

# **Building the Accountable Enterprise Through Care Redesign**



**The Case for Well-Timed**

# Care Redesign

right care  
right time  
right setting

*The health care industry has dabbled at the edges of process improvement for decades. Yet it remains plagued by skyrocketing costs and poor quality rooted in inefficiencies across the care continuum. Misaligned incentives are partly to blame. Public and private payers now seek to upend the payment models that have promoted overuse and poor coordination. Rather than rewarding volume, they are moving increasingly toward risk-based contracts that incent efficient service use, lower costs and higher quality.*

Incremental improvement initiatives will be insufficient to meet the demands of a value-driven health care marketplace. As payment incentives evolve market by market, provider systems must implement innovative approaches to care delivery to ensure their performance keeps pace. But care redesign cannot be pursued in a vacuum. Both its timing and focus must be tailored to market factors and institution-specific characteristics.

Targeted care redesign will take varied forms. Some organizations will continue to rely most heavily on minimizing costs and variation; others will take aim at unnecessary or inappropriate care rampant within services positioned as most crucial to their strategic plan. Restructuring where care is provided and by whom as well as implementing an infrastructure that promotes wellness and prevention will represent even more progressive redesign initiatives.

The necessity for care redesign is not in dispute. An organization's readiness to pursue specific redesign efforts is another issue entirely.

And a lot is at stake. Moves that are out of sync with changing financial incentives risk both margin and market position. Furthermore, effective care redesign will enhance patient engagement, in turn reducing system leakage, growing market share and improving overall performance.

In this publication, Sg2 details 4 categories of care redesign and examples of potential initiatives for each. We then provide a decision framework that planning teams can use to guide their approach to care redesign. This includes the institution-specific and market factors that must influence the direction of redesign efforts; scenarios showing how prioritization may vary based on these factors; and a final checklist to guide the process.

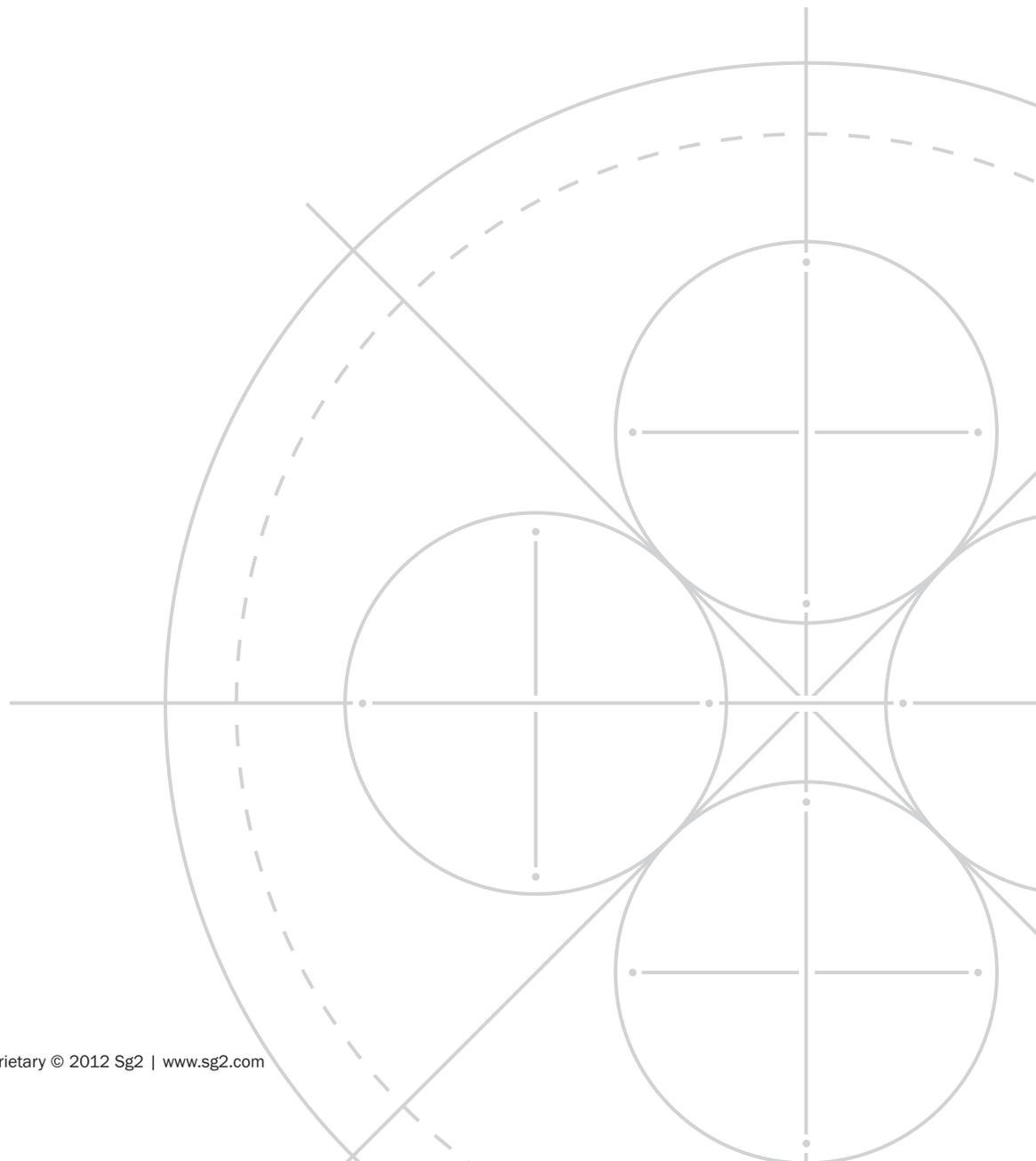
In the end, provider organizations will be evaluated on the quality of care they provide with the goal of ensuring that each patient receives the right care, at the right time, in the right setting. They cannot get there without a customized approach to care redesign.

# Investigate the Variety of Redesign Approaches

Effective performance strategy supports and informs provider systems' strategic direction. Care redesign then becomes an essential ingredient to execute on goals established in the strategic plan. Wisely implemented, it can:

- Improve outcomes as measured by quality metrics
- Decrease costs of the encounter and episode and, ultimately, the total cost of care
- Increase patient engagement and satisfaction

Yet, there is no one-size-fits-all approach. Redesign efforts must be shaped to reflect both the value sought (quality over cost) and the execution risk (eg, financial, competitive, cultural) involved in one type of redesign project vs another.



