



Accountable Care: The Focus of Reform  
*Balancing Opportunities in a Fee-for-Service  
& Pay-for-Performance World*

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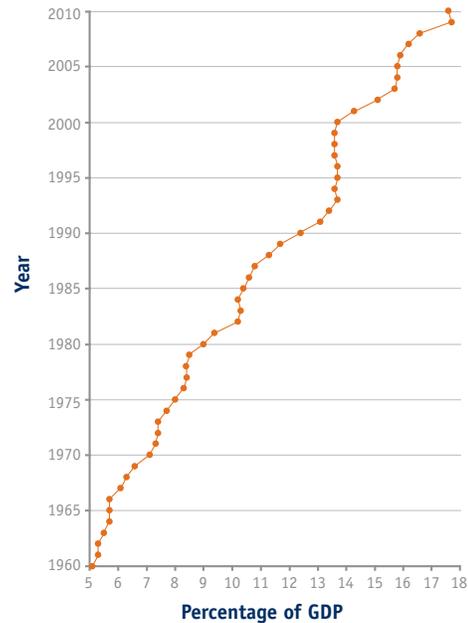


**E**ver since the introduction of Medicare in 1965, hospitals have been on a long and winding journey to a destination where patients always receive affordable, quality care; and health systems themselves remain fiscally healthy. With a fee-for-service payment system that drove utilization and the development of increasingly more sophisticated treatment technologies, the nation's healthcare expenditures as a portion of the GDP have risen at an unsustainable rate, to 17.9 percent in 2011 and are projected to reach 20 percent by 2021. Still, that perfect oasis of high-quality, affordable healthcare has continued to elude us.

To be sure, the bends in the road have been numerous, driven by both the federal government's and private industry's determination to put the brakes on skyrocketing healthcare costs. With the introduction of Diagnosis Related Groups (DRGs) for hospitals and the resource-based relative value scale (RBRVS) for physicians by the Centers for Medicare and Medicaid Services (CMS) and managed care by the commercial insurance industry, healthcare providers were put on notice that payers were no longer going to reimburse their total charges. Capitation continued the trend away from reimbursement of fee-for-service charges. At the same time greater emphasis was being placed on clinical outcomes and quality improvement. Patient satisfaction has now become one of the key indicators for hospital reimbursement, with health systems devoting significant resources to monitoring the non-clinical aspects of care.

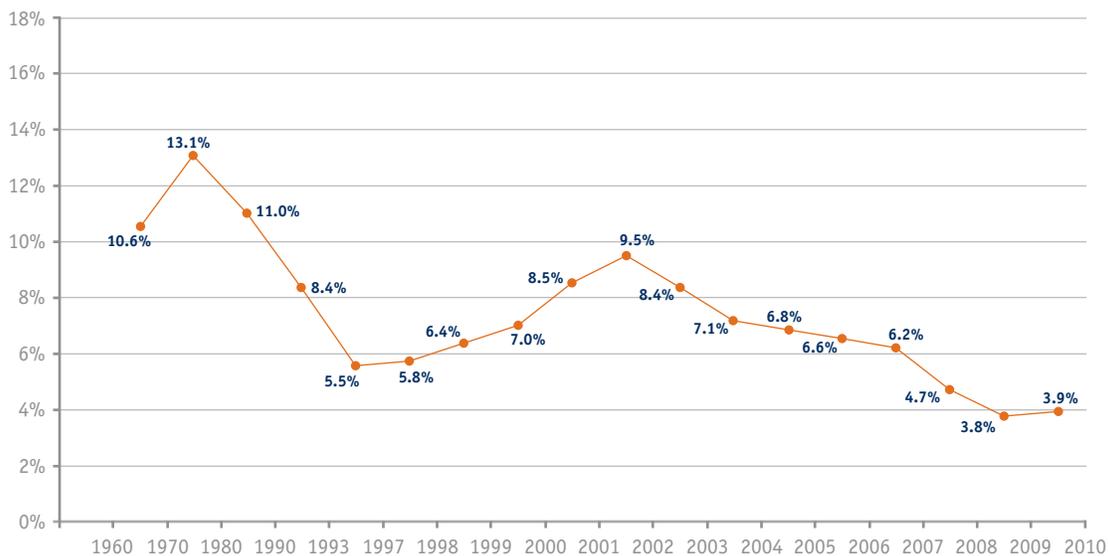
Still, healthcare costs continue to escalate. The federal government introduced measures to tie clinical outcomes and patient satisfaction to reimbursement through pay-for-performance and bundled payments. In some cases these measures brought hospitals closer to excellent outcomes, lower costs and a positive patient experience. But escalating expenses, coupled with the high number of uninsured or underinsured Americans, was unsustainable. Repeated attempts to “fix” the country's broken healthcare system culminated in the massive overhaul known as the 2010 Patient Protection and Affordable Care Act (PPACA).

