Advisory Board | Health System Performance Initiative

Ten Insights on Reducing Care Variation from Pioneer Health Systems

RESEARCH REPORT

Look inside for:

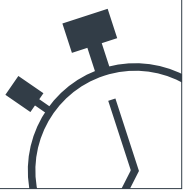
- How leading health systems are evolving their care variation reduction strategy
- Emerging challenges in designing and implementing new care standards
- Prioritizing care standardization efforts across multiple service lines and care processes

TOPIC

Reducing **care variation**

READING TIME

30 min.



BEST FOR

Clinical executives and care redesign leaders

LEARN HOW TO

- Structure and prioritize your care variation reduction program
- Avoid common pitfalls faced by peer organizations
- Design, implement, and monitor system-wide care standards

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RESEARCH REPORT

Health System Performance Initiative

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About the **Health System Performance Initiative** and This Report

The **Health System Performance Initiative**, or HSPI, is an ongoing initiative by the Advisory Board to explore some of the most challenging issues in health care through discussion with market leaders. Each year we convene a handful of small roundtable discussions where executives from early movers, along with senior Advisory Board research staff, test their thinking on strategic alternatives and share what seems to be working and not working. The focus of past HSPI roundtables includes breakeven health system economics, structural transformation needed to remain competitive, and managing the transition to shared risk.

Hosted by Banner Health in Phoenix, Arizona, on April 25, 2017, our most recent HSPI roundtable focused on reducing unwarranted care variation, or building a high reliability clinical enterprise. More specifically, senior executives from a cross-section of eleven health systems discussed how best to drive care variation reduction at the scale and speed needed to capture dramatic gains in quality and cost-savings. The participants are listed on the next page. We thank them for their willingness to share their learnings and drive a thoughtful dialogue. **This report** offers ten insights from the day-long discussion that we hope are helpful to other executives seeking to press the envelope of what's possible by reducing care variation.

Executive Roundtable **Participants**

Ascension Health

Ziad Haydar, MD, MBA
Senior Vice President and Chief Clinical Officer

Banner Health

Peter S. Fine, FACHE
President and Chief Executive Officer

John A. Hensing, MD, FACP
Executive Vice President and Chief Medical Officer

Twila Burdick, MBA, FHIMSS
Vice President, Organizational Performance

Centura Health

Brian Erling, MD, MBA
Senior Vice President and Chief Clinical Officer

Cynthia Latney, MSN, PhD
Chief Nursing Officer and Vice President of Patient Care Services

Hartford HealthCare

Rocco Orlando III, MD
Senior Vice President and Chief Medical Officer

Intermountain Healthcare

Brent E. Wallace, MD
Chief Medical Officer

Lehigh Valley

Thomas V. Whalen, MD, MMM
Executive Vice President and Chief Medical Officer

Memorial Hermann Health System

Nishant "Shaun" Anand, MD, FACEP
Physician-in-Chief, Physician Network

Emily Allinder Scott, MHA
Vice President, Memorial Hermann ACO

North Shore University Health System

J.P. Gallagher, MBA, FACHE
Chief Operating Officer

Orlando Health

Thomas Kelley, MD
Vice President, Quality and Clinical Transformation

Texas Health Resources

Winjie Tang Miao, MHA
Senior Vice President and System Integration Officer

Trinity Health

Mark I. Froimson, MD, MBA
Executive Vice President and Chief Clinical Officer

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Kimberly B. Denney, MBA

Dennis Weaver, MD

Teresa Breen, MA

Rebecca Nolan

Steven Berkow, JD

Veena Lanka, MD, MPH

Ten Insights on **Reducing Care Variation** from Pioneer Health Systems

1. Invest in reducing care variation to achieve your system's cost reduction goals
2. Add process design and finance experts to your clinical leadership team
3. Stop working around pockets of change-resistant physicians
4. Minimize physician involvement in designing standards for routine care
5. Rule out misleading documentation before assuming unwarranted care variation
6. Account for frontline workflow realities early in the design process
7. Set the pace based on your capacity to implement, rather than define, standards
8. Hardwire an outlet for revisiting standards that hit adoption roadblocks
9. Don't aspire to monitor all care standards in real-time
10. Invite uninvolved physicians to lead care variation reduction efforts

