

Performance Strategies

for Healthcare Leaders



Get Ready for Value-Based Reimbursement

Vol. 5, Issue 7, 2011

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Healthcare leaders see a future that challenges their physicians, staff and the bottom line — increased access, an aging population, declining reimbursement, a worsening payer mix and a shift to greater consumer responsibility. Faced with new payment models based on accountable care, such as bundled payments, organizations need analytics to attain an integrated view of their clinical and financial performance. This issue provides perspectives from experts and peers on how to prepare for value-based reimbursement.

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Moving Beyond a Value Gap to a 'Value Potential'

HFMA's CEO Richard Clarke advises providers to view value in healthcare from the eyes of the purchaser. When care costs outpace gains in care quality, there is a value gap.

By Richard L. Clarke, DHA, FHFMA
President and CEO
Healthcare Financial Management Association



Data Analysis Provides Intelligence for Success in New Payment Models

Analytics provides a pathway to success in preparing for value-based reimbursement via process improvement that integrates clinical and financial metrics across the enterprise.



By Connie Moser
Vice President and Solution Line Manager,
Enterprise Intelligence Solutions, McKesson Provider Technologies

SUCCESS STORIES



Preparing for the Future: The Value of Integrating Physician Practice Data

Previously, St. Luke's practice data was located in silos. Cross-continuum data integration now offers a clearer view to address the future of healthcare reform.



By Chad Brisendine, VP/CIO
St. Luke's Hospital & Health Network
Lehigh Valley, Pa.

Amanda Mazza, Director, Decision Support
St. Luke's Hospital & Health Network
Lehigh Valley, Pa.



Improve Patient Health – and Your Bottom Line – with Electronic Health Records

Cowherd Family Medical Center used its EHR to improve the population health of its patients. The practice received a top score from CMS and \$75K in P4P funds.

By Robert Cowherd, MD
Director
Cowherd Family Medical Center



Oregon Hospital Takes Action to Navigate Turbulent Financial Waters

Sky Lakes Medical Center implemented a variety of strategies to increase revenue and reduce costs — and ultimately improve the bottom line.

By Andrew Molatore, Director of Patient Financial Services
Sky Lakes Medical Center,
Klamath Falls, Oregon

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Preparing for the Future: The Value of Integrating Physician Practice Data



*By Chad Brisendine, VP/CIO
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At [St. Luke's Hospital & Health Network in Lehigh Valley, Pa.](#), we're quite proud of our data management. Recognizing the role information technology (IT) plays in delivering quality clinical care, we've deliberately stayed ahead of the electronic curve. So as the rapidly changing healthcare landscape began raising new challenges, we looked to data to help us navigate – and even lead – the industry's inevitable transformation.

Expanding Our Vision

As a fast-growing, integrated health network serving southeastern Pennsylvania and western New Jersey – with five hospitals and growing quickly – we've amassed a huge repository of [clinical and financial data](#). For years, we've put that data to work optimizing performance and operations via sophisticated [enterprise intelligence](#) tools.

Looking ahead, we saw that the flourishing St. Luke's of the future would have significant data visibility beyond our hospital walls. We could see analytics' integral and foundational role in: performance improvement, increased quality and performance reporting to regulatory agencies, physician practice acquisitions, value-based purchasing and monitoring increased outpatient delivery. Our organization saw that this called for a shift in strategy: away from a hospital-centric perspective and toward a population management model.

To propel our evolution, we needed data-driven decision support from across the entire care continuum. And therein was the problem: a glaring lack of data from our employed physician practices. On the one hand, our hospital data management was leading edge; on the other, we lacked a means to integrate data from our physician practices.

Integrating Physician Data for Comprehensive Analysis

We reviewed our situation: we owned 80 physician practice sites and employed 300+ physicians, using several different data management systems and tools. While we had recently centralized some physician practice reporting to establish a strong foundation for population management, we still needed to do some heavy electronic lifting. Given our complex needs, our goal was to centralize and integrate physician practice data (clinical and operational) with our well-established, comprehensive, acute-care reporting framework.