Four variations cross the care continuum, influencing the patient encounter from the pre-acute to the post-acute phases. There is fluidity across the 4 redesign elements; some components of the various approaches cross categories. To some extent, skills built in one lay the foundation for the next, and the impact on the organization ultimately is cumulative. Even so, recognizing what there is to gain from each unique element will be leadership teams' first step in logically selecting initiatives and allocating resources needed for implementation.

### Variance and Cost Reduction

Improving operational efficiencies

### Unnecessary Care Reduction

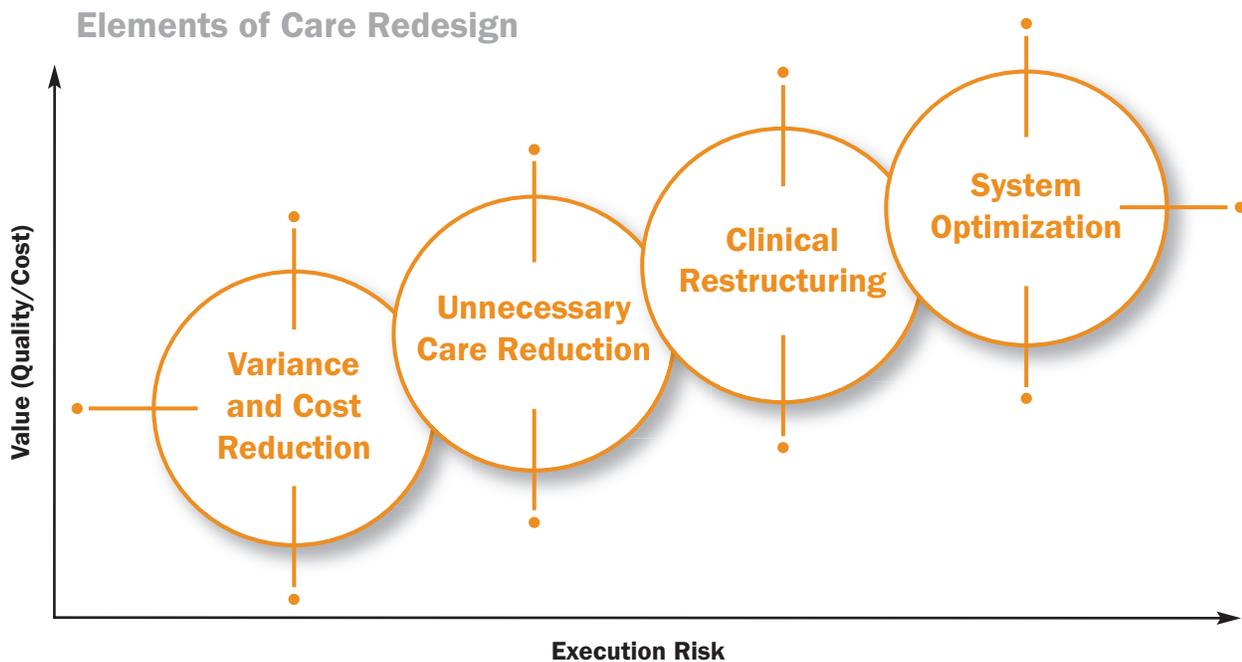
Decreasing avoidable, unproductive and duplicative services

### Clinical Restructuring

Ensuring treatment occurs in the optimal setting with the most appropriate level of provider

### System Optimization

Shifting focus to upstream, preventive care through clinical integration and population health management





## Elements of Care Redesign

# Variance and Cost Reduction

Health care quality and costs vary widely. Significant variance has been well documented in services ranging from diagnostic tests to procedures to rehabilitation. Even a cursory look at cost per case or length of stay (LOS) benchmarks shows the range.

Public payers have taken aim at this variance as proof of the potential to improve health care value. Individual institutions have also sought to rein in outliers within service lines and across the system.

Efforts to curtail costs and variance have underpinned performance initiatives for decades; large-scale full-time equivalent reductions and negotiation of supply chain costs have dominated the acute care-focused agendas of many performance departments. Now, heightened payment pressure and evolving risk-based models bring new urgency and demand for a more expansive view of these initiatives. Variance and cost reduction are central to remaining competitive and financially sound in any market, regardless of whether that market is still grounded in a fee-for-service (FFS) world or on the forefront of new payment models.

### Data Snapshot: Sg2 Comparative Database

Key Metric (Direct Cost)	Standard Performer	Strong Performer	Top Performers
Lumbar/Thoracic Fusion MS-DRG 460	\$20,750	\$18,539	≤\$15,899
Cervical Fusion MS-DRG 473	\$10,142	\$8,565	≤\$7,754

Note: **Standard Performer** indicates the median hospital in the Sg2 Comparative Database; **Strong Performer** indicates the hospital at the 75th percentile; **Top Performers** are those in the 90th percentile or higher. MS-DRG = Medicare severity diagnosis-related group.

### Examples

- **Supply chain costs:** Renegotiate contracts with implant suppliers for total joint cases.
- **Administrative and facility overhead costs:** Ensure they align with softening inpatient volumes.
- **Turnaround times:** Place chemotherapy patients in chairs only once ready for infusion; conduct administrative tasks in a separate area.
- **Emergency department (ED) triage of asthma patients:** Partner with pulmonary and ED physicians to ensure use of a standardized clinical pathway for all asthma patients after triage.
- **Staffing and productivity:** Target national benchmarks based on patient acuity, unit of service.

### Sample Analytics

- **Clinical variation data by provider or disease:** Orthopedic surgeons' costs per case
- **Margin mix:** Service line assessment of payment vs average cost
- **Labor effectiveness/appropriate staffing:** Worked hours per patient day in the medical intensive care unit (ICU)
- **Supply cost analysis:** Efficiency pricing and supply standardization data for trauma supplies

### Potential Hurdles

- Inadequate data capabilities
- Existing vendor relationships
- Physician resistance
- Lack of sustainable cost-cutting processes
- Safeguarding quality while cutting cost



Elements of Care Redesign

## Unnecessary Care Reduction

Breakdowns in current care delivery often result in unnecessary care. This includes clear-cut overutilization, such as duplicative imaging studies that occur when providers in separate care sites fail to coordinate their orders. However, costly readmissions—resulting from poor discharge planning, inadequate primary care physician (PCP) follow-up and limited health literacy—also are a prime focus of this redesign category. Postdischarge clinics and nurse navigators can help limit readmissions. But provider systems will be challenged to move beyond these Band-Aid solutions.

