

Request for Reconsideration after Final Action

The table below presents the data as entered.

Input Field	Entered
SERIAL NUMBER	85510511
LAW OFFICE ASSIGNED	LAW OFFICE 116
MARK SECTION (no change)	
GOODS AND/OR SERVICES SECTION (035)(current)	
INTERNATIONAL CLASS	035
DESCRIPTION	
Business consulting, business analysis and market research services for others in the field of health care in the nature of identifying and analyzing the business of health care and the business impacts of changing technology for health care systems, providers, payers, suppliers, consultants and medical equipment manufacturers; consulting services, namely, analysis of market research data and statistics using a method to quantify market share calculations and opportunities for others	
FIRST USE ANYWHERE DATE	At least as early as 03/14/2012
FIRST USE IN COMMERCE DATE	At least as early as 03/14/2012
FILING BASIS	Section 1(b)
GOODS AND/OR SERVICES SECTION (035)(proposed)	
INTERNATIONAL CLASS	035
DESCRIPTION	
Business consulting, business analysis and market research services for others in the field of health care in the nature of identifying and analyzing the business of health care and the business impacts of changing technology for health care systems, providers, payers, suppliers, consultants and medical equipment manufacturers; consulting services, namely, analysis of market research data and statistics using a method to quantify market share calculations and opportunities for others	
FIRST USE ANYWHERE DATE	At least as early as 03/14/2012
FIRST USE IN COMMERCE DATE	At least as early as 03/14/2012

STATEMENT TYPE	<p>"The substitute (or new, if appropriate) specimen(s) was/were in use in commerce at least as early as the filing date of the application" <i>[for an application based on Section 1(a), Use in Commerce]</i> OR "The substitute (or new, if appropriate) specimen(s) was/were in use in commerce prior either to the filing of the Amendment to Allege Use or expiration of the filing deadline for filing a Statement of Use" <i>[for an application based on Section 1(b) Intent-to-Use]</i>.</p>
SPECIMEN FILE NAME(S)	
ORIGINAL PDF FILE	SPU0-173922089-20150413182520407717 . SHARE OF CARE Specimen.pdf
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SPECIMEN DESCRIPTION	Brochure detailing Applicant's business consulting, business analysis, and market research services
GOODS AND/OR SERVICES SECTION (042)(current)	
INTERNATIONAL CLASS	042
DESCRIPTION	
Technological consultation, namely, analyzing the changing technology for health care systems, providers, payers, suppliers, consultants and medical equipment manufacturers	
FIRST USE ANYWHERE DATE	At least as early as 03/14/2012
FIRST USE IN COMMERCE DATE	At least as early as 03/14/2012
FILING BASIS	Section 1(b)
GOODS AND/OR SERVICES SECTION (042)(proposed)	
INTERNATIONAL CLASS	042
DESCRIPTION	
Technological consultation, namely, analyzing the changing technology for health care systems, providers, payers, suppliers, consultants and medical equipment manufacturers	
FIRST USE ANYWHERE DATE	At least as early as 03/14/2012
FIRST USE IN COMMERCE DATE	At least as early as 03/14/2012
STATEMENT TYPE	"The substitute (or new, if appropriate) specimen(s) was/were in use in commerce at least as early as the filing date of the application" <i>[for an application based on Section 1(a), Use in Commerce]</i> OR "The substitute (or new, if appropriate) specimen(s) was/were in use in commerce prior either to the filing of the Amendment to Allege Use or expiration of the filing deadline for filing a Statement of Use" <i>[for an application based on Section 1(b) Intent-to-Use]</i> .
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SPECIMEN DESCRIPTION

Brochure detailing Applicant's technological consultation services

ADDITIONAL STATEMENTS SECTION

Applicant has argued in their first Request for Reconsideration submitted on April 13, 2015, that the previously submitted specimens are acceptable. However, if the Examining Attorney is unpersuaded by Applicant's Request for Reconsideration, Applicant hereby submits this substitute specimen in their second Request for Reconsideration. The substitute specimen consists of a brochure outlining business and technological consulting services offered to participating health systems in connection with the SHARE OF CARE mark. Specifically, participating health systems are able to choose from a menu of

MISCELLANEOUS STATEMENT	options which business and/or technological consulting services the participating health system wishes to employ. Technological consultation services offered by Applicant in connection with the SHARE OF CARE mark, as detailed on page 4 of the specimen, include but are not limited to e-health initiatives, web portal strategies, and ambulatory electronic medical record subsidies. Further, business analysis and consulting services offered by Applicant in connection with the SHARE OF CARE mark, also detailed on page 4 of the specimen, include but are not limited to, new care sites, improved scheduling, customer service campaigns, and improving regional clinical networks. Therefore, Applicant submits that the substitute specimen is acceptable as it demonstrates use of the mark SHARE OF CARE in connection with Applicant's services.
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SIGNATURE SECTION

DECLARATION SIGNATURE	/Richard B. Biagi/
SIGNATORY'S NAME	Richard B. Biagi
SIGNATORY'S POSITION	Attorney of record, Illinois bar member
SIGNATORY'S PHONE NUMBER	847-881-2455
DATE SIGNED	04/14/2015
RESPONSE SIGNATURE	/Richard B. Biagi/
SIGNATORY'S NAME	Richard B. Biagi
SIGNATORY'S POSITION	Attorney for Applicant
SIGNATORY'S PHONE NUMBER	847.881.2455
DATE SIGNED	04/14/2015
AUTHORIZED SIGNATORY	YES
CONCURRENT APPEAL NOTICE FILED	NO

FILING INFORMATION SECTION

SUBMIT DATE	Tue Apr 14 11:59:54 EDT 2015
TEAS STAMP	USPTO/RFR-173.9.220.89-20 150414115954682480-855105 11-5309e60d4847e57ad47cda 3bac7fb7ee615d783f42c5326 aae4a79ef0e71196-N/A-N/A- 20150414111533781417

Request for Reconsideration after Final Action

To the Commissioner for Trademarks:

Application serial no. **85510511** has been amended as follows:

CLASSIFICATION AND LISTING OF GOODS/SERVICES

Applicant proposes to amend the following class of goods/services in the application:

Current: Class 035 for Business consulting, business analysis and market research services for others in the field of health care in the nature of identifying and analyzing the business of health care and the business impacts of changing technology for health care systems, providers, payers, suppliers, consultants and medical equipment manufacturers; consulting services, namely, analysis of market research data and statistics using a method to quantify market share calculations and opportunities for others

Original Filing Basis:

Filing Basis: Section 1(b), Intent to Use: The applicant has had a bona fide intention to use or use through the applicant's related company or license the mark in commerce on or in connection with the identified goods and/or services as of the filing date of the application. (15 U.S.C. Section 1051(b)).

In International Class 035, the mark was first used at least as early as 03/14/2012 and first used in commerce at least as early as 03/14/2012 .

Proposed: Class 035 for Business consulting, business analysis and market research services for others in the field of health care in the nature of identifying and analyzing the business of health care and the business impacts of changing technology for health care systems, providers, payers, suppliers, consultants and medical equipment manufacturers; consulting services, namely, analysis of market research data and statistics using a method to quantify market share calculations and opportunities for others

Deleted Filing Basis: 1(b)

In International Class 035, the mark was first used at least as early as 03/14/2012 . and first used in commerce at least as early as 03/14/2012 .

Applicant hereby submits one(or more) specimen(s) for Class 035 . The specimen(s) submitted consists of Brochure detailing Applicant's business consulting, business analysis, and market research services .

" The substitute (or new, if appropriate) specimen(s) was/were in use in commerce at least as early as the filing date of the application"*[for an application based on Section 1(a), Use in Commerce]* **OR "****The substitute (or new, if appropriate) specimen(s) was/were in use in commerce prior either to the filing of the Amendment to Allege Use or expiration of the filing deadline for filing a Statement of Use "***[for an application based on Section 1(b) Intent-to-Use]* .

Original PDF file:

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Converted PDF file(s) (24 pages)

[Specimen File1](#)

[Specimen File2](#)

[Specimen File3](#)
[Specimen File4](#)
[Specimen File5](#)
[Specimen File6](#)
[Specimen File7](#)
[Specimen File8](#)
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[Specimen File22](#)
[Specimen File23](#)
[Specimen File24](#)

Applicant proposes to amend the following class of goods/services in the application:

Current: Class 042 for Technological consultation, namely, analyzing the changing technology for health care systems, providers, payers, suppliers, consultants and medical equipment manufacturers

Original Filing Basis:

Filing Basis: Section 1(b), Intent to Use: The applicant has had a bona fide intention to use or use through the applicant's related company or licensee the mark in commerce on or in connection with the identified goods and/or services as of the filing date of the application. (15 U.S.C. Section 1051(b)).

In International Class 042, the mark was first used at least as early as 03/14/2012 and first used in commerce at least as early as 03/14/2012 .

Proposed: Class 042 for Technological consultation, namely, analyzing the changing technology for health care systems, providers, payers, suppliers, consultants and medical equipment manufacturers

Deleted Filing Basis: 1(b)

In International Class 042, the mark was first used at least as early as 03/14/2012 . and first used in commerce at least as early as 03/14/2012 .

Applicant hereby submits one(or more) specimen(s) for Class 042 . The specimen(s) submitted consists of Brochure detailing Applicant's technological consultation services .

" **The substitute (or new, if appropriate) specimen(s) was/were in use in commerce at least as early as the filing date of the application**"*[for an application based on Section 1(a), Use in Commerce]* OR "**The substitute (or new, if appropriate) specimen(s) was/were in use in commerce prior either to the filing of the Amendment to Allege Use or expiration of the filing deadline for filing a Statement of Use**" *[for an application based on Section 1(b) Intent-to-Use]* .

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[Specimen File19](#)

[Specimen File20](#)

[Specimen File21](#)

[Specimen File22](#)

[Specimen File23](#)

[Specimen File24](#)

ADDITIONAL STATEMENTS

Miscellaneous Statement

Applicant has argued in their first Request for Reconsideration submitted on April 13, 2015, that the previously submitted specimens are acceptable. However, if the Examining Attorney is unpersuaded by Applicant's Request for Reconsideration, Applicant hereby submits this substitute specimen in their second Request for Reconsideration. The substitute specimen consists of a brochure outlining business and technological consulting services offered to participating health systems in connection with the SHARE OF CARE mark. Specifically, participating health systems are able to choose from a menu of options which business and/or technological consulting services the participating health system wishes to employ. Technological consultation services offered by Applicant in connection with the SHARE OF CARE mark, as detailed on page 4 of the specimen, include but are not limited to e-health initiatives, web portal strategies, and ambulatory electronic medical record subsidies. Further, business analysis and consulting services offered by Applicant in connection with the SHARE OF CARE mark, also detailed on page 4 of the specimen, include but are not limited to, new care sites, improved scheduling, customer service campaigns, and improving regional clinical networks. Therefore, Applicant submits that the substitute specimen is acceptable as it demonstrates use of the mark SHARE OF CARE in connection with Applicant's services.

SIGNATURE(S)

Declaration Signature

DECLARATION: The signatory being warned that willful false statements and the like are punishable by fine or imprisonment, or both, under 18 U.S.C. Section 1001, and that such willful false statements and the like may jeopardize the validity of the application or submission or any registration resulting therefrom, declares that, if the applicant submitted the application or amendment to allege use (AAU) unsigned, all statements in the application or AAU and this submission based on the signatory's own knowledge are true, and all statements in the application or AAU and this submission made on information and belief are believed to be true.

STATEMENTS FOR UNSIGNED SECTION 1(a) APPLICATION/AAU: If the applicant filed an unsigned application under 15 U.S.C. Section 1051(a) or AAU under 15 U.S.C. Section 1051(c), the signatory additionally believes that: the applicant is the owner of the trademark/service mark sought to be registered; the applicant or the applicant's related company or licensee is using the mark in commerce and has been using the mark in commerce as of the filing date of the application or AAU on or in connection with the goods/services in the application or AAU, and such use by the applicant's related company or licensee inures to the benefit of the applicant; the original specimen(s), if applicable, shows the mark in use in commerce as of the filing date of the application or AAU on or in connection with the goods/services in the application or AAU; and to the best of the signatory's knowledge and belief, no other person has the right to use the mark in commerce, either in the identical form or in such near resemblance as to be likely, when used on or in connection with the goods/services of such other person, to cause confusion or mistake, or to deceive.

