

WHITE PAPER

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When President Obama signed H.R.3590, the Patient Protection and Affordable Care Act, into law on March 23, 2010, the face of healthcare in the United States changed forever. Along with expanding healthcare coverage to 32 million previously uninsured Americans, providers nationwide are challenged to drive meaningful change in the delivery of care... to contribute to an evolution centered on quality, payment reform and clinical integration.

QHR Blueprint for Successful Hospital Management in the Decade Following the Patient Protection and Affordable Care Act

How can hospitals successfully “walk the tightrope,” balancing today’s need to focus on growth, efficiency and cost control, with tomorrow’s call for integrated care delivery and the expanded responsibilities of managing overall population health?

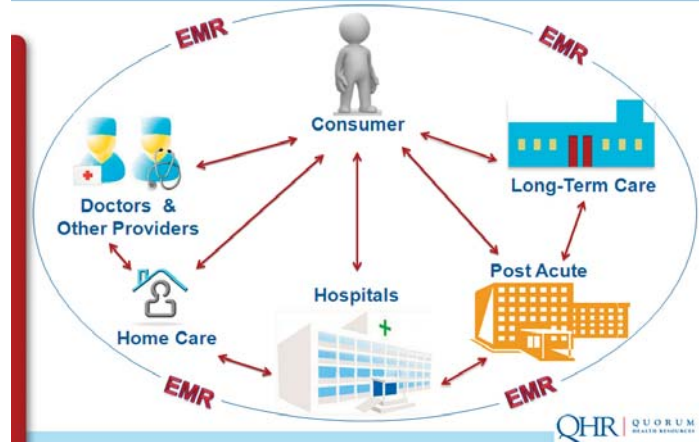
HELPING HOSPITALS SURVIVE *and* THRIVESM

HEALTH REFORM: FIRST STEPS

While health reform will be implemented gradually throughout the decade, hospitals and healthcare providers with an eye toward long-term sustainability should begin planning for the future today. Strong “first steps” involve coming to terms with the following 5 operational realities of healthcare reform.

1. **Expect and prepare for a considerable increase in demand for healthcare services, especially in primary and Emergency Department care.** Thirty-two million newly insured are heading our way, which means efforts to increase productivity will be more critical than ever. In many cases, we are caring for these patients already, but it’s important to understand that with these newly insured, there will be increased demand – and this will challenge our access points.
2. **Expect a reduction in reimbursement and prepare to operationally survive these reductions.** Payment reductions will support the expansion of healthcare coverage to millions of Americans, but for hospitals to survive at these new levels, they must act quickly to protect their financial futures and adjust their cost structure in order to be profitable at Medicare and Medicaid rates.
3. **Prepare for a shift from the cottage industry “pay for productivity” approach to value based purchasing models that are founded in “pay for performance”.** Quality improvement tactics should be deployed today to help pave the way for a stronger, more quality-centric, patient-centric tomorrow.
4. **Plan now to not only manage the delivery of care to the population you serve, but also its overall health.**
5. **Realize that clinical integration is the future.** We’re moving toward a day when hospitals and physicians will be held jointly accountable for outcomes. Steps taken today to ensure a seamless care delivery model will ultimately differentiate the successful from the unsuccessful.

Solving the Disconnect Through “Integrated” and “Patient Centric” Solutions... Circa 2020



What is clinical integration?

Clinical integration involves all providers working together in an **interdependent** way. It calls for hospitals and physicians to pool resources and adhere to and promote clinical best practices. It calls for them to work together to furnish higher quality care in a more efficient manner than they could likely achieve working alone.

The benefits of clinical integration include:

- Improved quality and efficiency
- Improved financial and clinical performance
- New opportunities to coordinate and integrate care
- Opportunities to control costs
- Differentiation in the marketplace
- Opportunities to implement new best practices

The challenge of clinical integration requires that providers collaborate at the point of care to improve processes and, in turn, outcomes. It requires the use of real-time data to help:

- Develop processes and best practice protocols
- Monitor results of care decisions
- Manage care across a continuum of services
- Intervene to correct inefficiencies

SO, WHAT NEXT?

First and foremost, as healthcare reform is implemented, hospitals must continue to do what they do well. But they must also prepare for and execute specific changes that will enable them to succeed in this new environment.

They must:

1. **Chart a sustainable course founded on clinical integration.** Doing so will not only support success in this decade, but also in future decades. Organizations that allow clinical integration to drive their overall business strategy will be well-positioned for long-term success, while those that do not may find it difficult to compete.
2. **Embrace the “value proposition” that is the center-point of healthcare reform.** Hospitals and other providers must work collaboratively to **improve access** to the newly insured, while **enhancing quality** and **reducing costs**.
3. **Clearly identify “core” clinical priorities, and disproportionately invest human and financial capital to assure success.** This may mean asking some tough questions and, in turn, making some tough choices. Consider:
 - What core services your community requires
 - What you do well, versus what challenges you the most
 - Which service lines are the most profitable, versus which are consistently cause for concern
 - Whether or not you should defer to your competitors in certain areas – with the goal of maintaining focus on your core clinical priorities
4. **Remember that productivity and revenue optimization tactics are critical to off-setting the downward pressure of payment reform.** Things like growing revenue, increasing market share, improving supply chain utilization and RAC readiness will never go out of style. They will be as valuable to your business tomorrow as they are today.
5. **Commit to collaborative optimization between hospitals and physician practices in order to pursue solutions in care management.** In this

new era of joint accountability, clinical and process reengineering to minimize practice variations is essential.

