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Investing in Value-Based Health Care

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Dear Reader

Welcome to “Investing in Value-Based Health Care,” a special supplement to Hospitals & Health Networks developed in conjunction with Citi and the Healthcare Financial Management Association. This is the 14th year of a partnership that seeks to promote the exchange of information between hospitals and health systems and the investment community.

This year, the focus is on the transition to value-based care and some of the critical ingredients to get there. Hospitals and health systems are embracing change, enhancing operational efficiency and developing strategic partnerships and new business models to ensure success and sustainability. The provider-investor dialogue takes on greater importance during this period of change, as access to capital and its application will help contribute to transformation and a higher-performing health care system.

This supplement will be distributed at the 14th Annual Non-Profit Health Care Investor Conference. We thank Citi and HFMA for their continued support and hope that this supplement will be of value to your organization.

Sincerely,

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President, Health Forum
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Even as media attention continues to focus on the unfolding of the Affordable Care Act, there are certain objectives that health systems must pursue under any circumstances. Perhaps the most crucial objective of our era, and one that has moved to the forefront of public discussion, is the effort to transform health care delivery to a system that is based on value rather than volume. Value is the quotient that drives reimbursement in most other industries, so why not health care? The Centers for Medicare & Medicaid Services have stated that transitioning to a value-based payment system will make health care safer and prevent injuries and unnecessary readmissions to hospitals, which increase overall health care costs. CMS officials say such a transformation will result in savings of $55 billion over five years for Medicare alone.
Based Health Care
Merging Texas Health Systems Target Greater Value

The move toward value-based health care is being cited as part of the thinking behind the planned merger of two Texas health systems: Baylor Health Care System and Scott & White Healthcare.

In a joint news release issued Dec. 14, 2012, the two health systems stated that “in this new era,” health systems must be prepared for declining reimbursement, high levels of information management, greater demand for primary care services and population health management.

Joel Allison, president and CEO of Dallas-based Baylor Health Care, says this type of thinking is not new to his organization. “At Baylor we have always been focused on quality. As we saw the continued emphasis on and the opportunity to move to value-based purchasing, we put even more emphasis on our commitment to safe, high-quality care.”

On Jan. 1, Baylor Quality Alliance, an accountable care organization, was launched. Areas of focus include patient access to care, clinical integration, electronic health record connectivity, population case management and care coordination for the highest-acuity patients.

“We also have within the Baylor Quality Alliance programs that align incentives for quality and savings with Cigna, Aetna, BlueCross BlueShield of Texas and Humana,” Allison says. “We have two direct employer contracts that are built around quality scores and shared savings targets.”

Allison says the proposed merger with Scott & White, which the parties hope to complete by June 30, will augment the value quotient. “We both are aligned on doing population health management, and we want to geographically expand that to be able to manage more populations in the right setting. This gives us an opportunity to improve quality, create better access to care and gain efficiencies.” — Julius A. Karash

This transformation — which points toward the formation of accountable care organizations — represents an enormous change from decades of volume-based reimbursement. It is no easy task, but it is one that health systems around the country are beginning to undertake. The task requires the utilization of evidence-based medicine at every level of care, the sharing of information among health care stakeholders, and heightened communication with patients and their families to ensure continuity of care.

Health systems must analyze the cost of care, pricing strategies and new ways to work with physicians. Sophisticated information systems are an essential element.

One of the most crucial requirements is an alignment of goals among entities that previously have sometimes been at odds: providers, payers and health plans. In a value-based environment, no stakeholder will achieve success unless all stakeholders achieve success.

Yet, while the task is far from easy, the transformation is under way.

“Hospitals and health systems are working hard to improve quality and efficiency and demonstrate value to patients and the communities they serve,” says Neil Jesuele, the AHA’s executive vice president of leadership and business development and president of Health Forum. “We are seeing greater integration within and across provider organizations that will lead to better coordination of services and resource utilization.”

