

Managing Congestive Heart Failure as a Business

September 13, 2010

Session M30

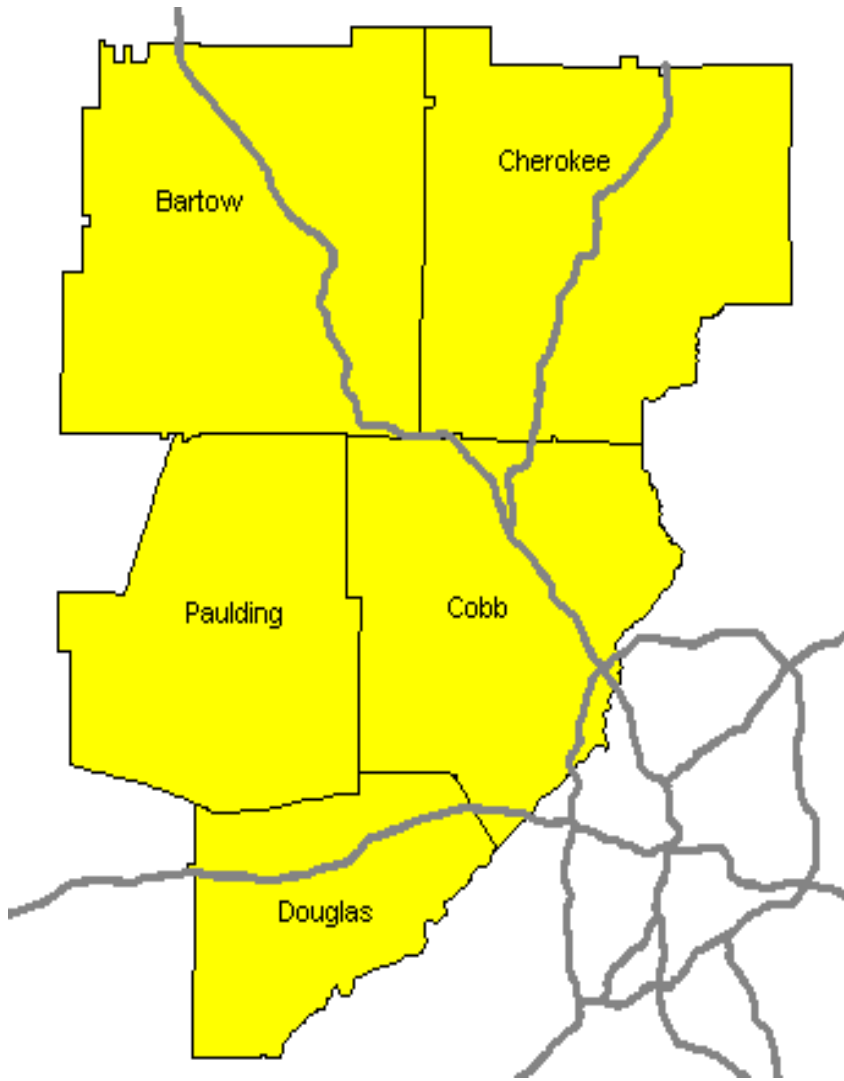
Society for Healthcare Strategy and Market Development annual meeting

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WellStar Health System Overview: Metro Atlanta



- 1.2 million area residents served
- Not-For Profit
- 5 Hospitals (1,321 licensed beds)
- 10 OP Imaging Centers; 5 Urgent Care Centers
- Nearly 300,000 ED Visits per year
- 1,200 physicians on medical staff
- Employed Multi-Specialty Group
 - 400+ Physicians/Adv. Practitioners
 - 1.1 million Office Visits
- 11,400 team members
- Revenues: \$1.5 Billion
- Highest market share in metro Atlanta

Session Outline

1. Current Situation for HF
2. Strategic Implications
3. Paradigm Shift
4. Approach used by WellStar Health System
5. Results to date
6. Key Challenges
7. Assessment tools for your hospital
8. Take-aways

Q & A – ask questions throughout the session

Patients with HF are part of the overall Cardiac service line, which is typically very profitable. However, *inpatient* HF is a financial drain for hospitals, and it will worsen unless significant corrective action is taken

- A. HF is the most common Medicare DRG
- B. Inpatient HF barely covers hospital variable costs
- C. Viewed on an opportunity-cost basis, HF patients use beds that could serve more-profitable patients
- D. The aging population will demand more medical beds for Medicare participants, but Medicare reimbursement does not cover variable costs *plus* incremental fixed facility costs
- E. Upcoming reimbursement changes would further decrease the financial viability of treating HF without altering treatment patterns and utilization

Background on Heart Failure

Prevalence: 5 million Americans;
lifetime risk of developing HF at age 40: 20%

Incidence: 550,000 new cases per year

Inpatient care: Most common DRG (Medicare)

Utilization by Chronic Condition for Medicare Members, 2006

Chronic condition	Inpatient days per 1,000
Heart Failure	12,000
COPD	8,500
Asthma	8,000
CAD	5,500
Diabetes	4,000
Non-Chronic	800

Source: Milliman, "Cost Trends for Chronic-Condition Cohorts with Medicare Benefits", May 2008

Inpatient Medical Cases, particularly HF, are not Attractive for Hospitals

1. Medical admissions are not financially attractive, particularly those for Medicare:

Contribution Margin per Day

	Surgical	Medical
Commercial	\$1,200	\$550
Medicare	\$350	\$75

2. Within cardiac, vast differences in economics, with CHF admissions barely covering variable costs:

Contribution Margin per Day: Cardiac

	All payors
Surgical	\$1,000
Medical other than HF	\$250
Heart Failure	\$25

3. Heart Failure's inpatient margin per day of \$25 is far below various potential opportunity cost figures:
 - (a) incremental cost to build new beds (\$250 per day)
 - (b) commercial volume if currently at capacity (\$750 per day)

Source: Disguised client data

The Aging Population will Demand Far More Inpatient Medical Beds

1. Hospital use rates (days/1000) for inpatient medical services are 10 times higher for age 65+ than those aged 18-64

2. Nationally, the 65+ segment will account for 18% of the population aged 20+ in 2010, but this segment will grow 8 times faster from 2010 to 2020 than the 20-64 segment, accounting for 68% of the total population growth aged 20+

3. With current inpatient use rates, from 2010 to 2020 (see Appendix):
 - a) Total medical days will grow 26% nationally
 - b) The 65+ segment will account for 96% of total medical day growth for the adult population

Inpatient Days per 1,000 Population by Age: Southeastern Suburb

Service Line	18-64	65+
Cardiac medical	12	176
Gastro	13	98
Pulmonary	14	221
Other medical (excludes cancer)	42	345
Total	81	840

National Census Trends

Age	2000	2010	2020
<u>Population (thousands)</u>			
20-64	166,515	185,456	192,285
<u>65+</u>	<u>35,061</u>	<u>40,243</u>	<u>54,632</u>
Total 20+	201,576	225,699	246,917
<u>Population Growth</u>		<u>2000 to 10</u>	<u>'10 to '20</u>
Thousands	20-64	18,941	6,829
	<u>65+</u>	<u>5,182</u>	<u>14,389</u>
	Total	24,123	21,218
CAGR	20-64	1.1%	0.4%
	<u>65+</u>	<u>1.4%</u>	3.1%
	Total	1.1%	0.9%

