HEALTHCARE MANAGEMENT AND LEADERSHIP: STRATEGIES FOR LONG-TERM SUSTAINABILITY OF THE U.S. HEALTHCARE SYSTEM

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1/10/18 – 1/13/18
AGENDA

- Big Changes
- Impact of Recent Changes in Healthcare Delivery on Healthcare Management and Leadership
- Current Outcome Literature Relevant to Healthcare Management and Leadership
- Strategies for Long-Term Sustainability of the U.S. Healthcare System
- Future Research Needs Relevant to Healthcare Management and Leadership
BIG CHANGES
YOU HAVE AN INSURANCE DEFICIENCY.
The Patient Protection and Affordable Care Act (PPACA) was brought about to address flaws in the US Healthcare System.

- High cost (technology & fee-for-service driven)
- Unequal access to care
- Ranked 37th in the world for performance (The World Health Report 2000)
- Fragmented care
- Government as subsidiary to the private sector
- Etc.
OBJECTIVES OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Triple Aim:

Improving the experience of care

Improving the health of populations

Reducing the per capita costs of health care
SUMMARY OF THE PPACA

- Individual Mandate – *Tax penalty will be removed with new tax bill*
- Employer Requirements
- Expansion of Public Programs – Medicaid, CHIP
- Premium and Cost-Sharing Subsidies to Individuals
- Premium Subsidies to Employers
- Tax Changes Related to Health Insurance or Financing Health Reform
- Health Insurance Exchanges
- Benefit Design
- Changes to Practice Insurance
- State Role
- Cost Containment
- Improving Quality/Health System Performance
- Prevention/Wellness
- Long-Term Care
- Other Investments
- Reducing Medicare Fraud

OUTSTANDING ISSUES, DESPITE THE PPACA

• Rising cost of healthcare
• Different payment models – Payment reform to incentivize performance while providing quality care
• Public health initiatives – population health
• Preventative care focus to lessen chronic diseases
• Ability for individuals to afford insurance plans
• Access to those who have fallen through the cracks of the law
• Organizational change
• State management of Medicaid
• Decreased funding of Medicare
• Making EHRs work
• Elder care
• Evidenced-Based Support for Theories Tested in The PPACA
• Etc. Etc.
THE CURVEBALLS

- The market is comprised of both private and public insurers
- Several insurers pulled out of the exchange in 2017
- Most individuals don’t understand their insurance benefits (or lack thereof)
- Drug prices are astronomical in the US
- Politics taint discussions
- Education is still majorly needed regarding the law –
  - Inaccurate terms are floating around (e.g. ACA plans)
  - Specific knowledge is often lacking by healthcare administrators
- We are still in the early stages of collecting data and analyzing the effectiveness of EMRs, coordinated care, various payment models, etc.
- Etc!
What’s on the minds of hospital and healthcare organization leaders?

Change in delivery models:
- Less care occurring in hospitals – Use of urgent care, day surgery centers, in-home services, etc.
- Increased use of nurse practitioners and physician assistants
- “Centers for Excellence”, “Accountable Care Organizations”, etc.

Altered reimbursement structures:
- Bundled Payments or Episode-Based Payment Initiatives, Value-Based Purchasing, Community-Based Care Transition Program, Individual State Initiatives

Organizational changes:
- Fewer small to mid-sized standalone hospitals
- Centralized buying and services (e.g. Human Resources, Legal, etc.)

Focus on quality for reimbursement
Focus on patient satisfaction for reimbursement
Managing insurance plans
- More insured, but with lower reimbursement rates
And more!
MANAGEMENT AND LEADERSHIP FOCUS

It boils down to:
- How do we reduce and contain costs?
- How do we attract patients and compete?