What needs to be done?
Michael Rowan, executive vice president and chief operating officer of Catholic Health Initiatives in Englewood, Colo., says value-based health care requires a new set of financial incentives.

“The incentives of the old model are to do as much as possible,” Rowan says. “The more you do, the more you get paid. Under the value proposition, it’s important to be able to show value. And value comes not by process, but by outcome. You should be paid for
delivering an outcome of wellness. Your incentive is to intervene in ways that are highly efficient and effective, to bring them to that state of wellness.”

Looking at it from an ROI standpoint, improved quality leads to fewer complications, which results in lower costs. Defining and calculating cost savings to complete an ROI calculation is doable, but it will take some practice. It’s not something that many organizations are doing on a regular basis.

At the same time, attention must be focused on the nonfinancial return that results from the value-based transformation, particularly improved patient care.

Cost of care, culture of care
Virtually every health system around the country is engaged in a cost-reduction initiative. Most are seeking to reduce costs by 20 to 30 percent over several years, industry analysts say.

Some of those organizations are crunching the same kind of data they have gone over for many years. This includes an evaluation of FTEs and an in-depth look at supply costs, among other things. “The reality, though, is you can’t get 20 or 30 or 40 percent of costs out without really redesigning the care processes,” says Joseph Fifer, president and CEO of the Healthcare Financial Management Association. “And some of that will point toward increased quality.”

Other more innovative organizations are investing in process improvement and value engineering, through such means as Lean, Toyota-style or Six Sigma production systems.

Ultimately, attaining value-based health care requires a cultural change in the health system, says Terry O’Rourke, M.D., executive vice president and chief clinical officer of Trinity Health, Livonia, Mich. “That’s not something that can be done by just sending out a memo. It’s challenging.

Reducing back pain and treatment costs in Seattle

In 2000, Virginia Mason Medical Center in Seattle adopted the Toyota Production System as part of a heightened focus on quality, affordability and access.

Four years later, Starbucks and other large Seattle-area employers, along with their health plan officials, asked Virginia Mason to help them reduce health care costs.

“As we talked with them about affordability, one of the issues was that health plan data suggested that Virginia Mason was more costly than other providers,” says Robert Mecklenburg, M.D., medical director of the Center for Health Care Solutions at Virginia Mason.

The discussion led to a marketplace collaborative in which employers leverage their purchasing power to bring out the best in providers and health plans.

“We started out by showing, in the case of back pain, a huge amount of waste in the system,” Mecklenburg says. “It showed great care embedded in a whole lot of inefficiency. So when we began working with Starbucks to redesign back pain care, 90 percent of the waits and delays and non-value-added care disappeared. We were left with a much more efficient model.”

As a result, time lost from work due to back pain decreased by 50 percent, physical therapy visits decreased by 50 percent and patient satisfaction increased to nearly 100 percent.

“This not only saved money for employers, but saved money for us, because we were producing back pain care at a much lower cost,” Mecklenburg says. “Our margin went up 50 percent in that spine clinic. We did much better financially. We had greatly increased capacity and a much lower cost of production.”

Virginia Mason has achieved the same kinds of results in Portland, Ore., Mecklenburg notes. — Julius A. Karash
working with people to change the care delivery process.”

Collaboration in California
In Sacramento, a health system has aligned its vision with a health plan and a physicians’ group to provide value-based health care to members of CalPERS, the California Public Employees’ Retirement System.

Dignity Health, formerly known as Catholic Healthcare West, formed California’s first ACO with Blue Shield of California and Hill Physicians Medical Group.

Michael Blaszyk, chief financial officer of Dignity Health, says the health system understood years ago that the amount of the gross domestic product consumed by health care in our national economy was unacceptable, and that Dignity needed to be part of the solution.

The health system and Blue Shield began having conversations with CalPERS about the rising health care costs and the growing obligations owed to current employees and retirees.

Then the health system, Blue Shield and Hill Physicians began discussing how they could meet the objectives of CalPERS collectively.

