Four CEOs share strategies for leading hospitals into a new health care world.

Every hospital executive knows it, but it's still hard to hear.

"It is very difficult, for a lot of reasons, for the traditional community hospital of a few years ago to exist on its own," says Michael Sachs, chairman and chief executive officer of the Sg2 health analytics firm. "There are going to be exceptions, but the general 200- or 250-bed community hospital that is 50 percent Medicare, 10 percent Medicaid and the rest commercial — that's going to be a tough model."

Indeed, regardless of payer mix, bed size or ownership status, the business model for American hospitals is in a time of upheaval. As health care moves from a volume-based payment system to one that rewards value — cost divided by quality — inpatient hospital utilization is no longer the breadwinner it used to be. In fact, emerging pay models discourage hospital use as much as possible.

"Not only do we need to transform our hospitals, we really need to redefine them," says John Bluford, president and CEO of Truman Medical Centers in Kansas City, Mo. "The future of the hospital can't be the building on the corner or down the street. It's got to be immersed in the daily culture of the community that it serves."

Bluford and other forward-thinking health care executives shared their strategies for the future with Trustee.

An Entirely Value-Based System

Western Maryland Health System, a one-hospital system in Cumberland, has seen inpatient admissions fall by 32 percent in the past four years — and is better off financially because of it. The health system generated a 5 percent operating margin in fiscal 2013 and is on track for an 8 percent margin in the current fiscal year.

Among the 10 hospitals in Maryland's Total Patient Revenue System demonstration, which started in 2010, WMHS is one of the few hospitals in the country that has moved entirely to a value-based payment system.

Because all payers support the system, WMHS' revenue is 100 percent fixed, with no fluctuations based on volume or changes in service. The state provided financial incentives to help with the transition to value-based care, which requires care to be delivered in the most appropriate location.

That means that the traditional delivery model, with the hospital and the emergency department at the center, has been replaced with a continuum of care that elevates the importance of pre-acute services such as retail pharmacies and urgent care centers, and post-acute services, including rehabilitation and skilled nursing facilities, hospice and palliative care.

"Everyone is on equal standing," says Barry Ronan, WMHS president and CEO. "And that includes the patient's home, which has become an integral component because of the amount of care — both pre-acute and post-acute — being delivered in the home."

Among its many changes to care delivery, the system created a Center for Clinical Resources to help patients with chronic obstructive pulmonary disease, congestive heart failure and diabetes avoid the ED and a hospital bed. The center, which operates extended hours, is staffed by mid-level practitioners, nurses, dietitians, pharmacists, respiratory therapists and care coordinators, all of whom are focused on helping patients to manage their chronic conditions.

WMHS also launched a care link coordination team to follow up with discharged patients who are older than 62 or high utilizers of health care services. It also created transition care coordinators to help patients discharged to a skilled nursing facility and expanded its capacity for home care visits.

WMHS has worked steadily to overhaul the way all stakeholders think about the health care system.

"One day everything is based upon how much volume you're bringing to your organization and then, virtually overnight, we changed to 'we don't want unnecessary admissions, we certainly don't want readmissions, and we need to reduce our use rates in a variety of areas, including the ED and ancillary services,'" Ronan says. "It was quite an education that we had to bring to our staff and our physicians, as well as our community."

He created a 12-member President's Clinical Quality Council of physician leaders who helped to design operational changes, establish a pay-for-performance program, focus on quality and efficiency measures, and communicate with other physicians about how and why the care delivery model was changing.

Meanwhile, all staff are required to attend an educational session about the forces that require change and how WMHS is responding to those forces. And the health system is conducting a "Meeting the Challenge of Healthcare Change" campaign to educate the community.

"We're out there, constantly trying to explain to folks why they need to seek alternatives to the emergency department and why they may not be admitted to the hospital now, when a few years ago, they would have been admitted for the same medical situation," Ronan says.
New Revenue, Lower Costs
Mountain States Health Alliance, with 14 hospitals, is the largest health care system in northeast Tennessee and southwest Virginia. A sign of the times: MSHA recently replaced the old 160-bed Smyth County Community Hospital with a 44-bed acute care facility comprising 109 nursing care beds and considerably more space for outpatient services.

"Where we see the world going is that there will be at least 30 percent less volume than what we have had in the past so, obviously, we are going to have to really focus in on the entire continuum," says Dennis Vonderfecht, the system's president and CEO until he retired at year-end 2013.

MSHA is in the fourth year of a 10-year strategic plan to reposition itself from a hospital-centric business model to one based on managing population health and accepting financial risk.

