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Innovation in hospitals can 'turbocharge' advances

Ed Avis

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Innovation in hospitals can 'turbocharge' advances

Ed Avis

"Innovisits" to other healthcare organizations are one way to learn about innovative ideas and partnerships.

"When we think about innovation, we shouldn't think it's about three people in the basement alone coming up with all these wonderful ideas. It really is more about teams, platforms and partnerships. And that is a good place for healthcare to be because these partnerships will end up accelerating or turbocharging a lot of our innovation efforts," says Phil Newbold, CEO emeritus of Beacon Health System in Indiana and author of the book *Wake Up and Smell the Innovation!*

In this interview, Newbold discusses the importance of what he calls "innovisits," which are visits to innovative organizations to observe what they do and learn about the value of partnerships that support innovation.

How did the idea of visiting other companies to learn about their innovation processes start?

Newbold: I was attending a conference presentation when the late healthcare futurist Leland R. Kaiser asked the question, "Why don't hospitals and health systems have R&D [research and development] functions just like everywhere else?" So, we decided to go out across corporate America and find out what was going on with their R&D new product development. We found that everyone in corporate America seemed to be focusing on innovation.

Don't companies resist when you ask to visit them and learn about their innovative processes?

Newbold: No, usually they're flattered and want to talk about it. We just pick up the phone and ask, and we've never been denied. That was how we learned how their innovation programs were structured, what the incentives were and how they organized. And they were so forthcoming. After every visit, we ask them, "Where else should we go?" They are happy to recommend another organization and open the doors for us.

Hospital and health system employees are great resources for testing innovative ideas and initiatives.

How do you apply the learnings of the innovisit?

Newbold: Once you learn the processes and some of the methods and the tools that go along with those, you can apply innovation anywhere in your organization. That was an "ah-ha" moment for us—you don't use a different innovation process if you have a new initiative in an outpatient area, versus inpatient versus home health. It's all the same process. And the companies we visited were more than willing to share lessons learned. They said, "Here are our mistakes, here's what to do first, and second and third."

Who goes on the innovisits?

Newbold: It's important to have the CEO go on the innovisits, because that helps get people excited. It's also good to take some members of your board, so they can

talk about it with other board members firsthand. It's also great to take a physician or two, because they can convince their medical staff colleagues of changes.

When you start getting into innovation, the medical staff says, "Don't we buy a lot of things already that are innovative?" And the answer to the physicians is, "Of course we buy it. We're talking about developing some of these things ourselves. So, we'll continue to buy new catheters, new surgical instruments and new pharma. But we'll also have the capacity and the ability to begin to design and come up with some of these things on our own. Because now we know a little bit about how to design some of these processes."

After you've done several of these visits and learned about the innovative methods, what typically are the next steps?

Newbold: The first thing you want to do is get a board approved policy that gives management a little cover, a little protection and some funding for a few years. Because it's a startup, it's a new skillset and a new competency like anything else. And you're not going to be good at it on day one.

On the front end, you need to do a lot of research on underlying needs to try to target, segment and zero in on what is exactly the problem that you're trying to solve with your innovation. A lot of people just say, "Well, it's all about coming up with an idea." An idea isn't very useful if it doesn't solve somebody's problem. So, you really do start on the front end doing an awful lot of research.

What are other important elements to an innovation program at a hospital?

Newbold: Partnerships are also important. You don't have to go it alone on this. The partners we recommend are called "platform partners." Platforms are like what Uber uses and Lyft and Airbnb. They link everything together.

For example, at Beacon we partnered with an organization that helped us develop a platform so that we're able to offer virtual urgent care visits. I could have gone over to the IT department and said, "Come up with a virtual urgent care app for a smartphone." And they probably could have done a decent job coming up with that. But a platform connects into the electronic medical record; it connects into our billing system; it connects into our referral systems; it connects into our appointment systems; and it connects to everything. That's what a platform does.

Who typically runs the innovation department in a hospital?

Newbold: If you're serious about it, you hire somebody from the outside who knows the process and have that person build out the department and focus on those high-priority areas that will establish that function right at the top. I really caution people that if innovation is 10% or 20% of five- or 10-people's time, it's really easy for that to get crowded out with the press of everything else.

Any other tips for innovation at hospitals?

Newbold: Hospital and health system employees are great resources for testing innovative ideas and initiatives. When we first started doing virtual urgent care visits, we offered that service free to our employees. They tested the idea. We made all our mistakes at a small scale and with our own employees, and we found out what worked and didn't. By the time we rolled out the program to the whole community, we worked all the bugs out by testing it first with our employees. //

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How to use contract testing and analysis to prepare for payment changes

Lauree E. Handlon and Laura Jacobson

Two areas that effect the impact of contract changes include how payers define categories and services and hierarchies of payment.

A substantial provider-payer contract is nearing the renewal period. The payer initiates proposed changes to current payment terms, but the provider already has in mind specific outcomes desired for the upcoming contract year. The provider is faced with two choices; accept and move forward with the proposed changes or engage in the negotiation process. What should the provider choose?

To make an educated next step, it is critical to gain specific information. Whether the contract is new or up for renewal, a thorough understanding of the financial implications of changes to provider-payment terms is vital for continued operations. Critical steps in the process include identifying the sources for contract testing, the approaches to analysis and the payment impacts.

Payer proposes payment terms

One approach involves testing the terms and methodology proposed by the payer. Through analysis, the provider can determine if the offered terms result in alignment with the organization's financial goals. This approach seems simple enough, but the following elements must be kept in mind.