To do that, Blaszyk says, the health system, the health plan and the physicians’ group would have to “set aside those things that would normally be incentives to each of the organizations separately, to come together for a common good, and to test a theory we had: by bringing an insurer and a large physician group together with a health system, that we could bring down the rate of admissions, that we could bring down costs, and we could provide higher levels of quality to this population.”

Bringing the parties together was difficult, says Rosaleen Derington, chief medical services officer for Hill Physicians.

“After many months of negotiating the financial structure, we then put governance structures in place,” she recalls. “That’s when the struggles began. The closer we got to where the actual work happens, the more difficult the processes were. We were changing years and years of culture and, in some cases, years and years of animosity between organizations. We then started to be very transparent with data, and that’s somewhat intimidating.”

The ACO was launched in 2009. “The results, I think, are pretty clear and compelling,” Blaszyk says. “We were able to reduce readmissions from 5.4 percent in 2009 to 4.3 percent in 2010, and to 4.1 percent in 2011. “

Derington says targeting readmission rates included bedside coaching of patients and family members; making sure patients saw their primary care physicians soon after discharge; and calling patients after they went home to make sure they understood their medication regimens.

The impact made itself apparent on the cost side of the ledger. “If you compare the cost with the remaining CalPERS population, the cost trend was 3.9 percent [annually], 8.8 percent for all CalPERS members,” Blaszyk says.

Movement in Michigan
Trinity Health’s O’Rourke says the move toward value-based health care represents objectives he has wanted to achieve throughout his entire career.

All those objectives revolve around taking better care of patients. “That means a number of things,” he says. “It means having access. It means having coordination of care. It means being compensated for the right thing.”

O’Rourke emphasizes that good care also constitutes cost-effective care. As an example, he points to a sepsis initiative in which Trinity has been involved for two years. Trinity brought together key practitioners from all of its hospitals and worked with outside consultants. The health system has developed protocols for sepsis, and those protocols are embedded into Trinity’s electronic health record system.

The program has helped Trinity to lower the mortality rate for sepsis patients from 15.8 percent two years ago to 13 percent in its most recent fiscal year, which ended July 1, 2012.

O’Rourke is proud of those results. “That reduction in mortality correlated in our saving some 406 lives in that period. That’s more than one person a day who walks out of our hospitals alive who wouldn’t have the year before.”

The sepsis initiative also has resulted in cost savings to Trinity that total $16.6 million.

In another example, Trinity has employed electronic health records and bar code technology to prevent medication errors. “We have reduced our medication error rates by 34 percent,” O’Rourke says. “According to national data, each medication error costs around $8,700. On a scale where we deliver millions of medications a year, reducing that by 34 percent not only improves the quality of care, but has great financial benefits as well.”

The significance of the transformation is not lost on O’Roarke. Health system leaders shoulder a big responsibility to see that the transformation succeeds. “It weighs heavily on us as leaders to get it right this time,” he says.

The Investor Perspective
Hospitals and health systems will need to demonstrate the value of their transformation initiatives to the investment community. “Capital market participants will be monitoring the evolution of value-based health care, its implementation and timing in the industry,” says Fred Hessler, managing director of Citigroup. “They will be particularly focused on the transition from fee-for-service payment arrangements to value-based payments.”

Julius A. Karash is a freelance writer and editor in Kansas City, Mo.
Sweeping changes in health care delivery are coming in all directions. No hospital can stand still in this environment. Everyone has to have a plan that is relevant to its community and its situation — a plan that moves them toward a value-oriented world that demands more accountability for the quality and cost of care.

In this evolving health care world, costs and quality are each integral parts of a hospital’s recipe for success. Providing value in everything you do is the key to remaining competitive in the marketplace, and the best and only way to drive sustained improvements in performance and satisfaction. The experience in numerous other industries tells us that this transformation is possible. It also tells us that there can be stunning progress for all stakeholders when this right kind of competition is unleashed.