Penalties levied by private and public payers, combined with the rapid rise of tiered networks, will drive providers to more aggressively and innovatively target unnecessary care.

### Data Snapshot: Sg2 Comparative Database

Key Metric (Readmission Index*)	Standard Performer	Top Performers	Stretch Goal
Total 30-Day	1.01	≤0.74	≤0.57
CHF	1.28	≤0.93	≤0.75
Diabetes	1.02	≤0.63	≤0.44

### Examples

- **Early advanced imaging for low back pain:** Implement clinical decision support tools to ensure compliance with medical necessity guidelines.
- **Daily blood draws on inpatients:** Move toward phlebotomy based on clinical necessity, rather than routine daily testing.
- **Prostate cancer screenings:** Provide physicians and elderly male patients with educational material that facilitates discussions about the lack of evidence to support screening.
- **Congestive heart failure (CHF) readmissions:** Combine strategies focused on discharge planning and transitional follow-up care for greatest impact.

### Sample Analytics

- **Evidence-based clinical criteria/utilization review:** Compliance with inpatient admission criteria for cardiac ICU
- **Mandated quality analysis:** HAC rate per 1,000 oncology patients
- **Diagnostic appropriateness:** Percentage of patients treated conservatively prior to MRI for low back pain
- **Readmission analysis:** Readmission rate for pneumonia patients discharged to SNFs

### Potential Hurdles

- Weak relationships with PAC providers
- Slow development and diffusion of clinical effectiveness research
- Lack of physician leadership to evaluate utilization across the System of CARE
- Access issues
- Poor care coordination among providers

\*The Readmission Index is risk adjusted and calculated as actual rate/expected rate. Expected rates are adjusted for age, comorbidities and primary diagnosis to ensure adequate comparisons based on variable patient populations.  
 CARE = Clinical Alignment and Resource Effectiveness; HAC = hospital-acquired condition; MRI = magnetic resonance imaging; PAC = post-acute care; SNF = skilled nursing facility.



## Elements of Care Redesign

# Clinical Restructuring

The who and where of care delivery are major cost drivers. Numerous trends have hamstrung efforts to wring cost out of the system, such as soaring physician-to-physician referral rates, failure to deploy midlevel providers widely enough and even the industry's overreliance on the acute care setting.

Moves into bundled payment (either for acute care only or for a full episode), as well as steps toward managing a patient population's total cost of care, will require newfound energy to reverse these trends. Only by restructuring the clinical experience will provider systems be able to substantially cut costs without compromising patient outcomes.

### Data Snapshot: AAPA Census

#### Most Common Practice Setting for Physician Assistants (2010)

Single-specialty physician group practice	<b>26%</b>
Solo physician practice	<b>15%</b>
Hospital IP unit*	<b>14%</b>
Hospital ED	<b>14%</b>
Multispecialty physician group practice	<b>12%</b>
Hospital OP unit	<b>11%</b>
Hospital OR	<b>8%</b>

\*Not including ICU/critical care unit.  
Source: AAPA. 2010 Annual Physician Assistant Census Report.

### Examples

- **Transfer plans:** Identify patients on admission day 1 or 2 and initiate necessary discharge processes to ensure timely step-down from acute care to SNF beds.
- **Pharmacist utilization:** Capitalize on the full extent of their licensure by charging them with managing the medications of patients with chronic conditions.
- **Early palliative care assessment:** Establish protocols for palliative consults across the inpatient setting.
- **Observation units:** Devise a process to appropriately triage patients with chest pain and other hemodynamically stable cardiac conditions to an observation unit rather than an inpatient admission.

### Sample Analytics

- **Site of care cost and payment data:** Margin analysis for CHF patients in observation vs inpatient status
- **Low-acuity access modeling:** Assessment of patient options for care of musculoskeletal conditions after hours/during weekends
- **Rate of primary care referrals:** Referrals to dermatology for simple skin conditions, such as acne

### Potential Hurdles

- Current regulations and benefit coverage limits (eg, a 3-day acute stay required within 30 days as a prerequisite for SNF Medicare coverage)
- Lack of human capital planning and staff education to redirect scarce staff resources to diverse care sites
- Capital investment to leverage technology across the system
- Physician resistance
- Limited access to PCPs/post-acute care
- Insufficient professional infrastructure

AAPA = American Academy of Physician Assistants; IP = inpatient; OP = outpatient; OR = operating room.



Elements of Care Redesign  
**System Optimization**

Many industry initiatives today aim to push provider systems to assume much broader accountability for the overall health of their communities. Greater emphasis on prevention, as well as work to build an enabling infrastructure, are core elements of system optimization initiatives. Ensuring upstream care and education needed to curtail chronic diseases, systematically tracking utilization and outcomes, and improving care coordination across providers and settings all constitute valuable work at this level.

Effectively executing on these components will be essential for organizations already assuming global risk for their patient populations through shared savings programs (eg, ACOs) and fully capitated contracts. Even in markets where payment models are not quickly evolving toward risk-based contracts, providers must begin to understand this care redesign element and be positioned to move forward as their specific market and institutional dynamics allow.

**Data Snapshot: Sg2 Comparative Database**

Key Metric	Standard Performer	Top Performers	Stretch Goal
Potentially Avoidable Admissions for COPD	33%	≤21%	15%

ACO = accountable care organization;  
 COPD = chronic obstructive pulmonary disease.

**Examples**

- **Disease-based medical homes:** Ensure high-risk, chronic patients receive coordinated care through a centralized provider.
- **Patient engagement strategies:** Deploy video-based telemonitoring for homebound patients as a new avenue for face-to-face encounters.
- **Disease registries:** Create and mine registries for patients with high-volume conditions or procedures, such as those receiving artificial joints.
- **Screening rates:** Prompt patient compliance with physician recommendations for timely colorectal cancer screenings through use of innovative information technology (IT).

