INTRODUCTION

In a value-based reimbursement environment, creating efficient models of care is a critical component to the success of every healthcare provider. The Centers for Medicare and Medicaid Services (CMS) are implementing mandatory value-based payment models to control total beneficiary spend that make providers accountable to quality metrics. One significant driver for this reduction is economic impact as evidenced in the Dartmouth Institute for Health Policy and Clinical Practice report estimating that 30 percent of all Medicare clinical care spending could be avoided without worsening health outcomes. Commercial payers are shifting their payment schemes to reward quality care that results in overall cost reductions. Employers are entering into value-based contracts that improve their bottom line while positively impacting the level of care provided to patients. This commitment to becoming more efficient is driving all key stakeholders to change the status quo and enter into innovative “Value-Based” models for care delivery.

One innovative model gaining traction is a Hospital Efficiency Program (HEP). An HEP is an accelerated solution to eliminate financial waste, improve quality and drive innovative best practices into the delivery of care. HEP programs are typically “whole-hospital internal cost savings programs” that drive cost containment, standardization and operational efficiency for the health system while ensuring attention is paid to quality metrics at the global level. Bottom line savings generated through the HEP that also maintain or improve quality create rewards that are paid to eligible providers based on demonstrated effort. A health system stands to benefit from an HEP by providing the following:

1. Coordinated focus on cost and quality across the health system with physicians taking on important leadership roles;
2. Creation of an internally funded value-based payment program that only creates rewards IF the system saves money; and
3. Development of a program that challenges the health system and physicians to work effectively together before entering into meaningful commercial contracts.

The HEP is a mechanism to create aligned incentives to help hospitals reduce costs associated with the delivery of care while economically rewarding physicians for their role in reducing those costs and improving quality delivered to patients. Hospitals with successful HEPs can see significant cost reductions and increased quality, all while improving the alignment with their physicians that allows the hospital to more nimbly address future challenges occurring as a result of payment reform.

FUNDAMENTAL COMPONENTS OF HOSPITAL EFFICIENCY PROGRAMS

HEPs can be created in a variety of ways; however they all have similar fundamental components. These fundamental components drive many decisions that are made by the hospital, health system and physician leadership. The following figure outlines the key HEP contract components and demonstrates how dollar savings can be shared between a hospital system and physicians. This example shows employed and independent physicians organized as a Clinically Integrated Network (CIN). A Clinically Integrated Network is one example of an approved legal structure to administer an HEP contract.

Filtering through Shared Savings Methodology:
- Thresholds
- Budgetary Targets
- Percent Splits
- Fair Market Value Assessment
THE FOUR FUNDAMENTAL COMPONENTS OF AN HEP INCLUDE:

1. **Legal structure and governance**: HEPs are created between the health system and a physician or physician organization. The approach to launching an HEP includes traditional methods of physician-hospital alignment, along with more advanced network structures to include a broad cross-section of the medical staff. Organizational structures are described in the following table.

### TABLE 1: SAMPLE LEGAL STRUCTURES

<table>
<thead>
<tr>
<th>LEGAL STRUCTURE</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>EMPLOYMENT</td>
<td>Hospital directly hires physicians or acquires private practices; physicians become part of a new multi-specialty provider organization that has aligned goals with the health system</td>
</tr>
<tr>
<td>CLINICALLY INTEGRATED NETWORK (CIN)</td>
<td>Network that evaluates, modifies and coordinates care among multiple providers focused on increasing quality, lowering costs and obtaining enhanced rewards for demonstrated performance; contracts on behalf of all participants</td>
</tr>
<tr>
<td>INDIVIDUAL CONTRACTS</td>
<td>Hospitals and Health Systems will contract with an individual physician through contracts similar to “co-management” that outline eligibility and performance requirements.</td>
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An HEP is typically led by a team of physicians and hospital executives who work together to improve the quality of care while reducing the total cost. The legal framework of an HEP must include a detailed governance structure and a set of managing committees that design, implement and report HEP quality and cost initiatives. Focused program initiatives can be specific to hospital departments, like Orthopedics, or be general hospital-wide initiatives such as surgical supply costs.

