Hospitals at a Crossroads:
Achieving Success in an Era of ACOs

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Healthcare has experienced many monumental changes over the decades. Perhaps none more so than the 2010 Patient Protection and Affordable Care Act, which impacts all aspects of the industry, from access to cost to quality. This thought paper explores the current dynamics in the wake of the emergence of Accountable Care Organizations and their prospective impact on hospitals nationwide. It also examines a cost-effective and proven business development strategy for hospitals in this environment as they wrestle with the new dynamics of the marketplace.

HOSPITALS AT A CROSSROADS: ACHIEVING SUCCESS IN AN ERA OF ACOS

Every decade, or so it seems, some pivotal issue engulfs hospitals around the country and threatens to fundamentally alter the way care is delivered and the role hospitals play in managing the health and welfare of their communities. At each of these crossroads, hospital CEOs have a choice – dismiss the change as simply the flavor of the month and cling to the present, or embrace the change as true progress and stake out a leadership role in advocating for its adoption.

This decade portends to be no different except for one key variance – the uncertainty of healthcare reform. Given the political fires being stoked by the 112th Congress, no one knows for certain how the components that comprise the 2010 Patient Protection and Affordable Care Act (PPACA) will eventually play out, as there are no less than four election cycles between now and its full implementation. Already we are seeing payers increase premiums by an average of 13 percent in preparation for full implementation of PPACA. Today there are 1,300 health plans in the United States, but it is estimated by some that only 40 will exist by the end of the decade. Will healthcare truly be more affordable? Will the emergence of health insurance exchanges lead to more value-based purchasing? Will access be provided to many of our nation's more than 45 million uninsured; and, if so, do we have the capacity to service that new demand? Will quality be rewarded as planned? Will electronic health records provide for better coordination of care without mortgaging patient privacy? What will happen to the estimated 40 million Americans that are anticipated to lose their coverage with small employers electing to pay penalties rather than continuing to provide insurance? And what about end-of-life care as people live longer and centenarians become more commonplace?

As Americans wrestle with and test these questions and assumptions over the coming years, there is one component of healthcare reform that is certain to impact hospitals, physicians, payers and communities from coast to coast. This component is, of course, the emergence of Accountable Care Organizations (ACOs).

By most accounts ACOs are designed as a method of intelligently integrating local hospitals and physicians – and potentially other members of a local healthcare community – and rewarding them for controlling costs and improving quality. It is speculated, and hoped, that if properly organized and managed, ACOs will drive payment reform in both the public and private healthcare sectors. While the alignment of physicians, hospitals and other providers into risk-bearing organizations is not a new concept, the innovation ACOs bring to the market lies in the flexibility of their structure, payments and risk assumption.

Although they originally comprised just seven pages of PPACA, ACOs have become one of the most talked about provisions among healthcare professionals. That's because ACOs force providers to focus outside the comfort zone of their own bricks and mortar toward patient-centered medical home models and total-population health management.

THE THREE TRUTHS ABOUT ACOS

As of the publication of this paper, only a handful of identified "trial" ACO models have emerged, yet three irrefutable truths have already surfaced.

The sunset of fee-for-service and volume-based reimbursement is on the horizon, and in its place will be pay for efficiency and value.

What's more, ACOs that can effectively demonstrate they meet quality thresholds (e.g., clinical processes and outcomes, patients' and caregivers' perspectives on care, and utilization and cost targets) may be eligible to receive additional incentive payments from the Centers for Medicare & Medicaid Services in the form of shared savings. For all of these reasons, many hospitals today are looking at what they need to effectively and selectively engage in this new arena.

The first truth is that ACOs are all about relationships. Looking at the nation's few successful integrated healthcare systems – Geisinger, Mayo Clinic, Advocate and Intermountain Health – it is abundantly clear that in order for ACOs to succeed, successful relationships built on trust and an alignment of incentives must be formed between hospitals and physicians and then, in turn, between the ACO and the community.

The second truth is that ACOs are going to breed a new species of competition that some hospitals and many communities have never before seen. That's because as hospitals work to align themselves with local physicians, their competitor across town is trying to do the same thing. Not to mention the payers that are entering the fray as well. Already commercial insurance companies such as United Health Care, Aetna and various Blue Cross/Blue Shield plans are announcing collaborative ACO trials with hospitals and health systems around the country. They can't all win. More than ever winners and losers are bound to emerge, and this is no time to be timid. Hospitals must be open to new business development opportunities, must be more focused with their marketing dollars, and must acknowledge the fact that taking calculated market share from their competition is their surest road to success.