But the goal wasn't limited to data. On the people side, we aimed to increase user understanding and use of that data, while strengthening resources surrounding its management. As a long-time customer, we enlisted McKesson's expertise to help us reach our goal of centralizing and integrating data.

Creating Data Integrity

To effectively manage operations in the wake of healthcare reform, hospitals must have access to current, accurate data from across the care continuum. Accordingly, Phase I of our project involved replacing scattered and duplicative physician practice reports with a consolidated, drillable scorecard that they could easily share. Milestones included:

- > Ensuring data accuracy from all sources
- > Assigning master patient identifiers across all sources to enable cross-continuum tracking
- > Standardizing the definition of "patient visit" across practices
- > Improving structures to support cost accounting

Once we confirmed data integrity, we pulled practice performance analysis into a centralized system that also included data from our [enterprise patient visibility](#) solution and hospital [data warehouse](#). The resulting scorecard includes these categories:

- > Financial
- > Productivity
- > Volume
- > Referrals
- > Patient satisfaction
- > Quality

With a drillable scorecard firmly in hand, it was time to put it to work.

Turning Data to Radar

To thrive under healthcare reform, hospitals must be able to knit clinical and financial data together to reveal the true potential of their business. Now in process, Phase II focuses on physician practice performance in terms of volume, revenues and referrals.

Insight into how individual practices affect patient flow through the system – from acute-care, to physician offices, to home health, to the business office – will provide clarity on population management. And not only will we be capable of employing near real-time data analysis across care settings, new predictive modeling tools will help us understand the impact of potential future initiatives such as those focused on population management and using data to align costs with procedures.

Pioneering the Future

Once the project is complete, we expect to have achieved both our data management and performance measurement goals. We'll have fortified our data foundation, made it visible and useful to users, enhanced collaboration with physicians and set the stage for healthy organizational growth. So when the future arrives – in whatever form it might ultimately take – St. Luke's will be ready.

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Amanda Mazza is the director of Decision Support at St. Luke's Hospital & Health Network Lehigh Valley, Pa.

St. Luke's Results from Physician Practice Data Integration Project

Phase I Results

- ▶ Improved data integrity and cross-continuum view
- ▶ Highly functional scorecard, providing visibility into physician practice performance.
- ▶ Improved practice analysis tools
- ▶ Greater accessibility of meaningful data

Phase II Expected Results

- ▶ Integration of physician data with other sources, such as hospital, homecare and finance, as well as expanded clinical, quality, and patient satisfaction information, to support the organization's changing needs
- ▶ Valuable downstream analysis, quality improvement, preparation for healthcare reform
- ▶ Improved operational collaboration with physicians, enabling hospital and physicians to align to achieve organizational goals
- ▶ Enhanced data mining capabilities, supporting cost accounting and predictive modeling to position St. Luke's for success in the future healthcare environment

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[Government Health IT: For hospitals, value-based purchasing starts with meaningful use](#)

[Amednews: Medicare Unveils Bundled Payment Models to Start in 2012](#)

[WBUR \(Boston\): Price list could be radical medical tool](#)

[HFMA: What Value-Based Purchasing Means to Your Hospital](#)

Improve Patient Health – and Your Bottom Line – with Electronic Health Records



By Robert Cowherd, MD
Director
Cowherd Family Medical Center



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Seldom has the daily practice of medicine been more challenging for physicians. Changes in healthcare and an accelerating drive to control costs have put particular pressure on the business side of the small practice. Even as the costs of operating an office are soaring, reimbursement levels are declining. Practices with large numbers of Medicare patients – such as my own – have faced reduced fees and even delays in reimbursement that can threaten a physician's financial stability.

