Leading the Change
Solutions for Today’s Healthcare Challenges

Kari S. Cornicelli, FHFMA, CPA
Vice President and CFO, Sharp Metropolitan Medical Campus, San Diego, and
2014-15 Chair, HFMA

Lone Star Chapter Winter Institute
George W. Bush Institute
February 26, 2015

“A great leader’s courage to fulfill his vision comes from passion, not position.”
- John Maxwell
What We Will Cover Today…

• What is impacting our industry?
• What strategies have to be in place to thrive and to win?
• Who has already started to tackle change and won?
• How is HFMA helping you embrace change successfully?
• What is your personal plan to embrace and lead the change?

Presentation Overview

• Organizational Performance
  – Cost Reductions & Capital Access
  – Business Analytics
  – Payment Reform & Value-Based Purchasing
  – Population Health & the Care Continuum
  – Revenue Cycle
• Leadership … What does it really mean?
Key Factors Reshaping the U.S. Healthcare Environment

- Demographic Changes
- Rising Costs
- Patient Experience
- Empowered Consumers
- Health Reforms
- Regulatory Pressures
- Personalized Medicine
- Disruptive Technology
- Information Technology
- Constrained Budgets

Note(s): ¹As aging population is increasing across the globe, focus on healthcare is going to increase. This will also increase the focus on preventive healthcare rather than treating people when they fall ill.

Realignment Is Erasing Traditional Healthcare Boundaries

Driven by demands for care transformation, the healthcare industry is realigning at an unprecedented pace.

SHARED GOAL

The Triple Aim Framework developed by the Institute for Healthcare Improvement in Cambridge, Mass. (www.ihi.org)
Strategies to Embrace the Change and Thrive

“Incredible change happens in your life when you decide to take control of what you do have power over, instead of craving control over what you don’t.”

— Steve Maraboli, Life, the Truth, and Being Free

An Interesting New Challenge

Shout-out to Relay Health as published in hfm magazine
Cost Reduction

The need for rigorous cost management is clear. Accelerated by unsustainable growth in national healthcare costs, the emerging value-based business model and healthcare reform will push hospitals and health systems to improve quality, access, and outcomes, while reducing expenses.

*From hfm, March 2012, Kaufman Hall*

---

**AMA’s Cost Reduction Strategies**

The American Medical Association identified four broad strategies to contain healthcare costs and get the most for our dollars:

1. **Reduce the burden of preventable disease**
2. **Make healthcare delivery more efficient**
3. **Reduce nonclinical health system costs that do not contribute to patient care**
4. **Promote value-based decision making at all levels.**

*Source: “Getting the most for our health care dollars”, AMA*
### Cost of Chronic Care 2003-2023


---

### Are We Efficient? U.S. Ranks Last

**EXHIBIT ES-1. OVERALL RANKING**

<table>
<thead>
<tr>
<th>#3 Rank</th>
<th>#2 Rank</th>
<th>#1 Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>USA</td>
<td>CAN</td>
<td>FRB</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>USA</td>
<td>3</td>
<td>$3,990</td>
</tr>
<tr>
<td>CAN</td>
<td>2</td>
<td>$4,522</td>
</tr>
<tr>
<td>FRB</td>
<td>1</td>
<td>$4,971</td>
</tr>
</tbody>
</table>

Note: *Table 1.1a* | **Table 2.1b** | Source: USP Am J Prev Med 2013 44(3S):S154-S166. *International Health Policy Program, Columbia University, New York, NY.*
AMA’s Cost Reduction Strategies

The American Medical Association identified four broad strategies to contain healthcare costs and get the most for our dollars:

1. Reduce the burden of preventable disease
2. Make healthcare delivery more efficient
3. Reduce nonclinical health system costs that do not contribute to patient care
4. Promote value-based decision making at all levels.

Source: “Getting the most for our health care dollars”, AMA.