Limitations:
- Not wanting to adapt
- Not knowing how to adapt
- Not being thoroughly educated on the laws
- Hoping the laws will change
- …
IMPACT OF RECENT CHANGES IN HEALTHCARE DELIVERY ON HEALTHCARE MANAGEMENT AND LEADERSHIP
What i’m about to tell you is gonna change your life forever. Are you really sure you want to know it?
Managers and leadership need to know what is going on at a:

- Federal level
- State level
- Organizational level
- Department level

- Within other organizations
- In the literature
- Within the profession
MODELS HAVE CHANGED

- Delivery models have changed
- Payment models have changed
- Reimbursement Incentives & Penalties
  - Patient satisfaction
  - Readmissions
  - Hospital acquired infections/complications
  - …
- Payor mix has shifted
- Contracts have been re-negotiated
- Etc.
STAKEHOLDER INVOLVEMENT CANNOT BE IGNORED

- Who are the traditional stakeholders?
- Are there new stakeholders? If so, who are they?
- The role of the stakeholder needs to be defined.

- For example, who are the stakeholders when adopting an Electronic Medical Record (EMR) System into a hospital?
  - Do stakeholders vary by department?
  - Who are the stakeholders in a primary care outpatient clinic?
ORGANIZATION CONSIDERATIONS FOR ADOPTING HEALTH POLICY AND STRATEGIES

Considerations:
- Type of Organization
- Mission Statement
- Community/Populations Served
- Leadership Preferences/Experience
- Etc.

Players:
- Payers – Employers, Insurers
- Providers – Professionals, Institutions, Professions
- Consumers
CURRENT OUTCOME LITERATURE RELEVANT TO HEALTHCARE MANAGEMENT AND LEADERSHIP
I can't say I'm entirely pleased with my hip replacement.
LOOK TO THE LITERATURE FOR FINDINGS & EFFECTIVENESS OF:

- Electronic Health Records
- Payment Methods and Reimbursement Maximization
- Delivery Models
- Organizational Changes
- Workforce Shifts
- Cost reduction
- Quality
- Patient Satisfaction
- Etc. – there are numerous topics of interest!

Consider what you think about the findings as we review several studies.
“Health information exchange (HIE), which is the transfer of electronic information such as laboratory results, clinical summaries, and medication lists, is believed to boost efficiency, reduce health care costs, and improve outcomes for patients. Stimulated by federal financial incentives, about two-thirds of hospitals and almost half of physician practices are now engaged in some type of HIE with outside organizations. To determine how HIE has affected such health care measures as cost, service use, and quality, we identified twenty-seven scientific studies, extracted selected characteristics from each, and meta-analyzed these characteristics for trends. Overall, 57 percent of published analyses reported some benefit from HIE. However, articles employing study designs having strong internal validity, such as randomized controlled trials or quasi-experiments, were significantly less likely than others to associate HIE with benefits. Among six articles with strong internal validity, one study reported paradoxical negative effects, three studies found no effect, and two studies reported that HIE led to benefits. Furthermore, these two studies had narrower focuses than the others. Overall, little generalizable evidence currently exists regarding benefits attributable to HIE.”

➢ Area for future research!
KAISER PERMANENTE – PATIENT PORTAL IMPACTS


**Background:** Patient portals may lead to enhanced disease management, health plan retention, changes in channel utilization, and lower environmental waste. However, despite growing research on patient portals and their effects, our understanding of the organizational dynamics that explain how effects come about is limited.

**Methods:** This paper uses qualitative methods to advance our understanding of the organizational dynamics that influence the impact of a patient portal on organizational performance and patient health. The study setting is Kaiser Permanente, the world’s largest not-for-profit integrated delivery system, which has been using a portal for over ten years. We interviewed eighteen physician leaders and executives particularly knowledgeable about the portal to learn about how they believe the patient portal works and what organizational factors affect its workings. Our analytical framework centered on two research questions. (1) How does the patient portal impact care delivery to produce the documented effects?; and (2) What are the important organizational factors that influence the patient portal’s development?
Results: We identify five ways in which the patient portal may impact care delivery to produce reported effects. First, the portal’s ability to ease access to services improves some patients’ satisfaction as well as changes the way patients seek care. Second, the transparency and activation of information enable some patients to better manage their care. Third, care management may also be improved through augmented patient-physician interaction. This augmented interaction may also increase the ‘stickiness’ of some patients to their providers. Forth, a similar effect may be triggered by a closer connection between Kaiser Permanente and patients, which may reduce the likelihood that patients will switch health plans. Finally, the portal may induce efficiencies in physician workflow and administrative tasks, stimulating certain operational savings and deeper involvement of patients in medical decisions. Moreover, our analysis illuminated seven organizational factors of particular importance to the portal’s development - and thereby ability to impact care delivery: alignment with financial incentives, synergy with existing IT infrastructure and operations, physician-led governance, inclusive decision making and knowledge sharing, regional flexibility to implementation, continuous innovation, and emphasis on patient-centered design.

