So...How Do You Convince Your Hospital Leadership Your Idea is Best for Patient Care?
Mission, Quality, Cost, and Standardization

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I have no disclosures or conflicts of interest

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Thank you to the NPA!
Objectives: To understand why hospitals support certain initiatives; what are we looking for?

1. Review the national and local economic & political climate driving changes in healthcare
2. To understand relationship between quality and finance
3. To review the basic elements of a good business plan: Time to be a salesman!
4. Standardization: Why now?
5. Why is Dr. C’s program supported and sound?
6. Concluding predictions & remarks
Healthcare Weather Forecaster
Institute for Healthcare Improvement Triple Aim

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing health-care costs
Value Definition

Value = Safety + Quality Outcomes + Experience Cost
Transition from FFS to Value-Based Care

• **Value** = quality/cost or the focus of quality (patient outcomes, safety, experiences) and cost at the same time

• **Value-based**: reimbursement tied directly to quality metrics

• Medicare: 70% change from FFS to Value by end of 2018 -- *delayed now*!

• Medicaid follows Medicare; Commercial follows Medicaid \(\rightarrow \text{always}!!\)

• **Key point**: Paid on how well our patients do!
Transition to Value-Based Care

• **Perinatal/OB**: Elective & overall C/section rates, postpartum depression screenings, GDM screenings, readmission rates, and SSI

• **Neonatal**: LOS, CLABSI now and soon → CLD, ROP, IVH, inpatient testing utilization, benchmarked against region, state, & nationally

• **Hospital**: Number of employees/discharge; supply chain costs/discharge

• **Focus**: HAI, Pt. Experience and Readmission rates
Fee for Service → Fee for Value
ACA: Revenue decreasing faster than expenses

The Business Risk Between Volume and Value

Where is your organization in this transition? How do you expect this transition to play out in your market? How will you measure success?

![Graph comparing Revenue and Expenses over time](image-url)
Future Challenges

• ACA: More insured, utilizing systems, delayed care, higher morbidity, higher deductibles, and higher co-pays

• **Not the windfall for hospitals as predicted & record amount of outstanding payments**

• Payer Mix: Shift from commercial insurance (BEST Payers) to government payers (Worst Payer)

• Projection (based on adult) $\rightarrow$ reimbursement decreasing much faster than expenses over next few years
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Clinical and Financial Quality Metrics

3M Philosophy: Measure, Manage, Make it about the right thing

Meaningful:

- Clinical: ALOS, readmission rates
- CMS/Regulatory: CLABSI, CAUTI, MRSA, mortality
- Revenue: Census, cost/DC, cost/FTE, days cash on hand, bond ratings
- Marketing: Patient volume, network sites, and growth potential
CMS Star Ratings are based on 57 measures from Hospital Compare

- **Mortality** – heart attack, COPD, pneumonia, stroke...
- **Safety** – HAIs, complications of knee and hip surgery...
- **Readmission** – following AMI, COPD, hip/knee surgery, stroke, hospital-wide readmission...
- **Patient Experience** – doctor and nurse communication, cleanliness, quiet, overall rating, recommend...
- **Effectiveness of Care** – flu vaccination, colonoscopy, delivery before 39 weeks, blood clots and others...
- **Timeliness of Care** – primarily timeliness of care in ED
- **Efficient use of medical imaging** – unnecessary CT / MRI
Quality is as Important as *Finance*

- Present perinatal/neonatal care contracts built on a FFS/DRG structure → change toward a value-based system
- Less revenue is a given -- approximately 10-20% over next 5 years
- Decreasing birth rate in NE; projected need for 10-15% fewer *true NICU* beds (*KaufmannHall*, 2016)
- Less subsidies → impact on academics, downstream effects on departments & hospitals
Keep Mowing the Lawn
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So How Do You Sell Your Idea to the “Hospital?”