Invest in reducing care variation to achieve your system's cost reduction goals

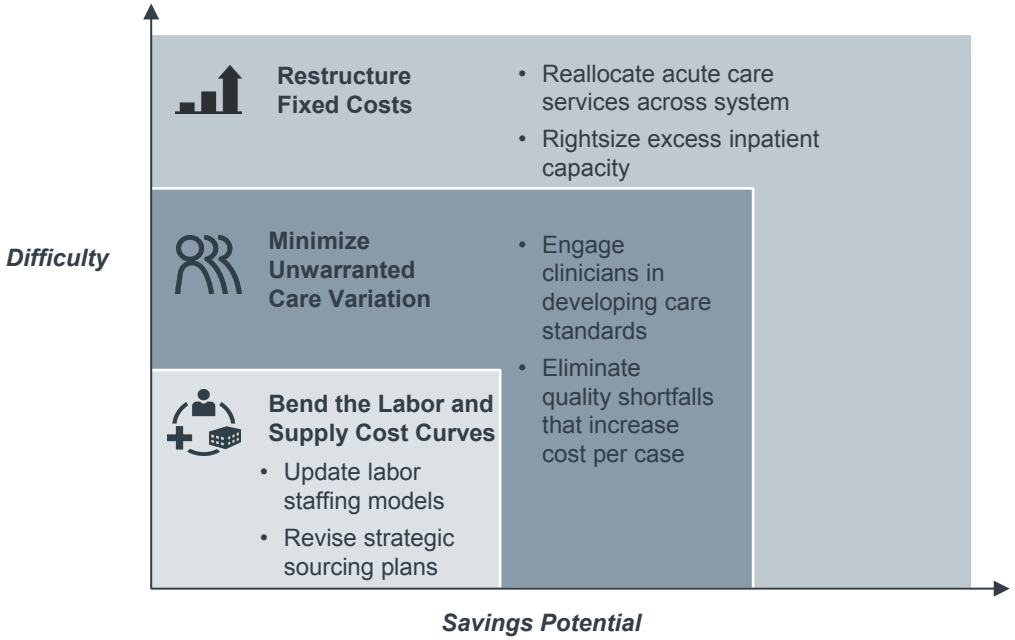
Efforts to extract cost savings from traditional sources, most notably labor and supplies, are yielding diminishing returns for high-performing providers. This trend is not indicative of failure but rather success. After focusing on these areas for over two decades to reduce costs, much of even the higher-hanging fruit has been picked. While efforts to increase labor productivity and improve sourcing should continue, organizations should no longer rely on these areas to generate more than a fraction of the savings needed to hit mounting cost reduction demands.

The largest untapped savings opportunity for health systems involves the restructuring of fixed costs, such as rationalizing redundant services across geographically proximate facilities and reducing excess inpatient capacity. As indicated by the table below, extracting these types of savings usually is quite difficult and requires an extended timeline. It necessitates overcoming a mix of entrenched roadblocks, ranging from key physician groups who don't want to combine their programs, to communities that will do anything to hold onto their full-service hospital.

Recognizing the limits of these two alternatives, roundtable participants are accelerating their efforts to minimize unwarranted care variation. When well executed, this strategy promises to improve care quality while significantly reducing costs within the near future. Additionally, reducing care variation can complement traditional efforts to extract cost savings from labor and supplies. Engineered workflows and standardized supplies enable organizations to go beyond frontline management of expenses and reduce overhead costs associated with multiple approaches to care.

Preliminary Advisory Board estimates from reducing care variation put the annual savings opportunity in the tens of millions for most systems. Projections by market leaders are similar. For example, Memorial Hermann Health System and Texas Health Resources have set three year savings targets for minimizing care variation in the range of 150 to 300 million dollars.

Assessing Health System Savings Opportunities



Add process design and finance experts to your clinical leadership team

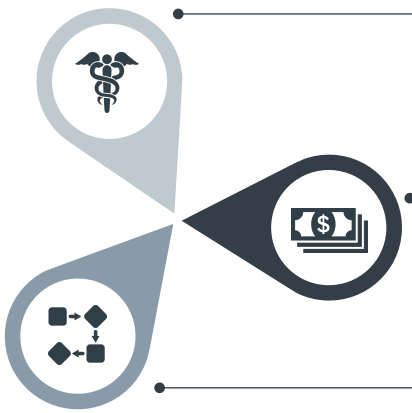
Achieving consensus on clinical specifications is no longer a top barrier to reducing care variation among progressive organizations. Indeed, roundtable participants widely acknowledge that this is now one of the more manageable components of effective care variation reduction. Instead, they list struggles with embedding standards into daily workflows and documenting measurable impact as their chief barriers to progress.

In response, roundtable participants are once again expanding who holds the reins of their efforts to reduce care variation. Most have already supplemented their physician-dominated teams with a mix of nurses and other clinicians, who collectively deliver the lion's share of care stipulated by their care standards. Leaders also underscore the importance of including team members with informatics expertise.