**Sample Analytics**

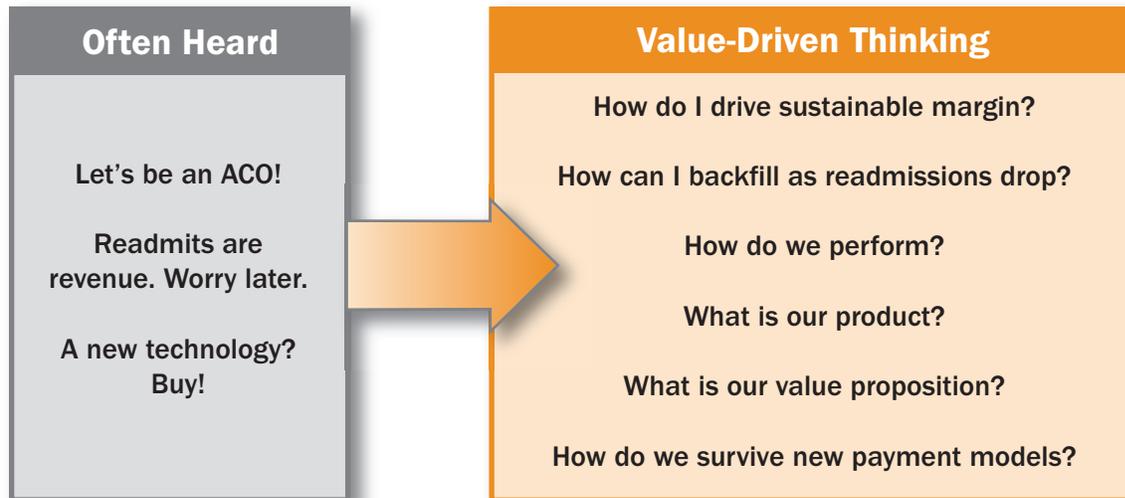
- **Patient and population health analytics:** Average annual cost of care for patients with diabetes
- **Personalized health plans:** Total monthly system utilization for patients with hypertension
- **PAC performance metrics:** Rates of readmissions and repeat ED visits from local SNFs for patients with CHF
- **Growth metrics:** Outpatient growth projections for patients with COPD

**Potential Hurdles**

- Lagging incentives for preventive care and care coordination
- Significant capital investment for a coordinated shared savings infrastructure
- Inadequate relationships with PAC providers
- Insufficient IT architecture

# View Customized Care Redesign as a Tool for Value-Driven Strategy

Care redesign initiatives possess the power to greatly elevate Value-Driven Strategy. They provide answers to many of the more nuanced questions that dominate this type of strategic thinking.



A deliberate approach to care redesign positions an organization to develop the competencies needed to address current priorities and to transition to new ones as they evolve. This begins with a few guiding principles:

**Anticipate change.** Care redesign will take different forms within and across markets. Careful selection and development of initiatives aligned with future market demands and financial incentives ensures they will not unnecessarily compromise financial margins today.

**Invest wisely.** Prudently allocate resources for the technologies, infrastructure enhancements, partnerships and human capital needed to implement care redesign. Allocation decisions must be based on projects' likely financial return, community benefit and alignment with the overall strategic plan.

**Reward innovation.** Recognize that cultural change is difficult, and allow for failure along the way to truly transform care delivery.

**Focus on quality.** Value creation is inexorably tied to quality and outcomes. Data transparency within a market will expand community and payer knowledge of comparative performance and care choices.

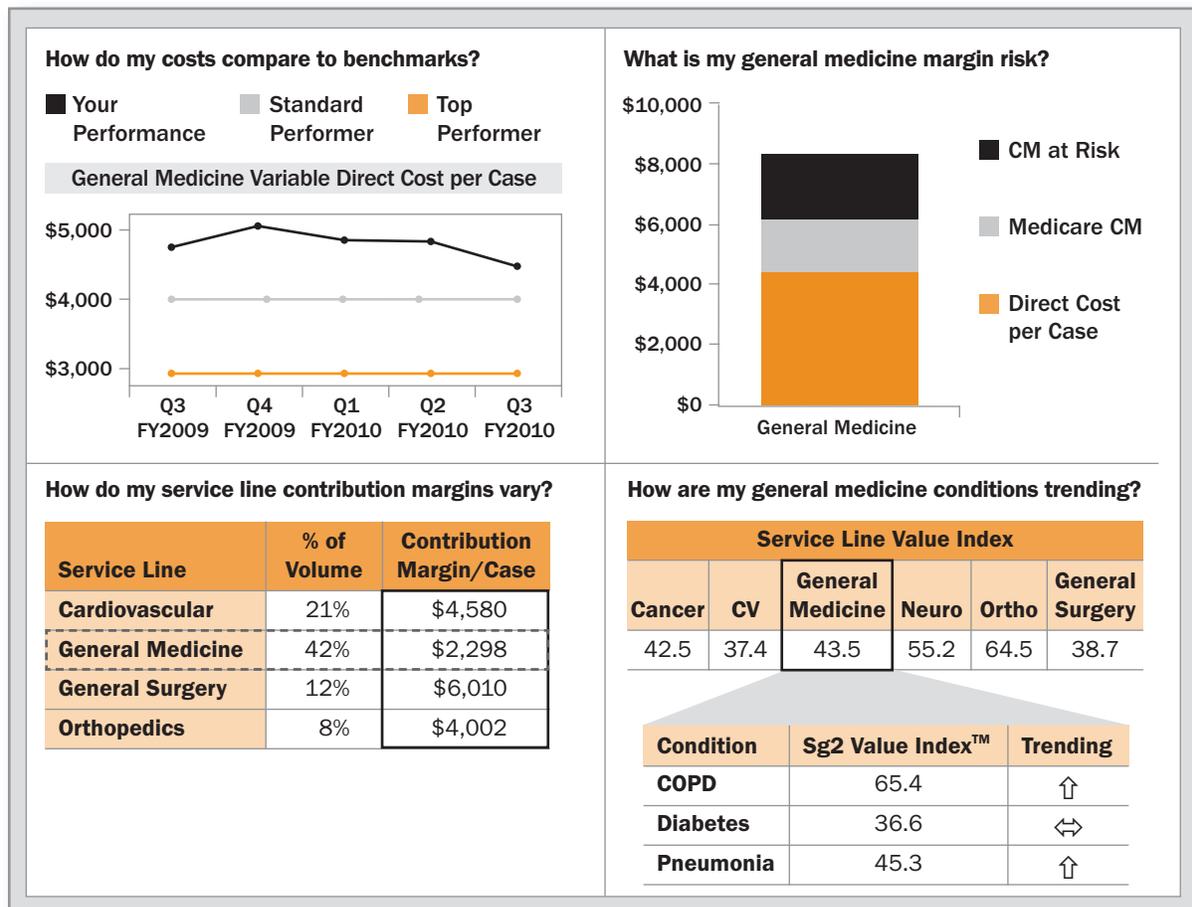
**Build the best team.** Consider the full range of staff members required for successful selection and implementation of each redesign initiative: strategic planning and quality personnel, facility planners, clinical leadership, and financial planners. Senior leadership support and clear communication of initiatives' goals will be crucial.

