BoardRoom Press

A Bimonthly Journal of News, Resources, and Events for Today's Healthcare Boards

THE GOVERNANCE INSTITUTE ■ VOLUME 27, NUMBER 3 ■ JUNE 2016

GovernanceInstitute.com

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Baptist Health Lexington Mobilizes to Serve Complex Patients

What Healthcare Boards Need to Know About Nursing

SPECIAL SECTION

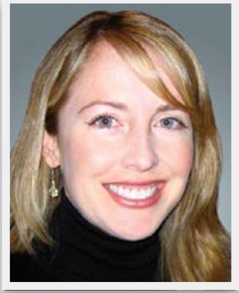
Getting Ready for Population Health

Leading an Organizational Turnaround

ADVISORS' CORNER

The Volume vs. Value Scale: What Is the Tipping Point in Your Market?

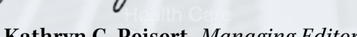
Continuum Partnerships Include Patients Themselves



Our lead article in this issue gives an important provider perspective on ways hospital staff can be proactive in facilitating post-acute care and follow up, not just by partnering with skilled nursing facilities and other post-acute facilities, but also in maintaining direct communication with patients to make sure their needs are met. The examples provided are done in financially sustainable ways and the board has tasked management with allocating resources appropriately.

Importantly, nurses are the staff members who lead these critical efforts, and this issue reminds us that boards need to have a greater understanding of the varying roles and types of nurses, and how they can help further strategic efforts around patient quality of care, experience, and population health. Is nursing a strong voice in your boardroom?

As population health models take a stronger hold across the country, there are few organizations left that can reasonably take minimal to no action. Our special section provides important information about building the capabilities necessary for value-based payment contracts with both upside and downside risk. Finally, our Advisors' Corner focuses on the importance of using local market dynamics to determine your organization's timeline and pace of change in moving to value.



Kathryn C. Peisert *Managing Editor*

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Baptist Health Lexington Mobilizes to Serve Complex Patients

BY WILLIAM G. SISSON, FACHE, BAPTIST HEALTH LEXINGTON AND BAPTIST HEALTH SYSTEM, EAST REGION

Today every healthcare organization faces the challenge of serving aging patients with complex needs who need additional support post-discharge.

In many cases, these patients would benefit from increased social support and preventive care to reduce their need for expensive hospital-based care. As the healthcare system shifts towards value-based purchasing, hospitals and health systems must develop a strategy to offer excellent care for complex patients throughout the continuum of care.

William G. Sisson, FACHE
President, Baptist Health Lexington
Regional Executive,
Baptist Health System, East Region

I've had the honor of serving as the President of Baptist Health Lexington for more than 25 years. We are a regional tertiary 383-bed Magnet®-designated hospital with over 2,900 employees and 690 physicians. Our services include six ambulatory centers, numerous physician practices, and two urgent care centers. Since we are a tertiary hospital, we tend to see some of the sickest patients in our region. Because of the recent Medicaid expansion in Kentucky, our proportion of complex cases with social needs has increased dramatically. We used to see about 6 percent Medicaid patients, while today they are about 15 percent of our case mix.

Our hospital is part of Baptist Health System, Inc., a Kentucky-based system that includes seven owned hospitals plus one managed hospital, as well as physician practices, a health plan, and a home health agency, among other services. About three years ago, in response to the increasing needs of complex patients and a desire to promote wellness across the state, the system determined that we will emphasize a population health approach to care. We feel strongly that this is the optimal approach for the future. To do this, we need to develop innovative ways of caring for the people who come to our doors in the most efficient, compassionate way.

In the past few years, we have developed several new approaches and alliances with community organizations that benefit patients and help us use our resources effectively.

Complex Case Management Demands Expanded Skills

Early in 2015, the hospital decided to re-examine its case management model, which was fairly traditional, based on discharge planning and utilization management. The impetus for this was based on several factors, including our shift to a population health model, the national trend from discharge planning towards more complex case management, and our effort to decrease unnecessary readmissions and increase quality of care. High-risk complex patients need more than a single discharge planning visit, so we looked at different ways for nurses and other professionals to assess, identify, and support these patients.

We expanded our case management model in the emergency department to cover evenings and weekends. Previously we found that when complex patients were treated for the presenting issue, contributing problems were missed. By having case managers on hand, we were able to connect these patients with resources, including assistance for medications, follow-up physician visits, and help with difficult social situations.

The hospital has six social workers, one of whom is dedicated to complex case management full time. She serves as our internal consultant to other nurse case managers and social workers because she has expertise to help this particular group of patients. She provides continuity of care with our home care agency, and has even accompanied patients to court, to help patients deal with unusual situations.

