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About FYA

FYA – For Your Advantage, is a free twice-monthly newsletter published by TrendLeader Connections.

With every issue, FYA provides insights into the topics that concern healthcare leaders today and the challenges that will be faced in the near future.

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Insurer Aims to Reduce Costs, Improve Quality of Healthcare

Massachusetts' dominant health insurer is proposing to overhaul the way it pays doctors and hospitals, in what company officials told the *Boston Globe* is an attempt to slow runaway healthcare costs and improve the quality of care.

Blue Cross and Blue Shield of Massachusetts wants to stop paying doctors and hospitals for each patient visit or treatment, a common arrangement that most experts agree has led to unnecessary, inefficient and fragmented care that is sometimes harmful to patients.

Instead, they want to pay doctors and hospitals a flat sum per patient each year, adjusted for age and sickness, plus a significant bonus if the providers improve care, Blue Cross officials said. In most cases, the payment would cover all services from primary care doctors, specialists, counselors and hospitals – forcing them to work together closely.

"We're not looking to spend less than we do today, but we want spending to grow at a rate that's affordable," said Andrew Dreyfus, executive vice president for healthcare services at Blue Cross. "And we want to empower physicians and hospitals to provide the right care."

The ambitious proposal makes Blue Cross and Blue Shield of Massachusetts a national pioneer in the effort to transform the way healthcare is delivered, health policy specialists said. But some fear the plan could bring back the most problematic aspects of managed care.

As national and state pressure intensifies to control healthcare spending, Blue Cross hopes to halve the growth in medical costs in two to four years among providers who accept the new payment system. Blue Cross also expects the move to attract more business, increasing its market share, which already includes about half of Massachusetts residents.

Blue Cross expects patients could see dramatic changes, such as quicker access to the doctor by phone or e-mail or same-day appointments, home visits by nurses to the chronically ill; and smoother transitions between hospital, rehabilitation center and home.

National health policy specialists praised the move.

"If we don't try something like this, the alternative is a continual free-for-all of spending or some sort of regulation," said Stuart Altman, dean of the Heller School for Social Policy and Management at Brandeis University in Waltham, MA. Altman believes the new payment plan should be mandatory for providers instead of optional, as Blue Cross proposes.

But healthcare providers and patient advocates are giving the proposal mixed reviews – praise for the effort, but concern about the details. Some question whether the plan would restrict patient choice and encourage doctors to withhold care on one hand and make doctors responsible for costs beyond their control on the other.

The most significant savings and changes may involve chronically ill patients. For

(Continued...)

Insurer Aims to Reduce Costs, Improve Quality of Healthcare (Continued...)

example, patients sent home after hospitalization for heart failure are now frequently left to manage on their own.

Typically, patients go home with a list of medications, a recommended diet, and instructions to alert doctors to any significant weight gain, which could signal worsening of the illness. A follow-up office visit is scheduled a week or two later, but all too often, patients' problems escalate and they end up rehospitalized.

Under the Blue Cross contract, the hospital or doctor might instead send a nurse to visit the patient on the first day home from the hospital, since those healthcare providers could get a bonus for providing continuity of care and ensuring patients understand how to care for themselves. The nurse could make sure the patient took needed medication and help the patient stock cabinets with healthy food. For the first few weeks, the nurse might call the patient daily to check on weight and give advice.

If any problems cropped up, the patient could get in to see the doctor quickly and would be likely to avoid another hospital stay with a simple medication change. The savings from fewer hospitalizations would go to the doctors and hospitals, to pay for home visits or for bonuses, but eventually could lead to slower growth in healthcare costs, Blue Cross said.

While the bonuses are designed to drive improvement, State Senator Mark Montigny worries that the payment system could distract doctors from making "a decision based solely on medical soundness." Montigny, a New Bedford Democrat, helped establish a patients' bill of rights in the mid-1990s to counteract problems in managed care.

The Blue Cross plan has some similarities to the "capitation" payment system behind those problems, which was widely used in the 1990s, but was vehemently rejected by many doctors and patients. Blue Cross says its plan includes

safeguards to avoid the undertreatment, underpayment and strict controls on patient choices that doomed capitation.

"We have no interest in returning to the heyday of managed care or denying care," Dreyfus said. He said several mechanisms would prevent patients from being denied appropriate care, including public scrutiny of doctors' performance and Blue Cross's commitment to cut off any caregiver providing substandard service.

While many insurers' contracts already include performance measures, the Blue Cross plan goes further, by offering up to a 10 percent bonus, based on progress toward dozens of quality standards, such as keeping blood pressure and diabetes under control, and providing immediate access to the doctor around the clock.

Blue Cross must get widespread participation from doctors and hospitals before the effort could slow the rise in insurance premiums. Dreyfus said they are finalizing contracts with two large doctors' groups.

Officials at Partners HealthCare, the state's largest medical system, and at Beth Israel Deaconess Medical Center said they support the principles driving Blue Cross's initiative, but are not quite ready to sign on. They are worried about the impact on their bottom lines and about being held responsible for care and costs over which they have little control, such as patient stays in nursing homes.

Blue Cross is still figuring out how the plan could work for doctors in small practices and for patients not in HMOs.

John McDonough, executive director of the advocacy group Health Care for All, said Blue Cross's initiative has promise, especially if other insurers and the government adopt similar approaches.