Deloitte’s “Radical Cost Reduction”

Basic Premise:

“By many estimates the reduction must reach 20%-30% of total cost structure by 2015 to be able to confront a lean, health-reformed environment.”

Why?

Reductions from government payers, pressures from lower commercial rates, pricing transparency, narrow networks… all equate to shrinking revenue base.

### Operational vs. Strategic Approach

**Operational**
1. Bottom up
2. Looks to drive incremental change
3. Derives value from making organization different

**Strategic**
1. Top down
2. Changes underlying delivery and profit model
3. Derives value from making organization better than peers


### Tool For Readiness Assessment

<table>
<thead>
<tr>
<th>Unprepared/Pressured</th>
<th>Well-Paced/Hospitable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interface setting and tracking</td>
<td>Focus of care management driven by patient-centricity and value-driven metrics</td>
</tr>
<tr>
<td>Scope of Cost Management</td>
<td>Focus of cost management driven by market-driven and value-driven metrics</td>
</tr>
<tr>
<td>Systemic Issues</td>
<td>Decision making driven by the broader strategic objectives</td>
</tr>
<tr>
<td>Alignment</td>
<td>Strategic alignment of goals, programs, and financial performance</td>
</tr>
<tr>
<td>Accountability and Ownership</td>
<td>Highly creative and uncoordinated; culture is the norm</td>
</tr>
<tr>
<td>Management Culture</td>
<td>Demanding culture with little room for mistakes</td>
</tr>
<tr>
<td>Operational Planning</td>
<td>String controls on hiring and use of premium rates</td>
</tr>
<tr>
<td>Overhead Management</td>
<td>Mechanisms in place to redirect unneeded and unproductive spending towards innovation</td>
</tr>
<tr>
<td>Composite Position</td>
<td>Weak</td>
</tr>
</tbody>
</table>

How Much Is Enough?

- Capital needs and related shortfalls
- Medicare breakeven analysis
- Current and desired bond rating
- Market dynamics
- Current negotiations and at-risk contracts
- The impact of transparency and benefit design

Capital Access

In an era of healthcare reform, with declining payment, concerns about reducing costs, and exploration of new organizational structures to improve accountability for population health, uncertainty abounds among healthcare providers. Considerable investment and reinvestments are critical to the profitability and survival of hospitals and health systems today.

U.S. Not-For-Profit Acute Health Care Rating Actions 2014: Upgrades and Downgrades

Data as of December 31, 2014

Business Analytics

“We developed the concepts in this work from the data we gathered, building a framework from the ground up. We followed an iterative approach, generating ideas inspired by the data, testing those ideas against the evidence, watching them bend and buckle under the weight of evidence, replacing them with new ideas, revising, testing, revising yet again, until all the concepts squared the evidence.”

From Great by Choice, Jim Collins 2011
Business Analytics Needs in an Era of Change

How to Apply Data Mining to Everyday Clinical Practice

- Standardizes knowledge work
- Systematically applies evidence-based best practices to care delivery

- Drives change through new organizational structures, especially teams
- Requires true organizational change to drive adoption of best practices throughout an organization

- Aggregates clinical, patient satisfaction, and other data
- Enables analysts to identify patterns that can inform decisions
Harnessing Data to Improve Physician Performance

BRYAN HEALTH’S PATIENT-CENTERED MEDICAL HOME PROVIDER SCORECARD

All physicians at Bryan Health can track their performance on key outcomes-based metrics, including clinical quality, patient experience, service, and growth. Although the scorecard is physician-specific, the physician care team reviews the scorecard together and works collaboratively to maintain or improve results.

