Extreme Hospital Makeover

Reform Prompts 'Sea Change'

By Tom Schuman

A January report from the American Hospital Association states that Indiana hospitals employ 126,860 people and create more than $33 billion in state economic activity. It adds that "ripple effects" support an additional 261,000-plus jobs and that hospitals spend more than $16 billion on goods and services from other businesses within the state.

The Indiana Hospital Association (IHA) notes that it is the professional trade association of 164 hospitals that are either independent or a member of one of the 23 health care systems in the state. In Indiana and across the country, the "systems" are growing larger and the independents are shrinking in numbers.

That was a fact before the Affordable Care Act (ACA), and it is a process that is expected to continue. Dan Evans of Indiana University Health says bluntly: "To achieve maximum efficiency, best outcomes and highest quality and safety, size matters."

BizVoice® spoke with seven hospital leaders throughout the state, two insurance industry representatives and a national health care expert. They discuss the hospital landscape, efforts to engage consumers in health care choices, the impacts of federal reform and related topics. The 10 authorities are:

Vince Caponi
St. Vincent Health
www.stvincent.org
Indianapolis

Edmund Haislmaier
Senior research fellow in health policy studies
Heritage Foundation
www.heritage.org

Kelly Dunham
Interim CEO of DeKalb Memorial Hospital at the time of this interview and an 18-year member of the management team
www.dekalbhealth.com
Auburn

Craig Kinyon
Reid Hospital and Health Care Services
www.reidhospital.org
Richmond

Dan Evans
Indiana University Health
www.iuhealth.org
Indianapolis

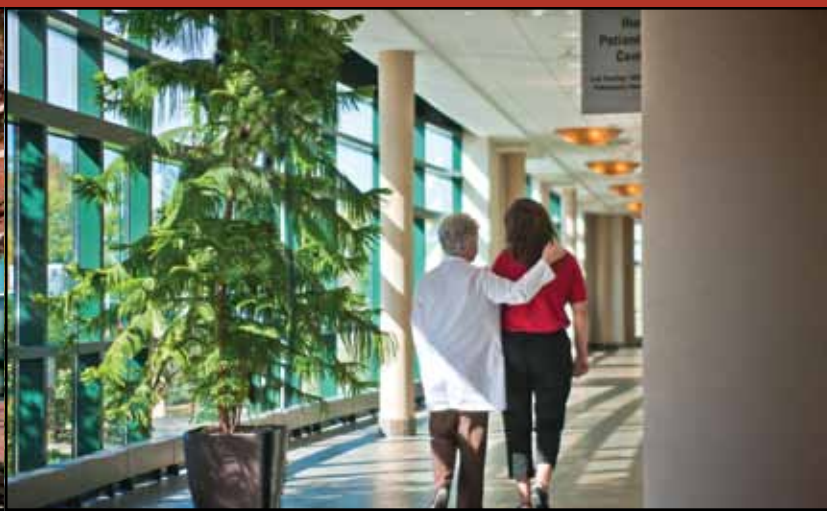
Dr. David Lee
Vice president of provider engagement and contracting
Anthem Blue Cross and Blue Shield in Indiana
www.anthem.com

Pat Griffey
President
Page 1 Benefits
www.page1benefits.com
South Bend

Rob McLin
Good Samaritan Hospital
www.gshvin.org
Vincennes

Al Gutierrez
Saint Joseph Regional Medical Center
www.sjmed.com
Mishawaka

Philip Newbold
Beacon Health System
www.beaconhealthsystem.org
South Bend



Reid Hospital, a fixture in Richmond since 1905, moved to its new campus in 2008. Craig Kinyon of Reid is anxious to see the health care industry focus move from "injury and illness" to "wellness and prevention" *(photo at left courtesy of HDR Architecture, Inc., Jeffrey Jacobs Photography).*

On the fast track

In separate discussions, Caponi and Kinyon utilized the same analogy to describe the changes taking place in the health care industry.