The third truth, and the one least discussed, is that ACOs are bound to set in motion a new era of cost shifting. This concept is not new to healthcare, as those who could pay have always fronted the burden for those who couldn't. Under ACOs this will become more imperative than ever. As hospitals become accountable for the care of their community in a variety of settings outside of the hospital walls, it will be essential that the sum of those patients who do wind up in the hospital have an overall favorable reimbursement profile/payer mix that assures sustainability for the sponsoring institution. For this to be successful, hospitals must take an active role in influencing patient self-care and preventative measures, which is largely impacted by primary care physicians, whose role will take on even more importance.

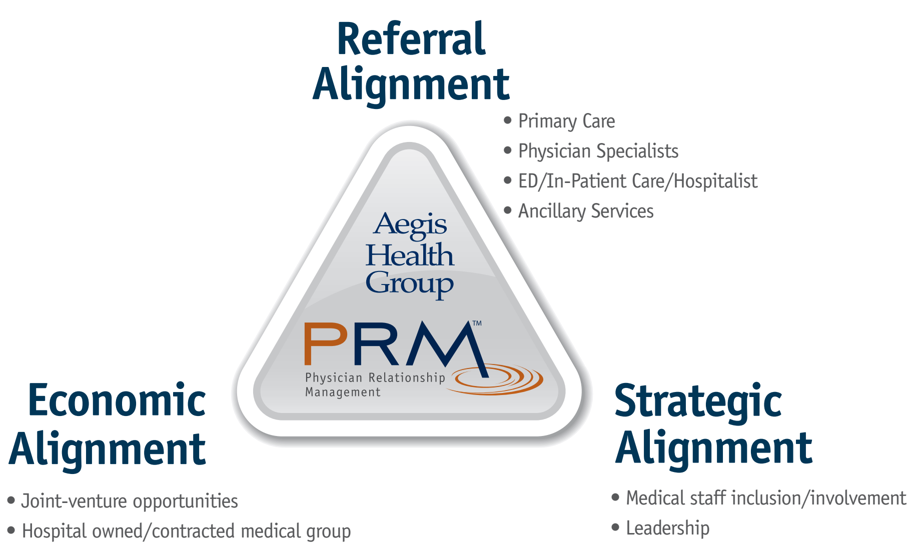
THE SECRET TO BUILDING SUCCESSFUL PHYSICIAN RELATIONSHIPS

As the first "truth" points out, for hospitals to implement a successful ACO model, relationships between hospital and physicians must be elevated to reach a new level of "mutual benefit" to truly achieve "win-win" status. True synergy is going to be necessary to deliver on the high-quality, low-cost model to which ACOs aspire.

Many hospitals already have some kind of physician relationship management program in place. Even though they are diligently calling on doctors, many are not achieving a significant impact. That is because, more often than not, instead of seeking opportunities for strategic alignment and ongoing engagement with physicians, they are spending their time in "meet-and-greet" activities or simply addressing quick fixes such as better instrumentation or more convenient block times in the OR.

According to a 2008 survey by the American College of Physician Executives (ACPE), only 16 percent of ACPE members consider the relationship between the hospital and private practice physicians as "doing well." That is a frightening and untenable statistic. What's more, 42 percent of hospital leaders expect ACOs to strain their relationships with physicians according to a new report from HealthLeaders Media. Unless hospital leaders take the initiative, the chasm between their institution and their affiliated physicians will only grow wider and deeper, and that's a dead-end street in a world of ACOs. Fortunately there are many avenues that hospitals can take to bridge this gap. One of the most effective, according to the 2008 ACPE survey, is the implementation of a formal physician relationship management (PRM) program.

Physician relationship management in 2011 needs to evolve beyond a reliance on conventional CRM tools and basic programs, such as "lunch and learns." When optimally planned and executed, physician relationship management creates referral alignment, economic alignment and strategic alignment that ultimately help doctors and hospitals achieve positive clinical and financial outcomes (see graphic).



» Referral Alignment

Many factors influence patient referrals between primary care physicians and specialists, and that directly impacts a hospital's patient volume. By working with PCPs to uncover barriers and help create and develop relationships with specialists, hospitals can facilitate a steadier flow of consumers who need inpatient and outpatient care. Referral alignment also helps identify problems PCPs and specialists may be having in terms of accessing and delivering services at the hospital. The issues may range from not having the right equipment or level of nursing care to needing a new cardiac cath lab, upgraded imaging services or additional surgery suites. Referral alignment also focuses on ensuring that PCPs are comfortable with hospital-based physicians, such as hospitalists and/or contracted emergency room doctors.

