Engaging Board Members and Physicians to Drive Hospital Performance

Pam Arlotto, Maestro Strategies

The National Medicare-Medicaid Payment Summit
Pam Arlotto, MBA, FHIMSS  
President & CEO, Maestro Strategies

- 30 year track record as a healthcare industry consultant, thought leader and entrepreneur
- Consulting clients include: leading healthcare providers, software and services providers, health information exchanges, certification agencies and associations
- Frequent speaker and author, HIMSS all time best selling series on *HIT Return on Investment* and winner Book of the Year
- Fellow and Past National President of HIMSS
- Board member of the Georgia Tech Foundation and The Wallace H. Coulter Department of Biomedical Engineering at the Georgia Institute of Technology & Emory University School of Medicine. She also serves on Advisory Boards for several privately held healthcare companies
Engaging the Board and Physicians in Driving Hospital Performance

- Set the stage with a review of the healthcare & the new role of the Board and Physicians
- Understand 7 Strategies for *Transformation*
- Discuss the Performance Committee of the Board
### Rating of U.S. Health System’s Performance

"On the whole, how successful is the U.S. health system in achieving high performance on the following domains?"

<table>
<thead>
<tr>
<th>Domain</th>
<th>Very successful/Successful</th>
<th>Neither successful nor unsuccessful</th>
<th>Very unsuccessful/Unsuccessful</th>
<th>Not sure</th>
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<tr>
<td>Outcomes, which include measures such as life expectancy, mortality, and prevalence of disability and limitations because of health</td>
<td>24%</td>
<td>25%</td>
<td>52%</td>
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<td>Quality, or the extent to which care is effective and well-coordinated, safe, timely, and patient-centered</td>
<td>14%</td>
<td>30%</td>
<td>57%</td>
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<td>Access, as measured by participation in the health care system and the affordability of insurance coverage and medical services</td>
<td>10%</td>
<td>16%</td>
<td>74%</td>
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<td>Equity, defined as an absence in disparities among population groups in terms of health status, care, and coverage</td>
<td>4%</td>
<td>6%</td>
<td>90%</td>
<td></td>
</tr>
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<td>Efficiency, meaning the degree to which there is overuse or inappropriate use of services, preventable hospitalizations and readmissions, regional variation in quality and cost, administrative complexity, and use of information systems</td>
<td>3%</td>
<td>7%</td>
<td>89%</td>
<td>1%</td>
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Source: Commonwealth Fund/Modern Healthcare Health Care Opinion Leaders Survey, Aug. 2011
US – Healthcare Spending Comparison

“Healthcare in America is badly organized, highly inconsistent, internally dysfunctional, sometimes brilliant, almost always compassionate, close to data free, amazingly unaccountable in key areas, too often wasteful, too often dangerous, and extremely expensive. Care costs more in American than it does anywhere else in the world.”

George C. Halvorson is chairman and chief executive officer of Kaiser Foundation Hospitals and Kaiser Foundation Health Plan, Inc. – the nation’s largest nonprofit health plan and hospital system.
Delivery System Redesign – “Flip the Triangle”

- Prevent health conditions from becoming chronic health conditions
- Manage chronic health for 45% of Americans with one or more of the conditions – 75% of total medical costs
- Reduce errors & waste in the system
- Reduce incentives for high cost, low value, procedure based care
Medical Progress Over Half a Century

Care circa 1960…

Care circa 2012…

“The complexity of modern American medicine exceeds the capacity of the unaided human mind.” David Eddy, MD, PhD
The Reality for the Health System

- 30% of every dollar spent on care is funding ineffective or redundant care  \textit{IOM 1995}
- 84,000 premature deaths could have been prevented if the US performed as well as some other nations  \textit{Commonwealth Fund 2011}
- $17 billion a year is spent on medical errors  \textit{Classen et al 2011}
- More than 13% of Medicare patients are injured or die from adverse events in medical treatment each year --- 1 in 7 experience harm from a potentially preventable event  \textit{Levinson, 2010 OIG Report}
### The Reality for Patients