STATEMENTS FOR UNSIGNED SECTION 1(b)/SECTION 44 APPLICATION: If the applicant filed an unsigned application under 15 U.S.C. Section 1051(b), Section 1126(d), and/or Section 1126(e), the signatory additionally believes that: the applicant is entitled to use the mark in commerce; the applicant has a bona fide intention and has had a bona fide intention as of the application filing date to use or use through the applicant's related company or licensee the mark in commerce on or in connection with the goods/services in the application; and to the best of the signatory's knowledge and belief, no other person has the right to use the mark in commerce, either in the identical form or in such near resemblance as to be likely, when used on or in connection with the goods/services of such other person, to cause confusion or mistake, or to deceive.

Signature: /Richard B. Biagi/ Date: 04/14/2015
Signatory's Name: Richard B. Biagi
Signatory's Position: Attorney of record, Illinois bar member
Signatory's Phone Number: 847-881-2455

Request for Reconsideration Signature

Signature: /Richard B. Biagi/ Date: 04/14/2015
Signatory's Name: Richard B. Biagi
Signatory's Position: Attorney for Applicant

Signatory's Phone Number: 847.881.2455

The signatory has confirmed that he/she is an attorney who is a member in good standing of the bar of the highest court of a U.S. state, which includes the District of Columbia, Puerto Rico, and other federal territories and possessions; and he/she is currently the applicant's attorney or an associate thereof; and to the best of his/her knowledge, if prior to his/her appointment another U.S. attorney or a Canadian

attorney/agent not currently associated with his/her company/firm previously represented the applicant in this matter: (1) the applicant has filed or is concurrently filing a signed revocation of or substitute power of attorney with the USPTO; (2) the USPTO has granted the request of the prior representative to withdraw; (3) the applicant has filed a power of attorney appointing him/her in this matter; or (4) the applicant's appointed U.S. attorney or Canadian attorney/agent has filed a power of attorney appointing him/her as an associate attorney in this matter.

The applicant is not filing a Notice of Appeal in conjunction with this Request for Reconsideration.

Serial Number: 85510511

Internet Transmission Date: Tue Apr 14 11:59:54 EDT 2015

TEAS Stamp: USPTO/RFR-173.9.220.89-20150414115954682

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the EDGE

**Growing Market Share
in the Middle Game**

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Executive Summary

Growing Market Share in the Middle Game

Health care's incumbent volume- and procedure-based payment model is shifting to one that rewards value. The slow transition leaves leaders of provider systems feeling uncomfortably stretched, attempting to generate the volumes that still pay the bills today while positioning for emerging financial incentives and penalties.

In this tricky middle game, the question for many remains: How do I prepare for the accountability framework of the future while the present still demands growth? The answer: Smart growth, anchored in the agility needed to capture service volumes that are not only profitable but appropriate and sustainable over the long-term.

Waning opportunities for organic growth necessitate both incremental and aggressive plays for market share. Provider systems must work harder than ever to retain existing patients, gain share in their primary market and wrest markets from competitors. Their efforts must be guided by data-driven strategy that selectively targets clinical opportunities and an exacting focus on program execution.

Numerous strategies can position a system to take aim at its prime growth targets. What they all share is a role in strengthening clinical alignment and resource effectiveness across the care continuum, Sg2's very definition of a high-performing System of CARE. These strategies may vary in the difficulty entailed for successful implementation, but each can help a provider system begin moving beyond traditional metrics of market share to a health delivery model positioned to build share of care from a defined population.

Strategies for Growing Market Share in the Middle Game

- Accelerate access.
- Extend outreach.
- Improve satisfaction.
- Offer new clinical services.
- Pursue strategic partnerships.
- Tighten physician alignment.
- Pilot innovative payment models.

Growing Market Share in the Middle Game details how, with the right execution, many traditional market share plays can evolve into tomorrow's share-of-care successes. It offers an array of case examples from organizations nationwide that deployed these strategies to achieve their goals. Recognizing that any approach must be tailored to local market dynamics and organizational structure, the report then describes how varied provider types should pursue middle game market share strategies to ensure they do not compromise their accountability endgame. In conclusion, an action checklist is offered to help organizations prepare to launch their own initiatives.

Bring Forward-Looking Tactical Execution to Tried and True Strategies

Finding growth in today's market requires organizational agility. Health systems must be attuned to competitive market dynamics and be able to identify how and when to exploit opportunities for product or service differentiation. The best approaches will yield incremental volume and cash flow today as well as nurture the competencies that will be essential under future payment models to bolster total share of care.

Each organization faces unique competitive dynamics and internal operating constraints. While those factors must dictate how each executes the strategies it selects, the menu of options can be applied by all.

Strategy	Imperatives for Today and Tomorrow	Examples
Accelerate Access	<p>Market Share: Bring more patients into the system.</p> <p>Share of Care: Provide clinically indicated services that lower total cost.</p>	<ul style="list-style-type: none"> ■ New care sites ■ Improved scheduling ■ E-health initiatives ■ Clinical triage pathways ■ Navigation
Extend Outreach	<p>Market Share: Attract new customers to the system.</p> <p>Share of Care: Manage population health needs.</p>	<ul style="list-style-type: none"> ■ Dynamic customer relationship marketing ■ Web portal strategies ■ E-health initiatives ■ Subspecialty outreach clinics ■ Transfer and referral centers
Improve Satisfaction	<p>Market Share: Enhance loyalty of existing patients and physicians.</p> <p>Share of Care: Position for payer steerage. Build referral channels.</p>	<ul style="list-style-type: none"> ■ Customer service campaigns ■ Accelerated care recovery programs ■ Improved site aesthetics ■ Hassle-free scheduling ■ Gender-specific packaging ■ Health coaching
Offer New Clinical Services	<p>Market Share: Differentiate clinical care vs competitors.</p> <p>Share of Care: Manage overall population health.</p>	<ul style="list-style-type: none"> ■ Preventive care and screenings ■ Niche services ■ Noninvasive therapies ■ Subspecialty clinical offerings ■ Multidisciplinary care delivery models
Pursue Strategic Partnerships	<p>Market Share: Extend reach of services across broader population.</p> <p>Share of Care: Leverage scarce resources; lower cost of care for a defined population.</p>	<ul style="list-style-type: none"> ■ Employer health strategy ■ Post-acute partnerships ■ Joint ventures with for-profit service providers ■ Retail and urgent care ■ Regional clinical networks
Tighten Physician Alignment	<p>Market Share: Increase referrals; defend existing market.</p> <p>Share of Care: Facilitate integrated, multidisciplinary care delivery models.</p>	<ul style="list-style-type: none"> ■ Practice support models ■ Ambulatory electronic medical record subsidies ■ Comanagement agreements based on quality metrics ■ Employment ■ Expanded physician liaison programs ■ Clinical integration contracting
Pilot Innovative Payment Models	<p>Market Share: Close a market option to a competitor.</p> <p>Share of Care: Provide superior value clinical services.</p>	<ul style="list-style-type: none"> ■ Narrow network contracting ■ Value-driven pricing strategies ■ Volume discounts ■ Bundled payment pilots ■ Removing barriers to downstream revenue

Explore a Wide Array of Effective Initiatives

		Strategies						
		Accelerate Access 	Extend Outreach 	Improve Satisfaction 	Offer New Clinical Services 	Pursue Strategic Partnerships 	Tighten Physician Alignment 	Pilot Innovative Payment Models 
WellSpan Health	4	■		■			■	
Mary Washington Healthcare	5	■					■	
Marshfield Clinic	6		■			■		
Wake Forest Baptist Health	7	■		■			■	■
Aspirus	8	■		■	■			
ThedaCare	9	■	■				■	
Large Midwest Health System	10		■					
Henry Ford Health System	11		■		■			■
St Vincent Health	12	■			■	■		■
Southcoast Health System	13				■			
Tallahassee Memorial HealthCare	14			■	■			
Large Community Hospital	15					■	■	■

Case Study

WellSpan Health, York, PA

Stellar customer service and effective throughput enhance satisfaction while expanding providers' potential caseloads. Escalating patient demand, coupled with physician shortfalls, makes it essential that systems develop competencies now to grow their patient panels without sacrificing quality.

Centralized Call Center Enhances Efficiency

Strategies	 Access  Satisfaction  Alignment
Background	<ul style="list-style-type: none"> WellSpan Health is a community-based, not-for-profit, integrated health system. With more than 60 care sites, 8,000 employees and 7 residency programs, the organization serves over 650,000 people in south central Pennsylvania and northern Maryland. Ringling phones at the front desks of physician practices prevented staff from giving patients their full attention and slowed the check-in process.
Solution	<p>The WellSpan Contact Center</p> <ul style="list-style-type: none"> WellSpan leadership sought solutions from organizations in and outside of health care. Centralized call centers emerged as a viable option for addressing patient and staff dissatisfaction. After studying models at such companies as Hershey Foods, LL Bean and Visa, WellSpan tested a “geographically separate” call center and relocated staff who answered phones to the back of the office building. Soon after, the administrative staff of several physician practices shifted to a separate, central location. The WellSpan Contact Center, for which additional staff were hired, operates from 2 locations. It offers organization-wide appointment scheduling, registration, and processing of referrals and authorizations. <ul style="list-style-type: none"> The center is currently staffed by 40 employees and 3 supervisors. Shifts cover 7 am–8 pm weekdays and 8 am–4 pm Saturdays. The center serves 14 family practice sites, a spine center, 2 orthopedics practices and 3 neurosciences practices. Calls are routed to an operator with the relevant service line focus. Operators also answer questions regarding WellSpan’s new retail clinics.
Impact	<ul style="list-style-type: none"> The center’s goal is to answer 80% of calls within 20 seconds; currently, calls are answered in 5 to 60 seconds. Call flow patterns and staffing levels are being analyzed by service line to achieve a goal of 20 seconds or less. Efficiencies gained through off-loading work to the call center helped practices increase the number of patients seen hourly. One family practice clinic now sees 2.1 patients per hour, up from 1.9, while also enabling physicians to spend more time with their patients. Noise reduction in physician offices enhanced staff productivity. And on the rare occasions phones do now ring, staff understand the issue must be urgent.
Lessons Learned	<ul style="list-style-type: none"> Ideas and metrics from industries beyond health care can be adopted. WellSpan used standard call center benchmarks presented at industry conferences (eg, answer times, hold times, downstream impact on visits). Although call centers can improve efficiency, they cannot overcome severe provider shortages that drive high appointment wait times. Work flow processes for scheduling at medical practices must be coordinated prior to launching a call center.

Source: Sg2 Interview, 2011.

Case Study

Mary Washington Healthcare, Fredericksburg, VA

Physicians who refer to multiple organizations always represent a potential market share drain. Finding pragmatic ways to support practice operations can enhance overall physician loyalty today and lay the groundwork for more integrated multidisciplinary care delivery models.