Definitions. How the payer defines payer categories and services represents the first key consideration. The definition of

Why initiate contract testing?

Contract testing may originate from a variety of sources.

Termination of contract. A provider could be faced with the termination of a contract and those patients could potentially leave the provider's payer mix entirely. Or the contract moving out of network creates a shift of patient volume, for example a large employer group, to another payer contract with different payment terms. What will either adjustment mean to the provider's net revenue?

Changes in legislation. Another foundation for contract testing involves the complications associated with changes in legislation. An example of this can be payment terms adjusting to include a provision to cap contracted payment at federal program methodology, such as the Inpatient Prospective Payment System or Outpatient Prospective Payment System. Providers also ought to be equipped with payment analysis for an adoption or variation of the "Medicare for All" initiative. Can the organization survive under this movement?

Modification to current terms. Most commonly, the source for initiating contract testing and analysis starts from the payer or provider desiring to alter current payment terms. If either party wishes to modify the terms, the relationship has now entered into a level of contract negotiations.

By using skilled resources to test changes, the provider increases the ability to validate any analysis estimated by the payer and develop counter scenarios to meet favorable objectives.

Bottom line, regardless of the cause, providers should ultimately want to prepare for the impact of payment changes. To accomplish full preparation or create a desired outcome, the various approaches to contract testing must be considered.

each service must be communicated to the provider, so payer and provider are on the same page. For example, does the payer use a specific set of revenue codes, HCPCS codes or a combination to define an emergency visit? Confirming detailed definitions will ensure each service is identified accurately in the tests.

Hierarchy of payment. The service category deemed primary, secondary and so on is another significant consideration. Hierarchy of payment involves determining how the payer pays a claim when multiple services are present. For example, the claim represents a patient presenting in the emergency department, followed by a surgical service in the OR and concluding with the patient being placed under observation. In this scenario, how will the payer apply payment if the contract includes payment categories in all three of these areas? Results could be significantly different if surgery groups are applied in the test, but the payer interprets that observation takes precedence in the hierarchy.

Payment methodology. How the rate is applied is another consideration when testing proposed terms. For example, is the payer paying a service at a case-rate level, at the unit level or once per day? Application of a per unit methodology can produce vastly different results than once-per-day payment methodology.

If testing a proposal provided by the payer, the next step will be to apply the current contract terms to a set of claims. This will determine the base or benchmark payment. Next, apply the proposed terms to the same set of claims. Using the same set of claims in the base and test is critical to provide an apples-to-apples comparison of terms. From here, the impact of moving to the new terms proposed by the payer can be determined.

Provider desires specific outcome

Another approach to contract testing is more complex. The provider may have an idea of a desired outcome (e.g., an overall increase of 5% for the payer over the previous year). In this situation, the provider may want to determine the optimal contract terms to help reach this goal and then present the terms to the payer. While the elements in the first approach are applicable here as well, additional key elements should be kept in mind for this approach.

Leverage. The first element is determining how much leverage the provider has with the payer. In some cases, the size of the hospital and payer may determine the negotiation ability of the provider. Knowing this up front can save time during the testing process.

Whether the contract is new or up for renewal, a thorough understanding of the financial implications of changes to provider-payment terms is vital for continued operations.

Extent of changes. Another aspect is determining how much of the original contract the provider wants to change and the payer is willing to change. Any combination of changing the rates or the methodology and structure can be involved. It is important to know what parts and to what extent they can be tested as certain terms may already be deemed non-negotiable in the contract.

Establishing the base or benchmark payment is still needed under this approach. The testing phase of various terms based on the provider desiring a specific outcome may take longer, depending on the goals, as well as the elements, changing in the tests. Consider the following example.

A provider's current contract includes a mix of fixed rates (e.g., per diems, case rates) and percent of billed charge payment. The goal is to increase overall payment for this contract by 5%. Constraints include limited flexibility to adjust only the fixed rates, and methodology must be kept the same.

The provider must now determine the level of increase to the fixed rates necessary to achieve an overall 5% increase. A complication arises due to an inpatient

stop-loss provision and a lesser of provision applied to inpatient and outpatient claims. Increasing the fixed rates will not only increase payment for some claims but will also cause movement in and out of stop-loss and lesser of claim status, making the overall payment more unpredictable.

With charge sensitivity involved, any future price increases to the chargemaster must be incorporated as well. Comparisons to the benchmark payment for each test will help determine the new rates that help reach the 5% increase goal.

For either approach, a key challenge associated with contract testing is utilizing a comparable base of claims data. The data criteria used by the payer to estimate impact is often a pitfall when comparing results as different claim date ranges may have been used for the analysis. A critical aspect of accurate testing is using the same criteria as the payer to define the data set involved, including covering seasonality.

Once the proposed rate impact or new rates are formulated, it is time to communicate the results to the payer.

Communication of testing outcomes

After initial testing is complete, results of the contract changes should be available for quick identification of impact. A report providing the impact is a useful way to communicate the results. Depending on the desired level of change the parties want to review, layout of the results can be displayed in a few ways. Several types of suggested views of results include:

- Overall impact
- Patient type impact (inpatient/outpatient)
- MS-DRG impact
- Service impact

A critical aspect of accurate testing is using the same criteria as the payer to define the data set involved, including covering seasonality.