**78 y/o WF**

**Problem List:**
1. Type II diabetes with neuropathy
2. Iron deficiency anemia
3. Breast cancer
4. Pernicious anemia
5. Coronary artery disease
6. Peptic ulcer disease
7. Osteoarthritis
8. Hypertension
9. Allergic rhinitis
10. Eczema
11. Glaucoma

**18 Medications**
- Calcium
- Temazepam
- Simvastatin
- Vitamin B12
- Lasix
- Lantus insulin
- Metformin
- Timoptic eye gtts
- Lumigan eye gtts
- Omeprazole
- Diltiazem, Requip
- Enalapril
- ASA, KCL
- Glipizide
- Metamucil
- Zyrtec

**12 Current Physicians**
- PCP
- Neurologist
- Podiatrist
- General Surgeon
- Endocrinologist
- ENT
- Ophthalmologist
- Gastroenterologist
- Oncologist
- Cardiologist
- Hospitalist
- Dermatologist

Source: Kaufman Strategic Advisors
The Reality for Care Providers

*Medicine is More Complex*

- A typical primary care physician who treats elderly Medicare patients must coordinate care with 229 other physicians working in 117 different practices. *Center for Studying Health System Change, 2009*

- Most physicians work in practices with insufficient numbers of beneficiaries to reliably detect meaningful differences in cost and quality measures. *The Commonwealth Fund, 2009*

- In 2011, there were 7,000 new Medicare beneficiaries each day. *Medical News Today, 2011*

- There are over 10,000 prescription drugs and biologics and more than 300,000 over-the-counter (OTC) medications on the market. Two-thirds of the U.S. population receive at least one prescription per year, and close to 40% receive prescriptions for four or more medications. *Institute of Safe Medical Practices, 2007*

- Genetic testing is available for approximately 2000 clinical conditions, and the number of available diagnostic tests is increasing exponentially. *NEJM, January 2012*
The Reality for Health System Boards

- Less than one half of hospital Boards rate quality of care as a top priority for their agenda
- Many boards believe their organizations are performing well at clinical care, with limited evidence one way or the other
- Many boards delegate responsibility for quality to the medical staff  
  \textit{Jha and Epstein, 2009}
High Value Healthcare

Increase Healthcare “Value”

Goal

Improve Quality
- Pay for Performance
- Reduce Preventable Readmissions
- Bundled Payments

Reduce Costs
- Reduce Hospital Acquired Conditions
- Accountable Care Organizations

Tactics

Prerequisite

Interoperable Electronic Health Records

Performance – Improved quality and reduced costs occurs through the transformation to a clinically integrated, systems based practice of medicine – providers work together through shared EHRs, clinical guidelines and unified care management.
Transformation of the Health System

“Create an innovative system of care and payment that results in measureable improved clinical outcomes and resource efficiency. To get there, leaders will need to completely abandon traditional ways of organizing care”

ACO’s, Bard & Nugent, 2011

“The focus on the existing system is on rules, regulations and bureaucratic processes….accountability for outcomes will require a significant paradigm shift”

Harber and Ball, 2003
## 7 Strategies for Transformation

*Engaging the Board and Physicians in Driving Hospital Performance*

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7 Strategies for Transformation

Engaging the Board and Physicians in Driving Hospital Performance

1. Create a Common Vision for the Future
A Future Vision

A Transformed Healthcare Delivery System where:

- Clinicians become healthcare coordinators, working in partnership with patients to manage wellness
- Patients undergo fewer tests and take fewer medications, reducing redundant and inappropriate care
- Patients have a much better understanding of quality, cost, and outcomes
- Hospitals compete based on the results they achieve rather than the grandeur of their buildings
- Healthcare value improves, as quality, outcomes and cost reporting enables transparency
- Patients have much more choice as consumers
- Access to health information including genomes enables personalized medicine – treatments align with patient care preferences, risk taking thresholds, and physiology
- Payers reimburse providers for quality rather than quantity