## PERCENTAGE OF GDP FOR HEALTHCARE



Source: Organisation for Economic Co-operation and Development (2010), "OECD Health Data," OECD Health Statistics (database). doi: 10.1787/data-00350-en (Accessed on 14 February 2011); Wikipedia.

## AVERAGE ANNUAL PERCENT CHANGE IN NATIONAL HEALTH EXPENDITURES, 1960-2010



Source: Kaiser Family Foundation

## DAWN OF A NEW ERA

The Affordable Care Act (ACA) clearly precipitates the dawn of a new era in American healthcare. Simply put, it has and will continue to impose sweeping transformation of our healthcare delivery system in ways that previous mandates could never accomplish. The ACA puts providers – hospitals and practitioners – solely at risk for managing the health of an entire population. In a relatively short period of time, the concept known as “episodes of care” will be obsolete as coordination of care becomes the norm.

What *will* become the overarching goal in American healthcare is keeping people healthy so they do not need more expensive care over the long haul. Providers will be responsible and potentially rewarded for maintaining the health of people who are well and managing the conditions of those who are at risk or chronically ill. Patient-centered medical homes will become the primary model for managing a given population’s health across the entire continuum. Greater emphasis than ever before will be placed on disease management, health coaching, wellness programs and preventive services such as screenings and immunizations.

In this pre-primary healthcare environment, consumers become “patients” before they *actually become* patients in the traditional sense; however, they could be more appropriately considered as beneficiaries. In essence the ACA aims to improve overall population health and allow organizations to better manage the care of beneficiaries as they move along the entire continuum: from health maintenance, disease management and episodic care to rehabilitation, long-term care, skilled nursing and hospice.

In 2010 the U.S. spent **\$2.6 trillion** on healthcare, an average of **\$8,402** per person.

The share of economic activity (GDP) devoted to healthcare has increased from **7.2 percent** in 1970 to **17.9 percent** in 2009 and is **projected to reach 20 percent** by 2021.

Healthcare costs per capita have grown an average **2.4 percentage points** faster than GDP since 1970.

**Half of healthcare spending** is used to treat **5 percent** of the population.

**Half of Americans** say their family cut back on medical care in the past 12 months because of cost concerns according to a Kaiser Family Foundation 2011 study.

## THE ROADMAP FOR TRANSFORMATION: ACOs

The ACA was based on the Institute for Healthcare Improvement's Triple Aim, which challenges the healthcare system to provide:

- » **Better care for individuals** – As described by all six dimensions of quality in the Institute of Medicine report: safety, effectiveness, patient-centeredness, timeliness, efficiency and equity.
- » **Better health for populations** – An emphasis on educating beneficiaries about the upstream causes of ill health – like poor nutrition, physical inactivity, substance abuse, economic disparities – as well as the importance of preventive services such as annual physicals and flu shots.
- » **Lower growth in expenditures** – Eliminating waste and inefficiencies in care while not withholding any needed care that helps beneficiaries.

The implementation of PPACA requires hospitals to broaden their reach beyond employer groups and assume a more prominent role aimed at improving community health. As healthcare fixtures in the community, hospitals are trusted and logical leaders in this effort.