Now many have added process design experts and representation from their finance departments. Process design specialists ensure that any needed changes to frontline workflows are designed to maximize efficiency and minimize the burden on care delivery staff. Finance representatives are being added to help access needed data and establish a methodology for measuring financial impact that meets the institution's standard for demonstrating ROI.

Additionally, finance and supply chain representatives are increasingly playing a key role in negotiating supply-side savings with vendors, securing budget to build out the infrastructure for reducing care variation, and ensuring that the organization's IT plan includes investment in a cost accounting system. Roundtable participants unanimously agree that as an organization's efforts to reduce care variation expand and mature, so must their ability to link better care to concrete cost savings.

Recommended Leadership Triad for Reducing Care Variation



Clinical Leaders

- Define appropriate order sets for a condition
- Provide input regarding frontline adoption barriers
- Advocate care standard adherence to peers

Financial Leaders

- Estimate cost-impact of care variation
- Define ROI methodology
- Negotiate supply pricing with vendors

Process Experts

- Design pathways for delivering standard of care
- Map tasks to care team roles
- Make 'allowable' adjustments for facilities

Stop working around pockets of change-resistant physicians

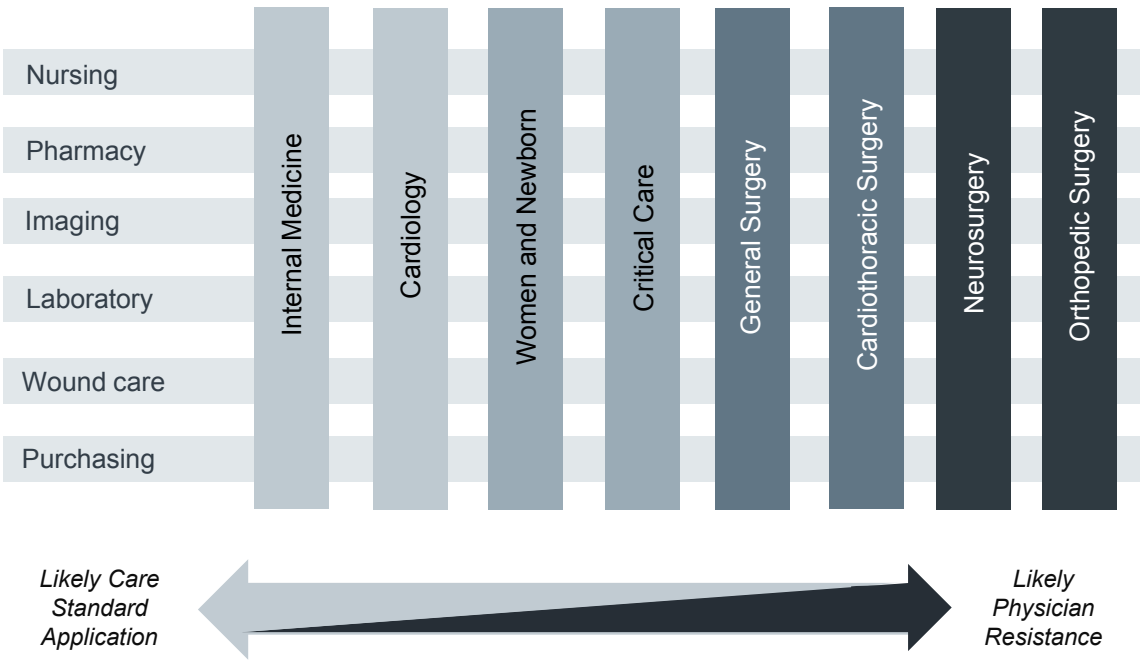
While leading organizations prioritize their efforts to reduce care variation principally by quality gaps, patient volumes, and cost-savings potential, many then filter their list for anticipated levels of physician resistance in some manner. The net effect of this additional screen is typically backloading highly specialized areas like orthopedic surgery, neurosurgery, and cardiovascular surgery.

Roundtable participants underscore the importance of eliminating this secondary and often informal filter for two reasons. First, they can no longer afford it. This practice all too often backloads specialty areas that account for an outsized share of unwarranted care variation within an institution and thus delays realization of cost-savings.

Second, the principled rationale for backloading care standards impacting more resistant physicians has not proven valid. Organizations taking this approach hope that such resistance would erode as efforts to reduce care variation generated positive results in other areas and won a growing bevy of physician champions. Unfortunately, roundtable participants report that improvements elsewhere have had little impact on the outlook of entrenched physicians toward efforts concerning their practice patterns. Moreover, allowing such exceptions signals a lack of accountability that is detrimental to creating a system-wide culture of reliability.