Source: John D. Halamka, MD, CIO, Beth Israel Deaconess Medical Center
http://geekdoctor.blogspot.com/
Consolidation Models

- **Affiliations**
  - Between NFP hospitals
  - With payers
  - Least impact on operations
  - Best practices are shared

- **Joint Ventures**
  - Create NEWCOs
  - Impact in targeted functions

- **Mergers**
  - Create greater synergies
  - Mutual governance, cultural & operational integration challenges

- **Acquisitions**
  - NFP by FP
  - Smaller NFP by larger NFP
  - One sided governance, cultural & operational integration challenges

2011 – 980 deals worth $227.4 billion

PwC, February 2012
Physician Alignment & Integration

Requires Significant Market Risk Spread Across Multiple Providers

Patient Centered Medical Home
(Population or Disease Focused)

Bundled Payments for Technical and Professional Component

Fixed or Incentive Compensation
(Fee for Service Model)

Goal: Move from a constellation of individual employee physicians to an integrated multispecialty group
The Advantage of Size

Scale can create:

- Reduced management layers and service line redundancy
- Strengthened brand equity
- Better access to capital
- Consolidated administrative and clinical operations
  - Central Business Offices
  - Consolidated Health Information Technology and Information Management
  - Consolidated Ancillaries including Pharmacy, Laboratory and Radiology
  - Health Information Exchange and Healthcare Analytics for Population Health Management
  - Improved Access to Patients and Referral Management
  - Expanded Management of the Care Continuum

Create economies of scale to improve profitability
&
Create infrastructure for care coordination across larger populations
What is the Future Vision

Enhanced Traditional Model
Mix of employed, affiliated, and minimally connected providers each with separate goals

v.

Integrated, Accountable Model
Financial and clinical accountability for value driven by a highly integrated medical staff working toward common goals
3 Components of Transformation

- Clinical Integration – Is much harder than consolidation
  - Commitment to a regular and timely transfer and exchange of pertinent information among everyone involved in the patient’s care

- Care Coordination – For patients with chronic conditions, targeted coordination of team based care models to reduce hospitalizations, manage costs and improve outcomes
  - Common Care Plan
  - Manage Transitions of Care
  - Ensure Positive Patient Experience

- Care Management – Traditionally performed by payers, engage support systems to support prevention & wellness, utilization management, disease management, readmission management and medication therapy management
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Board’s Fiduciary Responsibility

Governance responsibilities:

- Formulate organization mission and key goals
- Ensure high levels of executive performance
- Ensure high quality of care
- Ensure high quality financial management

“Boards are feeling the need to better understand the clinical care”
Goeschel, Wachter, Pronovost, CHEST Journal, 2010

“As hospitals develop more closely aligned economic relationships with physicians, physician board members may find themselves facing irreconcilable conflict”
Barry Bader, Great Boards Newsletter, 2011

“The vision of integration should be reflected in the model for physician participation in governance and leadership leadership structure”
Barry Bader, Great Boards Newsletter, February 2011
“As we look at doing more with less, the solution is to ask how we do things differently. That’s where chief innovation or transformation officers come in. They look at things with different eyes.”

Joanne Conroy MD, AAMC

New Physician Leadership Models
- Medical Group or PHO Board
- Ex-Officio Hospital Board Member, voting or non-voting
- Senior Clinical Operations Council
- Clinical Co-Management
- CTO, CMO, CMIO, CQO, etc.
Develop a Clinician Leadership Plan

Institutional Leaders

Attributes:
- Corporate-level strategic thinking, politically savvy strong in negotiation and influence
- Highly credible to colleagues as clinician and leader, Limited direct patient contact

Focus: Quality Improvement, EBM, EHR Adoption, Clinical Decision Support, Clinical Workflow

Service Leaders

Attributes:
- Fluent service-management skills (strategy/people development, budgeting)
- Highly credible to colleagues, primarily as clinician, well connected
- Innovative, willing to take risks
- Passionate advocate for own service
- Feels responsible for clinical and financial performance of service
- Moderate level of direct contact with patients