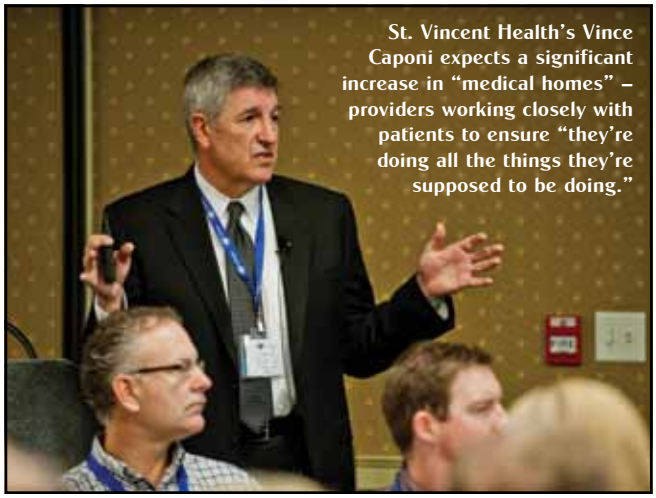
"It's one of those deals where you're driving down the road at 60 miles per hour and you're trying to change the wheels," claims Caponi, involved in health care since 1975. "It has that level of difficulty to it."

Kinyon, in the industry since 1983, offers a more detailed analysis with the same bottom line.

"The dynamics and challenges to us and other organizations have never been so intense in my mind as it is today. If you love change, if you love challenges, if you love the fact that you can't count on today's environment to be guaranteed next year – and how you are going to manage today and also prepare for the future – this is the place to be. It's like trying to change a flat tire while the car is moving."

Caponi – like Evans, Newbold and Gutierrez in this article – has more resources than Kinyon, or Dunham and McLin, to make those acrobatic adjustments.

But the three independents (among just 46 of IHA's 164 total members that are not part of a larger health system) cite special circumstances in maintaining their status despite the financial challenges.



St. Vincent Health's Vince Caponi expects a significant increase in "medical homes" – providers working closely with patients to ensure "they're doing all the things they're supposed to be doing."

Only game in town

Reid is the sole hospital in Richmond (a new facility four years ago replaced the campus that had existed since 1905) and the only one within a 20- to 25-mile radius. It is nearly equidistant from Indianapolis, Cincinnati and Dayton. Kinyon points out that Reid works with multiple systems in those cities when, for example, needs revolve around neurosurgery or transplants.

"We're not the norm for hospitals our size and demographic across the United States," he asserts. "In this new paradigm, in this new way medicine is being delivered, and the way insurance companies and contracts are impacting the medical community, certain smaller community (hospitals) can no longer exist on their own. They don't have the financial resources, the depth of medical staff.

"We have the financial wherewithal that is unique for hospitals our size. Good decisions have been made over decades, reinvesting in our technologies. We've made those investments; we've added those services."

Broad reach

Good Samaritan in Vincennes also has a neighboring state factor. Its service territory includes 10 counties and ventures 30 miles into Illinois (which provides one-third of its business). That territory includes eight smaller community hospitals. Most of those, according to McLin, are independent but operated by management companies. Nearly half of the hospital's business comes from outside its home county.

The Good Samaritan status as the first county system in the state (dating back to 1908) should not be underestimated. All three Knox County commissioners and four independent members selected by a local judge comprise the hospital board.

"They (the board members) feel very strongly about our independence and maintaining that independence as long as possible," McLin confirms. "Our community thinks of it as something special – being privately run, not part of a system."

A $110 million BEACON (Building Excellence Around Communities, Opportunities and Needs) Project that includes a five-story, 120-bed inpatient tower is in progress. McLin points out that the hospital was able to issue $80 million in

bonds to finance the expansion.