<table>
<thead>
<tr>
<th>IPILLAR</th>
<th>MEETING</th>
<th>CANC</th>
<th>CANC</th>
<th>CANC</th>
<th>CANC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>DB p/s Hg hasn’t ≥ 7</td>
<td>46.5</td>
<td>60.0</td>
<td>64.0</td>
<td>54.8</td>
</tr>
<tr>
<td></td>
<td>Hg/Hg BP &gt; 140/90</td>
<td>81.3</td>
<td>75.0</td>
<td>80.0</td>
<td>80.8</td>
</tr>
<tr>
<td></td>
<td>CHD/Atheros p/LDL ≤ 100</td>
<td>62.4</td>
<td>71.0</td>
<td>70.0</td>
<td>71.1</td>
</tr>
<tr>
<td></td>
<td>FM ≥ 74 Mannino</td>
<td>73.5</td>
<td>71.3</td>
<td>71.3</td>
<td>70.1</td>
</tr>
<tr>
<td></td>
<td>FM ≤ 84 Pop</td>
<td>65.3</td>
<td>67.0</td>
<td>68.0</td>
<td>67.2</td>
</tr>
<tr>
<td></td>
<td>M &amp; F 50-75 CRS</td>
<td>51.4</td>
<td>49.0</td>
<td>58.0</td>
<td>63.9</td>
</tr>
<tr>
<td>Service</td>
<td>Provider Communication</td>
<td>95.0</td>
<td>95.0</td>
<td>95.0</td>
<td>95.0</td>
</tr>
<tr>
<td></td>
<td>Access to Care</td>
<td>95.0</td>
<td>95.0</td>
<td>95.0</td>
<td>95.0</td>
</tr>
<tr>
<td></td>
<td>Follow up on Test Results</td>
<td>92.0</td>
<td>85.0</td>
<td>88.0</td>
<td>95.0</td>
</tr>
<tr>
<td>Growth</td>
<td>Will agree to Recommend</td>
<td>95.0</td>
<td>95.0</td>
<td>95.0</td>
<td>95.0</td>
</tr>
<tr>
<td></td>
<td>Overall</td>
<td>95.0</td>
<td>95.0</td>
<td>95.0</td>
<td>95.0</td>
</tr>
</tbody>
</table>


Payment Reform & Value Based Purchasing

Payment reform is changing health care, bringing with it the need for new competencies for success. Healthcare leaders need innovative strategies to integrate with physicians, manage risk, reduce cost and price bundled services, and enhance quality while lowering cost. Business as usual is not an option.

Healthcare Payment Reform – Accelerating Success, HFMA
Goals of Payment Reform

**Cost containment goals**
- Reverse the FFS incentive to provide more services
- Provide incentives for efficiency
- Manage financial risk
- Align payment incentives to support quality goals

**Quality goals**
- Increase or maintain appropriate and necessary care
- Decrease inappropriate care
- Make care more responsive to patients
- Promote safer care

Source: http://www.rand.org/pubs/periodicals/health-quarterly/issues/v1/n1/03.html

---

Moving Away From FFS…
on 1/26 CMS Issued this

- **Tie 30 percent** of traditional Medicare payments to quality or value through alternative payment models, such as ACOs or bundled payment arrangements by the end of 2016,
- **Tie 50 percent** of payments to these models by the end of 2018,
- **Tie 85 percent** of all traditional Medicare payments to quality or value by 2016, and
- **Tie 90 percent** by 2018 through programs such as VBP and Readmissions Reduction programs.

This is the first time in the history of the Medicare program that HHS has set explicit goals for alternative payment models and value-based payment models into their programs.

Per email correspondence on 1/26/15 from Centers for Medicare & Medicaid Services <mailists@subscriptions.cmc.hhs.gov>
Another way of looking at this...