Focus: Service line EHR Adoption, EBM, CDS, Quality Measures, Workflow

Frontline Leader

Attributes:
- Understanding of systems and quality improvement techniques
- Self starter, able to work well in teams
- Passionate about clinical work, credible to colleagues
- Close to patients and front line realities
- Great frontline clinician who focuses on delivering and improving excellent patient care
- High level of direct contact with patients

Focus: Personal Use of Systems, Advocate to Patients and Peers, Participate in Design of EHRs, EBM, CDS, Quality Measures, New Workflow

Source: "When Clinicians Lead" James Mountford and Caroline Webb, February 2009
Performance – Path to Accountability

Planning

- Regulatory Agencies
  - Policy
  - Strategic Plan
  - Transformation Plans
  - Improvement Plans
  - Learning Plan

Performance Measurement

- VBP, Accreditation, etc.
- Balanced Score Card
- Balanced Score Card
- Balanced Score Card
- Performance Review

Strategy

Care Delivery

Accountability

Learning
# 7 Strategies for Transformation

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Prevailing Misperception

EHR ≠ Meaningful Use

Prevailing misperception that implementing Epic, Cerner, McKesson, Meditech, Siemens, Allscripts, or any other EHR complies with HITECH requirements and incentive qualification

EHR implementation is only one part of meaningful use

MU depends on workflow, evidence based clinical practice, performance measurement and reporting
Not worried, believe their vendor has them covered, focused on compliance via minimal reporting

Focused on Stage 1 and IT functionality. Haven’t separated IT implementation from MU preparation

Meaningful Use is viewed as foundation for innovation and clinical transformation

Have created an Integrated Road Map that includes workflow and information flow with IT deployment

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“Smart” EHR

Online Evidence Based Guidelines

Health Information Exchange

Standard Nomenclature

Medication Reconciliation

“Dashboards” And Summary Of Care Information

Clinical Decision Support

Organized Problem Lists

Standard Order Sets

eQuality Metrics

Track & Manage Referrals

Standardized Clinical Processes
Future Technology Platforms

“…we believe that it will be common in the near future for Certified EHR Technology to be assembled from several replaceable and swappable EHR Modules” Health & Human Services, Interim Final Rule on Standards, December 2009

Yesterday
Monolithic Integration
McKesson, Cerner, Allscripts, eCW, GE, etc

Today
Interoperable Platform Vendors
Orion, Medicity, Harris, ICA, RelayHealth, etc

Tomorrow
Open EHR Technology Platforms with Plug-and-Play Modular Applications, Software as a Service, Apps pushed to users, Cloud Computing – public/private

“…we believe that it will be common in the near future for Certified EHR Technology to be assembled from several replaceable and swappable EHR Modules” Health & Human Services, Interim Final Rule on Standards, December 2009

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Patient Centered Care Continuum

**Level I**
Initial Entry Into Patient Centered Care
Traditional Roles & Responsibilities

**Level II**
“Vision” for Patient Centered Care
Initial Inclusion of MDs and Patients

**Level III**
“Vision” for Patient Centered Care
Team Defined Goals
Cross Departmental Processes

**Level IV**
Patient Centered Care Best Practice
Patient Defined Goals
Integrated Care Processes
Patient Engagement Early Adopter Strategies

- Health systems offering their patients “gateways” to their medical record with better and better functionality
- Independent companies aggregating data from multiple providers on the patient’s behalf
- Medical societies offering tools to link doctors to patients
- Pharmacy benefits managers and disease management companies offering specialized, partial PHRs to address very targeted needs (medication management, diabetes care)
- Local collaborations between health systems that provide patients with a portal into a pooled data set
- Government and private payers giving patients access to their claims and financial information, and adding as much functionality as they can to the administrative data
Patient Centered Community Care – Driven By Interoperable Health Records

