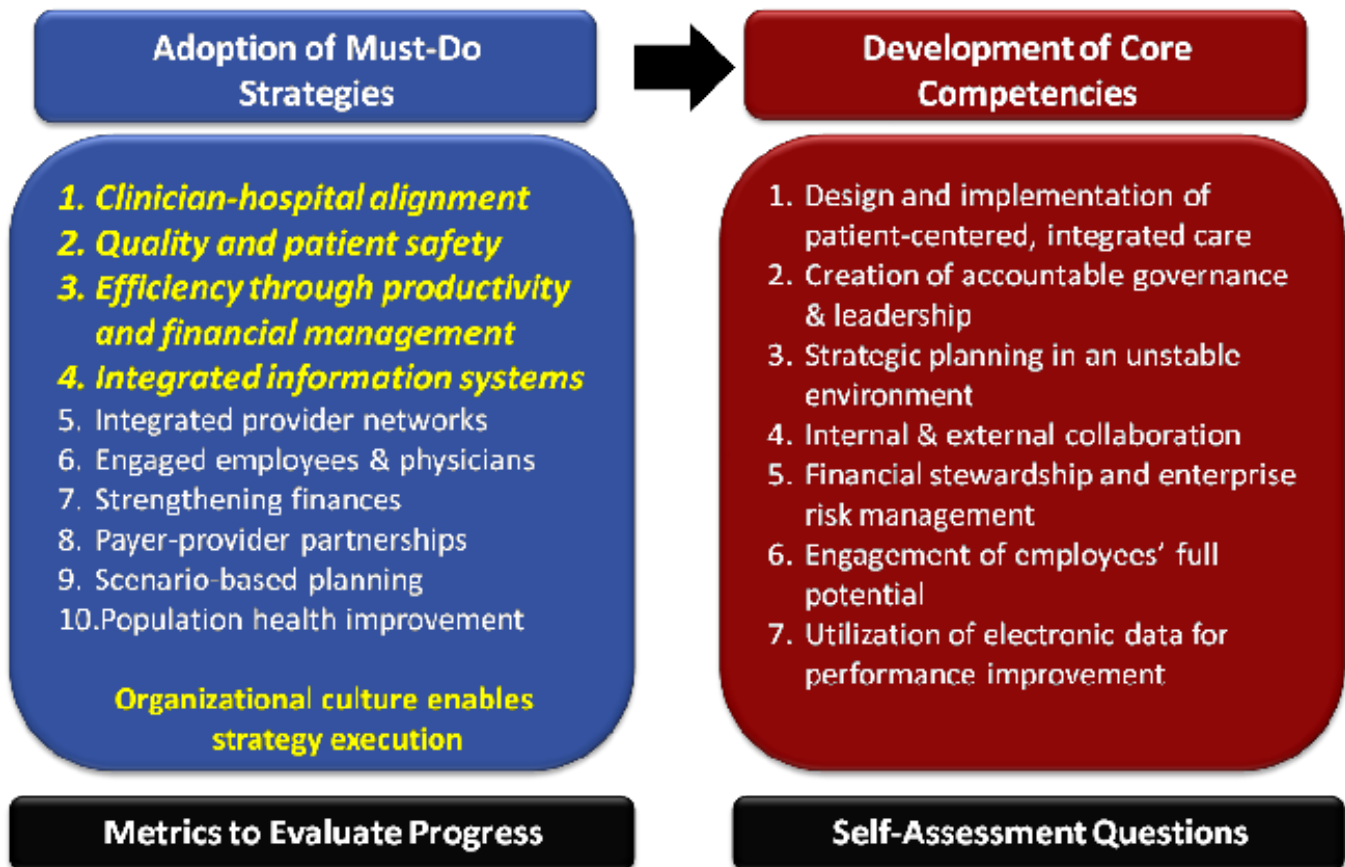
Engagement of employees’ full potential

- What is our strategy for employee and physician partner engagement?
- Are our employee and physician recruitment and retention systems aligned with our strategic direction and desired culture? For example, how are we assessing performance and values of collaboration?
- Are we a learning organization? How are we developing the knowledge and skills of physicians, middle managers, employees, and senior executives?

Collection and utilization of electronic data for performance improvement

- When will our information systems bring all pertinent information to the point of care?
- How far along are we in achieving digital connectivity among providers and with patients?
- How often is the data collected from information systems reviewed at clinical and administrative team meetings? What data is brought to senior leadership’s attention?

The following diagram outlines the linkage of the four major elements: (1) must-do strategies to be adopted; (2) second-curve metrics to aid in measuring success; (3) organizational core competencies that should be mastered by the end of the decade; and (4) self-assessment questions to assist in understanding how well the competencies have been achieved.



Introduction and Approach

Driving the Change

Hospitals and health systems face unprecedented pressure to change both in the near- and longer-term future. Industry experts have projected that multiple, intersecting environmental forces will drive the transformation of health care delivery and financing over the next decade. These influences include:

- Demand-altering demographic changes
- Employer, government, and consumer pressure to curb the unsustainable increase in health care spending
- Shift in financial incentives away from fee-for-service reimbursement in favor of value-based payments that reward positive outcomes and efficiency
- Rise in provider accountability for the cost and quality of health care
- Consistent demand to reduce care fragmentation by redesigning care delivery
- Increased transparency of financial, quality, and community benefit data
- Projected shortages of nurses, primary care physicians, and other health care providers to match population demand
- Persistent introduction of high-cost medical technology and pharmaceutical advances
- Difficulty in raising capital to meet the strategic needs for new facilities, medical technology, and information systems
- Uncertainty about federal and state health care reform legislation and regulation
- Overall decline in reimbursement
- Recognition and challenge to variations in care provisions and, as a result, cost

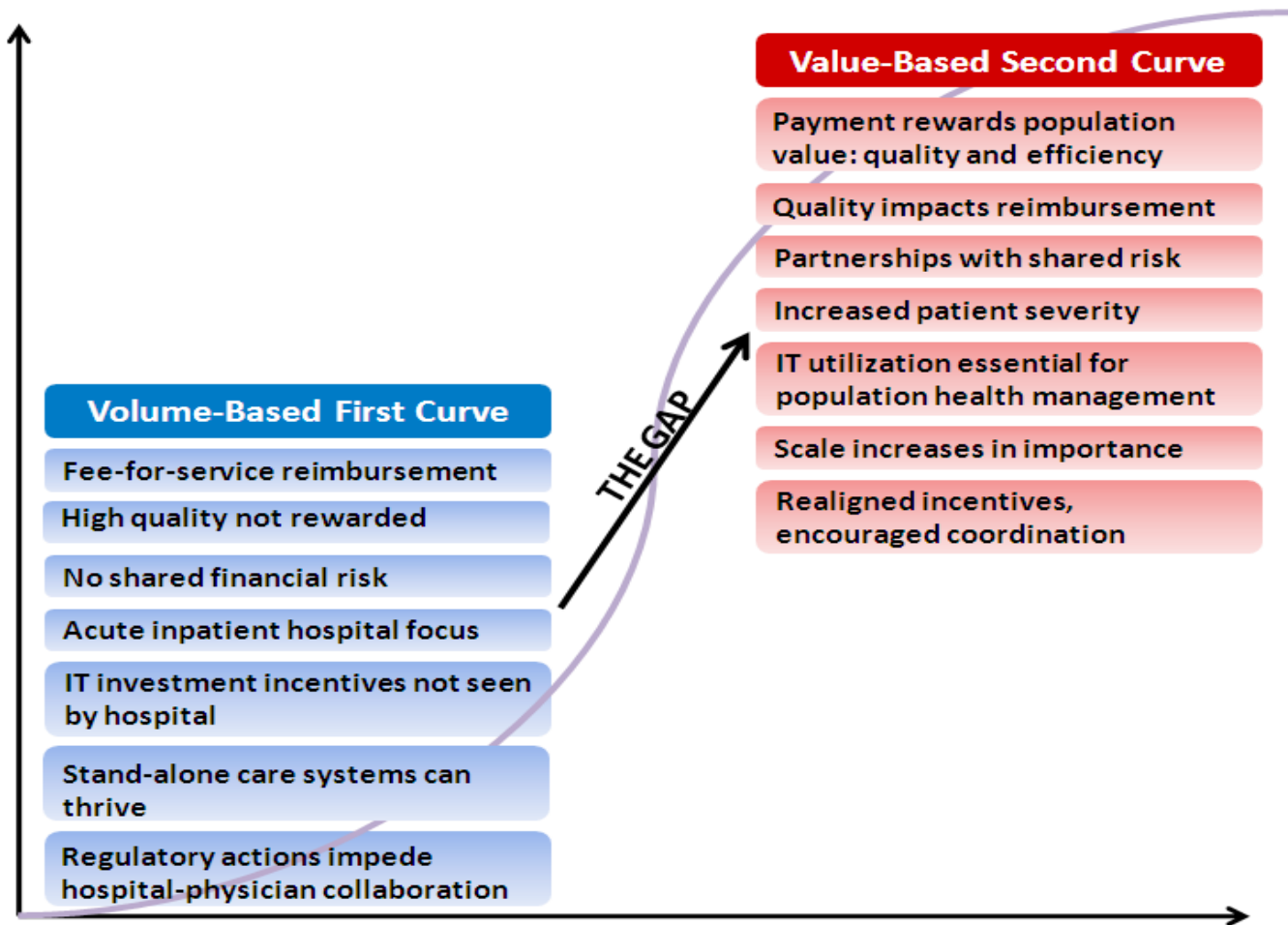
First Curve to Second Curve

These changes are transformational and are the most considerable concerns confronting health care leaders. They are agitating the economic incentives that drive patient, provider, and payer behavior. Economic futurist Ian Morrison believes that as payment incentives shift, health care providers will modify their core models for business and service delivery. He calls this a first-curve to second-curve shift.

As displayed in Figure 1, Morrison details the *first curve* as an economic paradigm driven by the volume of services provided and fee-for-service reimbursement. The *second curve* is concerned with value: the cost and quantity of care necessary to produce desired health outcomes within a particular population.

For example, in the first curve, hospitals and physicians are reimbursed different amounts for a patient's joint replacement surgery depending on the number and coding of surgeries, office visits, implants, and related services. If complications occur, divergent incentives generate more payments to the provider. As reimbursement moves toward second-curve economics, integrated hospital-physician teams will share payment for joint replacements and may be penalized for avoidable readmissions and complications. In return, these integrated care networks may be rewarded for shared savings, quality improvements, and use of best practices. Potential partnerships with health plans may form to share savings from keeping patient populations healthier, such as reducing obesity that increases the joint wear and tear.

Figure 1: First Curve to Second Curve



Life in the Gap

The most significant strategic issue for hospitals and health systems is establishing the transition rate from first-curve to second-curve economics in their respective markets. Morrison refers to this period as *life in the gap*.

Managing this period is an evolving equilibrium. Providers that entirely implement second-curve economics before the market is ready may see significant revenue reduction. For example, one health system executive said that his organization has taken \$400 million out of expenses while improving overall quality overall, but the majority of the savings has been realized by the insurance companies.

Conversely, providers that remain in the first curve for too long and do not sufficiently organize themselves will be deficient in the capabilities to succeed when the market transition is complete. *Life in the gap* is challenging on its own; as the number of pilot programs continues to grow and programs are eventually implemented, each individual institution will have to determine the appropriate time for them to make the leap to the second-curve market for the individual aspects of care. In health care, this will require a willingness of all parties—insurers, providers, consumers, and the government—to enter into shared-savings arrangements.

Approach

In 2011, the AHA conducted telephone and in-person interviews with senior leaders from health systems, hospitals, and stakeholder organizations. These interviewees, listed in **Appendix A**, represent a cross-section of providers, including safety-net and specialty hospitals; in urban, suburban, and rural communities; with tertiary, community, and critical-access facilities; and hospitals with independent medical staffs as well as those with closely integrated medical groups.

Interviewees overwhelmingly refrained from describing the organizational models of the “hospital of the future” with much specificity due to the large degree of uncertainty surrounding national health care policy platforms and upcoming payment models. However, the majority of leaders believe hospitals will evolve to become part of “care systems” or “integrated networks,” encompassing everything from home-based chronic care management to inpatient acute treatment.

The AHA Committee on Performance Improvement synthesized the results of the interviews, identifying the strategies for organizations to consider and the core organizational competencies developed from adoption of each of the specific actions; all are critical to survival in the second-curve economic dynamic. To prioritize the results, the strategies and aligned core organizational competencies were put in front of each of the nine AHA regional policy boards during June of 2011. The members voted on the most urgent of the strategies, developing the priority list. Accompanying each of the strategies is at least one example of how a hospital is following the strategy to reach the second curve. Although written summaries are provided within the report, the case studies are all available on <http://www.hpoe.org>.

Overall, the results provide a well-organized summary of the most important priorities of health care leaders from organizations of all sizes and geographic locations. The report serves to articulate a broad vision of the future and identify the right questions leaders should ask to chart their organization’s path. The description of strategies, core competencies, and suggested metrics can shape leaders’ strategic thinking about the future.

Assumptions Drive Strategic Planning Initiatives

The interviews for this report indicated that leaders are making a number of assumptions about the future that serve as the foundation for their strategic planning processes. Although large portions of this report express the uncertainty hospital leaders feel about the future and the shift from the first to second curves, strategic planning necessitates the creation of certain hypotheses which serve as the foundation of strategic plan development and capital investment. Such a foundation represents the “expected scenario” and therefore forms the basis not only for articulating a vision and strategic plan, but also for periodically reassessing the organization’s strategic direction in the context of a fast-changing environment and making necessary adjustments. The synthesis of the assumptions revealed from the interviews is detailed in **Appendix B**.

Must-Do Strategies Lead to Second-Curve Core Competencies

The results of the interviews indicated that there are two categories of elements critical to success in the second-curve market: actionable strategies and core competencies. The must-do strategic approaches are actions that organizations must take now to succeed in the first curve, in addition to managing life in the gap until value-based payment pushes institutions into the second-curve dynamic. Before adopting any of the strategies listed on the following pages, organizations must develop a culture that enables performance improvement, high reliability, and accountability.

Implementing the strategies will aid organizations in developing the second-curve core organizational competencies, which are longer-term organizational capabilities that will be crucial for survival in a new market focused on economic value, quality outcomes, service coordination, performance accountability, information transparency, and patient access.

As described previously, the strategies necessary to establish the core competencies are not going to be the same for every hospital and will depend on the organization's own capabilities, external collaboration potential, and the market. Additionally, the strategies are nonexclusive, meaning organizations cannot expect to pursue only one of the must-do strategies and succeed on the second curve. For example, it is difficult to focus on improving patient safety, quality, and efficiency without developing integrated information systems.

On each of the top-priority strategies, metrics¹ are listed which can help organizations measure the success of their institution in these actions.

Must-Do Strategies

Ten must-do strategies were identified for the hospital field to implement; however, the first four were identified as the major priorities.

1. [Aligning hospitals, physicians, and other providers across the continuum of care](#)
2. [Utilizing evidenced-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”](#)

Additionally, it was noted that organizational culture is an essential foundation to the success of the strategy execution. A culture of performance improvement, accountability, and high-performance focus is critical to enhancing the organization's ability to implement strategies successfully. The right culture will enable the transformation to the hospital and care system of the future. With each of these strategies is a case study, profiling organizations that have effectively implemented these strategies in a way that is amenable to their culture.

¹ Moody's Investors Service, Special Comment: Achieving Greater Cost and Quality Accountability will be Credit Positive for not-for-Profit Hospitals in Era of Reform, May 2011.

Second-curve metrics

Second-curve metrics are identified to assist in measuring the success of the top four priority strategies.

Aligning hospitals, physicians, and other providers across the continuum of care

- Number of “aligned and engaged” physicians
- Percentage of physician and provider contracts with quality and efficiency incentives aligned with ACO-type incentives
- Availability of nonacute services
- Distribution of shared savings/performance bonuses/gains to aligned physicians and clinicians
- Number of covered lives accountable for population health—e.g., ACO/medical home covered lives
- Number of providers in leadership

Utilizing evidenced-based practices to improve quality and patient safety

- Effective measurement and management of care transitions
- Management of utilization variation
- Preventable admissions, readmissions, ED visits, and mortality
- Reliable patient care processes
- Active patient engagement in design and improvement

Improving efficiency through productivity and financial management

- Expense per episode of care
- Shared savings or financial gains from performance-based contracts
- Targeted cost reduction goals
- Management to Medicare margin

Developing integrated information systems

- Integrated data warehouse
- Lag time between analysis and availability of results
- Understanding of population disease patterns
- Use of health information across the continuum of care and community
- Real-time information exchange
- Active use of patient health records

Strategy #1: Aligning hospitals, physicians, and other providers across the continuum of care

Over the past three decades, the relationship between physicians and hospitals has evolved from necessary association to competition to interdependency. The market and regulatory forces leading to tight budgets and second-curve economics are putting pressure on both sides to pursue physician employment and other alignment strategies. Hospitals are partnering with physicians to improve care coordination, reducing unnecessary admissions. Physicians seek partnerships with acute-care providers in the face of higher administrative costs and the threat of lowered payments through Congressional action on the sustainable growth rate. Seventy-four percent (74%) of hospital leaders participating in a 2010 survey revealed that they planned to increase the number of their employed physicians over the next year.² However, the interviewees overwhelmingly said that simply employing physicians does not effectively secure alignment beyond financial incentives. To succeed and move to the second curve, hospitals must collaborate with physicians and all other clinical providers not only on financial goals but also on quality and strategic objectives. This can only be accomplished through open and regular communication of progress. Successful alignment arrangements across the care continuum will create a system where all parties are accountable and rewarded for achieving high performance, reaching patient-centered goals, and allowing for an advantageous transition into the value-based payment systems.

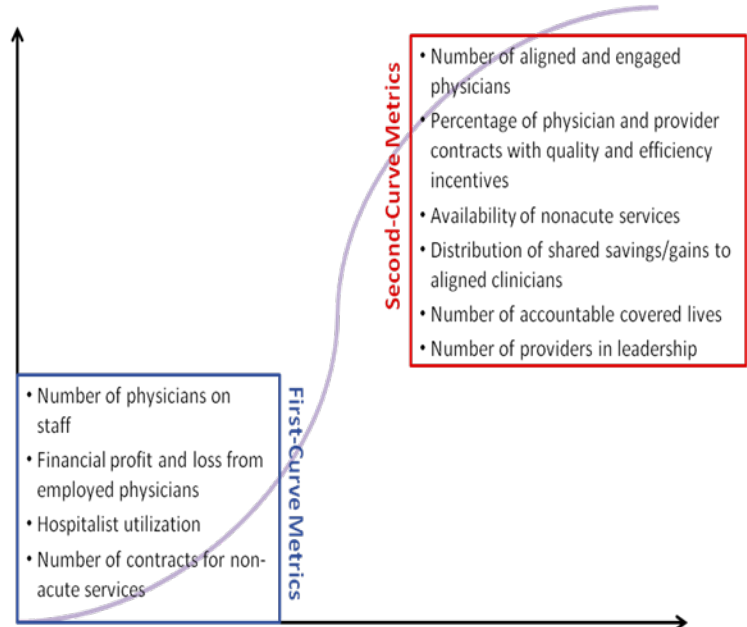
Wenatchee Valley Medical Center Wenatchee, Washington

Background: WVMC has a multisite clinic associated with 190 physicians and 86 nurse practitioners treating 160,000 patients and providing 750,000 ambulatory visits annually.

Analysis found that 48% of Medicare costs were due to ER visits and inpatient hospital charges, making their priority to reduce unnecessary ER visits and readmissions. WVMC engaged in a three-year CMS demonstration project to work with high-risk, high-cost-Medicare beneficiaries to reduce their costs of care.

What they did: WVMC created an effective approach to secure provider involvement throughout the process by: (1) holding preliminary meetings with all providers to gain momentum, ask for input, and create a “shared vision” on the project, (2) acting on provider suggestions for improvement throughout the engagement, (3) economically incenting group physicians with shared-savings agreements and outside physicians with upfront payments, and (4) creating a collaborative culture by releasing data as soon as it was available, including patient testimonials, and congratulating providers on strong performances.

Results: WVMC saw a decrease in inpatient admissions, length of stay, ER visits (17.7%), and SNF days as well as an 18% increase in outpatient visits, with the majority of benefit realized within the chronic heart failure population. Quality metrics increased, and the cost of providing care to the experimental group as compared to the control group decreased.³

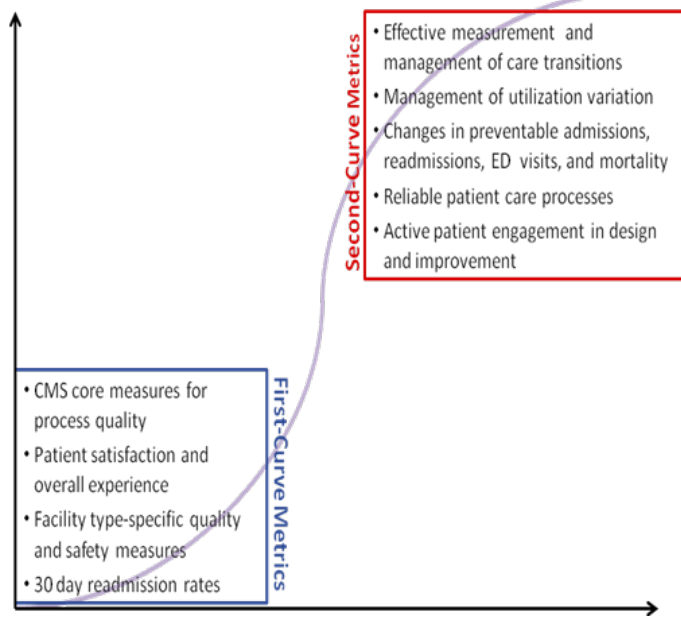


2 Cantlupe, J. Physician Alignment in an Era of Change. *HealthLeaders Media Intelligence*. www.healthleadersmedia.com/intelligence, Sep. 2010. Accessed July 2011.