2. **Performance metrics**: The goal of the HEP is to improve quality and reduce costs. In order to ensure quality is a focus throughout the program, quality and cost-saving metrics should be at the forefront. These metrics will be used to evaluate HEP performance and distribute economic savings to entities participating in the HEP process. As such they will be perceived as important by physicians and hospital staff and if selected correctly, can have an immense impact on the overall cost and quality of the hospital. The cost metrics must be measurable and their impact should be quantified prior to the launch of the HEP. Selected quality metrics should be aligned with defined cost-saving initiatives and value-based reimbursement metrics to ensure reinforcement of the cost/quality dyad and payer performance-based reimbursement. Table 2 provides examples of different cost-saving and quality metrics that can be used within an HEP.

### TABLE 2: SAMPLE HEP PERFORMANCE METRICS

<table>
<thead>
<tr>
<th>COST METRICS</th>
<th>DESCRIPTION</th>
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<tbody>
<tr>
<td>Standardize surgical and procedure products to eliminate waste and variation</td>
<td></td>
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<tr>
<td>Improve compliance for generic drug utilization</td>
<td></td>
</tr>
<tr>
<td>Decrease 30-day readmission rate for a patient population</td>
<td></td>
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<tr>
<td>Coordinate care and utilization resulting in a 0% increase to employer health plan spend</td>
<td></td>
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<tr>
<td>Reduce hospital-wide catheter-associated urinary tract infection rate</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>QUALITY METRICS</th>
<th></th>
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<tbody>
<tr>
<td>30-Day Readmission Rate for Medicare Patients</td>
<td></td>
</tr>
<tr>
<td>Healthcare Acquired Conditions for All Patients</td>
<td></td>
</tr>
<tr>
<td>HCAHPS (Patient Experience)</td>
<td></td>
</tr>
<tr>
<td>Mortality Rate</td>
<td></td>
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<tr>
<td>Reduction in Complications</td>
<td></td>
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</tbody>
</table>
Table 3 shows an example of a cost-savings metric and its associated quality metric.

**TABLE 3: EXAMPLE OF CORRESPONDING COST-SAVINGS AND QUALITY METRICS**

<table>
<thead>
<tr>
<th>COST-SAVINGS METRIC</th>
<th>QUALITY METRIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>COST PER CARDIAC VISIT</td>
<td>SCIP Card-2 Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker during the Perioperative Period</td>
</tr>
</tbody>
</table>

It is essential that the cost savings do not negatively impact the quality of care. This is central to the legal framework of the HEP. Physicians are not eligible for shared cost savings if the pre-defined quality metrics are not at least maintained throughout the term of the HEP contract.

An HEP program should be designed to give physicians the opportunity to create distinctive change across a hospital or health system by reducing variability of care and unnecessary utilization of services. The program’s performance metrics should be selected based on the level of impact physicians have on the materiality of the outcomes, thereby placing the results squarely in the hands of the clinicians. In Don Berwick’s article “Eliminating Waste in US Health Care,” he cites that failures in care delivery attributed to processes that are not consistent with best practices cost Medicare between $100B and $150B annually. The implementation of clinical pathways and the standardization of clinical behaviors through such a program should drive positive changes and savings attributed to reduced variability in care delivery.

3. **Eligibility/Participation criteria:** Physicians within the HEP are typically required to participate in a number of different areas including committee involvement, quality reporting, best practice research and evidence-based guideline development. These activities are necessary to make progress against the pre-determined outcomes established as part of the HEP. Physicians are tasked with clinical expectations as well as specific non-clinical duties that further the goals outlined in the HEP. Physicians can be fairly compensated for their time and effort to complete the following actions:

   - Physician to physician communication;
   - Participation and leadership within HEP and hospital committees; and
   - Development of educational training materials.

4. **HEP contract:** A legal contract is created between the health system or hospital and its physicians or physician organization. This contract includes the governance structure, performance metrics and eligibility/participation criteria outlined earlier in this article. Each performance metric must have a baseline and target prior to execution of the HEP contract. Furthermore, the contract must provide pre-determined methodologies to support defined payouts to the physician or physician organization.