Impact reports compliment the negotiation process by providing a tool to use with the payer to discuss outcomes and potential further testing. This is especially true when testing proposed rates provided by the payer. If the results are not at the level anticipated by the provider, presenting impact reports to the payer may aid in further negotiations until both parties are satisfied.

When developing contract terms to meet a desired goal, the provider also needs to communicate the new rates to the payer. Depending on what the payer requires, this can be accomplished by a summary letter or report of new terms presented with the impact reports. Including as much detail as possible about any changes made in the test ensures both parties are on the same page.

In addition to displaying the testing approach results, once again, benchmark data for payer-specific payment levels can significantly enrich the communication.

Next steps

Results are in, and now the provider needs to determine if additional testing is needed or if both parties are prepared to proceed. With the results information gathered and benchmark data for payer-specific payment levels in hand, providers may decide to continue strategizing other scenarios along with understanding the impact of each. Or the provider may determine the best options are already available. By executing the knowledge gained through this process, providers are equipped to arrive at the table knowing minimal, target and optimal payment-term goals. In addition, this process may bring to light any elements of the payment terms requiring additional attention and resolution with the payer. After new terms are accepted by both parties, the provider must now prepare for the upcoming effects of executing the payment changes.

Mutual understanding

Once the provider and payer gain a mutual understanding of the goals and process of contract testing, both parties can move forward with more confidence. Arming themselves with the proper tools and knowledge to accomplish financial goals can ensure a smoother negotiation process and transition to new contract terms.

What to test and how to test it?

Depending on the goals for finalized payment terms, the provider may approach the contract testing process in two general ways.

Payer proposes payment terms. This approach involves testing the terms and methodology proposed by the payer. Through analysis, the provider can determine if the offered terms result in alignment with the organization's financial goals.

Provider desires specific outcome. This approach to contract testing is more complex than the payer proposal of payment terms. For example, a provider may have an idea of a desired outcome (e.g., an overall increase of 5% for the payer over the previous year). In this case, the provider determines the optimal contract terms to help reach this goal and then presents the terms to the payer.

Either approach could be enhanced by attaining payment-term intelligence involving benchmark data. Utilizing existing comparison data for payer-specific payment levels along with either of the methods creates powerful information to assist with the testing and analysis process. Regardless, with either approach, specific element details are crucial to understand prior to initiating testing.

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Corporate social responsiveness regardless of tax status

William Marty Martin

It is up to senior healthcare leaders, including financial leaders, to address the tension of doing what is best for their organizations and their stakeholders.

In a 1970 *New York Times Magazine* article, the economist Milton Friedman wrote and promulgated that the social responsibility of business is to increase its profits. Sister Irene Kraus, who belonged to the Daughters of Charity order that led a number of hospitals, put a twist on Milton Friedman's belief by saying, "No margin, no mission." Earlier, around the First World War, one of the leaders of scientific management, Henry Gantt, wrote, "The business system must accept its social responsibility and devote itself primarily to service, or the community will ultimately make the attempt to take it over in order to operate it in its own interest (Gantt, H., *Organizing for Work*, Harcourt, Brace and Howe, 1919, p. 15).

Corporate social responsiveness is driven by organizational vision, mission and values and often framed as the "right thing to do."

The community has not sought to take over business, but there have been calls for greater accountability beyond making a profit or a positive operating margin in the case of not-for-profits. For example, reflect back on Occupy Wall Street. Another example is Sen. Charles Grassley challenging not-for-profit hospitals to contribute more to the benefit of society.

Milton Friedman and Henry Gannt are both now gone and nuns leading hospitals are quite rare in healthcare today. Now, it is up to senior leaders in healthcare, including financial leaders, to address this tension of doing what is best for organizations and stakeholders, including shareholders where applicable.

The aim here is to make the case for corporate social responsiveness regardless of the organization's tax status. Spending on charity is flat among hospitals (Bannow, T., "Charity care spending flat among hospitals," *Modern Healthcare*, Jan. 6, 2018). Charity care is part of community benefits. Overall, community benefit spending increased slightly as a percentage of operating expenses from 7.6% in 2010 to 8.1% in 2014 (Young, G.J., Flaherty, S., Zapeda, E.D., et al., "Hospitals changed little after ACA," *Health Affairs*, 2018).

There appears to be an overall upward trend regarding executive compensation even while healthcare organizations are containing costs (Kacik, A., "Steady executive pay hikes eclipse cost-containment concerns," *Modern Healthcare*, Aug. 4, 2018). Does this paradox add any validity to which stakeholders matter more than others?

Beyond corporate social responsibility

It is argued here that an emphasis on corporate social responsibility is often driven by compliance with laws, regulations and even norms. In contrast, corporate social responsiveness is driven by organizational vision, mission and values and often framed as the "right thing to do." Of course, a single organization can engage in both, but the focus here is on corporate social responsiveness.

Therefore, a question for senior healthcare leaders to ask is the following: What percentage of operating expenses would be invested in community benefit including population health if these expenses were not part of our demonstration of community benefit and associated with our tax-exempt status? For example, for-profit healthcare organizations, even those that are publicly traded, may decide to allocate a percentage of their operating expenses to community benefit and population health but do not receive a tax benefit for doing so.

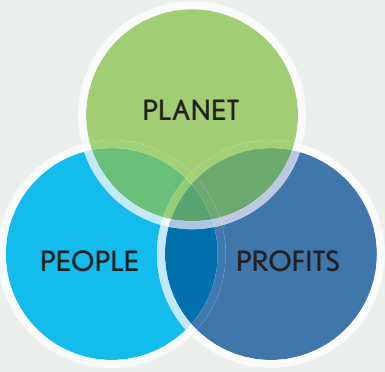
Model of corporate social responsiveness

Corporate social responsiveness revolves around the 3P model. Another name for the model is the Triple Bottom Line (TBL).