Concierge Scheduling Model Better Aligns Physicians, Secures Referrals

Strategies	 Access  Alignment
Background	<ul style="list-style-type: none"> ■ Anticipating market entry of a new regional medical center, this system of 2 hospitals and 28 health care facilities and wellness services sought ways to lock in physician loyalty. ■ Mary Washington already had a centralized scheduling system, yet doctors found it complex to get patients into the system.
Solution	<p>Concierge Services for Patients</p> <ul style="list-style-type: none"> ■ Beginning in May 2009, select schedulers were promoted to the role of concierge. They provided a higher level of service to physician practices with the goal of making it easier for physicians to refer business. ■ The concierges contact patients to schedule ancillary services after verifying insurance benefits and obtaining test authorizations. Any scheduling changes are handled by the concierge. ■ A total of 45 physicians at 10 practices (of 200 group practices in the system service area) have access to concierge services. Six of these practices offer primary care services and 4 provide specialty care. ■ Two of the specialty practices—general surgery and hematology/oncology—received on-site concierges. These high-volume practices were particular alignment targets for the system, had space to accommodate the concierge on-site and were located near prime competitors. <p>Other Alignment Methods</p> <ul style="list-style-type: none"> ■ Through its physician liaison service, each month Mary Washington reviews referrals by physician and contacts physicians when dips in volume are noted. ■ The organization is also investigating comanagement agreements to further improve physician alignment.
Impact	<ul style="list-style-type: none"> ■ Mary Washington successfully prevented out-migration that could have resulted due to entry of a new competitor. Comparisons of volumes before and 2 years after implementation of the concierge program showed no decline. ■ At the same time, use of certain ancillary services, such as sleep studies, rose among certain physicians once the concierge program heightened their awareness of these services. ■ Physician and patient satisfaction skyrocketed. Physician offices developed personal relationships with the concierges, who were viewed as additional staff.
Lessons Learned	<ul style="list-style-type: none"> ■ Concierge services are resource intensive and should target priority areas first. ■ Improving care accessibility and quality of care may be key to securing physician referrals.

Source: Sg2 Interview, 2011.

Case Study

Marshfield (WI) Clinic

Networks that extend the reach of key specialists help lock in patients in the primary market and carve inroads to secondary markets. For rural providers, these services can help keep patients from leaving the market today. Long-term, these virtual services represent the type of care redesign necessary to scale the physician workforce over larger populations.

Telehealth Network Improves Care Accessibility Across Markets

Strategies	 Outreach  Partnerships
Background	<ul style="list-style-type: none"> ■ Marshfield Clinic is a health care delivery system with 779 physicians in 54 locations throughout northern, central and western Wisconsin. ■ Marshfield has offered a growing range of telehealth services, including consults and remote monitoring, since 1997 through a grant covering care provision to rural residents.
Solution	<p>Telehealth Expansion</p> <ul style="list-style-type: none"> ■ The clinic expanded its network to improve care access across the community. ■ It now covers more than 30 clinical areas. Half of the sites receiving telehealth services are delivery sites owned by Marshfield; half are operated by independent providers.
Impact	<ul style="list-style-type: none"> ■ Network spokes were better able to retain patients for ancillary services, outpatient surgeries and admissions. Network participation also enabled them to expand their service offerings, collect facility fees and improve their brand image. ■ Hub sites improved productivity, cost control, market share and referral streams. ■ Telehealth enabled gains when the financial impact of reduced expenses and improved billable office time were taken into account: <ul style="list-style-type: none"> – For a cardiology telehealth program, gains totaled from \$4,000 to \$12,000, based on daily revenue from 29 to 37 RVUs. No expenses were incurred from driving time; no practice disruption reduced other billable visits. – In contrast, a traditional cardiology outreach program requiring site visits by interventional cardiologists would lose \$649, based on \$1,600 in daily revenue from 5 to 11 RVUs, offset by 5 hours of driving time, \$249 in expenses and \$2,000 in lost billable office time. ■ An activity-based cost analysis of a 15-minute cardiology consult demonstrated only a minimal increase for a teleconsult to independent sites and a savings at owned sites. The analysis took into account salaries as well as transmission and indirect costs. Marshfield Clinic costs totaled: <ul style="list-style-type: none"> – \$73 for an in-person consult – \$63 for a system-owned remote site – \$76 for an independent site
Lessons Learned	<ul style="list-style-type: none"> ■ Extending telehealth for a variety of clinical services—selected based on access, physician productivity or current market share—enhances the likelihood of success. ■ Setting up a telehealth consult relationship with an outside partner (in Marshfield’s case this cost \$400/month) enables organizations to test markets before investing in a bricks and mortar establishment in those locations.

RVU = relative value unit.

Source: Antoniotti N. Return on investment: creating value-added telehealth initiatives. Presented at: American Telemedicine Association 16th Annual International Meeting, May 2011, Tampa, FL.

Case Study

Wake Forest Baptist Health, Winston-Salem, NC

Collaborative, disease-specific centers of excellence break down traditional organizational silos that hamper downstream referrals today while creating the clinical care delivery model that can meet patients' needs for coordination and payers' demands for value.

Realignment Removes Barriers to Downstream Procedures

Strategies	 Access  Satisfaction  Alignment  Payment
Background	<ul style="list-style-type: none"> ■ This academic medical center operates 1,004 acute care, rehabilitation and psychiatric care beds. The CEO is a physician. ■ Wake Forest has a strategic initiative to form centers of excellence. Neurosciences is 1 of 5 centers of excellence promoted by the medical center. ■ Neurosciences leadership set out to develop business plans by disease state. They undertook growth efforts focusing on stroke, spine, epilepsy and movement disorders (eg, Parkinson disease). ■ They sought to maximize the patient experience by eliminating barriers created by a historical “silo” model. <ul style="list-style-type: none"> – Example 1: Movement disorder patients were required to undergo a series of tests to be candidates for deep brain stimulation. One such test was a neuropsychological exam; patients not in network with a medical center provider often encountered delays scheduling this exam. – Example 2: The Comprehensive Epilepsy Center required services of a neuropsychiatrist to best serve the population; recruiting additional faculty in the psychiatry department was difficult to justify within a single faculty department business model view.
Solution	<p>Business Model Overhaul</p> <ul style="list-style-type: none"> ■ Through a new business plan and disease state pro formas, Wake Forest combined neurosciences inpatient, outpatient and professional services. ■ Capital and program requests were evaluated based on what was needed to improve the patient experience, throughput, operations and clinical outcomes. <ul style="list-style-type: none"> – Example 1: To remove process bottlenecks, neuropsychologists at the medical center were held harmless for billings of desired neuropsychological exams. – Example 2: A new neuropsychiatrist position was approved for the epilepsy center; the dedicated position is designed to address the psychosocial needs of the center’s patients.
Impact	<ul style="list-style-type: none"> ■ Wake Forest accelerated patient flow and removed barriers to a lucrative downstream procedure (ie, deep brain stimulation). ■ Volume trends are favorable. ■ Effective length-of-stay management and reduced 30-day readmissions expanded capacity for new cases.
Lessons Learned	<ul style="list-style-type: none"> ■ Patient-centered program planning identifies gaps that compromise access. ■ Alignment of hospital and physician objectives is key to creating a care delivery model that overcomes organizational barriers to comprehensive care.

Source: Sg2 Interview, 2011.

Case Study

Aspirus, Wausau, WI

Demographic-focused growth strategies have historically met with mixed results. Programs likely to generate an acceptable return on investment (ROI) require careful targeting, packaging that focuses on convenience and coordination, and ongoing measurement of downstream revenue. The market for these types of services will likely expand as payer incentives begin to lean toward prevention and risk assessment.

Comprehensive Health Assessments Engage Women and Their Households

Strategies	 Access  Satisfaction  Services
Background	<ul style="list-style-type: none"> ■ Aspirus is a regional health system serving north central Wisconsin and Michigan's Upper Peninsula. It is licensed for 321 beds and staffed by 350 physicians in 35 specialties. ■ The Aspirus market is projected to grow 3% over the next decade, significantly below the national population growth rate (11%). ■ Aspirus wanted to address gaps in provision of comprehensive care while building loyalty among families' key health care decision makers.
Solution	<p>Journey to Optimal Health</p> <ul style="list-style-type: none"> ■ To better appeal to female consumers, Aspirus developed the Journey to Optimal Health program offering patient-centered women's health services. <ul style="list-style-type: none"> — A nurse practitioner conducts a wellness assessment for each patient, from which a customized health care action plan is generated. — During a 1- to 2-hour appointment, women receive relevant information and care advice based on their specific health status and needs. — A health navigator facilitates scheduling and coordinates additional services based on the patient's health plan. ■ The program cost \$400K to launch and operates with a \$250K annual budget. ■ Downstream impact is measured using an external customer relationship management vendor. Parameters, including use of health care services by the patient herself as well as those who share her residence, are tracked for 1 year from the date of clinic appointment.
Impact	<ul style="list-style-type: none"> ■ In calculating Journey to Optimal Health's ROI, it was assumed that 50% of downstream charges from new patients and their household members could be attributed to the program. ■ Average downstream charges associated with new patients and their families were \$1.4 million in FY 2009. ■ The program has continued to grow and for new patients seen in the clinic in the first quarter of 2011, average charges for the patient plus her household were over \$5,000.
Lessons Learned	<ul style="list-style-type: none"> ■ Although direct financial gains are important, a program's referrals, brand recognition and downstream services must be taken into account to fully gauge impact. ■ Comprehensive programs tailored to a specific demographic can generate growth opportunities in related services. Aspirus now offers fertility services through a reproductive endocrinologist who visits its facility once per month. Genetic testing and counseling are also being considered.

Source: Sg2 Interview, 2011.

Case Study

ThedaCare, Appleton, WI

Targeted, clinically indicated screening programs can increase downstream revenue today, particularly in cancer services. Tomorrow’s payment models increasingly will require and reward higher screening rates and early detection of cancer and chronic conditions. Successful systems will be those that learn to promote screening programs through employed and referring physician practices.

Cancer Screening Initiative’s Physician Focus Boosts Colonoscopy Rates

Strategies	 Access  Outreach  Alignment
Background	<ul style="list-style-type: none"> ThedaCare is the largest health care provider and employer in northeast Wisconsin, serving more than 250,000 patients in a 14-county area. The system includes 5 hospitals, a physician group with more than 120 employed primary care physicians, behavioral health, laboratories, senior living facilities, home health services and more. Physician recommendation remains a strong predictor of patient compliance with colorectal cancer screening. At ThedaCare, which does not employ its gastroenterologists, the colorectal cancer screening rate was only 52%.
Solution	<ul style="list-style-type: none"> ThedaCare launched a colorectal cancer initiative that called for a consistent, system-wide screening recommendation with use of colonoscopy as the preferred screening method. <p>Physician Messaging, Incentives and Metrics</p> <ul style="list-style-type: none"> Project leaders met with primary care physicians to present information on the screening initiative. Physicians received a “pitch” to use with patients. Nominal physician and administrator incentives were tied to improved screening rates, reported monthly at the clinic and physician levels. Electronic medical record alerts reminded physicians to discuss screening. <p>Seamless Referrals</p> <ul style="list-style-type: none"> Colonoscopy appointments were scheduled either before the patient left the primary care physician office or through the ThedaCare call center. ThedaCare streamlined scheduling with multiple independent gastrointestinal (GI) groups and implemented processes to ensure ThedaCare calls were answered at GI clinics and appointments were scheduled immediately. <p>Targeted Marketing</p> <ul style="list-style-type: none"> Educational and marketing materials were placed in physician offices and waiting rooms to spark conversation between patients and their doctors. A direct mail, phone and Web campaign was developed around the character Wally Polyp, the patient’s inner voice providing excuses for avoiding a colonoscopy.
Impact	<ul style="list-style-type: none"> The system’s screening rate increased 21 percentage points to 73% due to the marketing campaign coupled with heightened disease management efforts. During a 2.5-month period, 10% of patients targeted via marketing scheduled and underwent a colonoscopy. The program will be rolled out to other clinics and service areas.
Lessons Learned	<ul style="list-style-type: none"> Simplifying referral structures and engaging physicians early are key to success. Engaging patients in their own care is an effective way to grow market share.

Source: Sg2 Interview, 2011.

Case Study

Large Midwest Health System

Targeted direct marketing efforts focused on specific clinical services attract new patients to the system, at the same time laying the groundwork for patient engagement essential in population health management.