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DEVELOPMENT OF AN HEP

The development of an HEP requires a disciplined approach that evaluates the readiness of physicians to participate in such an agreement and properly identifies the economic opportunity available to the hospital to generate meaningful savings as part of the program. Due to the complexity and broad involvement of stakeholders, an inclusive process is recommended that provides early buy-in to the program. The HEP development process can be broken down into the five stages described below:

FIGURE 1: HEP DEVELOPMENT PROCESS

- Organize around key initiatives to maximize success
- Create standard “report cards” and distribute on a regular basis
- Identify the improvement opportunities across health system, both IP and OP
- Calculate financial impact of improvement
- Physicians must complete these criteria in order to achieve payout
- Made up of committee participation, IT adoption, clinical protocols and educational events among others
- Typically has levels of participation; the higher the level, the more participation and subsequent payout if financial and quality metrics are achieved
- Create dashboard of both quality and financial metrics to measure
- Identify thresholds and payout targets
- Create legal contract that must be signed by the health system and physician/physician organization

Ensuring the program is developed with the right level of focus on cost-saving initiatives and quality expectations supported by physician participation and broad education is critical prior to launching the HEP. Once the program is developed and the HEP begins, all stakeholders must stay engaged and organized to monitor performance across defined metrics and then adjust tactics or strategies to see meaningful results. HEP programs can be successful in the development process, but fail due to insufficient dedication of time and resources to continuous project management. Failure to engage all physicians on a regular basis and provide reports and active communication around program results will lead to disappointing outcomes.

Accordingly, physician leadership is an essential component to implementing a HEP supported by standardized processes and clinical solutions. The HEP must be designed to reward engaged physicians who create, implement and lead critical HEP initiatives. Physicians are only eligible for a financial reward if they have participated at a level that created positive change for the identified HEP performance metrics. Those physicians who did not appropriately participate, as outlined in the HEP legal framework, will not be eligible for a financial reward.
EXAMPLES OF HEPS ACROSS THE COUNTRY

HEPs are being implemented on a national level and realizing success across defined quality and cost metrics. Below is a summary of three HEP initiatives:

1. **Example 1:** A CIN located in the Southeast recently concluded the third year of their Hospital Efficiency Program, which was created to demonstrate improved quality and cost reduction capabilities to payers. The program achieved over $1 million dollars of net savings (retained by the health system after payments were distributed each year) with eligible physicians realizing on average $3,500 to $5,000 per year based on achieving the following performance metrics: (1) Supply cost reduction; (2) Pharmacy cost reduction; and (3) Reduction in Employee health plan cost as well as other administrative triggers such as ICD-10 training, CDI response rate and the achievement of Meaningful Use reporting requirements. One lesson this system learned was the importance of incentivizing physician engagement while also supporting strong IT adoption.

2. **Example 2:** A hospital in the Midwest recently concluded the first year of their program which was created to further align objectives and incentives between physicians and the hospital. The program has achieved savings to the health system in excess of $2 million dollars while eligible physicians received an average of $5,000 in incentive-based payments. Performance metrics included: (1) Per capita employee health plan costs; (2) Standardized surgical/procedural supply cost for the health system; and (3) Achieving appropriate core measures at 99% of target. One lesson learned by this hospital is the importance of creating a focused set of first-year initiatives to actively engage physicians.

3. **Example 3:** A Clinically Integrated Network (CIN) located in the Great Lakes region recently concluded the first year of their program, which was created to respond to healthcare challenges by focusing on cost and quality. The program has improved quality across evidence-based guidelines for readmission rates, patient safety and patient satisfaction scores. They have not yet made any financial distributions to physicians. One lesson they learned was the importance early in the process of identifying and engaging a physician leader who could successfully lead other physicians to achieve HEP objectives.

SUMMARY

The pace of change toward risk-based contracting is accelerating and will continue to be a critical healthcare driver for delivery model innovation and care improvement initiatives within the acute care setting. In preparation for risk-based contracting, health systems and providers must find creative ways to deliver care that is more efficient and coordinated with their physicians. HEPS offer an innovative solution that enhances a provider’s risk capability in an upside-only environment by applying key capabilities needed to succeed in risk-based contracts. An organization should consider the following critical success factors as they develop plans for their HEP program:

1. Respected physician leaders who can help design and market the program to other physicians;
2. Performance metrics that are easy to measure on a regular basis;
3. Distribution methodology which is transparent for all key stakeholders; and
4. Design of the HEP contract with “shelf-life,” allowing it to evolve over time.