» Strategic Alignment

While most hospitals have a loyal group of admitting physicians, in many cases the majority of medical staff members are "splitting" their referrals between one or more hospitals. There are also likely qualified and desirable physicians in the community who have chosen not to join the medical staff at all. The goal of strategic alignment is to educate physicians about the benefits of being associated with the hospital and becoming more involved at the leadership level. This provides opportunities for physicians to have a voice in the decision-making process, which can translate into increased personal and professional satisfaction. Strategic alignment also ensures that both hospital and medical staff leaders are working toward the same goals of cost efficiencies, enhanced patient experience and better quality, all necessary components if we are to be successful in an era of payment reform.

» Economic Alignment

Like hospitals, most physicians have seen their income decrease as reimbursement declines. Many doctors are looking for new ways to grow their income, such as through joint ventures and the addition of new services into their practices. Hospitals can help identify gaps in services within the community and, where appropriate and economically desirable, partner with physicians to fill those voids and foster hospital market share growth. Some hospitals have been strategically forming medical foundations or recruiting new physicians for existing, loyal medical groups. Others have created management agreements where medical staff members manage hospital services, with incentives for cost efficiencies and enhanced quality. One interesting example to consider is that of a gain-sharing model using APR-DRG* to adjust for risk in the patient population and then score the treating physicians based on percentiles. One hospital on the east coast using this model was gain sharing with its top 25th percentile doctors. Now, nearly all of its physicians are asking how they can improve their outcomes.

**Annual percentage rate – Diagnosis-related group*

PARTNER AND ENHANCE RELATIONSHIPS WITH PHYSICIANS

Wherever such opportunities exist, hospitals should look for ways to partner and enhance relationships with physicians to achieve the best possible relationship, alignment and competitive advantage. Additionally, hospital leaders would be wise to identify ways in which they can help physicians create stronger, more robust practices – from offering access to career-building events and seminars to consulting on ways to increase efficiency of physicians' offices – within the confines of the Stark laws, of course.

To achieve these ends, hospitals need to take a data-driven approach that allows them to identify growth markets, target physicians most likely to drive new referrals, and enhance relationships with their medical staff by addressing their physicians' core needs and professional goals.

A NEW ERA OF AGGRESSIVE, TARGETED MARKETING

If the goal were simply to build market share, the rules of the game would be the same today as they have been since hospital marketing and advertising first gained popularity 30 years ago. But if there are two things that hospital CEOs have learned over the past three decades, it is that all market share is not created equal and that those hospitals still spending the majority of their budgets on TV and radio airtime, newspaper and magazine ads, direct mail, and billboards are making a major mistake.

Simply building "top-of-mind" awareness may be well grounded in other industries; but since the "buy" decision for health services often occurs long after the commercials have stopped airing (such as when a patient needs a specialist or during annual open enrollment), the reality is that most hospitals cannot measure the impact of their messages on consumers. That makes tracking direct return on a traditional mass-media marketing investment very difficult.

Marketing healthcare must be targeted to those customers who are likely buyers, whose needs match the services a hospital (and medical staff) is offering and whose insurance profile is most optimal. If you think this sounds "commercial" and a bit too "retail," think again.

Hospitals must be strategic in identifying where their marketing efforts will have the greatest impact. As ACOs emerge, the answer is quickly going to become the local employer community. Why? As ACOs, hospitals will take on increasing accountability for the health of their entire community. This charter will greatly support the hospital's mission and (particularly for nonprofit hospitals) its "community benefit" requirements. But remembering Sister Irene Krause's declaration of "No Margin, No Mission," hospitals will more than ever need to look for those pockets where profitable market share is still possible. And that is through local employer groups.

The employer is where the majority of the commercially insured consumers still secure their benefits. On a daily basis, local employers are making purchasing decisions that can positively or negatively impact hospital and physician practice revenue growth. Most important, they represent an insured population right in the hospital's own backyard. For too long hospitals have been hesitant about seizing the opportunity to work closely with local employers and have deferred this activity to health plans or any assortment of entrepreneurial enterprises. For hospitals involved in an ACO, the private payers become even more important as they will almost certainly see an increase in their Medicare and Medicaid volumes.

> "The reality is, most hospitals cannot measure the direct impact of their messages on consumers."

AN EMPLOYER-FOCUSED BUSINESS DEVELOPMENT STRATEGY

In a world of ACOs, building relationships with local employers has never been more critical. That's because it is the one strategy that can simultaneously grow market share, tap into new streams of profitable revenue, and enrich the hospital's brand in the community, regardless of whether the hospital is in an ACO or not.