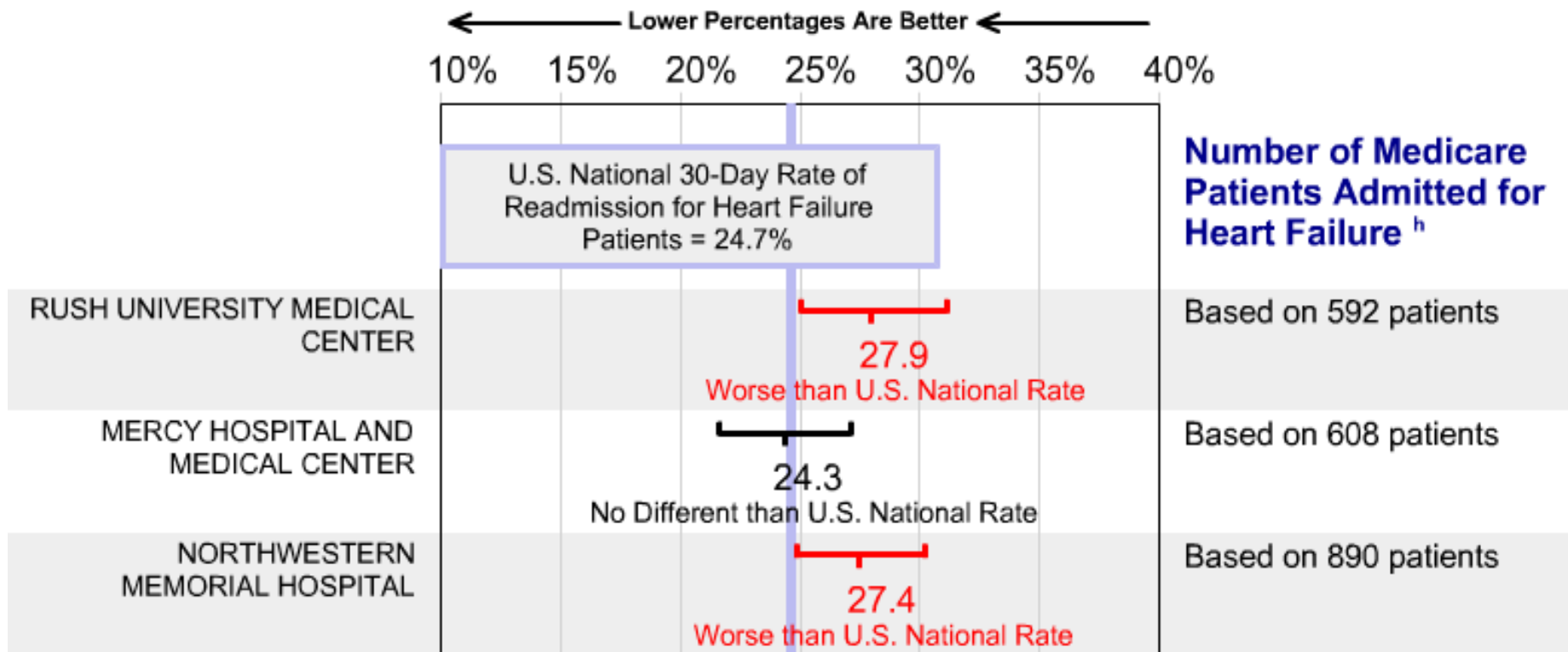
Sources: State discharge database; U.S. Census; Progressive analysis

Medicare Reimbursement Changes: Reform Law

Change	Description	Phasing & Impact
Value-Based Purchasing	Goal: improve outcomes and efficiencies AMI, HF, Pneumonia, Surgeries, Hospital acquired infections	2013: 1% 2014: increases 2017: 2%
Penalties for Readmissions	No payment for readmissions in excess of expected number; AMI, HF, Pneumonia	<u>Max total impact</u> 2013: 1% 2014: 2% 2015: 3%
Accountable Care Organizations	“Quasi-capitation” Details unknown	Jan 1, 2012
Payment Bundling	Fixed payment for 3 days pre-admission thru 30 days post-discharge	Jan 1, 2013 (pilot starts)

Re-admission Rates for Nearby Hospitals

Rate of Readmission for Heart Failure Patients

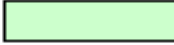



Source: HospitalCompare website, accessed 8/1/10

Potential Impact on Nearby Hospitals

Core Measure Performance: Chicago Hospitals

Top Three Conditions for Healthcare Reform

 = Better than National Rate
 = Worse than National Rate

Measure		Heart attack	Heart failure	Pneumonia	Total
Re-Admission within 30 Days					
Rate	National	19.9%	24.7%	18.3%	21.9%
	Mercy Hospital and Medical Center	19.7%	24.3%	19.7%	22.1%
	Northwestern Memorial Hospital	21.6%	27.4%	23.1%	25.0%
	<u>Rush University Medical Center</u>	<u>21.0%</u>	<u>27.9%</u>	<u>20.1%</u>	<u>24.4%</u>
	Total	20.9%	26.6%	21.3%	24.0%
Cases	Mercy Hospital and Medical Center	214	608	328	1,150
	Northwestern Memorial Hospital	318	890	517	1,725
	<u>Rush University Medical Center</u>	<u>142</u>	<u>592</u>	<u>358</u>	<u>1,092</u>
	Total	674	2,090	1,203	3,967
Excess Re-admits	Mercy Hospital and Medical Center	(0)	(2)	5	2
	Northwestern Memorial Hospital	5	24	25	54
	<u>Rush University Medical Center</u>	<u>2</u>	<u>19</u>	<u>6</u>	<u>27</u>
	Total	7	41	36	83

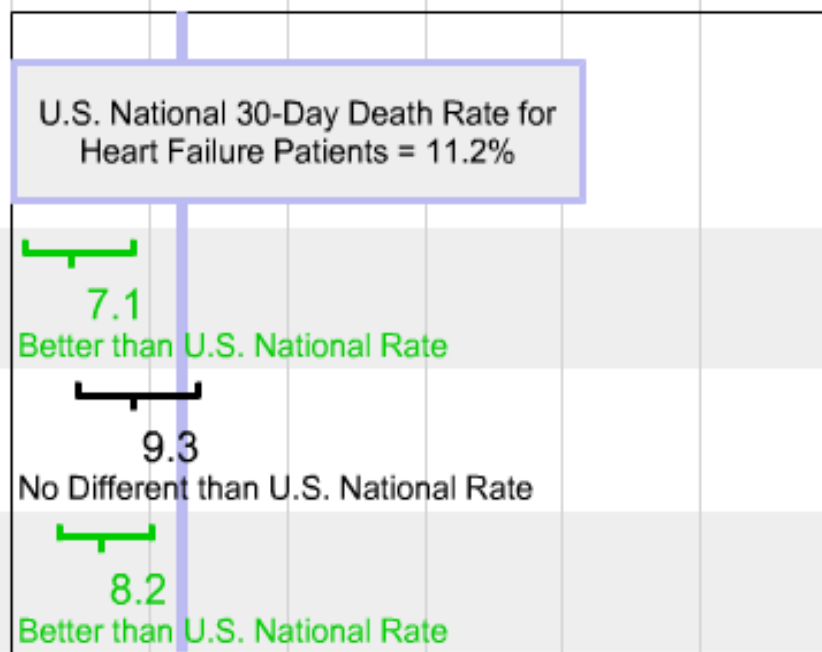
Source: CMS Hospital Compare website, accessed 8/1/10
 Data for period July 1, 2006 through June 30, 2009
 For Heart Failure, 193 of 4,209 hospitals were "worse than the U.S. National Rate"