# Pinpoint Performance Opportunities via Data and 2-Part Decision Framework

To establish realistic goals in the strategic plan, robust performance data must first shed light on the current value and comparative ranking of the organization’s clinical services. Without this, an organization may launch initiatives that ultimately have limited impact on total value or that compromise margins essential for current financial sustainability. Mine databases to identify service lines, diseases and sites of care that:

- Provide negative or low margin
- Are actively moving from the inpatient to the outpatient setting
- Represent high-volume conditions
- Offer greatest performance opportunity
- Represent revenue at risk
- Show high variability across the hospital or clinical enterprise

## Sample Data



*This internal, data-driven approach is one part of the process. In the end, care redesign will not succeed unless initiatives are precisely tailored to institutional and market specifications. The following pages present a 2-part decision framework to enable organizations to prioritize initiatives based on these factors.*

CM = contribution margin.

# Decision Framework: *Institution-Specific Factors*

Numerous institution-specific factors influence the optimal direction and likelihood of success in advancing care redesign.



## Margin Management

Without in-depth understanding of high- vs low-margin services, redesign efforts could have unintended financial consequences.

- Do current margins indicate substantial opportunity for further overhead and/or direct cost reductions?
- Is there a strong cost-accounting system to enable leaders to more precisely target enterprise-wide cost reduction opportunities and assess potential margin impact?
- To what extent are current margins at risk due to penalties or looming payment cuts?
- What financial exposure would the institution face if it was paid only at Medicare rates for all contracts?

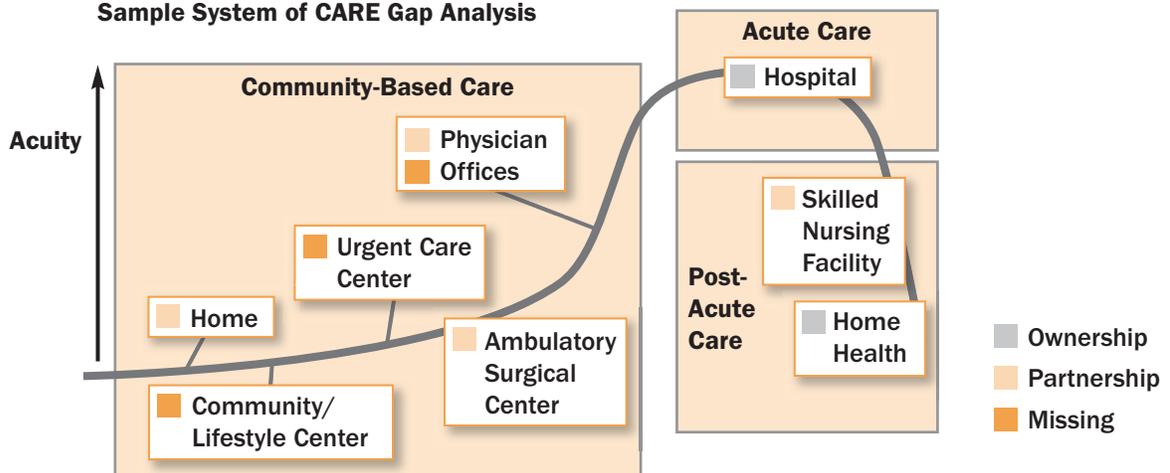


## System of CARE Strategy

Many redesign initiatives demand agility in navigating and assessing performance across both owned and independent sites that span the care continuum.

- Have inpatient volumes permanently softened to the extent that substantial unused capacity is possible?
- Is there adequate capacity beyond the acute care setting to pursue innovative care redesign? Is there a process in place to pursue strategic partnerships to fill gaps?
- How could care redesign efforts support ambulatory strategy?
- Is physician alignment strong enough to optimize community-based and post-acute care?
- Do metrics exist to track performance beyond the inpatient setting?

**Sample System of CARE Gap Analysis**





## Clinical Leadership

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A broad set of skills positions both clinicians at the point of care as well as those on the executive team to envision and deliver new approaches to care delivery.

- Is there recognition of the competencies needed to care for an aging, medically complex population?
- Does the institution have the right skill mix and competencies in the community and acute care settings?
- Do leaders have the skills and resources necessary to champion care redesign initiatives for this population?
- Is there a “culture of quality” within the institution?



## Innovation Competency

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Organizations already versed in traditional performance improvement and change management have a strong foundation from which they can effectively accelerate redesign initiatives.

- Does the institution currently focus solely on incremental innovations using Lean or Six Sigma concepts with the goal of optimizing processes? Or has it already taken steps toward disruptive innovation that could fundamentally transform care delivery?
- Does the organization employ a chief innovation officer?
- Do leaders have the experience and willingness to rethink financial incentives to better align them as needed to support new care delivery processes?



## Technology Assets

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Future success depends on provider systems’ ability to anticipate emerging technologies and strategically invest in those that will improve quality and differentiate services.

- Does the institution use a formal process to ensure adoption of technologies needed to remain competitive in areas essential for smart growth?
- Are high-cost clinical technologies vetted against future, disease-specific demand and impact on cost of care?
- Is there recognition of the equal importance of technologies needed for new care approaches: those designed to engage patients, share medical records, enhance provider communications and track performance?

# Decision Framework: Market Factors

Beyond institution-specific factors, shifts in the competitive landscape and the pace of moves toward new payment models also must be considered when prioritizing care redesign initiatives.



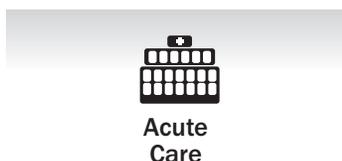
## Comparative Performance

Routinely benchmarking performance against that of competitors is essential with the heightened use of pay-for-performance incentives and tiered networks.

- Does the institution have an effective system for tracking such performance metrics as cost per case, length of stay, readmissions and patient satisfaction?
- Does the institution’s current performance qualify it as top tier in any commercial payer networks that may already exist in its market?
- Is it clear where performance outpaces or lags that of competitors for key services?