Under a population management model inherent to an ACO, the hospital is called upon to focus on the community as a whole and shift into an integrated health-system model rather than a more traditional health center. Part of this means thinking beyond admissions and adapting a "right-care, right-time, right-place" mindset. Working closely with local employers puts hospitals in a position to coordinate all elements in the continuum of care by developing programs and strategies that work to keep people healthy and out of the hospital whenever possible.

For many employers healthcare costs are their second biggest expense after salaries. More than a decade ago, Detroit automakers announced that they were spending more on healthcare than they did on the steel that went into their cars. Back then the statement was shocking. Today it is taken in stride as these automakers are not alone. According to a recent Towers Watson Healthcare Cost Survey, employer healthcare costs for active employees are projected to rise 8.2 percent (after plan changes) to an average annual cost of $10,730 in 2011 – the seventh consecutive year of increases. As a result, today's employers are looking for answers and will undertake any reasonable strategy that will help them both understand and control these skyrocketing healthcare costs.

According to a recent Towers Watson Healthcare Cost Survey, employer healthcare costs for active employees are projected to rise 8.2%, to an average annual cost of $10,730 in 2011.

Today, more than ever before, hospitals have an opportunity to step in and help employers manage their healthcare cost concerns by establishing partnerships with the local business community that result in improvements in employee health and a corollary reduction in expenses. They are also – in many cases for the first time – positioning the hospital as part of the solution, not part of the problem, of rising healthcare costs. After all, hospitals are employers, too, and usually one of the largest in any community.

The Aegis program, which has been embraced by hospitals of all sizes and sponsorships across the country for more than 20 years, begins with a thorough market analysis to identify appropriate employers in the hospital's catchment area. Once identified, the most successful partnerships launch by administering a health-risk survey among the company's employees (and, in some cases, spouses and other covered family members). The survey helps identify overall health trends, such as a high percentage of smokers or obese employees as well as current utilization of health services. By identifying the most pervasive health issues among an employee population, hospitals can then truly become accountable for the populations they serve, regardless of whether they are in an ACO or not. Examples might include offering interventional programs such as onsite smoking cessation classes and weight or stress management programs or offering blood pressure tests, diabetes screenings, BMI calculations and more. Such programs provide the opportunity to link employees to local physicians who can help address identified health risks or direct them to the hospital, if the problem is acute.

Hospitals typically realize a first year ROI of 2:1 and second year results of 3:1 to 5:1.

Out years often approach double-digit returns on investment.

PROGRAMS LIKE THIS REALLY WORK AND PAY HUGE DIVIDENDS: THREE EXAMPLES

Baptist Health System

baptisthealth system
Answering the call.
Citizens Baptist Medical Center · Princeton Baptist Medical Center
Shelby Baptist Medical Center · Walker Baptist Medical Center

Baptist Health System in Alabama launched its program in 2008 and today works with nearly 30 local businesses representing 8,000 enrolled employees. A large slice of this (about 3,000 lives) comes from the hospital's own employees as Baptist, like any other large employer, faced its own challenges with rising healthcare costs. From year two to three of the program, Baptist Health saw its own health claims expense decrease 11 percent – $2 million in annual savings – a substantial portion of which they attribute directly to their employee wellness program and credit the balance to a disease management program developed based on the rich data derived from the program. Employee participation grew significantly year over year, increasing 4 percent from year one to year two and 11 percent between years two to three. They also helped some 100 employees stop smoking. Through these quantitative results, Baptist was able to demonstrate to other employers in its marketplace that it is possible to have great healthcare and lower cost at the same time.

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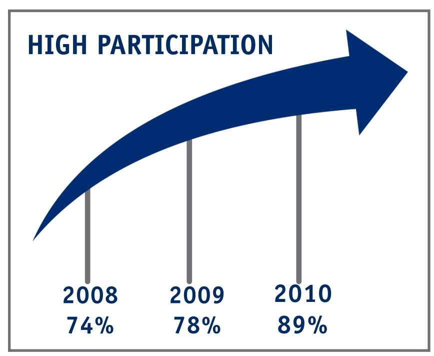


Looking beyond its own walls, Baptist took their primary care physicians out into their local business community to conduct educational programs, held numerous screenings, and participated in many health fairs. Not surprisingly, they found that a huge percentage of male employees didn't have a primary care physician, so they quickly introduced them to one. Baptist also collected blood pressure, body mass index, cholesterol and other baseline data and began to educate employees on what they should be concerned with based on health risks or family history. In doing so, the hospital has begun to build trusting relationships among local employees, the health system and its medical staff.