The PPACA aims to achieve lower costs, increased quality and an enhanced patient experience through the introduction of a new model for care delivery and reimbursement: the Accountable Care Organization (ACO). ACOs take the concept of the patient-centered medical-home model to a different level with more of a contracting emphasis and specific rules and regulations. The PPACA included some of the requirements set by CMS for the Shared Savings Program for Medicare ACOs. Additional requirements were set in early 2011, and the Medicare ACO program opened for business the following January. By early 2013, 106 new ACOs had entered into agreements with CMS, taking responsibility for the quality of care they provide to people with Medicare in return for the opportunity to share in savings realized through high-quality, well-coordinated care. An additional 32 ACOs began participating in the testing of the Pioneer ACO model by the Center for Medicare and Medicaid Innovation (Innovation Center). Some private payers have also opted to join the movement, such as Cigna, which aims to establish 100 accountable-care initiatives by 2014.

### PRINCIPAL CONCEPTS FOR ADVANCING THE TRIPLE AIM

As expected, improving access to PCPs has been shown to advance quality and enhance efficiency of care delivery. Advancing access to integrated primary care drives:

INCREASES FOR	DECREASES FOR
Preventative care	Emergency room visits
Immunization rates	Impatient hospitalizations
Coordination of care	Healthcare costs
Health outcomes	Duplicate or unnecessary tests and procedures

Clearly these early adopters have made a leap of faith. To ensure that savings are achieved, they must hit targets for improving care coordination and providing services that are appropriate, safe and timely and that meet quality standards. That is no small feat in the current environment in which most of the care provided is still reimbursed under the fee-for-service model. This reality is what economic futurist Ian Morrison calls “life in the gap” in an American Hospital Association report entitled “Hospitals and Care Systems of the Future.” The gap Morrison refers to is the period of time when healthcare organizations are being pressured to provide care more cost efficiently and with improved quality but are paid primarily using a fee-for-service system.

As a result, many healthcare organizations have one foot planted on the dock and the other one in the boat. The rock-solid dock represents the past where volume equals revenue; this is the environment most familiar to hospitals and physicians today. In juxtaposition the boat represents the future where they accept risk for population health management, where streamlining care will mean survival. Is it possible to maintain financial equilibrium in the waters of a fee-for-service environment while transitioning into a true ACO that assumes financial risk for the care of an entire population across the continuum?

### **MANY ORGANIZATIONS ARE SAYING “YES”**

While the model is still evolving, some CMS-approved ACOs are enjoying early successes in population health management. Other healthcare systems are focusing on building the infrastructure necessary to successfully launch and manage patients in an ACO environment. Here are two organizations that are in various stages of evolving into an ACO and the lessons they have learned doing just that.



Mercy Health Network was founded in 1998 under a joint operating agreement between two of the largest Catholic, not-for-profit health organizations in the United States: Catholic Health Initiatives and Trinity Health. The network includes 11 owned hospitals and 29 affiliated community hospitals throughout the state of Iowa. Mercy was the first system in Iowa to build a clinically integrated network when it began acquiring physician practices 27 years ago. *Today there are more than 600 aligned physicians within the network.* That was just the beginning of Mercy’s journey to becoming an ACO, according to Senior Vice President Joe LeValley.

“Fifteen years ago physicians at Mercy were among the first in the nation to begin developing disease registries to better track and manage the care of patients with chronic conditions,” LeValley says. “One of our physicians, Dr. David Swieskowski, asked himself ‘How many diabetics do I have, and are they getting the routine care my training tells me they should get?’ When he couldn’t answer that question, he asked his teenage son to write a computer program to track his patients. That was the first electronic disease registry at Mercy.” An early advocate for population health management, Dr. Swieskowski later was appointed Mercy Clinic’s vice president of quality. He expanded the use of more

sophisticated patient tracking systems, which are now standards of care across all Mercy primary care clinics. They are used to ensure that patients receive routine preventive screenings such as mammograms and prostate exams as well as proactively manage care of patients with chronic diseases such as diabetes.