Dynamic Direct Marketing Delivers More Patients

Strategy	 Outreach
Background	<ul style="list-style-type: none"> ■ A regional health care provider in a highly competitive, affluent area 25 miles west of a major city developed a “marketing division dashboard” to demonstrate outcomes of its marketing efforts. ■ Tactics were tied to corporate goals; results were reported monthly.
Solution	<p>Dynamic Marketing (launching promotions only to certain populations and then comparing outcomes with control groups)</p> <ul style="list-style-type: none"> ■ Success was measured as the uptick in engagement for patients who had received marketing materials vs those who had not. Patients who responded to marketing were tracked using associated identifiers (ie, a specific contact number or URL used in direct mail materials). The contribution margin of these incremental patients was measured downstream. <p>Tailored Messaging</p> <ul style="list-style-type: none"> ■ Tailored marketing was conducted via television, email and direct mail. It included patient stories that showcased success for someone with a condition similar to the recipient’s. <p>Online Interaction</p> <ul style="list-style-type: none"> ■ With the goal of driving 25% to 35% of commodity service interactions online, the organization asked patients for their email addresses at the point of service at its fitness center, primary care groups, central scheduling/registration and interactive Web modules. The organization also bought email lists with a choice to opt out. ■ Top Web page views, overall Web portal visits, emails obtained and online forms completed were tracked. <p>ED Satisfaction</p> <ul style="list-style-type: none"> ■ Patients could request current ED wait times via text or phone call; call and text volumes were displayed on the marketing dashboard. Exit interviews conducted with patients leaving the ED tracked their impression of the service.
Impact	<ul style="list-style-type: none"> ■ 70,000 patient emails were collected. ■ There were 8,000 views of physician video biographies on the provider’s Web portal in the first month. ■ Across 7 months, incremental gains led to increased contribution margins: <ul style="list-style-type: none"> – 476 incremental patients aged 25–39: \$466,998 – 1,303 incremental patients aged 40–54: \$2.1M – 1,159 incremental patients aged 55–64: \$3.0M ■ There were close to 750 new patient visits per quarter.
Lessons Learned	<ul style="list-style-type: none"> ■ The ability to measure downstream contribution margin enables organizations to rapidly expand, modify or abandon marketing campaigns based on outcomes. ■ Systems must be available to collect and provide data within a useful time frame.

ED = emergency department.
Source: Sg2 Interview, 2011.

Case Study

Henry Ford Health System, Detroit, MI

Tools that target at-risk patients or flag overdue care can stimulate service use today but also improve systems' long-term ability to manage chronic conditions and the total cost of care. Payers pursuing value-based care models will be looking first to systems already adept at this right time/right place care delivery concept.

Registries and Population Health Management Facilitate Outreach

Strategies	 Outreach  Services  Payment
Background	<ul style="list-style-type: none"> ■ Henry Ford Health System owns 6 hospitals and dozens of clinics across southeastern Michigan. It includes one of the nation's largest group practices, Henry Ford Medical Group (HFMG), with more than 1,200 physicians in over 40 specialties. ■ As part of a strategic effort to redesign chronic care delivery, HFMG adopted a patient-centered medical home (PCMH), incorporating an electronic medical record, case management and population health strategies. ■ The market's predominant payer offered a 10% payment increase for implementing certain PCMH components and meeting quality thresholds.
Solution	<p>Registry and Population Health Managers</p> <ul style="list-style-type: none"> ■ HFMG developed a registry that houses data on all HFMG patients. Embedded in this registry were evidence-based care guidelines for numerous chronic conditions, including asthma, coronary artery disease, COPD, CHF, chronic kidney disease, depression and diabetes. Preventive care guidelines also were included. ■ At any patient visit, the registry helps clinicians identify and order needed services. ■ Nonclinicians, typically with bachelor's or associate's degrees, were hired as population health managers to mine the registry for appropriate outreach opportunities outside of patient visits. <ul style="list-style-type: none"> – The registry flags for the population health managers patients who are due for an office visit or services, such as mammography and colon cancer screenings. – Based on this information, the registry managers can then conduct patient outreach, schedule appointments and order lab tests.
Impact	<ul style="list-style-type: none"> ■ Approximately one-third of patients contacted by a population health manager come in for an appointment. The program pays for itself through the visits and increased downstream services generated. ■ Registry data enable the medical group to generate physician- and clinic-level performance reports, bolstering efforts at continuous improvement as well as healthy competition among colleagues. ■ Clinical improvements in diabetes measures and cancer screening, 2 areas of strategic focus, have been observed.
Lessons Learned	<ul style="list-style-type: none"> ■ Ongoing registry updates are necessary to incorporate current guidelines. ■ The sunk cost of a well-developed information system can be used to support improved clinical quality while driving volume. ■ Registries complement numerous components of PCMH models.

COPD = chronic obstructive pulmonary disease; CHF = congestive heart failure.
Source: Sg2 Interview, 2011.

Case Study

St Vincent Health, Indianapolis, IN

Employer-based primary care clinics offer effective avenues for funneling commercially insured patients into a provider system today, while establishing the relationships that may lead to cooperation on future payment and contracting models. Partnership models limit up-front capital outlays, and discounts for patient steerage can pay long-term dividends.

Partnerships Enable Effective Employer Clinics

Strategies	 Access  Services  Partnerships  Payment
Background	<ul style="list-style-type: none"> ■ St Vincent, the Indiana subsidiary of Ascension Health, kicked off an employer engagement strategy to create a market presence as an advocate for self-funded employers. ■ Public-sector employers sought creative ways to reduce costs following property tax and other legislative reforms: <ul style="list-style-type: none"> — Many state-run school systems were covered by health plans other than the state's Anthem plan. Legislation was put into place forcing them to switch to the state plan if their costs were not within 10% of the state plan costs.
Solution	<p>Partnership With Novia CareClinics</p> <ul style="list-style-type: none"> ■ St Vincent partnered with Novia, a firm offering employer-based clinics, to provide on-site primary care services to employees and their dependents. <ul style="list-style-type: none"> — The hospital provided the physician base; employers owned the clinics/equipment. — Novia received a management fee from employers and reimbursed St Vincent for physician salaries. — Novia covered co-payments and coinsurance for prescription medications. <p>Volume Discount Contracts With Employers</p> <ul style="list-style-type: none"> ■ St Vincent offered a tiered reward system to reduce prices for employers. Employers that steered an increased percentage of their volume (via benefit plan redesign) to St Vincent received cash rebates. ■ Patients who chose the employer's benefit plan and opted to seek care at St Vincent facilities could avoid increased co-payments/deductibles. <p>Case Management</p> <ul style="list-style-type: none"> ■ Wellness and disease management services were targeted to the 5% of employees with the highest health care costs.
Impact	<ul style="list-style-type: none"> ■ St Vincent has since engaged 12 employer clients, including 8 schools, in an on-site clinic partnership, enabling patients outside its network to access its services. ■ Nationally, downstream revenue from primary care physicians is approximately \$1.3M net to the sponsoring hospital. Downstream revenue per physician generated by the on-site clinics, open 40 hours per week, approximated that figure. ■ Payer mix improved as the system's share of school district health plan enrollees increased from 55% to 75%.
Lessons Learned	<ul style="list-style-type: none"> ■ Employer partnerships work well when the on-site clinic becomes the primary care setting for employees rather than being viewed as an urgent care center. ■ Clinics typically must operate above 60% capacity for employers to have a positive ROI. ■ Tracking downstream utilization can be a challenge and is often easiest for patients seen by physicians who work only at the on-site clinics.

Source: Sg2 Interview, 2011.

Case Study

Southcoast Health System, New Bedford, MA

Some programs that deliver clinically indicated services to at-risk populations draw successfully from the self-pay marketplace. Bariatric surgery is a prime example for which Sg2's forecast anticipates strong growth over the next 5 years. Providers must move quickly to position for share of care as payers begin to direct patients to high-volume programs with superior outcomes.

New Bariatric Surgery Program Aims to Capitalize on Rising Obesity Prevalence

Strategy	 Services
Background	<ul style="list-style-type: none"> ■ Southcoast is a 3-hospital system in southern Massachusetts, just outside of Providence, RI. Tobey Hospital, with approximately 80 beds, is its smallest. ■ Out-migration is primarily pulled to the Boston market, although the population is largely averse to traveling far for care. ■ Sg2's forecast anticipates a wide range of growth opportunities regarding providing obesity-related clinical services over the next 5 years. ■ Weight loss surgery can reduce the prevalence of morbid obesity while treating high-cost comorbidities such as hypertension.
Solution	<p>Comprehensive Weight Loss Surgery Program</p> <ul style="list-style-type: none"> ■ Tobey Hospital launched a bariatric surgery program in January 2004. The comprehensive program includes free services, such as nutritional care and support groups.
Impact	<ul style="list-style-type: none"> ■ The program generated 24 cases its first year and 80 its second. The hospital qualified as a center of excellence in accordance with a 2005 Medicare determination. Current annual volumes for bariatric surgery total approximately 600. ■ Patients are drawn to the program from across southeastern Massachusetts, pulled from the service areas of 4 competing systems. Approximately 65% of patients seek treatment at Tobey because a friend or family member did. ■ Bariatric surgery patients follow up with the program for 5 years postsurgery; 80% of patients complete this follow-up. This has changed Tobey Hospital into a primary care center and essentially enabled it to create a captive market for ancillary services. ■ Competitors well beyond Tobey's primary market have begun establishing satellite clinics to make market share inroads among patients willing to travel for the actual surgery but reluctant to travel for follow-up care.
Lessons Learned	<ul style="list-style-type: none"> ■ Targeting clinical areas of high or increasing prevalence, such as obesity, is one essential step in prioritizing growth strategy. ■ Offering a new service can also boost specialist recruitment and retention. ■ Educating physicians and patients about bariatric surgery as a treatment for diabetes, hypertension and sleep apnea is one key to launching a successful program. ■ Physician champions are essential.

ICD-9 = International Classification of Diseases, Ninth Revision.
Source: Sg2 Interview, 2011.

Case Study

Tallahassee (FL) Memorial HealthCare

Most markets are saturated with comprehensive cardiovascular programs. Accelerating adoption of an innovative cardiac catheterization technique today can simultaneously improve patient outcomes, increase facility capacity, and enhance patient and referring physician satisfaction while enabling the outpatient shift essential for high-value future care.

Broader Adoption of New Technique Improves Quality, Optimizes Care Setting

Strategies	 Satisfaction  Services
Background	<ul style="list-style-type: none"> ■ Tallahassee Memorial is a private, not-for-profit community health care system that includes a 770-bed acute care hospital. ■ Cardiovascular service lines, faced with 30-day readmission penalties and Medicare Recovery Audit Contractor reviews, are under pressure to reduce complication rates and optimize sites of care. <ul style="list-style-type: none"> — One large, independent cardiology group and a 3-physician group perform cardiac catheterizations for the system. ■ Through a physician-led initiative, Tallahassee sought to diffuse a novel coronary cath technique to enhance the value of these services.
Solution	<p>Adopting the Radial Artery Approach</p> <ul style="list-style-type: none"> ■ The radial artery approach to cardiac caths, compared to the more common femoral artery approach, reduces bleeding complications, shortens recovery time and is preferred by patients. A physician champion on the medical staff uses this approach for 95% of the coronary caths he performs. He gained buy-in and helped train the other independent cardiologists. The technique now is used for more than half of all caths provided at Tallahassee. This includes diagnostic angiography, PCI and treatment of STEMI. <ul style="list-style-type: none"> — In most US hospitals, typically only 1 or 2 physicians have adopted the approach; thus, it is used in only a small percentage of total caths nationwide. For example, it currently is used in only 10% of PCIs. ■ The nursing staff supports the change; internal surveys show high job satisfaction. ■ Other cardiologists from across the country come to the hospital to learn the technique from the physician who spearheaded Tallahassee's initiative.
Impact	<ul style="list-style-type: none"> ■ The radial artery approach eliminates the need for several hours of bed rest postprocedure and an inpatient admission. Patients typically are discharged home directly from the postprocedure recovery area, obviating the need for an observation encounter as well. ■ The hospital's radial artery catheterization program is generating positive word of mouth from satisfied patients and physicians, creating a competitive advantage that should generate future referrals.
Lessons Learned	<ul style="list-style-type: none"> ■ Changes in strategic direction can reap benefits in care outcomes even before payment models realign. ■ Before undertaking new procedures, it is important to evaluate physician appetite for change and measure existing capacity.

PCI = percutaneous coronary intervention; STEMI = ST-segment elevation myocardial infarction.
Source: Sg2 Interview, 2011.