Conclusions: These findings show how organizational dynamics enable the patient portal to affect care delivery by summoning organization-wide support for and use of a portal that meets patient needs.
Purpose – The purpose of this paper is to explore the relationship between hospitals’ electronic health record (EHR) adoption characteristics and their patient safety cultures. The “Meaningful Use” (MU) program is designed to increase hospitals’ adoption of EHR, which will lead to better care quality, reduce medical errors, avoid unnecessary cost, and promote a patient safety culture. To reduce medical errors, hospital leaders have been encouraged to promote safety cultures common to high-reliability organizations. Expecting a positive relationship between EHR adoption and improved patient safety cultures appears sound in theory, but it has yet to be empirically demonstrated.

Design/methodology/approach – Providers’ perceptions of patient safety culture and counts of patient safety incidents are explored in relationship to hospital EHR adoption patterns. Multi-level modeling is employed to data drawn from the Agency for Healthcare Research and Quality’s surveys on patient safety culture (level 1) and the American Hospital Association’s survey and healthcare information technology supplement (level 2).
Findings – The findings suggest that the early adoption of EHR capabilities hold a negative association to the number of patient safety events reported. However, this relationship was not present in providers’ perceptions of overall patient safety cultures. These mixed results suggest that the understanding of the EHR-patient safety culture relationship needs further research.

Originality/value – Relating EHR MU and providers’ care quality attitudes is an important leading indicator for improved patient safety cultures. For healthcare facility managers and providers, the ability to effectively quantify the impact of new technologies on efforts to change organizational cultures is important for pinpointing clinical areas for process improvements.
Voluntary bundled payment programs until 2016, 48 episode types

Effective April 1, 2016: CMS mandatory bundled program in 67 markets

- E.g. Comprehensive Care for Joint Replacement, involves 800 hospitals, approximately 1/3 of all Medicare patient hip and knee replacements
- Payment for index hospitalization services + physicians + post-discharge providers
- Approximately 40% of hip and knee spending replacement spending goes to skilled nursing, inpatient rehab, home healthcare, and hospital readmissions

Strategies recommended for bundled payments

- Obtain needed data – from CMS, from internal sources
- Assess data thoroughly – create episodes of care, examine distribution of costs across defined services, ID sources of variation, map care pathways, assess post-acute care provider performance, examine physician practice patterns, assess risk, develop a price for the bundle
- Understand what is in the bundle – evaluate services and providers to be included in the bundle & the duration of the episode of care
- Engage stakeholders – buy-in from stakeholders, use of protocols, care coordination teams, discharge planning process, patient/family education

“Using national Medicare fee-for-service claims for the period 2011-12 and data on hospital quality, we evaluated how thirty- and ninety-day episode-based spending were related to two validated measures of surgical quality—patient satisfaction and surgical mortality.

We found that patients who had major surgery at high-quality hospitals cost Medicare less than those who had surgery at low-quality institutions, for both thirty- and ninety-day periods. The difference in Medicare spending between low and high-quality hospitals was driven primarily by postacute care, which accounted for 59.5 percent of the difference in thirty-day episode spending, and readmissions, which accounted for 19.9 percent.

These findings suggest that efforts to achieve value through bundled payment should focus on improving care at low-quality hospitals and reducing unnecessary use of postacute care.”

There are limitations associated with the categorization of high quality and low quality hospitals in this study.

Or, there is often an argument for – not doing certain procedures at certain hospitals
The ACO model aims to reduce cost and improve quality by aligning payment incentives to health outcomes. This is complicated for populations with behavioral health disorders and requires improving care coordination.