Twelve years ago physicians at Mercy developed an innovative system to better manage congestive heart failure (CHF) patients. “One of our leading cardiologists, Dr. Bill Wickemeyer, wanted to prevent the frequent hospitalizations these patients suffered on a regular basis. Not only did these patients use a lot of expensive services, they created a tremendous burden for clinicians to always be addressing their crisis. Most importantly, this was an extremely difficult lifestyle for patients. We purchased a computer program and assigned case managers to work with CHF patients who agreed to call in and enter their vital signs every day. If something in their health status changed, the computer sent a message to the case manager to follow-up with the patient. *Our program reduced CHF admissions by 85 percent.*” While it saved Medicare millions of dollars, LeValley points out the program meant less revenue coming into the hospital.

“In the fee-for-service environment, doing the right thing sometimes punishes doctors and hospitals,” he says. “But we have pursued these initiatives because it was the right thing to do – to proactively manage patients and keep them healthier. We see the accountable care organization as a great opportunity. For the first time in our careers, the payment systems are being created that align the economic system with our mission.”

Mercy continues to look for ways to streamline the care it provides while enhancing outcomes. Transition coaches have been placed in its medical

centers to follow patients after discharge from the hospital. They make sure patients get their prescriptions filled and are taking them correctly and keep follow-up appointments with family doctors. “It has made a huge difference in people getting better instead of worse and ending up back in the ER,” LeValley notes. Another innovation is the formal development of care protocols between specialists and PCPs in the clinic settings. “Our cardiologists sat down with our primary care physicians to work out protocols for treating – and referring – patients with heart disease. They worked out an extensive decision tree and then had every doctor agree to support it. It may seem obvious, but in reality this kind of coordination almost never happens.

**“Physicians from different specialties need to agree more formally than in the past on how to care for patients to avoid duplication, enhance communication and streamline services. It’s never been the culture of medicine for doctors to sit down and work out the details of care protocols across specialties and settings of care – before now.”**

Mercy was also an early adopter of the trend toward employee wellness. Mercy Medical Center contracted with Aegis Health Group in 2005 to collaborate with local employers to help combat rising healthcare costs through the Workforce Health Initiative. The program provides companies with a dashboard of their employees’ health through personal health-profile collection. Based on the results Mercy offers health screenings, metabolic syndrome programs for high-risk employees, stress management, and other health and wellness programs based on needs identified through the screening process. Using a personalized approach for each worksite, Mercy has helped its partner employers to reduce absenteeism, enhance productivity and effectively lower their health insurance premiums by creating a healthier

workforce. One local company that used Mercy's wellness program reports that its *annual healthcare insurance premium increase for 2012 was just 1.4 percent*. According to the company's insurance broker, this was the lowest increase in the company's history. *Premium increases have actually declined by 18.6 percentage points over five years*.

Mercy has taken its learnings from the Workforce Health Initiative and applied it to its own 13,000 employees. Mercy has changed its benefit plan to fund aggressive wellness activities, including a medically based fitness facility where doctors work with patients' health coaches to direct individualized wellness programs as part of a medical home structure. As a result, premium costs per employee have actually decreased for the past year. Mercy's program has received national recognition from the Wellness Council of America by earning the Platinum Well Workplace Award.

Mercy's lengthy history of physician alignment and clinical integration, coupled with its focus on wellness and prevention, have positioned it ideally for the age of ACOs. Mercy's ACO was approved by Medicare in June 2012. It also has an ACO agreement with Wellmark Blue Cross and Blue Shield of Iowa. In addition, Mercy Health Network has entered into a partnership, called the University of Iowa Health Alliance, which includes Mercy – Cedar Rapids, Genesis Health System based in Davenport, and the University of Iowa Health Care in Iowa City, to develop a statewide effort that brings best practices together.

"We're still working through the challenges of becoming a true ACO," LeValley says. Dr. Swieskowski, who developed Mercy's first disease registry, has been an ongoing champion of the concept and is Mercy's first chief accountable care officer. "Right now, we have some patients who are

in traditional payment systems and others who are in the ACO. The management challenge is enormous. For instance, our market share report is based on admissions. If admissions and market share have gone up, is that a good thing; or is it an indication we need to manage our covered populations better? One of the challenges of accountable care is the need to find new metrics for determining success.