"Our focus has always been staying strong financially, doing things the right way clinically and focusing on patient satisfaction. When you do those, patients keep coming, you have happy employees, you have a happy medical staff for the most part and you're able to stay independent."

Community pride

DeKalb Memorial Hospital (which officially changed its name to DeKalb Health in 2011 but still does business as DMH) has a much shorter life span – since 1964 – but no less of a community involvement.

"When we were formed, it was called the 'miracle of Indiana' as we were fully funded by private donations from people within DeKalb County," Dunham recalls. "Over the years, they have continued to have a feeling of ownership. It is the feeling of our community that they want to remain independent, so from the business side we have to look at what is realistic."

While focusing on the primary care needs of the community, DeKalb also boasts strong relationships with the two dominant systems in the area (Fort Wayne-based Parkview Health and Lutheran Health Network) and other facilities.

"The definition of independence is not what it used to be because so much has changed over the years in health care," Dunham notes. "We have meetings, collaborations with both Parkview and Lutheran on a very regular basis; we need them as a tertiary facility. It's very important that we work well together. They provide us with the specialties and the types of physicians we aren't able to secure for the DeKalb County market on our own."

"We bring people here from all over the world. When local communities see the whole package – education, research and the size (benefits), I won't say it's a no-brainer, but it's powerful draw."

– Dan Evans
Indiana University Health

What helps DeKalb stand out? Dunham says it's not unique to the Auburn facility (more of a smaller versus larger factor), but "we have always been praised for that personal service. You don't get lost here in the shuffle; you are taken care of differently in a small facility because there are just fewer people.

"The primary care physicians still function as the gatekeeper even when specialties get involved. They do a better job of talking to one another and maintaining that continuity of care. When we get feedback from our patients, they tell us that."

Kinyon and Dunham report there have been no recent overtures from the larger providers about potentially becoming part of their systems. McLin adds, "They haven't been really strong as far as saying, 'We're ready to come in and buy you out tomorrow,' but absolutely we've had visits from most of the major Indiana systems. We always listen."

Big and getting bigger

Evans of IU Health has been in the opposite position. He was chairman of the board of Methodist Hospital when it merged with Indiana University Hospital and Riley Hospital for Children to form Clarian Health on January 1, 1997. Clarian officially rebranded as Indiana University Health on January 24, 2011.

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Progress Toward a Consumer-driven System

Evans: "Consumers have come a tiny way to becoming more informed because it is hard to get information." He cites the difficulty of shopping for health care compared to a car, the latter featuring easier access among other advantages. "We have more and more transparency on price but it's not like the price of car where you can get an **exact quote**. I'm the CEO and I cannot get an exact quote."

Gutierrez: Baby Boomers "have a tremendous opportunity between technology and consumer-type behaviors to partner in their care most effectively. For the Medicare population, they're going to benefit from navigators. For the poor, it's a function of going into their communities and doing enrollment. Right now, hospitals spend a lot of time enrolling patients in Medicaid when they're on a stretcher in the emergency room. We need to move enrollment into the communities."

Lee gives an example of a program in which Anthem reached out directly to consumers (if physicians didn't refer patients to the highest-valued locations for certain scan services). "Within two months of launching that program, essentially every hospital in the nine-county area where we first piloted it had reached out to my team to at least discuss potentially lowering their rate of reimbursement for MRI and CT scans. It showed what the power of the marketplace could potentially do."

Lee also believes that technology and its tools "will play very nicely into consumerism."

Caponi: "We definitely have more informed consumers and I think the Internet has helped that. High deductible health care plan patients and families are not as insulated from costs as they once were."

Griffey says she sees the blank stares on employee faces during health care benefits meetings. "We don't have enough of them engaged yet in the process. The consumer really has to take more responsibility."

Time for a Health Care 'Model T'

Providers Testing the Waters

By Charlee Beasor

When Henry Ford introduced the Model T in 1908, he made quality, affordable motorized vehicles widely available to Americans.