Qualitative data was analyzed for 90 Medicare ACO demonstration programs (2012 – 2015)

Challenges:
- Lack of behavioral healthcare providers – and pre-existing integration into care
- Data availability – not sure how to best use providers
- Sustainable financing models – grants, organizational discretionary funds

Focus: Integrating behavioral health care into primary care for ACO success with patients with behavioral health disorders
- Integrating behavioral healthcare providers into primary care
- Using social workers in medical care coordination teams: time limited support, assistance with referrals
ACO – PERCEIVED ETHIC DILEMMAS


“This study of Pioneer accountable care organizations (ACOs) suggests that the ACO model is creating moral distress for physicians and business leaders in seven critical ways:

1. **Incompatible reimbursement models**: The combination of fee-for-service and risk-based contracts creates conflicting incentives.

2. **Two standards of clinical care**: Patients who are enrolled in an ACO have access to more effective care management programs than patients who are not enrolled.

3. **Financial incentives versus patient choice**: Providers are incentivized to refer patients within the ACO network, regardless of patient preferences.

4. **“Best” care disagreements**: Incentives to provide only necessary care result in disagreements between physicians about the right care, and the perception of rationing resources.

5. **Required ACO metrics versus evidence-based care**: Some required metrics do not reflect current evidence-based practices.

6. **Shifting resources to focus on prevention**: Creating the capacity to provide team-based comprehensive primary care could result in better patient outcomes at lower cost; however, clinician burnout is a risk.

7. **Limited support systems for resolving ethical conflicts**: Fragmented approaches to resolving ethical conflicts result in mismatches between organizational values and clinical and business practices.”
Number of stand-alone rural hospitals are shrinking. Study examined:
1. What are the characteristics of rural hospitals that merged or were acquired?
2. Were there changes in rural hospital financial performance, staffing, or services after an M and A transaction?

Findings
1. “Hospitals with weaker financial performance but lower staffing levels and staffing costs were more likely to merge or be acquired.”
2. “Statistically week evidence suggested that operating margins declined after the merger; stronger evidence suggested reductions in salary expense. There was no statistically significant evidence of changes to number of full-time equivalent (FTE) employees, the service lines that were included in the study, capital expenditures, or the amount of debt financing among the hospitals that merged or were acquired.”

Conclusions: “M And A may be a viable option for maintaining the hospital and the access to care it provides.”
CASE STUDY: ACA IMPLEMENTATION IN A COMMUNITY HOSPITAL


- **Purpose:** look at the outcome of a 350-bed not-for-profit community hospital in implementing the ACA through a co-management arrangement between administrations and physicians.

- **Findings:**
  - The physicians benefit through actual dollar payout, but also with improved communication and greater input in running the service line. The hospital benefits from reduced cost – or reduced penalties under the ACA – as well as better communication and greater physician involvement in administration of the service line.
  - The hospital improved in every quality metric under the co-management company.

- **Limitation – Case study, no control group**

- **Sounds like common sense, but even that needs to be tested!**
INTEGRATED CARE: PRIMARY & MENTAL HEALTH


**Background:** Integrating health care across specialized work units has the potential to lower costs and increase quality and access to mental health care. However, a key challenge for healthcare managers is how to develop policies, procedures, and practices that coordinate care across specialized units. The purpose of this study was to identify how organizational factors impacted coordination, and how to facilitate implementation of integrated care.

**Methods:** Semi-structured interviews were conducted in August 2009 with 30 clinic leaders and 35 frontline staff who were recruited from a convenience sample of 16 primary care and mental health clinics across eight medical centers. Data were drawn from a management evaluation of primary care-mental health integration in the US Department of Veterans Affairs. To protect informant confidentiality, the institutional review board did not allow quotations.
Results: Interviews identified antecedents of organizational coordination processes, and highlighted how these antecedents can impact the implementation of integrated care. Overall, implementing new workflow practices were reported to create conflicts with pre-existing standardized coordination processes. Personal coordination (i.e., interpersonal communication processes) between primary care leaders and staff was reported to be effective in overcoming these barriers both by working around standardized coordination barriers and modifying standardized procedures.

Discussion: This study identifies challenges to integrated care that might be solved with attention to personal and standardized coordination. A key finding was that personal coordination both between primary care and mental health leaders and between frontline staff is important for resolving barriers related to integrated care implementation.

