INDIANAPOLIS
BUSINESS JOURNAL

CENTRAL INDIANA'S BUSINESS AUTHORITY VOL. 35 NO. 14 • JUNE 2-8, 2014

FOCUS HEALTH CARE/BENEFITS/REFORM

Power of presence

Getting everyone into the same room is cutting costs and improving health at IU Health's Saxony hospital

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It can be as simple as getting all the players in the room.

That's what the joint replacement team at Indiana University Health Saxony Hospital has done to make care coordination—a key main strategy in President Obama's health care reform law for controlling health care spending—a reality.

That's no easy task, due to the byzantine way the industry is structured and financed. But unprecedented pressures now force all health care providers to follow IU Health's Saxony's lead in trying to work more closely as teams to boost quality and reduce costs.

IU Health Saxony credits the

See **HOSPITALS** next page

IBJ photo/Eric Learned

Prior to each week's surgeries, IU Health Saxony calls a meeting of everyone involved including the surgeons, nurses, pharmacists, anesthesiologists, the operating room team, orthopedic implant salesmen and even the hospital chaplain. The result is less need to readmit patients for further treatment and more predictable, lower costs.

Continued from previous page

teamwork for cutting costs and producing its nation-leading results.

At 7 a.m. on a recent Friday morning, 20 people slowly stream into a carpeted conference room on the second floor of IU Saxony—a shiny, quiet hospital in Fishers.

Most wear scrubs; some wear white lab coats. They fill up the rows of tables, most with small stacks of papers in front of them, although some bring laptops instead. Several have Starbucks cups or thermal mugs.

There are two surgeons, an internist, nurses, pharmacists, anesthesiologists, the operating room team, therapists, salesmen from two orthopedic-implant makers and even the hospital chaplain. Anyone who will have any contact with the patients is asked to attend.

"No one is paid extra to attend. They believe in this model," said Dr. Michael Meneghini, an orthopedic surgeon who directs the joint replacement program at IU Health Saxony.

They discuss in detail every patient who will come in the following week for surgery: their heights, weights, medical histories, reason for needing a joint replacement (most of the patients are obese, diabetic or nearly so).

The goal is not only high-quality surgeries—although IU Saxony is doing that. It had the eighth-lowest rate of readmissions last year out of the 120 academic medical centers and 307 affiliated hospitals that are part of the University HealthSystem Consortium.

Just 0.74 percent of Saxony's joint replacement patients had to come back for do-over surgery within 30 days of the first surgery. That compares with a national average of 5.4 percent, according to the Centers for Medicare & Medicaid Services.

But the IU Saxony team is also striving to catch anything that might delay completion of a surgery or postpone it altogether. Handling unforeseen issues on the day of surgery, which Meneghini calls "fire drills," can lead to overtime for staff or to fewer surgeries per day. Postponements waste staff and OR time.

"It shows you how much potential there is, if the care is really coordinated. It's reflective of how much room there is to work in the system. I don't see anything holding us back from moving in that direction."

Ken Weixel, Deloitte consultant

Delays can also keep patients in the hospital longer. But IU Saxony has been doing a good job of getting patients on their way. It ranked sixth nationally among the University HealthSystem Consortium hospitals for its length-of-stay index, which measures hospitals on how long their patients stay versus how much they were expected to stay based on the complexity of their health needs.

When Meneghini and his partner, Dr. Philip Ireland, were doing surgeries at IU Health's North hospital—while they waited for construction of the Saxony hospital to finish—the average length of stay of their patients was half a day longer.

That's because, Meneghini said, they had not instituted the care coordination that they now do at their Friday morning meetings.

"The coordination of care is getting the whole team on the same page. There's less errors, there's less confusion. So the patients are ready to go home faster," Meneghini said. "Every minute in a hospital is hugely expensive."

Impressive numbers

Meneghini is trying to figure out exactly how much IU Health Saxony is saving, compared with market averages. In a study published this year by researchers at New York University Hospital for Joint Diseases, readmissions accounted for nearly 5 percent of the average cost of knee and hip replacements for Medicare patients. That punched out to be $1,073 per patient.