3 Freed, SD. Delivering Patient-Centered, Accountable Care. *AHA Health Care System Reform Fellowship Retreat 3: Physician Alignment and Clinical Integration*. July 14, 2011. San Diego, CA.

Strategy #2: Utilizing evidence-based practices to improve quality and patient safety

Increasing quality and patient safety in health care has been a significant hospital-based objective for more than a decade. Although considerable gains have been made within defined areas, moving to the second curve requires widespread expansion of these programs. Medicare spent \$17 billion, or 20%, of all Medicare payments on unplanned readmissions in one year.⁴ Therefore, reimbursement is scheduled to eliminate payment for unnecessary readmissions in 2013, increasing the demand for quality in health care. Potential new value-based models tie quality metrics to financial reimbursement, and facility accountability will only increase. Several methodologies have been employed in this mission, ranging from evidence-based medicine and patient-focused care delivery to practice bundles and multidisciplinary team training. Additionally, organizations noted that reviewing patient satisfaction scores and changing accordingly is essential to obtain higher-quality scores in the future. High-quality care in the first curve is based on core measure improvement and sustainability of those values over time in addition to patient satisfaction scores. Moving to the second curve requires measurement, analysis, and reduction of clinical variation to improve quality.



High-quality care in the first curve is based on core measure improvement and sustainability of those values over time in addition to patient satisfaction scores. Moving to the second curve requires measurement, analysis, and reduction of clinical variation to improve quality.

Flowers Hospital Dothan, Alabama

Background: Flowers Hospital has 235 licensed beds, with a daily census averaging 160 patients. Flowers' CMS core measure scores were in the 85%–90% range. Through analysis, the team realized it was the delay in identifying the higher-risk patients, which led to lower outcomes.

What they did: Working with patients who experienced heart failure or pneumonia, the approach utilized a nurse reviewer to identify patients early and monitor their progress to ensure that appropriate

care was provided. Floor staff received a color-coded packet to assist them in delivering the appropriate and expected care. To secure long-term longevity of potential improvements, multidisciplinary teams reviewed cases which failed and modified the recommended processes, if necessary.

Results: Flowers Hospital attained a 99.7% compliance rate with CMS core measures in 2007, the second highest score in the country. In future initiatives, Flowers is going to spread the same efforts to prevent several hospital-acquired conditions, which are tied to financial reimbursement.⁵

Borgess-Lee Memorial Hospital Dowagiac, MI

Background: BLMH is a 25-bed critical access hospital that was seeing a spike in the number of hospital-acquired urinary tract infections due to unnecessary provisions of urinary catheters.

What they did: BLMH created cards which were distributed at medical staff meetings, documenting appropriate times to utilize catheters and when not to, and they assigned a point person to monitor each patient for appropriate catheter usage. The results were shared with the staff. Hourly rounding was implemented to monitor urinary catheters.

Results: BLMH reduced indwelling catheter usage by 25%, and appropriate use of catheters has reached 90%.⁶

For more information on reducing readmissions, please see HPOE's **Health Care Leader Action Guide to Reduce Avoidable Admissions** (<http://www.hret.org/care/projects/guide-to-reduce-readmissions.shtml>)

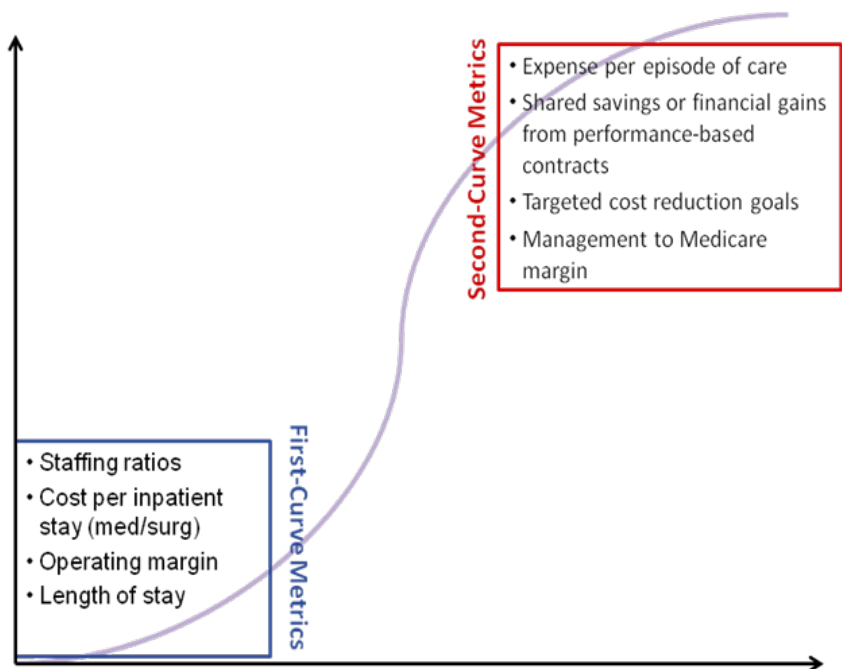
4 Jencks, SF et al. "Rehospitalizations among patients in the Medicare Fee-for-Service Program," *N Eng J Med* 2009. 360(14): 1418-1428.

5 Edwards, J. Flowers Hospital: Nearing Perfection on Core Measures. *The Commonwealth Fund*. December, 2008.

6 Borgess-Lee Memorial Hospital. Michigan Critical Access Hospital Best Practices 2010. MPRO. Accessed at www.mpro.org

Strategy #3: Improving efficiency through productivity and financial management

The demand for increased efficiency through productivity and financial management improvement is felt on all sides of the acute-care organization. For providers, the combination of a 29% increase in the primary care workload by 2025 with only a 2%–7% growth in the number of providers demands increased efficiency.⁷ The renewed focus by government and payers on quality-based reimbursement combined with tightening margins commands hospital leadership to eliminate duplicative efforts and standardize processes through a combination of operational improvements (such as Lean process design/Six Sigma) and redesigned care-delivery models. While some interviewees said that their organizations have achieved greater efficiency and cost management through a renewed focus on quality and access, others have said that financial margins are always considered throughout process improvement projects.



North Mississippi Medical Center

Tupelo, Mississippi

Background: NMMC is a 650-bed teaching hospital serving the northern half of Mississippi and part of Alabama. A member of the five-hospital Northern Mississippi Health Services, the system also includes 34 primary and specialty care clinics. The efficiency-based projects have two different goals: to improve patient satisfaction in the ED and to increase standardization in purchasing.⁸

ED project: A community-based survey told hospital administration that patients were extremely dissatisfied with the ED's atmosphere and wait times. After analyzing their challenges and capabilities, NMMC undertook several projects that would streamline the diagnostic and treatment processes, therefore increasing efficiency. The NMMC projects included instituting bedside triage, placing a computer in every room to provide physicians with histories and test results in the most convenient place, creating the ability to view and take X-rays in each patient room, and installing a computerized tracking system to increase knowledge of patient flow. These improvements, combined with other strategies, aided in reducing the average total time that patients spend in the ED by two to three hours.

Purchasing project: NMMC standardized orders for types of products in the purchasing department. To ensure that they purchased the best products, each potential supply enters a trial period, in which opinions of physicians and other providers are solicited in addition to thorough investigation of outcomes. Not until clinicians confirm buy-in are the supplies made standard. Standardization allows the hospital to keep more inventory on hand, buy in larger bulk to decrease price per item, reduce complications that arise during trainings, and decrease practice variation across physicians. In total, annual supply costs were reduced by almost \$3 million.⁹

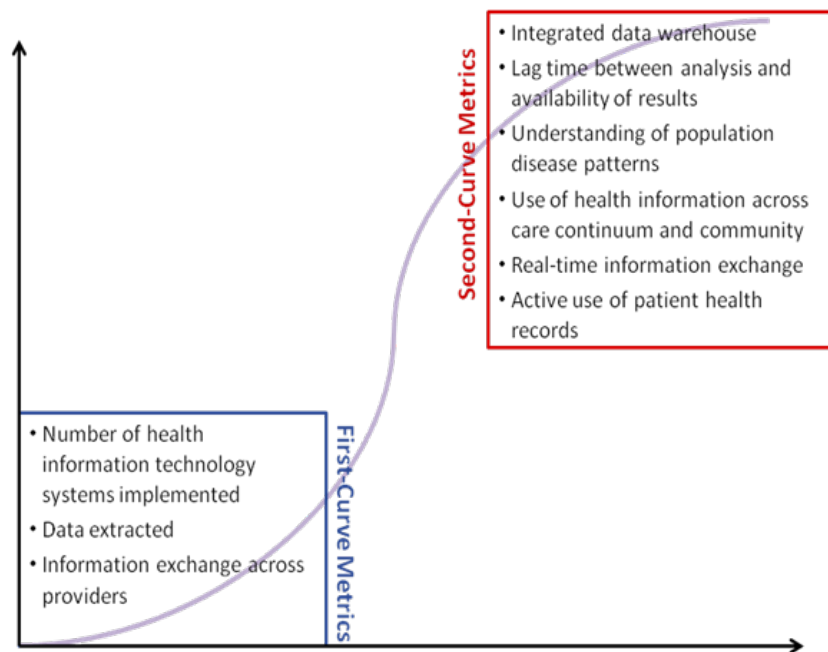
⁷ Bodenheimer, T et al. Primary Care: Current problems and proposed solutions. *Health Affairs* 2010. 29:799-805.

⁸ Edwards, JN et al. Achieving Efficiency: Lessons from four top-performing hospitals. *The Commonwealth Fund*. July 2011.

⁹ Silow-Carroll, S. North Mississippi Medical Center: Improving efficiency through hospital, system, and community-wide practices. *The Commonwealth Fund*. July 2011.

Strategy #4: Developing integrated information systems

The policy arena has positioned health information technology (HIT) as a key initiative to decrease costs within the health system through reductions in administrative overhead, duplicative tests, paperwork, and medication errors. While the Health Information Technology for Economic and Clinical Health (HITECH) Act within the American Recovery and Reinvestment Act (ARRA) in 2009 provided a financial incentive for physicians and hospitals to adopt electronic health records, the interviews revealed that the organizations who installed IT



systems have found that the literacy, cultural, and work flow barriers were much more critical than the cost barrier to successful implementation. Well-established and utilized systems are critical to future success in the second curve, connecting providers and providing critical real-time information to actively plan, measure, and improve efficiency and quality everywhere, from the bedside to the C-suite. It is not enough just to possess information systems or extract the important data. The ability of an organization to leverage the technology to perform sophisticated data mining and analysis in real time for continuous care improvement is critical for long-term organizational sustainability.

Piedmont Clinic Atlanta, Georgia

Background: Piedmont Clinic is a physician hospital organization consisting of four hospitals and almost 700 physicians, of which 250 are employed by the hospitals. Although organized as an integrated system, Piedmont faced a data challenge similar to other organizations: several sources of electronic data were incompatible for analysis.

What they did: Piedmont created Clinical Integration Trust (CIT), a single data warehouse designed to be used for clinical integration, population health analysis, and quality improvement and reporting. This one source combined recorded information on patient satisfaction, core measures, Physician Quality Reporting Initiative (PQRI), overall population health statistics, and billing. This information is available in real time without analytical delays. Providers and administrators can access the results daily and examine them for trends over time. To ensure understanding and procedure compliance, the CIT team initially met with each physician practice individually.

Results: Information that had never been readily available was retrievable with ease. Provided with daily updates of the data critical to their specific functions, both senior management and providers were able to adjust their functions to improve outcomes. Prior *inpatient* hospital-based quality initiatives had delivered 10% improvement over time, while within nine months CIT had improved *overall* performance by 11%.¹⁰

For more information, please see HPOE's **Health Care Leader Action Guide on Implementation of Electronic Health Records** (<http://www.hret.org/quality/projects/health-care-leader-action-guide-on-implementation-of-ehr.shtml>)

¹⁰ Hamby, LS et al. Integrated quality measures improve patient safety and care. *Patient Safety and Quality Healthcare*. November/ December 2010.

Strategy #5: Joining and growing integrated provider networks and care systems

The interviews revealed that the large majority of organizations have already, are in the process of, or are planning on extending their care reach. These expansions come in a variety of forms: mergers; co-management agreements; acquisitions; alignment with physicians; and strategic alliances of hospitals, ambulatory facilities, physician groups, and other providers. In a challenging environment, organizations have recognized that arrangements with well-chosen and directed partnerships with joint accountability to outcomes and cost measurement provide the opportunity and scalability to coordinate care, improve quality, increase efficiency, leverage expensive technology, increase profitability, and achieve service excellence. As the second curve commands a dedication to the overall patient population, these expanded affiliations facilitate an organization's ability to manage patient health across the continuum. Beyond traditional acute-care partnerships, health systems will begin to collaborate with community health, public health, government agencies, education departments, and criminal justice systems, developing a new competency for many management teams. While interviews revealed that the same model will not be successful for every organization, the thriving relationships all benefited each party involved in the transaction.

Hoag Hospital Newport Beach

Newport Beach, California

Background: A 489-bed member of the two-facility Hoag Memorial Hospital, HHNB was seeing such a large volume of orthopedic cases that the ORs were constantly occupied with small-margin cases.

What they did: HHNB established a joint-venture/co-management agreement to create the Hoag Orthopedic Institute with 30 surgeons, 70 beds, and 9 ORs, overseen by joint governance and leadership.

Results: The institute performed over 1,600 joint replacements in its first 10 months of operation (above the annual average of 1,200). The increased economies of scale have improved quality. No hospital-acquired infections were recorded in 500 hip replacements. Margins have improved, with a 30% decrease in the overall cost per case.¹¹

Johns Hopkins Medicine Baltimore, Maryland All Children's Hospital St. Petersburg, Florida

Background: Johns Hopkins Medicine (JH) is financially successful and wanted to expand its reach of care beyond its immediate market area. Simultaneously, All Children's Hospital (AC) was assuming debt and faced decreased Medicaid payments.

What they did: JH essentially acquired AC—its first hospital outside of the Baltimore-D.C. area—without any financial exchange. This agreement provides JH with an opportunity to expand its market into Florida as well as potentially in the Caribbean and South America. AC does not give up ownership of its daily operations and will increase its research capabilities as well as the supply of primary care physicians through additional residency programs to meet the area's demand.¹²

¹¹ Cox, J. Physician Alignment/Clinical Integration: A Place for Co-Management Agreements. Presentation to AHA Health System Reform Fellowship. July 14, 2011.

¹² Hundley, K. Ripples from All Children's-Johns Hopkins merger could touch many. *St. Petersburg Times*. July 21, 2010.

Strategy #6: Educating and engaging employees and physicians to create leaders

Several of the interviewees relayed that the power and success of their organization is completely based on the culture, desire, and dedication of their employees. To thrive in a second-curve market, every clinical and administrative employee must be involved in initiatives to control expenses, improve efficiency, increase quality, and understand the new accountability that hospitals have to overall population health. Interviewees emphasized that change is going to happen, and that their respective organizations must train a new breed of administrative and clinical leadership to manage that change effectively. This can be accomplished with a variety of educational and involvement strategies. Organizations noted that even small engagement in employee health and wellness programs positively impacted turnover rates. As physicians continue to become better aligned with the interests of acute-care facilities, it is a necessity to provide leadership training to clinicians who may be able to guide the integration process.¹³

Henry Ford Health System

Detroit, Michigan

Background: One of the country's largest health systems, Henry Ford Health System achieves more than 3.1 million patient contacts annually, providing care for the large majority of Southeastern Michigan. Almost a decade ago, HFHS was struggling financially and facing high turnover with dissatisfied providers and administrative staff. It became obvious that HFHS needed to change its culture, and the health system began by focusing on learning and development.

What they did: Beginning with just one general program, HFHS now offers five separate leadership and development academies for its own employees, specific to each group's needs. The Renewal Program, offered to all employees, is a two-day workshop that focuses on successful management behavior. The Leadership Academy includes 50 to 60 midlevel managers every year, and participants are selected by upper-level management. The New Leader Academy is required for any individual new to a managerial position. The Advanced Leadership Academy serves employees already at a higher level within the organization who display the potential to become senior leaders within the next three to five years. Finally, although physicians participate within the other academies as well, HFHS still recognized their unique needs and created the Physician Leadership Institute.

Results: Although these statistics are not released publically, HFHS analyzes the program's impact on the performance of the individuals participating in the programs as well as the departments where they are applying their new knowledge. Overall, HFHS reports that the continued presence, expansion, and utilization of these programs has led to diminished turnover (as compared to those not involved in the programs), higher promotion rates, greater engagement, and generally better performance.¹⁴

For more information please see HPOE's guide **Using Workforce Practices to Drive Quality Improvement: A Guide for Hospitals** (<http://www.hret.org/workforce/index.shtml>).

¹³ Bakhtiari, E. Don't Skimp on Physician Leadership Development. *HealthLeadersMedia*. March 12, 2009. Accessed August 2, 2011.

¹⁴ Sinioris, M. Best practices in healthcare leadership academies. The National Center for Healthcare leadership. 2010.

Strategy #7: Strengthening finances to facilitate reinvestment and innovation

Hospitals must prepare for tightening margins. The future of decreased reimbursement and a more severe case-mix commands today's organizations to find the means to cut costs and improve their operating margin without sacrificing any quality in the care provided. Simultaneously, technologies are being designed that significantly improve outcomes but are also a huge financial investment for the majority of institutions. Interviewees commented that without maintaining or improving current operating margins, they would not have the financial resources to perform any of the other must-do strategies such as focusing on quality and patient safety, creating strategic alliances with physicians and other providers, or engaging employees. To achieve the financial status desired for future innovation, organizations will have to fix their current service offerings, capital, and management structure to meet the needs of their population and reduce fixed costs throughout their budget.

Novant Health

Charlotte, North Carolina

Background: Novant Health is a 13-hospital integrated health care system centered in Charlotte and Winston Salem with an extended service area covering North Carolina, South Carolina, Virginia, and Georgia. As with most organizations, Novant was concerned about future potential payment reductions.

What they did: Novant transferred from cost shifting to a payer-neutral revenue (PNR) system, essentially considering all payers as if they were Medicare to prepare for the days of lower payment. They analyzed the resulting data in various ways as a means to reduce variation between organizations and providers and establish best practices. The new evidence-based practices were presented to hospital leadership and put into place systemwide to increase standardization across the system.

Results: After the first round of analysis, Novant identified 12 opportunities to trim more than \$24 million in variation, ranging from differences in labor costs between two different imaging facilities to a 25% cost differential between joint replacement surgeries in their top-performing orthopedic programs. Their operating margin was significantly better in the first few months of 2009, 4.5% compared to 1.5% for the same period the year prior. Costs improved from being at 20% of Medicare reimbursement in 2008 to 16% after the variation analysis was performed.^{15, 16}

For additional information please see HPOE's **Striving for Top Box: Hospitals Increasing Quality and Efficiency** (<http://www.hret.org/topbox/index.shtml>) and HPOE's **A Guide to Financing Strategies for Hospitals – With Special Consideration for Smaller Hospitals** (<http://www.hret.org/financial-strategies/index.shtml>).

¹⁵ Striving for Top Box: Hospitals increasing quality and efficiency. Hospitals in Pursuit of Excellence. www.hpo.org accessed August 11, 2011

¹⁶ Weinstock, M. A model for efficiency. *Hospitals and Health Networks*. July 2009. Accessed August 11, 2011.

Strategy #8: Partnering with payers

As hospitals undertake several quality and patient safety initiatives to improve overall care in the current fee-for-service reimbursement system, savings have the potential to be realized mostly by the payer if new agreements are not signed. Additionally, as CMS and private payers increasingly reward clinical integration and high-quality care, health care organizations will need to assume greater accountability. For these reasons, the majority of interviewed organizations has considered or has already entered into contractual arrangements with payers to align the risk and rewards of new projects and payment systems. It is not expected that accountable care organizations will be the appropriate arrangement for all organizations. However, it is essential for organizations to work closely with their clinical staff throughout the negotiation process, to receive buy-in, and to expose the means by which clinical quality improvements might be able to reduce costs overall.

Advocate Health Care

Chicago, Illinois

Background: Advocate Health Care is the largest health care system within Chicago and its surrounding suburban areas. Growing in prominence and market share over the past few years, the health system partnered with over 3,800 of its affiliated physicians to become Advocate Physician Partners and work to integrate and improve patient care. However, Advocate encountered a Chicago market with an unsecure future, and it wanted to prove the value of clinical integration to payers as well.

What they did: Advocate signed an agreement with Blue Cross Blue Shield of Illinois to manage over 300,000 HMO and PPO patient lives in an accountable care agreement worth approximately one billion dollars. Effective since the beginning of 2011, the deal requires Advocate to limit the rate increases it typically negotiates annually with BCBS over the two-year agreement. In return, Advocate receives an undisclosed share of any savings realized by meeting established performance targets tied to the quality, safety, and efficiency of provided care.

Results: While the project is still in its infancy, Advocate adopted a first mover strategy within the Chicago market. Due to its prominence, it can serve as a tipping point for other organizations within the area.¹⁷

¹⁷ Japsen, B. Blue Cross, Advocate Raise Bar on Accountability. *Chicago Breaking Business*. <http://archive.chicagobreakingbusiness.com/2010/10/blue-cross-advocate-deal-raises-bar-on-accountability.html>. October 6, 2010. Accessed July 28, 2011.

Strategy #9: Advancing an organization through scenario-based strategic, financial, and operational planning

In a turbulent and unpredictable market facing economic and regulatory changes, it is essential that organizations move beyond expected future-focused strategic planning. They must use methods that prepare them for a large number of potentially new situations, including the incorporation of financial and operational considerations into these plans. This is an advanced strategy for many organizations and requires a strong basis in financial management and established core-planning capabilities. The common route of scenario-based analysis includes a market environment scan, analysis of internal capabilities, identification of the unknown, development of key scenarios, and plans to implement the necessary strategies.