During the redesign, we realized that some patients were not able to schedule a post-discharge follow-up visit with their primary care doctor within a reasonable time. To address this issue, we placed an appointment coordinator in the medical group specifically to facilitate these appointments.

Key Board Takeaways

Healthcare organizations are facing challenges with increasing numbers of complex, high-acuity patients. A few things for boards to consider as they work to create a strategy for providing excellent care to patients include:

- The focus of care must shift to the continuum versus episodic.
- Models of care must focus on populations and partnerships to be effective and efficient.
- Adding case managers to the emergency department is a value-added step to enhance care.
- Pilot efforts including call centers, appointment liaisons, and advanced practice nurse-led post-discharge clinics are proving to be effective in supporting care plans.
- Healthcare boards must be educated about new quality indicators targeted to populations and hold administrators accountable to reallocate resources accordingly.

We also opened clinics to handle follow-up visits for two specific conditions: congestive heart failure and atrial fibrillation. These clinics, staffed by nurse practitioners, offer both drop-in visits and scheduled appointments. While the new clinics initially caused some concern among physicians, they are now seen as a valuable complement to the services physician practices offer, and an excellent way to provide speedy initial access for complex patients.

Alliance with Community Organization Yields Positive Results

In May 2014, the hospital set up a pilot project with the Bluegrass Area Agency on Aging and Independent Living to better serve congestive heart failure and chronic obstructive pulmonary disease (COPD) patients. This program relies on health coaches, trained nurses, and social workers to:

- Make a home visit to the patient ideally within three days of discharge.
- Conduct a health assessment including medication reconciliation (pharmacists

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What Healthcare Boards Need to Know About Nursing

BY MICHAEL R. BLEICH, PH.D., RN, FAAN, NURSDYNAMICS

The largest segment of nearly any healthcare workforce is nurses. Yet too often, board members shy away from a proper understanding needed to act on clinical and credentialing initiatives that involve nurses. This article offers a primer to enhance governance dialogue about nursing.

Key Board Takeaways

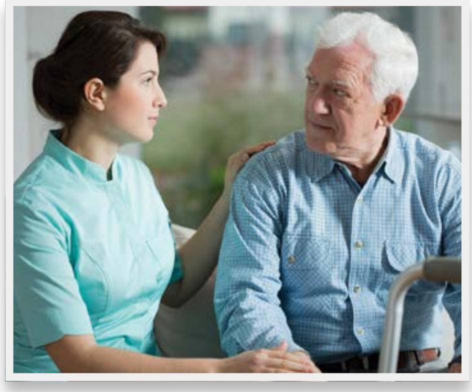
Nurses are critical to the success of any hospital or health system. To enhance governance dialogue around nursing, boards need to have a basic understanding of their education and roles. Boards should consider the following:

- Know the institutional mix of RNs with varying levels of education.
- Support advancing nurse education to improve clinical outcomes.
- Advanced practice nurses are educated in a nursing model that focuses on populations.
- Credential APRNs as nurses, not physician assistants, to mitigate risk management issues.

The Evolution of Nursing

From the time of Florence Nightingale, nursing was rooted in science. Nightingale, herself a renowned statistician, was clear that there was a scientific basis to care, different than but complementary to medical diagnosis. Her landmark studies on hospital design and infection control revolutionized ward management and ensured a positive patient experience, reducing hospital-acquired infections and overall morbidity and mortality. World War I and II shifted the science-base for nursing to an apprentice model, where nurses were serving physicians and a labor source for hospitals. During this period, task orientation prevailed as physicians came to dominate nurse practice. By the 1970s, nursing science once again prevailed and today forms the foundation for evidence-based practice.

The medical model of care is oriented to the diagnosis and treatment of disease, an upstanding and critical social contribution. The nursing model of care is no less important. It includes health promotion, symptom management, disease abatement, and care coordination for individuals, families, and communities. Nurses, unlike most physicians, practice in all of these arenas. The Affordable Care Act and the advancement of population health elevate the opportunities for use of a nursing model of care, in concert with the medical model already in place. Economic factors and reimbursement shifts will highlight the value of each discipline in the near future.



Nursing Education

Nursing education has taken on several forms, which confuses the public, particularly because all nurses take the NCLEX-RN examination in order to practice in the United States (and now, Canada) through the National Council of State Boards of Nursing. This examination does not test for optimal knowledge. It tests at the application level to determine if a candidate meets the foundation for safe entry-level practice. The blueprint for this examination is used by nearly all schools to ensure adequate pass rates and to ensure that nursing curricula contain field-based clinical demands.