In order for us to survive, physicians must adapt to new payment models that move away from fee for service and toward value-based reimbursement — better health, better care and lower costs. For practices making the transition to [electronic health records](#) (EHR), there is a wide range of opportunities for providing more efficient and better healthcare to patients, helping the practice qualify for increased reimbursement.

Data Drives Superior Patient Care

Located in a retirement community amid the scenic Ozark Mountains, Cowherd Family Medical Center relies on our McKesson [EHR](#) to electronically document patient labs, progress notes, diagnoses and managed care milestones. The EHR has changed our workflow and created positive improvements in patient health.

I can sit down at my computer and quickly generate a list of patients who need a particular screening test. Also, when a patient checks in for an office visit, the EHR immediately flags any tests and screenings that are needed. By incorporating standing orders into the system's health maintenance templates, the nurse can schedule an EKG, chest X-ray or prostate-specific antigen (PSA) test even before I see the patient.

We joined the [Practice Partner Research Network](#) (PPRNet), a practice-based research network, to more efficiently care for our patients and monitor their health outcomes. Our practice uploads secure patient data collected by the EHR to PPRNet, where the information is translated into easy-to-read graphs and charts. These reports enable us to treat patients proactively and track trends against industry benchmarks for chronic diseases. The reports also trigger maintenance checks that comprise the heart of our preventive care plans and provide a focus for staff to improve the percentage of patients who receive basic screenings.

Value-Based Performance Earns Rewards

By documenting and treating patients proactively, we achieved one of the top scores in the nation in the [Medicare Care Management Performance \(MCMP\)](#) report from the Centers for Medicare & Medicaid Services (CMS). We generated reports on our patients in the areas of congestive heart failure, cardiovascular disease, diabetes and preventive health.

Using PPRNet we exported data into a reporting tool for the demonstration project showing:

- > Colorectal screening rate: 85% (state average: 17%)
- > Diabetic blood sugar measured (HbA1c rates <7 in diabetic patients): 75% (national average: 38%)

These successes led to a top score from CMS and \$75,000 in pay-for-performance dollars for our practice. In addition, we recently brought osteoporosis checks into our clinic and increased bone density scanning rates from 25% to 95% for patients over 65 and at risk. This netted an additional \$50,000 in reimbursements.

As Medicare payments have declined, we have focused on other services such as wellness physicals. This annual exam is reimbursed at a higher level than an office visit — typically \$150 to \$200. We now track more than 3,000 eligible patients to ensure that they receive the exams when needed. By incorporating one to two of these checks in our office routine each day we have improved care while capturing revenue that might otherwise be lost.

PPRNet has also helped us to achieve certification as a Patient-Centered Medical Home (PCMH). This approach enables us to provide more personalized and effective care by creating an ongoing relationship between patient and physician. It also ensures that our office staff is more tightly integrated into care of the patient.

Networking and Knowledge Can Improve Practice

Our affiliation with PPRNet has opened up rich opportunities for knowledge and networking with other physicians who are also deep into the transition to electronic health records. At our annual meeting, we share best practices such as how to achieve Patient-Centered Medical Home (PCHM) certification. We also learn how to use patient data to achieve meaningful use and improvements in care delivery that help us qualify for incentive payments available through Medicare and Medicaid.

For physicians, electronic health records offer great opportunities for not only improving patient care, but finding new sources of revenue in an ever-tightening healthcare marketplace. Achieving these goals requires that we take the time to understand how the technology works and how to get the most from its functionality. It also demands being knowledgeable about reimbursable procedures. Otherwise, you and your patients will miss opportunities that can benefit you both.

Robert Cowherd is director of the Cowherd Family Medical Center in Heber Springs, Ark. He practices with his wife, Kristy Cowherd, MD. He earned the doctor of medicine degree from the University of Arkansas for Medical Sciences in 2000. There he became only the second person to complete the combined MD/PhD program.