Additionally, this skill commands attention to risk assumption. Organizations should ensure that the proper infrastructure is in place for flexibility due to any of the expected scenarios. Potential scenarios described by interviewees include planning for health exchanges, Medicaid cuts, natural emergencies, and the dissolution of a large employer. While this is going to vary between organizations, interviewees said that the most important aspect of the process occurs through the collaborative efforts between clinical and administrative professionals to define the potential scenarios and the organizational skill development necessary to get there. Successful strategic planning is market- and organization-specific, and this process allows for the entire team to determine their future direction and success within the second-curve market.

HealthPartners

Minneapolis, Minnesota

Background: HealthPartners is the largest not-for-profit, consumer-governed, health care system in the United States. Minneapolis is an advanced market, already seeing high consolidation. HealthPartners had already realized success with initiatives focused on integration and care improvement, but it remained concerned about how future policy and regulations were going to impact its larger system.

What they did: The strategic planning department inspected future political and regulatory scenarios and performed data analysis which revealed that quality within their outpatient primary care and disease management programs was below their standards. HealthPartners transitioned care delivery into a medical home-based model for a specific group of patients with complex chronic diseases. While planning the design of this initiative, the health system enforced principles that would be beneficial in both the first- and second-curve market dynamics, including transparency, efficiency, and quality.

Results: While creating more cohesive patient-provider relationships is only acknowledged through provider stories, this program realized dramatic improvements across health measures. Forty-one percent (41%) of patients achieved optimized levels of diabetes control, and 98% of current patients involved in the program said they would recommend HealthPartners Clinics. Additionally, analysis from HealthPartners' information system verified that the system had reached benchmark levels for employee and physician satisfaction as well as clinical productivity.¹⁸

¹⁸ Etchen, L et al. Transition Economics- Strategic Challenge and Opportunity. The Chartis Group Management Consultants. July 2011.

Strategy #10: Seeking population health improvement through pursuit of the “triple aim”

In a cooperative environment, hospitals historically were able to leave population health considerations to public health officials and organizations throughout their market area. However, the increased aging population and the onset of value-based payment structures have encouraged hospitals to take a more prominent role in disease prevention, health promotion, and other public health initiatives. The “triple aim” is an initiative launched by the Institute for Healthcare Improvement in 2007 to encourage hospitals to simultaneously focus on population health, increased quality, and reduction in health care cost per capita. The pursuit of these three goals permits organizations to identify and fix a wide range of problems, but most importantly, it allows them to redirect resources to activities that will have the greatest impact on overall health. For the organizations interviewed, these activities included community-wide education and wellness projects, disease screening initiatives, and chronic disease management programs.¹⁹

Genesys Health System

Flint, Michigan

Background: Genesys is an integrated health care system focused on providing care within its surrounding county. Anchored by a 410-bed acute care facility, the care network also includes a convalescent center, home health agency, durable medical equipment store, and hospice care. Genesys also is affiliated with more than 150 community-based primary care physicians through a PHO. In the Detroit area, the financial status and health of the Genesys market is extremely dependent on the status of the motor industry. As the economy worsened, the health of the health system’s patients and their ability to pay both declined significantly.

What they did: Genesys pursued three key programs that highlighted the importance of primary care, community health involvement, and the involvement of patients in their own care. The health system became affiliated with community-based primary care providers through a PHO, highlighting its emphasis on primary care. They employed a large number of health navigators who supported Genesys patients in adopting a healthy lifestyle to improve the management of current chronic diseases and prevent any future ones. Finally, Genesys partnered with community organizations to extend its care model beyond the health system’s regular patients and to improve the health and screening capabilities of the entire county population.

Results: The new care delivery model lowered the cost of care per patient over specific periods of time, while also improving overall physician performance on analyzed quality measures. A study released by General Motors revealed that the automaker was spending 26% less on health care for employees enrolled and receiving care at Genesys as compared to other local competitors. The commitment of the health navigators led to improved patient health behavior in areas such as smoking, body mass index, physical activity, alcohol drinks, and medication compliance.²⁰

¹⁹ McCarthy, D et al. The triple aim journey: improving population health and patients’ experience of care, while reducing costs. *The Commonwealth Fund*. Vol. 48. July 2010.

²⁰ Klein, S et al. Genesys HealthWorks: Pursuing the triple aim through a primary care-based delivery system, integrated self-management support, and community partnerships.

Core Organizational Competencies

Interviewees were asked for their insights on the essential capabilities that will be critical for hospitals to master in an environment that demands delivery systems to provide economic value, quality outcomes, service coordination, information transparency, performance accountability, and greater patient accessibility.

Acting on the strategies detailed in prior sections determines not only the successful movement of a hospital from the first curve and volume-based payment to the second curve and value-based payment, but it also facilitates these longer-term core organizational competencies. These competencies reflect essential capabilities that enable an organization to implement its strategies and deliver great value. Utilizing the strategies to develop the core competencies is not a mathematical equation—that is, there is no exact action combination that will lead to a specific competency.

The core competencies are described below. Additionally, discussion questions are listed for each core competency, so organizations can establish where success has already occurred or where future strategies need to be developed to ensure an appropriately timed move to the second curve.

Similar to the strategies, these competencies are intrinsically connected and aligned.

1. Design and implementation of patient-centered, integrated care
2. Creation of accountable governance and leadership
3. Strategic planning in an unstable environment
4. Internal and external collaboration
5. Financial stewardship and enterprise risk management
6. Engagement of employees' full potential
7. Collection and utilization of electronic data for performance improvement

Self-Assessment Competency Questions

For an organization to track how successful it has been in establishing the core organizational competencies, the following set of questions can serve as a guide for self-assessment.

Design and implementation of patient-centered, integrated care

- Have we developed a clear and compelling approach to clinician alignment and integration?
- Are we developing sufficient capabilities to measure, manage, and improve the quality and efficiency of patient care across the continuum of care?
- How are we rapidly assimilating best practices into clinical medicine?
- What is our role in improving overall population health?

Creation of accountable governance and leadership

- Does the board drive the organizational strategy for moving toward the second curve while assessing the balance of risks and rewards?
- Does the board have an explicit succession planning process in place to ensure the selection and development of leaders with the right attributes?
- Does physician/clinician engagement in governance and management activities reflect their emerging roles as economic and clinical partners?
- Does the board have the appropriate competencies for executing the must-do strategies?
- Is there transparency in the communication of patient outcomes, financial results, and community benefit to the community?

Strategic planning in an unstable environment

- Do we have a clear/compelling vision for the second curve?
- Do we have a plan and timeline for moving toward the second curve of value-based care delivery, as compared to current financial incentives?
- What is the necessary mix of inpatient beds, ambulatory facilities, physicians, midlevel providers, and emerging technologies to meet future demand?
- What size and scale of our organization will be sustainable in the future?
- Should our organization explore new strategic partnerships? What type of organization best meets our needs while still fitting with our mission?
- Are we utilizing scenario-based planning techniques to monitor key changes in our assumptions and making necessary adjustments?
- Do we assess the health needs of the community we serve? Do we also identify potential partners to improve access to necessary care?

Internal and external collaboration

- Have we examined our mission to determine if we can financially sustain high quality in all of the services we currently provide?
- How well are we developing trust within our organization?
- What is our desired culture? Does it value collaboration, accountability, transparency, excellence, patient focus, and similar core values?
- Are our leaders “role models” for a collaborative culture?
- Are we considered a valuable partner to physicians and other organizations within the community?
- Do we know our partners well enough?

Financial stewardship and enterprise risk management

- Do we have a capital investment plan for testing strategic activities in payment pilot projects and health management strategies (e.g., service line management, population health, use of health information technologies)?
- Can we measure revenues and expenses by each clinical service?
- Are we utilizing an annual enterprise risk management assessment?
- Have we identified long-term financial goals and a plan to get there?

Engagement of employees’ full potential

- What is our strategy for employee and physician partner engagement?
- Are our employee and physician recruitment and retention systems aligned with our strategic direction and desired culture? For example, how are we assessing performance and values of collaboration?
- Are we a learning organization? How are we developing the knowledge and skills of physicians, middle managers, employees, and senior executives?

Collection and utilization of electronic data for performance improvement

- When will our information systems bring all pertinent information to the point of care?
- How far along are we in achieving digital connectivity among providers and with patients?
- How often is the data collected from information systems reviewed at clinical and administrative team meetings? What data is brought to senior leadership’s attention?

Core Competency #1: Designing and implementing patient-centered, clinically integrated models of care that optimize quality, safety, the patient experience, and economic value

Hospitals, as parts of care systems, will need the capacity to integrate with physicians as economic and clinical partners, working together to redesign delivery systems. Key strategies will include developing a collaborative culture among previously independent physician practices; investing in physician leadership development training; adopting evidence-based care protocols; developing care delivery models and maps that cover all network providers and the full continuum of care; deploying accountable multidisciplinary teams including primary care partners and nurse practitioners; developing the capability to extend pilot projects in value-based payment to all payers; and putting patients at the center of all care plans, encouraging them to make healthy lifestyle changes and follow recommended treatments. These can be accomplished with several different methods.

Core Competency #2: Creating accountable governance and leadership

Hospitals and care systems will demand boards and leadership teams that have a passion for their mission, understand the changing environment, and are prepared to accept accountability for making and overseeing visionary decisions. Successful boards will consist of trustees with relevant expertise, equipped to meet the rising demands for timely direction-setting, diligent oversight, and public accountability. They will need to approve and monitor metrics of the first-to second-curve strategic goals and culture. On the management side, thriving hospitals and medical groups will increasingly reject traditional hierarchies in favor of structures that reflect the integrated properties of networks and care systems. The combination of governance teams and management will be responsible for optimizing care system performance, rethinking system performance metrics, recruiting trustees based on their skill sets for specific facility needs, engaging physician participation in major decisions and initiatives, constructing effective and efficient decisions, managing change as it occurs, and ongoing board development. (Please see **Appendix C** for more detail).

Core Competency #3: Strategic planning in an unstable environment

Strategic planning is not a new competency. Driven by their mission and assessment of community needs, the majority of hospitals and health systems develop a rolling, multiyear strategic plan with annual updates to address market and regulatory changes. Numerous hospitals and systems have adopted a clear vision for the future, with defined approaches and performance metrics. However, as transformational change looms overhead, hospitals and health systems must add new dimensions to their strategic planning process. The majority of interviewees agreed that this planning must be continuous to reflect ongoing changes in the operating environment. Scenario-based planning will be needed to retest assumptions against developments. Some leaders called for conducting community health needs assessments to study the health needs and characteristics of a community and linking those results with forecasting activities. Financial pressures to operate more efficiently will compel not-for-profit hospitals and health systems, particularly safety-net providers and rural hospitals, to establish a finely honed “mission discipline,” which will objectively assess the appropriate combination of facilities and services that the organization can continue to provide based on both financial and quality metrics. Hard choices may be necessary.

Core Competency #4: Facilitating internal and external collaboration

Knowledge-driven organizations in the second-curve arena are complex webs rather than hierarchical structures, with multidisciplinary leadership groups, patient care teams, and working committees. In such organizations, leadership authority is exercised more by relationships, influence, and shared processes than by formal management methods. Therefore, in the care systems of the future, interviewees overwhelmingly listed collaboration at the top of every core competency list. The prerequisites for collaboration are trust, communication, a history of mutually beneficial relationships, common goals, integrating mechanisms such as joint committees and teams, shared economic incentives, and a performance-based system of evaluation. Health care will increasingly be delivered by multidisciplinary teams using real-time information and evidence-based practices. These teams will be accountable for results. True collaboration, however, extends beyond patient care teams. A culture of collaboration inside an organization will be scalable outside an organization, in partnerships with community- and regional-based physicians, other providers, and the extensive public health community. True collaboration will necessitate considerable investment in data analysis capabilities, technology, and infrastructure.

Core Competency #5: Exercising financial stewardship and enterprise risk management

In the second-curve market, hospitals and health systems need accurate financial and operational information, including cost accounting systems for clinical service lines, which enable them to understand their expenses and resource use. Effective organizations will have the capability to analyze this information to reduce drivers of unnecessary costs. They need to embrace improvement methodologies such as Lean/Six Sigma and to apply best practices that will increase efficiency, reduce costs, improve productivity, and increase value. Adopting best practices should involve systemwide coordination and standardization. Successful organizations will require strong capabilities in enterprise risk management and capital financing.

Core Competency #6: Engaging employees' full potential

Hospitals and care systems are fundamentally knowledge-driven organizations that require an extremely educated and engaged workforce. The ability to recruit, retain, engage, and develop highly motivated clinical and administrative teams will be essential for hospitals and care systems to succeed. Aligned physicians and other health care professionals will be trained in leadership skills and team-based care to increase collaborative abilities as well as to generate succession planning for the next generation of health care leaders.

Core Competency #7: Collecting and utilizing electronic data for performance improvement

Hospitals and health systems in the second curve need to achieve digital connectivity by fully integrating information systems into all patient care and giving providers and patients real-time information at the bedside and in ambulatory facilities. Successful implementation will facilitate care coordination through informed, shared, and evidence-based decision making. However, such coordination is not sufficient to thrive in the next generation. Organizations must implement explicit programs of focused knowledge management, in which providers and executives use the organization's information for continuous learning, planning, evaluation, and improvement.

Conclusion

This report has drawn on interviews with hospital and health care leadership as well as published literature to synthesize a list of essential strategies to implement in the first curve today in order to develop the core competencies necessary to thrive in the future second curve. Additionally, metrics are listed by each of the actionable strategies, which allow an organization to assess its own status in the implementation process while living life in the gap between volume-based and value-based payments. Organizations are urged to think about and discuss the questions listed under each of the core competencies as a means to evaluate the institution's current capabilities and to identify areas for potential improvement.

In addition, **Appendix D** contains a summary of ideas and steps taken by interviewed organizations as they undergo their individual transitions into the next market and regulatory environment. **Appendix E** provides a list of the additional resources available on the *Hospitals in Pursuit of Excellence* website at <http://www.hpoe.org> to aid organizations in adopting the must-do strategies and core competencies. **Appendix F** is a Power Point presentation based on the report, which organizations can customize and use as a discussion tool in their own leadership and board meetings in the future.

This is the initial phase of the *Hospitals and Care Systems of the Future* series. The AHA Committee on Performance Improvement will be continuing a dialogue with the field about this report and subsequent efforts as the committee continues focusing on strategies to improve performance today in order to succeed tomorrow.

**Hospital Readiness for
Accountable Care**



Signature Leadership Series

Hospital Readiness for Population-based Accountable Care

May 2012

Resources: For information related to population health, visit www.hpoe.org.

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Executive Summary

With the generous support of The Commonwealth Fund, the Health Research & Educational Trust performed a national survey of all hospitals in 2011 to assess the current state of hospital readiness in the development of accountable care organizations (ACOs). There were 1,672 responses to the survey for a response rate of 34%. Based on the survey responses and analyses, the following major themes were identified:

1. A small percentage of hospitals currently participates in an ACO (3%) or is preparing to participate in an ACO (10%).

These hospitals were more likely to be larger, a teaching hospital, part of a health system, and located in urban areas. Most hospitals participating or preparing to participate in an ACO reported it as a joint venture between physicians and the hospital.

2. Hospitals expect their revenue sources from risk-based financial reimbursements to double over the next two years (from 9% to 18%).

Across all hospitals, bundled payments (physician plus hospital services) are expected to increase 6%, and partial and global capitation payments are expected to increase 3%.

3. A majority of hospitals are actively engaged in numerous care coordination efforts, though there is variation in the use of specific practices.

Although there is variation in the standard implementation of care coordination practices, hospitals participating or preparing to participate in an ACO more often implemented these practices than hospitals not exploring the ACO model.

4. There are different perceived barriers between hospitals preparing to participate in an ACO and hospitals participating in an ACO.

The greatest challenges for hospitals participating in an ACO were perceived to be reducing clinical variation and reducing costs (mean score of 3.62 on both measures on a scale of 1 to 5 where 5 = extreme challenge). For hospitals preparing to participate in an ACO, the greatest challenge was increasing the size of the covered patient population (mean score of 3.67).

5. ACO hospitals are significantly involved in population health management services.

Hospitals participating in ACOs are working to improve coordination across the continuum of care through involvement in a variety of health management services. These services include the use of wellness or preventive care services (80%), chronic disease management services (87%), end-of-life/palliative care services (73%), and complex case management services (87%).

ACO hospitals also identified several processes used to determine which patients were eligible to receive these health management services, including: the use of health risk assessments (77%); the use of outpatient claims or encounter data from participating practitioners and providers (100%); the use of outpatient claims or encounter data from nonparticipating practitioners and providers (69%); and the use of inpatient claims or encounter data from participating practitioners and providers (100%).

6. There are significant gaps in care coordination functionalities.

Although a high percentage of hospitals reconcile medications as part of an established plan of care (89% of hospitals participating in an ACO, 90% of hospitals preparing to participate in an ACO, and 85% of hospitals not exploring the ACO model), there is a low use of risk stratification and other care coordination activities. For example, only 38% of hospitals participating in an ACO, 33% of hospitals preparing to participate in an ACO, and 24% of hospitals not exploring the ACO model assign case managers to patients at risk for hospital admission or readmission for outpatient follow-up. Less than one-quarter of the hospitals in each group have nurse case managers

who work with patients with chronic diseases. Similarly, 23% of hospitals participating in an ACO, 21% of hospitals preparing to participate in an ACO, and 11% of hospitals not exploring the ACO model have a post-hospital discharge continuity of care program with scaled intensiveness. This scale is based on a severity or risk profile for adult medical-surgical patients using defined diagnostic categories or severity profiles.

7. ACOs are striving to improve the quality of their services by using valid performance measures and making results available to the public and participating providers.

Far more hospitals participating in an ACO have an organized program to train clinical leadership in continuous quality improvement (84%) than hospitals not exploring the ACO model (54%). Half of ACO hospitals track and routinely share performance against measures with all members of the ACO. Of those currently sharing performance data, 46% are providing utilization measures by each setting of care as well as clinical quality measures by each setting of care. Forty-four percent (44%) are providing financial measures by each setting of care, and 39% are providing patient satisfaction measures by setting of care.

Using the findings from the survey and an in-depth literature review, we developed an HRET ACO Readiness Tool as a basis for internal discussions by the hospital leadership regarding self-assessment of the capabilities, attributes, and experiences that are critical to the success of an accountable care organization.

- This report is organized as follows:
- Introduction
- Methods
- Current Progress in Hospital Participation in the ACO model
- Governance Structure
- Legal Structures of ACOs
- Ability to Take on Financial Risk
- ACO Payment Models
- Partnerships and Ability to Provide Primary, Acute, and Post-acute Care
- Care Management
- Performance Reporting and Quality Improvement
- ACO Challenges
- Conclusion
- The ACO Readiness Tool

Introduction

There is widespread agreement among policymakers, payers, and health care leaders that the current fee-for-service method of paying for care is one of the drivers of the unsustainable growth in health care costs in the United States. In response, the concept of accountable care organizations (ACOs) has been widely touted as a potential solution to bending the health care cost curve and encouraging care coordination. ACOs accept responsibility for the cost and quality of care delivered to a specific population of patients cared for by the group's clinicians. ACOs serve to align the incentives of multiple providers, and they hold the potential to address some of the limitations in the fee-for-service payment system. The success of the ACO model resides in fostering clinical excellence and continual improvement; effectively managing costs hinges on its ability to incentivize hospitals, physicians, post-acute care facilities, and other providers to form linkages that facilitate coordination of care delivery and collect and analyze data on costs and outcomes.

The Patient Protection and Affordable Care Act of 2010 established a national voluntary program under Medicare for ACOs in 2012. If it is successful, the U.S. Secretary of Health and Human Services has the authority to expand the program. Although the concept of ACOs has been embraced by health care and health policy leaders, there are no national indicators of how many hospitals are participating in ACOs

and what their current capabilities are in care management, financial management, information management, and performance improvement.

The full report can be accessed at: <http://www.hpoe.org/resources-and-tools/5330004946>

Improving Perinatal Safety

The Elimination of Elective Deliveries Before 39 Weeks

Hospitals and health systems are feeling the push to eliminate early elective newborn deliveries within their organizations. Up to 10 percent of all U.S. newborn deliveries are scheduled to be induced before 39 weeks without medical reason.¹ This practice may carry medical risks for both the infant and mother.

Emerging Importance

The national rate of labor induction has more than doubled, from 9.5 percent in 1990 to 22.5 percent in 2006.² The growth rate for elective inductions is much greater than the rate for inductions that are ruled medically necessary. Possible reasons for inducing labor are detailed in the box to the right.

Recent initiatives have focused on eliminating inductions during weeks 37 to 39 of gestation. Although the mother is considered at term, clinical evidence has shown that inducing labor during this period increases the likelihood of negative health outcomes for the newborn and mother (see figure 1).

Studies have confirmed that fetal brains continue to develop even during the last week before birth. As a result, elective early term deliveries can lead to adverse neonatal outcomes such as increased neonatal intensive care unit admissions, tran-

sient tachypnea, respiratory distress syndrome, sepsis and feeding problems.³

Frequency of Elective Deliveries

Despite the risks associated with early elective deliveries, they remain prevalent due to patient and physician demand. Expectant mothers appreciate the convenience of knowing their delivery date and being able to plan around it. Additionally, mothers with prior difficult pregnancies often push for early inductions to ensure that their physician will be at the delivery. Obstetricians and gynecologists can avoid potential calendar conflicts by scheduling inductions and also please their patients in a competitive market.

Work of External Organizations

The American Congress of Obstetricians and Gynecologists has been advocating against elective inductions for almost 20 years, distributing guidelines for hospitals to follow. The Institute for Healthcare Improvement and the March of Dimes each have hospital-focused programs to guide implementation of 39-week rules. The Leapfrog Group has begun to publish early elective delivery data annually. The Centers for Medicare and Medicaid Services and the Partnership for Patients, a federally funded program, are bringing

together facilities across the country to pledge to eliminate early elective deliveries. Also, hospitals that choose to report the Joint Commission's five perinatal core measures must include the number of elective deliveries before 39 weeks.