<table>
<thead>
<tr>
<th>Category 1: Fee for Service—No Link to Quality</th>
<th>Category 2: Fee for Service—Link to Quality</th>
<th>Category 3: Alternative Payment Models Built on Fee for Service Architecture</th>
<th>Category 4: Population-Based Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>At least a portion of payments vary based on the quality or efficiency of health care delivery.</td>
<td>Some payment is linked to the effective management of a population or an episode of care.</td>
<td>Payment is not directly triggered by service delivery or volume and is not linked to payment.</td>
</tr>
<tr>
<td>Examples</td>
<td>Medicare Limited to Medicare fee-for-service, majority of Medicare payments are linked to quality.</td>
<td>Hospital value-based purchasing, Physician Value-Based Modifier.</td>
<td>Accountable care organizations (e.g., shared savings, bundled payments).</td>
</tr>
<tr>
<td>Medicare</td>
<td></td>
<td></td>
<td>Eligible Payers accountable for organizations in value- and risk-based programs and payments to clinicians and organizations.</td>
</tr>
</tbody>
</table>

And Now the Physicians

The penalty phase

<table>
<thead>
<tr>
<th>Year/Program</th>
<th>eRx</th>
<th>PQRS</th>
<th>Meaningful Use</th>
<th>Value Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>-1.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>-1.5%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>-2.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>-1.5%</td>
<td>-1.0% *</td>
<td></td>
<td>-1.0%</td>
</tr>
<tr>
<td>2016</td>
<td>-2.0%</td>
<td>-2.0%</td>
<td></td>
<td>-2.0%</td>
</tr>
<tr>
<td>2017 - 2019</td>
<td>-2.0%</td>
<td>-3.0% - 5%**</td>
<td>(each year)</td>
<td>-4.0%***</td>
</tr>
</tbody>
</table>

* Penalties will be greater for unsuccessful e-prescribers.

** Penalty amount could increase up to 5% depending on meaningful use success rate.

*** As indicated in the proposed 2015 Medicare physician fee schedule.
The Mandatory Programs under ACA

<table>
<thead>
<tr>
<th>Payment Type</th>
<th>VBP</th>
<th>RRP</th>
<th>HAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Medicare Inpatient $s</td>
<td>1%</td>
<td>2013</td>
<td>1%</td>
</tr>
<tr>
<td></td>
<td>1.25%</td>
<td>2014</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>1.5%</td>
<td>2015</td>
<td>3%</td>
</tr>
<tr>
<td></td>
<td>1.75%</td>
<td>2016</td>
<td>2015+</td>
</tr>
<tr>
<td></td>
<td>2%</td>
<td>2017+</td>
<td></td>
</tr>
<tr>
<td>Description of Metrics</td>
<td>Addition of domains through 2015 with dynamic metrics every year</td>
<td>Three core diagnoses with additional 2 in 2015 and more to be added in later years</td>
<td>Two domains: Safety and Infections with infections weighted higher and additional infections added</td>
</tr>
</tbody>
</table>

Maximizing & Protecting: Hospital

Legend
- COVID-19
- Employee Screening
- IT Support
- Manufacturer Programs
- Total System Census
- Total System Discharge
- Trend Reports
- Uninsured
- Comprehensive Primary Care Initiative (CPCI)
VBP Shifting of Domain Weights

- Clinical Care
- Patient Experience
- Safety - Outcomes
- Efficiency (MSPB)

Texas VBP FFY 13-15
Readmission Reduction Program

- 3 Performance periods in play at a time
  - 3% penalty of Medicare Reimbursement at risk each program year
  - Measured Populations 30 days from DISCHARGE
    - AMI, HF, PN, COPD, THA & TKA
- CABG is added in FY 2017 which is in play now
- Performance Periods: 3 Year Rolling Program
  - FY’15: July 1, 2010 – June 30, 2013 – 3%
  - FY’16: July 1, 2011 – June 30, 2014 – 3%
  - FY’17: July 1, 2012 – June 30, 2015 – 3%
  - FY’18: July 1, 2013 – June 30, 2016 – 3%
  - FY’19: July 1, 2014 – June 30, 2017 – 3%

Currently participating in 3 performance periods simultaneously

Texas RRP Penalties FFY 13-15

![Graph showing Texas RRP Penalties FFY 13-15](image)
# Hospital Acquired Conditions: FY17

