HOSPITAL ASSOCIATION OF SOUTHERN CALIFORNIA®

Briefs Focus

View of the Future

"**Now that the deficit-reduction supercommittee has failed to reach agreement, health care providers are dealing with the reality that things could get worse before they get worse.**"

Modern Healthcare, November 28, 2011

By Jim Barber, President/CEO
Hospital Association of Southern California

It is not certain that every hospital will successfully cross the transformational chasm. Radical change and major financial investment are required by hospitals while at the same time we face the most problematic economic outlook in 20 years.

Inpatient volumes are falling and it's not only because of the depressed economy. Admissions/1,000 and days/1,000 are being reduced through better care coordination, fewer readmissions, more outpatient work and improved quality. Comprehensive chronic disease management and post-acute care help people stay at home longer, perhaps for their lifetime, whereas before those at-risk and elderly populations consumed many admissions and inpatient days.

Payments to hospitals for the work they perform will flatten out and possibly go down in real dollars. The overall economy and job situation may improve, but hospitals will not be carried along with a rising economic tide and thrown a financial life ring the same way other businesses anticipate. Coverage may improve under national reform, but Medicare, Medi-Cal and commercial payers will ratchet down payments and expanded managed care enrollment will wipe out any relief realized from reductions in bad debt and charity care.

Given this gloomy financial forecast, business as usual simply won't cut it. Hospitals must fundamentally change their operations, including how and by whom care is delivered, and create a new level of permanent cost and quality efficiencies. The fact that hospitals have survived bad times before without a big upheaval is no guarantee we can do it again this time. This is no time for smugness over past success; a strategy based on hope that we'll weather the storm and things will get back to normal is a losing strategy. This is not a temporary situation!

Three Categories of Hospitals

There are hospitals that know what to do and are doing it. There are hospitals

that know what to do but for financial or medical staff reasons can't do it. And there are hospitals that just don't know what they should do and so they're stuck in neutral.

Hospitals in the first category are transformational organizations. They have somehow managed to forge a common vision among board, medical staff and administration. They are moving away from the old fee-for-service financial model and toward a new value model based on quality and outcomes. They are piloting accountable care organizations (ACOs), bundled payments, and forming medical practice foundations. They are achieving superior quality and patient safety, and they are weaning themselves away from the episodic treatment of acute illness in a fragmented manner and toward achieving the "triple aim" of better health, better health care and lower cost.

Transformational hospitals are in systems and they are independent; they are for-profit and not-for-profit. They chart their own course based on location, population served, financial depth and medical staff factors. They have different levels of capital, market share and physician alignment. But what they all have in common is a roadmap that is well-defined and clearly communicated, and a consensus (hard won and maybe not 100%) that change must come and risks must be taken.

Hospitals in the second category see what's coming down the road but they don't have the financial strength, market clout or physician support to move to the next level of clinical integration, care management and aligned incentives. Their current level of success may dull their sense of urgency. Perhaps they feel the pressure is off because they are a big winner in the hospital fee program so successfully managed by CHA.

Hospitals that know what to do but can't are the ones most likely to be merger or acquisition targets over the next three to five years. The HASC region still looks like the cottage industry of yesteryear more than either Northern California or San Diego, where hospital consolidation is much more pronounced.

Knowing what to do is a call to action. Not being able to do it calls for finding a strategic partner and aggressively pursuing that option. The HASC region may be primed for a substantial uptick in merger/acquisition activity even though we've been fairly calm and steady for the past couple of years.

The third category of hospitals are the ones in a mode of "watchful waiting". Sometimes a doctor will tell a patient that watchful waiting is their best course of action, and that intervention such as surgery is not called for, at least not yet. For hospitals in this circumstance, leadership may believe the pundits of doom and gloom are wrong. Their boards have seen health system crises come and go, but say, "We're still here, aren't we?"

Or perhaps internal hospital politics is the roadblock, or it's paralysis by analysis or fear of the unknown. Many hospital leadership teams are up to their elbows in alligators with day-to-day issues or they lack a well-oiled strategic planning process. For deep pocket hospitals, a watchful waiting strategy may indeed be okay. But for hospitals living on financial thin ice, a strategy based on "old school" thinking could spell trouble.

Health Plans and Physician Groups Are Not Sitting Still

In the midst of hospital strategic turmoil, other health care entities are doing all sorts of interesting and provocative things.