### Sample Comparative Performance Ranking

Hospital	Percentage Difference From Market Average			
	PQI	LOS Index	WAMAC	30-Day Readmits
Hospital A	-6.2%	-3.5%	-23.4%	-2.9%
Hospital B	13.4%	-10.2%	33.7%	-5.0%
Hospital C	-14.1%	12.2%	24.4%	1.0%
Hospital D	-6.2%	10.7%	9.6%	2.8%



## Smart Growth

Understanding historic and future trends in service demand enables organizations to identify their best growth opportunities and then initiate plans to ensure they can deliver the value to capture that growth.

- Is market share in the organization’s primary and secondary service areas locked in or shifting in particular services or care sites?
- Is patient out-migration impacted by patient satisfaction/engagement?
- Do opportunities exist in the tertiary market to enable a bigger share of total care, thus spreading any risk exposure in new payment contracts over a broader population?
- Which strategic partners are needed to respond to growth trajectories?

PQI = Prevention Quality Indicator; WAMAC = wage-adjusted, mix-adjusted cost.

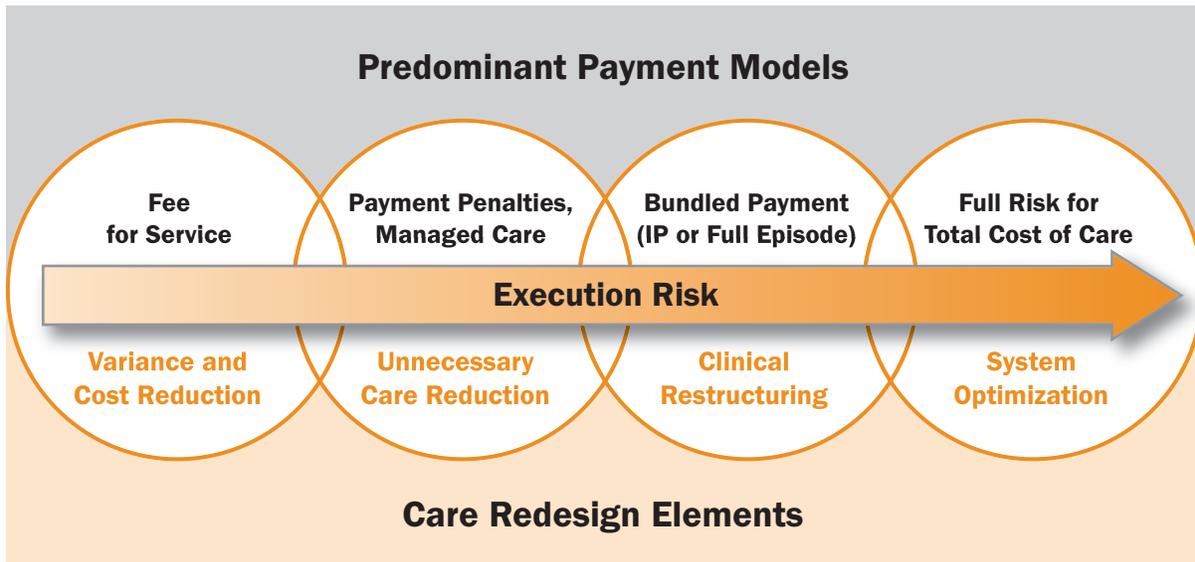


## Payment Evolution

The local market’s movement toward risk-based contracts also must be a key decision factor. To some extent, the varied elements of care redesign align with specific payment models. Over the course of the decade, business increasingly will be tied to metrics related to the total cost of care, outcomes and the patient experience. Increasingly innovative care redesign will be imperative to move the needle in each area.

- Can the organization project the local market’s readiness to take on risk?
- Does the institution’s current approach to care delivery and the value it delivers position it to thrive under new payment models?

### Alignment of Payment Evolution With Care Redesign



*Ultimately, there is no definitive formula for selecting an ideal care redesign approach. And the care redesign elements are not mutually exclusive. Organizations likely will need to simultaneously pilot varied redesign approaches based on the strategic goals of specific services or service lines. At the same time, an element of care redesign best suited to today’s landscape may not be the right fit for the future. Both short- and long-term redesign options should be considered. The scenarios on the following page suggest how such decisions could play out.*

# Consider Varied Scenarios to Guide Short-term vs Long-term Care Redesign

## Scenario 1

Strategic goal: Become the most efficient orthopedics provider in the region

### Institution-Specific Factors

- **Margin:** \$2,579 per case at risk if all cases were paid at Medicare rates
- **System of CARE:** Adequate IP capacity; limited community-based, post-acute sites and partners
- **Clinical Leadership:** Limited
- **Innovation:** Lagging
- **Technology:** Focused on clinical advances