Conclusion: Integrated care interventions can involve both new standardized procedures and adjustments to existing procedures. Aligning and integrating procedures between primary care and specialty care requires personal coordination amongst leaders. Interpersonal relationships should be strengthened between staff when personal connections are important for coordinating patient care across clinical settings.
**Fig. 1** Organizational process antecedents and outcomes of personal and standardized coordination for integrated mental health care. Relationships were suggested by key informant interviews. Dashed arrow indicates that the discrepancies between the current and ideal state of standardized coordination may result in procedure adjustment if supportive personal coordination is present between leaders of different services and/or between frontline staff.
Value-Based Purchasing (VPB) program = incentive, Hospital Readmissions Reduction Program (HRRP) = penalty, Hospital-Acquired Conditions (HAC) = penalty

“For FY 2016, only 799 of 3,414 eligible hospitals (20%) avoided a penalty for excessive avoidable readmissions, meaning that 77% of eligible hospitals are being penalized under HRRP”.

- Penalty fell from FY 2015 to FY 2016, in which most hospitals paid a penalty of 0.01-0.5%
- Readmissions have dropped since the enactment of the penalties in FY2013

In FY 2015, 55% of eligible hospitals received a bonus from the VBP program. But, only 25% avoided a net penalty.
VALUE-BASED INCENTIVES, USING PERFORMANCE AS AN ADVANTAGE: Q&A

To succeed:
(a) Discharge process with specific elements,
(b) Hospitals should have an implementation plan, assigned accountability, and meaningful performance incentives,
(c) Input and participation at every level of the organization,
(d) Multidisciplinary team for discussion, ultimate accountability with one person,
(e) Adjust role assignments, role descriptions, performance metrics, and incentives,
(f) Transition to more population health-based models,
(g) Ignoring CMS quality programs may result in patient loss due to readily available information, and
(h) Emphasize value in competitive market.
MEDICARE’S HOSPITAL PAY-FOR-PERFORMANCE PROGRAMS


➢ Similar to the last article, abstract follows:

Three separate pay-for-performance programs affect the amount of Medicare payment for inpatient services to about 3,400 US hospitals. These payments are based on hospital performance on specified measures of quality of care. A growing share of Medicare hospital payments (6 percent by 2017) are dependent upon how hospitals perform under the Hospital Readmissions Reduction Program, the Value-Based Purchasing Program, and the Hospital-Acquired Condition Reduction Program. In 2015 four of five hospitals subject to these programs will be penalized under one or more of them, and more than one in three major teaching hospitals will be penalized under all three. Interactions among these programs should be considered going forward, including overlap among measures and differences in scoring performance.
In 2015 the Medicare Hospital Value-Based Purchasing (VBP) program paid hospitals $1.4 billion in performance based incentives; 30 percent of a hospital's VBP Total Performance Score was based on performance on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) measures of the patient experience of care. Hospitals receive patient experience points based on three components: achievement, improvement, and consistency. For 2015 we examined how the three components affected reimbursement for 3,152 hospitals, including their impact on low-performing and high-minority hospitals. Achievement accounted for 96 percent of the differences among hospitals in total HCAHPS points. Although achievement had the biggest influence on payments, payments related to improvement and consistency were more beneficial for low-performing hospitals that disproportionately served minority patients. The findings highlight the important inducement that paying for improvement provides to initially low-performing hospitals to improve care and the role this incentive structure plays in minimizing resource redistributions away from hospitals serving minority populations. Additional emphasis on improvement points could benefit hospitals serving disadvantaged patients.”