Cowherd Family Medical Center Improves Patient Population Health

Cowherd Family Medical Center increased screening rates:

- ▶ **Colorectal screening: 85% vs. the state average of 17%**
- ▶ **Diabetic blood sugar (HbA1c rates <7): 75% vs. the national average of 38%**
- ▶ **Bone density scanning for at-risk patients: increased from 25% to 95%**

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[iHealthbeat: Quality Group Offers Recommendations on Collecting Health Care Data](#)

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Oregon Hospital Takes Action to Navigate Turbulent Financial Waters



*By Andrew Molatore,
Director of Patient Financial Services
Sky Lakes Medical Center,
Klamath Falls, Oregon*



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As healthcare reform drives all of us toward improving outcomes, avoiding readmissions and reducing costs, reimbursement is at greater risk than ever. Our department realized we needed to tighten up our revenue cycle to do our part in maintaining our business health.

With the economy in the throes of a recession and reimbursement dwindling, the bottom line at our 176-bed regional healthcare center was an unrelenting concern. To exacerbate the situation, [Sky Lakes Medical Center](#) had been operating without a Director of Patient Financial Services for quite some time. So, when I became director of the department four years ago, there were some pressing challenges.

Bottom-Line Challenges

Revenue was down, and the days in accounts receivable had crept up to more than 90 days. Not only was the bottom line suffering, but our reputation was also on the line. Patients were complaining of slow billing processes. They sometimes received patient statements five or six months after services were performed.

Simply put, we needed to do whatever it took to increase our revenue and reduce our costs — all while improving the service delivered to our patients. That meant taking a high-level look at everything related to “money in, money out” and then adopting a variety of strategies that would tip the financial equation in our favor.

To start, we analyzed all of our patient service offerings. Some non-essential service lines simply were not financially feasible. For example, even though we don’t offer cardiac surgery, we offered a cardiac rehab service as a convenience to patients in our community. Because we never had enough patients to make the service line profitable, we decided to discontinue the service.

Reassessing Popular Trends

We jumped on the provider-based billing bandwagon, a popular trend that enables hospitals to bill for physician services and collect a facility fee in addition to the professional fee. The new billing process helped us bring additional revenue into the system. The change also has streamlined billing operations overall. One office now handles both hospital and physician office billing.

However, we aren’t afraid of bucking some trends as well. For example, we have brought all self-pay collection activities back in-house instead of using an outsourced vendor to handle this duty. Because our community is relatively small and isolated geographically, our patients expect personal service. Our in-house collectors, who all live in the community and are much more in tune with the local culture, can establish the connections needed to effectively communicate with patients and improve collections.