6. **Recognize the role of the patient in selecting a provider, making medical decisions and paying for services.** The most successful providers will look at services through the eyes of their patients and then let this view guide their redesign of processes, procedures and priorities.
7. **Consider whether or not a collaboration(s) with another area provider might compliment your clinical priorities.** In some cases, a specific clinical affiliation can help broaden your service offerings and, even, enhance your market share. But, it must be a “two way street.”
8. **Differentiate your hospital in the marketplace by achieving the requisite level of clinical integration.** Doing so can open doors for participation in demonstration projects and pilot programs, or even new payment methodologies.

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THE NEXT 12 TO 18 MONTHS...FOCUS, FOCUS, FOCUS ON OPERATIONS!

Hospital trustees and leadership teams are going to be challenged like never before. In addition to preparing for and executing the specific changes described above, you are also going to have to renew your focus on operations. Among other things, you should be looking for ways to reduce overhead costs, adjust to declining volumes, improve the profitability of key service lines and relentlessly pursue enhancing the quality of your services. In other words... **build a solid foundation that will allow you to prepare for and execute the strategy necessary to succeed throughout this decade of change.**

REDUCING OVERHEAD COSTS

By nature, hospitals have high overhead costs, which means, for hospital leaders looking to rebalance their budget for future payment reform, there may be some low hanging fruit. While there is no industry standard benchmark that exists for comparison, begin by evaluating total expense for overhead departments as a percent of net operating revenue. Then, consider the bottom line impact of a 10 percent reduction. **Cutting this level of expense across a large list of overhead departments can be done.** Next:

Assess the following categories of cost in your overhead departments:

- Labor – management and clerical
- Purchased services (You may be surprised at the level of savings you can find here.)
- Professional fees (Ask yourself: Are there any long-standing relationships that need to be “re-thought and re-bid”?)

Cluster “like” departments and evaluate their overall costs (e.g. Accounting, Business Office, Admitting and Decision support – or Patient Education, OB Education and Diabetes Education)

Consider opportunities to consolidate small overhead departments.

ADJUSTING TO DECLINING VOLUMES

Hospitals nationwide have experienced declines in operating volumes dating back to the beginning of the recession in fall 2008. While volumes have stabilized somewhat recently, they are still below pre-recession levels and your hospital must adjust accordingly. Begin by:

Evaluating your hours of operation in ancillary departments, where the workload is scheduled and rarely emergent (e.g. Physical Therapy and Wound Care)

- Evaluate volume by hour of day to identify opportunities for reductions in operating hours
- If you cannot reduce the hours of operation, identify opportunities to drop to “skeleton staffing” (e.g. Friday afternoons)

Evaluating opportunities to consolidate inpatient bed units. Assess the “ED visits to inpatient admissions conversion rate” to determine if admission declines are a function of system issues related to call coverage, the hospitalist system, or emergency medicine protocols. Then, pinpoint opportunities to reduce the operating hours of certain overhead departments when the reductions could enable you to reduce FTEs.

IMPROVING PROFITABILITY OF KEY SERVICE LINES

By optimizing your core service lines, you can improve your bottom line. To achieve optimization, **begin by evaluating each core service line closely.**

- Can length of stay be reduced by process improvement in certain service line patient segments? Target a small, but impactful, subset of patients (e.g. total knee replacements in patients with no complications).
- Is the proper nursing unit being utilized during the stay? Is the ICU (or other monitored-bed areas) being overutilized? Overutilization is often the result of physician preference in nursing care and should be addressed and corrected.
- In surgical service lines, look closely at medical supplies. Don’t simply rely on GPO pricing. Have a nurse look at product utilization and identify lower-cost alternatives. For example, switching from a thigh-high compression device to a knee-high one can drive significant savings.

RELENTLESSLY PURSUE ENHANCEMENT OF QUALITY

While hospitals have invested heavily in the past decade in developing a culture of continuous quality improvement, efforts have been – primarily – a function of public relations and reporting. But this, too, will change. Over the next decade, being a top performer in quality will not only be important in our relations with our patients, but also key to our ability to receive the best payment for services we provide. Here, our goal should be to be in the top quartile in clinical core measures, HCAHPS and readmissions.

IN THE END, IT'S NOTHING MORE THAN A HIGH WIRE ACT



Adapting to this new age of healthcare and the many new demands that come with it (all the while improving your existing operations) will be challenging for even the most seasoned hospital leaders. At QHR, we have three decades of hospital management experience and expertise to help your

hospital achieve this balancing act of controlling costs and providing positive outcomes. Our reimbursement, productivity and clinical operations consultants are ready to help you make decisions that will help ensure you survive and thrive amidst health reform. For more information, visit www.qhr.com.

Here's How QHR Can Help:

- Strategic Business Plans
- Reimbursement/P4P Modeling Tools
- Readmission/HAC Modeling/Monitoring Tools
- Service Line Profitability Analysis
- Blueprints for Clinical Integration Business Structures
- IT/EMR Initiatives
- RAC Appeals Management
- Blueprint for Establishing FQHC
- Governance Education
- Physician Leadership Program
- Clinical PI Programs Focused on Reform Initiatives
- ACO/Bundling Payment Strategies