Cases at-risk for \$0 payment

Observation: No Incentive for Low Mortality under Discussion

Death Rate for Heart Failure Patients

← Lower Percentages Are Better ←
5% 10% 15% 20% 25% 30% 35%



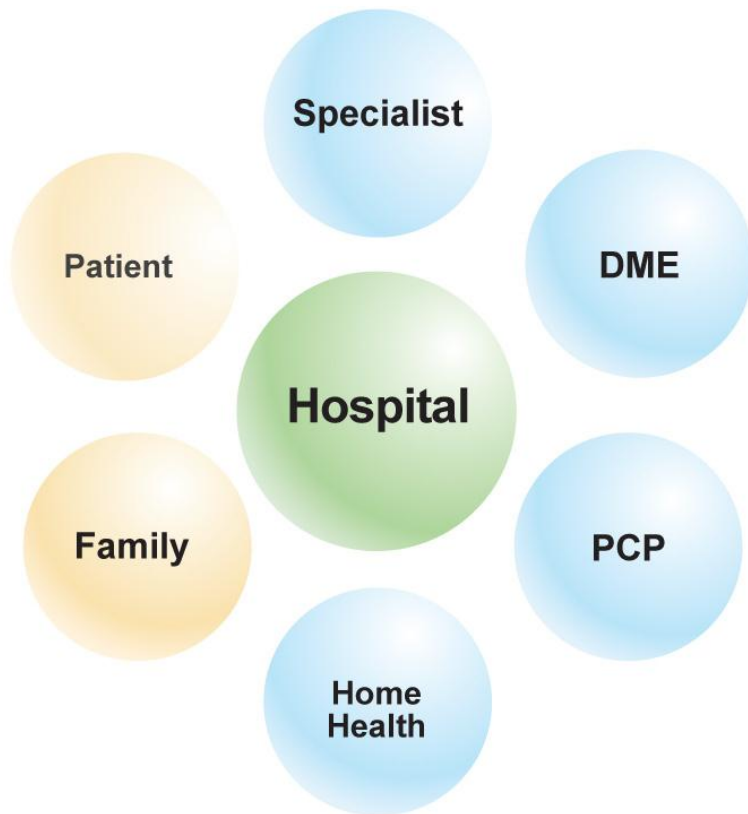
Number of Medicare Patients Admitted for Heart Failure^h

Based on 433 patients

Based on 459 patients

Based on 694 patients

Current Situation for Patients with Heart Failure



1. For hospitals, inpatient HF barely covers variable inpatient costs – **Hence HF rarely pursued.**
2. **Current reimbursement does not drive collaboration** across the continuum – Hospitals are not typically taking a leadership role.
3. **For HF patients, care is very fragmented.**
4. Each business unit optimizes its FFS performance, not on the requirements for an optimal integrated system
5. Often, **payors** are the only organizations with a **comprehensive view** of the patient

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New Paradigms

FROM:

Encounters by Business Unit
(e.g., admissions to a
hospital from a service area)



TO:

All care across the
continuum for *specific
people* for their *life*

Profitability of encounters
(e.g., margin per DRG)



Value Chain
Profit Pools

Acute care



Chronic Care Model

Building referral networks
and facilities/programs that
encourage usage



Pro-actively managing
patient care across
continuum and over time

Heart Failure as a Target Market...very big

Prevalence: **5 million Americans;**
lifetime risk of developing HF at age 40: 20%

Incidence: **550,000 new cases per year**

Inpatient care: **Most common DRG (Medicare)**

Utilization by Chronic Condition for Medicare Members, 2006

Chronic condition	Inpatient days per 1,000	PMPM costs
Heart Failure	12,000	\$3,100
COPD	8,500	\$2,300
Asthma	8,000	\$2,300
CAD	5,500	\$1,800
Diabetes	4,000	\$1,300
Non-Chronic	800	\$400

\$230 billion market
(2010 estimate)

For typical patient,
inpatient care
accounts for only 12 of
365 days annually

Source: Milliman, "Cost Trends for Chronic-Condition Cohorts with Medicare Benefits", May 2008

Value Chain and “Profit Pools”: Heart Failure

ILLUSTRATIVE

Provider	Service	Units	\$/unit	Revenue	Margin	Profit
Hospital	ED & Observation	2	\$800	\$1,600	\$400	\$50
	Inpatient – Medical	10	\$1,000	\$10,000	\$250	\$(2,000)
	Inpatient – Surgical	2	\$3,000	\$6,000	\$1,000	\$400
	Diagnostics	3	\$500	\$1,500	\$750	\$250
Cardiologists	Office visits	8	\$200	\$1,600	\$600	\$200
	Diagnostics	6	\$250	\$1,500	\$800	\$500
	Prof fees: in Hosp	12	\$125	\$1,500	\$600	\$300
Other MDs	Prof Fees	2	\$1,000	\$2,000	\$800	\$100
Pharma	Medications	8	\$600	\$4,800	\$3,000	\$1,000
DME	Devices	1	\$400	\$400	\$200	\$100
<u>Other</u>	Home health, other			<u>\$6,100</u>	<u>\$1,300</u>	<u>\$200</u>
Total				\$37,000	\$9,700	\$1,075