The Ford Motor Company revolutionized transportation.

Medical providers are trying to figure out how to do the same thing with health care: revolutionize the system. The goal is to provide good quality care for a lower cost.

In Indiana, two major health systems and six regional hospitals are partnering to change the health care model from one that "rewards illness" to one that educates and prevents chronic diseases and hospital trips, "rewarding health" instead.

To achieve this, forming a yet-unnamed accountable care consortium (ACC) are Community Health Network, St. Vincent Health and six hospitals in the Suburban Health Organization network: Hancock Regional Hospital, Hendricks Regional Hospital, Henry County Hospital, Johnson Memorial Hospital, Riverview Hospital and Witham Health Services.

"In the past, where we have been a volume-based type business – the more you did the more you got paid – it's not sustainable," maintains Vince Caponi, CEO of St. Vincent Health. "This takes a look at turning things on its ear … how do we keep patients out of the hospital, healthier and manage these populations?"

The accountable care consortium will focus on prevention and keeping patients out of the hospital. The new model will include caregivers from St. Vincent Medical Group – Dr. Amanda Beach is shown – as well as those from Community Health Network and six regional hospitals.

Building the chassis

Though accountable care consortium might sound similar to the federal Affordable Care Act, it is not related to any federal government initiative. The federal plan does include a pilot program of accountable care organizations (ACOs), but those are sponsored by the Centers for Medicare & Medicaid Services (CMS) Innovation Center and include Medicare patients specifically. The Franciscan Alliance has emerged as the first pilot ACO in Indiana.

"What we're talking about doesn't have anything to do with the government plan," contends Bryan Mills, CEO of Community Health Network. "Part of the reason why we call it a consortium is to separate the definition (from the federal ACO)."

Caponi explains that the federal plan wasn't a correct fit at this time, but there might be pieces considered in the future.

"There are some opportunities for us to take a look at Medicare Advantage, different parts of the Medicare population, contracts where we're already at risk. … But that's not where we've decided we're going to start," he describes.

Hancock Regional Hospital CEO Bobby Keen points to how federal reform is "realigning incentives in health care."

"CMS has said, 'We're going to pay you based on value … if a patient comes back into the hospital in the same 30 days with the same diagnosis they had, you're not getting paid anything,' " he states.

Firing on all cylinders

An integrated health information system and standardized care protocols across the board are two big pieces of the ACC. The integrated health information system would allow all facilities to access a patient's records.

"The next step is a regional system, and regional systems being connected at the national level. In the end, the primary objective is to improve quality and reduce cost," Keen offers.

Physicians at all facilities are working to determine the best standards of care for all of the consortium partners, particularly in regard to chronic illnesses, such as diabetes.

"It's invigorating to me, as we've gone to our physicians and other various leadership. There was immediate buy-in," Mills emphasizes.

Standardized care protocols and adapting to new best practices is where Keen expects to see "the biggest bang for the buck," particularly when transferring patients among facilities.

"If we have to transfer a patient to Community or St. Vincent, there will be better communication in that handoff, better (communication) between doctors," he notes. "Just a much better integrated system where everybody knows what's going on."

Keen recalls a time when a chronically-ill patient experienced all of her care providers in the hospital room at one time.

"As I turned to walk out of the room – the patient had destroyed her lung capacity because she'd smoked all her life – she was gasping for air and the team was there with her. They told her what was going on with her. She, with tears in her eyes, says, 'I have never had care like this,' " he remembers.

"It's driving us. We needed to have a boot in our rear end. It is driving us to be very much more attentive to what we need to be doing."

Routine maintenance

Reducing Hoosier health risks are key objectives for the ACC. Much of this will start in each hospital's "own backyard" by targeting employee health and insurance costs.

"We know we're a large employer like anybody else. … We find that a large percentage of health care costs are being consumed by a small number of people," Mills asserts. "One percent of our enrollees account for 22% of our claims cost."