Case Study

Large Community Hospital

In some markets, providers have a near-term opportunity to dramatically lower their imaging service pricing to shift market share, anticipating that provider price advantage will quickly evaporate anyway. These approaches typically require strategic partnerships with other imaging providers, careful payer negotiations, and aggressive marketing to patients and referring physicians.

Pursuit of Imaging Joint Venture and Price Cuts Creates Competitive Edge

Strategies	 Partnerships	 Alignment	 Payment
Background	<ul style="list-style-type: none"> ■ This hospital owns several outpatient imaging centers in its primary service area. A large retail provider operates 6 freestanding imaging centers in the same geographic area. ■ Previously, 2 outpatient imaging centers that had been formed from a partnership with independent radiology groups closed due to low volume and competition with the freestanding imaging corporation. ■ The hospital estimated that 35% of outpatient imaging was taking place outside of the hospital network. The main drivers of this out-migration were the procedures' relatively high price when performed at a hospital-owned imaging center, coupled with the economic recession and patients' higher out-of-pocket responsibility. ■ Many physicians were reluctant to refer internally and force patients to incur higher costs. They also were lured by the freestanding center's high-quality service. 		
Solution	<p>Divestment From Imaging and Partnership With Freestanding Centers</p> <ul style="list-style-type: none"> ■ Over a 24-month period, the hospital explored a joint venture under a shared revenue model with the freestanding imaging corporation. ■ The goal was to gain imaging volumes downstream and benefit from the freestanding center's operational expertise. Prices for imaging services could then be cut and, ultimately, competitors could be forced out of the market. ■ The predominant payer agreed to work with the hospital to set the price point. 		
Impact	<ul style="list-style-type: none"> ■ Now in early stages of implementation, scenario planning projects that market share ultimately should enable the system to quickly break even on its plan. <ul style="list-style-type: none"> – The most likely scenario estimates an expected volume increase to offset the price cut within 24 months. – The worst-case scenario projects a \$3 million loss in the first few years if volume growth is slow and, consequently, the hospital receives a lower share of the joint venture's profits. Leaders saw this as an acceptable trade-off for long-term growth. 		
Lessons Learned	<ul style="list-style-type: none"> ■ A competitive analysis of ancillary services that are price elastic (eg, imaging, rehabilitation) should not focus solely on the hospital market but also take into account for-profit competitors. ■ Short-term blows to the bottom line may be warranted while establishing the infrastructure for market strength in the long-term. 		

Source: Sg2 Interview, 2011.

Tailor Strategy to Organizational Archetype

The starting point for any middle game strategy must be established based on what the organization is today, how its local market is configured and where it wants to end up over the long-term. Variations across 4 provider archetypes highlight strategic options. Many of the strategies and tactics in this report are relevant to all types of providers. Some may be more appropriate for those with specific characteristics and organizational structures.

Community-Based Partial Systems of CARE

Starting Point: Benefit from playing the middle game longer. Most organizations require time to improve care transitions, workforce alignment, operations and quality for specific clinical programs.

Examples: ThedaCare's cancer screening; Mary Washington's concierge scheduling model; Tallahassee Memorial's adoption of radial artery cardiac catheterizations; Large Midwest Health System's direct marketing approach

Rural Primary or Secondary Care Access Points

Starting Point: Gain from partnering with larger systems and finding ways to keep health care service local.

Example: Marshfield Clinic's telehealth network

Tertiary or Quaternary Centers

Starting Point: Carefully navigate increasing accountability. Improving performance while increasing market share would be a welcome stepping stone to risk-based contracting because larger risk pools are more stable and easier to manage.

Example: Wake Forest Baptist Health's disease-focused service line model

Regionally Consolidated Health Systems With Continuum of Care Reach

Starting Point: Embark more quickly on the path of change toward a value-based model. Shaping market structures, incentives and relationships will be core to this approach.

Example: Henry Ford Health System's population health management approach; St Vincent Health's contracting model; Large Community Hospital's imaging joint venture

Plan Your Strategy

More than one path may lead to success in the middle game. Provider systems may find inspiration in the examples included in this report, but ultimately they will have to chart their own course. Working through an action checklist up front, before launching any growth initiative, increases the chance for success.

Quantify local market opportunities.

Use data to accurately forecast growth of key service lines, and then identify new strategic targets. Analyze local epidemiology and then gradually enhance the focus on prevention as much as possible to reduce the disease burden over the long-term.

- Could competitors in the market be open to a partnership? Use local economic and payment-related challenges as a pitch for external partnerships.

Evaluate the payer landscape.

Payers in some markets may be primed to collaborate on payment innovation, either by adapting traditional pricing structures or piloting risk-sharing structures.

- Are your payers dominant and conservative or competitive and innovative?

Assess your System of CARE's level of integration.

Ambulatory care and physician office visits will demand enhanced focus in the future. Follow the progression of different diseases across the full range of settings: community-based, acute, recovery/rehabilitation.

- Where do patients typically interact with your delivery system?
- Where do gaps exist?
- Where might improved coordination drive increased market share in profitable services today?
- Is it most feasible to own, partner or otherwise align with other providers to complete the continuum?

Evaluate current physician alignment.

A strong referral pipeline is imperative for market share growth.

- Is your physician market highly fragmented or regionally consolidated?
- Do you know which physicians are most key to the volumes you likely will target for growth? Are they splitters?
- Have you proposed alignment approaches previously?
- How could use of midlevel providers and nonclinical staff enhance physician productivity, satisfaction and loyalty to your organization?

Identify short- vs long-term wins.

Careful selection of initial or short-term growth initiatives helps build confidence and momentum. The best approach is to identify a full range of potential growth options and then prioritize them based on their impact and ease of implementation.

- Are there areas in which change agents—people with drive and readiness for innovation—will be readily available?

Track the Impact

Once under way, growth initiatives must be closely monitored. Strong analytical competence, combined with the ability to translate extensive data into fact-based decisions, will be key.

Provider systems should track smart growth that results from a new initiative by distinguishing clinically “good growth” (right care, right place, right time) from “bad growth” (volumes linked to readmissions or questionable inpatient stays likely to draw scrutiny or penalties). Market share inroads also should be seen across the continuum. Thus, pre- and post-acute volumes, captured through strong offerings in the System of CARE’s community-based and recovery/rehabilitation sites, need to be tallied along with inpatient days.

In addition, financial and clinical performance thresholds must be predetermined by clinical area and continuously measured. By establishing the desired endgame and tracking progress, organizations can pursue or abandon growth initiatives as warranted. Success should be measured against targets set on 6 metrics:

- Inpatient and outpatient disease-based forecasts
- Site of care volume
- New patient acquisition and encounters
- Channel access improvement
- Patient/physician conversion rates (eg, downstream revenue and profitability)
- Patient attrition

Related Sg2 Resources

Sg2 provides a wealth of resources to help organizations grow their business. Additional tools and intelligence focused on performance then enable systems to enhance their value in clinical areas most essential to their long-term growth. As a starting point, Sg2 clients can access the [Smart Growth Planning: Essential Intelligence Resource Kit](#) at members.sg2.com. The Web site also offers ready access to resources in varied forms, noted below.

Analytics	Intelligence
<ul style="list-style-type: none"> ■ National, regional and localized forecasts ■ Sg2 Growth Index™ ■ Growth trackers ■ Sg2 Value Index™ 	<ul style="list-style-type: none"> ■ Growth guides ■ System of CARE guides ■ Planning workbooks ■ Improvement guides

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the EDGE

**Growing Market Share
in the Middle Game**

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Executive Summary

Growing Market Share in the Middle Game

Health care's incumbent volume- and procedure-based payment model is shifting to one that rewards value. The slow transition leaves leaders of provider systems feeling uncomfortably stretched, attempting to generate the volumes that still pay the bills today while positioning for emerging financial incentives and penalties.

In this tricky middle game, the question for many remains: How do I prepare for the accountability framework of the future while the present still demands growth? The answer: Smart growth, anchored in the agility needed to capture service volumes that are not only profitable but appropriate and sustainable over the long-term.

Waning opportunities for organic growth necessitate both incremental and aggressive plays for market share. Provider systems must work harder than ever to retain existing patients, gain share in their primary market and wrest markets from competitors. Their efforts must be guided by data-driven strategy that selectively targets clinical opportunities and an exacting focus on program execution.

Numerous strategies can position a system to take aim at its prime growth targets. What they all share is a role in strengthening clinical alignment and resource effectiveness across the care continuum, Sg2's very definition of a high-performing System of CARE. These strategies may vary in the difficulty entailed for successful implementation, but each can help a provider system begin moving beyond traditional metrics of market share to a health delivery model positioned to build share of care from a defined population.

Strategies for Growing Market Share in the Middle Game

- Accelerate access.
- Extend outreach.
- Improve satisfaction.
- Offer new clinical services.
- Pursue strategic partnerships.
- Tighten physician alignment.
- Pilot innovative payment models.

Growing Market Share in the Middle Game details how, with the right execution, many traditional market share plays can evolve into tomorrow's share-of-care successes. It offers an array of case examples from organizations nationwide that deployed these strategies to achieve their goals. Recognizing that any approach must be tailored to local market dynamics and organizational structure, the report then describes how varied provider types should pursue middle game market share strategies to ensure they do not compromise their accountability endgame. In conclusion, an action checklist is offered to help organizations prepare to launch their own initiatives.

Bring Forward-Looking Tactical Execution to Tried and True Strategies

Finding growth in today's market requires organizational agility. Health systems must be attuned to competitive market dynamics and be able to identify how and when to exploit opportunities for product or service differentiation. The best approaches will yield incremental volume and cash flow today as well as nurture the competencies that will be essential under future payment models to bolster total share of care.

Each organization faces unique competitive dynamics and internal operating constraints. While those factors must dictate how each executes the strategies it selects, the menu of options can be applied by all.

Strategy	Imperatives for Today and Tomorrow	Examples
Accelerate Access	<p>Market Share: Bring more patients into the system.</p> <p>Share of Care: Provide clinically indicated services that lower total cost.</p>	<ul style="list-style-type: none"> ■ New care sites ■ Improved scheduling ■ E-health initiatives ■ Clinical triage pathways ■ Navigation
Extend Outreach	<p>Market Share: Attract new customers to the system.</p> <p>Share of Care: Manage population health needs.</p>	<ul style="list-style-type: none"> ■ Dynamic customer relationship marketing ■ Web portal strategies ■ E-health initiatives ■ Subspecialty outreach clinics ■ Transfer and referral centers
Improve Satisfaction	<p>Market Share: Enhance loyalty of existing patients and physicians.</p> <p>Share of Care: Position for payer steerage. Build referral channels.</p>	<ul style="list-style-type: none"> ■ Customer service campaigns ■ Accelerated care recovery programs ■ Improved site aesthetics ■ Hassle-free scheduling ■ Gender-specific packaging ■ Health coaching
Offer New Clinical Services	<p>Market Share: Differentiate clinical care vs competitors.</p> <p>Share of Care: Manage overall population health.</p>	<ul style="list-style-type: none"> ■ Preventive care and screenings ■ Niche services ■ Noninvasive therapies ■ Subspecialty clinical offerings ■ Multidisciplinary care delivery models
Pursue Strategic Partnerships	<p>Market Share: Extend reach of services across broader population.</p> <p>Share of Care: Leverage scarce resources; lower cost of care for a defined population.</p>	<ul style="list-style-type: none"> ■ Employer health strategy ■ Post-acute partnerships ■ Joint ventures with for-profit service providers ■ Retail and urgent care ■ Regional clinical networks
Tighten Physician Alignment	<p>Market Share: Increase referrals; defend existing market.</p> <p>Share of Care: Facilitate integrated, multidisciplinary care delivery models.</p>	<ul style="list-style-type: none"> ■ Practice support models ■ Ambulatory electronic medical record subsidies ■ Comanagement agreements based on quality metrics ■ Employment ■ Expanded physician liaison programs ■ Clinical integration contracting
Pilot Innovative Payment Models	<p>Market Share: Close a market option to a competitor.</p> <p>Share of Care: Provide superior value clinical services.</p>	<ul style="list-style-type: none"> ■ Narrow network contracting ■ Value-driven pricing strategies ■ Volume discounts ■ Bundled payment pilots ■ Removing barriers to downstream revenue

Explore a Wide Array of Effective Initiatives

		Strategies						
		Accelerate Access 	Extend Outreach 	Improve Satisfaction 	Offer New Clinical Services 	Pursue Strategic Partnerships 	Tighten Physician Alignment 	Pilot Innovative Payment Models 
WellSpan Health	4	■		■			■	
Mary Washington Healthcare	5	■					■	
Marshfield Clinic	6		■			■		
Wake Forest Baptist Health	7	■		■			■	■
Aspirus	8	■		■	■			
ThedaCare	9	■	■				■	
Large Midwest Health System	10		■					
Henry Ford Health System	11		■		■			■
St Vincent Health	12	■			■	■		■
Southcoast Health System	13				■			
Tallahassee Memorial HealthCare	14			■	■			
Large Community Hospital	15					■	■	■

Case Study

WellSpan Health, York, PA

Stellar customer service and effective throughput enhance satisfaction while expanding providers' potential caseloads. Escalating patient demand, coupled with physician shortfalls, makes it essential that systems develop competencies now to grow their patient panels without sacrificing quality.