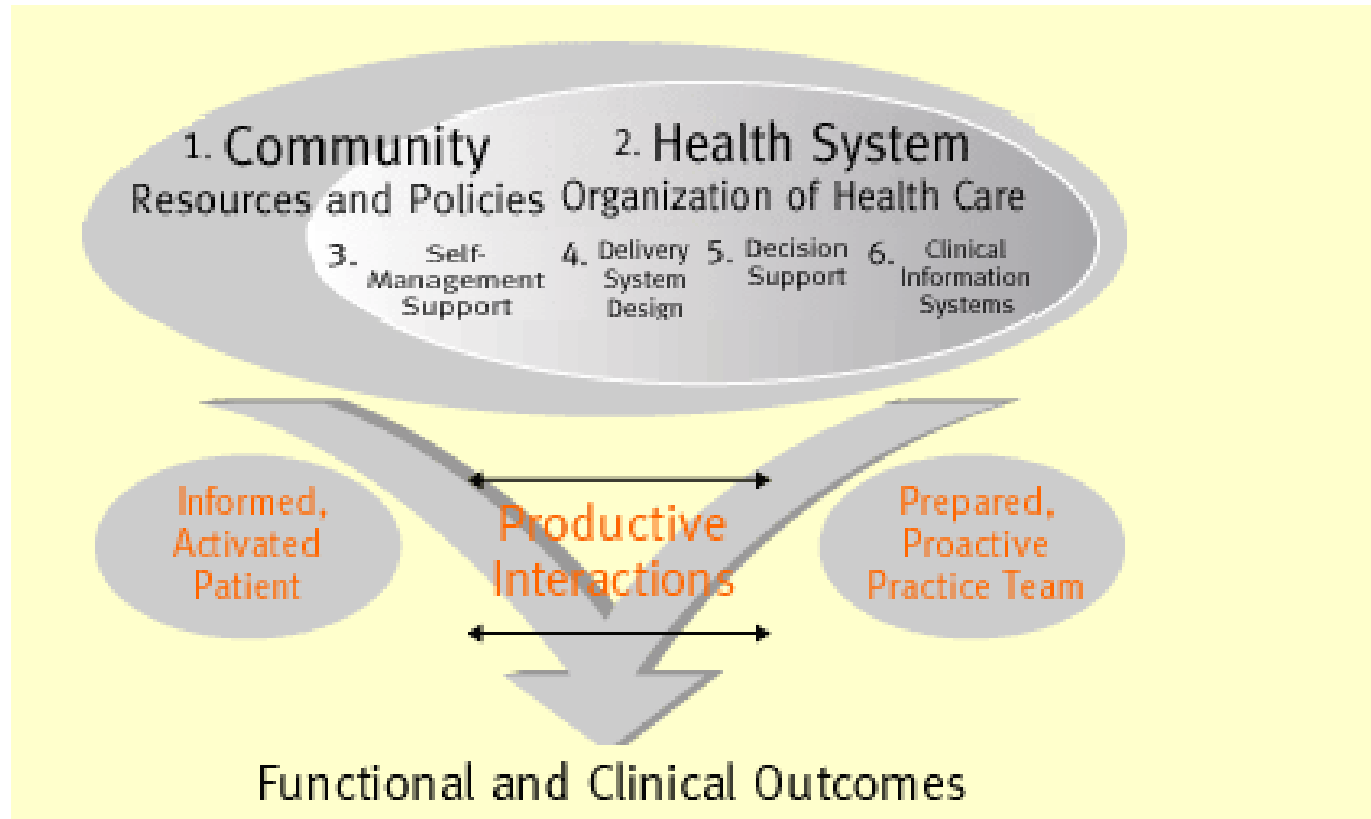
Hospital portion	52%	25%	(126)%
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Approach to Improve a Value Chain's Financial Performance

1. Estimate profits for the current value chain
2. Identify:
 - a) Industry constraints that may have inhibited improved performance across the value chain
 - b) New technologies that could alter the value chain in a meaningful fashion (protocols, IT, new diagnostics/treatments)
 - c) “Choke Point(s)” where the hospital could direct the value chain with minimal investment
3. Design and implement a hospital-driven HF business that:
 - a) Improves performance of the overall value chain (for patients and payors)
 - b) Substantially improves the health system's profitability on these patients
 - c) Strengthens relationships with key partners (e.g., cardiologists)

The Chronic Care Model provides a Framework for Heart Failure

- **The Chronic Care Model (CCM) “leads to improved patient care and better health outcomes” (Coleman et al 2009)**



Sources: Coleman, Austin, Brach and Wagner, “Evidence on the Chronic Care Model in the New Millennium”, Health Affairs, Jan/Feb 2009.

Asch et al, “Does the Collaborative Model Improve Care for Chronic Heart Failure?”, Medical Care, July 2005. Note: the IHI approach was based explicitly on the Chronic Care Model.

- “Patients enrolled in chronic care management programs using a multi-disciplinary team approach had significantly fewer hospital readmissions and readmission days than routine care patients – a 2.9 percent reduction in readmissions per months and a 6.4 percent reduction in readmission days per month over routine care.”
- “Program patients had **25 percent fewer all cause readmissions** and 30 percent fewer all cause readmission days.”
- No impact was found for programs that relied completely on telephonic communication

Source: “What Works in Chronic Care Management: The Case of Heart Failure,” Health Affairs, Jan/Feb 2009 page 132.

- The objective of integration:
 - “is to manage the orderly shifting of care *away* from costly venues and costly providers, and *toward* disruptive business models that can capitalize on technological enablers as they emerge” (p. 200)
 - “should not be size and overhead cost-sharing, but the creation of enterprises that can profit from wellness, rather than sickness. This would result in systems with disruptive business models for the practice of intuitive, empirical, and rules-based medicine, employing mechanisms that channel patients to appropriate providers” (p. 204)

Source: Christensen, Grossman, Hwang, The Innovator’s Prescription (2009)

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Cardiovascular: Key WellStar Service Line

more heart
than anyone else in Georgia.

Believe it. The WellStar Cardiac Network is proud to be one of the largest – and fastest growing – cardiac programs in Georgia.

Everyday, across five counties and five hospitals, our heart specialists are helping people like you get well, stay well, and live well. Count on us for world-class cardiac services, from prevention to catheterization and open-heart surgery to rehabilitation.

At WellStar, your heart's in good hands. To learn more – or to find a cardiac specialist – call 770-956-STAR or visit wellstar.org.

We believe in heart.



wellstar.org * 770-956-STAR



Barry Mangel, MD
Chief Cardiology Officer

WellStar Cardiac Network includes:

WellStar Cardiovascular Medicine
WellStar Cobb Hospital *
WellStar Douglas Hospital *
WellStar Kennestone Hospital *
WellStar Paulding Hospital

WellStar Windy Hill Hospital
Cardiac Surgery
Cardiac Anesthesia
Vascular Surgery
Cardiac Rehabilitation

Cardiac Wellness
Cardiac Patient Support
Cardiovascular Imaging
WellStar Physicians Group
* Accredited Chest Pain Center

we believe
you deserve world-class cardiologists.

That's why WellStar is proud to welcome Cardiovascular Medicine (CVM) to our team. As one of metro Atlanta's largest cardiology practices, CVM has been recognized by the Medical Group Management Association as one of the Top Performers in the country.

What does this new partnership mean to you? Even more of the collaborative cardiac care you've come to expect from WellStar. From heart attack prevention to vascular intervention, we're helping more people live well than ever before.

To find a WellStar cardiologist, just call 770-956-STAR.