ProHealth Care

ProHealth Care

ProHealth Care in Wisconsin is another of the many hospitals around the country that is seeing the tangible ROI of launching such an employer-focused program. In 2005, they expanded their pre-existing occupational medicine program into a comprehensive worksite wellness program for employers. As a result, the hospital saw net revenues increased by nearly $1.5 million in the first 21 months of the initiative and another $1.3 million in the following 12 months. Since the time the program was introduced, ProHealth Care's overall marketshare in its historical service area has increased from 43.6 percent to 46.4 percent. Most importantly, all of these new patients are favorably insured individuals, meaning that the hospital isn't just building market share but is doing so through a targeted and strategic approach that mass advertising or other mass communication tactics simply cannot match.

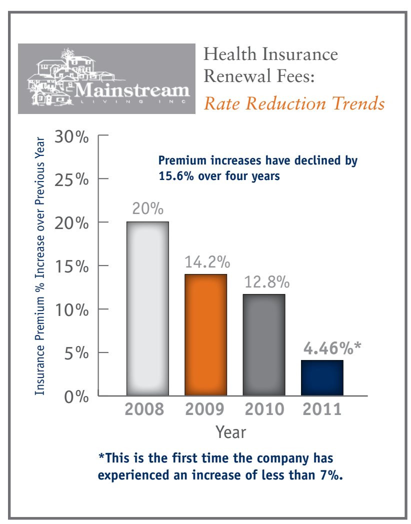
Implementing programs such as these succeed because it is one where everyone wins. Hospitals win by driving desirable patient volume into their facilities (and medical staffs) and establishing themselves as the provider of choice in the community. Employers win because by working with the local hospital they are able to identify employee health risks and implement early detection initiatives that ultimately save them dollars in insurance premiums, absenteeism and workers' compensation claims. And, employees win by learning more about their health risks and gaining the knowledge and tools they need to lead a healthier lifestyle.

Mercy Medical Center

Mercy

Excellence.
Every Day in Every Way.™

In 2006 Mercy Medical Center in Des Moines, Iowa, enrolled local employer Mainstream Living in its Aegis-directed workforce health initiative. In 2010 Mainstream reported that its healthcare insurance premium renewal increase for 2011 was 4.46 percent – the first time the company has experienced an increase of less than 7 percent and a far cry from the 20 percent increase they witnessed just three years earlier. They attribute this dramatic improvement to their workforce health program that directly and effectively addresses their employees' health and wellness needs. They fully expect these positive, downward trends to continue as they maintain a high level of employee participation in the workforce health initiatives provided on an ongoing basis.



NOW IS YOUR OPPORTUNITY

The goal of ACOs is to pay providers in a way that encourages them to work together, to pay providers in a way that does not encourage supplier-induced demand, and to create an organization that is rewarded for providing high-quality care. By bringing together the different elements of care at a reduced cost for the patient – primary care, specialists, hospitals, home healthcare, etc. – all of the parts will work better together and the patient benefits as a result.

With the ACO concept still in its infancy, this is the opportune moment for hospital leadership to play a defining role in deciding how they are going to compete in this new healthcare era. It is clear that we have entered a point in time that demands an unprecedented level of collaboration between physicians and hospitals. So, too, employers and payers are looking for answers and solutions to their continually rising healthcare costs coupled with the uncertainty that healthcare reform will bring. Those hospitals able to forge closer alignment now with these critically important audiences will find themselves on the precipice of a winning strategy in this age of true transformation.

Whether your organization opts to embrace an ACO model or wait and observe market developments, all providers will continue to share three common goals: optimize patient service, affect change for a healthier community and realize market growth while staying "on mission." Building a robust and loyal customer base can only positively impact these objectives.

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

For 20 years Aegis has helped hospitals across the country form lasting and profitable relationships with area employers by pioneering the concept of employer-directed health-management partnerships. Today, Aegis' program can be found in many of the most progressive-thinking for-profit, nonprofit and academic medical centers across the country. No other company has been able to match the breadth of services, track record and bottom-line proven performance of Aegis' reimbursement-sensitive business development strategies.

To create a win-win-win relationship for hospitals, employers and employees, Aegis utilizes proprietary software, Internet applications, educational initiatives and the skills of a talented team of associates. Hospitals win by driving profitable marketshare into their facility and enhancing their standing in the community. Employers win by reducing their health-related costs. Employees win through increased health improvement and access to hospital services and programs geared specifically to them. No wonder Aegis has been chronicled in many of the nation's leading healthcare publications, is a member of the Nashville Chamber of Commerce "Hall of Fame," and is frequently turned to when revenue growth is fundamental to success.

The Power of Relationships.℠

Aegis

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