### Market Factors

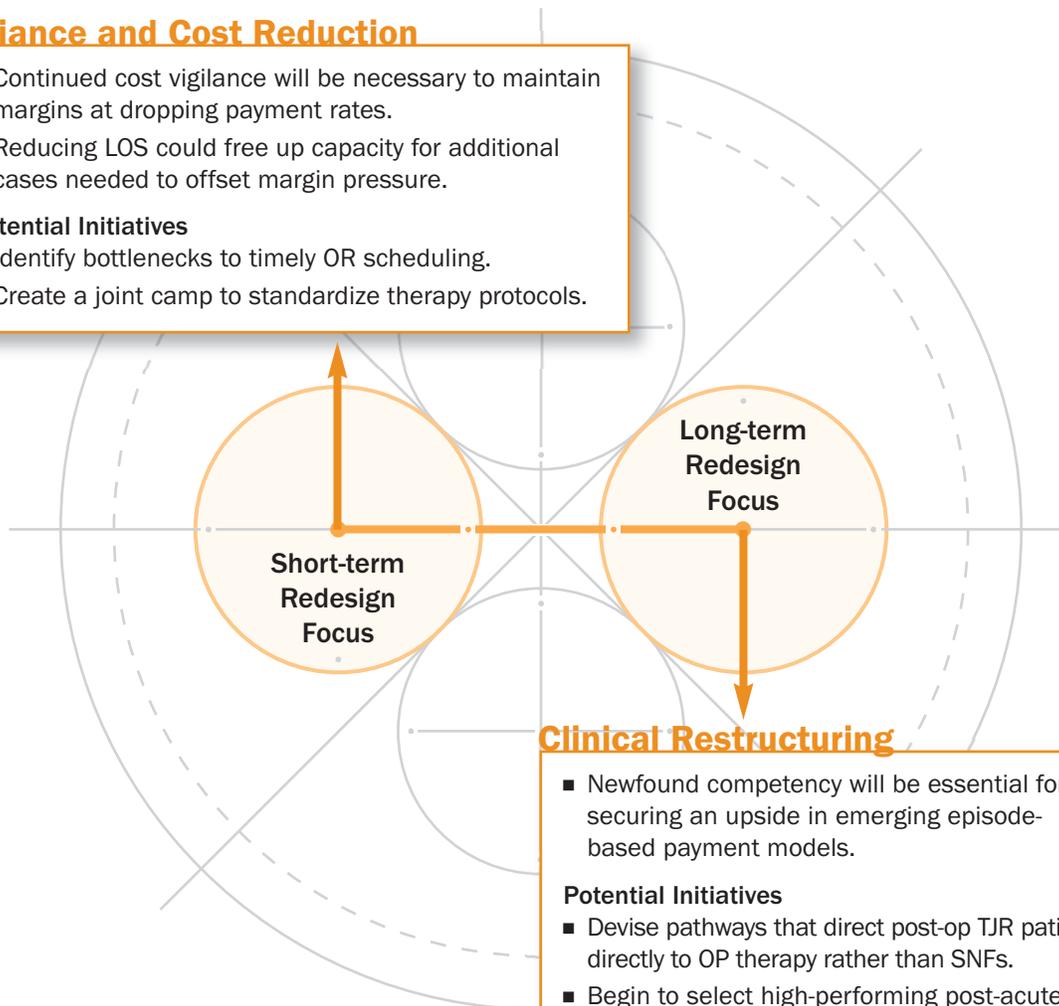
- **Comparative Performance:** Average
- **Growth:** Strong IP future demand
- **Payment:** Mostly FFS; major payers exploring bundled payment

## Variance and Cost Reduction

- Continued cost vigilance will be necessary to maintain margins at dropping payment rates.
- Reducing LOS could free up capacity for additional cases needed to offset margin pressure.

### Potential Initiatives

- Identify bottlenecks to timely OR scheduling.
- Create a joint camp to standardize therapy protocols.



## Clinical Restructuring

- Newfound competency will be essential for securing an upside in emerging episode-based payment models.

### Potential Initiatives

- Devise pathways that direct post-op TJR patients directly to OP therapy rather than SNFs.
- Begin to select high-performing post-acute partners.

TJR = total joint replacement.

## Scenario 2

Strategic goal: Increase market share of outpatient cardiovascular (CV) volumes

### Institution-Specific Factors

- **Margin:** \$2,015 per medical case at risk if all cases were paid at Medicare rates; \$6,758 per surgical case at risk
- **System of CARE:** Constrained IP capacity; limited community-based, post-acute sites and partners
- **Clinical Leadership:** Short supply of CV specialists
- **Innovation:** Lagging
- **Technology:** Limited IT infrastructure

### Market Factors

- **Comparative Performance:** Average
- **Growth:** Weak IP future demand
- **Payment:** Emerging bundled payment pilots for implantable cardioverter defibrillator (ICD) implantation; rapid market acceleration toward full-risk contracts

### Unnecessary Care Reduction

- Heightened emphasis of the CMS National Coverage Determination for ICDs will be necessary to limit payment risk.

#### Potential Initiative

- Develop an education program for referring physicians to reduce guideline discordance.

Short-term  
Redesign  
Focus

Long-term  
Redesign  
Focus

### System Optimization

- Success under total cost of care contracts requires aggressive efforts to manage chronic disease and to improve patient engagement in the ongoing care required after device implantation.

#### Potential Initiatives

- Implement an OP heart failure clinic staffed by midlevel providers to better manage chronic disease.
- Invest in remote monitoring technology to optimize home-based care.

# Prepare for Care Redesign

Based on results from the institution and market decision framework on the preceding pages, and congruent with the organization's strategic plan, senior leaders should be able to effectively determine the focus of care redesign and prioritize related performance initiatives. Some comprehensive redesign efforts may require a multiyear commitment. Leadership can use the following checklist to ensure effective performance strategy formulation.

## Institutional Assessment

- Identify diseases and/or service lines with: subpar performance, high cost or quality variability, low margins, and/or high levels of payment at risk from penalties.
  - Use the **Sg2 Value Index™** to easily generate the necessary reports.
- Map your **System of CARE**, both owned sites as well as areas maintained through strategic partnerships, to spot gaps in care delivery that could hamstring future care redesign.
  - Register for the Sg2U course, **Strategic Planning 2.0: Value-Driven Strategy**, to learn how to augment traditional strategic planning by layering in a value-driven imperative and new data.