We believe in heart.



wellstar.org/heart * 770-956-STAR



WellStar Cardiac Network includes

WellStar Cobb Hospital
WellStar Douglas Hospital
WellStar Kennestone Hospital
WellStar Paulding Hospital
WellStar Windy Hill Hospital
WellStar Cardiac Partners
Health Place

Goal: improve the patient experience & the providers' financial performance

Vision: The CHF care model is optimized so that:

1. Care is patient-centric:
 - Patient experience
 - Health improvement

2. Protocols are evidence-based and driven by local providers

3. Providers earn a sustainable financial return

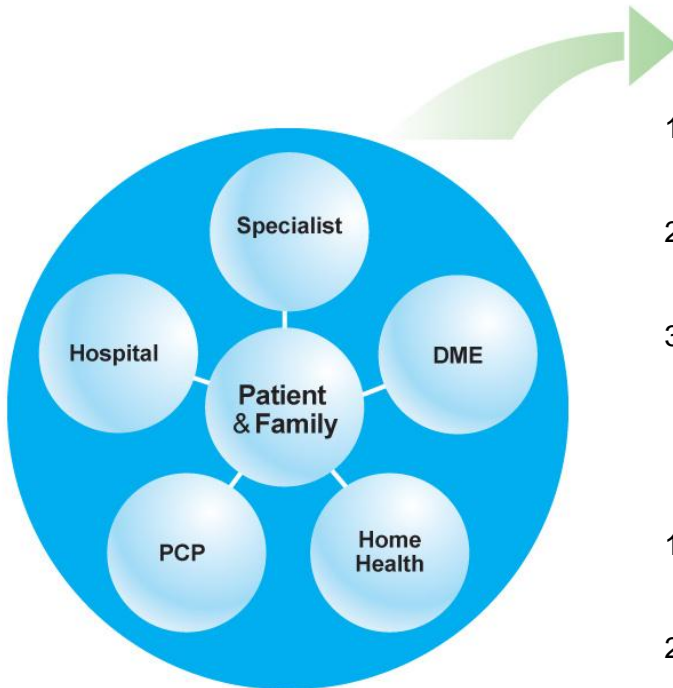
4. Total costs meet the needs of payers



1. Establish post-discharge protocols and on-going care plans by prospective patient severity.
2. Proactively manage care across the continuum via process changes and dedicated coordination resources (staff, IT)
3. Ensure all routine office visits and diagnosis occur to keep these patients as well as possible. Address process issues across the continuum.



1. Patients experience seamless care post-discharge and throughout the year.
2. Providers generate more outpatient activity (high margin) and reduce inpatient usage (admits and re-admits).
3. LOS reduction; overall resource/admit reduction
4. Improvement in functional status (KCCQ, clinical)



Health System

Protocol 1: Post-Discharge Care

Preferred CarePath: WellStar HomeCare

Occurs **50%** of the time (for patients discharged to home)

Calendar

Assumes Sunday discharge

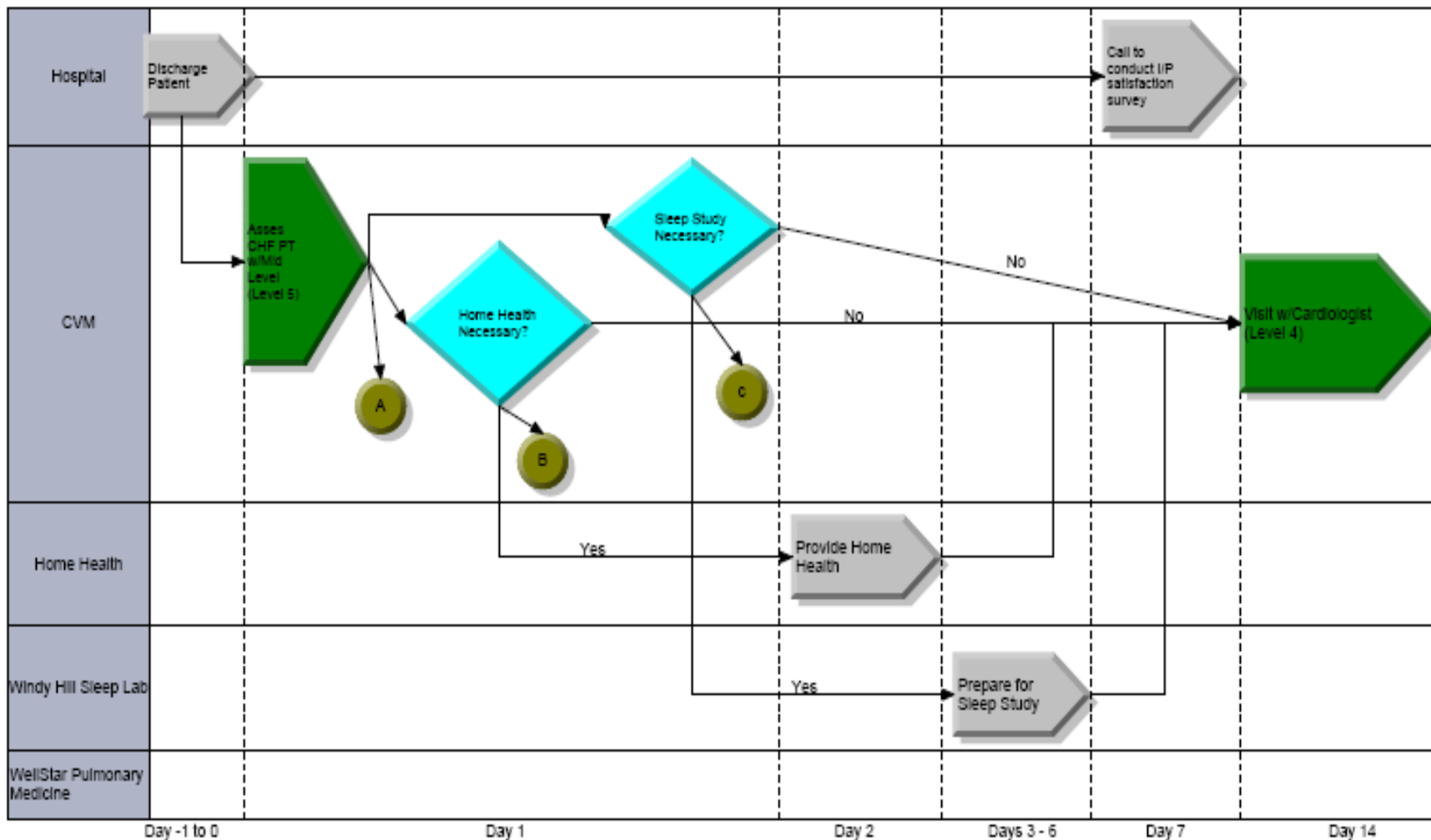
Activity per CVM-HF Guidelines

Wk	M	T	W	R	F	S	S	OV	HC	C	Diagnostics				
											BMP	BNP	6-min	ECHO	
1	HC	HC	OV	HC	Chc		HC	1	4	1	1	1	1	0.1	
2		HC	OV	Chc	HC		Chc	1	2	2	1	1			
3	HC		OV		HC		Chc	1	2	1	1	1			
4	HC		OV	HC			Chc	1	2	1	1	1	1		
5				HC					1		0	0			
6			OV				Chc	1		1	1	1			
7				HC					1		0	0			
8			OV	HC			Cpn	1	1	1	1	1	1		
9											0	0			
10			OV					1			1	1			
11							Cpn			1	0	0			
12			OV					1			1	1	1	0.8	
Total								8	13	8	8	8	4	0.9	
								29							

\$4,470 Revenues
\$1,525 Margin

6 Chc Calls by HomeCare
2 Cpn Calls by CVM's Patient Navigator

High-level Swim Diagram: Post-Discharge Care Process (14 of 90 days)