If NYU had had the same low readmission rate as IU Saxony, including the same percentage of complex cases called revisions, it would have saved $921 per patient.

Since IU Saxony did 600 surgeries last year and is on pace to do 800 this year, those savings would range from $550,000 to more than $700,000 per year.

If those kinds of results were applied across the entire IU Health system—as IU Health executives have asked Meneghini and Ireland to do—it could save more than $3 million per year.

And, Meneghini figures, IU Saxony's work on shortening patients' time in the hospital, reducing overtime and making a point to use lower-cost orthopedic implements when possible, can rack up even more savings.

Costs at the forefront

During the Friday morning meeting, Meneghini asks his team questions about the price of the orthopedic implants it could use—even as representatives from the orthopedic companies, Stryker and Zimmer, sit in the room.

He noted that using a cone-shaped implant on one patient would cost $1,000, even though screws would work as well and cost just $60.

Meneghini chalks up his price sensitivity to the fact that his parents were both financial planners in Terre Haute. But Meneghini's partner, Ireland, says it's also the way health care is moving now.

"It's all about keeping the costs down," Ireland said. Fifteen years ago, "We never even talked about it. But it reached a fever pitch in the last three years."

Indeed, IU Health plans to offer joint replacements as a package deal—complete with a 90-day guarantee insurers and employers can buy. IU Health Plans, the health insurance arm of IU Health, intends to start offering such bundled prices later this year, Meneghini said.

Determining exactly how much IU Health Saxony is saving will be key to setting a competitive yet profitable price on those bundles.

Other Indianapolis-area hospitals—including Franciscan St. Francis Health, Community Health Network and Indiana Orthopaedic Hospital—have also been offering bundled prices—although none has offered a 90-day guarantee.

The idea is to use lower operating costs to create a profitable package price—also known as a bundled price—which will also be attractive to health insurers because it will be guaranteed and it will be lower than what they might pay when surgeries are billed in piecemeal fashion, as they are today.

Average prices paid in the Indianapolis area by private health insurers for knee and hip replacements are $23,300 to $37,300, according to a February study by the National Institute for Health Care Reform.

"It shows you how much potential there is, if the care is really coordinated. It's reflective of how much room there is to work in the system," said Ken Weixel, a Deloitte health care consultant. "I don't see anything holding us back from moving in that direction."

Forced by Obamacare

Coordinating care has been a buzzword in health care for years. But making it a reality has been extremely difficult.

That was partly because health care providers were fragmented—with doctors running separate practices from the hospitals where they worked.

Even more, the regulations that govern health care directly prevented or highly discouraged various health care entities from working together for the good of patients.

The federal Stark laws forbid any financial compensation for directing patients from one health care entity to another—unless those entities were all subsidiaries of the same organization. That's one reason hospitals have purchased so many physician practices—to get around the Stark law's barriers to working together.

But being on the same team doesn't fix the piecemeal way in which the federal Medicare program and private health insurers pay doctors and hospitals. Nearly all health plans use the system of procedure codes—developed by the American Medical Association—to pay doctors and hospitals.

"Today, nurses are being asked to critically think, in a way that we probably haven't before."

Margaret Harvey, Chamberlain College of Nursing in Indianapolis president

So even though a nurse is standing right next to a physician, anticipating what he needs next in the surgery and handing each tool to him, the nurse's work is paid via a facility fee to the hospital while the physician's fees are paid separately and the equipment used is paid for separately.

Meanwhile, health plans have typically paid providers nothing for time spent on the hand-offs among different medical staff that occur constantly when a patient comes in for care—and in between a patient's visits for care.

Yet, noted Deloitte's Weixel, those are the areas in which the cost of care gets out of whack the most.

"I think the biggest variance in the overall cost of care doesn't have to do with the things that surgeons do often and do well," he said.