Consumers
- Results Delivery
- Inquiry/Viewing
- Common Data Exchange
- Patient Enrollment
- Self Health Mgmt
- Patient/Family Education
- Patient Portal
- Benefit Eligibility
- Chronic Disease Mgmt

Health Systems
- Physicians
  - Results Delivery
  - Inquiry/Viewing
  - Referrals/Consults
  - Common Data Exchange
  - Patient Enrollment
  - eRefill/ePrescribing
  - eOrdering
  - Patient Portal
  - Benefit Eligibility
  - Incentive Programs
  - Decision Support
  - Chronic Disease Mgmt

Health Plans
- Health Systems
  - eRefill/ePrescribing
  - eOrdering
  - Patient Portal
  - Claims/Payment Processing
  - Benefit Eligibility
  - Decision Support
  - Chronic Disease Mgmt
  - Incentives & Performance Measurement

Other Providers
- Consumers
  - Results Delivery
  - Inquiry/Viewing
  - Common Data Exchange
  - Patient Enrollment
  - Patient Portal
  - Benefit Eligibility
  - Chronic Disease Mgmt

Public Health
- Research
  - Data Collection
  - Clinical Data Mining
  - Admin Data Collection
  - Admin Data Mining
  - Bio-Terrorism Surveillance
  - Bio-Medical Research

Other Providers
- Physicians
  - Health Systems
  - eRefill/ePrescribing
  - eOrdering
  - Patient Portal
  - Claims/Payment Processing
  - Benefit Eligibility
  - Incentive Programs
  - Decision Support
  - Chronic Disease Mgmt

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Patient Driven Healthcare Services

Supplement traditional healthcare delivery models and empower patient self care

Increase information flow, transparency, customization, collaboration, patient choice and responsibility taking

Patients are more engaged in self management of chronic conditions

- Research
- Self Testing
- Tracking
- Self Management of Symptoms
- Communication with Other Patients
7 Strategies for Transformation

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1. Create a Common Vision for the Future
2. Develop a New Clinical Leadership Structure
3. Create a “Smart” EHR
4. Expand Patient Engagement
5. Develop “Real-Time” Quality Measures
Hospital and physician quality reporting and performance requirements have recently become much more complicated!

**Reporting hospital quality data for annual payment update (2% penalty in 2011)**

**Calculated by CMS from enrollment and claims data**

**Meaningful use and Leapfrog require a sub-set of Core indicators**

**AHRQ inpatient quality and patient safety indicators**

**TJC Core Measures**

- Dec 2010
- AHRQ metrics
- Nursing metric

**HCAHPS**

**RHQDAPU***

**Risk-adjusted 30 day mortality rates for AMI, Heart Failure, Pneumonia**

**Risk-adjusted 30 day readmit rates for AMI, Heart Failure, Pneumonia**

**AMIP***

**Pneumonia***

**PC**

**HBIPS CAC**

**Stroke VTE**

**Reporting/Performance Requirements as of 2008.**

These requirements are associated with financial incentives and penalties!

*Reporting hospital quality data for annual payment update (2% penalty in 2011)  **Calculated by CMS from enrollment and claims data  ***Meaningful use and Leapfrog require a sub-set of Core indicators  ****AHRQ inpatient quality and patient safety indicators
Clinical Reporting/Performance Requirements

Healthcare payment reform and meaningful use incentives and penalties begin in October, 2010.

- **Meaningful Use, Stage 1**
  - OP
  - SCIP
  - Heart Failure
  - AMI***
  - Pneumonia***
  - Risk-adjusted 30 day readmit rates for AMI, Heart Failure, Pneumonia**

- **PC**
  - HBIPS
  - CAC
  - Stroke
  - VTE

- **Variant of SCIP**
  - IHI process metrics
  - CDC infection metrics
  - All-cause readmit index
  - EHR performance metrics

- **Healthcare Payment Reform**
  - OPPE (Physician Credentialing)

- **HACs**
  - Other VBP

- **Healthcare Payment Reform and Meaningful Use, Stage 2, and Beyond**

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Today’s Work Practices

Current work practices have evolved over time, been designed to support regulation and compliance, typically vary by person, by unit, by organization, etc. and have resulted in:

- Work arounds
- Variation
- Duplication
- Delays
- Rework
- Errors

Future processes will have to be patient centered, evidence based, metrics driven, accountable and transparent.
Rule of Thumb

Generally speaking, the number of people an organization needs to train in process improvement is the square root of the total number of personnel.