<table>
<thead>
<tr>
<th>First Domain: PSIs</th>
<th>Second Domain: CDC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pressure Ulcer Rate</td>
<td>CLABSI</td>
</tr>
<tr>
<td>Foreign Object Left in Body</td>
<td>CAUTI</td>
</tr>
<tr>
<td>Iatrogenic Pneumothorax Rate</td>
<td>SSI Following Colon Surgery (FY 2016)</td>
</tr>
<tr>
<td>Postoperative Physiologic and Metabolic Derangement Rate</td>
<td>SSI Following Abdominal Hysterectomy (FY 2016)</td>
</tr>
<tr>
<td>Postoperative Pulmonary Embolism and Deep Vein Thrombosis Rate</td>
<td>Methicillin-Resistant Staphylococcus Aureus (MRSA) Bacteremia (FY 2017)</td>
</tr>
<tr>
<td>Accidental Puncture and Laceration Rate</td>
<td>Clostridium Difficile (FY 2017)</td>
</tr>
</tbody>
</table>

# Texas HAC Scores: FFY 15

![Texas HAC Scores Chart](chart.png)

Penalized
Bundled Payments Overview

<table>
<thead>
<tr>
<th>MODEL NAME</th>
<th>MODEL 1</th>
<th>MODEL 2</th>
<th>MODEL 3</th>
<th>MODEL 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>MODEL NAME</td>
<td>Retrospective</td>
<td>Acute Care</td>
<td>Hospital Stay Only</td>
<td>Retrospective Post-Acute Care</td>
</tr>
<tr>
<td>SCOPE OF EPISODES</td>
<td>Entire Hospital</td>
<td>Up to 48 Episodes</td>
<td>Up to 48 Episodes</td>
<td>Up to 48 Episodes</td>
</tr>
<tr>
<td>SERVICES INCLUDED IN EPISODES</td>
<td>All Part A services paid as part of the MSDRG payment</td>
<td>All non-hospice Part A and B services during the initial inpatient stay, post-acute care period and readmissions</td>
<td>All non-hospice Part A and B services during the post-acute period and readmissions</td>
<td>All non-hospice Part A and B services (including the hospital and physicians during retroactive stay and readmissions)</td>
</tr>
<tr>
<td>PAYMENT</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Retrospective</td>
<td>Prospective</td>
</tr>
<tr>
<td>BPCI DISCOUNT</td>
<td>0.5% and increasing over time</td>
<td>2-3%</td>
<td>3%</td>
<td>3-3.25%</td>
</tr>
<tr>
<td>ADMITTED BPCI HEALTHCARE ORGANIZATIONS AS OF 7/31/14</td>
<td>19</td>
<td>2,055</td>
<td>4,534</td>
<td>17</td>
</tr>
</tbody>
</table>

Note: Model 1 is on a different implementation timeline than Models 2, 3 and 4.

Early Results of BPCI Cohort 2

- Tremendous increase in the number of applications in the most recent open enrollment in April 2014: Nearly Triple!
- Models 2,3,4 were open for enrollment
- Currently in the Phase 1 period which is the non risk, decision making period. Phase 2 is when the Episode Initiator starts to accept risk
What Is Accountable Care?

Outcomes

- Improve the individual experience of care
- Improve population health
- Reduce the cost of health care for populations

Processes

- Oversee the provision of clinical care
- Coordinate the provision of care across the continuum of health services
- Invest in and learn to use appropriate IT to manage population health

Structure

- Bear financial risk for the measured health of a population
- Align incentives to encourage the production of high-quality health outcomes

Where Are the MSSPs?

As of April 2014, there are 23 Pioneer ACOs and 343 Shared Savings ACOs. 89 Shared Savings ACOs joined in January 2015.