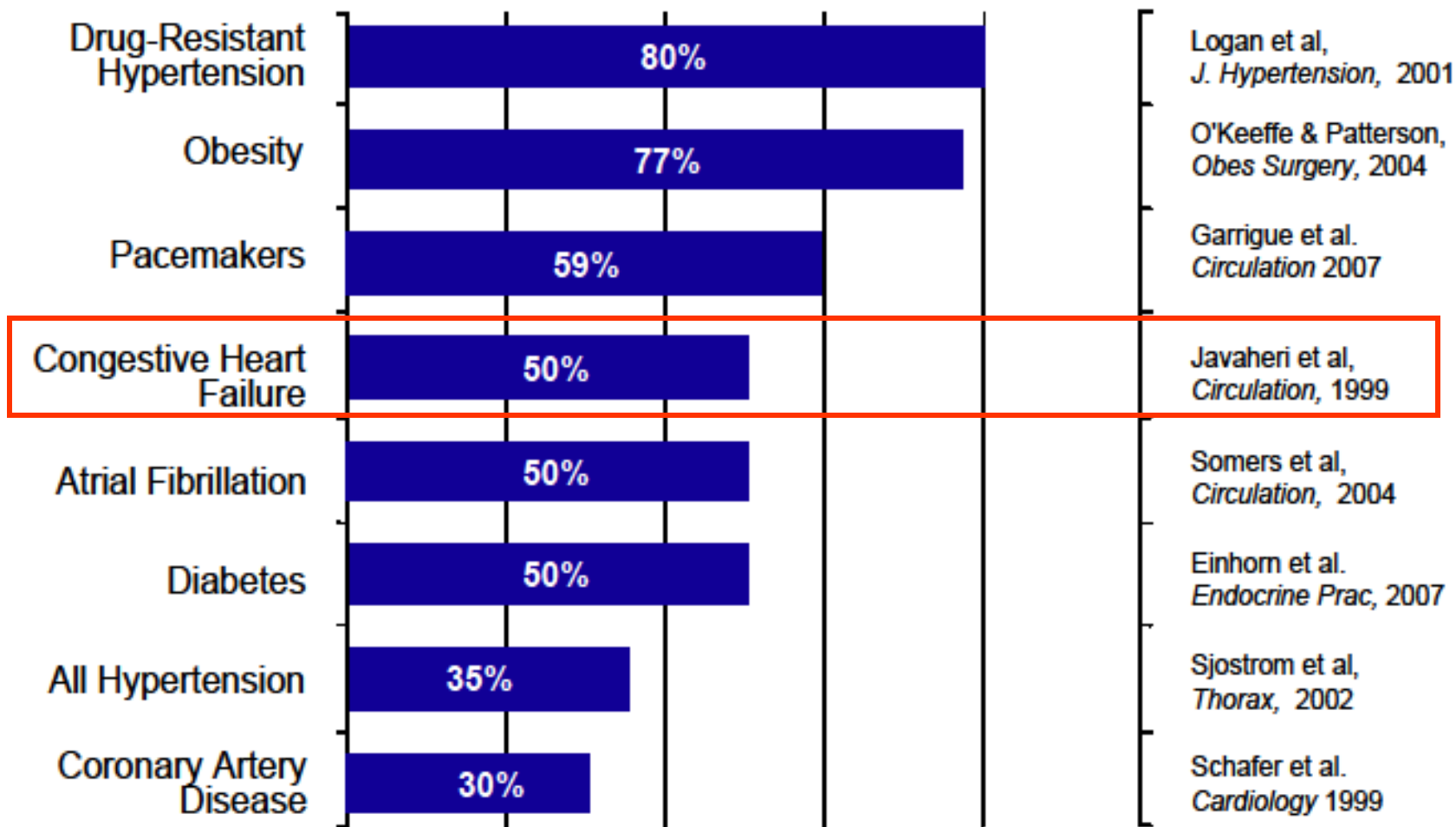


Embedded Case Managers are Key to Success

- Embedded Case Manager (per **700-800 Medicare pts**)
 - **High risk** patient case load 15 - 20% (125 - 150 pts)
 - NOT disease education – focus those at most risk and what is driving issue with the care
- Personal patient link
 - **Comprehensive care review** – medical, social support
 - **Transitions follow up** (acute/SNF discharges, ER visits)
 - **Direct line access** – questions, exacerbation protocols
 - Family support contact
- **Recognized site team member**
 - Regular follow ups high risk patients
 - Facilitate access – PCP, specialist, ancillary
 - Facilitate special arrangements (emergency home care, hospice care)
- Linked to remote tele-monitoring for specific populations

Geisinger presentation, April 22, 2010, page 14. Accessed from website

Sleep Apnea Prevalence for Common Cardiac Conditions



1. Build inpatient capabilities via IHI collaborative for readmissions (at small facility, as System pilot)
2. Develop comprehensive outpatient model via employed cardiology group (at largest facility (open heart program))
3. Ensure consistency between efforts via workplan and approach coordination
4. Extend care model other providers (hospitals, group)
5. View HF program as initial chronic care program, with many more to follow
6. Use HF effort to drive process improvement within and across Business Unit

Approach Used: Comprehensive HF Model

Team Members

Cardiologists (2 HF MDs and 1 mid-level), inpatient cardiac care leader (nurse), Home Health, Sleep Medicine and Sleep Lab, Cardiology practice management, DME

Workplan & Sequence of Issues Resolved

- Consensus of team on goals / vision
- Protocol (post-discharge; on-going care), to provide framework
- Develop economic model for each protocol; volume impact & impact
- Identify integration/coordination issues and approach to resolve
- Start implementing (often via pilots) protocols and process changes

Budgeting

- Create budget for each Business Unit based on the integrated economic model, with phasing
- Model all drivers for volume growth
- Consider resources needed to manage care (and facilitate growth)