When providers win by delivering superior care more efficiently, patients, employers and health plans also win. When health plans help patients and referring physicians to make better choices, assist in coordination and reward excellent care, providers benefit. And competing on value goes beyond winning in a narrow sense. When hospital executives and their teams compete to achieve the best medical outcomes for patients, they pursue the aims that led them to their profession in the first place.

The good news is how hospitals and health systems across the country are demonstrating their commitment to value-based care — whether in their work to make care more equitable and to build healthier communities as a collaborative endeavor, or in their response to the public’s desire for transparency by defining, ensuring and reporting quality and financial information.

These hospitals and health systems are harnessing the power of evidence-based care to achieve positive patient outcomes and are mastering the art of applying those care processes consistently. In the process, they are revolutionizing the culture within their organizations, breaking down previously sacrosanct silos and bringing all kinds of caregivers together in a coordinated effort to improve performance.

As reimbursement shifts away from fee-for-service and toward value-based payments, hospitals are deliberately and effectively moving from volume to value and toward a transformed delivery system. Because these hospitals recognize they must do better with less, they are investing in long-term strategies to simultaneously reduce costs and increase quality by speeding adoption of information technology and better managing the care of patients with chronic conditions.

The hospitals that successfully navigate this changing health care landscape will make high-quality care less costly and reward innovations that increase value. They will focus on value for patients — not just on lowering costs — and on competition that is based on results and centered on medical conditions over the full cycle of care.

It’s a tall order, but necessary to fill, if we are to reinvent health care and lay the groundwork for a true system of care that will ensure a healthier America.
Defining Value
How will you quantify excellence?

Joseph Fifer

We live in a time of great change in the healthcare marketplace. From the Affordable Care Act to changes in payment to an increased drive for price transparency, multiple forces are conspiring to reshape the market landscape beneath our feet. Yet, for their many divergent aspects, all of these forces have one thing in common: the drive for value. In the days ahead, it will become imperative for all health care providers to articulate the exact nature of the value they bring to the table, and to develop approaches that consistently align with that value proposition.

There isn’t a one-size-fits-all approach to defining value in health care. This is because organizations bring different value propositions to unique customer segments. They operate in a variety of markets that can have a wide range of expectations for the provider. Take, for example, rural hospitals and academic health centers. The customers at a rural hospital are looking for emergency care and basic treatment. An academic medical center, in contrast, is expected to provide leading-edge research and innovation. Both of these provider types can seek to define and enhance the value that they provide, but they probably will need to focus on different services.

Providers seeking to thrive in today’s health care market must begin by defining their value proposition. In an age of increased transparency, consumers and purchasers will be asking, “Why are you the best hospital for me?” Providers will need to be ready to quantify the advantages of the care they provide.

Make no mistake; I’m proposing a change to the status quo. The drive for value is creating a fundamental reorientation of the health care system around quality and cost-effectiveness. Players in the market increasingly expect to know the value of the care that is being purchased.

Despite these varied definitions of value, we still must be able to quantify excellence in a value-based system. I think that value will be quantifiable when we look at some new indicators of business success for providers.

- Have you been able to maintain or improve performance on quality metrics while achieving demonstrable savings in the cost of care?
- Have you been able to persuade payers and purchasers that the care your organization provides is of high value (achieving, for example, preferred provider status in an insurer’s network)?
- Have you been able to create value for the health care purchaser while sustaining the financial health of your organization?

If you can answer “Yes” to these and similar questions, then I believe you are well on the path to success in a value-driven, competitive marketplace.

The Healthcare Financial Management Association’s Value Project research has been devoted to helping providers develop the capabilities they need to adapt to the new payment environment and define their value proposition. Through the project’s ongoing research, we are working with providers of all sizes and types — serving all manner of markets — to help them actively foster the change within their organizations that will be necessary to thrive in the coming marketplace. Consumers increasingly are seeking out providers that offer a strong value proposition and follow through with [high]-quality, cost-effective care. To keep pace with these demands, providers must define their value propositions and drive their organizations to achieve that value.