## Market Assessment

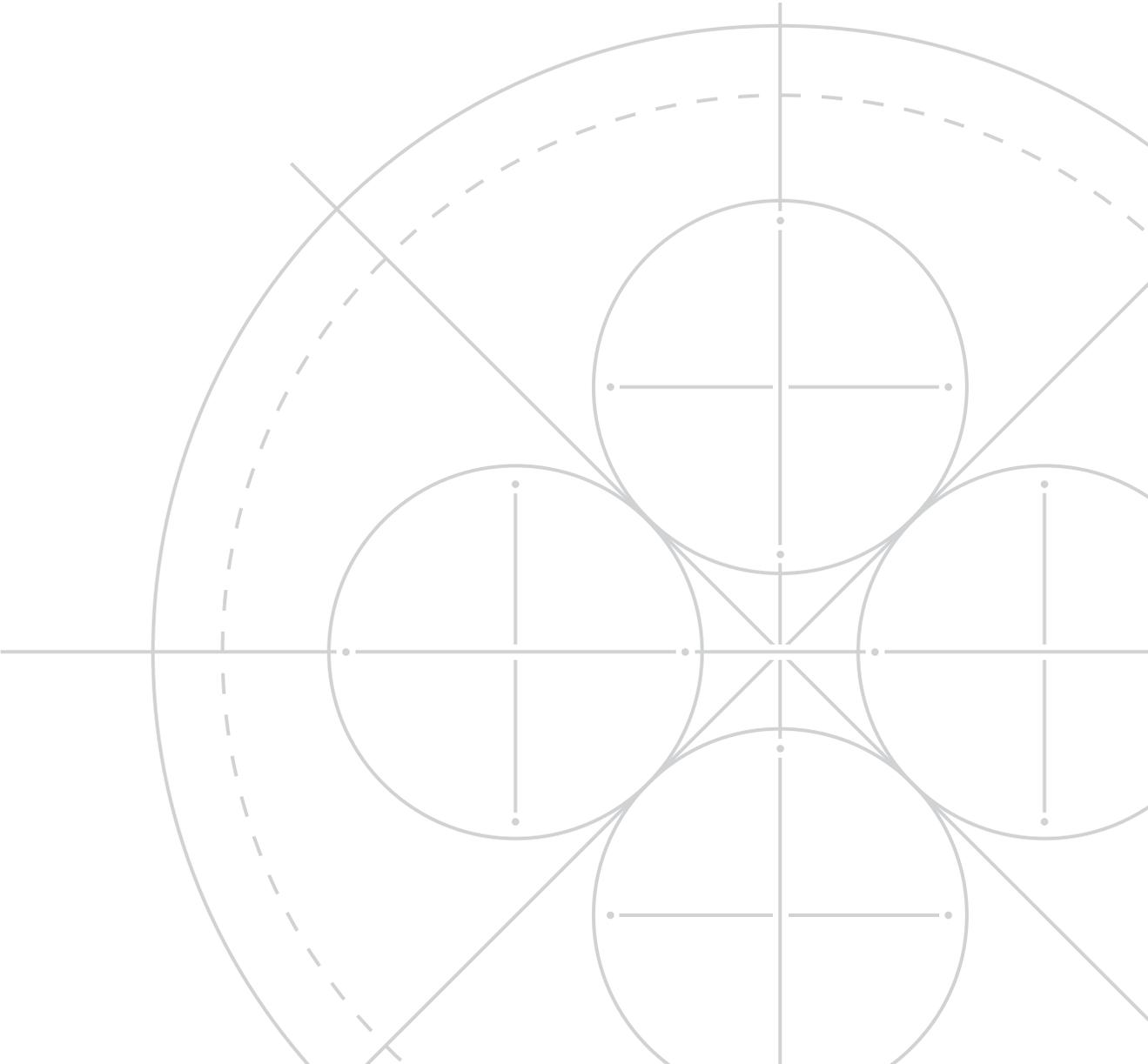
- Benchmark performance against that of competitors.
  - Use the **Sg2 National Performance Ranking** and **Market Performance Ranking** tools.
- Gather historical census data and match against projected service demand to determine future capacity.
  - Use Sg2's **Impact of Change®** demand forecast.
- Anticipate how quickly your market may move toward new payment models.
  - Refer to the Sg2 publication, **Preparing for Payment Evolution: Risk...Reward...Readiness**, for more information.

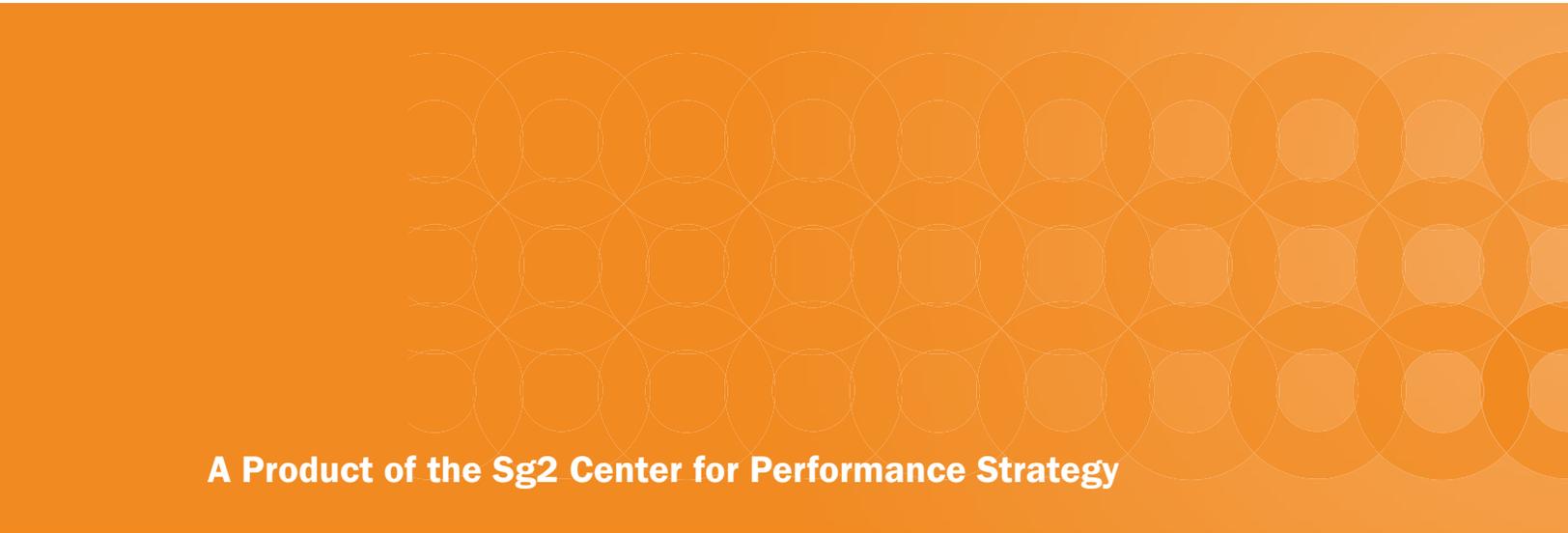
## Strategic Response

- Target efforts to specific services and/or service lines that are the focus of goals established in the strategic plan.
  - Identify the element(s) of care redesign that best aligns with your current competencies and short-term market dynamics.
  - Plan the logical progression of care redesign elements based on expected market evolution.
- Minimize execution risk.
  - Pilot small-scale performance initiatives, perhaps for a single disease.
  - Consider your employees as an effective laboratory for care delivery innovation.
  - Address potential hurdles at the outset: physician resistance, lack of sustainable process for change management, questionable leadership support, insufficient IT, weak performance metrics.

Note: Access to Sg2 tools listed above may vary based on your relationship with Sg2.

For additional intelligence on care redesign or related strategic analytics, call **+1 847 779 5500** or click on the Sg2 Analytics tab at **members.sg2.com**.





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## **Anticipate the Impact of Change**

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