**"We will be better off economically in the long run if we succeed in an accountable-care approach to providing value, but we anticipate the next couple of years to be very difficult. Once the cost savings begin, however, I predict the ACO model will become the predominant payment system in the nation."**



Summa Health System, headquartered in Akron, Ohio, is one of the largest integrated healthcare delivery systems in Ohio. Summa serves more than 1 million patients each year in comprehensive acute, critical, emergency, outpatient and long-term/home-care settings and has eight hospitals with more than 2,000 licensed inpatient beds and a number of outpatient health centers throughout five counties.

In 2001 Summa was faced with a decision regarding the continuance of its Physician Hospital Organization (PHO). PHOs nationally had been divesting of their risk arrangements and had been coming under increased scrutiny by the Federal Trade Commission specific to PHO/payer contracting

models. Recognizing the value of being aligned with its physicians, Summa decided to pursue a PHO model that would address the FTC concerns and more importantly create a better model for both delivery and financing of healthcare within the communities they serve. The model that achieved that goal required Summa and its aligned physicians to become both clinically and financially integrated.

“We determined the best place to start was to pursue clinical integration,” says Jeff Price, vice president of Summa Health Network. Summa’s leadership began searching for physicians who were interested in joining the PHO in this unique venture. The goal was to find physicians who would commit to adopting and using electronic medical records (EMR) and were willing to share their clinical data. In 2005 Summa created a grant program that would fund a portion of the acquisition cost of the EMRs for those physicians who wanted to participate. “We had specific criteria and a contract that they were required to sign to become part of our Clinically Integrated Model,” Price notes. Out of the original PHO, 200 physicians had committed to join the high-performance subgroup by 2010.

Using the data collectively generated via the clinical network, physicians in the group began to apply quality improvement principles and develop clinical protocols that were continually refined by monitoring outcomes. The best practices they created, particularly for chronic diseases, made the group highly marketable among payers. At about the same time, discussions surrounding health reform on the national level advanced the concept of the accountable care organization. It was a concept that resonated at every level of the Summa organization.

“We decided that whether or not healthcare reform became a reality for the rest of the country, we felt

strongly about the principles of an ACO. We were committed to creating an integrated healthcare delivery system that provides coordinated, value-based care across the continuum for the populations we serve. We started to build our own ACO based on the groundwork we had laid via the PHO clinical integration model.”

Summa embarked on developing its ACO in partnership with the five largest primary care groups in the region in 2010. Much of the work required to form an ACO – a clinically integrated IT structure, data collection, the creation of care protocols and disease suites – had already been started within the PHO. Over 400 physicians opted to join the ACO by 2012, most of them primary care physicians. Summa viewed the ACO model as an appropriate alternative to full employment that provides the operational and financial support its physicians need, along with the medical autonomy to care for a defined population. Because Summa owns its own insurance plan – with both commercial and Medicare lives – the system was well positioned to take on its first population in 2011. That year Summa launched a pilot ACO with an 11,000-member Medicare Advantage population.

Summa and its aligned physicians realized 8.5 percent in cost reductions that resulted in some modest shared savings, gleaned primarily from heart disease treatment protocols and prescriptions management. Those savings were passed back to the providers. In 2012 Summa brought its employees into the ACO along with the medical spend associated with caring for them. In July 2012 Summa’s ACO was selected to participate in the Medicare Shared Savings Program. Between the Medicare plans and Summa’s own employees, approximately 15 percent of the hospitals’ revenues are currently managed through the ACO.

