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From Leading Health System CEOs
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Ten Strategies To Lower Costs, Improve Quality, And Engage Patients: The View From Leading Health System CEOs

ABSTRACT Patient-centeredness—the idea that care should be designed around patients' needs, preferences, circumstances, and well-being—is a central tenet of health care delivery. For CEOs of health care organizations, patient-centered care is also quickly becoming a business imperative, with payments tied to performance on measures of patient satisfaction and engagement. In *A CEO Checklist for High-Value Health Care*, we, as executives of eleven leading health care delivery institutions, outlined ten key strategies for reducing costs and waste while improving outcomes. In this article we describe how implementation of these strategies benefits both health care organizations and patients. For example, Kaiser Permanente's Healthy Bones Program resulted in a 30 percent reduction in hip fracture rates for at-risk patients. And at Virginia Mason Health System in Seattle, nurses reorganized care patterns and increased the time they spent on direct patient care to 90 percent. Our experiences show that patient-engaged care can be delivered in ways that simultaneously improve quality and reduce costs.

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A dozen years ago a landmark Institute of Medicine report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, recognized the importance of patient-centeredness, listing it as one of six aims for health care improvement. The report described patient-centered care as "respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions."¹ A contemporary interpretation of this concern for patient-centered care is patients' engagement in their own health care: the idea that engaged, empowered patients are central to achieving better outcomes at a better value.

The 2012 Institute of Medicine report *Best Care at Lower Cost: The Path to Continuously Learning*

Health Care in America lists "engaged, empowered patients" as one of seven characteristics of an effective, efficient, and continuously improving health system. The report describes the ideal relationship between patients and providers in this way: "Clinicians supply information and advice based on their scientific expertise in treatment and intervention options, along with potential outcomes. Patients, their families, and other caregivers bring personal knowledge regarding the suitability—or lack thereof—of different treatments for the patient's circumstances and preferences. Information from both sources is needed to select the right care option."²

For CEOs of health care organizations, the move toward engaging patients in their own care is not simply the right thing to do. It is quickly becoming the norm amid growing evidence that

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patient-engaged care is associated with better health outcomes, better care experience for patients, and lower health care costs.

In primary care settings, patient-centered communication is associated with faster recovery, improved clinical outcomes, a better care experience, and fewer diagnostic tests and referrals.³ Patient-centered care is also linked to decreased use of health services and lower annual charges.⁴ Well-informed patients are less likely to choose more aggressive and costly courses of treatment.^{5,6} Efforts to encourage patients to manage their own health and engage in healthy behavior are particularly effective when they are tailored to patients' needs and meaningfully address patients' goals.^{7,8}

New telehealth capabilities also improve patient engagement. Structured help lines, tele-monitoring of physiological data such as weight and blood pressure, and telecoaching in order to provide patients with structured after-care contact with clinicians can improve patients' decision making, confidence, and satisfaction.⁹⁻¹¹

Telehealth opens the door to many streams of communication among patients and clinicians and creates opportunities for patients to become engaged in their health care planning. Although more research is needed on different modes and methods for effective engagement with patients—in particular, the health care system's most vulnerable patients—early results show great promise. For example, telehealth interventions have been shown to reduce mortality and hospitalizations for patients with chronic heart failure.⁹

Recognizing the transformative potential of patient-engaged care, new methods of organizing and paying for health care tie reimbursement to performance based on measures of patient satisfaction and engagement. For example, to be eligible for Medicare's Shared Savings Program,¹² accountable care organizations must define, establish, implement, and update processes to promote patient engagement. Each organization must conduct a needs assessment of its patient population, effectively communicate medical evidence to patients, and engage both providers and patients in shared decision making.

To be eligible for incentive payments for high-quality care under Medicare's Hospital Value-Based Purchasing Program,¹³ hospitals must assess their patients' experience of care, as measured by Medicare's Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.

Patients actively seek meaningful engagement in their care. Focus-group and survey results from the National Partnership for Women and

Families indicate that patients want their providers to take a holistic, rather than a disease-based, approach to their care.¹⁴ They want clinicians to coordinate their care and communicate effectively across care settings. They want tools to help them manage their health conditions.

Patients also expect to have a say in decisions about their care, as do their family members. And patients see efforts to engage them in their care as a path toward shared decision making and getting help from their clinicians in better understanding their health conditions.¹⁴

Survey results published by participants in the Institute of Medicine's Evidence Communication Innovation Collaborative show that patients who report that their health care provider effectively engages them in shared decision making are more satisfied than others with their provider.¹⁵ Of the patients surveyed who reported having one or more chronic conditions, almost all agreed that their care should be well coordinated, but only half reported that their care actually was coordinated. And—notable in an era of overtreatment—only half of the surveyed patients strongly agreed that their provider explained the risks of their options. Even fewer said that their provider explained the option of not having a test or treatment.¹⁵

The question for many health care executives today is how to build a patient-centered health care system and deliver high-quality care in ways that are beneficial for both their patients and their bottom lines. Taking the notion of patient-centered care a step further, we would argue that each health care organization must make meaningful patient engagement possible by building a role for patients and their families into the organization's systems and processes. The question then becomes, How can health care organizations deliver high-quality care that better engages patients, at a lower cost?