Centralized Call Center Enhances Efficiency

Strategies	 Access  Satisfaction  Alignment
Background	<ul style="list-style-type: none"> WellSpan Health is a community-based, not-for-profit, integrated health system. With more than 60 care sites, 8,000 employees and 7 residency programs, the organization serves over 650,000 people in south central Pennsylvania and northern Maryland. Ringling phones at the front desks of physician practices prevented staff from giving patients their full attention and slowed the check-in process.
Solution	<p>The WellSpan Contact Center</p> <ul style="list-style-type: none"> WellSpan leadership sought solutions from organizations in and outside of health care. Centralized call centers emerged as a viable option for addressing patient and staff dissatisfaction. After studying models at such companies as Hershey Foods, LL Bean and Visa, WellSpan tested a “geographically separate” call center and relocated staff who answered phones to the back of the office building. Soon after, the administrative staff of several physician practices shifted to a separate, central location. The WellSpan Contact Center, for which additional staff were hired, operates from 2 locations. It offers organization-wide appointment scheduling, registration, and processing of referrals and authorizations. <ul style="list-style-type: none"> The center is currently staffed by 40 employees and 3 supervisors. Shifts cover 7 am–8 pm weekdays and 8 am–4 pm Saturdays. The center serves 14 family practice sites, a spine center, 2 orthopedics practices and 3 neurosciences practices. Calls are routed to an operator with the relevant service line focus. Operators also answer questions regarding WellSpan’s new retail clinics.
Impact	<ul style="list-style-type: none"> The center’s goal is to answer 80% of calls within 20 seconds; currently, calls are answered in 5 to 60 seconds. Call flow patterns and staffing levels are being analyzed by service line to achieve a goal of 20 seconds or less. Efficiencies gained through off-loading work to the call center helped practices increase the number of patients seen hourly. One family practice clinic now sees 2.1 patients per hour, up from 1.9, while also enabling physicians to spend more time with their patients. Noise reduction in physician offices enhanced staff productivity. And on the rare occasions phones do now ring, staff understand the issue must be urgent.
Lessons Learned	<ul style="list-style-type: none"> Ideas and metrics from industries beyond health care can be adopted. WellSpan used standard call center benchmarks presented at industry conferences (eg, answer times, hold times, downstream impact on visits). Although call centers can improve efficiency, they cannot overcome severe provider shortages that drive high appointment wait times. Work flow processes for scheduling at medical practices must be coordinated prior to launching a call center.

Source: Sg2 Interview, 2011.

Case Study

Mary Washington Healthcare, Fredericksburg, VA

Physicians who refer to multiple organizations always represent a potential market share drain. Finding pragmatic ways to support practice operations can enhance overall physician loyalty today and lay the groundwork for more integrated multidisciplinary care delivery models.

Concierge Scheduling Model Better Aligns Physicians, Secures Referrals

Strategies	 Access  Alignment
Background	<ul style="list-style-type: none"> ■ Anticipating market entry of a new regional medical center, this system of 2 hospitals and 28 health care facilities and wellness services sought ways to lock in physician loyalty. ■ Mary Washington already had a centralized scheduling system, yet doctors found it complex to get patients into the system.
Solution	<p>Concierge Services for Patients</p> <ul style="list-style-type: none"> ■ Beginning in May 2009, select schedulers were promoted to the role of concierge. They provided a higher level of service to physician practices with the goal of making it easier for physicians to refer business. ■ The concierges contact patients to schedule ancillary services after verifying insurance benefits and obtaining test authorizations. Any scheduling changes are handled by the concierge. ■ A total of 45 physicians at 10 practices (of 200 group practices in the system service area) have access to concierge services. Six of these practices offer primary care services and 4 provide specialty care. ■ Two of the specialty practices—general surgery and hematology/oncology—received on-site concierges. These high-volume practices were particular alignment targets for the system, had space to accommodate the concierge on-site and were located near prime competitors. <p>Other Alignment Methods</p> <ul style="list-style-type: none"> ■ Through its physician liaison service, each month Mary Washington reviews referrals by physician and contacts physicians when dips in volume are noted. ■ The organization is also investigating comanagement agreements to further improve physician alignment.
Impact	<ul style="list-style-type: none"> ■ Mary Washington successfully prevented out-migration that could have resulted due to entry of a new competitor. Comparisons of volumes before and 2 years after implementation of the concierge program showed no decline. ■ At the same time, use of certain ancillary services, such as sleep studies, rose among certain physicians once the concierge program heightened their awareness of these services. ■ Physician and patient satisfaction skyrocketed. Physician offices developed personal relationships with the concierges, who were viewed as additional staff.
Lessons Learned	<ul style="list-style-type: none"> ■ Concierge services are resource intensive and should target priority areas first. ■ Improving care accessibility and quality of care may be key to securing physician referrals.

Source: Sg2 Interview, 2011.

Case Study

Marshfield (WI) Clinic

Networks that extend the reach of key specialists help lock in patients in the primary market and carve inroads to secondary markets. For rural providers, these services can help keep patients from leaving the market today. Long-term, these virtual services represent the type of care redesign necessary to scale the physician workforce over larger populations.

Telehealth Network Improves Care Accessibility Across Markets

Strategies	 Outreach  Partnerships
Background	<ul style="list-style-type: none"> ■ Marshfield Clinic is a health care delivery system with 779 physicians in 54 locations throughout northern, central and western Wisconsin. ■ Marshfield has offered a growing range of telehealth services, including consults and remote monitoring, since 1997 through a grant covering care provision to rural residents.
Solution	<p>Telehealth Expansion</p> <ul style="list-style-type: none"> ■ The clinic expanded its network to improve care access across the community. ■ It now covers more than 30 clinical areas. Half of the sites receiving telehealth services are delivery sites owned by Marshfield; half are operated by independent providers.
Impact	<ul style="list-style-type: none"> ■ Network spokes were better able to retain patients for ancillary services, outpatient surgeries and admissions. Network participation also enabled them to expand their service offerings, collect facility fees and improve their brand image. ■ Hub sites improved productivity, cost control, market share and referral streams. ■ Telehealth enabled gains when the financial impact of reduced expenses and improved billable office time were taken into account: <ul style="list-style-type: none"> – For a cardiology telehealth program, gains totaled from \$4,000 to \$12,000, based on daily revenue from 29 to 37 RVUs. No expenses were incurred from driving time; no practice disruption reduced other billable visits. – In contrast, a traditional cardiology outreach program requiring site visits by interventional cardiologists would lose \$649, based on \$1,600 in daily revenue from 5 to 11 RVUs, offset by 5 hours of driving time, \$249 in expenses and \$2,000 in lost billable office time. ■ An activity-based cost analysis of a 15-minute cardiology consult demonstrated only a minimal increase for a teleconsult to independent sites and a savings at owned sites. The analysis took into account salaries as well as transmission and indirect costs. Marshfield Clinic costs totaled: <ul style="list-style-type: none"> – \$73 for an in-person consult – \$63 for a system-owned remote site – \$76 for an independent site
Lessons Learned	<ul style="list-style-type: none"> ■ Extending telehealth for a variety of clinical services—selected based on access, physician productivity or current market share—enhances the likelihood of success. ■ Setting up a telehealth consult relationship with an outside partner (in Marshfield’s case this cost \$400/month) enables organizations to test markets before investing in a bricks and mortar establishment in those locations.

RVU = relative value unit.

Source: Antoniotti N. Return on investment: creating value-added telehealth initiatives. Presented at: American Telemedicine Association 16th Annual International Meeting, May 2011, Tampa, FL.

Case Study

Wake Forest Baptist Health, Winston-Salem, NC

Collaborative, disease-specific centers of excellence break down traditional organizational silos that hamper downstream referrals today while creating the clinical care delivery model that can meet patients' needs for coordination and payers' demands for value.

Realignment Removes Barriers to Downstream Procedures

Strategies	 Access  Satisfaction  Alignment  Payment
Background	<ul style="list-style-type: none"> ■ This academic medical center operates 1,004 acute care, rehabilitation and psychiatric care beds. The CEO is a physician. ■ Wake Forest has a strategic initiative to form centers of excellence. Neurosciences is 1 of 5 centers of excellence promoted by the medical center. ■ Neurosciences leadership set out to develop business plans by disease state. They undertook growth efforts focusing on stroke, spine, epilepsy and movement disorders (eg, Parkinson disease). ■ They sought to maximize the patient experience by eliminating barriers created by a historical “silo” model. <ul style="list-style-type: none"> – Example 1: Movement disorder patients were required to undergo a series of tests to be candidates for deep brain stimulation. One such test was a neuropsychological exam; patients not in network with a medical center provider often encountered delays scheduling this exam. – Example 2: The Comprehensive Epilepsy Center required services of a neuropsychiatrist to best serve the population; recruiting additional faculty in the psychiatry department was difficult to justify within a single faculty department business model view.
Solution	<p>Business Model Overhaul</p> <ul style="list-style-type: none"> ■ Through a new business plan and disease state pro formas, Wake Forest combined neurosciences inpatient, outpatient and professional services. ■ Capital and program requests were evaluated based on what was needed to improve the patient experience, throughput, operations and clinical outcomes. <ul style="list-style-type: none"> – Example 1: To remove process bottlenecks, neuropsychologists at the medical center were held harmless for billings of desired neuropsychological exams. – Example 2: A new neuropsychiatrist position was approved for the epilepsy center; the dedicated position is designed to address the psychosocial needs of the center’s patients.
Impact	<ul style="list-style-type: none"> ■ Wake Forest accelerated patient flow and removed barriers to a lucrative downstream procedure (ie, deep brain stimulation). ■ Volume trends are favorable. ■ Effective length-of-stay management and reduced 30-day readmissions expanded capacity for new cases.
Lessons Learned	<ul style="list-style-type: none"> ■ Patient-centered program planning identifies gaps that compromise access. ■ Alignment of hospital and physician objectives is key to creating a care delivery model that overcomes organizational barriers to comprehensive care.

Source: Sg2 Interview, 2011.

Case Study

Aspirus, Wausau, WI

Demographic-focused growth strategies have historically met with mixed results. Programs likely to generate an acceptable return on investment (ROI) require careful targeting, packaging that focuses on convenience and coordination, and ongoing measurement of downstream revenue. The market for these types of services will likely expand as payer incentives begin to lean toward prevention and risk assessment.