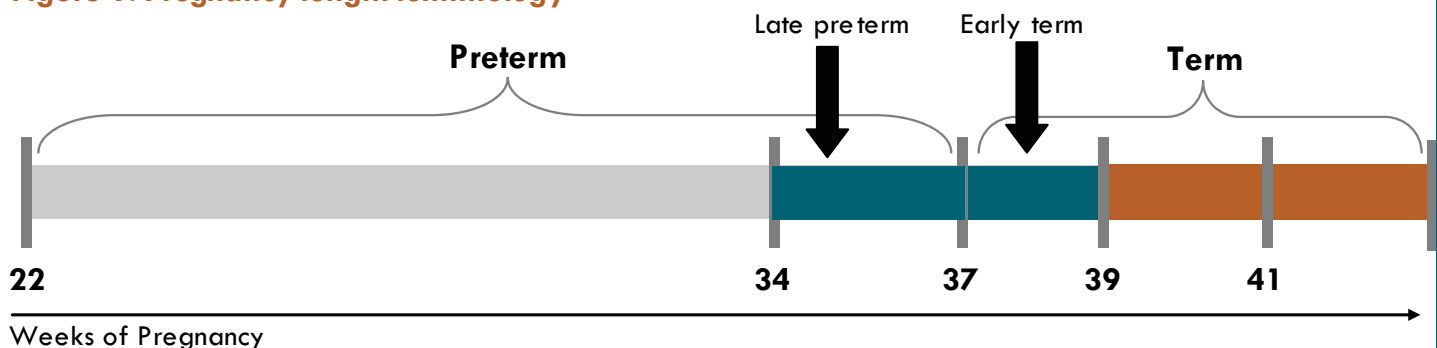
Role of the Hospital

To effectively decrease the occurrence of elective inductions, hospitals must address the causes for demand and educate patients on potential adverse outcomes. Some hospitals will have to collaborate with physicians to restructure their current labor and delivery case-referral processes to prevent early elective inductions.

Medical Reasons to Induce Labor⁴

- * Placenta abruptio
- * Postterm pregnancy (≥ 41 weeks)
- * Maternal conditions including:
 - » Preeclampsia
 - » Hypertension
 - » Diabetes
 - » Chronic renal disease
- * Fetal problems including:
 - » Insufficient growth
 - » Congenital anomalies
 - » Prior stillbirth
 - » Fetal demise
- * Psychosocial

Figure 1. Pregnancy length terminology



Case Studies

Woman’s Hospital: Eliminating elective early term deliveries through interdisciplinary teamwork

Background: Woman’s Hospital is a 225-bed, nonprofit tertiary care center located in Baton Rouge, Louisiana. The hospital employs five hospitalist ob/gyns and five fetal medicine physicians. Additionally, 65 independent ob/gyns are affiliated with the hospital. Woman’s formally launched a collaborative with the Institute for Healthcare Improvement in 2007 to eliminate elective inductions prior to 39 weeks. This partnership initially created a perinatal bundle for clinical use to address concerns about the health outcomes of newborns, which can vary by gestational age and cervix favorability. As clinical and policy support grew, the initiative evolved into a larger movement to reduce all early elective deliveries, including cesarean sections and inductions.

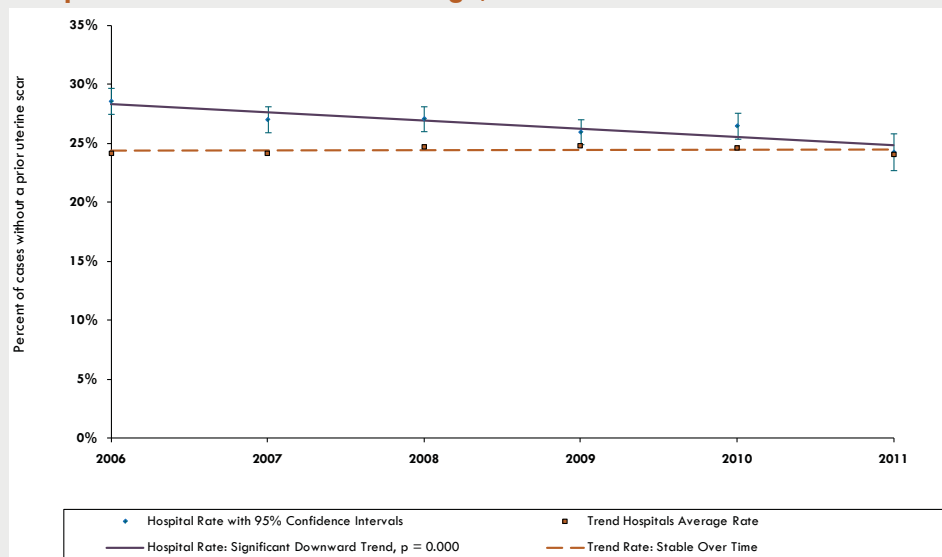
Goal: 90 percent of all babies will be delivered at 39 weeks or later as a result of 100 percent perinatal bundle compliance.

What they did: Woman’s formed a multidisciplinary council of nurse managers, quality specialists and the chief of obstetrical services. Team members including nurse champions and community physicians attended IHI meetings every six months to review evidence-based practices and discuss their progress in perinatal bundle implementation with other organizations in the same pursuit. These team members later shared what they had learned and led a discussion on Woman’s most recent data. The entire team addressed any discrepancies in the data and suggested changes that could perfect the guidelines and thereby improve outcomes. All team members provided input and would agree on the appropriate next steps.

Impact: Senior management instituted a “hard stop” on all early elective deliveries. From 2006–2011, Woman’s saw a 19 percent decrease in primary C-section deliveries (see figure 2) and more than a 50 percent decrease in operative vaginal deliveries. NICU admissions declined by 28.9 percent over the same period.

Challenges to implementation: Many physicians believed the decline in NICU admissions was not a direct result of the decrease in early elective deliveries, attributing the change to the updated NICU admission criteria. Patients argued that scheduling childbirth was more convenient, giving them the opportunity to plan for child care and family leave, for example. To alleviate tension between patients, physicians and the hospital, Woman’s instructed physicians to cite hospital regulations that restricted them from performing inductions without medical necessity, essentially putting “blame” on the facility. To directly educate patients, the hospital provided physicians with pamphlets identifying the risks associated with elective inductions.⁵

Figure 2. Primary cesarean delivery rates at Woman’s Hospital in comparison to the national average, 2006–2011



*Source: National Perinatal Information Center

Seton Family of Hospitals: Using clinical outcomes and data to gain system support for quality initiative

Background: Seton Family of Hospitals, a member of Ascension Health, operates 38 facilities in 11 counties of Central Texas and employs more than 500 physicians for its 1,341 beds. As a result of the release of *To Err Is Human* by the Institute of Medicine, in 2003 Ascension launched “Journey to Zero,” a systemwide campaign to deliver safe care within several clinical areas. Ascension piloted a different safety and quality initiative within different facilities, and Seton was designated as the pilot site for programs to reduce birth traumas.

Goal: The Perinatal Safety Alpha Initiative, a part of the Ascension Health Handling All Neonatal Deliveries Safely (HANDS) program, aimed to eliminate inductions prior to 39 weeks unless medically necessary.

What they did: In late 2003, Seton Family implemented the “39-week rule.” The hospital held physicians accountable for declining all induction requests prior to 39 weeks that were not medically necessary. Each hospital has a review process in place for induction requests. The unit clerk reviews each request and then sends it to a labor and delivery nurse for approval. The request eventually reaches the chief of obstetrics for final approval. During the implementation, if a physician performed an elective induction prior to 39 weeks, the case was sent to a peer review panel. This process, first tested in one facility, became standard across the six Seton hospitals that have labor and delivery services and eventually across Ascension.

Impact: Since July 2005, Seton has not performed one elective induction before 39 weeks within the system. Birth trauma incidence rates decreased significantly, from 30 per 10,000 in the period 2000–2003 to an average of 2 per 10,000 since 2007 (a 93 percent reduction). NICU admissions also declined, and for more than six years, Seton has seen zero NICU admissions that are attributable to elective inductions prior to 39 weeks. NICU charges declined from \$4 million to about \$186,000 per year. As a result, annual malpractice premiums across Ascension dropped by millions of dollars.

Challenges to implementation: Physicians were initially skeptical of the 39-week rule, but they adhered to the policy once data confirmed the correlation between early elective inductions and poor outcomes. Regular data updates, which highlighted the positive health outcomes, also compared the number of elective inductions by physicians, encouraging compliance. Additionally, Seton provided interdisciplinary training for obstetrical team members to further educate them of the new rule. Some patients did complain of uncomfortable pregnancies and indicated a desire for the added convenience of scheduled deliveries. In response, physicians reminded expectant mothers of the health risks associated with early elective delivery and advised them to focus on the health of the baby.⁶

Eliminating early elective deliveries at the state level in Louisiana and Texas

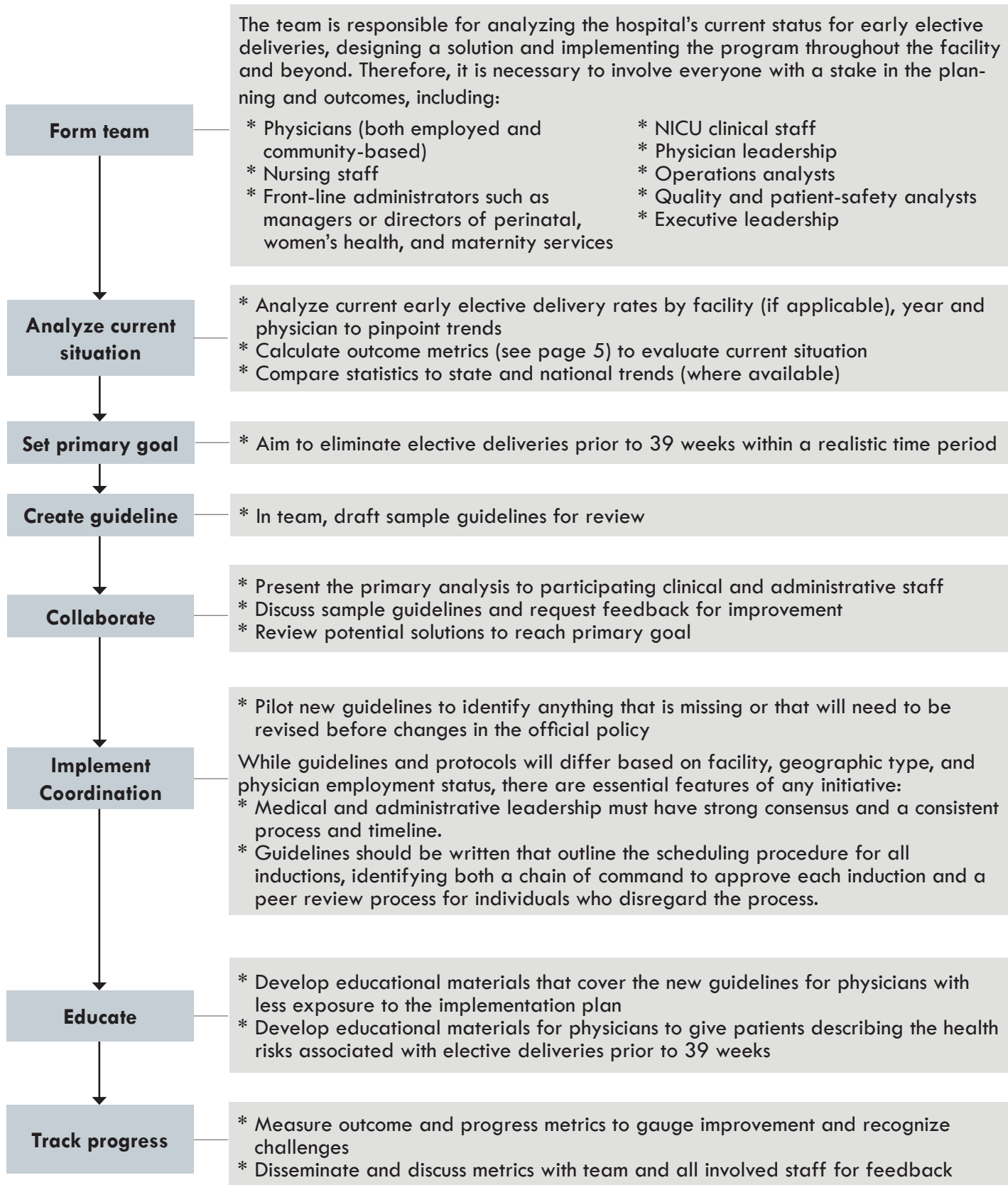
The desire to improve birth outcomes while reducing Medicaid expenditures has encouraged state governments to join the quest to eliminate unnecessary inductions prior to 39 weeks. States are working with hospitals and physicians in different ways to accomplish the same goal.

Louisiana: The Louisiana Department of Health and Human Services announced the 39-Week Initiative as part of a statewide project to improve birth outcomes. Led by Woman’s Hospital, 19 other hospitals throughout the state also pledged to eliminate elective deliveries prior to 39 weeks. To increase physician compliance, AMMICO, the largest supplier of malpractice insurance in the state, has partnered with DHH to provide a training course for continuing medical education credit. Completion of the course in combination with other educational programs will qualify each participating physician for a 10 percent reduction in malpractice premiums.⁷

Texas: Under a 2011 law, Texas Medicaid no longer reimburses hospitals for elective deliveries occurring prior to 39 weeks’ gestation when not medically necessary. Physicians will still be reimbursed at the normal rate.⁸

API Implementation Overview

While program design will vary among organizations, there is a basic framework that hospitals and health systems can use as a guide to begin the process of eliminating elective deliveries before 39 weeks.



Measuring Progress

The metrics detailed below are useful to evaluate the current state of the organization, monitor progress, identify challenges and recognize unforeseen consequences. Many process, outcome and balance metrics can be analyzed, and organizations may realize that changes come within each segment at different phases in program development and implementation. Gaining an understanding of the metrics in the beginning will aid teams in developing a program appropriate for their hospital. Organizations do not have to measure all of the metrics below but should choose the ones that make sense for their own situation.

Process Metrics

- * Maternal or newborn hospital admissions >5 days
- * Community awareness of the dangers of elective early term deliveries
- * Clinical team adherence to induction bundle policies
- * Overall adherence to each step of new guideline
- * Labor and delivery length of stay
- * Physician, nurse and other clinical provider training attendance rates
- * Use of combined vacuum and forceps
- * Use of vacuum before 34–36 weeks

Outcome Metrics

- * Neonatal mortality rates
- * Obstetric trauma
- * Birth trauma
- * Primary cesarean rate in electively induced patients
- * Fourth-degree laceration rates
- * Number of elective inductions before 39 weeks
- * Episiotomy rates
- * Respiratory distress syndrome
- * Transient tachypnea of the newborn
- * Newborn sepsis
- * CPR or ventilation in first 24 hours
- * Number of elective caesarean sections before 39 weeks

Balance Metrics

- * Employee satisfaction
- * Independent physician satisfaction
- * Labor and delivery overall volume
- * Percent of market labor and delivery volume
- * NICU admissions (overall and attributed to elective inductions)
- * NICU charges

Essential for Success

Leadership Buy-in

- * Retain clinical and administrative leadership from the beginning as a necessary precursor to physician buy-in
- * Encourage collaboration among all stakeholders throughout the organization, including administrative and clinical management
- * Improve adherence to the new policy through recognition by hospital leadership of the clinical staff's efforts to implement the new guidelines

Physician Adherence

- * Gain physician buy-in from the beginning by providing irrefutable data evidence (clinical outcomes and physician comparison data) to all affiliated physicians, focusing on the impact of induction rates on NICU admissions and adverse health outcomes in newborns
- * Gather physician feedback on processes when guidelines are originally written and after initial test
- * Maintain adherence through continual education and enforcement of agreed-upon processes
- * Allow independent physicians to play a role in the implementation process

Patient Education

- * Educate patients about the risks that elective early term deliveries pose to both mother and child
- * Provide educational information in various forms (written, electronic and oral) for consistent message on the importance of the last few weeks of pregnancy
- * Recognize that hospital-sponsored education can ease difficulties faced by physicians who may refuse patients' requests to induce labor unless medically necessary

Documented Process

- * Avoid putting one staff member in a policing role, which can negatively impact staff satisfaction and adherence
- * Establish a clear chain of command and process for correcting deviations from guidelines
- * Document one consistent process, which will facilitate easier adoption across the hospital, system or region

Endnotes:

1. *Strong Start Initiative: Improving Maternal and Infant Health Fact Sheet*. Centers for Medicare and Medicaid Services. Released February 7, 2012. Accessible at <http://www.cms.gov>
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Resources:

For more information and resources on elective deliveries and perinatal safety, please visit <http://www.hpoe.org/topic-areas/obstetrical.shtml>

If you would like to participate in a perinatal safety national improvement project, please contact HEN@aha.org.

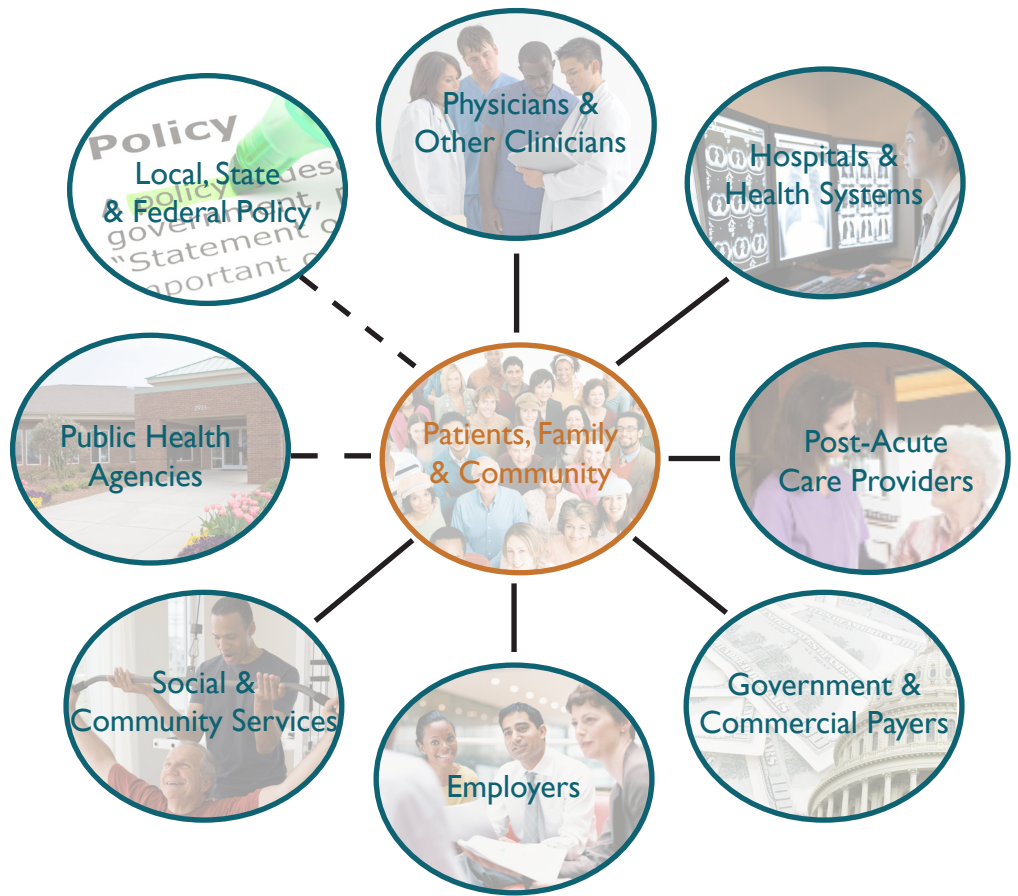
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**Managing Population Health:
The Role of the Hospital**



Managing Population Health: The Role of the Hospital

April 2012

Resources: For information related to population health, visit www.hpoe.org.

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Executive Summary

The American Hospital Association Committee on Performance Improvement’s inaugural report, *Hospitals and Care Systems of the Future*, prioritizes population health as a must-do strategy for hospitals and health systems to succeed in the evolving health care environment. As the publication asserts, “The aging population and the onset of value-based payment structures demand hospitals to take a more prominent role in disease prevention, health promotion, and other public health initiatives.”

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, health screenings 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.

Hospitals and health systems of varying size, patient demographics, and geographic regions have begun to recognize that the main mechanisms to advance population health—improving quality and patient safety, increasing care coordination, and expanding preventive services—are the outcomes of initiatives they are already pursuing. Although the financial incentives are not yet truly aligned, there are efforts that health care organizations can take to improve care delivery in the current volume-based market that will be even more essential in the future value-based reimbursement system.

This guide is designed to define population health, describe strategies to improve the health of a hospital’s patient population, inform leaders why these initiatives are essential, and explore potential partnerships that can help achieve the desired goal as illustrated in the diagram below. Short case examples provide supporting evidence and show that every health care organization already possesses some of the capabilities necessary to institute programs that improve health outcomes within a defined population.

Figure 1. Population Health Requires Partnerships to Improve Outcomes



Source: HRET, 2012.

Introduction

Defining population health

Population health can serve as a strategic platform to improve the health outcomes of a defined group of people, concentrating on three correlated stages:

1. The distribution of specific health statuses and outcomes within a population;
2. Factors that cause the present outcomes distribution; and
3. Interventions that may modify the factors to improve health outcomes.

Population health resides at the intersection of three distinct health care mechanisms (see figure 2). 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 2. Mechanisms to Improve Population Health



Source: HRET, 2012.

Table I below outlines the childhood asthma program at Cambridge Health Alliance¹ to illustrate the use of prevention and care coordination strategies to improve population health management.