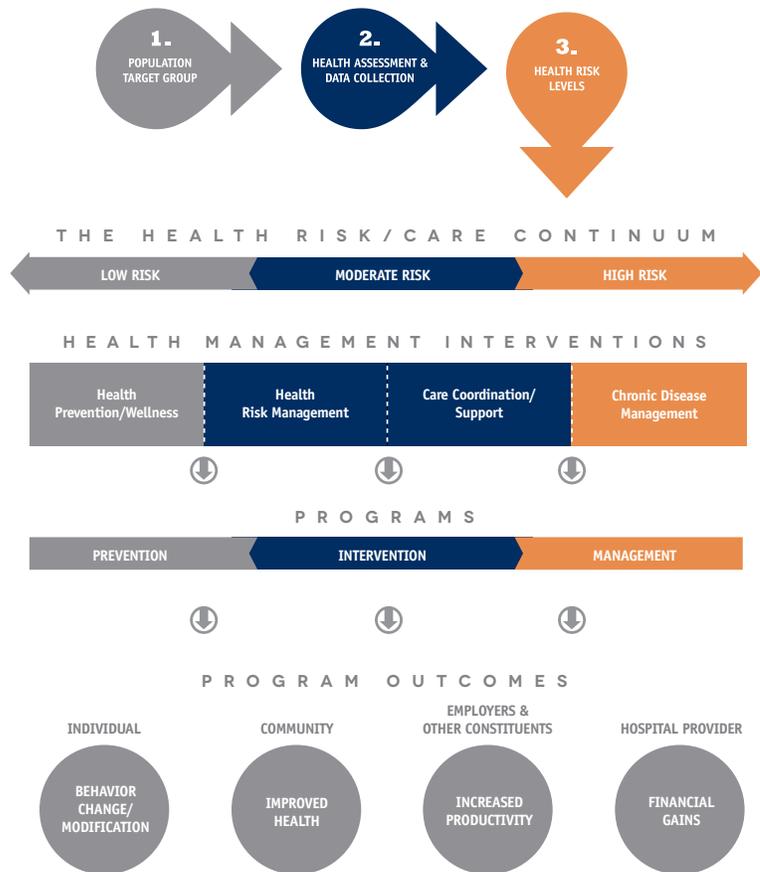
Despite early successes Price says there is still work to be done before rolling Summa’s ACO out to the commercial market. “We need to work some of the kinks out,” he says. “We’re using our own employee population as a test market to create proactive wellness solutions that keep people healthy and out of the acute setting. We also need to find the right payer partners who are committed to a level of data transparency that makes the ACO a viable alternative to traditional reimbursement models.” A key initiative going forward also will be having its physician groups formally designated by the National Committee for Quality Assurance as patient-centered medical homes.

“We’re leveraging a system that has just about every capability you need to take risk for a defined population,” Price notes. The process can be summed up in the white paper that Summa’s ACO leadership has posted on its website: We know this is the beginning of a long, challenging journey. The complexities of this transformation cannot be overstated. Then again, neither can the anticipated benefits. There are challenges to changing both the culture and the delivery of healthcare in this country. We welcome that opportunity and responsibility. To this effort we hold ourselves accountable.

## MANAGING THE RISK BY MANAGING THE CARE CONTINUUM

While both Mercy Health System and Summa Health System have made great strides in becoming true ACOs, the evolution has been incremental over time. Healthcare executives with one foot on the dock and the other in the boat are right to be thoughtful and deliberate as they navigate toward true ACO status. Reduced costs can lead to profitability under the PPACA. But how do they get there? The reality is that healthcare analysts and early adopters agree that key elements must be in place for an ACO to function at optimal efficiency and meet Triple Aim objectives. One plan is to address population health management.

### POPULATION HEALTH MANAGEMENT CONTINUUM



## KEY STRATEGIES TO ACHIEVE READINESS FOR AN ACO

The fundamental question any health system must answer is: Do we have the clinical and technological infrastructure in place to offer our community true patient-centered medical homes? If the answer is no, here are some key strategies organizations should implement to achieve that state of readiness.

### PHYSICIAN INTEGRATION

Over the last 20 years, many healthcare organizations have invested heavily in physician practices or have moved to outright physician employment. Now is the time that this strategy will pay off. In the fee-for-service environment, the goal was all about building volume. In an ACO environment, the focus needs to be on clinical integration and having physicians lead the redesign of the care process so patients are treated sooner and have better outcomes. In this environment incentives are truly aligned for achievement of these objectives.

CMS has been very clear in its message of putting physicians front and center in terms of responsibility for the ongoing care of a defined population. The PPACA mandates that physicians must be a part of any Medicare ACO. In fact, a standalone physician group with sufficient numbers of primary care doctors can be certified as an ACO without a hospital affiliation; hospitals without aligned physicians cannot. The success of any organization seeking ACO status will depend upon physicians who embrace the concept of managing care across the continuum, leading teams of professionals committed to evidence-based medicine in a spirit of continuous quality improvement.