Comprehensive Health Assessments Engage Women and Their Households

Strategies	 Access  Satisfaction  Services
Background	<ul style="list-style-type: none"> ■ Aspirus is a regional health system serving north central Wisconsin and Michigan's Upper Peninsula. It is licensed for 321 beds and staffed by 350 physicians in 35 specialties. ■ The Aspirus market is projected to grow 3% over the next decade, significantly below the national population growth rate (11%). ■ Aspirus wanted to address gaps in provision of comprehensive care while building loyalty among families' key health care decision makers.
Solution	<p>Journey to Optimal Health</p> <ul style="list-style-type: none"> ■ To better appeal to female consumers, Aspirus developed the Journey to Optimal Health program offering patient-centered women's health services. <ul style="list-style-type: none"> — A nurse practitioner conducts a wellness assessment for each patient, from which a customized health care action plan is generated. — During a 1- to 2-hour appointment, women receive relevant information and care advice based on their specific health status and needs. — A health navigator facilitates scheduling and coordinates additional services based on the patient's health plan. ■ The program cost \$400K to launch and operates with a \$250K annual budget. ■ Downstream impact is measured using an external customer relationship management vendor. Parameters, including use of health care services by the patient herself as well as those who share her residence, are tracked for 1 year from the date of clinic appointment.
Impact	<ul style="list-style-type: none"> ■ In calculating Journey to Optimal Health's ROI, it was assumed that 50% of downstream charges from new patients and their household members could be attributed to the program. ■ Average downstream charges associated with new patients and their families were \$1.4 million in FY 2009. ■ The program has continued to grow and for new patients seen in the clinic in the first quarter of 2011, average charges for the patient plus her household were over \$5,000.
Lessons Learned	<ul style="list-style-type: none"> ■ Although direct financial gains are important, a program's referrals, brand recognition and downstream services must be taken into account to fully gauge impact. ■ Comprehensive programs tailored to a specific demographic can generate growth opportunities in related services. Aspirus now offers fertility services through a reproductive endocrinologist who visits its facility once per month. Genetic testing and counseling are also being considered.

Source: Sg2 Interview, 2011.

Case Study

ThedaCare, Appleton, WI

Targeted, clinically indicated screening programs can increase downstream revenue today, particularly in cancer services. Tomorrow’s payment models increasingly will require and reward higher screening rates and early detection of cancer and chronic conditions. Successful systems will be those that learn to promote screening programs through employed and referring physician practices.

Cancer Screening Initiative’s Physician Focus Boosts Colonoscopy Rates

Strategies	 Access  Outreach  Alignment
Background	<ul style="list-style-type: none"> ThedaCare is the largest health care provider and employer in northeast Wisconsin, serving more than 250,000 patients in a 14-county area. The system includes 5 hospitals, a physician group with more than 120 employed primary care physicians, behavioral health, laboratories, senior living facilities, home health services and more. Physician recommendation remains a strong predictor of patient compliance with colorectal cancer screening. At ThedaCare, which does not employ its gastroenterologists, the colorectal cancer screening rate was only 52%.
Solution	<ul style="list-style-type: none"> ThedaCare launched a colorectal cancer initiative that called for a consistent, system-wide screening recommendation with use of colonoscopy as the preferred screening method. <p>Physician Messaging, Incentives and Metrics</p> <ul style="list-style-type: none"> Project leaders met with primary care physicians to present information on the screening initiative. Physicians received a “pitch” to use with patients. Nominal physician and administrator incentives were tied to improved screening rates, reported monthly at the clinic and physician levels. Electronic medical record alerts reminded physicians to discuss screening. <p>Seamless Referrals</p> <ul style="list-style-type: none"> Colonoscopy appointments were scheduled either before the patient left the primary care physician office or through the ThedaCare call center. ThedaCare streamlined scheduling with multiple independent gastrointestinal (GI) groups and implemented processes to ensure ThedaCare calls were answered at GI clinics and appointments were scheduled immediately. <p>Targeted Marketing</p> <ul style="list-style-type: none"> Educational and marketing materials were placed in physician offices and waiting rooms to spark conversation between patients and their doctors. A direct mail, phone and Web campaign was developed around the character Wally Polyp, the patient’s inner voice providing excuses for avoiding a colonoscopy.
Impact	<ul style="list-style-type: none"> The system’s screening rate increased 21 percentage points to 73% due to the marketing campaign coupled with heightened disease management efforts. During a 2.5-month period, 10% of patients targeted via marketing scheduled and underwent a colonoscopy. The program will be rolled out to other clinics and service areas.
Lessons Learned	<ul style="list-style-type: none"> Simplifying referral structures and engaging physicians early are key to success. Engaging patients in their own care is an effective way to grow market share.

Source: Sg2 Interview, 2011.

Case Study

Large Midwest Health System

Targeted direct marketing efforts focused on specific clinical services attract new patients to the system, at the same time laying the groundwork for patient engagement essential in population health management.

Dynamic Direct Marketing Delivers More Patients

Strategy	 Outreach
Background	<ul style="list-style-type: none"> ■ A regional health care provider in a highly competitive, affluent area 25 miles west of a major city developed a “marketing division dashboard” to demonstrate outcomes of its marketing efforts. ■ Tactics were tied to corporate goals; results were reported monthly.
Solution	<p>Dynamic Marketing (launching promotions only to certain populations and then comparing outcomes with control groups)</p> <ul style="list-style-type: none"> ■ Success was measured as the uptick in engagement for patients who had received marketing materials vs those who had not. Patients who responded to marketing were tracked using associated identifiers (ie, a specific contact number or URL used in direct mail materials). The contribution margin of these incremental patients was measured downstream. <p>Tailored Messaging</p> <ul style="list-style-type: none"> ■ Tailored marketing was conducted via television, email and direct mail. It included patient stories that showcased success for someone with a condition similar to the recipient’s. <p>Online Interaction</p> <ul style="list-style-type: none"> ■ With the goal of driving 25% to 35% of commodity service interactions online, the organization asked patients for their email addresses at the point of service at its fitness center, primary care groups, central scheduling/registration and interactive Web modules. The organization also bought email lists with a choice to opt out. ■ Top Web page views, overall Web portal visits, emails obtained and online forms completed were tracked. <p>ED Satisfaction</p> <ul style="list-style-type: none"> ■ Patients could request current ED wait times via text or phone call; call and text volumes were displayed on the marketing dashboard. Exit interviews conducted with patients leaving the ED tracked their impression of the service.
Impact	<ul style="list-style-type: none"> ■ 70,000 patient emails were collected. ■ There were 8,000 views of physician video biographies on the provider’s Web portal in the first month. ■ Across 7 months, incremental gains led to increased contribution margins: <ul style="list-style-type: none"> – 476 incremental patients aged 25–39: \$466,998 – 1,303 incremental patients aged 40–54: \$2.1M – 1,159 incremental patients aged 55–64: \$3.0M ■ There were close to 750 new patient visits per quarter.
Lessons Learned	<ul style="list-style-type: none"> ■ The ability to measure downstream contribution margin enables organizations to rapidly expand, modify or abandon marketing campaigns based on outcomes. ■ Systems must be available to collect and provide data within a useful time frame.

ED = emergency department.
Source: Sg2 Interview, 2011.

Case Study

Henry Ford Health System, Detroit, MI

Tools that target at-risk patients or flag overdue care can stimulate service use today but also improve systems' long-term ability to manage chronic conditions and the total cost of care. Payers pursuing value-based care models will be looking first to systems already adept at this right time/right place care delivery concept.

Registries and Population Health Management Facilitate Outreach

Strategies	 Outreach  Services  Payment
Background	<ul style="list-style-type: none"> ■ Henry Ford Health System owns 6 hospitals and dozens of clinics across southeastern Michigan. It includes one of the nation's largest group practices, Henry Ford Medical Group (HFMG), with more than 1,200 physicians in over 40 specialties. ■ As part of a strategic effort to redesign chronic care delivery, HFMG adopted a patient-centered medical home (PCMH), incorporating an electronic medical record, case management and population health strategies. ■ The market's predominant payer offered a 10% payment increase for implementing certain PCMH components and meeting quality thresholds.
Solution	<p>Registry and Population Health Managers</p> <ul style="list-style-type: none"> ■ HFMG developed a registry that houses data on all HFMG patients. Embedded in this registry were evidence-based care guidelines for numerous chronic conditions, including asthma, coronary artery disease, COPD, CHF, chronic kidney disease, depression and diabetes. Preventive care guidelines also were included. ■ At any patient visit, the registry helps clinicians identify and order needed services. ■ Nonclinicians, typically with bachelor's or associate's degrees, were hired as population health managers to mine the registry for appropriate outreach opportunities outside of patient visits. <ul style="list-style-type: none"> – The registry flags for the population health managers patients who are due for an office visit or services, such as mammography and colon cancer screenings. – Based on this information, the registry managers can then conduct patient outreach, schedule appointments and order lab tests.
Impact	<ul style="list-style-type: none"> ■ Approximately one-third of patients contacted by a population health manager come in for an appointment. The program pays for itself through the visits and increased downstream services generated. ■ Registry data enable the medical group to generate physician- and clinic-level performance reports, bolstering efforts at continuous improvement as well as healthy competition among colleagues. ■ Clinical improvements in diabetes measures and cancer screening, 2 areas of strategic focus, have been observed.
Lessons Learned	<ul style="list-style-type: none"> ■ Ongoing registry updates are necessary to incorporate current guidelines. ■ The sunk cost of a well-developed information system can be used to support improved clinical quality while driving volume. ■ Registries complement numerous components of PCMH models.

COPD = chronic obstructive pulmonary disease; CHF = congestive heart failure.
Source: Sg2 Interview, 2011.

Case Study

St Vincent Health, Indianapolis, IN

Employer-based primary care clinics offer effective avenues for funneling commercially insured patients into a provider system today, while establishing the relationships that may lead to cooperation on future payment and contracting models. Partnership models limit up-front capital outlays, and discounts for patient steerage can pay long-term dividends.

Partnerships Enable Effective Employer Clinics

Strategies	 Access  Services  Partnerships  Payment
Background	<ul style="list-style-type: none"> ■ St Vincent, the Indiana subsidiary of Ascension Health, kicked off an employer engagement strategy to create a market presence as an advocate for self-funded employers. ■ Public-sector employers sought creative ways to reduce costs following property tax and other legislative reforms: <ul style="list-style-type: none"> — Many state-run school systems were covered by health plans other than the state's Anthem plan. Legislation was put into place forcing them to switch to the state plan if their costs were not within 10% of the state plan costs.
Solution	<p>Partnership With Novia CareClinics</p> <ul style="list-style-type: none"> ■ St Vincent partnered with Novia, a firm offering employer-based clinics, to provide on-site primary care services to employees and their dependents. <ul style="list-style-type: none"> — The hospital provided the physician base; employers owned the clinics/equipment. — Novia received a management fee from employers and reimbursed St Vincent for physician salaries. — Novia covered co-payments and coinsurance for prescription medications. <p>Volume Discount Contracts With Employers</p> <ul style="list-style-type: none"> ■ St Vincent offered a tiered reward system to reduce prices for employers. Employers that steered an increased percentage of their volume (via benefit plan redesign) to St Vincent received cash rebates. ■ Patients who chose the employer's benefit plan and opted to seek care at St Vincent facilities could avoid increased co-payments/deductibles. <p>Case Management</p> <ul style="list-style-type: none"> ■ Wellness and disease management services were targeted to the 5% of employees with the highest health care costs.
Impact	<ul style="list-style-type: none"> ■ St Vincent has since engaged 12 employer clients, including 8 schools, in an on-site clinic partnership, enabling patients outside its network to access its services. ■ Nationally, downstream revenue from primary care physicians is approximately \$1.3M net to the sponsoring hospital. Downstream revenue per physician generated by the on-site clinics, open 40 hours per week, approximated that figure. ■ Payer mix improved as the system's share of school district health plan enrollees increased from 55% to 75%.
Lessons Learned	<ul style="list-style-type: none"> ■ Employer partnerships work well when the on-site clinic becomes the primary care setting for employees rather than being viewed as an urgent care center. ■ Clinics typically must operate above 60% capacity for employers to have a positive ROI. ■ Tracking downstream utilization can be a challenge and is often easiest for patients seen by physicians who work only at the on-site clinics.

Source: Sg2 Interview, 2011.

Case Study

Southcoast Health System, New Bedford, MA

Some programs that deliver clinically indicated services to at-risk populations draw successfully from the self-pay marketplace. Bariatric surgery is a prime example for which Sg2's forecast anticipates strong growth over the next 5 years. Providers must move quickly to position for share of care as payers begin to direct patients to high-volume programs with superior outcomes.