Progressive systems have stopped exempting even the highest volume physicians from adhering to consensus-based standards. This approach is made more palatable to physicians by these systems not mandating 100% compliance, but rather allowing for 20%-30% running room for principled exceptions.

Physician Resistance Overinforming Focus Areas for Standard Setting



Minimize physician involvement in designing standards for routine care

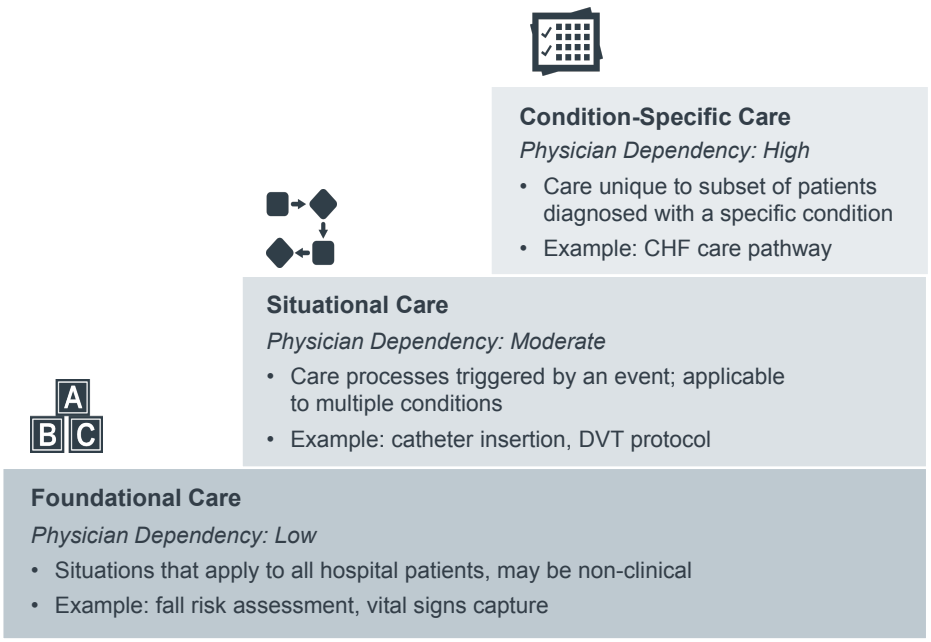
As organizations strive to scale their efforts to reduce care variation, physician availability can readily become a bottleneck. Physicians must play a central role in care variation reduction, but their time outside of clinical practice is a scarce resource. Moreover, there are already a host of other activities competing for this limited time, such as documentation, governance committees, and continuing medical education.

To avoid such bottlenecks, health systems should establish differentiated expectations for physician involvement based on the clinical complexity of the task at hand. As illustrated below, Texas Health Resources has created a sliding scale for physician involvement depending on which of three care categories a standard addresses. So, minimal physician input is sufficient for standardizing fall assessments, which is considered Foundational Care, while defining appropriate criteria for CABG surgery concerns Condition-Specific Care and thus requires a high level of physician input.

At Banner Health, clinical consensus groups, which focus on condition-specific care, are staffed with professionally trained program managers to allow physicians, as well as other clinicians, to work at the top of their license. Activities like tracking project progress, issuing memos, and addressing concerns fall to the program manager. So demands on physician time taper off as a project shifts from standard definition to implementation.

The net effect of such practices is not only more judicious use of physician time but greater physician willingness to participate in care standard design. Physicians tend to be more giving of their time when it is used wisely.