Source: The Advisory Board
Early Results: 2012 & 2013 Cohorts

<table>
<thead>
<tr>
<th>Year One</th>
<th>MSSP ACOs</th>
<th>Pioneer ACOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced Spending Enough to Earn Shared Savings</td>
<td>49</td>
<td>12</td>
</tr>
<tr>
<td>Reduced Spending Enough to Earn Shared Savings, but Failed to Satisfactorily Report Quality Metrics</td>
<td>4</td>
<td>N/A</td>
</tr>
<tr>
<td>Reduced Spending, but Not Enough to Earn Shared Savings</td>
<td>52</td>
<td>6</td>
</tr>
<tr>
<td>Had Neutral Financial Performance or Spent Over Budget</td>
<td>114</td>
<td>13</td>
</tr>
<tr>
<td>Significantly Overspent Budget and Had Shared Losses</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL Participants</td>
<td>220</td>
<td>32</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year Two</th>
<th>MSSP ACOs</th>
<th>Pioneer ACOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced Spending Enough to Earn Shared Savings</td>
<td>Data Not Available</td>
<td>11</td>
</tr>
<tr>
<td>Reduced Spending or Had Neutral Financial Performance</td>
<td>Data Not Available</td>
<td>6</td>
</tr>
<tr>
<td>Spent Over Budget, but Not Enough to Have Shared Losses</td>
<td>Data Not Available</td>
<td>3</td>
</tr>
<tr>
<td>Significantly Overspent Budget and Had Shared Losses</td>
<td>Data Not Available</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL Participants</td>
<td>23</td>
<td></td>
</tr>
</tbody>
</table>

And then you have Meaningful Use

CMS Medicare and Medicaid EHR Incentive Programs
Milestone Timeline

- Fall 2010
- Winter 2011
- Spring 2011
- Fall 2011
- Winter 2012
- 2013
- 2014
- 2015
- 2016
- 2017

http://www.aha.org/advocacy-issues/hit/mu/overview-time.shtml
Now the Penalties Hit for MU

At first there were incentives...now there are penalties...

<table>
<thead>
<tr>
<th>% Decrease</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>25%</td>
<td>50%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
</tr>
</tbody>
</table>

For example if the increase to IPPS for 2015 was 2%, then an Medicare subsection (d) eligible hospital that is not a meaningful user would only receive a 1.5% increase in 2015.

The timing of the first year of reporting is critical.

<table>
<thead>
<tr>
<th>Payment Adjustment Year</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Full Year EHR Reporting Period</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2019</th>
</tr>
</thead>
</table>

Partnering for Success
Under Value-Based Payment

Who Collaborated
- Aetna
- Consultants in Medical Oncology and Hematology, a 9-physician practice in Southeastern Pennsylvania

What They Did
- Collaborated on a patient-centered medical home model for oncology
- Used a common medical home approach: management fee plus shared savings

Results They Achieved
- 71% fewer ED visits and 51% fewer hospitalizations for chemotherapy patients in 2012, compared to national benchmarks

Source: “Partnering Around Value-Based Payment,” Leadership, Summer 2014, available at hfma.org/leadership
Population Health
The Care Continuum

Improving the health of populations is one of three dimensions that make up the Institute of Healthcare Improvement’s Triple Aim.

Advancing Population Health Management

Best Health, Best Care, Best Experience

- Care Delivery Models
- Care Coordination
- Patient Engagement
- Information Technology and Analytics
- Alignment of Incentives

Source: Sharp Healthcare, San Diego, CA
Care Management Programs

- Hospital Care Management
- Disease Management
- Skilled Nursing Care Management
- Complex Case Management
- End-of-Life Care Management
- Out-of-Network Care Management

Source: Sharp Healthcare, San Diego, CA

Transitions Program

<table>
<thead>
<tr>
<th></th>
<th>Pre Transitions*</th>
<th>During Transitions</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalizations, n</td>
<td>71</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Hospitalizations per patient, mean (SD)</td>
<td>.46 (.84)</td>
<td>.21 (.55)</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Hospitalization rate</td>
<td>32%</td>
<td>17% (26)</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>ED visits, n</td>
<td>157</td>
<td>67</td>
<td></td>
</tr>
<tr>
<td>ED visits per patient, mean (SD)</td>
<td>1.01 (1.3)</td>
<td>.43 (.78)</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>ED visit rate</td>
<td>57% (88)</td>
<td>31%</td>
<td>&lt; 0.01</td>
</tr>
<tr>
<td>Total Cost of Care, (SD)</td>
<td>$73,025 ($109,708)</td>
<td>$46,588 ($81,616)</td>
<td>&lt; 0.01</td>
</tr>
</tbody>
</table>

