

MISSION

Good Business Practice Enhances Mission

BY ANDREA Y. COLEMAN, FACHE

Health reform is now a reality — yet many of its key provisions will not be implemented for several years. This gives health systems an unprecedented time to think through and prepare strategies consistent with the way the wind is blowing. Where must Catholic health care focus its change efforts?

From a strategic perspective, reform components likely to create new winners and losers are these: the ability to design and develop Accountable Care Organizations (ACOs) or look-alikes, the escalation of pay for performance (quality and safety) and the creation of “new” customers — the newly insured who will emerge from reform.

The reductions in reimbursement will further stress many hospitals, particularly those in inner cities or distressed regions that may already be serving a disproportionate number of the poor and marginalized. A new Innovation Center within Medicare is likely to spawn opportunities for experimentation and participation for health systems ready to act. Perhaps most importantly, the insurance reforms in the law will help many people that Catholic health care organizations now serve, either through eliminating loopholes to avoid coverage or by providing coverage options where none existed before.

These elements potentially change the nature of organizations and the people they serve. They will alter what Catholic health care needs to provide, how to provide it and where to focus attention and talent.

Every hospital and market is different, and

each has to look at its particular opportunities. Nevertheless, we do know one thing: If we organize care better, if we work closely with all the parts of delivery to affect a coordinated and efficient experience and if we get started now, everyone we serve benefits. For faith-based and community-based organizations in particular, the opportunities to change inherent in reform may

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serve to strengthen care of the poor and marginalized and the mission of your community.

A note: It is essential to have a leader in each organization whose task it is to study, identify and communicate the possibilities in reform’s details, from the nature of the “call for pilots” that will emanate from the Centers for Medicare and Medicaid Services, to following the industry successes and failures in various experiments. The winners will be those that show up early, practice and create, learn and stay in the forefront.

Excluding high quality and efficient costs — two core strategic imperatives that already are

the subject of much health care literature — here are five other areas around which to plan strategy in the post-reform era.

MISSION CRITICAL: FIVE ESSENTIAL STRATEGIES

- Identify a “big tent” physician alignment strategy — accelerate, energize and adequately staff it with the best people, because delay is deadly
- Develop care management experience, those features needed to manage global payment, provide reliable outcomes and to manage high-risk populations
 - Audit, repair and re-invent outpatient services
 - Embrace and assist the uninsured population now served
 - Create innovative partnerships, those that position organizations for greater continuity and coordination of care

PHYSICIAN ALIGNMENT STRATEGY

Most health systems have a potpourri of physician organizations, relationships and joint ventures. They also have a large medical staff, with doctors who predominantly practice with them, and those who predominantly practice elsewhere. It is essential to create a structure that links doctors and the health system into an entity that can accept global payment and that can show demonstrably improved care. Models do exist, and there is no time like now to initiate study and evaluation.

Starting with a task force composed of health system and medical leaders, evaluate the current relationships and ventures. Which ones work well? Which ones could mature into an organization capable of accepting risk and reward?

While evaluating the working models already in the field, do a thorough scan of potential populations that the newly designed organization could serve. For example, many states are experimenting with new forms of payment for Medicaid, or they might be amenable to a pilot. Commercial insurers have global payment or similar pilots running now. An organization’s own self-insured population is a natural, if it’s large enough. In one community, a chief executive officer organized four or five self-insured employers that agreed to become value-based purchasers and to redesign their benefits to align more closely with achieving and rewarding outcomes.

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sure to answer the powerful question, “What’s in it for me?” Physicians will listen. They often are surprised by the downstream benefit to them of working

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more closely with the hospital to improve care and in so doing, reap a host of improvements for their own insurance profile or for their practice efficiency. Many physicians also will find meaningful the ability to deliver better care and to gain some system to handle the burden of coordination and management of complex patients.

Provide your doctors with a trusted, credible and comprehensible physician report on their performance — quality, costs, service and anything else of value. This can get everyone on the same page about the true level of variation and the case for change.

A note on timeliness: Depending on the market’s dynamics, the price of delay may be steep. Particularly in smaller markets, if a competitor organizes most of a medical community into an ACO or ACO look-alike, physicians may not be interested in participating in others.

CARE MANAGEMENT IS CRITICAL

Care management is the critical factor in putting together an aligned physician-hospital organization that can improve care, lower costs and therefore be successful under global payment. Care management includes the infrastructure to identify at-risk populations, and it involves a host of other operational features proven to result in better outcomes when imbedded in primary care practices. Care management encompasses protocol-driven referrals, mitigation of redundant tests and a mechanism for making information available to all caregivers. Every organization with a functional ACO look-alike today has spent years developing successful care management, and that means many sources of expertise are available.

Some tactics worth implementing with employees or local customers:

- Developing chronic disease management program features for employees. Implement them

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through incentives and disincentives in order to improve experience and credibility in managing better outcomes

- Develop at least one primary care practice as a working prototype for an enriched medical home, and work with a local insurer to establish a pilot for improved payment and measuring improved outcomes for that practice

- Undertake an information technology audit. What would it take to provide connectivity and the efficient exchange of information across multiple providers? This is a must-have for managing global payment and/or creating a successful ACO or ACO look-alike. The goal might be to link not only owned entities, but also the all-volunteer free clinic and the county health department.