Joseph Fifer is president and CEO of the Healthcare Financial Management Association in Westchester, Ill.
Without a doubt, reimbursement realities and cost pressures are causing health care in America to change dramatically. The greatest causes of the federal deficit are Medicare and Medicaid. And employers and employees are feeling the effect of the growing cost of health benefits. By the end of the decade, the average family insurance plan could exceed $27,000 per year. This is unsustainable.

America’s health care system was designed for the 1950s, but illness has changed significantly since then. More than three-fourths of hospitalizations are due to chronic illness, which requires greater coordination and improved care across specialties. Today, in each population, 5 percent of the individuals will consume 50 percent of the resources, primarily because of the impact of chronic conditions.

Health providers currently are compensated for the volume of services provided. Tomorrow’s health delivery model likely will compensate for value — keeping patients healthy ... in fact, keeping entire populations healthy. Providers will be expected to assume some financial risk and achieve specified outcomes or measures.

At Catholic Health Partners, our vision is to build high-quality health delivery in each community to empower those we serve to achieve their optimal health status. To succeed, CHP is developing:

• a tightly aligned physician network;
• coordinated access to the most effective cost points of care across the continuum;
• an entire system enabled for population health management and capped risk.

We’re creating organizational changes in structure, processes and capabilities to transition to value-based health delivery. We’re implementing evidence-based medicine to eliminate unnecessary procedures and readmissions, reduce complications and ensure the highest quality.

CMS has awarded a Medicare accountable care organization pilot to CHP’s Cincinnati market through which more than 22,000 patients will receive their care. CHP will expand ACOs to other markets. CMS’s goal is to financially reward organizations that deliver high quality at a low price.

Patient-centered medical homes are at the heart of the ACO model, so CHP’s goal is to have 70 percent of its primary care practices achieve National Committee for Quality Assurance certification as PCMHs this year. These certifications involve a number of criteria aimed at having primary care practices work more proactively with patients, especially those with chronic conditions. Nationally, the PCMH has been proven to dramatically reduce admissions and emergency department visits — expensive care.

In some ways, Medicare has been leading the change from fee for service and episodes of care to compensation for integrated networks that provide value-based care. This started with the value-based purchasing program and the introduction of penalties for omissions or errors in care. In addition to causing harm, errors lead to explosive follow-up treatment.

Medicare has been headed down a path of payment transition and adherence to entirely new structures, including ACOs. Passage of the Affordable Care Act in 2010 guides the nation in the direction of Shared Savings Programs with Medicare and entry into risk contracts via Medicare Advantage and selected commercial plans.

The American Recovery and Reinvestment Act of 2009, the so-called stimulus bill, provided significant funding to accelerate digitized medicine. At CHP, we are investing $400 million in an electronic health record system that enables us to maintain a single, continuously updated record for each patient that can be accessed by our provider teams anytime, anywhere. The result is enhanced safety, quality and efficiency.
Health systems continue their transformation journey focusing on patient-centered, cost-efficient, high-quality outcome, integrated care. And the health care industry continues to evolve as new payer programs are developed and tested and new partnerships emerge while we see the early signs of consumerism appearing on the horizon. In the midst of all this change, capital providers should be investing in those companies and organizations that create value. Companies that create and provide value don’t just survive, they thrive. We see this in virtually every industry in our worldwide economy. Consumers buy products and services every day that provide value for the money. And as long as we have a fundamentally free market, competitive, capitalistic health care industry structure, health systems that provide value will thrive as well.

In health care, value is generally accepted to mean patient outcome divided by total cost per patient over time. In reality, many of the leading health systems have been on a mission of striving for value-based care for quite some time. Health systems have been cutting out expenses and lowering costs as financial pressures continue from current payment models. Systems are doing this by merging with and acquiring other providers to achieve economies through scale. They’re also doing it through consolidating support processes and standardizing care processes from the patient floor to the operating room. Systems increasingly are integrating not just to achieve more cost-efficiencies, but to enhance the management and the coordination of care toward higher-quality outcomes. Standardization of processes and procedures and the utilization of supplies contribute significantly to this effort. And, of course, capital being invested in information technology capabilities enables health systems to accomplish many of these, all of which, hopefully, lead to consistently better outcomes at a competitive cost.