Health plans, or their business divisions, are creating delivery capacity a la Anthem and CareMore, and also Optum (United) and Monarch/AppleCare/Memorial Healthcare IPA. These activities are definitely not based on a hospital-centric model and it remains to be seen how hospitals will be included (or not) in their emerging delivery system.

The huge profits enjoyed by health plans in the past will get squeezed by Obama Care, state driven rate review/regulation, and new taxes and mandates. Government agencies such as county organized health plans and health benefit exchanges will gain significant population enrollment, while employer-based commercially insured enrollment will decrease. Some facts on California residents regarding their health care coverage source:

	2000	2009
Employer based	60.8%	52.3%
Medicaid	13.8%	19.4%
Medicare	1.5%	2.1%

Source: CHCF

And for California employers with less than 50 employees:

# of businesses	Those offering insurance	%
2010		
567,244	235,406	41.5
2009		
562,535	246,953	43.9
2008		
583,444	271,301	46.5

Source: Medical Expenditure Panel Survey (MEPS)

To repeat: The number of people with private insurance is decreasing while the number of people with public coverage is increasing. It is not out of the question that by 2020 or so we could get a single payer system where almost everyone is in a government-paid system.

Given these trends, it makes total sense for health plans to diversify into other health care business lines, including care management and more efficient delivery models.

Cost and quality can be managed better with aligned provider groups than what is working now under the "network model." Kaiser Permanente proved this concept and now the network model health plans may see the value in running a K-P like plan alongside their other HMO and PPO plans.

Health plan executives see themselves as health system transformational agents, in part because they don't see hospitals and physicians moving fast enough for their liking to a coordinated care model. The plans see population health management – actually coordinating care across the continuum and not just paying for it – as their big opportunity. Health plans have actuarial skills, benefit design experience, superior data and analytics capability and, here's the key, lots and lots of capital. What they don't have is a patient care delivery operation, which they are perfectly capable of buying.

Physician groups may be more willing sellers over the next few years, especially at the extremely high multiples reported (and rumored) for recent acquisitions. If a physician group or IPA isn't now thinking to themselves, "I wonder what I'm worth?" they probably will be in 2012. Like all price bubbles, the physician group bubble will inflate until it, too, bursts and, hey, why not sell the group when prices are so historically high? It won't last forever … it never does.

HASC's Response to These Threats and Opportunities

Given all the threats to hospitals, HASC has the opportunity to provide support and leadership in a number of ways.

At the HASC Board meeting of November 16, the Board approved five major Strategic Initiatives that address many of the current issues hospitals face:

Strategic Initiative #1: Local Advocacy

- Create an optimal level of transparency, collaboration and accountability with the Medi-Cal managed care plans serving each county, and ensure hospital input on governance, population enrollment and role with the state exchange.
- Conduct a hospital economic impact analysis, by region and by hospital, and then demonstrate to policymakers and opinion leaders just how critical hospitals are to jobs and local community economies.

Why this is important:
County boards of supervisors and departments of health will become more involved in health care issues, and play more active roles in coordination and delivery of services.

County governments and agencies are the logical focal point for regional planning, disaster preparation and response, trauma/EMS coordination and programs to improve public health and wellness. All of these areas impact hospitals.

County-level Medi-Cal managed care plans will grow to include all Seniors and Persons with Disabilities (SPDs) on Medi-Cal and, most probably, many more dual eligibles on Medicare and Medi-Cal. These same managed care plans are poised to take on a significant share of the private individual and small business health insurance market when the California Health Benefits Exchange starts enrolling in 2014.

Realignment of dollars and patient populations (e.g., mental health and prison populations) will put greater financial obligations on counties, which will not have sufficient capacity.

County delivery systems, including hospitals and clinics, will have to work more closely with private sector providers to assure access and maintain patient transfer channels.

Regarding the value of the economic impact analysis, we believe that business coalitions and chambers of commerce will become more politically active in hospital and health affairs.

On one hand, hospitals are huge contributors to local economies, providing jobs and supporting local vendors and suppliers. Hospitals are large businesses and share many common interests with other business sectors.

On the other hand, health care costs are rising faster than what business considers acceptable and hospital costs are in the crosshairs. Business will be more aggressive as coordinators of care and payers of care for their employees and families. Business will demand greater transparency in quality, pricing and outcomes.

Strategic Initiative #2: Transition to Coordinated Care
• HASC will help hospitals implement successful physician alignment and post-acute strategies.
• HASC will engage with any and all stakeholders seeking to transform the delivery system to be more coordinated, cost effective, clinically integrated and patient responsive.