**Patient level:**

(a) demographics: less satisfaction for minority racial and ethic groups, older patients (85 years +), women (cleanliness, communication about meds, discharge info), patients with poorer self-rated health status; (b) reason for hospitalization

**Hospital level:**

- Higher patient satisfaction at: (a) non-profits, magnet status, system membership, use of an EHR, “better website”; (b) work environment of a culture that emphasizes compassion, has well-defined nursing standards for high-quality care, cultural competency, positive staff perception of a safety culture; (c) shorter lengths of stay, higher surgical volume, low mortality index, low readmission rates, higher nurse-to-patient ratios, availability of chaplains, use of therapy dogs

- Lower patient satisfaction at: safety net facilities, higher proportion of nurses working shifts > 13 hrs, increased proportion of Medicaid patients
Market Level:

High patient satisfaction: unemployment rates, % college grads in county, higher competition, availability of specialists

Low patient satisfaction: metropolitan status, % population 65 yrs or >, per capita income, % non-English speaking individuals, availability of general practitioners
NURSING IMPACT ON PATIENT SATISFACTION


This study looked at the patient satisfaction component of Value-Based Purchasing (VBP) using performance scores from the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey of the patient experience. The HCAHPS survey evaluates 8 dimensions:

1. communication with nurses;
2. communication with doctors;
3. responsiveness of hospital staff;
4. pain management;
5. communication about medicines;
6. cleanliness and quietness of hospital environment;
7. discharge information (transition of care);
8. overall rating of hospital

Patient satisfaction score data was taken from 2,984 hospitals.

Findings: “Nursing communications accounted for 75.35% of the variance in the patient satisfaction domain score in a stepwise regression.”

Practical Implication: Presents target area for hospitals to improve patient satisfaction scores and reimbursement under VBP.
PATIENT PERCEPTION OF QUALITY


**Design/methodology/approach** – This research examines patient satisfaction data from a multi-specialty Medical Practice Group, and uses regression analysis and paired comparisons to provide insight into patient perceptions of care quality.

**Findings** – Results show that variables related to Access, Moving Through the Visit, Nurse/Assistant, Care Provider and Personal Issues significantly impact overall assessments of care quality. In addition, while gender and type of care provider do not appear to have an impact on overall patient satisfaction, significant differences do exist based on age group, specialty of the physician and clinic type.

**Originality/value** – This study differs from most academic research as it focusses on medical practices, rather than hospitals, and includes multiple clinic types, medical specialties and physician types in the analysis. The study demonstrates how analytics and patient perceptions of quality can inform policy decisions.

See the article for specific elements associated with each variable.
Three models for APPs in hospital medicine at UPMC emerged:

• Team Approach – side by side with physician
• Divide and Conquer – independent with intermittent physician contact
• Hybrid Model

Results of this case study show APP roles are influenced by:

• Environmental pressures
• Organizational initiatives
• Clinician experience

Environmental Context: scarce hospitalist resources - resource availability, improving inpatient efficiency – economic consideration, satisfaction – patient needs

Organizational Context: rapid expansion in use of APPs resulted in unclear expectations by physicians and improvisation of use
SURVEY OF PHYSICIAN OPINIONS OF THE ACA


Results from “a comprehensive physician leadership survey conducted by the American Association for Physician Leadership® and the Navigant Center for Healthcare Research and Policy Analysis” on 2,398 physician members. Findings follow:

“55 percent of survey respondents said they agreed or strongly agreed that the ACA has more good in it than bad.”

“69 percent of the survey respondents agreed or strongly agreed that physicians should be held accountable for costs of care in addition to the quality of care.”

“57 percent ... of survey respondents agreed or strongly agreed that accountable care organizations (ACOs) will be a permanent model for risk-sharing with payers in the coming years.”

“63 percent of respondents disagreed or strongly disagreed with this statement: ‘The elimination of FFS incentives in favor of value-based payments will hurt the quality of care provided patients’.”

“58 percent of survey respondents agreed or strongly agreed that transparency about physicians’ business dealings is a positive trend for the profession.”

Key comment: “Former CMS Administrator Don Berwick, MD, has estimated that total U.S. health care expenditures could be cut by more than 20 percent if waste was eliminated in six categories, including overtreatment, failure of care coordination and failures in the execution of care processes.”
PHYSICIAN SUPPORT FOR IMPROVING QUALITY AND LOWERING COSTS


Results “according to a survey conducted by the American Association for Physician Leadership® and the Navigant Center for Healthcare Research and Policy Analysis” of over 2,300 physician leaders. Findings follow:

“92 percent of survey respondents agreed that reducing unnecessary care that is not evidence based is an issue of high or very high importance.”