*Transitions LOS is unique for each patient: pre-Transitions LOS = During-Transitions LOS

Source: Sharp Healthcare, San Diego, CA
Who Is Eligible?

**Health & Wellness**

**Disease Management**

Education and support customized to the patient’s level of health, allowing them to self-manage their chronic medical condition, promote wellness and prevent complications.

**Disease Managers/Coordinators**
- Diabetes
- Asthma
- COPD
- Obesity/Sleep Apnea
- Heart Failure
- CAD
- Heart Failure
- COPD

**Pharmacy**

Focus on medication therapy management and improved patient adherence.

- Lipid Clinic
- Refill Clinic
- Medication Reconciliation

**Chronic Care Nurses**

Provide patient support in the Primary Care Offices. The RN supports and reinforces the treatment plan prescribed by the physician.

- 5 or more chronic medical conditions
- 4 or more ER visits in the last 12 months
- 4 or more hospital admissions in the last 12 months

**Complex Case Management**

Coordination and assessment of care and services for members who have experienced a critical event or diagnosis that requires the extensive use of resources and system navigation in order to facilitate appropriate delivery of care & services.

Who Is Eligible?

Promotion of knowledge, healthy attitudes, and practices to help our patients achieve their personal best health.

- Healthier Living - Chronic Disease Self Management
  - Weight Management
  - Dietician Consultation
  - Heart Failure
  - Healthy Hearts
  - Asthma
  - Stress Management
  - Strength Training
  - Smoking Cessation

Source: Sharp Rees-Stealy, Sharp Healthcare, San Diego, CA

Accountable Care Collaborations: Will They Succeed?

<table>
<thead>
<tr>
<th>Key Attribute for Successful Alliances</th>
<th>Present in ACOs?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A common pain/shared problem</td>
<td>✔</td>
</tr>
<tr>
<td>A convener of stature</td>
<td>?</td>
</tr>
<tr>
<td>Representatives with authority to make decisions</td>
<td>?</td>
</tr>
<tr>
<td>Committed leaders</td>
<td>?</td>
</tr>
<tr>
<td>A clear goal</td>
<td>✔</td>
</tr>
<tr>
<td>Formal rules</td>
<td>✔</td>
</tr>
<tr>
<td>Confidence that the alliance will get to its destination</td>
<td>?</td>
</tr>
<tr>
<td>A shared pool of reliable information</td>
<td>✔</td>
</tr>
</tbody>
</table>

Bottom line: Many essential elements for alliance success are present but it’s up to the leaders of each ACO to make it successful!
Revenue Cycle

The revenue cycle presents unique opportunities for bottom-line improvement. As payment continues to decline, hospitals should take a renewed interest in improving their financial performance through the revenue cycle.

HFMA

Revenue Cycle
The New Norm - Basic Expectations

• Efficient – Low cost work flows.....
  ▪ Exception based processing
  ▪ Automation through EDI
  ▪ Patient Self Service Options

• Accurate – Get it right the first time!
  ▪ Right Insurance, Right Authorization
  ▪ Right Patient Responsibility at Time of Service
  ▪ Mandate Real Time Concurrent Review, Open EMR

• Timely – Introduce expectations early in cycle
  ▪ Patient and payers timely payment expectations
It’s a “New Era” in Revenue Cycle

- Price Transparency, New Payment Methodologies and Patient Liabilities
  - Cost Based Charge Masters or Defensible Charge Master
  - Bundled Payments & Capitation
  - Self Pay Initiatives

---

Improve the Billing and Payment Experience for Patients

![Diagram showing healthcare dollars and sense with Price Transparency, Patient Financial Communications, and Medical Account Resolution](hfma.org/dollars)
HFMA Resources

My goal each year is to introduce promising young professionals and colleagues to HFMA and help integrate them within the organization. The HFMA network enhances their careers, strengthens our chapter, and allows us to follow their success. My chapter leaders did it for me, and I want to pass it on. It’s a win-win!