Laddering Physician Involvement in Standard Setting at Texas Health Resources



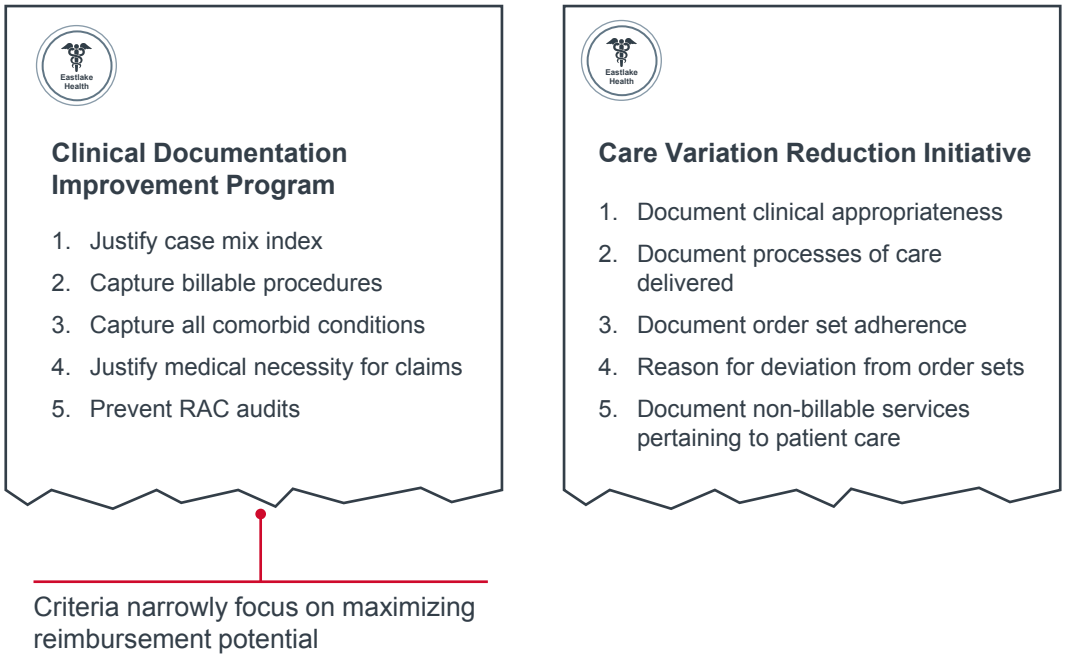
Rule out misleading documentation before assuming unwarranted care variation

Poor documentation can undermine nearly every aspect of efforts to reduce care variation, from opportunity prioritization to impact assessment to public reporting to incentive payouts. Moreover, this problem plagues every health system. As roundtable participants underscore, poor documentation often results from logical trade-offs rather than inexcusable behavior. For example, one roundtable participant volunteered how nurses in the last 20 minutes of their shifts must frequently choose between completing outstanding clinical tasks before patient handoffs versus struggling with a recalcitrant EHR.

Additionally, documentation that is technically correct can be misconstrued. For example, another roundtable participant shared how a group of cardiologists were targeted for longer lengths of stay for certain DRGs. Manual chart review, however, attributed this deviation to their practice of ensuring an endocrinology consult for all diabetic patients, which in turn resulted in fewer readmissions and healthier patients.

So even high performers should never launch care standardization efforts to close a care gap without first ruling out the possibility of a documentation gap. To help, leading organizations are working to better align their care variation reduction efforts with ongoing CDI (clinical documentation improvement) initiatives. CDI programs typically focus on maximizing coding accuracy and reimbursement but could better bolster their institution's bottom line by considering top waste-reduction opportunities as well when prioritizing projects.

Misaligned Priorities Among Documentation Improvement Initiatives



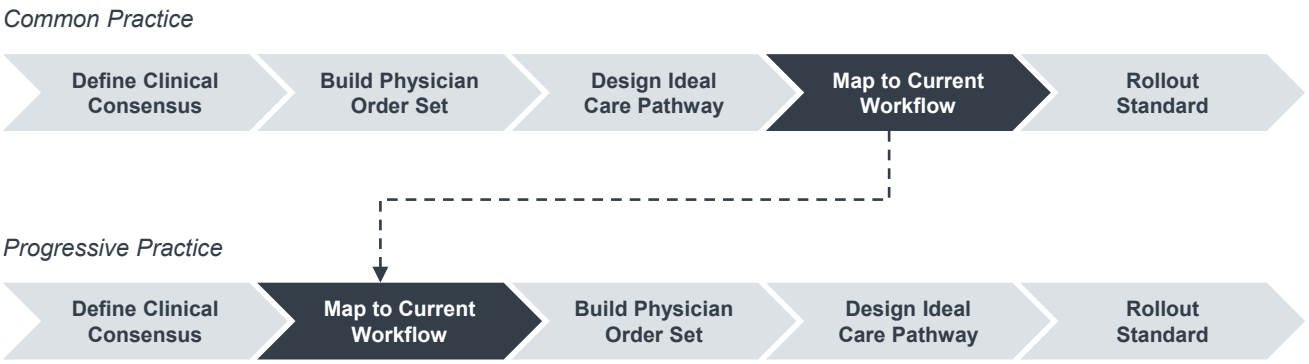
Account for frontline workflow realities early in the design process

Providers must rethink when and how to incorporate workflow considerations into the creation of new care standards. Workflow complications all too often are recognized only after the design of a new order set is largely complete and clinicians turn to how best to embed it in daily practice. Such backloading of real-world constraints commonly undercuts standard rollout in three ways:

- Stops rollout when a prerequisite for order compliance is not yet in place, such as the introduction of a system-wide tool for sepsis screening before standardization of how to document vitals
- Compromises adoption when necessary resources aren't readily available, such as requiring same day ambulation for post-operative patients even though physical therapists don't work past 5 p.m. at most care sites
- Hardwires inefficiency by locking in unnecessary care steps, such as directing alerts about a destabilized patient to the charge nurse rather than a rapid response team

To prevent such oversights, many roundtable participants are pulling forward workflow mapping and assessment when designing new standards. More specifically, they are inserting workflow mapping between their definition of clinical specifications and finalization of functional requirements so that these requirements can reflect existing workflows and frontline realities whenever possible. Leading organizations note that it is often far easier to modify an order set to reflect an existing workflow than the reverse, as long as this change is made early in the standard setting process. Additionally, fewer workflow changes typically translate into faster and wider adoption of new care standards.

Leading Health Systems Frontload Workflow Mapping in Standard Design



Set the pace based on your capacity to implement, rather than define, standards

Market leaders have hit a common pinch point when transitioning from the traditional campaign approach for reducing care variation to a comprehensive enterprise. To date, they have understandably prioritized engaging a broad base of physicians. Their programs place few guardrails around the number and types of clinical consensus groups or committees that can be formed and where participating clinicians focus their group's energies. Consequently, the number of such groups as well as engaged physicians has ballooned. This success, however, has spurred a new challenge: the number of new clinical specifications and order sets these groups are generating now far outpaces what their organizations can embed into practice in a timely fashion.

To address this bottleneck, roundtable participants are pursuing two strategies. First, while no one has placed hard caps on how many new order sets each clinical consensus group can create or the overall number of such groups, nearly all roundtable participants are deliberately directing where these groups should focus their energies. For example, Hartford HealthCare and Texas Health Resources are proactively asking their groups to address specific high priority questions, and Intermountain Healthcare has focused all of its Clinical Guidance Councils on incorporating existing order sets into their new EHR. Additionally, Memorial Hermann Health System is hoping to reduce the number of its Clinical Program Subcommittees in the coming year.

Second, Texas Health Resources is piloting a "heat map" that displays the aggregate impact of all ongoing change initiatives, including care standardization efforts, on myriad groups of frontline staff. This transparency allows leaders to identify "hot spots" where frontline staff are being asked to absorb too many changes at one time and, in turn, shift roll-out dates as well as re-prioritize what new care standards they are developing.

Early returns on both strategies are promising. Nonetheless, organizations starting this work may want to pivot to such strategies earlier in the maturation of their program for minimizing care variation. Building up an outsized backlog of newly minted standards risks disengagement among consensus group leaders who don't see a return on their hard work, frustration among overloaded frontline staff, and delays in implementing higher impact changes.

Texas Health Resources' Heat Map for Monitoring Change Overload

Initiative	Type	Audience	Dec-16	Jan-17	Feb-17	Mar-17
Antibiotic Stewardship	Refresher Training	Internal Medicine	Medium			Low
DVT Prophylaxis	New process change	All clinicians		High		
COPD Guidelines	New process change	All physicians		High		
Glycemic Control	New process change	All clinicians		High	Medium	
Heart Failure Diagnosis Guidelines	New process change	IM, Cardiology				High
CABG Guidelines	New process change	Cardiac Services				High
Physician Leadership Initiative	Training	Physician Leaders	Low		Medium	
Pressure Ulcer Protocol	Training	All nurses		High		

Impact of each initiative on staff rated low, medium or high

Leaders able to readily spot months with heavy concentration of initiatives and shift some work to slower months