The purpose of an organization is complex. This is not news to healthcare leaders but is often a source of distress for healthcare board members who often come from the world of for-profit companies and believe that the solution to more effective healthcare is to mimic the organizational practices of for-profit and even publicly traded companies. This view approaches

3P Model (Triple bottom line)

The purpose of a healthcare organization is complex and must incorporate sustainability, the workforce and patients, and financial viability.



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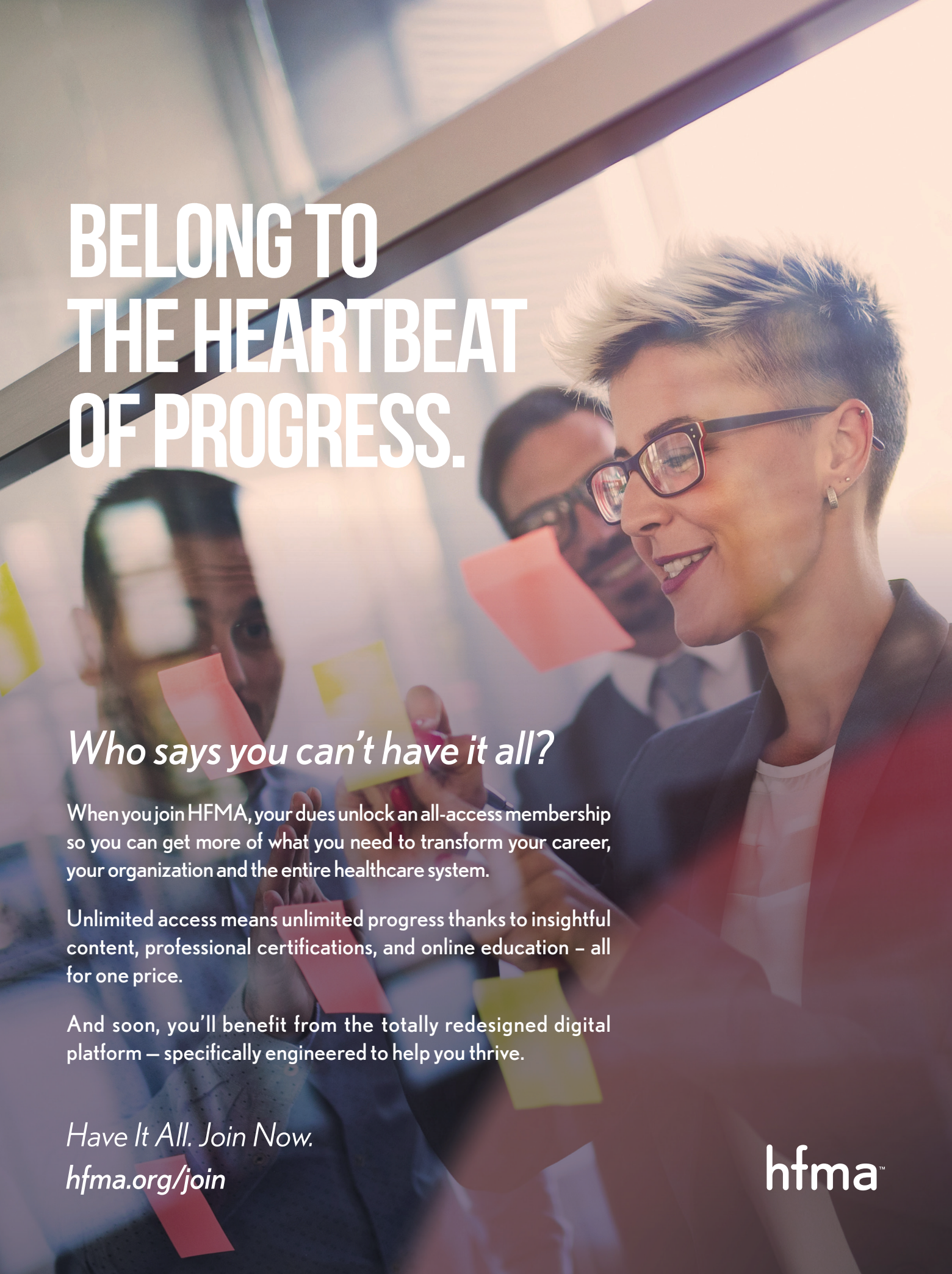
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Aurora, Illinois seeks Blue Zones community status

Healthy Aurora is a community-based population health initiative in Aurora, Illinois, which is the second largest city and one of the most ethnically and racially diverse in Illinois. Healthy Aurora's short-term goals include increasing awareness and knowledge about health insurance, health services and preventive screening. One of the longer-term goals of Healthy Aurora is to have the city certified as a Blue Zones community, which is recognition achieved when a specific level of community health-based achievements is reached.

The lead funder, the Dunham Foundation, viewed the launch of this initiative from an impact investment perspective seeking to generate health literacy and healthy behavior outcomes. Healthy Aurora is supported financially or in-kind by several organizations: Delta Dental, The City of Aurora, The Center for Healthcare Innovation, Breaking Free, VNA of Illinois, Bureau Gravity, Illinois Poison Center, Kane County Health Department and Zesty Sleep. Of these 10 supporting organizations, six are health-related agencies, associations and organizations. Noticeably absent from the list of current organizational sponsors are the major health systems and health plans serving individuals and families in Aurora.