Banishing Paper Processes

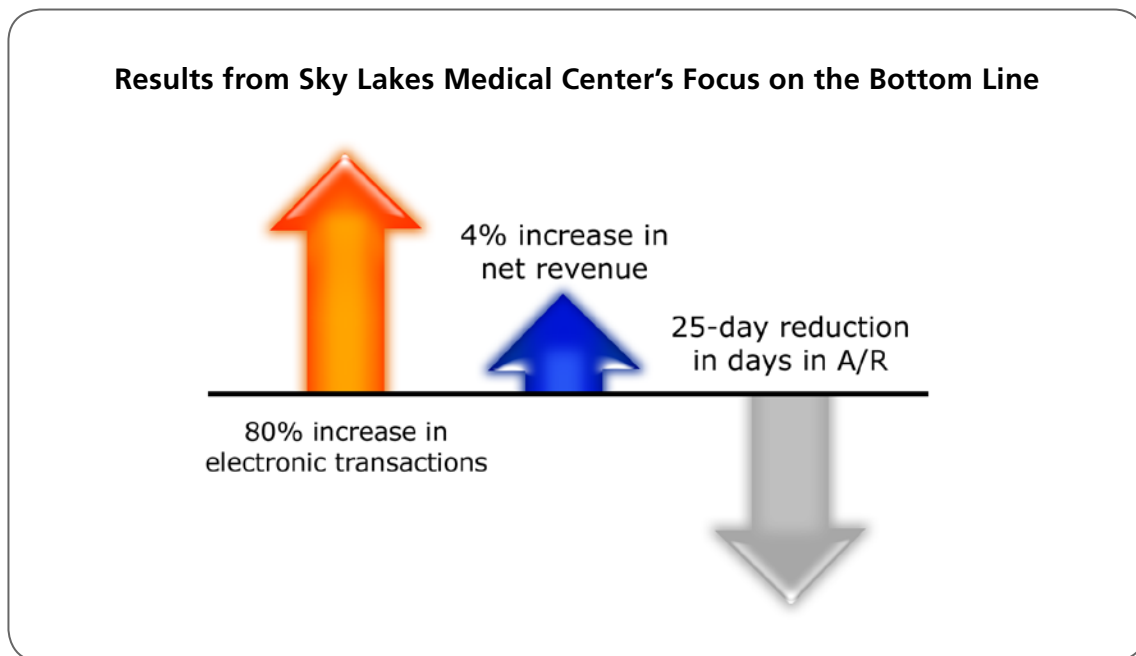
In an effort to bring much needed efficiency to our manual and paper-intensive billing processes, we decided to fully tap into technology. By leveraging a [claims management solution](#) from McKesson’s RelayHealth, we now process claims electronically to the majority of our payers, including Medicare. The system provides electronic processes that help to reconcile claims automatically with payer responses, check eligibility before billing, and automatically bill secondary payers.

In addition, the electronic solution helps us stay on top of emerging requirements. For instance, the Oregon Medicaid system and other major payers recently made the inclusion of National Drug Codes a requirement for reimbursement. To deal with this new requirement, we populated our hospital information system with the billing codes and then pushed these codes into the claims processing system, which sent the information to each payer. As a result, we qualified for reimbursement as soon as the change took effect. If we didn’t have the system in place, we likely would have missed out on reimbursement during the struggle to make the changes to our paper processes.

Another solution from RelayHealth provides an online self-pay Web solution that enables patients to conveniently take care of their financial obligations. Online access enables patients to pay balances even when we're closed, providing convenience that promotes timely payments. Our software checks patients' insurance eligibility and provides estimates of financial obligations to increase our point-of-service collections. Payments received during registration are integrated into the online self-pay module.

By making these changes, we've coped better with the challenges of a struggling economy and have done our part to keep our organization's bottom line healthy. In just 18 months, we reduced AR days by about 25. And for two consecutive years, we have beaten our net revenue estimates by 4% each year. These efforts have paid off in financial stability, ensuring we are better able to provide care to the residents of south-central Oregon and northern California.

Sky Lakes Medical Center's Director of Patient Financial Services since 2007, Andrew Molatore holds an MBA with double concentrations in finance and management from the University of Oregon, and a BS in business administration with double emphases in accounting and finance from the University of Montana.



Learn More

[Health Reform's Impact on the Revenue Cycle](#)

[McKesson Health Reform Blog](#)

[HFMA: Value-Based Purchasing: Maximize Revenue through Accurate Clinical Documentation](#)

Moving Beyond a Value Gap to a 'Value Potential'



By Richard L. Clarke, DHA, FHFMA
President and CEO
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Now more than ever, value in healthcare must be viewed from the eyes of the purchaser.

We've reached a point in our country where the rising costs of care are outpacing improvements in quality of care, creating a "value gap" that healthcare providers are struggling to address. It's not surprising, then, that purchasers – patients, employers, government agencies, and health plans – increasingly want to know what they can expect to receive for what they are paying for care. And

although many providers may be efficient at cost reduction within certain components of their delivery systems, if the purchasers are not experiencing these benefits, these providers will have missed the value equation.