"We've got to forget about the competition and do what's right for the patient and health care," says Hancock Regional Hospital CEO Bobby Keen. "We've got to get our costs down. I think in the end the patient will be the big winner."

Assessments for employees and insured dependents are necessary to gauge current health status. One example is buying insulin for diabetic employees to make sure they follow through with treatment and avoid serious health costs down the road.

"We provide insurance, attract and retain the best people, offer benefits for employees and family members," Caponi notes. "But at the same time, we've been unwilling – at least in the past – to begin to say, 'We've got to be as thoughtful around our health insurance program as we would anything else.' "

Employees want to be healthier, he adds.

"It's interesting to me, any time we bring in health counselors or coaches, the level of interest there is. People are looking for good information and a support system – navigation to live healthier lives," Caponi affirms.

Rolling off the line

The ACC has hired a CEO (at the time of this writing, the name had not been announced) and Caponi explains that getting the new model into place and support built around it is important. He lists expansive geographic coverage and widespread commitment as being among the next steps.

"They (leaders, board members and others within the systems) know things will have to change. There is accountability to this. We've got to make those changes; it's the commitment of a lot of people," he conveys.

Mills notes that this new model is a work in progress.

"We've got the current way of doing business happening every minute in our facilities. We are creating the future – a new entity, funded one-third, one-third, one-third. The governance is the same way. We've collectively hired this new person to come in and create models for the future. At the same time, we'll continue to do the business we're doing, but in the new model and outside the current," he comments.

They've got "more than enough work to do for the next four or five years," Caponi notes.

"In the short term, we want to get it up and going. We've got a short-term agenda of things we want to do, so much to learn to try to predict what's going to happen. … We do know we've got to do it differently – more health oriented, less care oriented, in terms of in-patient care."

Resources: Bryan Mills, Community Health Network, at www.ecommunity.com

Vince Caponi, St.Vincent Health Systems, at www.stvincenthealth.org

Bobby Keen, Hancock Regional Hospital, at www.hancockregionalhospital.org

Hospitals

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"I was the guy who gave the keys away. There was a lot of opposition but it took a select few to say this was better for the community," he recalls. "I understand the feeling that somehow I've diminished my role (for those in smaller communities today that join forces with IU Health)."

IU Health has hospitals from Elkhart County in the north to Orange County in the south. It covers most metropolitan areas in the state, Evans relates, with a few exceptions. He cites the statewide footprint with the vision of "one standard of care everyplace all the time" and the opportunities provided by the affiliation with the Indiana University School of Medicine as game changers.

"The general feeling is that health care providers, hospitals and others can't go it alone. There's some hand wringing going on. As the state's academic medical center, we're a logical (partner) to have that first conversation with," he contends.

"This is Richard Florida's creative community, right here. We bring people here from all over the world. When local communities see the whole package – education, research and the size (benefits), I won't say it's a no-brainer, but it's powerful draw."

Keys to success

The St. Vincent system was formed in the 1990s with Caponi coming on board in 1998. Partnerships and expansions

Quick Hits: Federal Reform Impacts

McLin: "Our focus going forward is to look toward improving our efficiencies, reducing our costs while providing the same level of quality care. For us, that's a five-year plan to try and get to the point of break even with Medicare and Medicaid. That means looking to enhance reimbursement or reduce costs by a total of 20% over those five years."

Newbold: He also sees a need to move toward a "Medicare-like fee structure," adding, "There are numbers in the Medicare program that only about 13% of Medicare beneficiaries account for about 69% of all the Medicare costs. That means if you can target those 13%, you may be able to reduce the growth of expenses and costs in the Medicare program. We've never been paid to do that and that's what some of these new payment methodologies are intended to do – create some incentives to begin to coordinate care and lower the cost of care, particularly for the high users in the Medicare program."