CEO Checklist For High-Value Care

In *A CEO Checklist for High-Value Health Care*,¹⁶ we surveyed our own experiences in providing care as executives at leading health care delivery institutions. We identified ten key points in reducing costs and improving the quality of care, which have become essential to our operations. The points we identified spanned the care delivery continuum (Exhibit 1).

One theme present in many of the points in our *Checklist* is that patient-engaged care is often also high-value care. The changes made within our organizations that moved us toward increased patient engagement fell into the following five broad categories: delivering evidence-based care, developing team-based approaches and

shared decision making, making care delivery more efficient, providing care in new ways, and targeting care to patient and community needs.

DELIVERING EVIDENCE-BASED CARE Many of our organizations improved patient experience while implementing evidence-based protocols to ensure safe, efficient, and consistent care delivery. For example, in Kaiser Permanente's Healthy Bones Program, which identifies and proactively treats patients at risk for osteoporosis and hip fractures, practice guidelines for osteoporosis management were standardized so that patients were treated in accordance with the latest clinical evidence. The program also includes osteoporosis patient education and home health components. Through education and proactive prevention, patients can become proponents of their own health. In five years the program has resulted in a 30 percent reduction in hip fracture rates for at-risk patients.^{16,17}

Other organizations applied evidence-based protocols to manage perinatal services. At Hospital Corporation of America (HCA)—one of the nation's leading providers of health care services, with approximately eighteen million patient encounters annually—a bundle of standardized practices for high-risk obstetrical conditions yielded \$68 million in systemwide savings and a maternal death rate that is half the national average.¹⁶

At Intermountain, an evidence-based approach to labor and delivery resulted in \$50 million in savings and a twenty-six-percentage-point drop in inappropriate elective inductions of labor since 2001.¹⁶ At the same time, Intermountain's approach improved patients' experiences: Women at Intermountain's labor and delivery facilities spend 750 fewer hours in delivery per year.

TEAM-BASED APPROACHES AND SHARED DECISION MAKING Some of our organizations implemented changes in the way care is delivered, favoring team-based approaches with an emphasis on shared decision making. For example, Cleveland Clinic's care enhancement program for lung transplant patients calls for daily huddles involving patients and caregivers, which helps keep caregivers, patients, and their families informed about each patient's prognosis and recovery and allows for the development of a cohesive care plan. The improved lung transplant program has reduced lengths-of-stay, improved survival rates, reduced costs, and improved patients' satisfaction with clinicians' communication by nearly 30 percent.¹⁶ As patients have become engaged in every step of the process, they have become an integrated part of the care team.

EXHIBIT 1

A Checklist For High-Value Health Care

Category	Item
Foundational elements	Governance priority—visible and determined leadership by CEO and board Culture of continuous improvement—commitment to ongoing real-time learning
Infrastructure fundamentals	IT best practices—automated, reliable information to and from the point of care Evidence protocols—effective, efficient, and consistent care Resource use—optimized use of personnel, physical space, and other resources
Care delivery priorities	Integrated care—right care, right setting, right providers, right teamwork Shared decision making—patient-clinician collaboration on care plans Targeted services—tailored community and clinic interventions for resource-intensive patients
Reliability and feedback	Embedded safeguards—supports and prompts to reduce injury and infection Internal transparency—visible progress in performance, outcomes, and costs

SOURCE Cosgrove D, et al., *A CEO Checklist for High-Value Health Care* (Note 16 in text). **NOTE** IT is information technology.

Similarly, at ThedaCare, a community health system in Wisconsin, collaborative care units organize care delivery around the patient's experience. When a patient is admitted, an interdisciplinary care team coordinates with him or her to arrive at a mutually agreed-on care plan. The program has reduced hospital lengths-of-stay, errors in patient care, and inpatient care costs (by 25 percent), while improving care protocol compliance by providers and achieving a patient satisfaction rate of 5 out of 5, 95 percent of the time.¹⁶

At HCA, typical clinician rounds—Involving private, spoken exchanges among caregivers—were converted into open discussions between caregivers and patients at each patient's bedside. The change created multiple opportunities for patients' active participation in their care and resulted in improved communication scores on the HCAHPS survey, as well as improved nursing efficiency and better end-of-shift handoffs.¹⁶

MAKING CARE DELIVERY MORE EFFICIENT Other interventions in our organizations improved patient experience while making care delivery more efficient. At Cincinnati Children's Hospital Medical Center, improved surgical scheduling practices resulted in fewer delays and cancellations of elective surgeries because beds were not available, as well as a more predictable flow of patients through the intensive care unit.^{16,18} The changes also saved the facility \$100 million in capital costs, by eliminating the need for seventy-five new beds.