For starters, MSHA established CrestPoint Health insurance company through Integrated Solutions Health Network, and created the AnewCare Collaborative, the region’s first community-based accountable care organization. In its first year of operation, AnewCare saved the federal government about $15 million through its management of 14,000 Medicare recipients in the Medicare Shared Savings Program, generating $7.5 million for the health system. Meanwhile, its CrestPoint insurance company has grown to cover more than 2,600 Medicare beneficiaries after just two years in the market.

"Our saving grace in the long run is that, as these reimbursement systems change, we will be positioned well because we have an insurance company and an integrated network that can contract with other insurance companies, so we can generate revenue that way, not just from inpatient activity," Vonderfecht says.

Those risk-bearing entities force MSHA to learn how to effectively manage the health of a population. One of its first populations is the 15,000 employees in MSHA’s self-insured health plan; their benefits have been changed to provide financial incentives for preventive care and healthy lifestyle choices.

MSHA’s second strategy — increasing outpatient and retail services — also will help to offset reduced inpatient revenues.

"The third strategy recognizes that it is likely we are not going to be able to backfill all the lost revenue as volume is taken out of hospitals and as reimbursement is taken out as well," Vonderfecht says. "That means we're going to have to reduce our cost significantly from where we're at today."

MSHA hired a consulting firm to embed Lean management principles throughout the organization; in the first two years, that work has generated savings or revenue enhancements of about $23 million.

Focusing on What Matters Most
Cheshire Medical Center, a 169-bed hospital in New Hampshire, is clinically integrated with Dartmouth-Hitchcock Keene, a medical practice associated with Dartmouth-Hitchcock Medical Center. While the two organizations are independent, their operating agreement aligns them financially.

Dartmouth-Hitchcock was a participant in the federal government’s Physician Group Practice Demonstration, a pay-for-performance precursor to today’s accountable care organizations that started in 2005. Its physicians are currently in the government’s Pioneer ACO program. "When your physicians join an ACO, it fundamentally begins to change your business model," says Art Nichols, Cheshire’s president and CEO.

Cheshire’s inpatient census has dropped by nearly 40 percent in the last five years because of fewer admissions and shorter lengths of stay. "We are not losing market share, because we’re the only hospital in our county," he says. "And I think utilization will slip further."

In particular, he expects medical-surgical utilization to fall, although the need for intensive care may increase. "The things that are primarily important are, first of all, being able to take care of people in emergencies, so you’ve got to have a top-notch emergency room," Nichols says. "Then as medical practice continues to change, we keep people healthier but, when they do get sick, they get really sick. So we need a lot of emphasis on improving critical care and intensive care services."

In 2007, Cheshire Medical Center/Dartmouth-Hitchcock Keene initiated a citizen-engagement initiative with the bold goal of making their service area — known as the Monadnock Region — the healthiest community in the nation by 2020. Healthy Monadnock 2020 is tracking more than 30 indicators in five domains: social determinants that influence health; education and awareness of healthy lifestyle behaviors; healthy eating; active living; and mental well-being. More than 2,200 people and 100 groups have joined the effort, largely funded by grants and philanthropy.

The focus on health seems to be working. Nichols boasts that, as of year-end 2013, 85 percent of D-H Keene patients had a blood-pressure reading at or below 140/90 within the previous six months. "That’s a pretty astounding figure," he says, pointing out that U.S. best practice is defined as 80 percent or higher.

Under the fee-for-service payment system, Cheshire sees no financial benefit from making the community healthier, but new pay models reward it. "Now that we are in a Pioneer ACO, and we have a lot of our commercial insurance contracts flipping over to risk-based arrangements, suddenly it really starts to make sense financially," he says. "If your community is healthy, it is very likely that you can do well under these fixed payment arrangements.

From Safety Net to Quality Net
Truman Medical Centers, with 600 beds in two hospital academic medical centers, has been the primary providers for Kansas City’s uninsured patients for decades. But even though nearly 30 percent of its patients are self-pay and TMC provided $130 million in uncompensated care in its most recent fiscal year, the term “safety net” does not appeal to Bluford, who recently announced that he will retire from TMC in July, but will continue to mentor up-and-coming professionals through the Bluford Healthcare Leadership Institute.

"There’s no room today in the market for the traditional safety net. If it’s not a quality net, it doesn’t play," he says. "The name of the game for all hospitals, safety net or otherwise, is developing a niche and providing quality service, both in terms of customer satisfaction and quality outcomes, and competing in areas in which they have superior expertise."

For Truman, the top niche is chronic disease management. As of 2013, more than 73,000 patients with hypertension, diabetes, asthma and other chronic illnesses were enrolled in patient-centered medical homes. TMC’s Diabetes Center provides care on a planned, rather than episodic, basis for more than 4,000 patients, and it is working with Harvard affiliate Joslin Diabetes Center to test a new system for gauging the effectiveness of care.