“93 percent of respondents said improving physician satisfaction within the profession is a high or very high priority.”

“92 percent of survey respondents said increased transparency about quality is an issue of high or very high importance.” Difference in opinion – payers are focused on outcome measures, providers are focused on process measures. Some quality measures are not meaningful to physicians based on specialty.

“92 percent of respondents said adherence is an issue of high or very high importance.” – Rather than compliance.

Key comment: “A significant amount of waste is driven by inefficient workflow, not by reimbursement or malpractice.”
"Practices reported that their physicians and staff spent 15.1 hours per physician per week dealing with external quality measures including the following: tracking quality measure specifications, developing and implementing data collection processes, entering information into the medical record, and collecting and transmitting data. … with the average physician spending 2.6 hours per week and other staff spending 12.5 hours."

"By far the most time-12.5 hours of physician and staff time per physician per week-was spent on "entering information into the medical record ONLY for the purpose of reporting for quality measures from external entities."

"Primary care practices spent 19.1 hours of physician and staff time per physician per week dealing with quality requirements of external entities; cardiology, orthopedic, and multispecialty practices spent 10.4, 11.3, and 17.6 hours per physician per week, respectively."

"Primary care practices spent $50,468, compared to $34,924 for cardiology practices and $31,471 for orthopedics practices."

"Forty-six percent reported that it was a significant burden to deal with measures that were similar but not identical to each other. Only 27 percent believed that current measures were moderately or strongly representative of the quality of care. Just 28 percent used their quality scores to focus their quality improvement activities."
“If your organization’s payers incentivized you through some type of risk-based contract to reduce expenses, what do you believe are the three most likely ways your institution could reduce operating costs?”


Responses from 74 C-Suite executives from large hospitals and health systems across the US follow.
MOST LIKELY SOURCES FOR OPERATING COST REDUCTIONS

- Reduce the number of hospitalizations: 54%
- Reduce the number of hospital readmissions: 49%
- Reduce the number of ER visits: 39%
- Reduce the costs for supplies such as devices, consumables, etc.: 36%
- Reduce drug costs: 27%
- Improve back office efficiency (e.g., billing): 23%
- Reduce the number of radiological tests per admission: 22%
- Reduce the number of lab tests per patient admission: 12%
- Reduce support staff: 12%
- Reduce the number of surgical procedures per patient admission: 7%
- Reduce physician staff: 5%
- Reduce nursing staff: 1%
- Reduce pay for staff: 1%
- Other: 11%

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<th>Strategic Positioning Model for Medical Practice Post 2015</th>
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<td><strong>Make compliance top priority</strong></td>
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<td>Risk assessments</td>
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<td>Chart reviews</td>
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<td>Coding patterns</td>
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<td>EOB reviews</td>
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<td><strong>Invest in state-of-the art, secure technology</strong></td>
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<td>Internal MU audit and controls</td>
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<td>HIPAA compliance</td>
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<td>MU Phase 2 and MU Phase 3: implement Clinical Decision Support (CDS) and PQRS attestation</td>
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<td><strong>Invest in education</strong></td>
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<td>ICD-10 training of all physicians, staff and administrators</td>
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<td>Continuing documented compliance training of all physicians, staff and administrators</td>
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<td>Clinical Support Systems</td>
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<td>Focus on patient care and patient safety</td>
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<td>Accounts Receivable Management (by payer class)</td>
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<td>Profit-center budgeting</td>
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LESSONS ON HEALTHCARE TRANSFORMATION


- Purpose: To gain input from CEOs at top-performing academic medical centers on transforming from a volume-based care delivery model to a valued-based model.

Words of Wisdom:

- Build your team around a shared vision
- Construct the pillars of strategy development and execution at every level of the organization
- Healthcare is the ultimate team sport
- Foster a high-reliability learning organization
- Align your people with a shared language and a common toolkit for change
- Healthcare transformation requires continuous and effective 360-degree communication and accountability
- Translate big picture goals in meaningful ways to employees at all levels
- Transparency is a prerequisite to successful transformation
- There is no single organizational structure that yields success
- Translate success
STRATEGIES FOR LONG-TERM SUSTAINABILITY OF THE U.S. HEALTHCARE SYSTEM
“Give it to me straight, Doc. How long do I have to ignore your advice?”
KNOW THE DATA

- Consider your experiences, but also know the data.
- Know the assumptions that make the findings valid (e.g. organization size/type, state, population specifics, etc.).
- Keep an open mind.
- Value all players/stakeholders.
- ...