For individuals, Newbold expects the insurance exchanges "to look a lot more like GEICO or AFLAC than what we've been expecting from employers. A lot of consumers are going to be buying health insurance like they're buying homeowners or car insurance – they're going to buy it online."

Kinyon: "We have hired people who have worked in industry who have been educated in lean technologies and lean tools, and taught them more about how health care works. If you reduce the variation, you can decrease your wastes and costs and also help stabilize your outcomes."

Caponi: "As we look to the future, we feel we have to reduce our expenses somewhere between 15% and 20%. That's just to play. You're going to need a lot of courage. This is totally changing the industry."

Gutierrez: "Health care cannot occupy 18% of the gross domestic product. It is just too big a barrier to overcome. Our industry realizes this, government has acknowledged it and the ACA, I think, is going to be just one of many pieces of legislation that are going to continue to affect our industry."

Griffey: "It's going to be a long process. The learning curve for the average consumer is probably going to be painful for some. I don't think even the government believes it (reducing costs) is going to be overnight when they do Medicaid funding cuts for the next 10 years. That's a pretty good beginning as a rough estimate on how long it might take to turn this ship in the harbor."

Many of those interviewed cite the "sea change" for providers being compensated for value instead of volume with incentives for wellness and prevention. Evans terms it "population management. We have to manage the health of the community."

have been on the fast track ever since. Today, it has 22 ministries and serves more than half of the state's counties. St. Vincent Health is sponsored by Ascension Health, the nation's largest Catholic health system.

Caponi uses the acronym TILE – talent, information, leverage and execution – to describe the keys to future success. With the accompanying belief that "variance is always the enemy of quality" on the clinical side of the equation, all the elements are enhanced by not just being in a larger system, but the "right system."

"First and foremost, to be successful, you have to attract and retain the best talent that you can. Second, we have a lot of data points but we don't have a whole heck of a lot of information. You've got to be able to get that data to the decision-maker, in this case the clinician, at the time they're seeing the patient and making those decisions. Great information after the patient's been discharged and gone home isn't of much use.

"In any business in which you're getting paid less and the accountability has increased and the cost grows so exponentially, there's going to be great consolidation and you're already seeing that," Caponi continues. "In that consolidation, how do you leverage it? Having size, scope, locations and access points are absolutely critical.

"The last item you're going to need to be successful in the future is you're just going to have to flat out execute. I believed that a year and a half ago when I wrote it (TILE), and I believe it even more so today."

More to come

Saint Joseph Regional Medical Center is part of Trinity Health. In October 2012, Trinity and Catholic Health East announced an intention to join forces. The consolidation would result in a system that serves people in 21 states through 82 hospitals, 89 continuing care facilities and more than 87,000 employees.

Gutierrez, a licensed radiologist who has been in health care since 1974 and recently completed his second year in Indiana after a lengthy career on the East Coast, cites three major size

Al Gutierrez of Saint Joseph Regional Medical Center, shown speaking at the dedication of the hospital's 9/11 memorial in March 2012, believes today is the "peak of the clinical technology" in the medical profession. He worries, however, that "we can no longer afford that technology."

advantages. They include the "speed at which clinical practice guidelines are deployed throughout our entire healthy system nationally, being able to get to cost points that wouldn't be achievable in smaller systems (the consolidation will result in a $13 billion corporation) and advocacy, our ability to understand national policy."

Like his colleagues, Gutierrez firmly believes that reform only enhances the "bigger is better" philosophy.

"If you're a smaller system or stand alone, it's going to very difficult to get there based on the revenues we are going to be receiving in the future. There will be further proliferation of consolidation. The theme of 'organize nationally but execute locally' is kind of our mantra."

"We have always been praised for that personal service. You don't get lost here in the shuffle; you are taken care of differently in a small facility because there are just fewer people."