AUDIT, REPAIR AND RE-INVENT YOUR OUTPATIENT SERVICES

As competition grows among providers of outpatient services, take the opportunity to improve outpatient services, expand their procedures or services and/or invent new venues to encompass volume growth potential.

Implement on-line registration. Track and trend its use.

WELCOME THE UNINSURED

Redefine the uninsured as a key customer group. With reform comes a huge opportunity to serve people who have difficulty accessing the right care at the right time in the right way. Few organizations invest extra resources in growing this customer group, serving them in unique ways and in cultivating a long-term relationship. Catholic health care, on the other hand, brings a historic and cherished commitment to the poor, so some of the ideas here may be enhancements to a dedicated attention already present.

Reform kicks in only gradually, so few Catholic hospitals will see a sudden increase in the insured. The shift will be gradual as people enroll in their new options over the next several years. The strategy is to work now to connect more effectively

with the uninsured, help them view you as a place people experience being valued and respected.

Serving those who have gone without either health care or insurance might prove to be a game changer in a community and net loyal customers for the day when these same people become insured. Here are some ideas:

- Brand your care for the uninsured by naming the initiative something like EasyCare, or whatever reflects efforts to make processes and access easier for the uninsured. The goals are to send a message of dignity, remove fear, provide a safe haven for people who are rarely welcomed — and provide better services for them.

- Map the uninsured and if there is geographic concentration, provide mobile services or joint venture primary care services in those areas.

- Provide new features that will help the uninsured: a care coordinator in every emergency department who handles financial counseling, social services, arranges for enrollment in Medicaid or other special programs and who assists with needed prescriptions and transportation. This same capability will prove essential if the health system is able to procure other global payment populations or has an opportunity to manage a Medicaid population.

- Develop follow-up programs to connect all “undoctored” patients to a medical home.

- Develop methods to communicate — provide people frequent updates on staying healthy, where to get flu shots and other “free” health services and constantly reinforce the charity care policy and the hospital’s interest in helping them. These capabilities could be redeployed in different ways to communicate to a Medicare-based ACO population in 2012.

- Develop a membership program with some key features — available to those who meet the guidelines for charity care — for free or reduced-cost preventive services such as mammograms and other screening tests.

- Partner with your community health center to connect the dots. They are a vital part of the local primary-care delivery system. Federally qualified community health centers, for example, can purchase vans and deliver care on a mobile basis and use federal money to do it.

PARTNERSHIPS CAN HELP

Partnerships with community organizations, a competitor or others may be essential to your suc-

cess, and it's time to take a fresh look.

You may need help with an ACO or other organization created to accept enrollees and to manage care for people within a continuum. It may be time to outsource more or to stop living with less than top national results in a key service line. Perhaps a partner might improve results. An organization and its potential competitors might find their views of partnerships greatly changed in a capital-constrained environment.

Here are some examples:

- Partner for unique expertise. For example, you could purchase the rights to a program framework for a genetic institute, modify its ethical framework to reflect Catholic values and be “first to market” with a community cancer center.

- Partner with a national leading provider of cardiac surgery services in return for exceptional outcomes, the brand, the patient experience and superior delivery of sub-specialty care.

- Partner with a consumer health information company to launch a product on a website that provides multiple online methods for connection to a system's services and value-added features such as self-care, health assessment and know-how for self-insured employers.

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- Partner with a vendor. The possibilities are endless, but choose wisely, based on the kinds of programs and technology essential to better delivery of care.

- Assess every provider in the region, from hospitals to physician groups. Who would be a fit with mission and also provide synergy, value and economy? Make a plan to reach out with a well-prepared case statement for merger or affiliation, clinical co-management, co-creation of a new primary care enterprise, co-development of a health-plex or medical mall. The list is long.

- Partner with employers. Convene several large self-employed company CEOs for a proposal: Describe value-based care, what could be done to bend the cost-curve and how their different design of benefits could foster and catalyze the creation of a better delivery system such as an ACO or similar model.

- Partner with local health systems. Bring them together and propose collaborative work on one or more systemic issues that affect everyone. Overcrowded emergency departments or the Medicaid-eligible but not enrolled populations are just two examples. Develop a plan to improve one root cause of upstream problems.

- And don't forget the obvious — partnering with patients to critique care design, serve on advisory committees and to find the flaws and foster the fixes needed.

AN OPPORTUNITY TO ENHANCE OUR MINISTRY

Reform holds a promise for Catholic health care ministry, even though some of its features may not be as we would design them. Under the new law, the enormous issue of the uninsured in our country will begin to be addressed, increasing moral equity and practical access to health care. As providers of a ministry founded on Christ's love and his direction, not to mention his complete and total embrace of all people, we cannot help but appreciate this historic change.

Reform calls us to become even more effective and to energize outreach to and adoption of the newly insured. Reform provides a precious moment, using the strength of the roles we play in communities, to unify the fragmentation we see, to foster greater collaboration across many providers and to strive to create a communal system of care in addition to our own.

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