The governance of Healthy Aurora seeks to equalize decision-making by uncoupling the amount of financial contribution/investment from decision-making authority. This practice is in part driven by the reality that finances represent the "tip of the iceberg" in investing in population health initiatives.

Milton Friedman's line of thinking described earlier, but it is misplaced. Even if healthcare organizations are for-profit, they can still serve more than one bottom line. Indeed, this requires a far greater degree of executive agility and ability to embrace complexity, but this should not be the reason to singularly focus on profit, EBIDA (Earnings Before Interest, Depreciation and Amortization), or operating margin.

It is beyond the scope of this article to exhaustively describe the meaning of planet, people and profit but a brief description is warranted. The descriptions that follow are from the lens of a single healthcare organization that serves one or more communities.

Planet. The focus is on the natural and built environment. Ideally, both types of environments promote healthy living.

People. The focus is on factors that contribute to healthy living required by individuals and families such as a living wage, health literacy, social support, and freedom from oppression, bias and violence of all types. Beyond these absolute requirements for healthy living is a focus on optimal well-being, meaning and joy.

Profit. The focus is on generating, allocating and investing financial resources in a way that creates and sustains organizations that have a symbiotic relationship with the community (including its own workforce) rather than a parasitic relationship. To express this more colloquially, as an organization are you a taker or a giver?

Corporate social responsiveness can take on many different forms. For example, Kaiser Permanente made an impact investment of $200 million to address affordable housing in communities the health system serves (Reynolds, K., Fedorowicz, M., and Eldridge, M., "Why hospitals and health systems are becoming impact investors," *Urban Wire*, Aug. 8, 2019).

An impact investment is different from a grant. It is an allocation of funding/resources by an organizational entity with the expectation of a social, environmental and/or health return. Private equity firms are also beginning to focus on population health as illustrated by the Healthy Neighborhoods Equity Fund, LP in Boston, which is now closed at $22.35 million. Other ways to invest in population health beyond a financial investment are the following (Reynolds, Fedorowicz, & Eldridge, 2019).

> Donating space, land or buildings.
> Partnering with another not-for-profit organization in the social services sector.
> Volunteering talent and expertise.

Hospitals are no different: Stakeholders demand accountability

As an industry, less than two out of three U.S. survey respondents (61%) trust healthcare (*Trust Barometer*, Edelman, 2019). This contrasts with almost three out of four survey respondents in Canada (72%) and eight out of 10 in Singapore (82%). In the U.S., women trust healthcare less than men. A more detailed look at trust in healthcare by sectors reveals a different picture (see the table on page 9).

In the U.S., trust in hospitals/clinics decreased to 71% in 2019 from 72% a year earlier. Moreover, 64% of healthcare employees agreed with this statement, "My employer has a greater purpose, and my job has a meaningful social impact" compared to 67% in other industries (Trust Barometer, Edelman, 2019). Both of these indicators of trust are significant given that it is generally assumed that healthcare as an industry is inherently focused on corporate social responsibility due to the nature of the work.

In summary, there is a trust gap in the industry and healthcare leaders should ask these questions.

> What is the trust gap in the communities you serve?
> What is the trust gap among employees who live in the communities you serve?
> Can you drive employee engagement when the trust gap revolves around the relationship with the community and is not restricted to management and organizational culture?

The benefit corporation

A fair question is how a healthcare organization can actualize corporate social responsiveness with laws and accreditation standards which may conflict with the

Public trust by healthcare sector, 2019	
Sector	**Trust Percentage**
Hospitals/clinics	71%
Biotech/life sciences	64%
Insurance	62%
Consumer health	59%
Pharmaceuticals	57%
Source: Trust Barometer, Edelman	

3P model or TBL. The good news is that laws are changing. For example, Northwest Permanente, which is part of the Kaiser Permanente system, became a B corporation. Imelda Dacones, MD, CEO and president, remarked, "The fundamentals of a B corp company of being a force for good, good for workers, good for communities, good for the environment, echo our values of Permanente Medicine ("Northwest Permanente's B Corp Journey," Permanente Medicine, 2018)."

To begin your journey to become a B corporation, you must first determine if the state(s) in which you operate or are headquartered allows that type of legal entity. Corporate social responsiveness goes beyond the ideology, will and motivation of board members and senior leaders and must be interwoven into the fabric of the organization in a way that is proactive not reactive and holistic not myopic.

Guidance for healthcare financial leaders

Contemplation and deliberation are laudable, but these cognitive activities alone are ethereal at best. You must act. Below is guidance to reflect upon and incorporate into your behavior as a leader.

- Change now rather than waiting for a change by government or an accrediting body.
- Engage in frank discussion about the degree to which your vision, mission and strategic priorities embrace the 3P model or TBL.
- Align incentives and disincentives, including executive compensation, with the 3P model or TBL.
- Appoint board members who are experts in at least one of the elements of a 3P model or TBL to ensure governance is responsiveness too.
- Evaluate your performance as an organization on the degree to which symbiosis is created with the communities you serve at a minimum and raising the quality of life optimally. //

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5 ways to drive patient privacy law compliance from within your organization

Isaac Kohen

Start from the inside to mitigate top healthcare data risks.