• Program idea: novel, modification
• Mission Focus: How does it align with current and future goals, patients, clinical care, educational, etc.?
• “Hospital” connection: Director, Chief, Chair, CMO, CNO, CFO, President
• Climate: new, competition, timeline
• Funding: philanthropy, hospital, grant, foundation, and sustainment
• Marketing: who is your “audience?”
Now Comes the Sound Business Plan:  

*Don’t Panic*

- Project owner(s): who are the responsible parties?
- Narrative: describe the program
  - Customers, champions, sponsors, benefits, and risks
  - Current market demand, known competition, projected annual volume, and competitors’ existing capabilities
- Market Assessment: primary population, secondary population
- Assumptions: where will volume come from?
  - Detail growth assumptions
- Funding: hospital, philanthropy, grant, state, and federal
- Cash flow: equipment -- buy or *lease* and labor
- ROI: capital, operating expenses
- Executive Summary
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Questions For All of You

Are we really “evidence-based?”

What can we do to address fluctuating census and payment reform?
Possible Answer

Standardization

*It is NOT the actual protocol; it is the fact you have a protocol*
Why Standardize?
Just Ask the Pilot on your next flight...

• **NOT** a threat to individual clinical judgment or adoption of “cookbook” medicine

• Increasing trend of publically-reported measures on safety, outcomes

• Public is demanding high quality and safe care as cost becomes more of a domestic budget item

• Reduces variations in practice → enhances better outcomes

• Reduces waste (supplies and labor)

• Helps define team roles more clearly
What approaches do we have to control variation in Perinatal Care Utilization, Resource Consumption, AND to **Improve** Outcome?

- Identify and report provider variations *(Report Card?)*
- Identify and enhance opportunities for increased maternal *(parent)* involvement *(Parent Support Specialists)*
- Create “NICU/OB Bundles” to leverage opportunity, minimize risk, garner resources, and share in benefits
Regional Variation in Late Preterm Births in North Carolina

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Abstract

Objective—Late preterm (LPT) neonates (34 0/7th to 36 6/7th weeks' gestation) account for 70% of all premature births in the United States. LPT neonates have a higher morbidity and mortality risk than term neonates. LPT birth rates vary across geographic regions. Unwarranted variation is variation in medical care that cannot be explained by sociodemographic or medical risk factors; it represents differences in health system performance, including provider practice variation. The purpose of this study is to identify regional variation in LPT births in North Carolina that cannot be explained by sociodemographic or medical/obstetric risk factors.
## Variations in Imaging Utilization Rates

### Utilization Measure

<table>
<thead>
<tr>
<th>Measure</th>
<th>Crude Rate</th>
<th>Adjusted Rate</th>
<th>Relative Rate (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chest X-Rays</strong></td>
<td>221.6</td>
<td>191.5</td>
<td>1.26 (1.20, 1.33)</td>
</tr>
<tr>
<td></td>
<td>106.6</td>
<td>120.1</td>
<td>0.79 (0.75, 0.83)</td>
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<tr>
<td></td>
<td>135.9</td>
<td>152.2</td>
<td>1.00 (1.00, 1.00)</td>
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<tr>
<td></td>
<td>116.2</td>
<td>131.5</td>
<td>0.86 (0.82, 0.91)</td>
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<tr>
<td></td>
<td>84.8</td>
<td>114.0</td>
<td>0.75 (0.70, 0.81)</td>
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<tr>
<td></td>
<td>157.6</td>
<td>149.8</td>
<td>0.98 (0.92, 1.05)</td>
</tr>
<tr>
<td><strong>Abdominal X-Rays</strong></td>
<td>40.9</td>
<td>35.2</td>
<td>1.16 (0.98, 1.36)</td>
</tr>
<tr>
<td></td>
<td>24.0</td>
<td>26.6</td>
<td>0.87 (0.76, 1.06)</td>
</tr>
<tr>
<td></td>
<td>43.2</td>
<td>43.8</td>
<td>1.44 (1.25, 1.65)</td>
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<td>37.9</td>
<td>40.5</td>
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<td></td>
<td>39.3</td>
<td>22.2</td>
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<tr>
<td></td>
<td>30.8</td>
<td>30.5</td>
<td>1.00 (1.00, 1.00)</td>
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<td><strong>Chest/Abdominal CT</strong></td>
<td>9.4</td>
<td>9.7</td>
<td>1.00 (1.00, 1.00)</td>
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<td>8.1</td>
<td>7.5</td>
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<td>6.6</td>
<td>7.9</td>
<td>1.05 (0.88, 1.27)</td>
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<td></td>
<td>11.9</td>
<td>11.6</td>
<td>1.55 (1.29, 1.86)</td>
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<tr>
<td></td>
<td>2.0</td>
<td>2.6</td>
<td>0.34 (0.22, 0.53)</td>
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<tr>
<td></td>
<td>12.6</td>
<td>12.2</td>
<td>1.63 (1.29, 2.06)</td>
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<tr>
<td><strong>Head CT</strong></td>
<td>10.7</td>
<td>9.3</td>
<td>0.93 (0.70, 1.24)</td>
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<tr>
<td></td>
<td>13.1</td>
<td>13.7</td>
<td>1.34 (1.16, 1.80)</td>
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<td>10.5</td>
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<td>1.00 (1.00, 1.00)</td>
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<tr>
<td><strong>Head MRI</strong></td>
<td>11.8</td>
<td>11.1</td>
<td>0.85 (0.65, 1.11)</td>
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<td>8.9</td>
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<td>0.68 (0.54, 0.85)</td>
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<td>23.6</td>
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<td>1.81 (1.47, 2.23)</td>
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What is the magnitude and impact of individual provider variation on Nursery or NICU utilization, resources, and outcome?
NICU Provider Practice Variation