The problem is health systems that are creating value today aren’t being recognized or rewarded for it. One of the most significant challenges that health system executives face is judging how payments by all payers will evolve toward some value-based model and over what time frame. System executives know how to operate in today’s payment environment and are building competencies enabling them to operate in the payment model of the future as they define it. But the fear is that the transition from today’s model to a future model has the potential to be financially devastating.

CMS has the Hospital Value-based Purchasing (HVBP) Program for hospitals, clinicians and other stakeholders. This is the first year in which value-based incentives are available under the program. It will run for the next several years. Anecdotally, there is evidence that some health systems are entering into programs with payers to share the “rewards” of agreed-upon outcomes and certain cost levels. Systems rightfully are making the necessary investments in systems and competencies with a goal of delivering high-quality outcome care at a reasonable cost. In the future, that reasonable cost will need to be a competitive cost.

Regardless of your view of the pace of evolution from a volume-based, fee-for-service, patient-centered model of care and payment to one of a consumer-oriented, value-based model, capital providers should be investing in those health systems that are investing for the future and building the requisite competencies to operate and thrive.

Frederick A. Hessler is managing director, Citigroup Global Markets Inc., New York City.
We all know that finances can ignite a powerful shift in focus. But is the anticipated value-based payment powerful enough to move an industry from focusing on episodic care to managing “health”? To really change the future of health care delivery, we must integrate financial risk management across the continuum of care. For the survival of our health system, we need to get off the treadmill of fee-for-service medicine. Sentara Healthcare is strategically well-positioned to adapt to this change. We call the journey from volume- to value-based payment, “Transformation of Care.”

Creating “value-defined populations” enables health care professionals to identify risks, understand their specific needs, analyze utilization and collaborate to improve care. Population segments can include a specific group of chronic disease patients with high hospital use/high cost history, employers’ covered lives, seniors or even healthy groups. Sentara has two goals in mind: (1) Keep the population healthy by preventing upward movement into the less healthy portions of the pyramid; and (2) maintain the health of those at or near the top of the pyramid by working to drive them downward into healthier categories.

Once the population is defined, we can accomplish our goal of patient-centered care collaboratively by delivering the right care, by the right caregiver, at the right time, in the right place, and at the right cost (as defined by payer or by patient). It is essential to create a safe space to design, test, evaluate and invest in small-scale pilot projects that are then implemented on a large scale.

Sentara is well-positioned for the future with more than 30 years of experience accepting financial risk for populations through our insurance plan, Optima Health. After launching Optima in 1984 to diversify our portfolio and gain the capacity to evaluate the population’s health, we have grown to more than 450,000 members in Virginia, with a large commercial business as well as Medicaid managed care.

However, health care systems without their own health plans may want to consider developing one, or joint venture with an existing insurance plan (regional or national) to participate in the new economics of health care. Optima is working with other care delivery systems outside of Sentara to help it meet future challenges. Premium management, data analysis and adjudicating claims are complex, but the biggest advantage is combining the skills of a good financial risk manager with redesigned components of clinical delivery systems.

How do we achieve the best possible health for a population while managing risk? The answer lies in what the industry has been waiting for — the collaboration of key stakeholders. Our newly formed clinically integrated network, the Sentara Quality Care Network, represents a collaboration of employed and community physicians, our care delivery system, Optima (the financing mechanism), and other payers to set goals, prioritize, measure outcomes and standardize best practices to improve the quality of patient care and, of course, reduce costs.

This doesn’t happen overnight. Transformation of care is a continuous journey. Sentara consistently strives to provide the best care with the best outcome at the best cost.