Debbie Teesdale
Executive Director of Corporate Development
Paragon Hospital Services, LLC

HFMA Changes Health Care

OUR MISSION
Leading the financial management of health care

OUR VISION
HFMA will bring value to the industry as the leading organization for healthcare finance
Affinity Groups

• Formed and Actively Meeting
  – Health Care Economics Professional Council
  – Physician Group Practice Executive Council
  – Strategy Executive Council
  – Academic Medical Center CFO Council
• Being Formed
  – CMMI Bundled for Care Improvement Council
  – Payer Focused Affinity Group

Master Level Seminars

• Seattle, WA | March 25-27, 2015
  – Beyond Big Data: Developing a Business Intelligence and Analytics Practice
New HFMA Value Project Report Reflects Industry Realignment

Current State & Future Directions of Value

Defining & Delivering Value

Acquisition and Affiliation Strategies

Organizational Road Maps for Value-Driven Health Care

Physician Engagement & Alignment

hfma.org/valueproject

Leadership...
Your personal plan...what does it really mean?

“Leadership has nothing to do with titles;
it has everything to do with,
“Do you inspire other people?
Do they want to follow you?
Do they want to be with you?”

-Tom Atchison, author of
Followership: A Practical Guide to Aligning Leaders and Followers
New Skills for A Leader

- Convening collaborative efforts
- Making decisions on behalf of your organization
- Commitment to move the alliance forward
- Confidence that the alliance will "get to its destination"

Trend Toward Collaboration Across Traditional Boundaries

8 Key Elements Required for Successful Collaboration
1. A common pain (a shared problem)
2. A convener of stature (an influential leader)
3. Representatives of substance with authority to make decisions
4. Leaders committed to move the alliance forward
5. A clearly defined purpose
6. Established rules
7. Confidence that the alliance will "get to its destination"
8. A shared pool of reliable information
Collaboration Success Stories

WITHIN A HEALTHCARE SYSTEM

A California healthcare system created core revenue cycle teams with representatives from 10 departments across all system hospitals.

Improvement: $9.4 M

HOSPITAL & COMMUNITY

Community banks and residents bought 38% of the $45M in bonds that a rural Nebraska critical access hospital used to fund construction of a replacement facility.

PAYER & PROVIDER

A payer funded an initiative to make a Minnesota healthcare system’s primary care clinics more efficient and patient-centered. Physicians, nurses and other clinicians provided the ideas.


Be an Exceptional Leader

- Well cultivated self awareness
- Compelling vision
- A real way with people
- Masterful execution
Be “Great by Choice”

- 10ers are extremely disciplined
  - They use empirical data and continually plan for the “what if”
- The take the 20 Mile March
  - Performance markers and self imposed constraints
- Fire bullets instead of cannonballs.
  - Only shoot cannon balls after testing.
- Show great financial constraint
- Zoom out – then zoom in.

"If your actions inspire others to dream more, learn more, do more, and become more, you are a leader."

– John Quincy Adams
President of the United States
1825-1829
Everyone Is a Leader….

Everyone in this room is a leader. I’m asking each of you to renew your commitment to leading our industry forward, to ensuring its long term viability and quality. Together, we CAN improve health care. Together, we can and we must

• Mentor young professionals as we have been mentored,
• Rise above the uncertainty and frustration of today, and
• Work in partnership with our colleagues throughout the industry to lead the change.

Kari Cornicelli
HFMA National Chair
2014/2015