– Kelly Dunham
DeKalb Memorial Hospital

In the same market as Saint Joseph Regional, South Bend-based Memorial Hospital and Elkhart General Hospital came together as two equals in November 2011. Each maintains its name and brand, with Beacon Health System the moniker for the parent structure. While expanding clinical services and recruiting physicians were at the top of the priority list for the merger, Newbold adds that there were $14 million in largely administrative savings (information technology, human resources, marketing, etc.) in the first year.

In addition to the Catholic system "mega-mergers," he shares that, "We will continue to see providers coming together and part of this is to realize the advantages of scale and access to capital markets – being able to borrow capital and have access to capital. Regional systems, like what we're developing here and more like what IU Health has, are what many of us think is a very successful model for the near-term future."

Another major change for hospitals is the increased management of physician groups.

Bringing it all together

Anthem's Lee agrees theoretically with all the advantages cited by the hospital leaders. He adds that larger systems can also help drive the conversion to electronic medical records, a very significant investment for all hospitals and physician groups.

A caution, however, is that while "you would hope consolidation would bring efficiencies and standardization that ultimately result in improved quality of care, the reality is that standardization is much easier said than done."

Evans did concede that integrating partners into a system of care is the No. 1 challenge of growth. Caponi says patient "handoffs" from one health care facility to another are where inefficiencies potentially occur. While in-system transfers at St. Vincent are "much better … it needs to improve even more."

Speaking not about Indiana specifically but in addressing the never-ending compensation discussions between hospitals and insurers, Lee points out the following:

"In general, within business, competition is good, at least for the consumer as it typically results in lower prices. Hospital consolidation has the potential to reduce the number of competitors, which could in turn drive up the costs for goods and services. When we look historically nationwide at hospital acquisitions, it generally has shown that it drives up the cost of services in those areas. From the insurance standpoint, the result is as hospitals consolidate, it gives those hospitals a greater negotiating leverage."

The Heritage Foundation's Haislmaier is of the opinion that hospital system size is "not inherently good or bad," but that the entire health care model ("a procurement system instead of being driven by consumer choice") is broken and the federal reform that is playing out will only make the situation worse.

"Even among people who should know better, the attitude is that the way to control health care costs is to get bigger. And I'm fundamentally skeptical about that. You see this on the employer and insurer side – we've got to get bigger and go beat up the providers. And the provider side, to push back, we've got to get bigger so they have to take our prices," he argues.

"Regional systems, like what we're developing here and more like what IU Health has, are what many of us think is a very successful model for the near-term future."

– Philip Newbold
Beacon Health System

"The legislation not only doesn't do anything to undo that, but in some ways actually encourages more of it. You don't see that in consumer-driven markets, where size is a function of efficiency and consumer choice." He adds that Apple got to be Apple because it provided a better product at a better price, not because it bought in bulk.

That same model, according to Haislmaier, prevents what he considers would be a positive tiering of doctors and hospitals – similar to what is done with drug co-pays.

"But they're (insurers) not doing it. Why not? Because that's not who their customer is. Their customer is the employer. It's a lot easier to just beat up on doctors and hospitals, or deny enrollees something, as a way to control the cost for your employer customer or the government in the case of Medicaid or Medicare. That's the fundamental structural problem I see in the system."

What will be the results of reform 18 months from now?

"It will be a mess at that point. The provider and delivery market isn't going to change much. If you go further out, if you're looking five, six, seven years down the road, then I see market segmentation and I see stratification based on income," Haislmaier concludes. "The exchanges and the standardized coverage start to collapse into something like Medicaid. As the costs go up, more and more people on the upper end pay their health care freedom tax and they opt out.

"Ten years down the road, I'm looking at a radically bifurcated market both on the consumer and provider side. The bottom half looks like Medicaid and top half looks like consumer-driven care on steroids. With primary care, you will either be a galley slave to an accountable care organization model or you're going to say 'the hell with this' and go to concierge – I prefer to say retainer – which is quite affordable for the vast majority of the middle class."