Paid for efficiency

Obama's 2010 health reform law, the Affordable Care Act—in addition to other recent changes made by Congress and the federal Medicare program—is pushing health care providers to work more closely together.

Medicare is bundling prices and payments, one strategy now being copied by private insurers.

Medicare and private insurers are also dinging hospitals that have higher-than-average rates of readmissions in key areas.

Doctors and hospitals can now earn bonuses from Medicare if they work closely together to manage the health of specific groups of patients, and can show they provided high-quality care that reduced expected spending.

Private insurers, such as Indianapolis-based WellPoint Inc., have been structuring similar contracts with doctors and hospitals.

Above all those things, the Affordable Care Act instituted rules that tie future payments to doctors and hospitals to inflation in the rest of the economy. Since health care spending has typically grown twice as fast as general inflation, those new rules almost certainly mean providers will be paid less—in constant dollars.

That is pushing them to cut unnecessary costs in their systems. And care coordination is one way to do that.

"Everybody's going to be doing it," Meneghini said of care coordination, "because they've got no choice but to improve the quality of care and decrease their costs."

Pressure from patients

But perhaps the greatest pressure long term won't be from the government or health insurers, but from patients themselves.

The growing prevalence of high-deductible health plans—which has been furthered by the insurance exchanges created by Obamacare—means patients are paying for larger chunks of their care.

That has affected primary care physicians, pharmacies and medical labs more than big-ticket items like joint replacements.

But now WellPoint is rolling out "reference prices" for joint replacements—which make patients themselves pay any costs above a pre-set price. And the federal Medicare program announced in May it would follow suit.

The need to coordinate care and focus on patients is creating such change in the health care sector, it's even trickling down to the training of new doctors, nurses and other medical staff.

"A decade or more ago, nurses were really training to be more skills-

See **HOSPITALS** next page

Continued from previous page

based. By that I mean, they would get an order from a doctor and would do whatever was required," said Margaret Harvey, president of the Chamberlain College of Nursing in Indianapolis. "Today, nurses are being asked to critically think, in a way that we probably haven't before."

Nurses are often the ones who connect different people within a hospital who interact with a patient—from doctors to therapists to the chaplain and even family members, Harvey said.

"It's really about coming together and talking about how these different roles impact the patient so we can give the best outcome," she said.

Channeling Ritz-Carlton

That's exactly what the IU Saxony team is trying to do at its Friday morning meetings. And those discussions were not led by the surgeons, but instead by Meneghini's top nurse, Shelly Smits, and by Dr. Pete Caccavello, an IU Health internist who sees patients after they've been scheduled for surgery.

Meneghini acknowledged that it was difficult to get everyone at IU Health Saxony to buy into the coordinated care approach.

"Some of the therapists came from downtown at Methodist [another IU Health hospital], and they would say, 'Well, this is the way we do things downtown. Why do we have to come to this meeting?'" Meneghini said.

One way Meneghini made the vision clear to the IU Saxony staff was to tell them a story of how he proposed to his fiancée at the Ritz-Carlton hotel in Laguna Beach, Calif. The staff knew when the couple expected to arrive and—when their plane was late—called his cell phone to see if he needed any help.

The Ritz staff knew Meneghini planned to propose before dinner, but since things were running later than planned, also knew better than to mention it and blow the surprise. At dinner, Meneghini got down on his knee and presented a ring. After his fiancée said yes, only then did the Ritz staff bring out the cheesecake they had prepared that said, "Congratulations."

Meneghini later learned that the Ritz was able to pull off such impressive customer service because, every day, the entire staff—from concierges to cooks to cleaning maids—discusses each guest who will be staying at the hotel that night: why they're there and what they need.

"I thought, 'Why can't we do that in medicine?'" Meneghini said. Now he's trying to do exactly that.

"So much of medicine has always been doctor-centric or hospital-centric. We're trying to flip it around and make it about the patient, who is the customer," Meneghini said. "That's a paradigm shift."•