Return

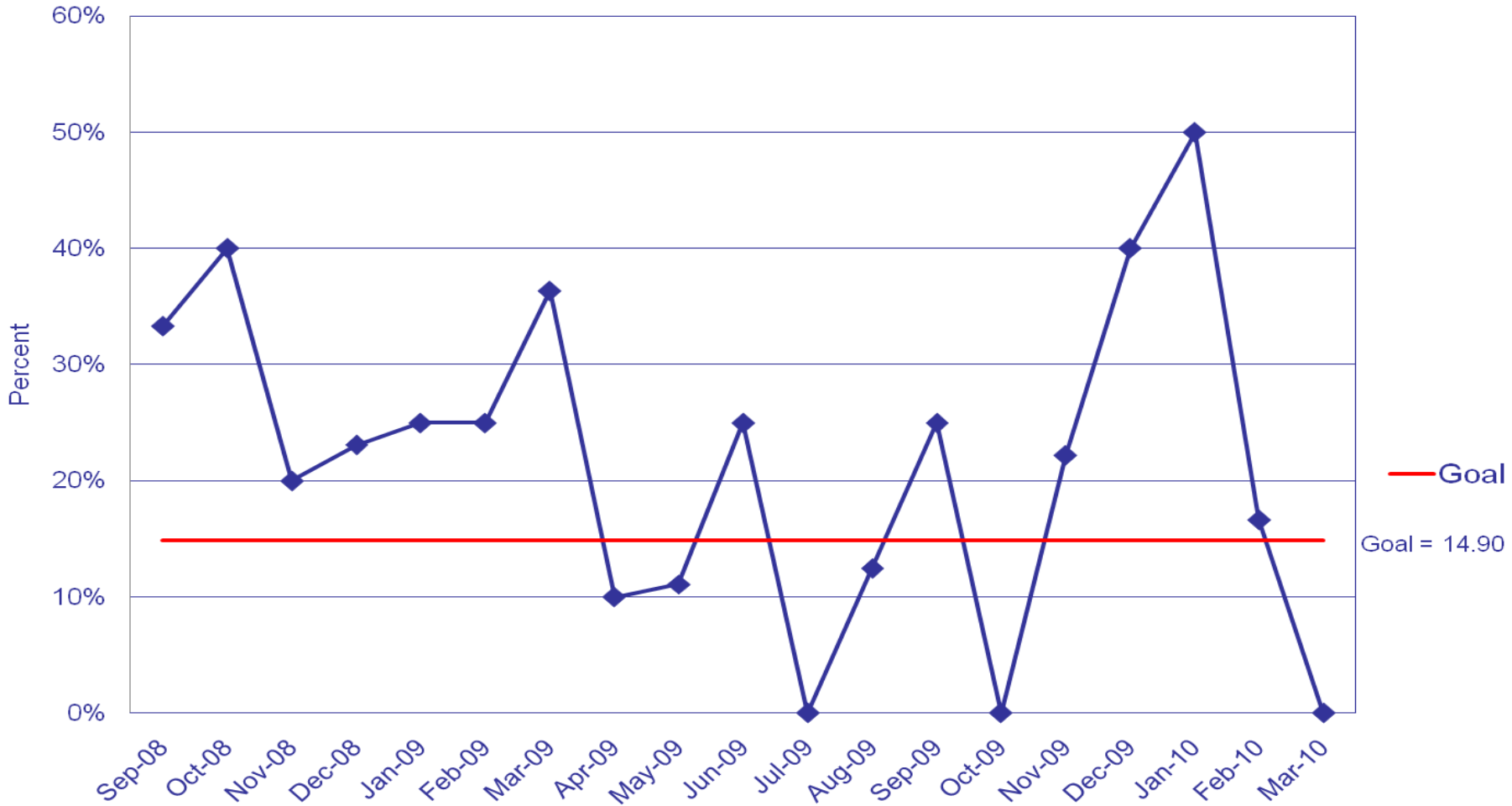
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|--|
| 1. New Level 5 office visits (post-discharge) at CVM |
| 2. Additional CVM Diagnostics during Post-Discharge Period |
| 3. Additional Hospital Labs during Post-Discharge Period |
| 4. HomeCare during Post-Discharge Period |
| 5. More routine Office Visits for CVM patients w/ Mid-Level |
| 6: More CVM diagnostics for routine CVM office patients |
| 7: More Hospital diagnostics for routine CVM office patients |
| 8. New Sleep Studies (for post-discharge CVM patients) |
| 9. New Sleep Studies (for CVM patients in office - routine) |
| 10. Prof fees for Sleep Mmgt (WellStar Pulmonary Medicine) |
| 11. DME for CPAP |
| 12. LOS Reduction: Clinical pathway (HF DRGs) |

Investment

- | |
|---|
| A. Dedicated Resource Nurse for Inpatient HF Patients |
| B. Patient Navigator for CVM patients |
| C. Patient Registry & Care Coordination Application |
| D. HF Clinical Director |

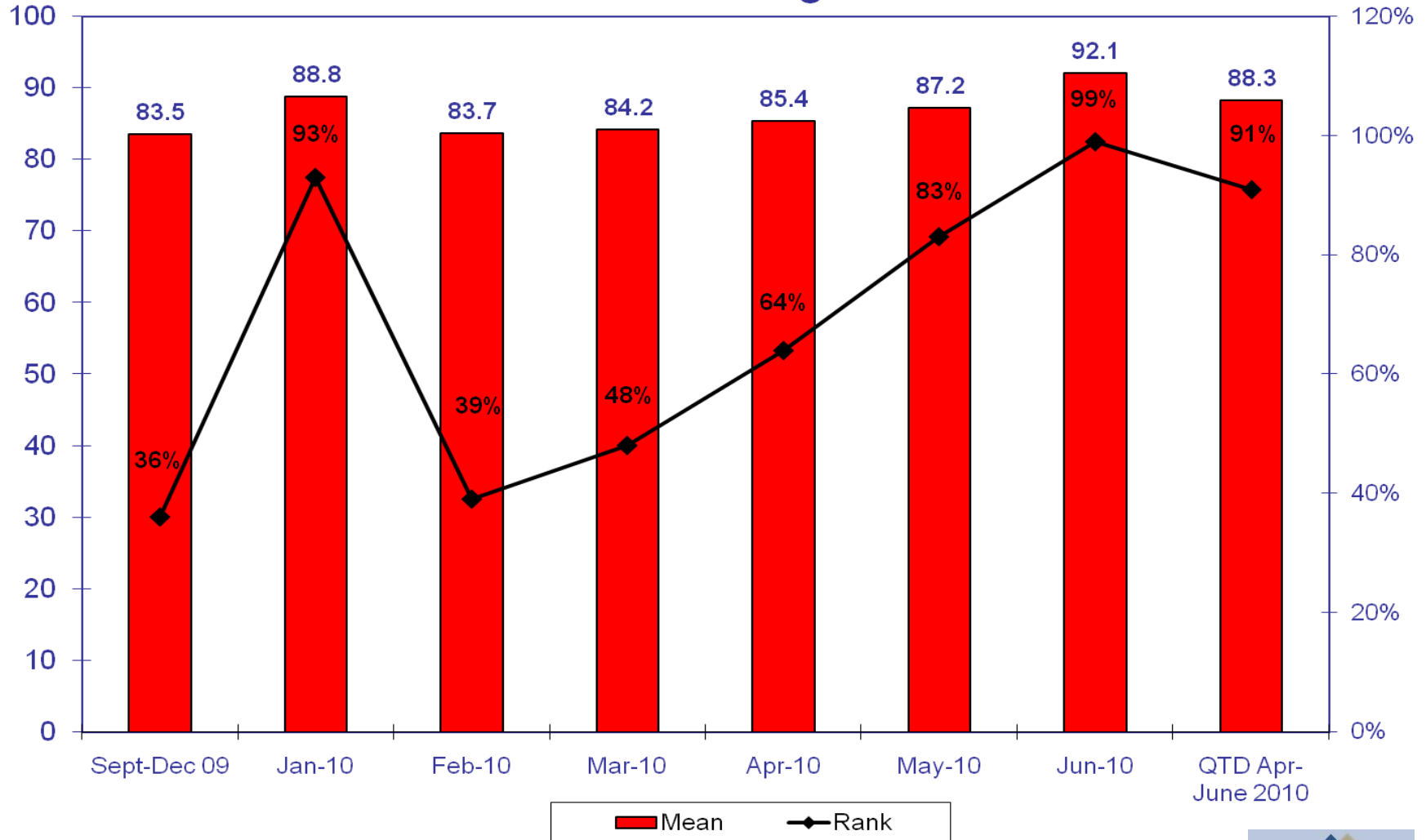
Results To-Date of IHI Readmissions Project