"What we have now is killing us financially, and in some cases medically," he said.

About



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Reader Response to "Best or Worst?!"

By: Rick Kneipper, Chief Administrative Officer and Co-Founder of PHNS

My "Best or Worst?!" commentary in the 1/22/08 *FYA* (regarding a recent study that ranked the U.S. "worst" among 19 leading industrialized nations on preventable deaths) evoked this very thoughtful reader response:

"One must first make the distinction between quality of healthcare and access to healthcare. One can also argue that the bottom line is the same, i.e., preventable deaths and that is true. However, there are very large differences in the mechanics of the statistics.

If one is fortunate enough to be insured and to receive healthcare in the U.S., I suspect our quality numbers among that population would be quite high. The problem is centered around the large population of the working poor, who cannot afford health insurance. God help them; they are priced out of preventable deaths. The real problem with healthcare in the U.S. is access...the hundreds of thousands, including immigrants huddling in our big cities, the pizza shop workers in the mom and pop store, those people who make too much money to qualify for Medicaid, but not enough to buy decent health insurance and all the others who are simply not able to afford healthcare in this country. Many of these people simply live with symptoms until they are too far gone to treat when they show up in our hospital emergency rooms. A high rate of birthing deaths from poor mothers compounds the issue.

Those of us who can access healthcare, I believe receive among the best care in the world. Statistics can certainly be misleading. When comparing preventable deaths, I think it is useful to know the reason. Do our providers do a terrible job compared to the rest of the world, or do we have huge numbers of citizens who simply go without?"

Ronald J. Babcock
Administrator
Hudson Valley Heart Center
Poughkeepsie, New York

I think Ron makes some excellent points-what do you think?



I would like to hear your comments.
Send them to:
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About

TrendLeader Connections

FYA - For Your Advantage is brought to you by TrendLeader Connections. The function of TrendLeader Connections is producing educational materials and seminars that help healthcare executives differentiate between fads and trends; and making connections with "Trend Leaders" within the healthcare industry.

We are committed to delivering new perspectives and ideas, creative and innovative healthcare solutions, provocative concepts and quality educational materials to today's healthcare leaders. We want to concentrate on "what comes after what comes next."

A Board Game Provides Training and Insight

Our Lady of Mercy Hospital in Bristol, CT., turned to Johns Hopkins University for help in improving its various departments. The help it got was in the form of a board game.

The game leader, William Ward, a professor of health finance and management, explained the game to a reporter for the *Hartford Courant*: "It's about collaboration and teamwork, about seeing your department as one piece of an enormous mosaic. Whether it's lab, registration, records, we tend to manage just in our own little departments.

Played out over a simulated 24-hour day at a hospital, "Friday Night at the ER" graphically shows the downside of short-term thinking, faulty assumptions and an every-manager-for-himself philosophy.

Teams try to juggle a limited number of hospital beds, a relentless influx of patients and a gradual attrition of nurses to care for them, all while racing against a clock that forced faster and faster decisions. Every so often, game cards announce another mini-crisis to ramp up the pressure.

A few dozen department managers and board members at Bristol Hospital got a fresh look at patient care, staffing levels, revenues and hospital administration through a staff training workshop based around the board game. Divided into groups of four, they got to watch which decisions led to success or failure; invariably, the teams that worked together well scored higher.

The lessons were seemingly simple: Managers produce better results working collegially than when they care only about their own little piece of the system. Developing strategies is more effective than just handling a series of crises.

When the game began, the game's emergency room chief was doing fine until about 8 p.m., when a couple of nurses went home sick, a flood of patients showed up at the emergency room and the medical-surgical floor ran out of rooms.

A little while later, the game's ER chief moved pieces around the game board, flipped over a card and groaned at the bad news: "I'm in big trouble here: I'm getting

four more patients and I've already got 12 in the waiting room."

The patient count in the ER waiting room soared as the simulated day went on, especially when the players running the operating room, critical care unit and medical-surgical floor initially didn't cooperate to free up bed space, share nursing staff and think ahead to the next challenge.

Our Lady of Mercy's information technology manager, landed the game job of running its ER, and almost instantly was counting on teammates for help. They swapped the tokens that represented staff workers back and forth, trying to cut through the backlog of patients without resorting to the potential budget-buster of calling in expensive off-duty staff. For part of the game, they had to turn away new patients – a decision that proved costly.

When John Hopkins' Ward reviewed the scores afterward, Our Lady of Mercy fared better than many of its competitors. But he said that hiring extra staff during peak periods is essential – in the game and at real hospitals.

"It's cheaper sometimes to bring in temporary people at \$60, \$70 or even \$100 an hour than to turn away admissions," he said. "In Maryland, we figured that for every ambulance we diverted [to another hospital], we lost \$7,500 in profit."

Over-reliance on cost containment is part of an entrenched attitude in the healthcare field that must change, Ward said. And department-by-department goals, measured strictly in isolation, are another, he told the audience.

"Department managers often see their objectives as [just] their department's objectives," he said. "If you're a lab manager looking to have the lowest cost per test, what are you going to do? Not staff evenings, not staff on weekends. But what effect does that have on the rest of the operation?"

The game results supported that idea.

"The ER backs up [in the game]," Ward says. "But it doesn't start in the ER – it starts in the other departments."