So how can we reach our "value potential" in an environment of healthcare reform and payment reform? Recently, HFMA invited 100 thought leaders in healthcare finance to a conference in Washington, D.C., to generate ideas regarding how our nation's healthcare system can move beyond a value gap to a value potential. The consensus was that healthcare providers need to become better at managing relationships with purchasers and other providers in progressing toward a value-based model of care delivery – and in developing the key competencies needed to succeed under value-based business models.

Capabilities for Value-Based Success

HFMA's Value Project has defined four key capabilities for closing the gap between quality and cost and making the transition to a value-based business model:

- > Developing a culture with stronger collaboration, communication, and accountability between finance and clinicians
- > Enhancing the organization's ability to collect, analyze, and connect accurate quality and financial data to support decision making
- > Using evidence-based care processes to reduce variation in care
- > Measuring, assessing, and mitigating risk

These strategic capabilities are interwoven. A culture of collaboration, creativity and accountability is supported by meaningful performance metrics. These performance metrics drive sustainable improvements in quality and cost, with risk capabilities that vary according to each provider's role in the healthcare ecosystem.

Throughout HFMA's recent thought leadership retreat, participants shared their perceptions of providers' progress in developing these capabilities and the strategies that providers should incorporate now to prepare for a value-based business model.

Fifty-seven percent of participants believe that in the face of reduced Medicare and Medicaid payments, the most realistic response on the part of providers would be to reduce costs to maintain margins, rather than increase rates to private payers. This is a sign that providers are working on designing systems that will curb the rate increases that payers have experienced, and it's a positive step toward moving away from a value gap to a value potential.

Forty-five percent of participants predicted that within the next 10 years, providers will accept performance-based risk on more than half of overall payments. This will involve managing patients and processes to take on a greater share of risk in the delivery of care — and participants' response to this question says a great deal about the capabilities that healthcare organizations believe they have and will have to manage risk in the future.

There was a strong consensus among thought leadership participants that the costing data, from a user perspective in healthcare, are not very good: Sixty-one percent of participants believe decision makers at most provider organizations would say costing data are only sometimes accurate, timely, appropriate, and reported in a useful manner.

Stronger relationships—with patients, in engaging them in managing their health; with purchasers; and with providers—also will be critical to providers' success under this new business model, participants agreed.

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Making the Transition

As I talk with my colleagues throughout the healthcare industry, there is a sense that the industry will move forward with progress toward a value-based business model regardless of what happens with the Affordable Care Act. There is also the sense that it has never been so difficult to be a healthcare finance professional — but it's also a really invigorating and exciting time for finance professionals. We all know that our healthcare delivery system is not sustainable in its current form — that it has to change, and that we have to be part of that change. And we know that the changes ahead will improve healthcare in our country.

Dr. Richard Clarke is president and chief executive officer of the [Healthcare Financial Management Association \(HFMA\)](#), Westchester, Ill. He has held this position since June 1986. Dr. Clarke is a past Chair of the Commission on Accreditation of Healthcare Management Education, having served in various capacities for that organization since 1997. He is also a former chair of AHA Financial Solutions, Inc. (a wholly owned subsidiary of the American Hospital Association). Dr. Clarke holds an instructor faculty position in the Department of Health Systems Management at Rush University in Chicago and the MBA in Health program for the University of Miami in Coral Gables, Fla.

Rural Hospital Reduces Observation Rate by 60% and Protects Reimbursement

[Morehead Memorial Hospital](#) is located in a secluded, rural area in North Carolina and has had limited access to new technologies. The case management staff at the hospital was using [InterQual® evidence-based clinical criteria](#) in book form. Eventually, it was built into a semi-automatic system that offered limited access to criteria manually embedded in its HIS system. Because staff had no formal training in the proper use of the criteria sets, there was variance in compliance, accuracy and how data was applied.