David Bernd is CEO of Sentara Healthcare in Norfolk, Va.
We’ve reached the tipping point for the U.S. health care system — costs, quality and access issues have to be addressed. It is not possible to make the progress we need without the effective implementation of diverse, sophisticated information technology. Indeed, the American Recovery and Reinvestment Act HITECH program recognized the need for this IT imperative. Meaningful use incentives, regional extension centers, state health information exchange grants, quality measures development and data exchange standards are all intended to establish the base of interoperable electronic health records that will serve as the foundation to address our care delivery challenges.

The country’s movement to coordinated care and population health management requires more than information technology. Reimbursement strategies must move from incentives to increase volume to incentives that reward quality, efficiency, disease prevention and the management of care over a continuum. The business and clinical models of care must shift to enable care to span a continuum, team-based care and care that follows the evidence. Information technology serves to support the new reimbursement approaches and clinical and business models.

The broad adoption and meaningful use of the EHR is the first building block. In addition, health information exchanges, based on interoperability standards and strong privacy protections, can facilitate interconnectivity and data-sharing across care settings. An HIE liberates clinical information collected within disparate EHRs, enabling a holistic view of the patient and a coordinated approach to care.

This is critically important in caring for the growing population of individuals with chronic diseases. All members of the care team need access to information to coordinate care and to ensure that it is targeted to the most cost-effective setting and with the greatest chance for a positive outcome.

In addition to the exchange of data between EHRs, health care organizations must be able to manage populations. This requires information technology that ensures that providers know for which patients they are accountable, each patient’s care plan, deviations from those plans and which members of the care team need to follow up to address the deviation. IT allows providers to collect and aggregate population data and to use that data proactively to identify and stratify patients into cohorts for specific interventions and management. Care management helps with the management of both individuals and the populations of individuals.

Business intelligence and analytics provide the care delivery organization with the ability to monitor its care performance and costs, reimbursement and quality of care, and assess the degree to which patients are managed and are achieving their health goals. These analytical tools also enable providers to assess the reimbursement implications of changes in quality scores and to predict individuals who may need special care.

IT systems are important contributors in engaging patients in their own care, enabling patients to comply better with treatment plans and enabling earlier interventions, when necessary. Personal health records and mobile access to health information and reminders all serve to help patients become active participants in their own care.

Recently, IT has been both praised and criticized for its role in helping to alleviate the ills of the health care system. Regardless of opinion, without a solid IT infrastructure and sophisticated clinical and administrative systems, the goal of a cost-effective, efficient health care system that delivers high-quality care simply isn’t possible.

John Glaser, Ph.D., is CEO of Siemens Healthcare’s health services business unit in Malvern, Pa.
We are excited to host the 14th Annual Non-Profit Health Care Investor Conference. The conference brings leading health care providers together with capital market participants to address major topics at the forefront of the health care industry. In light of ongoing market volatility, changing investor needs and implementation of health reform, the conference continues to be one of the most important platforms for connecting health systems with the capital markets.

The theme this year is “Investing in Value-Based Health Care.” Our goal is to gain greater insight into the key strategies health systems are implementing to plan, develop and execute value-based health care initiatives. We hope to learn, among other things:
• how health systems and key constituents are defining value;
• what factors health systems are considering when striving to create a high-value care delivery system and how return on investment is measured;
• what operational, financial and quality-based initiatives health systems are implementing to reduce the overall cost of care;
• what strategies are being utilized to build a more robust and efficient continuum of care;
• how health systems are using technology to advance coordinated care and population health-management initiatives.

The AHA, HFMA and Citi are committed to providing a forum for health care systems and investors to exchange insights and to foster greater understanding of key issues.

Sincerely,

Frederick A. Hessler
Managing Director and Health Care Finance Group Head
Citigroup Global Markets Inc.
Citi strives to be a leader and partner in assessing the ever-changing health care industry environment, addressing today’s challenges and developing solutions for the future.