Moving toward ACO status healthcare organizations must consider if they have the critical mass of physicians necessary to efficiently manage patients across the continuum of care. While the patient-centered medical home is driven by primary care physicians, specialists will always be integral to successful population health management. A Medicare ACO must have at least 5,000 assigned beneficiaries and a sufficient number of physicians to be accountable for the quality, cost and overall care of its beneficiaries. Healthcare organizations hoping to successfully navigate toward ACO status should perform a community-needs assessment to determine the numbers and types of physicians that need to be aligned with the organization. Patient data alone is not sufficient when conducting a needs assessment. As the name implies it requires gathering data on the entire community. This does not mean just census data, but information to help build a complete profile of the healthcare needs of the hospital's local population of consumers. If gaps exist it will be critical to build the physician network necessary to serve patients along the entire care continuum.

## POPULATION HEALTH MANAGEMENT

A key success factor for thriving in an ACO environment is creating whole-scale population health management protocols. Some visionary healthcare organizations have already tested the waters in wellness and health management in certain populations: their own employees. Because many hospitals are self-insured, there is limited risk in managing the entire medical spend for their employees. Organizations such as Mercy Health System have taken an across-the-continuum view of managing employee health. By aggregating the data gleaned from individual employee health-risk appraisals, these systems have been able to offer suites of services aimed at mitigating risk factors such as obesity, high tobacco use, diabetes or lack of primary care. Aligned physicians coordinate the care for employees, assigning them to health coaches, case managers or specialists as necessary. Incentives such as reduced insurance costs for employees who perform certain wellness activities have resulted in higher participation and compliance. Workers benefit through improved health, and organizations reap real-time savings through health cost reductions now and over the long term.

There are other significant advantages to experimenting with population health management tactics within a system's own employee base. It allows organizations to gain a track record of transforming the delivery of care with very little risk. The effort also helps organizations to prepare for working within new payment models by starting with their own employees.

Applying these learnings and techniques out in the broader marketplace, with employers, has established these organizations as early leaders in population health management. Their understanding of the broad-based health risks in a given region makes hospitals and their aligned physicians authorities in creating healthier communities. As these businesses make health insurance buying decisions in the future, their experiences with hospital partners in wellness activities will establish them as preferred providers in the value-based environment now taking shape.

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A critical necessity for organizations moving to a value-based model, health information technology (HIT) provides the backbone to seamlessly manage and analyze population health data. The federal government's Electronic Health Record Incentive Program with "meaningful-use" requirements underscores its intent to move the nation's providers to documenting patient interactions via computer. Electronic medical records are quickly becoming the standard data-collection point in physicians' offices, with many hospitals moving to a paperless environment as well.

Investing in advanced HIT now will provide the framework to trend patient metrics, develop best practices, and support continuous quality improvement over the long term. HIT should be able to track patient data both inside the four walls of the hospital and in the community-based provider setting. Patient portals will facilitate communication between providers and beneficiaries and allow for self-reporting and management of health issues. Data collection and metrics reporting will be crucial for healthcare organizations to demonstrate that they are meeting the financial and quality targets for which they will be reimbursed in the value-based setting. Providers will also benefit if they reach beyond their data set of current patients through deployment of a consumer portal. It offers the opportunity to build relationships and understand and address health risks of their local community *before* they become patients.

## TESTING THE WATERS, TAKING THE PLUNGE

Better care coordination. Excellent outcomes. Lower costs. It is clear that the American healthcare system is being transformed in ways never envisioned a generation ago. As healthcare organizations move to the value- and performance-based reimbursement structure of ACOs, incremental strategies can help ensure a more seamless transition. Tackling the all-encompassing strategies of physician integration and population health management can seem daunting, but successful models for these strategies do exist. Health systems lacking the experience or resources to effectively implement these initiatives would be well served to partner with organizations who can provide turnkey solutions for physician integration and population health management. As health systems head toward the uncharted waters of ACOs, having a roadmap from other successful ventures will prove invaluable in the journey ahead.