Proof of the need for improvement in the interpretation of criteria was Morehead's high observation rate, which was around 32% in 2008. The high rate signified that patients were being assigned to observation when it may have been more appropriate to discharge them from the ER or admit them for inpatient care.

Morehead addressed the challenge by implementing the online version of the criteria set to automate the review process, streamline workflows and provide a more efficient patient tracking process. At the same time, it enlisted McKesson in providing in-depth training on applying the criteria. An additional online solution enables the evaluation of consistency and compliance in how case managers apply the criteria.

Some physicians direct patients to the ER when they are unable to see them during office hours, creating long wait times. "By extending the hours of the ER case manager and using the [automated criteria](#)," said Renee Angiulli, RN, BSN, MHA, CCM, director of case management at Morehead Memorial Hospital, "we have increased the number of patients getting the right level of care by referring patients whose needs could be better met to another location."

As a result, of the changes, Morehead's initial review rate increased by 20%, decreasing the incidence of patients going to the floor with the wrong status. In addition, Morehead's observation rate dropped 60% to an observation rate of 19.3% in 2010. Reducing observation days helped avoid unnecessary care and expense while ensuring revenue from appropriate hospital admissions.

Data Analysis Provides Intelligence for Success in New Payment Models



By *Connie Moser*
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About 10 years ago, the world of professional baseball was rocked by the introduction of a new approach to statistical analysis. Instead of looking at batting averages or stolen bases, “sabermetrics” examined what actually determined success on the field. The conclusion: it was largely due to on-base percentage. The GM of the cash-strapped Oakland Athletics used that statistical approach to stock his team with less expensive but more effective players and managed to compete with the Yankees who paid their stars three times as much.

In healthcare, we’re seeing our sabermetrics moment arrive. Most health systems are being squeezed financially even as they are driven to improve care outcomes. New payment pressures include bundled services, pay-for-performance initiatives, accountable care, patient consumerism and the looming influx of millions of new users. But financial incentives seem to be at odds with clinical practice.

According to a 2009 [NY Times article](#), Park Nicollet, a hospital and clinic system in St. Louis Park, Minn., reportedly spent \$750,000 on readmission prevention follow-up that reduced readmissions by 25% but earned only a \$247,000 bonus from Medicare. Organizations will always opt for quality improvement at whatever cost, but when does quality become financially impossible to deliver? The answer may be that, like professional baseball, healthcare needs to manage under a new set of metrics.

Many Questions, One Answer

A better understanding of what care processes cost and how breakdowns impact quality across the healthcare continuum will help organizations prepare for the future. That future is likely to be characterized by value-based reimbursement — reimbursement that looks at quality, cost and population health.

Fortunately, a better approach to data analytics will help organizations meet these challenges immediately. Effective use of analytics points the way to improvements from an integrated clinical and financial view across the enterprise. However, developing a level of analytics maturity requires long-term discipline and attention to detail across the organization. Doing it wrong means devoting significant resources to systems that will fail to improve efficiency or quality.

Three Capabilities to Manage

Donald Marchand, in his book, “[Information Orientation, The Link to Business Performance](#)” outlines three capabilities that must be managed when tying analytics to strategic objectives:

- > Implementing information technologies to support business operations, decision making and innovation
- > Management of the tsunami of data that healthcare technology creates so that it is “consumable” by caregivers and administrators
- > Inform decision-making and influence behavior using intelligence generated from the data

The convergence of these capabilities sets a new standard for how progress is measured. And since reimbursement is tied to that progress, it will affect strategic decisions about service lines, staffing, technology investments and care delivery.

For example, as an organization launches readmission prevention programs, it must evaluate the cost and quality of care across the continuum, not in silos. This means it must aggregate data from all of those care settings in order to look at where costs are incurred, identify appropriate care settings to achieve the highest level of quality and monitor patient experience.

If organizations use the information to identify high-risk patients while they are still in the hospital, they can target their limited resources to patients where they can make a difference. The measure of success becomes not just readmission rates or patient days but variable cost by phase of care linked to patient outcome and experience. When viewed holistically, one may find that

investment in prevention does produce a financial return, especially under a bundled payment model.