Table I. Defining Population Health Initiatives at the Cambridge Health Alliance

	Process Questions	Results
Outcomes	What health statistics are inadequate for our catchment area and what population does this impact?	<ul style="list-style-type: none"> • Asthma is the leading chronic disease among children. • Cambridge Health Alliance was seeing a high number of pediatric inpatient admissions for asthma.
Factors	What is causing the outcomes that we are seeing?	<ul style="list-style-type: none"> • Low adherence to medication regimen • Lack of knowledge about asthma attack triggers in children
Interventions	What initiatives can we implement to modify and improve on the factors listed above?	<ul style="list-style-type: none"> • Web-based registry used by physicians and school nurses to assess correct prescription and medication adherence • Home visits by providers to help parents decrease or remove asthma triggers
Impact	What are the results of the intervention?	<ul style="list-style-type: none"> • Increased adherence to asthma medication regimens • Asthma-related hospital admissions dropped by 45% from 2002-2009 • Asthma-related ED visits dropped by 50% over the same time period

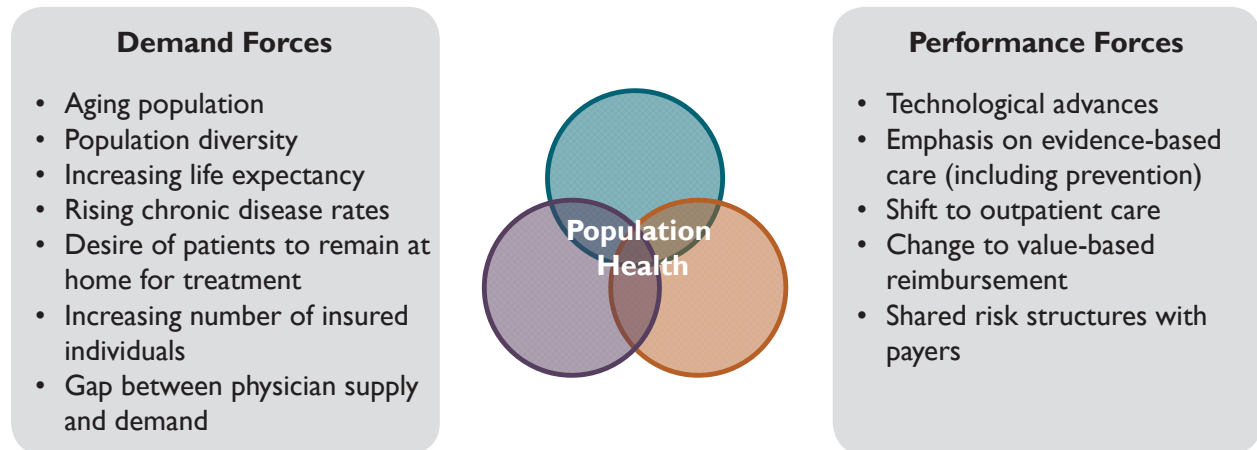
Source: HRET, 2012.

Why Population Health?

Forces are driving hospitals toward population health

The current volume-based reimbursement system is designed to address acute care needs, and in this system, hospitals can succeed by treating patients that come to them. The increasing rates of chronic disease and the change to a value-based reimbursement system are among the demand and performance forces pressing organizations to take a more proactive approach to patient care—that is, reaching out to the population beyond the traditional four walls of the hospital.

Figure 3. Forces toward Population Health



Source: HRET, 2012.

ACA encourages hospitals to adopt population health management strategies

Several sections within the Patient Protection and Affordable Care Act (ACA) are driving hospitals toward population health management by promoting and incenting prevention, quality and safety, and care coordination strategies. Table 3 summarizes the most actionable initiatives.²

Table 2. Population Health Management Strategies through ACA

1. ACA requires tax-exempt hospitals to conduct community health needs assessments every three years and adopt implementation strategies that meet the identified needs, including identifying reasons why any such needs are not being addressed.
2. The law expands coverage for a wide range of prevention and wellness services, increasing incentives for employers that establish wellness programs and eliminating copayments for immunizations, screenings, and other clinical preventive services.
3. The elimination of payment for unnecessary readmissions and the development of delivery payment pilots increase the hospital's accountability for care outside its four walls.
4. Medical home demonstrations, coordination grants, and increased financial support for health centers encourage partnerships between hospitals and other community organizations.
5. ACA creates a fund to provide sustained national investment in preventive and public health programs, including those offered by hospitals to increase access to clinical preventive services and create healthier communities.

Source: HRET, 2012.

The Hospital's Role in Population Health Management

As hospitals move toward population health management, they face considerable barriers to practicing it as an overall strategy. For example, the current volume-based reimbursement system does not provide significant funding to pursue population health initiatives. Additionally, the traditional definition of population health encompasses a broad range of factors that may change health outcomes—everything from the physical environment to social structure to resource allocation. As a result, hospitals may find it difficult to identify which population health factors they can directly impact with their limited resources.

Hospitals and health systems have started to realize that the mechanisms to advance population health—improving quality and patient safety, increasing care coordination, and expanding preventive services—support the patient initiatives they are already pursuing. Although the financial incentives are not yet fully aligned, specific efforts by organizations to improve care delivery in the current volume-based market also will be essential for care delivery in the future value-based market.

Table 3 identifies factors typically included within population health, grouped according to those outside the health care system and those inside the health care system. Another tier separates the factors within control of the health care system into groups based on care delivery and the external regulatory environment. The orange box in the middle represents opportunities for hospitals to explore. Not all efforts to improve the health of the population necessarily address the entire community. Some organizational efforts may focus on changes for one segment of the overall patient population.

Table 3. Factors Influencing Population Health³

Outside Health Care System	Related to the Health Care System	
Societal Factors	Care Delivery	Regulatory Environment
<ul style="list-style-type: none"> • Food safety • Healthy food availability • Housing conditions • Neighborhood violence • Open space and parks/recreation availability • Genetic inheritance • Disease prevalence • Income levels • Poverty rates • Geographic location • Unemployment rate • Uninsured/underinsured rate • Median age • Sex • Race/ethnicity • Pharmacy availability • Care-seeking behaviors • Health literacy • Patient choice • Morbidity rates • Transportation availability 	<ul style="list-style-type: none"> • Quality of care • Efficiency • Access • Physician training • Health IT system availability • Distance to and number of hospitals, primary and urgent care centers, retail clinics, etc. • Provider supply (MDs, RNs, etc.) • Physician mix (primary versus specialty care) • Payer contracts • Physician employment and payment structure • Disease management • Population subgroup disparity • Advanced technology availability • Care integration and coordination • Behavioral health availability • Cultural and linguistic access 	<ul style="list-style-type: none"> • Medicare payment rates and policies • Medicare and Medicaid care delivery innovation • CON regulation • Medicaid/CHIP policies (payment rates, eligibility) • Implementation of ACA • Local coverage determinations (LCDs) • Other local, state, and federal laws that impact the way health care is delivered and which treatments are provided

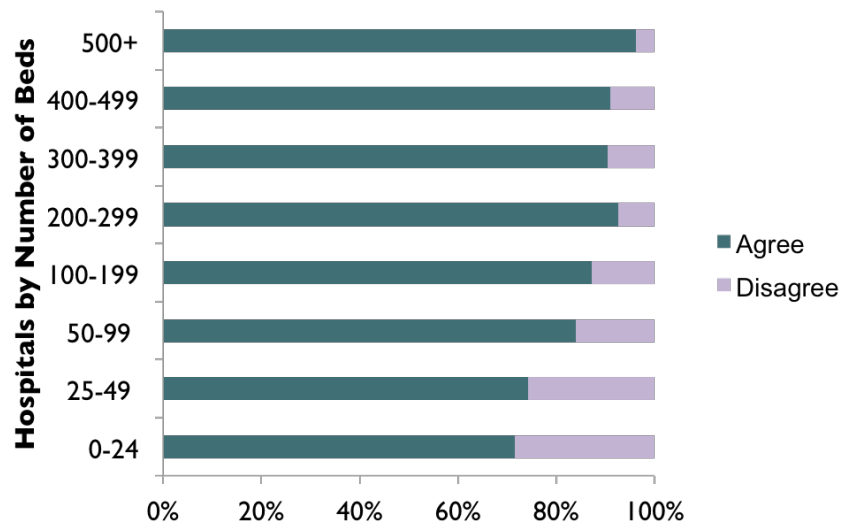
Source: HRET, 2012.

How Hospital Leaders View Population Health Management

The shift from managing individuals to managing populations varies by hospital size

A recent American Hospital Association survey of hospital chief executives shows that leaders of larger facilities are more likely than leaders of smaller facilities to focus on population health management as a necessary strategy in the current market to guarantee success in the future. The variation is attributed to the overall size of the organization's patient population—the larger the patient base, the stronger the push will be to examine and explore solutions in the aggregate. Additionally, smaller rural and critical access hospitals typically will have neither the human capital nor the financial resources to implement overarching population health strategies in ways comparable to larger facilities.

Figure 4. Hospital CEO alignment to pursue population health by bed size (n=652)



Source: SchellingPoint, LLC, and AHA Committee on Performance Improvement survey, November 2011.

A focus on population health is already occurring at most organizations

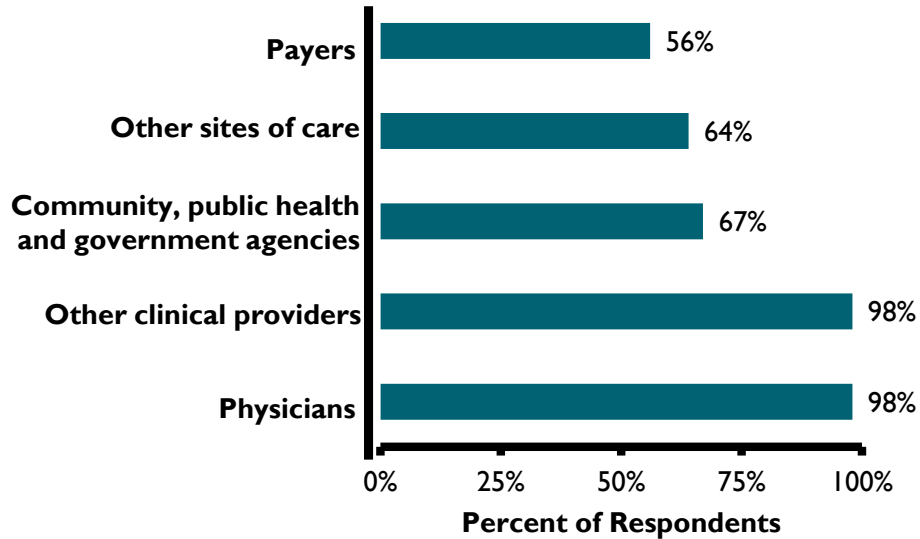
The AHA survey revealed that 98 percent of chief executive respondents agree, at least at some level, that hospitals should investigate and implement population health management strategies. More than 75 percent of senior management, even at the smallest organizations, recognizes the value of exploring these initiatives. Anecdotal quotes from organizational leaders indicate that it is not “if” they will have to pursue these strategies but “when” — within the timed shift to a value-based reimbursement system.

Responses from hospital leaders are more varied when they detail their individual roles within the overall strategy for population health management. The chief executives of smaller and more rural hospitals and health systems indicate they will most likely be collaborating on a larger organization's charge toward population health rather than implementing their own strategy. As previously noted, many larger organizations with more resources are already pursuing population health strategies such as chronic disease registries and disease management programs for their bigger base of patients.

Population health requires partnerships for success

The mechanisms to improve population health—improving quality and patient safety, increasing care coordination, and expanding preventive initiatives—demand greater accountability from all parties within the health care system. Hospital leaders point to a variety of collaborations that may help them achieve these goals, exhibited in figure 5. Although the area of most agreement among executives is the desire to work with physicians and other clinical providers, a majority indicated the need to go beyond historical partnerships and explore relationships with community organizations, payers, and other clinical care sites to address health care issues that they cannot accomplish on their own.

Figure 5. Percentage of CEO respondents who would explore collaborations with the following partners (n=652)

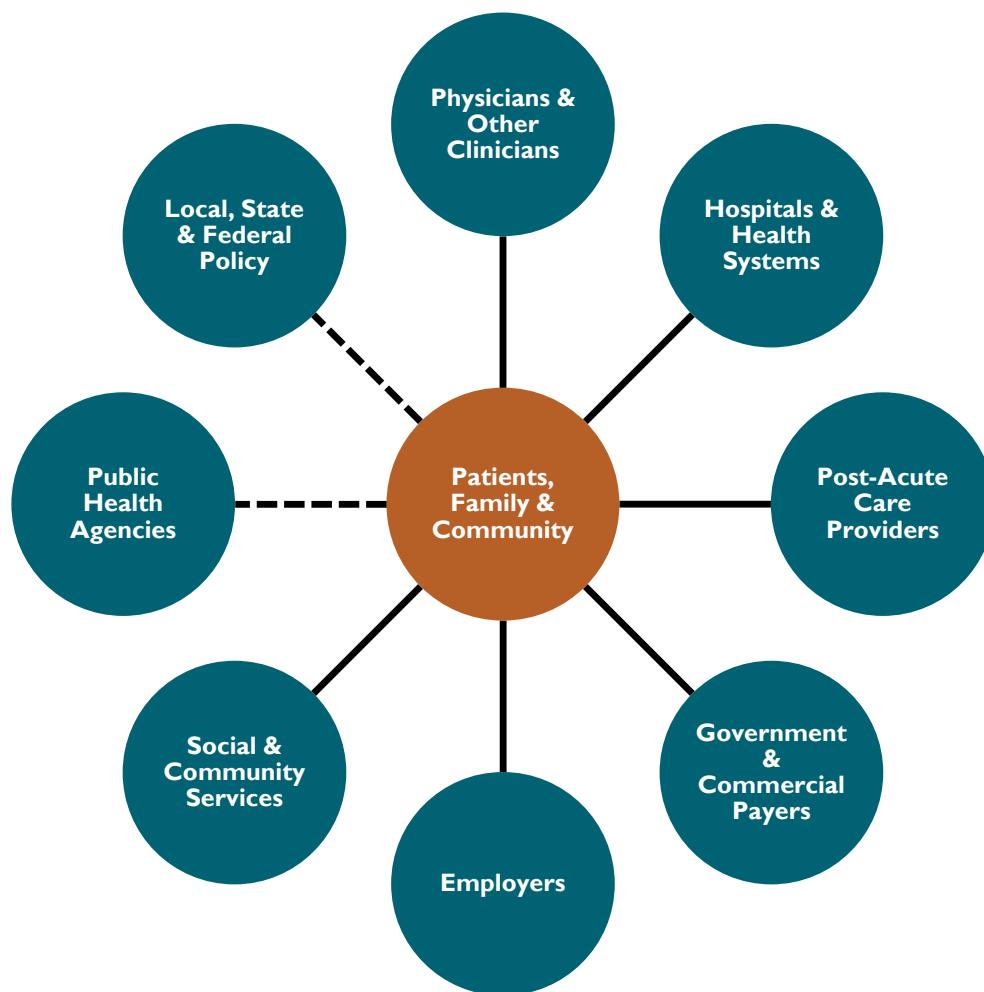


Source: SchellingPoint, LLC, and AHA Committee on Performance Improvement survey, November 2011.

Successful Population Health Management: Partnerships Focus on Patients, Family, and Community

True population health improvement is not an outcome that hospitals and health systems will be able to achieve without collaboration and shared ownership of goals with other sectors. As depicted in figure 6, several segments of the health care system play roles in population health management. The solid lines in the diagram represent the sectors that have more direct interaction with individuals within the population, whereas the dotted lines signify a service relationship with the population more generally. While each sector plays a distinct role, all follow the mechanisms to advance population health—improving quality and safety, increasing care coordination, and expanding preventive care services for patients, their families, and the overall community. The methods to achieve successful outcomes will vary by the missions and abilities inherent within each sector of the health system.

Figure 6. Population Health Requires Partnerships to Improve Outcomes



Source: HRET, 2012.

Hospitals are already partnering to achieve goals of population health

Hospitals already have an established record of partnering to improve population health. Collaborations with other sectors enable hospitals to have a deeper and more comprehensive reach in population health management and to share financial and other resource commitments necessary to pursue their goals. The organizations that have started the collaboration process recognize the need to establish these relationships now, so operations will be in place before the transition to a value-based reimbursement system. If organizations wait for financial incentives to align with these initiatives, they may not be prepared to succeed.

Table 4 identifies partnerships that are currently in place between various segments of the health care system, with the goal of improving population health through changing care delivery. As evident by the outlined (in orange) box, hospitals and health systems are in the unique position of partnering with every other other segment.

Table 4. Current Health Care System Partnerships to Improve Population Health

	Physician	Hospital	Payer	Employer	Social Services	Public Health
Physician	•	•	•	X	X	•
Hospital	•	•	•	•	•	•
Payer	•	•	X	•	X	X
Employer	X	•	•	X	X	X
Social Services	X	•	X	X	•	•
Public Health	•	•	X	X	•	•

X = Partnership not yet common in population health management

• = Partnership common in population health management

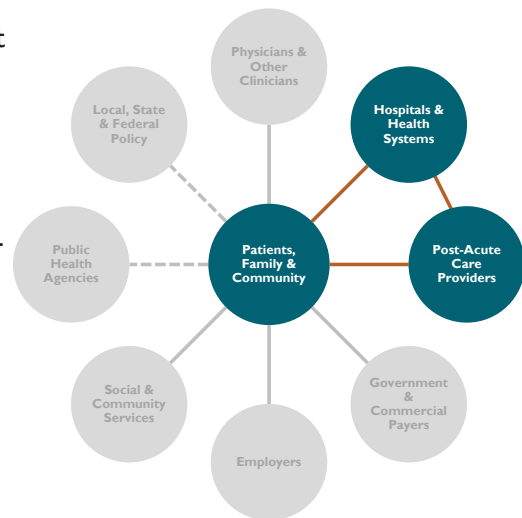
Source: HRET, 2012.

The following pages describe the characteristics of different collaborations across the health care system. Short case examples profile organizations that have implemented these initiatives, already recognizing the partnerships' benefits despite financial challenges.

These collaborations illustrate how population health initiatives can focus on patient subgroups large and small, on frequent hospital users, and on those who need more preventive screening and more support to improve health literacy and change health behaviors. Some partnerships are more common than others and have realized specific benefits already. Others will take more time to gain prominence and prove they can produce positive outcomes. The case examples further emphasize that many hospitals have already been pursuing population health management to some degree, and those that have not yet done so have the tools to start. The examples also highlight many partnerships that involve more than two segments of the health care system and their keys for success.

Establish provider collaborations that span the care continuum

The reality of future payment restrictions is one factor that has encouraged hospitals to analyze segments of their patient populations to determine if they are being treated in the right location at the right time with the most appropriate services. Unnecessary ED visits and readmissions are the obvious targets. Collaborations with other sites of care such as clinics, long-term care providers, urgent care centers, and even other hospitals can ensure that the population is receiving the appropriate level of care. The case studies below provide two examples. The capacity and characteristics of the partnerships vary according to the needs of each organization and its population. Both Summa Health System and the University of Chicago Medical Center found success by identifying other organizations that were open to collaboration and serving as facilitators in the partnerships between a large number of competitive institutions. While these case examples focus on the resulting hospital benefits, successful provider collaborations also will lead to a better distribution of patient volume across partners and ensure patient populations have access to the appropriate providers based on their care needs.



Who: Care Coordination Network at Summa Health System, Akron, Ohio

Outcomes: Summa was seeing lower quality outcomes, longer hospital stays, and higher rates of readmissions for patients transferred to and from SNFs.

Factors: Impractical transfer forms, area SNF competition, and the complex patient population all led to ineffective communication and unnecessary hospital readmissions.

Interventions: Summa collaborated with 37 local SNFs to create the CCN, which streamlined patient transitions. They worked to create an electronic referral process, an easy-to-use form, and encouraged regular meetings among the parties to encourage collaboration.

Impact: Analysis has shown fewer readmissions from SNFs, reduced length of stay, improved schedule adherence, and better volume distribution at SNFs.⁴

Who: University of Chicago Medicine and UCM's Clinics, Chicago, Illinois

Outcomes: About 40% of the more than 55,000 visits to the adult emergency department at UCM were either preventable, low acuity and treatable in a different setting, or both.

Factors: Lack of patient knowledge and of familiarity with accessible health centers to manage chronic illnesses.

Interventions: UCM created the Southside Healthcare Collaborative, a partnership to encourage patients to find a medical home. Patient advocates were placed in the emergency department to refer low-acuity patients to high-quality care faster or to help find a primary care physician for follow-up visits.

Impact: The number of unnecessary ED visits decreased by 10% in the first year of the program (2005–2006). More than 5,600 patients gained a medical home, and the number of clinic appointments increased by 40% in the same period (2006–2010).^{5,6}

Partner with physicians for an expanded focus on quality and outcomes



According to an AHA survey, more than 98 percent of hospital chief executives believe they should seek further alignment with physicians and other clinical providers. Both parties understand that they all will be held more accountable for their patients' health outcomes in the future, and collaborations are the best way to ensure that high-quality care is provided across the continuum. Hospitals have the clinical data resources to analyze and reduce unnecessary variation and establish best practices in quality improvement interventions, and physicians have the direct patient interaction to support individual behavior change. Successful partnerships will facilitate improved care coordination, reduce unnecessary admissions, and improve physician access to appropriate evidence-based standards—leading to better population health outcomes.

Who: Billings Clinic, Billings, Montana

Outcomes: Billings had a large diabetes population not following typical care protocols.

Factors: Diabetes care is challenging in rural areas where there can be a limited number of primary care physicians. These physicians typically have limited resources, and patients have fewer local educational opportunities to better manage their chronic diseases outside of physician visits.

Interventions: Billings enrolled patients, regardless of insurance status, in its disease registry and disease management program, emphasizing the physician's role to achieve compliance with clinical guidelines. PCPs are provided with data profiles on diabetes patients before appointments, including real-time reminders on various diabetes health outcome measures to facilitate necessary discussions. The Billings-sponsored EMR allows physicians to input patient-specific report cards to monitor health progress and make changes to treatment as necessary.

Impact: More than 7,000 diabetes patients are enrolled in this program, and physician compliance has increased significantly.⁷

Who: Wenatchee Valley Medical Center, Wenatchee, Washington

Outcomes: Average annual cost of care for their costliest Medicare population was \$17,500, compared to the \$6,000 average annual cost for traditional Medicare patients in the same region.