New Bariatric Surgery Program Aims to Capitalize on Rising Obesity Prevalence

Strategy	 Services
Background	<ul style="list-style-type: none"> ■ Southcoast is a 3-hospital system in southern Massachusetts, just outside of Providence, RI. Tobey Hospital, with approximately 80 beds, is its smallest. ■ Out-migration is primarily pulled to the Boston market, although the population is largely averse to traveling far for care. ■ Sg2's forecast anticipates a wide range of growth opportunities regarding providing obesity-related clinical services over the next 5 years. ■ Weight loss surgery can reduce the prevalence of morbid obesity while treating high-cost comorbidities such as hypertension.
Solution	<p>Comprehensive Weight Loss Surgery Program</p> <ul style="list-style-type: none"> ■ Tobey Hospital launched a bariatric surgery program in January 2004. The comprehensive program includes free services, such as nutritional care and support groups.
Impact	<ul style="list-style-type: none"> ■ The program generated 24 cases its first year and 80 its second. The hospital qualified as a center of excellence in accordance with a 2005 Medicare determination. Current annual volumes for bariatric surgery total approximately 600. ■ Patients are drawn to the program from across southeastern Massachusetts, pulled from the service areas of 4 competing systems. Approximately 65% of patients seek treatment at Tobey because a friend or family member did. ■ Bariatric surgery patients follow up with the program for 5 years postsurgery; 80% of patients complete this follow-up. This has changed Tobey Hospital into a primary care center and essentially enabled it to create a captive market for ancillary services. ■ Competitors well beyond Tobey's primary market have begun establishing satellite clinics to make market share inroads among patients willing to travel for the actual surgery but reluctant to travel for follow-up care.
Lessons Learned	<ul style="list-style-type: none"> ■ Targeting clinical areas of high or increasing prevalence, such as obesity, is one essential step in prioritizing growth strategy. ■ Offering a new service can also boost specialist recruitment and retention. ■ Educating physicians and patients about bariatric surgery as a treatment for diabetes, hypertension and sleep apnea is one key to launching a successful program. ■ Physician champions are essential.

ICD-9 = International Classification of Diseases, Ninth Revision.
Source: Sg2 Interview, 2011.

Case Study

Tallahassee (FL) Memorial HealthCare

Most markets are saturated with comprehensive cardiovascular programs. Accelerating adoption of an innovative cardiac catheterization technique today can simultaneously improve patient outcomes, increase facility capacity, and enhance patient and referring physician satisfaction while enabling the outpatient shift essential for high-value future care.

Broader Adoption of New Technique Improves Quality, Optimizes Care Setting

Strategies	 Satisfaction  Services
Background	<ul style="list-style-type: none"> ■ Tallahassee Memorial is a private, not-for-profit community health care system that includes a 770-bed acute care hospital. ■ Cardiovascular service lines, faced with 30-day readmission penalties and Medicare Recovery Audit Contractor reviews, are under pressure to reduce complication rates and optimize sites of care. <ul style="list-style-type: none"> — One large, independent cardiology group and a 3-physician group perform cardiac catheterizations for the system. ■ Through a physician-led initiative, Tallahassee sought to diffuse a novel coronary cath technique to enhance the value of these services.
Solution	<p>Adopting the Radial Artery Approach</p> <ul style="list-style-type: none"> ■ The radial artery approach to cardiac caths, compared to the more common femoral artery approach, reduces bleeding complications, shortens recovery time and is preferred by patients. A physician champion on the medical staff uses this approach for 95% of the coronary caths he performs. He gained buy-in and helped train the other independent cardiologists. The technique now is used for more than half of all caths provided at Tallahassee. This includes diagnostic angiography, PCI and treatment of STEMI. <ul style="list-style-type: none"> — In most US hospitals, typically only 1 or 2 physicians have adopted the approach; thus, it is used in only a small percentage of total caths nationwide. For example, it currently is used in only 10% of PCIs. ■ The nursing staff supports the change; internal surveys show high job satisfaction. ■ Other cardiologists from across the country come to the hospital to learn the technique from the physician who spearheaded Tallahassee's initiative.
Impact	<ul style="list-style-type: none"> ■ The radial artery approach eliminates the need for several hours of bed rest postprocedure and an inpatient admission. Patients typically are discharged home directly from the postprocedure recovery area, obviating the need for an observation encounter as well. ■ The hospital's radial artery catheterization program is generating positive word of mouth from satisfied patients and physicians, creating a competitive advantage that should generate future referrals.
Lessons Learned	<ul style="list-style-type: none"> ■ Changes in strategic direction can reap benefits in care outcomes even before payment models realign. ■ Before undertaking new procedures, it is important to evaluate physician appetite for change and measure existing capacity.

PCI = percutaneous coronary intervention; STEMI = ST-segment elevation myocardial infarction.
Source: Sg2 Interview, 2011.

Case Study

Large Community Hospital

In some markets, providers have a near-term opportunity to dramatically lower their imaging service pricing to shift market share, anticipating that provider price advantage will quickly evaporate anyway. These approaches typically require strategic partnerships with other imaging providers, careful payer negotiations, and aggressive marketing to patients and referring physicians.

Pursuit of Imaging Joint Venture and Price Cuts Creates Competitive Edge

Strategies	 Partnerships  Alignment  Payment
Background	<ul style="list-style-type: none"> ■ This hospital owns several outpatient imaging centers in its primary service area. A large retail provider operates 6 freestanding imaging centers in the same geographic area. ■ Previously, 2 outpatient imaging centers that had been formed from a partnership with independent radiology groups closed due to low volume and competition with the freestanding imaging corporation. ■ The hospital estimated that 35% of outpatient imaging was taking place outside of the hospital network. The main drivers of this out-migration were the procedures' relatively high price when performed at a hospital-owned imaging center, coupled with the economic recession and patients' higher out-of-pocket responsibility. ■ Many physicians were reluctant to refer internally and force patients to incur higher costs. They also were lured by the freestanding center's high-quality service.
Solution	<p>Divestment From Imaging and Partnership With Freestanding Centers</p> <ul style="list-style-type: none"> ■ Over a 24-month period, the hospital explored a joint venture under a shared revenue model with the freestanding imaging corporation. ■ The goal was to gain imaging volumes downstream and benefit from the freestanding center's operational expertise. Prices for imaging services could then be cut and, ultimately, competitors could be forced out of the market. ■ The predominant payer agreed to work with the hospital to set the price point.
Impact	<ul style="list-style-type: none"> ■ Now in early stages of implementation, scenario planning projects that market share ultimately should enable the system to quickly break even on its plan. <ul style="list-style-type: none"> – The most likely scenario estimates an expected volume increase to offset the price cut within 24 months. – The worst-case scenario projects a \$3 million loss in the first few years if volume growth is slow and, consequently, the hospital receives a lower share of the joint venture's profits. Leaders saw this as an acceptable trade-off for long-term growth.
Lessons Learned	<ul style="list-style-type: none"> ■ A competitive analysis of ancillary services that are price elastic (eg, imaging, rehabilitation) should not focus solely on the hospital market but also take into account for-profit competitors. ■ Short-term blows to the bottom line may be warranted while establishing the infrastructure for market strength in the long-term.

Source: Sg2 Interview, 2011.

Tailor Strategy to Organizational Archetype

The starting point for any middle game strategy must be established based on what the organization is today, how its local market is configured and where it wants to end up over the long-term. Variations across 4 provider archetypes highlight strategic options. Many of the strategies and tactics in this report are relevant to all types of providers. Some may be more appropriate for those with specific characteristics and organizational structures.

Community-Based Partial Systems of CARE

Starting Point: Benefit from playing the middle game longer. Most organizations require time to improve care transitions, workforce alignment, operations and quality for specific clinical programs.

Examples: ThedaCare's cancer screening; Mary Washington's concierge scheduling model; Tallahassee Memorial's adoption of radial artery cardiac catheterizations; Large Midwest Health System's direct marketing approach

Rural Primary or Secondary Care Access Points

Starting Point: Gain from partnering with larger systems and finding ways to keep health care service local.

Example: Marshfield Clinic's telehealth network

Tertiary or Quaternary Centers

Starting Point: Carefully navigate increasing accountability. Improving performance while increasing market share would be a welcome stepping stone to risk-based contracting because larger risk pools are more stable and easier to manage.

Example: Wake Forest Baptist Health's disease-focused service line model

Regionally Consolidated Health Systems With Continuum of Care Reach

Starting Point: Embark more quickly on the path of change toward a value-based model. Shaping market structures, incentives and relationships will be core to this approach.

Example: Henry Ford Health System's population health management approach; St Vincent Health's contracting model; Large Community Hospital's imaging joint venture

Plan Your Strategy

More than one path may lead to success in the middle game. Provider systems may find inspiration in the examples included in this report, but ultimately they will have to chart their own course. Working through an action checklist up front, before launching any growth initiative, increases the chance for success.

Quantify local market opportunities.

Use data to accurately forecast growth of key service lines, and then identify new strategic targets. Analyze local epidemiology and then gradually enhance the focus on prevention as much as possible to reduce the disease burden over the long-term.

- Could competitors in the market be open to a partnership? Use local economic and payment-related challenges as a pitch for external partnerships.

Evaluate the payer landscape.

Payers in some markets may be primed to collaborate on payment innovation, either by adapting traditional pricing structures or piloting risk-sharing structures.

- Are your payers dominant and conservative or competitive and innovative?

Assess your System of CARE's level of integration.

Ambulatory care and physician office visits will demand enhanced focus in the future. Follow the progression of different diseases across the full range of settings: community-based, acute, recovery/rehabilitation.

- Where do patients typically interact with your delivery system?
- Where do gaps exist?
- Where might improved coordination drive increased market share in profitable services today?
- Is it most feasible to own, partner or otherwise align with other providers to complete the continuum?

Evaluate current physician alignment.

A strong referral pipeline is imperative for market share growth.

- Is your physician market highly fragmented or regionally consolidated?
- Do you know which physicians are most key to the volumes you likely will target for growth? Are they splitters?
- Have you proposed alignment approaches previously?
- How could use of midlevel providers and nonclinical staff enhance physician productivity, satisfaction and loyalty to your organization?

Identify short- vs long-term wins.

Careful selection of initial or short-term growth initiatives helps build confidence and momentum. The best approach is to identify a full range of potential growth options and then prioritize them based on their impact and ease of implementation.

- Are there areas in which change agents—people with drive and readiness for innovation—will be readily available?

Track the Impact

Once under way, growth initiatives must be closely monitored. Strong analytical competence, combined with the ability to translate extensive data into fact-based decisions, will be key.

Provider systems should track smart growth that results from a new initiative by distinguishing clinically “good growth” (right care, right place, right time) from “bad growth” (volumes linked to readmissions or questionable inpatient stays likely to draw scrutiny or penalties). Market share inroads also should be seen across the continuum. Thus, pre- and post-acute volumes, captured through strong offerings in the System of CARE’s community-based and recovery/rehabilitation sites, need to be tallied along with inpatient days.

In addition, financial and clinical performance thresholds must be predetermined by clinical area and continuously measured. By establishing the desired endgame and tracking progress, organizations can pursue or abandon growth initiatives as warranted. Success should be measured against targets set on 6 metrics:

- Inpatient and outpatient disease-based forecasts
- Site of care volume
- New patient acquisition and encounters
- Channel access improvement
- Patient/physician conversion rates (eg, downstream revenue and profitability)
- Patient attrition

Related Sg2 Resources

Sg2 provides a wealth of resources to help organizations grow their business. Additional tools and intelligence focused on performance then enable systems to enhance their value in clinical areas most essential to their long-term growth. As a starting point, Sg2 clients can access the [Smart Growth Planning: Essential Intelligence Resource Kit](#) at [members.sg2.com](#). The Web site also offers ready access to resources in varied forms, noted below.

Analytics	Intelligence
<ul style="list-style-type: none">■ National, regional and localized forecasts■ Sg2 Growth Index™■ Growth trackers■ Sg2 Value Index™	<ul style="list-style-type: none">■ Growth guides■ System of CARE guides■ Planning workbooks■ Improvement guides

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