Additional Data/Physician:
- Laboratory utilization/ APR DRG SO1
- MRI/APR DRG SO1
- ULTRASOUND/APR DRG SO1
- PHARMACY/APR DRG SO1
CT/ MRI Services Per Case

Radiology/ Ultrasound Services Per Case

Individual Provider
The Neonatal Variation Rainbow

Intensive IV
- RDS
- Surfactant
- Ventilation
- HAL
- Imaging

Intermediate III
- CPAP / NIPV
- HAL
- Feeding
- Imaging

Convalescent II
- Feeding, NAS
- Monitors

Bundle During this Phase!

INHERENT PRACTICE VARIATION*
Standardization & Future of Healthcare

- Our national healthcare economic climate will not improve dramatically. **Our efforts** will help stabilize our hospital (and system) financially.

- Accelerate our implementation of standardized practices: more than just NRP, EOS, LOS, hypoglycemia → bili(transcutaneous), spells, feeding, lab utilization, D/C milestones.

- We need to monitor those implementations.

- Most importantly...we cannot afford to just do something because we’ve always done it that way!
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Now Back to Dr. C.’s Novel NAS Program: Why Do We Support and Promote it?

• All the Elements of High Value: safe, better outcomes, better family experience, decrease meds, and decrease LOS (divided by) lower cost

• Keeps appropriate babies from the higher-cost NICU even at same level of care

• Parents perceive their babies as more stable

• Community service, public relations, and connection to community providers
Now Back to Dr. C.’s Novel NAS Program: Why Do We Support and Promote it?

- Parents and caregivers have more time to connect and improve the patient experience
- STANDARD APPROACH and Protocol
- Accountability
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DON'T THINK ABOUT WHAT MIGHT GO WRONG
THINK ABOUT WHAT COULD GO RIGHT
“So Let’s Do It”
We are in the Driver’s Seat!

• Successful programs/systems → will be cost $$ conscious, less non-evidence based tests and Rx
• Innovate, **standardize**, consolidate, and make the team accountable!
• Re-analyze-- reinvent delivery of care/coverage
• Shift more elective/pre-discharge management from more expensive inpatient (NICU, L2) to less expensive (evidence-based) nursery or outpatient settings (hearing, MRI’s, Ophthalmology, hernia repair, *etc*…)
• Retool/repurpose our Follow-up/Pedi clinics? Family-centered facilities
“So Let’s Do It”
We are in the Driver’s Seat

Thank you