Factors: About 48% of costs for these patients were due to ED visits and inpatient hospital charges; a lack of care coordination with physicians increased these expenses.

Interventions: WVMC entered into a CMS payment demonstration project to improve care coordination for these patients. They secured provider involvement by (1) holding meetings with providers to create a "shared vision," (2) acting on those providers' suggestions, (3) incenting physicians with shared savings, and (4) creating a collaborative culture.

Impact: WVMC saw a decrease in inpatient admissions, length of stay, ER visits (17.7%), and SNF days, as well as an 18% increase in outpatient visits. The cost of providing care to the experimental group decreased as compared to the control group.⁸

Create hospital-payer collaborations to advance care coordination

In the current fee-for-service system, hospitals continue to undertake quality and efficiency initiatives. Savings from these programs, however, have the potential to be realized mostly by the payer if new financial arrangements are not established. As both parties face increased accountability for quality and cost, hospital-payer collaborations have the potential to improve care for the population by sharing data, encouraging alignment with physicians, and facilitating a focus on primary care. This does not mean that all organizations must consider becoming accountable care organizations. Less complex arrangements still lead to incentives to provide preventive care and to adhere to evidence-based protocols. While formal programs with federal payers are more common, relationships with private payers are increasing as well.



Who: Eastern Maine Health Systems and Cigna, Bangor, Maine

Outcomes: Like other hospitals and health systems, EMHS was seeing increased chronic disease rates and a push to reduce costs.

Factors: There was a lack of care coordination across the continuum. Situated in a very competitive market, EMHS could not follow patients leaving the system for other care providers.

Interventions: Cigna entered into a “collaborative accountable care” arrangement with EMHS. Covering 12,000 lives, Cigna aids EMHS to embed care coordinators within primary care practices, provides semiannual reports on patient utilization, and compares EMHS utilization with other organizations. Analysis showed that EMHS was seeing higher ED rates than other area hospitals.

Impact: EMHS care coordinators follow up with patients who have been in the ED unnecessarily the night before and with those who have three or more ED visits within six months, to monitor health and provide information on other available care sites. EMHS also built walk-in care centers to accommodate patients with nonemergent health care issues.⁹

Who: Baptist Health System, San Antonio, Texas

Outcomes: Discharges for specific cardiac and orthopedic procedures were the most costly.

Factors: There was lack of physician engagement in clinical improvement.

Interventions: Baptist applied and was accepted into the Medicare Acute Care Episode Demonstration, which bundled Medicare Part A and B payments for 29 cardiac and orthopedic diagnosis-related groups. The program required the hospital to create standard order sets for routine cases and initiated gainsharing with physicians after four hospital- and physician-level cost and quality goals were met. Baptist committed to a lower base payment from Medicare, with incentives if spending across the continuum was reduced.

Impact: After one year of implementation, there were significant improvements in orthopedic quality metrics as well as increased standardized order set utilization (0–87%). About \$1 million was distributed in shared savings to both patients and physicians, and Baptist saved approximately \$8 million from June 2009 through December 2011.¹⁰ They reduced cost by more than \$2,000 per case.¹¹

Work directly with community employers to improve health outcomes



Many health systems and hospitals have recognized that one of the easiest ways to reach a large portion of their patient population is by working directly with local employers. These collaborations can begin by offering community wellness classes on prevention and common illnesses or preventive screenings at employers' offices during work hours. Other organizations have established onsite health clinics and more direct contract payment relationships. For the employer, working with hospitals has the potential to decrease health care costs and employee absences while increasing productivity and employee morale. For hospitals, working with employers can help them reach a wider demographic for preventive services at patients' convenience, thereby increasing the patient populations seeking care at the right place and time.

Who: AtlantiCare Special Care Center, Atlantic City, New Jersey

Outcomes: Local 54 Health and Welfare Fund provides benefits for 14,000 union workers employed by restaurants, hotels, and casinos. These employees were experiencing rising insurance costs due to increased rates of chronic diseases. AtlantiCare was seeing high rates of uncompensated care spending for preventable ED use and hospitalizations

Factors: There was a lack of care coordination for complex patients, typically those with low socioeconomic status, multiple chronic conditions, and low health literacy.

Interventions: AtlantiCare opened the Special Care Center for Local 54, which is a primary care center for patients with chronic illnesses that features personalized health coaches, longer visits with physicians, protocol-based planning, multidisciplinary clinical care, no pharmacy copayments, and salaried physicians. The health coaches work directly with patients to proactively manage care. Local 54 pays AtlantiCare per member per month rates for all primary care.

Impact: According to analysis conducted between 2008 and 2009, SCC patients experienced 41% fewer inpatient admissions and 48% fewer emergency visits. There were improved outcomes in pharmaceutical compliance, quality indicators, and generic use. Spending on primary care visits, prescription use, labs, and testing increased because patients were more compliant with care protocol.^{12, 13}

Who: Indiana University Health Goshen, Goshen, Indiana

Interventions: To encourage partnerships with employees of local businesses, this 125-bed facility started "Get Fit, Get Health," an employee wellness program. Working at the employers' work sites, the program includes health risk appraisals for employees and onsite wellness clinicians and health coaches to share confidential individualized reports and suggest care plans. Periodically, Goshen provides the employers with summary reports, to track employee health improvements.

Impact: While results have varied by partner employer, Goshen's employer partnerships have helped employees lose weight, lower cholesterol, and reduce blood glucose levels.¹⁴

Look beyond clinical care partnerships to improve access to care and other necessary community services

Hospitals recognize that if they help improve community access to health care, preventive care, and healthy lifestyle behaviors, they have the ability to significantly reduce the incidence of chronic diseases and reduce unnecessary inpatient admissions and ED visits. Hospitals also realize that this is something they cannot do on their own, due to limitations in both financial means and expertise. Therefore, organizations have begun to partner with social service organizations ranging from community and wellness centers to schools and soup kitchens to tackle health issues such as obesity, diabetes, and unhealthy habits. Community organizations have a thorough understanding of population needs and which programs have the most potential for success. These collaborations may be difficult to evaluate based on short-term health outcomes, as these initiatives may identify and expand access for populations with significant health care needs. Promoting prevention and improving the societal factors that support good health are long-term strategies.



Who: Rush University Medical Center, Chicago, Illinois

Outcomes: Humboldt Park had a 14% type 2 diabetes rate, two times the national rate.

Factors: A predominantly uninsured and underinsured population, the neighborhood population also has difficulties accessing care due to low health literacy and language barriers.

Interventions: RUMC partnered with the Sinai Urban Health Institute, Norwegian American Hospital, Saint Mary and Elizabeth Medical Center, the Puerto Rico Cultural Center, the Greater Humboldt Park Community of Wellness, and Pueblo Sin Fronteras to create the “Block by Block” program. Captains conduct door-to-door diabetes screenings, connecting residents to community PCPs and other resources available through the newly established Greater Humboldt Park Community Diabetes Empowerment Center. The center has a test kitchen that offers discussions of healthy food options, educational programs, and is staffed by nurses and clinicians who answer clinical questions.

Impact: RUMC committed to accept diabetes patients from Humboldt Park for ongoing care. More than 1,000 residents have been connected to a health care provider to discuss their diabetes risk.^{15 16 17 18}

Who: Chadron Community Hospital, Chadron, Nebraska

Interventions: A rural critical access hospital, Chadron has three different food banks, partners with two community action agencies to provide low-cost dental services, and has collaborated to create “Closer to Home,” a soup kitchen for the area’s homeless population. The hospital works with the local college and primary school systems to provide various nursing services, in addition to developing an alcohol education program with area law enforcement agencies.

Who: Suburban Hospital, Bethesda, Maryland

Interventions: As a result of its community health assessment, Suburban increased cardiovascular outreach and access in the surrounding county in conjunction with the NIH Heart Center, providing free vascular and blood pressure screenings. The hospital donated money directly to two area nonprofit clinics to expand their own services. For the hospital’s aging population, Suburban provided more than 1,000 home visits and 68 senior health education seminars and senior-focused exercise classes.¹⁹

Work with public health agencies, the government, and other partners to achieve improved health care outcomes



Most local, state, and federal governments are dealing with large budget deficits that have forced them to turn to various means to cut spending, and attention has turned to reducing health care costs. The requirement for hospitals to conduct community health assessments will help identify areas for collaboration between hospitals and public health and other governmental agencies, leading to new programs with the potential to reduce costs in the long run. Policy changes create opportunities to significantly increase access to care for complex patients and also help create community conditions that support people’s ability to enjoy healthier lives. Combining the expertise in patient care that hospitals have with the broader perspectives and public health experience of the government, this type of collaboration can improve overall population health outcomes.²⁰

Who: Woman’s Hospital, Baton Rouge, and East Jefferson General Hospital, Metairie, in conjunction with 19 other Louisiana hospitals and the Louisiana Department of Health and Hospitals

Outcomes: The National Center for Health Statistics ranked Louisiana 49th in several birth outcomes including infant mortality, percentage of low-birthweight babies, and preterm births.

Factors: There was a lack of collaboration among hospitals, health care agencies, and the government to make perinatal education and services a priority.

Interventions: In late 2011, Louisiana became the first state to adopt a “39 Week Initiative.” A voluntary program, participating hospitals agreed to eliminate the practice of scheduling and performing elective deliveries prior to 39 weeks’ gestation. Woman’s and EJGH leaders, in addition to DHH administrators, met with other hospitals throughout the state to encourage participation. Additionally, the state worked with the largest malpractice provider to reduce malpractice rates for physicians who participate in training related to this topic.

Impact: Though the initiative is still in early stages for most of the state, Woman’s and EJGH have reduced NICU admissions and cesarean section rates by eliminating early term elective deliveries.²¹

Who: Healthy San Francisco, a partnership between the San Francisco Department of Public Health and more than 30 other hospitals and community clinics

Outcomes: The city had a growing number of uninsured residents, leading to high ED usage.

Factors: Uninsured and underinsured populations have reduced access to necessary health care services.

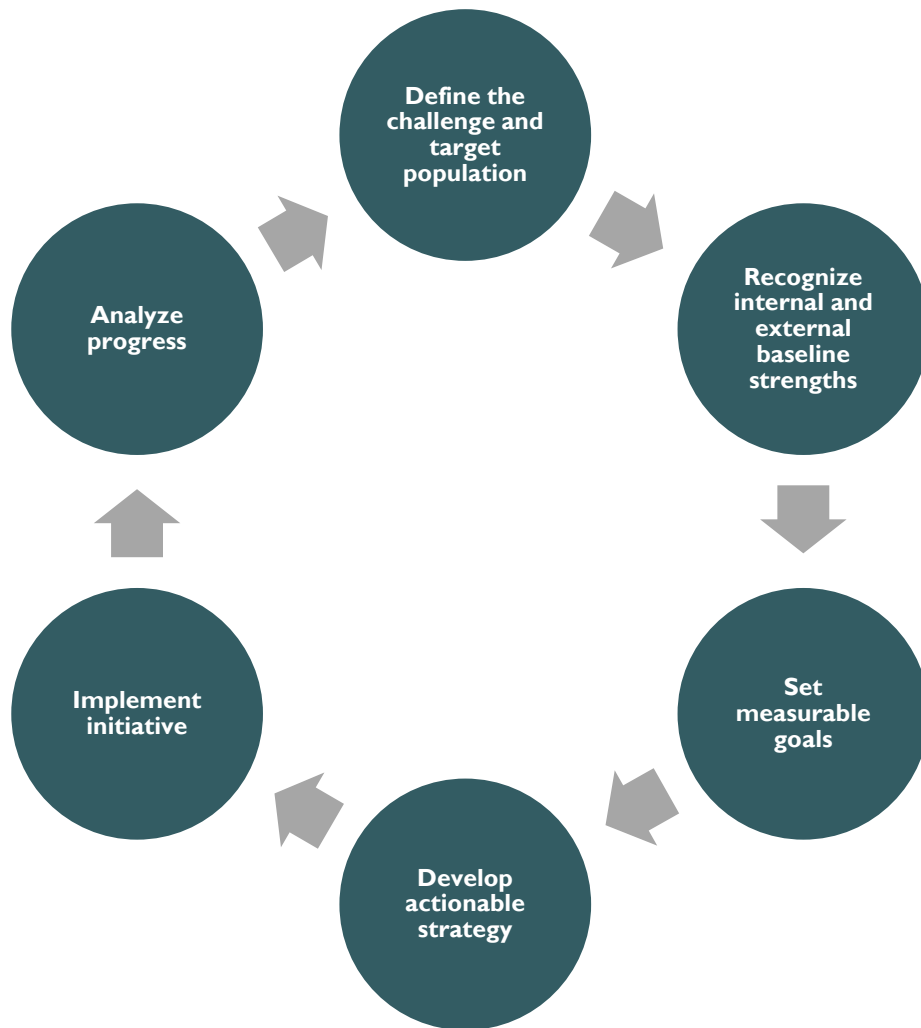
Interventions: The participating hospitals and clinics created Healthy San Francisco, a safety-net consortium of providers for the uninsured coordinated by SFDPH. Emphasis lies on improved care coordination and early treatment, utilizing the medical home model for primary care. Enrollment is offered in a subsidized health care system. Rather than covering uninsured patients with a health insurance product, the consortium provides services through a network of clinics that meet all medical, dental, and vision needs.

Impact: Since its inception, HSF has enrolled 100,000 uninsured residents, 85% of the analyzed uninsured population. Data for 2010–2011 suggest that HSF beneficiaries utilize primary care at the same rate as the national Medicaid population (three office visits per year), go to the ED for avoidable conditions at half the state rate (9% versus 18%), and have a hospital readmission rate at half the national rate (9% versus 18%).²²

The Discussion Is Just Beginning

This guide is designed to define population health for the hospital executive, describe population health approaches and potential partners, and explain why these initiatives are essential for the future value-based market. The American Hospital Association's Hospitals in Pursuit of Excellence initiative will continue the conversation with more action-oriented case studies based on the framework depicted below. Information and resources are available on the HPOE website at www.hpoe.org.

Figure 7. Framework for Population Health Improvement Initiatives



Source: HRET, 2012.

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**Principles & Guidelines:
Changes in Hospital Ownership**



Principles and Guidelines for Changes in Hospital Ownership

January 2012

**JONES
DAY**®


American Hospital
Association

Principles and Guidelines for Changes in Hospital Ownership

Keeping the Public's Confidence and Trust

Community Accountability with Changes in the Ownership or Control of Hospitals or Health Systems

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Accessible at: <http://www.hpoe.org/resources-and-tools/2130004485>

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Overview

Hospitals face a dramatically changing regulatory landscape with increased pressure from state and federal agencies, news media and others to improve health care services, enhance access to health care services and identify and respond to community needs. Additionally, hospitals increasingly encounter government and commercial payors aggressively seeking to reduce the costs that they pay for health care services. Together, these 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.

Hospital leaders must approach potential integration opportunities in a manner that protects the delivery of health care services in their communities but that recognizes the hospital's need to adapt in a changing environment. Moreover, hospital leaders must consider how to engage their communities as well as state and federal regulatory agencies regarding potential changes in ownership or control. The American Hospital Association has prepared these voluntary guidelines to help hospital executives, directors, officers and physicians meet these challenges.

Significance of Fiduciary Duties in Fulfilling the Hospital's Mission

Hospitals serve as an important resource for their communities. The core values of a hospital are defined by its mission, including for tax-exempt, charitable hospitals an emphasis on providing benefits to the community that include caring for indigent and vulnerable populations, conducting research and educational programs, improving community health and performing other valuable community-building activities. Board decisions regarding changes of ownership or control should be made in a manner that furthers the hospital's mission and that allows directors to fulfill their fiduciary duties.

Directors owe a fiduciary duty to the hospital to act with the level of care, loyalty and diligence that a reasonably prudent person would utilize in similar circumstances. Potential changes in the ownership or control of a hospital heighten the need to ensure that directors fulfill these duties. Exercising appropriate care requires more than just merely attending and participating in board and committee meetings about potential transactions. Each director should:

- Understand the community's need for health care services and determine the best organizational structure for meeting those needs;
- Prepare in advance for meetings about potential changes in ownership or control of the hospital by reading relevant reports regarding these potential changes and any other options considered;
- Participate actively in board and committee meetings by questioning hospital executives, legal counsel and other consultants about changes in ownership or control;
- Exercise independent judgment in votes pertaining to the potential change in ownership or control; and
- Follow up throughout the decision-making process regarding any outstanding questions about the potential change.

Directors must also ensure that the hospital's interest take precedence over his or her personal and financial interests or those of his or her family. This duty of loyalty requires directors to assure the community that conflicts of interest are disclosed particularly when considering fundamental changes to the hospital's organizational or operational structure. Directors should regularly examine the hospital's policies for identifying, disclosing and resolving conflicts of interest to ensure appropriate safeguards are in place, including:

- Establish written policies for addressing conflicts of interest;
- Recusal by directors from activities that may compete with the hospital or impede its ability to determine whether a change in control is in the hospital's best interests; and
- Avoid diverting opportunities available to the hospital to preserve or protect a personal or financial interest.

The Internal Revenue Service has stepped up its efforts to educate board members about the relationship that exists between compliance with federal tax laws and good corporate governance practices. An IRS official described the relationship as follows: "good governance and compliance go hand in hand, and that an active and independent board is the best defense against the misuse of charitable assets, as well as against bad press."

Key Considerations for Potential Changes in Ownership or Control

Potential changes in the ownership or control of a hospital present unique challenges for hospital directors, executives and physicians. Perhaps the most important challenge that these hospital leaders encounter is balancing the needs of the community for efficient and effective health care services with the needs of the organization for adaptation. It is important for directors and executives to keep the following questions in mind as they explore potential changes in the hospital's organizational or operational structure:

- Why is the transaction being considered?
- Will this transaction help to fulfill the hospital's mission?
- Will the boards (local and system, if applicable) be receptive to the proposed change?
- Is the change consistent with the hospital's strategic planning?
- What are the financial advantages and disadvantages of the proposal?
- What are the internal and external political consequences of the change in ownership or control?
- Will the medical staff and other professionals be receptive to the idea? How will the community respond to the proposed change?
- How will the changes be communicated to key constituencies?
- Are there any legal or regulatory constraints that may hinder the proposal?
- Are any constraints imposed by existing collective bargaining agreements?
- Are there any tax-exempt bonds or other debt covenants that may be triggered by the potential change?
- Have all potential liabilities been disclosed?
- Are there quality of care issues and, if so, how will they be addressed?
- How will the new organization be structured?
- What are the selection criteria for the management team?
- What are the selection criteria for governance?

Guidelines for Review of Potential Changes in Ownership and Control

Changes in ownership or control present several challenges for hospital and health system leaders. While many of these challenges – such as regulatory issues – may be easily anticipated, others – like community reaction – may be more difficult to predict. These voluntary guidelines have been prepared by the American Hospital Association to help hospital and health system leaders – directors, executives and clinical leaders – meet the challenges that are frequently encountered when an organization considers a potential change in ownership or control.

I. Engage the community to identify its future health improvement needs

Many parties and constituencies will be interested in proposed changes in the ownership or control of the hospital, and hospital leaders should consider the most appropriate means of including representatives from these various constituencies in discussing these changes. Including representatives from these constituencies in the periodic community health needs assessments and implementation strategies that the federal health reform law requires may be a means of engaging the hospital’s constituencies early on with respect to potential changes in ownership or control.

The degree of engagement by these constituencies will depend upon the type of transaction, the stage of the proposed change and the specific facts at hand. Interested parties/constituencies often include:

<ul style="list-style-type: none"> • Church sponsors (if applicable); • Governing board/advisory boards; • Federal, state and local governmental agencies; • Internal and external publics; • Labor unions represented at the hospital; • Major employers/business coalitions; 	<ul style="list-style-type: none"> • Media; • Medical staff; • Nurses; • Other employees; • Patients and consumers; • Payors; and • Related foundations.
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II. Initial steps in considering a change in ownership or control

Hospital leaders should regularly adopt and review strategic plans to determine how changes in ownership or control may further strategic objectives. This process should ensure that these leaders:

- Understand the process that the organization and its governing body will use for deciding about a change in ownership or control;
- Identify the organization’s values and goals in advance of considering a change in ownership or control;
- Review strategic plans to determine how changes in ownership or control may further strategic objectives;
- Understand any state or federal legal limitations of the organization’s certificate of incorporation, articles of organization, or charter that may restrict changes in ownership or control, such as combinations of tax-exempt charitable hospitals with for-profit organizations; and
- Adopt criteria for evaluating any change in ownership or control before examining proposals.

III. Carefully evaluate proposed changes in ownership or control

Hospital leaders should develop policies and procedures that designate task forces to review, evaluate and make recommendations regarding proposals to partner with other hospitals and health systems through changes in ownership or control. Hospital leaders should:

- Evaluate proposals based on community health needs, the organization’s values and mission, the protection and use of community assets, and organizational financial viability;
- Encourage compatibility in values and philosophy by favoring changes that reflect shared missions, visions and strategies;
- Obtain a legal analysis, by a party not involved in the transaction, of the potential regulatory and other legal implications of the transaction;
- Obtain background information about other similar transactions in which the organization has been involved, if any, and whether those transactions have been successful;
- Understand thoroughly the terms of the proposed transaction and of all collateral arrangements to ensure that the terms comply with all legal requirements; and
- Conduct the due diligence necessary to ensure that hospital executives and directors have fulfilled their fiduciary duties to the hospital in evaluating the transaction and its terms, including addressing the key factual and legal questions.