When healthcare organizations fail to protect patient personal information, they may face damage to their reputation and lose patients to other healthcare providers viewed by the public as more responsible and reliable. In addition, when privacy laws are violated, financial penalties and other sanctions may ultimately make it more challenging for these healthcare providers to deliver quality patient care.

While it makes sense to protect patients' health-specific data, social security numbers and home addresses from external bad actors, the most significant threats are *on the inside*. From accidental data leaks to malicious theft, according to a *HIPAA Journal* April 3, 2018 article, insiders account for the vast majority of healthcare-related data breaches.

Healthcare providers need to develop plans for protecting patient information. Unfortunately, there isn't a silver bullet that ensures 100% security under every circumstance, but every organization can do a better job of protecting patient data.

Here are five steps that every healthcare provider should take to guard against insider threats in 2020.

1. *Detect and prevent insider threats.* Insider threats are more than just an abstraction, and they occur with frightening regularity both from accidental data disclosures and malicious theft.

According to Verizon's 2018 Insider Threat Report, more than half of all healthcare companies were impacted by an insider threat, and carelessness is one of the main culprits. Everything from ubiquitous access to mobile technology to the blurring lines between personal and professional data creates an environment that's poised for data misuse.

For example, nearly 30% of all healthcare team members use personal devices to transmit patient information, a practice that creates data privacy concerns on many levels, according to an article in *JMIR Human Factors*.

Protecting patient data in a dynamic healthcare environment is replete with unique challenges.

In this dubious digital environment, IT administrators can't be expected to protect what they can't identify. Fortunately, there are many indicators of an insider threat, and software solutions, like robust monitoring software, that can detect those bad actors while preventing them from misusing personal health information (PHI) and personally identifiable information (PII).

Regardless of an employee's intent, healthcare companies have a responsibility to detect and prevent data misuse, and deploying the right tools is the first step in the process.

2. *Provide guidelines and policies for data mismanagement.* If employees are expected to protect patients' data, then healthcare organizations need to provide clear guidelines and policies to help prevent data mismanagement. These might include:

> Specifying the devices that can be used to access patient data
> Identifying appropriate time and place of data access
> Maintaining a need-to-know posture toward healthcare data
> Prioritizing discretion when transmitting patient information
> Utilizing approved communication channels for professional discourse

At the same time, healthcare leaders need to provide employees with real-time awareness to execute this priority.

Protecting patient data in a dynamic healthcare environment is replete with unique challenges. Even the most well-intentioned employees can violate HIPAA privacy regulations, so checks and balances such as real-time alerts to promote data awareness are both helpful and necessary.

In addition, automated technical safeguards that control access to PHI can significantly reduce patient data exposure while lessening the possibility of a compliance violation.

3. *Data-driven training and retraining.* HIPAA requires that companies handling PHI and PII prepare their employees to handle this information. While the HIPAA regulation requires companies to "train all workforce members on its privacy policies and procedures, as necessary and appropriate for them to carry out their functions," the tangible expression of this training is largely left up to individual entities.

Healthcare data breaches at a glance

According to a report by EMC and IDC, healthcare data expands by 48% a year, far faster than other sectors, and it will reach 2,314 exabytes by 2020. This rapidly expanding digital ecosystem offers a treasure-trove of personal data, and, like all information today, that data is under attack.

Reported data breaches in the healthcare industry have risen steadily but precipitously since 2009, culminating in 365 reported data loss events in 2018, the highest on record. Collectively, the *HIPAA Journal* estimates that nearly 190 million healthcare records were stolen along the way.

Regardless of the methodology, data security and privacy training should be consistent, clear and accountable. First-day orientation and annual meetings are not enough to protect PHI and PII.

It needs to be baked into the company's ethos, and that only occurs with repetition and regular instruction.

Other training-related keys include:

> Data security training should be specific and data-driven, ensuring that employees are prepared to protect patient data.

> Healthcare companies can leverage their monitoring software to address specific shortcomings within an organization.

For example, it's estimated that nearly 500,000 records are compromised every day because of mobile devices, according to *HIPAA Journal*. If a company finds that its employees routinely access patient data from a mobile device, they can target their training to restrict or prioritize data access from these devices.

4. *Endpoint data loss prevention.* Whenever possible, preventing a data loss event is a top priority for healthcare IT administrators, and software is the best weapon in this ongoing battle. Employee monitoring software can provide real-time notifications to suspicious data activity. This can reduce response time from hours or days to minutes, potentially preventing a data disaster before it starts.

To put it simply, identifying possible threats is important, but stopping them from stealing or revealing sensitive data is the goal.

5. *IT forensics in the aftermath of a data breach.* Of course, data security is an evolving threat with many manifestations, and, when something does go wrong, healthcare providers need to learn from the episode and demonstrate a burden of proof. Today's employee monitoring software allows hospitals and other healthcare providers to produce detailed incident reports derived from session recordings, access logs and other data points. This information can be shared with privacy officers and can be analyzed to improve best practices going forward.

Meanwhile, IT forensics allows companies to hold perpetrators responsible, ensuring that malicious data theft is detected and appropriately punished.

To adequately protect patient data, healthcare companies need to turn their attention to potential insider threats, implement guidelines and policies for data mismanagement, focus on employee training and retraining, prevent data loss in the first place and enable IT forensics to manage and analyze data breaches. //

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Staking a claim in home-centered care: A partnership-based strategy

Dawn Samaris and Andre Maksimow

Home health's position among post-acute care options is likely to strengthen.