EMPLOY POLICY ANALYSIS PROCESSES

- Identify, define, and prepare for changes and challenges
- Health technology impact and assessment:
  - Recognize the need for health technology and impact on the organization
  - Use technological forecasting
- Evidence based medicine
  - **Aim**: To reduce variation, save resources, and promote quality outcomes
- Economic viability policy analysis
  - I.e.: Evaluate Opportunity Costs – Cost, Value, Alternatives, Financing
- Trade off analysis/analysis of values
  - Value issues may still shape policy and strategy
  - Etc.
IMPLEMENTING STRATEGY AND PLANNING

- Creating a policy is not enough. Implementation and planning are ongoing.
  - Involve stakeholders throughout the process
  - Define scope of work
  - Consider funding
  - Include risk management
  - Schedule and create timelines
  - Consider program objectives, outcomes, and governance connected to the strategic decision-making process

- To succeed, you will need:
  - Accepted shared responsibility
  - Leadership at multiple levels
  - Understood core business, technical processes, values, and mission
  - Managed expectations
  - Continuous planning
  - Prospective orientations
  - Assessed and rewarded performance
STRATEGY RECOMMENDATIONS FROM THE LITERATURE

There are strategies we know from studying healthcare management.

And, there are specific strategies we can identify from peer publications. The literature is an excellent source for specifics!

What stands out to you from our literature review?
WHAT ELSE?

What else might you add to the list of strategies for long-term sustainability of the U.S. Healthcare System?

- Consider workforce flexibility and inter-changeability
  - I.E. How to best use advanced providers and multidisciplinary teams
- Look in trends – Consider CMS and Government Reports
- Educate stakeholders (e.g. staff, physicians, etc.) on impact of role and gain feedback
- In addition to staying current on the literature, try implementing what works for others if the assumptions and inputs align with your institution
  - ...
FUTURE RESEARCH NEEDS RELEVANT TO HEALTHCARE MANAGEMENT AND LEADERSHIP
“Good news. Your cholesterol has stayed the same, but the research findings have changed.”
CONDUCTING RESEARCH IN A FLUID STATE

Focus on:

- Don’t assume you have the answer or that one size fits all
- Dialogue with professionals
- Sort through inflammatory and/or politically based proclamations
- Be knowledgeable on Federal and State legislation
- Current literature – We really need to keep on top of current events!
- Methodology – What you learn in the doctoral program is how to conduct research
  - Good Methodology – Accurate Findings – Good Conclusions
- Keep perspective
STAYING CURRENT, GRAY LITERATURE SOURCES

Vetting gray literature – Is it?

• Evidence based
• Policy based
• From a credible source – establishment/author
• Avoid editorials/perspectives
LOOK TO JOURNALS IN HEALTH POLICY AND HEALTH AFFAIRS

Journals on Health Policy, Health Affairs, etc:
https://www.journals.elsevier.com/health-policy/
http://www.healthaffairs.org/
https://www.nlm.nih.gov/hsrinfo/health_economics.html
http://www.nejm.org/health-policy-and-reform
INFORMATION SOURCES

www.hhs.gov (US Department of Health and Human Services)
www.kff.org (Kaiser Family Foundation)
www.ncsl.org (National Conference of State Legislatures)
www.cms.gov (Centers for Medicare and Medicaid Services)
www.medicaid.gov (Medicaid)
www.cdc.gov (Centers for Disease Control and Prevention)

State level health websites

Etc!

What would you add to this list?
FUTURE RESEARCH

What would you like to research (or are you researching)?

What do you think needs to be researched or researched more?

… More on effectiveness and progress related to the topics we discussed today:

- EHR outcomes
- Making financial models work
- Essentially further exploration in to each PPACA mandate and the outcomes
- …