WellStar Paulding Hospital 30 Day All Cause Readmissions for a Specific Clinical Condition Heart Failure



Results To-Date of IHI Readmissions Project

WellStar Paulding Hospital Patient Satisfaction with Overall Discharge Process



Results To-Date: Comprehensive Program

	Status
<u>Inpatient</u>	
Daily multi-disciplinary discharge planning rounds	Done
Home care assessment & order	Done
Schedule post-discharge office visit	Done
<u>Outpatient</u>	
Integrated protocol	Done
Sleep assessment – all patients	Pilot
Patient Registry	Manual

Scope

- Full continuum except PCPs
- Developing integration capabilities (Process, roles, IT)

Financial impact

- Diagnostic and office visit increase (per protocol)
- Currently setting up data collection to track impact

Long-Term Metrics: Balanced Scorecard for HF

People

Employee satisfaction for staff on Inpatient Unit where most HF patients are treated

Customer Service

Patient satisfaction across the continuum:

- a. Inpatient care
- b. Home Care
- c. Care at CVM
- d. Diagnostics

Quality and Patient Safety

Re-admission rate (inpatient), by MS-DRG

Mortality rate:

- a. Initially, inpatient. Note: this could increase if readmissions (and admission rates) are reduced
- b. Ultimately, this should be measured for participants in the HF program, once a stratification method is identified for the managed population

Functional status:

- a. 6-minute walk
- b. Kansas City Cardiomyopathy Questionnaire

Financial

Inpatient resource usage:

- a. LOS by MS-DRG (291-293)
- b. Eventually: Variable Cost by MS-DRG

Comprehensive financial performance across WellStar for HF patients (collections; profit; margin):

- Inpatient care
- Hospital-diagnostics
- Cardiologist professional services
- Cardiologist-provided diagnostics
- Home Care
- Sleep diagnostics and treatment (prof fees; DME)

Total excluding primary care

Successful Growth

Market share of HF DRGs

Number of active HF patients in CVM's HF program

Lesson Learned

1. HF (inpatient) is far larger than HF DRGs: 2-5X
2. There's no one "right" protocol for either post-discharge or on-going care – use what cardiologists believe is right, and agree to evaluate it with data
3. Integration across the continuum is very difficult: process and information flow issues
4. Key paradigm shift: making the provider "system" perform the role of pro-actively managing the care for each patient
5. Get team agreement on the vision upfront

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Key Challenges

Category	Challenge	Approach to address
Physician	Paradigm shift to population health	Focus on protocols, then process improvement
Inpatient focus by Hospital	Getting the focus elsewhere	Team design Identify how strong O/P program helps hospital
Financial	Belief that all care for chronic patients is unprofitable, like I/P HF	Build fact-based profit model for O/P growth
Infrastructure	None really exists	Focus on each task, and identify targeted changes required
Data & Reporting	Data are non-existent or not timely	Start with manual patient registry; focus on data needs for each process change

- **Ball-park ROI tool for Size of Financial Opportunity:**
 - ROI Driven by:
 - HF size (inpatient discharges; population with HF)
 - Protocol assumptions
 - Portion of Value Chain owned by Hospital
 - Spreadsheet tool that requires basic data

- **Ability to Implement**
 - Driven by:
 - Clinical consensus by sufficient number of cardiologists
 - Process capabilities of organization (e.g., IHI collaborative)
 - All parts of continuum either owned by hospital or willing to “partner”
 - Leadership (with time to do work)
 - Ability to fund infrastructure investments (1-3 FTEs, targeted IT)

Heart Failure: Marketing Considerations

Element	Importance	Comment
Mass media	Low	New orientation: “chunks” of patients Choke points (operational patient acquisition)
Direct mail	Low	
Online communities	Moderate	Critical after patient acquisition, for self-mgmt
Senior affinity group	Moderate	HF target = patients with chronic conditions are not active seniors
Collateral materials	High	Patient’s view across the continuum...integrated collateral across business unit

1. New perspective: “money losing” chronic conditions can become profitable if managed across continuum — replace no-margin inpatient care with high-margin outpatient services
2. Protocols (to start with)
3. An economic model of the value chain (encounter types, volume drivers, reimbursements)
4. Framework for integrated budget (i.e., sources of margin to bear the cost of infrastructure)
5. Leverage the Institute for Healthcare Improvement’s collaboratives
6. 5-step process (next page)

5-Step Process

1. Design care **protocols** and **processes** across continuum (population mgmt):

- a. Post-discharge period
- b. On-going care

2. Develop **financial model** for optimal program and business case for investment (time and fees); quantify impact of target utilization

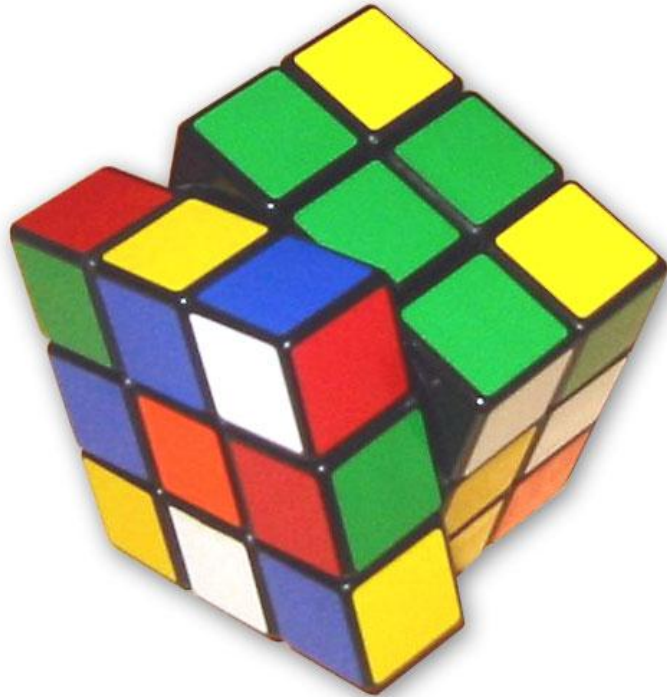
3. Build **infrastructure** for care management (operating expense):

A.	CHF clinical director
B.	Patient Registry & Care Management application
C.	Nurse Navigator
D.	Dedicated inpatient resource nurse
E.	Function status measurement
F.	Process mapping & re-design/"lean"
G.	Web-based patient 'activation & education

4. Increase **outpatient utilization** (diagnosis and treatment) and reduce inpatient care (LOS, admit rate)

Leverage existing diagnostic facilities and capabilities (hence, high margin)

5. Measure **functional outcomes**, **fine-tune** protocols and processes, and **promote** as distinctive program



- ✓ **HF is complicated, but it's...**
- ✓ **Right thing to do for the community**
- ✓ **Opportunity for your organization and you as a planning/marketing executive**

Managing Congestive Heart Failure as a Business

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