This approach applies to any performance improvement initiative in healthcare, such as preventing hospital-acquired conditions. [PeaceHealth Southwest Medical Center](#) used McKesson's enterprise visibility solution to display real-time messages to alert nurses of patients with a fall risk, leading to workflow changes, a 17% fall reduction and \$630,000 in cost avoidance over two years.

Ensuring Success

Data credibility is improving as technology becomes more widely adopted. However, tight governance and data stewardship are essential, as are business advisors that ensure data use is optimized. It is equally important that care providers are presented data in a manner that truly affects the way they do their work. Whatever alert system is used to push the [business intelligence](#) to providers, it must be simple, timely and insistent of notice.

Ultimately, however, the success of a better approach to data analytics starts with leadership. To adopt a sabermetrics model in healthcare means organizations have to rethink the traditional measures of success and engage their stakeholders in a new dialog about performance. A new analytics solution can't be relegated to the financial administrators or the clinicians — it must be seen as an enterprise-wide, integrated view of performance. Real executive sponsorship and awareness are essential for the organization to improve its numbers and provide better care.

*Read an article by Donald Marchand, "[Real IT Success Comes With Use, Not Deployment](#)," in a previous issue of *Performance Strategies*.*

Connie Moser leads the Enterprise Intelligence division within McKesson Provider Technologies and has more than 21 years experience in the healthcare industry. She served a three-year term as the public board member for the Competency and Credentialing Institute, a nonprofit organization focused on enhancing patient safety through surgical nurse certification, where she also held the roles of Secretary/Treasurer for two years. Additionally, Moser has presented on various topics sponsored by HIMSS, HFMA and NAHAM, and most recently at the HFMA Thought Leadership Leadership Conference in Washington, DC.

Patient Outreach Can Help Reduce Readmissions

Starting in Federal fiscal year 2013 (October 2012), hospitals face a reduction in payments for all Medicare patients for preventable readmissions incurred by the hospital in 2012. Each year through 2015, an additional 1% reduction in reimbursement is added, capping at a 3% reduction.

The preventable readmissions defined under the healthcare reform legislation, include: heart failure, acute myocardial infarction and pneumonia. In addition, the [Hospital Compare website](#) reports how hospitals' 30-day readmission rates for certain conditions compare to the US national rate.

To prevent readmissions, hospitals need to ensure that there are education and discharge instructions before the patient leaves the hospital, and that outreach continues after the patient returns home. To build a bridge to the home, hospitals are enlisting family members to help ensure the prescribed treatments are followed and medications taken.

Some hospitals are using call centers to provide: post-discharge care coordination, education on the condition, follow-up on medication adherence, customized care plans, scheduling and reminders for recommended appointments, and monitoring of the patient's condition via telehealth devices.

[Affinity Health Systems](#), a regional healthcare network in northwestern Wisconsin, uses RelayHealth's [RelayCare™ comprehensive contact center solution](#) to support its efforts to tackle heart failure readmissions.

"In 2008, we launched our heart failure disease management program," says Rita Satvos, RN, BSN, PN, director of [Affinity NurseDirect/Population Health NurseDirect](#). "Our nurses work with patients to educate them on their condition and the importance of adhering to the treatment plan. We integrate telemedicine technology and monitor patients on a regular basis, based on their need.

"As a result of our efforts, Affinity Health Systems places in the top percentage for heart failure treatment in the Hospital Compare rankings. Two area healthcare organizations also use our services, and in the first quarter of 2010, they significantly reduced their readmissions. Only three patients were readmitted to either facility."

Affinity Health was featured in a previous issue of Performance Strategies for [reducing tobacco usage through its Tobacco Cessation Program](#), which achieved a 72% quit rate vs. the national average of 42%.

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