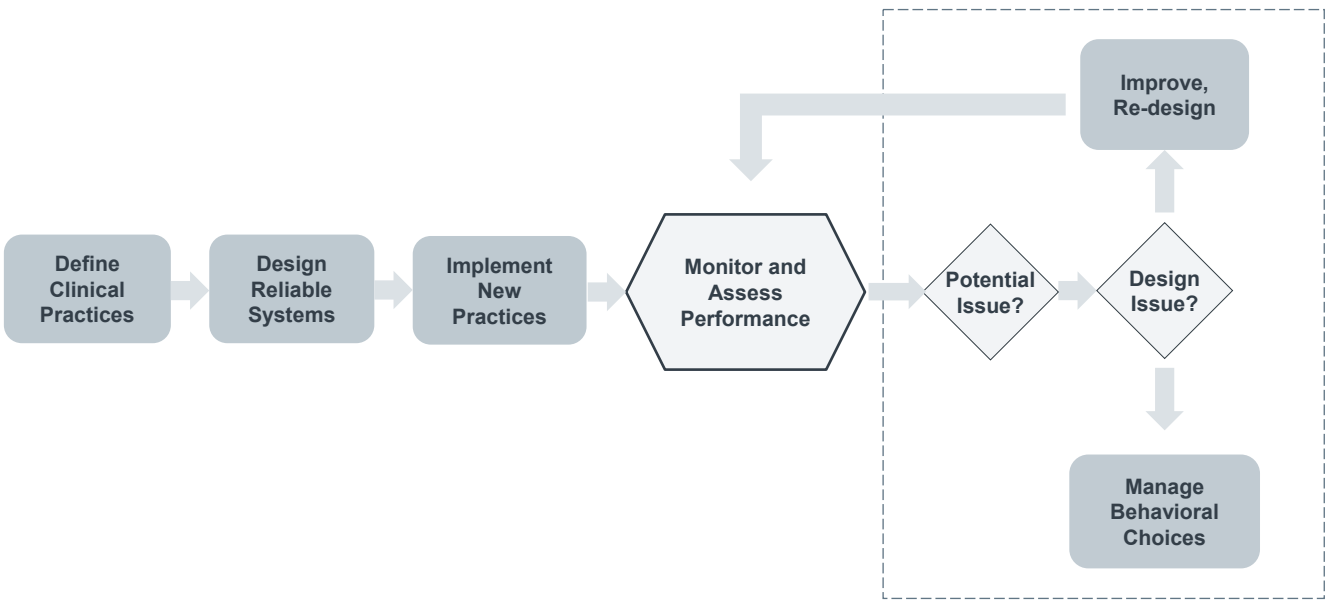
Hardwire an outlet for revisiting standards that hit adoption roadblocks

Implementing a new care standard should not be viewed as a "one and done" activity but rather one that allows for iteration when significant adoption barriers emerge. There are simply too many differences among care sites across today's health systems to set the right standard from the outset every time. Worse yet, frontline staff will invent a smorgasbord of workarounds for care standards that don't readily translate to their environment when there is no clear mechanism to address such gaps. Put another way, design processes that don't include an express mechanism for revisiting problems with new care standards actually promote variation.

As illustrated below, Banner Health has formalized a process for addressing adoption challenges for recently implemented standards surfaced by their systems for monitoring and assessing performance. Buoyed by its "just culture," they first consider whether the situation results principally from behavioral issues or requires a design change. When the issues are related to design, centralized resources are then marshalled to improve the associated workflows and support systems.

Somewhat similar, Texas Health Resources hardwires an opportunity for iteration on new standards through an extended rollout process. More specifically, deployment of a new standard spans six full weeks before the final version goes live. During this period, THR undertakes a formal impact inventory to surface potential barriers at each facility and account for them. There is also a single implementation leader for each facility who oversees all aspects of this extended rollout process for all standards to both minimize communication gaps and facilitate workable solutions. Further, these individuals are responsible for providing a summary of surfaced issues to the design team to factor into future care standard design.

Banner Health's Process for Managing Adherence to Care Standards



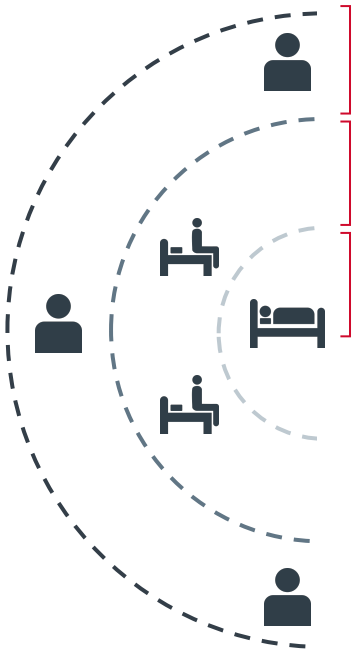
Don't aspire to monitor all care standards in real-time

Preventing deviation from care standards in real-time is an appealing concept and increasingly possible with the rise of real-time monitoring technologies. There are a number of instances where real-time monitoring is no doubt warranted, such as sepsis care. However, there are a larger number of instances where investment in real-time (or near real-time) monitoring will neither improve care nor generate cost savings. For example, there is no urgency to redressing a patient who was discharged a day later than expected. Likewise, there is no corrective action that can be taken in the moment when an orthopedic surgeon inserts antibiotic-fortified bone cement rather than regular bone cement.

More important, striving to monitor every significant clinical activity as it occurs can do real harm, to both our patients and clinicians. It will obfuscate care deviations requiring a rapid response and overwhelm practitioners. Indeed, the ballooning number of metrics for which physicians and other clinicians are accountable is already driving burnout at record rates.