"We have declared home health as the new frontier in value-based medicine." This quote by William Fleming, president of Humana Healthcare Services, was made in a presentation to investors that also identified home health as one of the "five most impactful areas of influence in health (Humana: Investor Day 2019, March 19, 2019)."

There is a good deal of logic behind Humana's focus on the home. The U.S. population is aging. Technology is expanding the range of medical services that can be delivered at home, as well as the ability to remotely monitor and connect with patients. Home health is typically a much lower-cost alternative to care delivered in institutional settings. Payers are increasingly recognizing the value of home-based non-medical services that address social determinants of health. New market entrants — including electronics retail giant Best Buy — are investing in home-centered services.

For health systems, a home-centered strategy may be advantageous across a range of settings. Home health can help manage costs under value-based payment structures. Home care can increase patient satisfaction and help build consumer engagement with a health system through services that assist aging or recuperating individuals with the necessities of daily life. For those systems with provider-based health plans, a home-centered strategy can help manage total cost of care, enhance member satisfaction and offer a point of value differentiation.

This article takes a closer look at the case for home health and home care services as components of a home-centered strategy. It then discusses why a partnership option with a home health or home care operator may be the best path for health systems to explore.

The case for a home-centered strategy

Home health services and personal home care services are the pillars of a home-centered strategy.

Home health services. Home health is already the leading site for post-acute care following an inpatient discharge. It is second only to skilled nursing facilities (SNFs) in Medicare fee-for-service spending, but costs for an episode of home-health care are significantly below the cost of an episode of care in a SNF (see the chart below).

Home health's position among post-acute care options is likely to strengthen. While there is some risk associated with changing payment models, home health operators have proven adept at containing cost growth. Factors to consider include the following:

Growth trends. The CMS Office of the Actuary predicts that home health services will be one of the fastest growing areas of healthcare professional services over the next decade.

Clinical outcomes evidence. Studies have found little difference in outcomes for patients who receive post-acute care at home instead of from an institutional provider and have found the potential for significant cost savings.

Consumer preferences. There is clear data that consumers would prefer to stay in their homes as long as possible and avoid hospitalization and intensive care in the later stages of life.

Comparison of post-acute sites of care

HIGHER ACUITY ← → LOWER ACUITY

Acute care facility	Long-term acute care hospital	Hospice	Inpatient rehab facility	Skilled nursing facility	Home health
Medicare spending ($B)	$5.3	$15.9	$7.4	$27.2	$18.1
Providers	391	4,199	1,182	15,052	12,346
Freestanding %	62%	75%	22%	95%	N/A
Base payment	$42k/admission	$150-$725/day	$15k/admission	$11k/admission	$3k/episode
Patients first site after acute	2%	0%	11%	41%	45%

Source: Post-Acute Care: A Review of Regulation and Reimbursement 2017 Edition, Stephens, Aug. 30, 2017.

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Payment trends. The new Home Health Patient-Driven Group Model goes into effect on Jan. 1, 2020; the model is intended to be budget-neutral and financial impacts on the home health sector are not yet known. The Medicare Payment Advisory Commission (MedPAC) has also recommended reductions in the base payment rate for home health agencies, in part because of the industry's success in controlling costs and maintaining Medicare margins. The possibility of reduced rates for home health should, however, be weighed against the savings that a home health strategy could generate under risk-based payment structures.

Home care services. A combination of demographic and policy trends makes a home-centered strategy that incorporates personal home care services worth consideration. Factors to consider include the following:

Growth trends. With the U.S. Census Bureau predicting that the over-65 age group will grow from 49.2 million in 2016 to 78 million in 2035, the opportunities for personal home care services will grow significantly. Growth in the senior population will also put strains on the ability of family members to serve as caregivers.

Policy changes. Medicare Advantage plans, which have seen enrollment nearly double over the past decade, are now able to offer supplemental benefits to their members to include services that might have been considered daily maintenance and thus not allowable under previous guidance.

Understanding social determinants of health. Despite widespread belief that addressing social determinants of health can have significant beneficial impacts, there is still limited evidence of which interventions are most effective and for which populations. A home-centered strategy that focuses initially on private pay home care services can start to build that understanding, while positioning the health system to serve the daily needs of a growing senior population.

The partnership option

Although demand for home-centered services is likely to grow, many health systems have been divesting their home-centered operations and are opting instead for joint ventures or other partnerships with home health and home care operators.

Partnership offers health systems several benefits:

- Creating a partnership that leverages the resources of an existing home health or home care operator can provide a faster route to bringing a home-centered program up to scale.
- A home health or home care operator already will have the bandwidth and skills to manage a home-centered program. They may also have expertise in areas such as improved patient experience and data analytics to inform post-acute care decisions.
- Home health and home care operators have experience with the employee recruitment and compensation issues unique to the business, including relatively high employee turnover.
- A partner operator can free up health system management expertise and capacity to address other strategic priorities.

There are some key considerations for health systems when structuring a partnership. First, the health system should enter into the partnership with a clear view of what it hopes to achieve. It should work with its potential partner to define mutually agreed upon financial and quality of care metrics for the partnership and milestones for determining the partnership's success.

Next, if a health system is trying to build a home-centered strategy, it should not make the success of that strategy dependent solely upon its partner's performance. The health system should negotiate appropriate control provisions to ensure that its community mission is enhanced and that incentives are aligned to support broader strategic objectives such as population health management. It should also define an exit strategy if the partnership does not meet expectations.