Hospital leaders also need to clearly understand the business purpose(s) of the proposed change in ownership or control. Business purpose includes both the strategic implications of the proposed change and the tactical objectives, both long-term and short-term objectives. Business purposes(s) that often drive decisions include:

<ul style="list-style-type: none"> • Geographic expansion; • Capital access or enhanced capital base; • Service/product line expansion; • Financial base expansion/cash flow enhancement; • Achievement of cost and quality-related efficiencies; • Acquisition of unique assets, including personnel or location; 	<ul style="list-style-type: none"> • Development/analysis of multiple future organizational scenarios; • Allocation of expense and loss of business opportunity issues; • Association with high-quality, reputable organization; • Improved return on equity; • Greater flexibility to respond to market pressures; and • Infusion of new physicians.
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IV. Conduct an appropriate review of state and federal health care laws

Various federal and state agencies enforce the myriad of laws that apply to potential changes in the ownership or control of the hospital. These regulatory authorities include:

<ul style="list-style-type: none"> • Office of the Inspector General of the U.S. Department of Health and Human Services (OIG); • Centers for Medicare and Medicaid Services (CMS); • Internal Revenue Service (IRS), as well as income and property tax authorities; 	<ul style="list-style-type: none"> • State attorneys general; • Certificate of need authorities; • State licensure agencies; and • State Medicaid agencies.
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The laws that each of these agencies enforce are highly technical and depend on the unique facts of the potential change in ownership or control at issue. Important facts for the analysis of these laws include such things as whether both hospitals are tax-exempt, charitable organizations, whether either of the hospitals has physician ownership, whether the executive officers of the hospital will be retained as part of the transaction, etc. As a general matter, although these laws have extremely broad application, each one targets arrangements that result in unnecessary utilization of government-funded health care services or provide improper financial benefits to hospital directors, executives or other insiders, including physicians in certain circumstances. In order to ensure that a proposed change in control or ownership does not violate any of these restrictions, hospital leaders should engage qualified legal counsel to evaluate the structure of the transaction against this highly technical framework of federal and state laws.

V. *Conduct an appropriate antitrust analysis where necessary*

- If the organizations considering the transaction are competitors, and particularly if they are large enough to require premerger notification, it is essential that a thorough analysis of the potential antitrust implications be completed.

<ul style="list-style-type: none"> ▪ Structure of transaction: Is it sufficiently integrated to be a single entity? ▪ Market analysis: What are the service lines and geographic areas affected by the transaction? 	<ul style="list-style-type: none"> ▪ Competitive effects: Are there entry barriers? Are the hospitals more complementary than directly competitive? What is the history of payor contracting? Other considerations? ▪ Defenses: Efficiencies, financial condition of one or both parties, state action (if one of the hospitals is a government hospital).
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- Antitrust process

<ul style="list-style-type: none"> ▪ Transactions over a certain size must be reported to federal antitrust agencies up front; ▪ Even if a transaction is not reportable, agencies can still investigate; 	<ul style="list-style-type: none"> ▪ State attorneys general often conduct their own antitrust reviews; and ▪ It is important to be prepared.
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VI. *Protect the value of the community's assets*

Because many states have adopted explicit requirements for review by state attorneys general or other agencies regarding changes in the ownership or control of tax-exempt, charitable organizations, hospital and health system leaders should:

- Obtain a valuation, by a party not involved in the transaction, of charitable assets being converted or restructured to ensure receipt of reasonable value is received or used in structuring the transaction;
- Identify financial incentives that may influence the views of directors and executives involved in proposing and evaluating any change in ownership or control;
- Disclose all conflicts of interest, offers of future employment, future remuneration or other benefits related to the transaction;
- Prohibit private inurement or personal financial gain by employees or directors of any tax-exempt, charitable entity involved in the transaction;
- Evaluate covenants not to compete with regard to tax-exempt status and community benefit;

- Control and administer any foundation or charitable trust created by the transaction separate and distinct from the restructured health care organization;
- Ensure that a foundation, charitable trust, or community payment created from the transaction continues to alleviate burdens that impede access to health care services;
- Establish requirements for any foundation or charitable trust created by the transaction to make capital expenditures to improve facilities or health care services available to the community; and
- Require any foundation resulting from the change in ownership to provide regular reports to the community on how it improves community health.

VII. Educate and inform the community about the changes taking place

Changes in the ownership or control of a hospital require careful and consistent communications about the transaction with the constituencies that it affects. Accordingly, hospital and health systems should:

- Work with the community to increase understanding of the issues involved in the change of ownership or control, the evaluation and decision-making process involved in the transaction, and how the transaction will benefit the community;
- Inform the appropriate state regulatory agencies of the terms of a transaction once a letter of intent (or memorandum of understanding) is signed;
- Work diligently with medical and nursing staff and employees who have not previously been involved in the potential change in ownership or control to alleviate any concerns regarding the need for their services; and
- Communicate to patients the effects, if any, of the transfer of control or ownership on how they obtain health care services, including continuity of care and availability facilities and service lines.

Achieving these objectives requires that hospital directors and executives develop a detailed communications plan that addresses each potential constituency. The communications plan should include the following:

<ul style="list-style-type: none"> • Objectives of the transaction and its parties; • Audiences to be addressed; • Implementation and start-up of new organization(s); • Methods of communicating (meetings, memos, emails, newsletters, videos); 	<ul style="list-style-type: none"> • Impressions created to reinforce or dispel certain aspects of the transaction; • Objectives that need to be listed; • Frequency of communications; • How external/internal publics will feed into the communications process; and • How the media will be informed.
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REQUEST:	Provided Herewith	To Be Provided
<i>A. Organizational History; Planning and Marketing</i>		
1. Copies of consultant’s reports or other information concerning operations or strategic plans of Hospital and each Affiliate. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
2. Copies of brochures and reports describing Hospital and each Affiliate.	[]	[]
<i>B. Corporate/Organizational Documents</i>		
1. List of each Affiliate, including, without limitation, any Affiliate that has been dissolved or terminated within the past five (5) years. List should include (i) name of Affiliate, (ii) form of organization/entity (e.g., partnership, corporation, LLC), (iii) jurisdiction of incorporation/formation/establishment, (iv) address of principal and other locations where such Affiliate is qualified/registered to do business, and (v) brief business description.	[]	[]
2. Organizational chart reflecting the corporate organization and ownership structure among Hospital and the Affiliates.	[]	[]
3. Copies of the Articles of Incorporation, Articles of Organization, Articles of Partnership, Partnership Agreement or similar charter documents, as amended to date, for Hospital and each Affiliate.	[]	[]
4. Copies of Bylaws, Code of Regulations, Operating Agreements or similar organizational documents, as amended to date, for Hospital and each Affiliate.	[]	[]
5. Copies of any Close Corporation Agreements, Shareholder’s Agreements and/or Trust Agreements, as amended to date, for Hospital and each Affiliate.	[]	[]
6. Copies of the minutes from board, committee, shareholder/member/partner meetings for the past five (5) years for Hospital and each Affiliate.	[]	[]
7. List of the current (i) trustees/directors, and (ii) officers for Hospital and each Affiliate. List should include terms and qualifications of each trustee/director and officer.	[]	[]
8. Organizational chart of the hierarchy of officers and key managers at Hospital and each Affiliate (including names of those individuals serving in such positions).	[]	[]
9. List of salary and any other compensation or payments (including, without limitation, any loan agreements) to any trustee/director and/or officer from Hospital or any Affiliate. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]

REQUEST:	Provided Herewith	To Be Provided
10. Copies of Conflict of Interest statements executed by the trustees/directors of Hospital and each Affiliate for the past three (3) years.	[]	[]
11. List of current shareholders/members/partner (“ equity holder ”) of Hospital and each Affiliate. List should include (i) number of interests held by equity holder, (ii) price paid by equity holder, and (iii) whether equity holder is a physician.	[]	[]
12. Summary of (i) the number of shares/membership/partnership interests currently authorized, (ii) the number issued and outstanding, and (iii) outstanding options, warrants, rights and/or any other commits to issue interests in Hospital or any Affiliate.	[]	[]
13. Copies (or description if oral) of any proxies, voting trusts, powers of attorney or similar agreements, formal or informal, with respect to voting interests in Hospital or any Affiliate.	[]	[]
14. Copies of any stock purchase agreements, buy-sell agreements and other agreements or commitments that may establish limitations on the transfer of interests in Hospital or any Affiliate.	[]	[]
15. Copies of any documents relating to the acquisition, establishment or divestiture of Hospital or any Affiliate.	[]	[]
16. Summary of any commitment to make additional investments or to sell or otherwise transfer any current investments in Hospital or any Affiliate.	[]	[]
17. Copies, including, without limitation, offering materials, federal and/or state securities filings, and any opinions of counsel, respecting compliance with or basis for exemption from federal and state securities laws with respect to the issuance and transfer of interests in Hospital or any Affiliate.	[]	[]
18. Copies of the medical staff bylaws for Hospital and each Affiliate.	[]	[]
19. Organizational chart reflecting the structure of the departments, committees and executives and the members thereof for Hospital and each Affiliate.	[]	[]
20. Summary of all transactions (contracts, loans, contributions, etc.) between Hospital and any Affiliate during the past three (3) years. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
21. To the extent not otherwise provided, list of any ownership or similar relationship with an HMO, PPO or other third party payor or managed care company.	[]	[]
22. Summary of all trusts and foundations of which Hospital or any Affiliate is the exclusive or primary beneficiary.	[]	[]

REQUEST:	Provided Herewith	To Be Provided
23. To the extent not otherwise provided, copies of any other corporate, shareholder, membership, partnership or similar records material to Hospital or any Affiliate.	[]	[]
C. Regulatory/Accreditation Issues and Compliance		
1. Copies of all significant licenses, permits, registrations, certifications and authorizations issued by the United States federal, state or local authorities (“ Governmental Authority ”) to carry out the business or operations of Hospital and each Affiliate, including, without limitation, Medicare/Medicaid certification, DEA licenses and pharmacy permits. Copies should include relevant correspondence/ filings with the applicable Governmental Authority. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
2. Copies of all civil and criminal judgments, settlements, corporate integrity agreements or other agreements with any Governmental Authority entered into by Hospital or any Affiliate regarding conduct governed by the federal or state anti-kickback statutes, physician self-referral laws, beneficiary inducement laws, false claims acts, the Medicaid Rebate Statute or any other laws related to health care fraud and abuse (collectively, “ health care fraud and abuse laws ”). (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
3. Summary regarding the nature, status and outcome of any investigations by any Governmental Authority of Hospital or any Affiliate regarding conduct governed by the health care fraud and abuse laws. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
4. Summary of any current or past exclusion of Hospital or any Affiliate or any of Hospital’s or any Affiliate’s directors, officers or employees, from participation in any United States federal health care program.	[]	[]
5. Copies of all Certificate of Needs (“ CON ”) held by Hospital or any Affiliate, including, without limitation, a list of facilities operating pursuant to a specific CON exception. Should also include copies of any documents regarding any administrative or judicial pending, threatened or completed within the past five (5) years involving Hospital or any Affiliate in connection with such CONs.	[]	[]
6. Copies of audit reports issued by any Governmental Authority with respect to the business or operations of Hospital and each Affiliate within the past five (5) years.	[]	[]

REQUEST:	Provided Herewith	To Be Provided
7. Copies of accreditation letters from The Joint Commission,AMA, AOA and any other equivalent agency or authority for Hospital and each Affiliate. Should also include underlying survey letter and follow-up progress reports.	[]	[]
8. Copies of (i) the regulatory compliance plan and policy, and (ii) the corporate ethics and compliance plan and policy for Hospital and each Affiliate. Should also include a copy of the form disclosure provided to patients by physician investors, if applicable.	[]	[]
9. Copies of all necessary permits, licenses and compliance plans to operate the facilities of Hospital and each Affiliate, including, without limitation, air pollution emission permits, surface water discharge, identified waste disposal (landfill or sewer), or other industry specific or environmental related permits.	[]	[]
10. Summary of radioactive and other hazardous materials used or hazardous or infectious wastes generated or located at the facilities of Hospital and each Affiliate. Summary should include copies of environmental reports, if any, and set forth (i) the nature of such hazardous or infectious materials and waste, (ii) how such hazardous or infectious materials and waste have been disposed of by Hospital and/or Affiliate, and (iii) information regarding the presence or removal of asbestos in any such facilities.	[]	[]
11. Copies of engineer, safety, fire or other equivalent reports regarding the condition of the facilities of Hospital and each Affiliate, including, without limitation, all medical office buildings.	[]	[]
12. List of any underground storage tanks and copies of notices given to any Governmental Authority by Hospital or any Affiliate regarding the existence of such tanks.	[]	[]
13. List of properties owned, leased or operated by Hospital or any Affiliate that have at any time been used to treat, store, recycle, reuse or dispose of hazardous materials or waste.	[]	[]
14. Copies of, or description of oral notice with respect to, any consent decree, citations, mandatory compliance plan, adverse inspection, finding of deficiency, finding of non-compliance, investigation, penalty, fine, sanction, assessment, audit, request for corrective or remedial action, or other compliance or enforcement-related action or communication from any Governmental Authority relating to environmental matters, zoning, tax, equal opportunity and anti-discrimination, food or drug or price control laws, health and safety of employees, etc. within the past three (3) years for Hospital and each Affiliate.	[]	[]
15. To the extent not otherwise provided, copies of all submissions by Hospital and each Affiliate to any Governmental Authority related to emergency planning.	[]	[]

REQUEST:	Provided Herewith	To Be Provided
<i>D. Financial – Accounting and Tax Records</i>		
1. Copies of audited financial statements of Hospital and each Affiliate for the past four (4) fiscal years, together with accountants' management letters.	[]	[]
2. Copies of the most current interim financial statements and interim financial statements for the equivalent period for the preceding fiscal year for Hospital and each Affiliate.	[]	[]
3. Copies of Internal Revenue Service (“IRS”), state and local tax and/or informational returns for Hospital and each Affiliate for the past three (3) years.	[]	[]
4. Copies of any determination letters or similar correspondence or certification from the IRS and/or state taxing authorities regarding qualification of Hospital and any Affiliate that is qualified as an IRS Section 501(c)(3) organization or under any other federal tax exemption provision and analogous state tax exemption determination. Should also include copies of relevant correspondence, application form(s) and any letter or other confirmation received from the IRS and/or state taxing authority confirming that Hospital and any Affiliate meets qualification to avoid treatment as a private foundation under federal law and/or under equivalent provisions of state law.	[]	[]
5. List providing the date of the latest IRS audit report for Hospital and each Affiliate and, if the audit report was issued within the past three (3) years, provide a copy of such audit report.	[]	[]
6. Copies of all audits, 30-day and 90-day letters and revenue agent's reports for Hospital and each Affiliate.	[]	[]
7. Copies of all settlement documents and correspondence for the past three (3) years for Hospital and each Affiliate. Should also include any agreements waiving statute of limitations or extending time for assessment.	[]	[]
8. Copies of any elections or selection of tax accounting methods under the Internal Revenue and summary of any changes in accounting methods or policies in the past three (3) years for Hospital and each Affiliate.	[]	[]
9. Summary of any pending capital investment projects, improvement projects or construction in progress for Hospital and each Affiliate. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]

REQUEST:	Provided Herewith	To Be Provided
10. Copies of all open Medicare cost reports, audit cost reports and NPRs for Hospital and each Affiliate for the past three (3) years. Should also include any audit adjustments and open appeals. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
11. Statistical information on patient consensus, patient days or admissions by doctor, patient transfer, Medicare case mix indexes, outpatient utilization, number of emergency room and operating room visits, and categorization of Medicare diagnosis related groups by admission for Hospital and each Affiliate. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
12. Copies of current detailed accounts receivable aging and summary of accounts receivable data for Hospital and each Affiliate for the past twelve (12) months.	[]	[]
13. Copies of accounts payable data for the past twelve (12) months and internal computation of bad debts and contractual allowances for the past three (3) fiscal years for Hospital and each Affiliate.	[]	[]
14. Summary of all inventory generally maintained by Hospital and each Affiliate. Summary should include a description of all inventory valuation and pricing policies.	[]	[]
15. List and summary of all contingent liabilities for Hospital and each Affiliate.	[]	[]
16. Copies of the complete detailed general ledger and detailed depreciation reports for Hospital and each Affiliate.	[]	[]
17. Schedule of accrued paid time off balances for the employees of Hospital and each Affiliate.	[]	[]
18. Copies of any Form 1099s issued to physicians and/or physician practice groups by Hospital or any Affiliate for the past five (5) years.	[]	[]
19. Summary of any liabilities not otherwise reflected on the financial statements of Hospital or any Affiliate.	[]	[]
E. Contracts <i>(FOR EACH OF THE FOLLOWING, ALSO DESCRIBE ANY ASSIGNMENT AND/OR THE NATURE OF ANY EXISTING OR PAST DEFAULT)</i>		
1. Copies of agreements (with price terms deleted) between Hospital or any Affiliate and Medicare, Medicaid, HMOs, PPOs or any other third-party payor and managed care companies. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]

REQUEST:	Provided Herewith	To Be Provided
2. To the extent not otherwise provided, copies of all documents, correspondence and other information relating to any alleged violations, orders, deficiencies or overpayments to any provider under any agreement provided pursuant to Section E.1 within the past five (5) years.	[]	[]
3. To the extent not otherwise provided, copies of any agreements between Hospital or any Affiliate and any Governmental Authority.	[]	[]
4. Copies of affiliation, shared service or other agreements between Hospital or any Affiliate and other hospitals, health systems, ambulatory surgery centers or other providers of health care services. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
5. Copies of affiliation, shared service or other agreements between Hospital or any Affiliate and other institutional providers of health care services.	[]	[]
6. Copies of agreements between Hospital or any Affiliate and providers of ancillary services, material vendors and suppliers, third party administrators or billing and collection service providers. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
7. Copies of agreements between Hospital or any Affiliate relating to clinical research programs.	[]	[]
8. Copies of service agreements between Hospital or any Affiliate and suppliers of personnel, maintenance, etc. with annual payments in excess of \$10,000.	[]	[]
9. Copies of management agreements involving Hospital or any Affiliate.	[]	[]
10. Copies of retainer agreements or other similar agreements between Hospital and any Affiliate and accounting and/or legal service providers. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
11. List of all providers of professional services (i.e., medical, accounting and legal) for Hospital and each Affiliate. List should include the amount paid to each such provider for the past five (5) years. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]

REQUEST:	Provided Herewith	To Be Provided
12. List of all agreements between Hospital and any Affiliate. List should include (i) a description of the services or items provided, (ii) compensation, and (iii) expiration date. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
13. Copies of any non-competition covenants and/or agreements binding Hospital or any Affiliate.	[]	[]
14. To the extent not otherwise provided, copies of all loan agreements by Hospital or any Affiliate to any individual (including, physicians, employees, directors/trustees or officers).	[]	[]
15. List of all agreements of Hospital or any Affiliate (including, without limitation, management, service, lease or otherwise) pursuant to which a party is permitted to manage, occupy or provide services in space financed with tax-exempt bonds.	[]	[]
16. To the extent not otherwise provided, copies of any other material agreements imposing a significant or unusual commitment on Hospital or any Affiliate. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
<i>F. Assets – General</i>		
1. Summary of (including, without limitation, description, cost, current valuation and basis for same) all capital equipment of Hospital or any Affiliate that will be included within the scope of the affiliation.	[]	[]
2. Copies of property leases and equipment leases of Hospital or any Affiliate that will be included within the scope of the affiliation. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
3. Summary of (including, without limitation, description, cost, current valuation and basis for same) all other equipment, inventory, supplies, etc. of Hospital or any Affiliate that will be included within the scope of the affiliation.	[]	[]
4. Summary of (including, without limitation, description, cost, current valuation and basis for same) all software of Hospital or any Affiliate that will be included within the scope of the affiliation.	[]	[]

REQUEST:	Provided Herewith	To Be Provided
5. To the extent not otherwise provided, copies of any other lease, license or other agreement that establishes or effects the rights to use Hospital's or any Affiliate's assets that will be included within the scope of the affiliation. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
6. Summary of (including, without limitation, name, cost, market value, term and performance for the past three (3) years) all investments of Hospital or any Affiliate that will be included within the scope of the affiliation.	[]	[]
7. Copies of all other relevant information/documentation regarding the ownership and valuation of the assets that will be included within the scope of the affiliation (e.g., appraisals, UCC, tax judgment or other liens against the assets).	[]	[]
G. Intangible Assets		
1. List of names, patents, copyrights, trademarks, service marks or other ownership interest in any other intellectual property used in the business and operations of Hospital and each Affiliate that will be included within the scope of the affiliation. Should also include copies of registration and rights to use of same, including, without limitation, (i) all patents, patent applications and descriptions of inventions considered patentable, (ii) all registrations and/or renewals of trademarks and service marks, and (iii) any license agreements.	[]	[]
2. Copies, or summary, of all other relevant documentation regarding rights to and valuation of intangible assets of Hospital or any Affiliate that will be included within the scope of the affiliation.	[]	[]
H. Real Estate		
1. List of all real estate owned by Hospital or any Affiliate and any other real estate that will be included within the scope of the affiliation.	[]	[]
2. Copies of deeds and surveys for all real estate owned by Hospital or any Affiliate.	[]	[]
3. Copies of all previously issued title insurance policy or title opinions on any real property owned by Hospital or any Affiliate.	[]	[]
4. Copies of planning, building and zoning permits, variances and/or other similar approvals for any real property owned by Hospital or any Affiliate.	[]	[]
5. Copies of all real property leases entered into by Hospital or any Affiliate. Should also include a list of all leasehold improvements pursuant to any of the foregoing real property leases.	[]	[]