At Virginia Mason Health System, a Seattle-based integrated health services system, nurses analyzed their workflows and implemented changes to improve efficiency. The changes included reorganizing nurses' care patterns on the hospital floor so that they could care for patients who were in groups of rooms rather than spread across a unit. In areas where this change has been implemented, Virginia Mason nurses now spend 90 percent of their time on direct patient care and attend to patients' needs more quickly and effectively.¹⁶

And at Denver Health—Colorado's primary safety-net institution, which cares for almost one-third of Denver's residents—the use of Lean quality-improvement processes across its integrated system resulted in more than \$170 million in financial benefits and increased Denver Health's overall patient satisfaction ranking by almost fifty percentage points.¹⁶

PROVIDING CARE IN NEW WAYS Still other interventions implemented by our organizations increased patient engagement by delivering care where and when patients need it, often outside the hospital. For example, at Partners HealthCare in Massachusetts—a nonprofit, integrated health system that includes community and specialty hospitals, community health centers, and other health-related entities—the Connected Cardiac Care Program, a self-management and telemonitoring program, helps patients with heart failure manage their health at home. Through advanced care coordination, patient education, and the use of technology, patients are able to report their weight, blood pressure, heart rate, and symptoms daily to telemonitoring nurses, reducing the need for trips to the hospital. The program has yielded an estimated \$10 million in savings and a 51 percent reduction in hospital readmissions for patients with heart failure during the ten years it has been in operation.¹⁶

At the Veterans Health Administration, patient-aligned care teams increase patients' access to primary care, in part by using technology to allow them to interact with their providers in new ways, including telephone clinics, home telehealth, secure messaging, and mobile applications. Successful, high-performing teams have shown 14 percent fewer urgent care visits and 7 percent fewer hospital admissions, compared to teams that are less reliant on the patient-centered care innovations.¹⁶

Similarly, at Geisinger—a nonprofit, integrated health services organization serving over 2.6 million residents of central and northeastern Pennsylvania—the ProvenHealth Navigator is a medical home model that uses data from Geisinger Health Plan in conjunction with

Geisinger Clinic primary care to monitor and manage the member population's health, measure and improve care quality, and implement value-based reimbursement. Over the past five years the program has yielded a 20 percent reduction in risk-adjusted readmissions, and members have rated the program highly on effectiveness and quality.¹⁶

TARGETING CARE TO PATIENT AND COMMUNITY NEEDS

Finally, some of the programs that our organizations have put in place make care more patient-centered by targeting care to the needs of patients and the community. At Denver Health's community health centers, registries of patients with chronic conditions help identify high-risk patients suffering from one or more of the conditions. Once identified, each patient is assigned to a medical home and a primary care provider. The providers are responsible for communicating with patients and improving the management of their care between clinic visits. Denver Health increased breast cancer screening rates by 20 percent and colorectal cancer screening rates by 50 percent, and the rate of hypertension control among its patients increased by 12 percent over a three-year time span.¹⁶

To improve care for its 20,000 patients with HIV, Kaiser Permanente developed a multidisciplinary care team model for HIV care. The approach encourages collaboration among health care professionals, ensures the delivery of needed care by the most appropriate provider, supports providers and patients with tools that outline the optimal order and timing of interventions, and helps both patients and providers manage each patient's interactions with the HIV care team. Compared with national averages, Kaiser Permanente patients with HIV start receiving the right care faster, experience better treatment adherence and better viral control, and live longer.¹⁶

Conclusion

In this article we have presented just some of the programs that our organizations have initiated to improve the value of the health care we deliver. It is no surprise that many of these programs rely on high degrees of patient engagement in their health care to achieve results.

Importantly, our experiences show that even among high-performing health systems, the definition and measurement of *patient-engaged care* differs based on context. For a patient with HIV and a complex treatment regimen and care plan, such care might mean better care coordination and management. For a patient admitted to a hospital, it might mean reorganizing nurse staffing to ensure more direct care time with patients.

And for patients in the community, it might mean using registries to identify at-risk people so that they get the screenings they need.

The diversity of our efforts to improve patient engagement illustrates that further research is needed into the modes and methods of effective engagement for different patient populations and care settings. Further research is also needed on the effective measurement of patient engagement as a result of interventions like ours, and on the ways in which the results of such measures can drive continuous improvement.

Finally, although patient engagement is

quickly becoming a necessary part of health care delivery, no one approach will suit every health care organization. Each organization must take stock of its unique culture, patient population's needs, and other elements that will contribute to the ultimate success of any intervention aimed at improving patients' engagement in their health care. Our experiences are merely examples of the kinds of patient engagement interventions that, when used separately or together, can lead to better health outcomes and reduced costs. ■

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NOTES

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In this month's *Health Affairs*, Delos "Toby" Cosgrove and ten fellow health system CEOs draw on *A CEO Checklist for High-Value Health Care*, published in 2012 by the Institute of Medicine, and outline ten key strategies for reducing costs and waste while improving outcomes through patient-centered care. Citing a number of examples of what their systems have accomplished, they also call for further research on the effective measurement of patient engagement and on the ways in which such measures can drive continuous improvement.

Cosgrove is president and CEO of Cleveland Clinic, where he presides over a \$6 billion health care system, nine community hospitals, and eighteen family health centers, with facilities in Florida, Nevada, Toronto, and Abu Dhabi. He has published nearly 450 journal articles, one book, and seventeen training and continuing medical education films. He received a medical degree from the University of Virginia.



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