"To the extent that we can get our hands around chronic conditions and prevent those diseases from escalating, we’ll bend the cost curve," Bluford says.
Beyond taking care of the sick, TMC is making it easier for patients to stay well. The hospital’s weekly product markets and mobile market saw 21,000 consumer transactions last year. This year, it is building a grocery store focused specifically on reducing the incidence of diabetes, hypertension, congestive heart failure and obesity within its service area.

Other strategic priorities include emphasizing ambulatory services — a new outpatient cancer facility opened in February — as well as behavioral health and oral health.

“We’re really getting into the depths of economic determinants of health because that speaks to prevention and avoidance of sickness,” Bluford says. “We run the Jackson County Health Department — now that’s a sweet spot if there ever was one — and we need to accelerate that relationship and maximize it.”

That said, the revenue streams that support population health management and preventive care are not yet in place.

“The fact of the matter is that reimbursement reform has not materialized enough yet to help promote and incentivize all these other things, and that has to happen,” he says. “So we’re not there now, but the more progressive systems and hospitals are taking a leap of faith that we are going to get there and be reimbursed for these services.”

Lola Butcher is a freelance writer in Springfield, Mo.

Taking Stock: Q&A with Rich Umbdenstock

In his 40 years as a leader in the hospital field, including the last eight as president and chief executive officer of the American Hospital Association, Rich Umbdenstock often has heard the prediction that a huge number of U.S. hospitals would close in the foreseeable future — which just goes to show that the future is not always foreseeable.

“Yes, some hospitals have closed, but many hospitals have opened, so our numbers have stayed essentially the same over the past decade,” he says. “Overall, I’m watching the redefinition of hospitals more than the wholesale closure or reduction of hospitals.”

1. What business models will gain traction?

Umbdenstock: Some health systems will be integrators of care that put together all the elements for care management and geographic reach, and management of financial risk. But in most cases, I think individual organizations will play a part in some larger system — providing coverage for a particular geography, providing a unique array of services or otherwise playing to some strength that the larger system needs. And “larger system” does not necessarily mean the multihospital system that has central ownership and control as we have thought about it in the past, it could, but it also could mean a regional collaborative.

I don’t see the independent hospital going away. I predict some will remain strong and independent and freestanding because of their role in their market, the configuration of their market, and the patient and provider preferences in a given market.

2. Given the importance of population health, what does the fact that some organizations quit the Pioneer Accountable Care Organization demonstration portend?

Umbdenstock: Whether ACOs, bundled payments or pay for performance, most of the new forms of payment in the Affordable Care Act, with few exceptions, are on a demonstration or test basis, as we figure out the right incentives and the right structure. I was not the least bit surprised that some dropped out — and at the same time, that others are joining. What it told me is that we are learning, but learning is never in a straight line.

3. What do the changes in the field mean for the AHA?

Umbdenstock: They clearly mean that we have to continue to redefine ourselves. Our most recent iteration has been to become much more of a member engagement organization in which we engage our members in safety and performance improvement projects, particularly around reducing hospital-associated infections, early-elective deliveries, potentially avoidable 30-day readmissions and other medical situations. Our national grant projects have supported that work, and the state hospital associations have come into that space more than ever before. We have become a very strong support system for our members, while also continuing the priority of advocacy and public policy.

4. What lies ahead?

Umbdenstock: Our next step is to help fill in some of these blanks about the future. We are going to have to push the conversation nationally as to what it means to manage the health of a population. How do we interact with public health agencies? How do we work together with other nonmedical organizations in the community that can address some of the socioeconomic determinants of health? The AHA has to help drive that exploration and definition in ways that we have never been called on to do before.

We also have to be very agile in how we relate to different organizations that have different elements of new configurations. Some health systems will be full integrators and some will be partners with or providers to integrated systems. Some members will have health plans or see a payer as their primary partner.

Everyone is in a different place and many paths will be followed. We have to understand the different needs of different segments, so we may have to segment and serve our membership differently.

That’s a new area of focus for us, so we have spent the last year trying to learn from our members with health plans and from our members with public health departments, so that we get outside our own traditional orientation largely to the acute care institution. — L.B.

Different Roles, Different Goals

For more on hospitals’ changing business model, including measuring success and identifying leaders, see Five New Ways to Think about the Term ‘Hospital’.
Every Patient is Beloved
Every person in health care has been told to imagine the patient as his or her mother. This time, the patient was my mother.
05.12.2014 by Jane Jeffrie

The Great Migration
Embracing growth in outpatient care is a transformative trend for hospitals
05.12.2014 by Rebecca Vesely

Consumers Show Interest in Alternative Venues for Care
Patients are willing to try new forms of care, but have strong preferences about where they receive services.
07.14.2014 by Trustee Staff