REQUEST:	Provided Herewith	To Be Provided
<i>I. Debt and Other Long-Term Liabilities and Obligations</i>		
1. Description of bonds or other similar long-term obligations of Hospital and any Affiliate. Description should include, without limitation, (i) financial terms, (ii) current debt service and coverage obligations, (iii) security interests, (iv) prepayment/funding obligations, (v) significant negative covenants, and (vi) material defaults in the past ten (10) years.	[]	[]
2. Copies of, and all documents related to, any notes, security agreements, mortgages, line of credit agreements, guarantees, loan-related indemnifications or any other similar loan documents entered into by Hospital or any Affiliate.	[]	[]
3. To the extent not otherwise provided, copies, or summaries, of any other long-term financial obligations of Hospital or any Affiliate.	[]	[]
4. Copies of the description of Hospital or any Affiliate used in offering circulars, official statements, private placement memoranda or other similar financial documents within the past five (5) years.	[]	[]
5. Copies of the index to any closing transcript of any transaction (e.g., asset purchase, stock purchase, etc.) of Hospital or any Affiliate within the past five (5) years.	[]	[]
<i>J. Operational Liabilities</i>		
1. Summary of, in general terms, participation in and valuation of exposure under risk-sharing or similar arrangements between Hospital or any Affiliate and third party payors or other providers. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
<i>K. Physician Services</i>		
1. Copies of all agreements between Hospital or any Affiliate and physician(s) or physician practice group(s) currently in force, including, without limitation, employment agreements, consulting agreements, professional services agreements, research agreements and independent contractor agreements (each a “PSA”). (ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
2. Summary of all severance or other non-pension plan deferred obligations under any PSA. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]

REQUEST:	Provided Herewith	To Be Provided
3. Summary of physician recruitment history during the past five (5) years for Hospital and each Affiliate. Summary should include policy regarding loans, subsidies and other incentives used to recruit and retain physicians. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
4. Summary of participation by physicians and/or their employees in Hospital or any Affiliate benefit programs. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
5. List of physicians on Hospital's and each Affiliate's medical staff (active, provisional, consulting, courtesy and allied). List should include (i) physician specialty, (ii) board certification(s), and (iii) practice location.	[]	[]
6. Copies of medical staff appointment and credentialing policies and procedures for Hospital and each Affiliate.	[]	[]
7. Copies of peer review organization notices and reports received by Hospital or any Affiliate.	[]	[]
8. Summary of all disciplinary actions taken (or pending) by Hospital, any Affiliate or any peer review organization, against physicians during the past three (3) years.	[]	[]
<i>L. Labor and Employment</i>		
1. Organizational chart covering all employees for Hospital and each Affiliate.	[]	[]
2. List of all current full-time, part-time and temporary employees of Hospital and each Affiliate.	[]	[]
3. To the extent not otherwise provided, copies, or summary, of any agreement (including employment agreements) between Hospital or any Affiliate and any senior executive employee of Hospital or any Affiliate. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
4. Summary describing the benefits provided by Hospital and each Affiliate. Summary should include benefits relating to (i) pension, profit-sharing or other retirement plans, (ii) other severance/retirement benefits, (iii) vacation/sick leave policy, (iv) health insurance, (v) life insurance, and (vi) any other employee benefit plans or programs. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]

REQUEST:	Provided Herewith	To Be Provided
5. Summary of any management incentive programs in effect for Hospital and each Affiliate and list of all employees eligible for such programs. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
6. Copies of separation or release agreements between Hospital or any Affiliate and any current or former employees or applicants.	[]	[]
7. Copies of any collective bargaining agreements of Hospital or any Affiliate.	[]	[]
8. Summary of any union organization activity, strikes or labor disputes at Hospital or any Affiliate.	[]	[]
9. Summary of any unfair labor practice claims against Hospital or any Affiliate.	[]	[]
10. Copies of employee manuals, handbooks and any other relevant materials of Hospital or any Affiliate regarding employee matters that may not be included in manuals or handbooks (e.g. policies and procedures regarding drug and alcohol testing, blood testing, pre- and post-employment medical examinations).	[]	[]
11. Summary of the procedures undertaken by Hospital and each Affiliate to comply with COBRA and EEOC requirements.	[]	[]
12. List of all employees of Hospital or any Affiliate who are not citizens or resident aliens (i.e., “greencard holders”) of the United States. Should also include documentation of I-9 (Immigration Act) compliance.	[]	[]
13. List of all positions at Hospital or any Affiliate that are funded in whole or in part by grants or contracts with any Governmental Authority.	[]	[]
14. To the extent not otherwise provided, copies of all consultant and other independent contractor agreements entered into by Hospital or any Affiliate. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
15. Statistical information regarding age and length of service for employees of Hospital and each Affiliate.	[]	[]
16. List of outstanding contractual grievances, pending arbitrations and recently concluded arbitrations involving Hospital or any Affiliate. Should also include summary of the issues raised in the foregoing grievances and/or arbitrations.	[]	[]
17. Copies of all arbitration decisions, settled arbitrations and settled grievances that interpret a collective bargaining agreement of Hospital or any Affiliate.	[]	[]

REQUEST:	Provided Herewith	To Be Provided
18. List of all outstanding litigation (including employee litigation) involving Hospital or any Affiliate.	[]	[]
19. Copies of recent decisions, settlements, consent decrees, conciliation and compliance agreements issued by the National Labor Relations Board, National Mediation Board, Equal Employment Opportunity Commission, State and Local Fair Employment Practices Agencies, Federal and State Departments of Labor, state boards and agencies and any other Governmental Authority involving Hospital or any Affiliate. Should also include copies, or summary, of any current, recently completed or anticipated investigations or any threatened or pending claims by any of the foregoing entities against the Hospital or any Affiliate for any employment matter (e.g., wage and hour, human rights violations, OSHA, employee benefits litigation, etc.).	[]	[]
20. Copies of OSHA Form 2000 (log of injuries and illnesses) for the past five (5) years for Hospital and each Affiliate.	[]	[]
21. Copies of the affirmative action manual for Hospital and each Affiliate.	[]	[]
22. Summary of current experience rating of Hospital and each Affiliate from the applicable state employment security commission.	[]	[]
<p>23. Copies of applicable qualified retirement plans (defined contribution/ defined benefit) of Hospital and each Affiliate together with copies of the following, as applicable:</p> <ul style="list-style-type: none"> • most recent plan document and trust agreement; • corporate resolution adopting plan; • plan amendments; • all governmental agency rulings and IRS determination letters; • most recent summary plan description; • three (3) most recent Form 5500s; • most recent actuarial and financial reports; • allocation reports and coverage and nondiscrimination test runs for the last three (3) years; • any correspondence from the IRS, PBGC or Department of Labor regarding the plan or trust; • any open requests for IRS rulings or letters; • insurance contract held by plan; • documentation of any claims against the plan or plan fiduciaries; and • any returns, correspondence or other documentation regarding prohibited transactions with the plan. <p>(POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)</p>	[]	[]

REQUEST:	Provided Herewith	To Be Provided
<p>24. Copies of applicable welfare benefit plans (and related summary plan description) of Hospital and each Affiliate together with copies of the following, as applicable:</p> <ul style="list-style-type: none"> • health and dental plans and COBRA notification forms; • trust document (if plan assets held in trust); • group term life insurance plan; • short- and long-term disability plans; • cafeteria/flexible benefits plan; • dependent care assistance plan; • educational assistance plan/program; • employee assistance program; • deferred compensation arrangements and rabbi trust; • severance or salary continuation arrangements; • supplemental unemployment benefit; • incentive compensation arrangements; • stock option plans, restricted stock agreements, phantom stock plan or other stock-based compensation arrangement; • bonus arrangements; • vacation policies; • employee fringe benefits (e.g., club and membership dues, hospital-provided automobile, etc.); • director/trustee plans/benefits; • retiree benefits; • other employee benefit arrangements; • correspondence or other documentation from the IRS, Department of Labor or possible claimant; • if any plan had 100 or more participants at the beginning of the last three (3) plan years, provide copies of the Form 5500s for the last three (3) years; and • Form 5500s for the last three (3) years for cafeteria plan and educational assistance plan (regardless of the number of participants). <p>(POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)</p>	[]	[]
<i>M. Insurance and Claims</i>		
1. Copies of all insurance policies of Hospital and each Affiliate. Should also include a summary of amounts, deductibles and options regarding tail coverage.	[]	[]
2. List of all matters resolved or settled within the past five (5) years involving Hospital or any Affiliate in which compensation was paid.	[]	[]

REQUEST:	Provided Herewith	To Be Provided
3. List of all matters referred to by insurance carriers as “claims,” “incidents” or “circumstances” during the past two (2) years for Hospital and each Affiliate.	[]	[]
4. Summary of the risk management program for Hospital and each Affiliate.	[]	[]
5. To the extent not otherwise provided, copies of directors and officers liability insurance policies for Hospital and each Affiliate.	[]	[]
6. To the extent not otherwise provided, copies of fidelity insurance or similar risk protection for Hospital and each Affiliate.	[]	[]
7. Summary of stop-loss or reinsurance with respect to “at risk” component of managed care obligations for Hospital and each Affiliate.	[]	[]
8. To the extent not otherwise provided, summary of any other insurance arrangements applicable to the business and/or assets of Hospital or any Affiliate (and with respect to any of the properties utilized by Hospital or any Affiliate).	[]	[]
9. Summary of valuation and right to realize equity interest/investment in any mutual or similar insurance organization for Hospital and each Affiliate.	[]	[]
10. Summary of any self-insurance program, current status of funding for possible claims thereunder and description of reinsurance for Hospital and each Affiliate.	[]	[]
11. List of known lapses in insurance coverage or any risks that there are self-insured but would ordinarily be insured against, occurring at any time during the period for which the financial statements are furnished for Hospital and each Affiliate.	[]	[]
<i>N. Other Litigation</i>		
1. To the extent not otherwise provided, list of all pending litigation against Hospital or any Affiliate, the prayer for which exceeds \$50,000 or does not specifically state the amount of damages sought.	[]	[]
2. To the extent not otherwise provided, copies of any injunctions, court orders or consent decrees to which Hospital or any Affiliate is subject.	[]	[]
3. To the extent not otherwise provided, list of all investigations, inquiries, legal, administrative or arbitration proceeds or any event which might result in litigation or similar action against Hospital or any Affiliate.	[]	[]
4. To the extent not otherwise provided, copies of all counsel letters to independent public accountants regarding pending or threatened litigation that were furnished to or that include Hospital or any Affiliate.	[]	[]

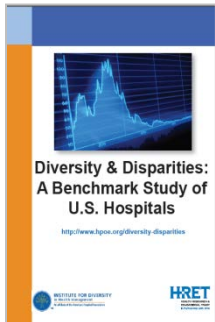
REQUEST:	Provided Herewith	To Be Provided
<i>O. Miscellaneous</i>		
1. Summary of the Hill-Burton obligations of Hospital and each Affiliate.	[]	[]
2. Summary of any religious guidelines for patient care of Hospital and each Affiliate.	[]	[]
3. Summary of the charity care policy for Hospital and each Affiliate.	[]	[]
4. Summary of the policies, practice and circumstances of Hospital and each Affiliate relating to (i) abortion – therapeutic, (ii) abortion – elective, (iii) sterilization, (iv) tubal ligations, (v) vasectomies, and (vi) contraception (other).	[]	[]
5. Summary of do-not-resuscitate orders, living wills and right-to-die policies for Hospital and each Affiliate.	[]	[]
6. Summary of patient consent policies for Hospital and each Affiliate.	[]	[]
7. Summary of policies for Hospital and each Affiliate regarding individuals living with HIV/AIDS.	[]	[]
8. Summary of human investigations by Hospital or any Affiliate. Should include summary of ethics committee: membership, purpose and recent outcomes.	[]	[]
9. Summary of pastoral care policies for Hospital and each Affiliate.	[]	[]
10. Copy of the Mission Statement for Hospital and each Affiliate.	[]	[]
11. Summary of recent patient questionnaire responses and methods of addressing complaints for Hospital and each Affiliate. Should also include copies of customer service documents (e.g., complaint resolution documents, corrective action documents, etc.).	[]	[]
12. Copies of HIPAA policies, procedures, manuals, etc. for Hospital and each Affiliate.	[]	[]
13. Copies of Business Associates Agreements entered into by Hospital or any Affiliate.	[]	[]
14. Copies of EMTALA policies, procedures, manuals, etc. for Hospital and each Affiliate.	[]	[]
15. Copies of CLIA policies, procedures, manuals, etc. for Hospital and each Affiliate.	[]	[]
16. Copies of medical records retention policies and procedures for Hospital and each Affiliate.	[]	[]
17. Copies of corporate ethics and compliance programs and policies for Hospital and each Affiliate. Should also include a summary of all actions and investigations regarding the violation of such policies and procedures. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]

REQUEST:	Provided Herewith	To Be Provided
18. To the extent not otherwise provided, copies of complaints or reports from the Office for Civil Rights of the Centers for Medicare and Medicaid Services involving to Hospital or any Affiliate.	[]	[]
19. Copies of the National Practitioner Data Bank reports for Hospital and each Affiliate for the past three (3) years.	[]	[]
20. Summary of physician attitude surveys and employee surveys for Hospital and each Affiliate.	[]	[]
21. Copies of policies and procedures for quality review, assessment, improvement or assurance programs for Hospital and each Affiliate. Should include copies of committee minutes addressing such programs.	[]	[]
22. Summary of the information systems of Hospital and each Affiliate.	[]	[]
23. Copies of any reports filed during the past three (3) years relating to errors or accidents involving blood or biological products at Hospital or any Affiliate.	[]	[]
24. Copies of Conflict of Interest policies and procedures for Hospital and each Affiliate. Should also include a summary of all actions and investigations regarding the violation of such policies and procedures. (POTENTIAL ANTITRUST CONCERNS REQUIRE DISTRIBUTION ONLY TO OUTSIDE LEGAL COUNSEL OR APPROPRIATE THIRD PARTY CONSULTANTS.)	[]	[]
25. To the extent not otherwise provided, summary of the material terms of all transactions with “disqualified persons” by Hospital or any Affiliate and copies of relevant documentation regarding the same.	[]	[]
26. List of actual and pending gifts and/or endowments for the benefit of Hospital or any Affiliate. List should include a summary of the basic terms of such gifts and/or endowments.	[]	[]
27. Summary of any lobbying activities or political campaign contributions by Hospital or any Affiliate for the past ten (10) years.	[]	[]

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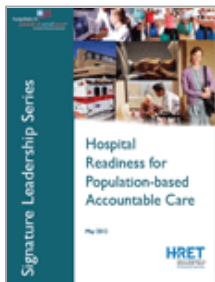
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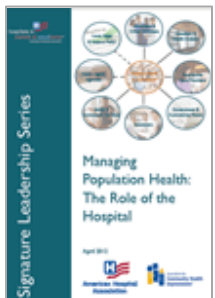
Diversity and Disparities: A Benchmark Study of U.S. Hospitals –June 2012

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.



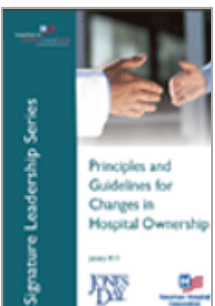
Hospital Readiness for Population-based Accountable Care – May 2012

This report therefore 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

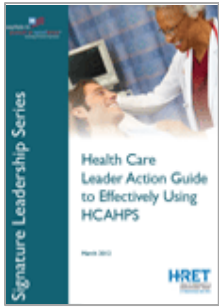
To meet patient needs in the current market, hospitals have traditionally focused their efforts on caring for individuals and personalizing care for each person admitted to their facility. Common community health initiatives, such as mobile vans and health screening and education fairs, are sometimes 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.

For more information on HRET/HPOE Guides & Reports contact:
Natasha Goburdhun, MPH, Vice President of Healthcare Innovation
P: (312) 422-2623 | E: ngoburdhun@aha.org | W: <http://www.hret.org/guides-reports>



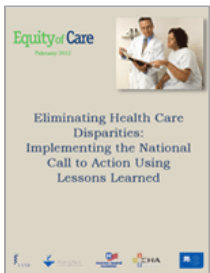
[Health Care Leaders Action Guide to Effectively Using HCAHPS](#) – March 2012

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.



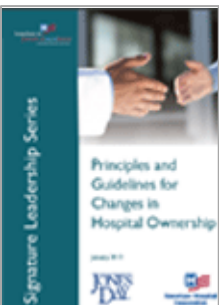
[Eliminating Health Care Disparities: Implementing the National Call to Action Using Lessons Learned](#) – February 2012

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.



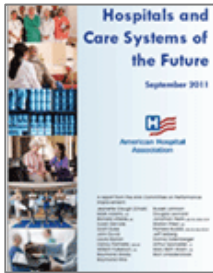
[Caring for Vulnerable Populations](#) – January 2012

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, *Caring for Vulnerable Populations*, 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.



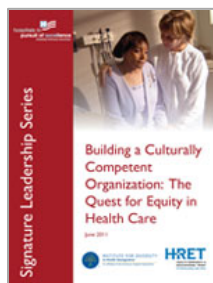
Hospitals and Care Systems of the Future – September 2011

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.



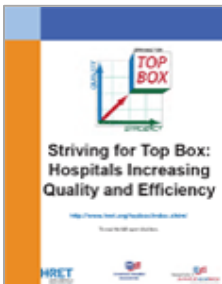
Allied Hospital Association Leadership for Quality – July 2011

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.



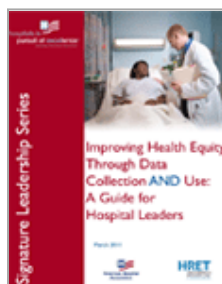
Building a Culturally Competent Organization: The Quest for Equity in Health Care – June 2011

This guide showcases three organizations’ strategies to implement performance improvement processes. Their goals are to improve efficiency and quality of patient care.



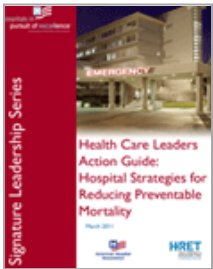
Striving for Top Box: Hospitals Increasing Quality and Efficiency – April 2011

This guide showcases three organizations’ strategies to implement performance improvement processes. Their goals are to improve efficiency and quality of patient care.



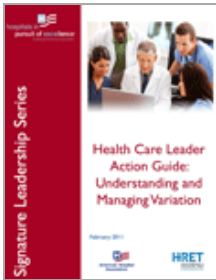
Improving Health Equity Through Data Collection AND Use: A Guide for Hospital Leaders – March 2011

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 on ways reduce for reducing preventable mortality.



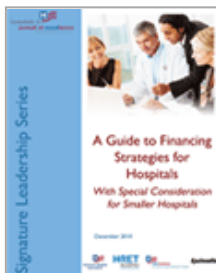
[A Health Care Leader Action Guide: Understanding and Managing Variation](#) – February 2011

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

The AHA's Long-Range Policy Committee developed a comprehensive report, *A Call to Action: Creating a Culture of Health*. It 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.



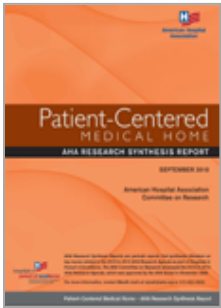
[AHA Committee on Research: Strategic Issue Forecast Report](#) – November 2010

AHA Committee on Research developed the Strategic Issues Forecast 2015. 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.



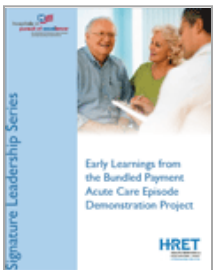
[Hand Hygiene Project: Best Practices from Hospitals Participating in the Joint Commission Center for Transforming Healthcare Project](#) – November 2010

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.



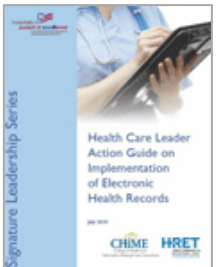
[AHA Research Synthesis Report: Patient-Centered Medical Home \(PCMH\)](#) – September 2010

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.



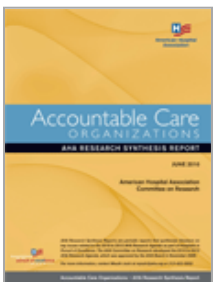
[Early Learnings from the Bundled Payment Acute Care Episode Demonstration Project](#) – July 2010

An overview and summary of lessons learned from the current CMS pilot project, the CMS Acute Care Episode Demonstration Project, that is testing the effect of bundling Part A and B payments for episodes of care improve coordination, quality and efficiency of care.



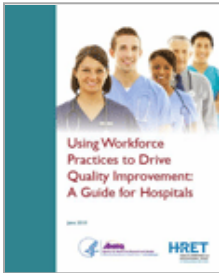
[Health Care Leader Action Guide on Implementation of Electronic Health Records](#) – July 2010

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.



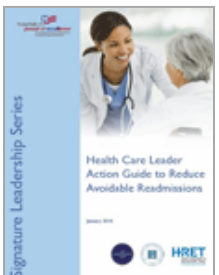
[Using Workforce Practices to Drive Quality Improvement: A Guide for Hospitals](#) – June 2010
This guide provides practical advice on workforce practices that hospitals can adopt to develop a high-performing workforce that can deliver safe, high quality and efficient health care.



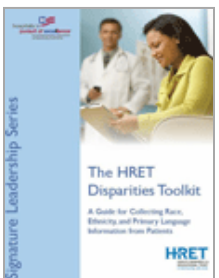
[AHA Research Synthesis Report: Bundled Payment](#) – March 2010
An AHA Research Synthesis Report presents an overview of bundled payment, including evidence of its impact in the public and private sector, as well as questions that must be considered.



[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 if they are part of a health system; the lessons are transferrable to all hospitals.



[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.

HOSPITALS IN PURSUIT OF EXCELLENCE

ABOUT HPOE

Hospitals in Pursuit of Excellence (HPOE) is the American Hospital Association's strategic platform to accelerate performance improvement

HPOE spreads improvement by sharing best practices and synthesizing evidence for application

SUPPORTING THE FIELD

Education

- » Case Studies
- » Webinars
- » Articles

Tools and Guides

- » Best Practice Guides
- » AHA Research Synthesis Reports

Leadership

Development

- » AHA-NPSF Patient Safety Leadership Fellowship
- » Health Care System Transformation Fellowship

National Engagement Projects

- » CUSP Infection Elimination Projects
- » AHRQ Quality and Patient Safety Tools
- » Hospital Engagement Network

TOPIC AREAS

- » Efficiency
- » Care coordination
- » Health and wellness
- » Health care equity
- » Patient safety
- » Healthcare-acquired infections
- » Medication management
- » New payment and care delivery models
- » Health information technology
- » Patient throughput



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