A home-centered strategy aligns both with a health system's interest in engaging with and meeting the needs of an aging population and with the increasing demand for high-quality, low-cost care delivery models. Home health and home care operators already know the terrain of this new frontier. For health systems seeking to stake a claim in home health, home health and home care operators can be valuable partners in executing a successful home-centered strategy.

For a more detailed discussion of a home-centered strategy, go to kaufmanhall.com/hcp.//

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Seminars focus on revenue cycle essentials, value-based payment and chargemaster strategies

Erika Grotto

Healthcare finance professionals looking for a deep dive into the most pressing issues in the industry can register for HFMA's seminars, a two-day focused education Dec. 5 and 6 in Chicago.

In a revenue-cycle-focused session updated for this year, Sandra Wolfskill, consultant, and Lucy Zielinski, managing partner at Lumina Health Partners, will provide resources and best practices for today's revenue cycle. The session, "Revenue Cycle Essentials and KPIs," will include a review of the patient-friendly revenue cycle and offer discussion on how to face key challenges.

Integrated organizations need integrated processes

Merger and acquisition activities over the past several years have left many health systems with several legacy organizations still using their own processes, Zielinski said. As stakeholders come together to integrate care, revenue cycle managers should look at their processes to ensure the entire organization is in sync.

"Revenue cycle has to follow suit in being integrated so providers of care are getting paid for what they're doing," she said. Revenue cycle processes are different for acute care and ambulatory care, so it's necessary to find a way to bring those processes together as care is integrated.

Key performance indicators for every stakeholder

A key idea for Zielinski is that different stakeholders should focus on different key performance indicators (KPIs). For example, a physician cares more about KPIs that determine how they are paid, such as relative value units. The front office staff cares about clean claims but isn't as focused on margin. "Every stakeholder group cares about different things, and KPIs have to be aligned for each group," she said.

Patient communication is the key to consumerism

At the core of revenue cycle performance is a focus on the patient, Wolfskill said. The rise of high-deductible health plans as well as conversations around consumerism and price transparency have made for a patient population hungry for information. Healthcare organizations need to respond by talking with patients about their financial responsibility so there are no unwelcome surprises when the final bill arrives. "Even a ballpark or a range will help patients understand where they fit in," Wolfskill said. "We wouldn't be talking about this if it weren't possible."

Staff must draw on different skills from those they used in the past, and they need to be trained to respond to patient questions. More healthcare organizations are seeing a need to set up call centers and other resources for patients to get more information about their financial responsibility, Zielinski said.

"We talk about increasing access to care. I think we have to increase access to the revenue cycle," she said.

New payment models also require a focus on individual patients. It's important to identify patients with chronic conditions who fit into specific value-based payment programs and then code their care appropriately, so those patients are counted as part of the correct programs, Zielinski said.

The role of technology

The session also will focus on using technology to improve performance. Having artificial intelligence (AI) technology is essential to success in today's revenue cycle, Wolfskill said. Automating processes increases efficiency and provides data that revenue cycle managers can use to improve results. However, it's also essential to have the right people who know what to look for in that data. "AI will find the issue for you. It won't tell you how to fix them," she said.

For example, AI can tell an organization which health plans are not responding to claims.

A duplicate claim is unlikely to get good results. But a conversation with the health plan could help an organization figure out where the process breaks down and take steps to remedy the issues. //

HFMA Seminars present focused healthcare finance education

The HFMA Seminars Two Days of Deep Dive Education program will be held Dec. 5 and 6 in Chicago. The program includes the following sessions:

- Leveraging Cost Accounting to Create Strategic Advantage
- Return on Analytics
- Chargemaster Update and Strategies
- Medicare Cost Reporting
- Revenue Cycle Essentials
- Contracting Under Today's Payment Models

Register now at hfma.org/seminars.

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// finance at a glance //

Physician pay increased but productivity remained stagnant in 2018

Physician compensation increased in 2018, while changes in productivity remained low, according to AMGA's 2019 Medical Group Compensation and Productivity Survey.

The survey, conducted by AMGA's subsidiary, AMGA Consulting, found that overall physician compensation increased by a median of 2.92%, compared to a 0.89% increase the previous year. Productivity increased by 0.29%, compared to a 1.63% decline in 2017. The data are from 272 medical groups and represent more than 117,000 providers,

"The 2019 survey shows that physician compensation in 2018 rebounded from a stagnant 2017," said Fred Horton, M.H.A., AMGA Consulting president. "While productivity also increased, it did not increase enough to surpass the decline we saw in last year's survey, meaning productivity still has not risen since 2016."

Medical specialties saw an increase of 1.9% in median wRVU production over last year's survey. The compensation per wRVU ratio increased by 2.65%, and the overall median compensation was up for medical specialties by 3.39%. A sample of medical specialties with more noticeable changes to the compensation per work RVU ratio are cardiology, dermatology, gastroenterology, hospitalist–internal medicine and psychiatry. //

Productivity and pay change specialty care, 2017-18

Specialty	Compensation	wRVUs	Compensation per wRVU
Cardiology (General)	4.4%	1.8%	4.3%
Dermatology	3.3%	1.6%	5.4%
Gastroenterology	-0.4%	0.7%	4.2%
Hospitalist (Internal medicine)	2.1%	1.1%	4.4%
Psychiatry	15.6%	-1.1%	5.9%
Medical specialties	3.39%	1.9%	2.65%

Source: AMGA's 2019 Medical Group Compensation and Productivity Survey