## CONSUMER HEALTHCARE PORTALS FORGE A VITAL LINK

Since providers are now expected to proactively engage consumers in taking better care of their health, forward-thinking organizations are leveraging health information technology beyond the four walls of the hospital. To this end consumer health portals are about going beyond just patient portals that integrate clinical information with electronic health records, they are about enabling pre-primary care. Taking it a step further, consumer-health portals offer a turnkey solution to customized health management where individuals can actively manage their own health using a variety of “health trackers,” educational content, and ongoing management of their personal health status.

Some strategic healthcare organizations have refined this concept even further by offering a hospital-branded, consumer-facing portal to employers in their marketplace. *These portals unite the hospital, employers and their employees in a common goal of good health while meeting market demand for results-based health management programs.* Making provider-sponsored consumer-health portals available to local businesses offers five strategic advantages:

1. They enable employers to plan, manage and measure the results of their workforce health initiatives.
2. Just as important they can be tailored to the specific health needs of the business' own employee population and benefits.
3. By offering customized health management sites to workers, employers are encouraging workers to take control of their own health.
4. They help employers manage incentive-based wellness initiatives more easily and provide turnkey calculations for productivity and return on investment.
5. Portals can ultimately quantify healthcare cost savings realized through controlled insurance costs.

Hospitals are also reaping impressive benefits because:

- These portals facilitate continuous interaction with consumers on behalf of the hospital to promote service lines, special programs and physician practices.
- They build top-of-mind awareness as the hospital's brand is up-front and center, along with the ability to connect directly with hospital-based services.

*In the age of accountable care, managing the health of an assigned population along the entire continuum of care is critical to long-term success.*

AEGIS HEALTH GROUP PRESENTS



**ONE COMMON GOAL – GOOD HEALTH**

OneCommunity.com, which is designed around each hospital's brand, enables them to connect with individuals *before* they become patients by actively engaging consumers in ways that specifically target their health needs. It positions healthcare providers as a solution to rising healthcare costs while solidifying their relationships with the local business and community population. Highly scalable, it is cost effective especially for small and medium businesses. OneCommunity.com also offers hospitals a solution to compete with insurance companies and other third parties, expanding their market reach and heightening brand awareness and loyalty.

**For more information or to arrange a demonstration of OneCommunity, go to:**

**[www.aegisgroup.com/CONTACT-US](http://www.aegisgroup.com/CONTACT-US)**

**or**

**Call 1-800-883-0080 Extension 212**



**CONTACT US TO DISCUSS YOUR COMPLIMENTARY,  
PERSONALIZED MARKET ANALYSIS:**  
**[www.aegisgroup.com/contact-us](http://www.aegisgroup.com/contact-us) or 800-833-0090**

## REVENUE GROWTH STRATEGIES FOR HOSPITALS

Aegis Health Group has assisted hundreds of hospitals with proven-effective business development strategies for more than 20 years. Aegis' strategic Population Health and Employer Relationship Management solutions enable hospitals to grow market share and revenue by identifying and intelligently managing the health risks of local consumers and employer groups within the communities they serve. Complementing this, Aegis' data-driven Physician Relationship Management program creates strategic alignment between hospitals and their medical staff to drive service-line growth.

Using proprietary software, Internet applications, data aggregation systems, educational initiatives and the skills of a talented team of associates, Aegis' approach provides a synergy through which everyone wins.

- > **Hospitals win** by positioning themselves as central to the community's healthcare solutions and by retaining the best local physicians, who drive market share into their facility.
- > **Physicians win** through increased opportunities to influence hospital leadership, grow their practices and provide quality services to their patients.
- > **Employers win** by fostering a healthier workforce, which lowers health-related costs and increases productivity.
- > **The community as a whole wins** through greater access to hospital services and programs specifically geared to them and improved health, which is the foundation for business and economic growth.



Check out the Aegis Blog: [www.aegishi4.com](http://www.aegishi4.com)  
**HI4: Hospital Intel, Insight, Innovation, Impact**