Why this is important:
A key to success will be a hospital's ability to create an integrated delivery system that aligns physicians and presents an attractive ACO to private and public payers.

Hospitals are in a good position to lead the coordinated care movement in their communities and thereby transform health care to meet the triple aim – better health, better health care and lower costs. Hospitals have enterprise management expertise, capital and are the current epicenter of health care in most communities.

What many hospitals don't have is a mature physician alignment structure or a population health strategy. Physician groups believe they are in a great position to lead ACOs. Commercial health plans are developing delivery capabilities by acquiring physician groups and post-acute clinical services. Some county organized health systems see themselves in the role of leading system transformation.

HASC and CHA must create a level playing field for hospitals – including systems and independents – to create community-based integrated delivery systems and effectively manage care across the continuum. If a significant number of our members are not able to cross the bridge from fee-for-service and traditional medical staff models to the integrated delivery future, then hospitals' role in the health care system will dramatically diminish.

The legal and regulatory environment that puts a lid on hospital/physician alignment must be blown off. If hospitals and physicians choose not to pursue an integrated strategy, that is their prerogative; but it is not acceptable to artificially deny hospitals and physicians the opportunity to lead the coordinated care movement.

Strategic Initiative #3: The Institute for Performance Excellence (IPE)
• HASC will provide hospitals with seminars, on-site training and project management support to help them build and sustain Lean, Six Sigma and other performance improvement competencies required to achieve the highest levels of financial, operational and clinical performance.

Why this is important:
Hospital executives who make a full-blown investment in Lean and Six Sigma get results. These proven performance improvement techniques are tried and true in other industries – most notably manufacturing – but not so much in hospitals.

Our industry needs a rapid transfer of quality/cost/efficiency best practices to keep from getting buried in red ink. Slow, incremental change is not good enough. We need to overhaul many of our clinical and administrative procedures, and improve the efficiency of medical management from admission to post-discharge care.

In order to advance this transformation agenda, hospitals could spend hundreds of thousands of dollars on high-priced consultants and sending staff to out-of-town training sessions.

IPE can do the job locally, at a fraction of the cost, using our proven collaborative learning/sharing methods. We will have staff who speak hospital-speak and not just Toyota-speak. By reducing waste and increasing productivity, many hospitals will lower their operating costs by 10 to 20% or more without sacrificing quality or patient safety, and thereby arrive at the place where costs match Medicare payment levels.

Strategic Initiative #4: Optimizing hospital performance with data analytics
• HASC will provide hospitals with a comprehensive and timely comparative database of key performance metrics.

Why this is important:
Strategies that executives adopt when the competitive and economic situation changes dramatically must be supported by advanced analytics.

Hospitals will need timely performance data and valid apples-to-apples external comparative benchmarks to know where they stand and how their position is changing relative to the top performers. We will enhance and integrate

data from existing HASC sources, such as our Compensation Surveys and our Professional Data Services health plan contract program, with new data elements obtained from the new Lodestone database.

National databases are okay, but local market information is needed because a hospital's strategy is largely dependent on its location. Threats and opportunities facing hospitals in Chicago may be very different from what HASC hospitals face. Hospitals need the ability to select peer groups from Southern California for performance comparison and trending.

Strategic Initiative #5: Quality Improvement and Patient Safety

• HASC and CHA will provide leadership in quality improvement and patient safety through the Patient Safety First collaboratives and the California Hospital Patient Safety Organization (CHPSO).

Why this is important:

Everyone sees what is coming down the road: winning or losing will hinge on a hospital's quality and patient safety outcomes at least as much as its cost structure or market share. All the new revenue models – bundling, gain sharing, value-based purchasing – are driven by quality and patient safety metrics.

The blinders are coming off consumers and payers in terms of hospital quality and patient safety. Unexplained variance will not be tolerated. It's no longer a conversation-stopper to say, "Our patients are sicker" because risk adjusting methodologies are getting too good.

Everybody and their brother are getting into the act: Group purchasing organizations, independent consultants and even the California Department of Public Health. HASC and CHA must prove that we can be the central hub for quality and patient safety by providing everything from confidential incident reporting, to statewide root cause analytics, to peer-to-peer learning collaboratives.

Conclusion

As always, we welcome your input and advice as we advance health care transformation and promote hospitals' expanding role in the delivery systems of the future. Thank you for your continued support of HASC and CHA. The association is only successful if first and foremost our member hospitals are successful.