So leaders in reducing care variation are not aspiring to monitor compliance with all care standards in real-time but rather the right time. As suggested by the illustrative diagram below, roundtable participants are working to define different tracking frequencies and mapping each measure of clinical compliance to the right frequency based on feasibility as well as need—with the aim of limiting what is tracked real-time to a manageable number of actionable indicators.

Mapping Standard Monitoring to Response Urgency



Low Urgency: Supply standardization, preference item adherence, discharge delays, unwarranted imaging

Moderate Urgency: Procedure appropriateness, chronic comorbidities treatable in outpatient setting

High Urgency: Crashing vitals, Missed antibiotic dose, Sepsis screen positive

96% Drug alerts never opened by clinicians[1]

0.3% Sepsis alerts followed by clinicians[2]

1) Overriding of Drug Safety Alerts in Computerized Physician Order Entry, JAMIA 2006.
2) Advisory Board Interviews and Analysis 2016.

Invite uninvolved physicians to lead care variation reduction efforts

Physician interest in leadership opportunities is a prized commodity by virtually every health system. There is a strong correlation between such interest and physician engagement. Perhaps more critical, the number of initiatives needing physician leaders far outstrips the supply at most institutions. Initiatives focused on care variation reduction, however, hold the potential to expand the physician leadership bench.

More specifically, roundtable participants are finding that physicians who steer clear of opportunities concerning medical staff governance, incentives, and other such matters are often interested in leading pursuits more narrowly centered on clinical or care delivery challenges. For example, one participant shared how her broad survey outreach on hospital design to roughly 500 physicians yielded detailed responses from nearly 100 physicians, many of whom had never before expressed any interest in guiding larger health system decisions. Additionally, respondents skewed toward younger demographics.

Put another way, health systems seeking physicians to lead efforts to reduce care variation must guard against limiting their search to physicians already involved in other initiatives. Looking beyond the usual suspects is likely to speed identification of interested physicians and may grow the health system's overall physician leadership bench.

Physician Involvement in Leadership a Top Engagement Driver[1]

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Employed Physicians

Top Engagement Drivers

1. Confidence in recommending this organization to a friend or relative.
2. Organization is open to my input.
3. The actions of the executive team reflect the goals of clinicians.
4. **I am interested in physician leadership opportunities here.**
5. Organization is prepared to meet the challenges of the next decade.

Advisory Board

Independent Physicians

Top Alignment Drivers

1. **I am interested in physician leadership opportunities at this organization.**
2. Organization provides excellent clinical care.
3. I have a high degree of confidence in this organization's medical staff.
4. Organization provides excellent service to patients.
5. Organization is my partner in navigating the changing healthcare landscape.

> "Health systems today suffer from the STP problem. We tap the same ten people for every initiative and we are starting to run out of leaders. Organizations need ways to identify new physicians with leadership potential that aren't already known to them."

Winjie Tang Miao
Senior Vice President, Texas Health Resources

1) Employed physicians surveyed on 28 drivers, independent physicians surveyed on 21 drivers. Advisory Board Survey Solutions, Physician Engagement Survey 2016.

Beyond Your Membership

This report is just the beginning of how Advisory Board helps you accelerate and scale your efforts to reduce unwarranted care variation. Our comprehensive portfolio of research memberships, consulting services, and technologies helps you find your path forward using best practices forged from more than 30 years of health care industry research.

Build Governance and Leadership Structures

Advisory Board helps you to create an organization- or system-wide clinical excellence entity including oversight and reporting structures, rules of engagement, and team composition, and to align clinically integrated networks around care variation initiatives.

Align Physicians and Clinical Stakeholders

Our consultants and technologies engage physicians in care variation by redesigning physician incentive models and contractual arrangements, clarifying accountability, leading education sessions, and providing severity-adjusted cost and quality performance profiles.

Design New Clinical Standards

We illuminate and quantify your care variation opportunities and their root causes, including defining appropriate levels of variability. Our ongoing research on effective clinical practice and consultative expertise helps you define new care standards that improve quality and decrease costs.

Embed New Standards in Clinical Workflows

Advisory Board technologies and consultative guidance hardwire new protocols into your EHR, using an expert-curated library of more than 200 decision-support rules, and oversee system-wide rollout. We build support with your clinical teams through education and track adherence through real-time alerts.

Measure Quality and Cost Outcomes

Advisory Board analytics help you continuously identify care variation opportunities, diagnose root causes, track protocol adherence, and measure overall quality and cost impact, allowing you to innovate for ongoing performance improvement.

Our National Partner John Deane works with hospitals and health systems on transformational solutions focused on large-scale return on investment.

Contact John to learn more about how Advisory Board can help your organization.

John Deane, National Partner

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