Thus, if you have 100 people,

---

you need to train 10; if you have 10,000, you need to train 100. Most organizations have a long way to go to reach this goal.

HBR, April 2010
Process Redesign Framework

Mission, Strategy, Goals & Objectives

- Mission, Strategy, Goals & Objectives supports Business Process

Business Process

- Workflow Design
  - Stakeholders
  - Steps and decisions
  - Flow: sequence, dependency and handoffs

- Information Systems
  - Applications
  - Data
  - Information
  - Integration

- Culture, Motivation, Measurement
  - Cultural assessment
  - Incentives - “Reward and Punishment”
  - Process performance indicators

- Human Resources
  - Capabilities
  - Matching people to roles and tasks
  - Recruitment, selection and placement

- Policies and Rules
  - External laws and regulations including Meaningful Use, etc.
  - Internally set constraints

- Facilities
  - Workplace layout
  - Equipment availability and capacity

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| 7 | Develop Business Intelligence & Analytics Capabilities |
From Data to Knowledge

Data

Point of Care Transaction Systems
- Administration, scheduling, ADT
- Assessments and care documentation
- Orders, tests and results
- Outcomes capture

Information

Population Level Analytical Systems
- Repositories, BI tools, analytics, query
- Comparative data, EBM, best practices
- Tools for process and quality improvement
- Practice profiles for clinicians

Knowledge

Record structured data

Patient Centered Care Record

Exchange health information

Clinical decision support

Data extraction & analytics

Quality outcomes reporting

Transform care delivery practices and models

Value Based Reimbursement

Medicare, Medicaid & Commercial Payers

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Board’s Role

- Align business, information technology and quality strategies
- The Board must make the quality/IT connection – *clinically integrated system of care driven by evidence and best practice*
  - Extend oversight beyond the hospital – relationships with physicians and other entities
- Expand the board’s overall understanding of integration issues, challenges and consequences
- Appraise and critically review the progress of major initiatives, budgets and decisions
- Foster *communication* among executive team, transformation leaders, clinical leaders and the board
- Review management processes, score cards, benchmarks, best practices and *ask why*
- Set the bar high
Understand the Required Investment

*Information Technology Alone Can be Overwhelming*

**Hospital**
- A complete EHR for a 500 bed hospital will take $50 million and at least four years *Accenture*
- Average start-up cost per bed $80,000 – $100,000 (200 beds) *McKinsey and Company*
- Most hospitals under estimate by 100% average cost to implement EHR *Accenture*

**Physicians**
- The average cost of a practice EHR ranges from $55,000 to $200,000 per physician *Various Sources*

**HIE**
- Major vendors charge $20k to $50k for just their side of an ADT interface *HIMSS LinkedIn Group*
- Average cost per physician practice to interface to one “trading partner” is $19,000+ *Various Sources*
Establish an Performance Committee of the Board

- **Purpose:** Ensure alignment to key health system strategies and creation of value through improved clinical outcomes and business performance

- **Functions:**
  - Strategy Alignment
  - Performance Management
  - Risk Management
  - Delivery Management
  - Resource Management
  - Partnership Oversight

- **Membership:**
  - Individuals who aren’t intimidated by clinical issues and can frame probing, constructive questions and understand the answers
  - Quality and Information Technology backgrounds
  - Able to build relationships with clinical leadership
Go Where No One Has Gone Before

Experience:
- Engineer
- Doctor
- Replicator

Away Teams:
- Some discover new world’s
- Some are pursued by enemy space ships
- Some don’t come back
Questions

For More Information Contact
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