From the Nightingale science-based model, diploma programs expanded using the medical model described above. National nurse leaders worked to align nursing as a profession by stimulating college-based programs. The associate degree nurse was intended to be a technical nurse at its onset (this never materialized) and the baccalaureate nurse (the bachelor of science in nursing) was the professional entry. For reasons of supply and demand and societal pressures, all programs led to single licensure, with little role differentiation.

In the past year, for the first time, the number of nurses with a bachelor's degree nationally has outpaced those graduating from community colleges and diploma nursing programs (of which very few remain). Science has demonstrated repeatedly that—given the complexity of clinical dynamics, shifts in technology, and more—the higher educated nurses contribute to the reduction of morbidity and mortality in hospitals and health systems. Some states and healthcare organizations are moving to regulations that allow nurses to enter the field with an associate degree, but they must achieve the B.S.N. within a defined timeframe. The B.S.N. is the international standard and it appears that the U.S. may be moving in that direction.

Beyond basic practice, nurses are now engaged in advanced practice—securing degrees at both the masters and doctoral level. Known as APRNs (advanced practice registered nurses), there are four types that fit this category: nurse practitioners (largest in number), nurse midwives, nurse anesthetists, and clinical nurse specialists, nearly all requiring a graduate degree and national certification (given that each state can define its own regulations, there are slight variations). Within nursing, two doctoral degrees exist: the Ph.D. (preparing nurse scientists) and the D.N.P. (the practice doctorate). Board members may question whether advanced education is necessary. Simply, yes. Nursing has infused a much needed primary care workforce to manage some of the most underserved populations. Interprofessional science is addressing many of our nation's most perplexing health problems that extend beyond disease, therefore, enriched by the nursing model.

Nurse practitioners are educated and certified for the population they will serve. For example, the family nurse practitioner (FNP) is prepared to address primary care needs across the lifespan. The psychiatric and mental health nurse practitioner may be certified for children and/or adults. The acute care nurse practitioner is certified to focus on the population of patients in the

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Getting Ready for Population Health

BY RITA E. NUMEROF, PH.D., AND MICHAEL N. ABRAMS, M.A., NUMEROF & ASSOCIATES, INC.

Healthcare delivery in the U.S. is entering a period of business change that is likely the most profound in its history. Driven by unsustainable levels of cost inflation, providers are being challenged by payers to adopt a new business model in which they accept greater accountability for the total cost and quality of care.

In a population health model, delivery organizations commit to providing comprehensive care to a designated segment of patients at an agreed-upon price with specific quality guarantees. Success will require dramatic changes in the management of clinical cost and quality, and in where, when, and how care is delivered.

The Centers for Medicare and Medicaid Services (CMS) is the country's largest payer and, by default, in the best position to lead this change. Under pressure to curtail cost inflation that threatens to overwhelm the national budget, CMS is becoming more aggressive in its efforts to force change on a system that nearly all agree is seriously flawed.

The CMS Bundled Payments for Care Improvement Initiative (BPCI) was one of many pilot programs implemented as an outgrowth of the Affordable Care Act (ACA) in 2010, intended to test new models and encourage hospitals and health systems to assume greater risk for care episodes. While participation in BPCI and numerous pilot programs that followed has been voluntary, Medicare is now introducing new bundled payment models where participation is mandatory. The recently implemented Comprehensive Care for Joint Replacement (CJR) program mandates that 800 hospitals in 67 selected metropolitan statistical areas across the country accept bundled payments that cover knee and hip replacement surgery from initial hospitalization through rehabilitation to 90 days post-surgery. CJR is indicative of where CMS is going, and we expect to see similar bundled payments in other high-cost, high-utilization therapeutic areas.

Key Board Takeaways

Population health management represents a new business model in care delivery that forces providers to take accountability for cost and quality. However, it requires dramatic changes that run counter to established cultural norms. Successful transition must be accomplished with active guidance from the board. Now is the time to assess where your organization is in its ability to successfully handle value-based payment initiatives, and where you want to be in the future. Based on the results from Numerof's national survey on the state of population health, below are five steps for the board:

- Develop a clear vision for population health and plan to operationalize it.
- Communicate the vision broadly.
- Allocate resources to develop necessary capabilities.
- Identify where partnerships are needed.
- Hold staff accountable for implementing the organization's plan and achieving results.

The ACA also introduced measures intended to hold delivery organizations accountable for quality shortfalls like medication errors, hospital-acquired infections, and excessive 30-day readmissions. The net effect has been to pressure delivery organization finances and spotlight quality and safety systems. CMS remains focused on the "Triple Aim" of improved patient experience, improved health of populations, and lower per capita cost. Through its efforts to test other payment models, CMS is also making it clear that the fee-for-service (FFS) payment model that has characterized the current care delivery landscape is going to be replaced by one in which providers accept risk for the quality and cost of the treatment they provide.

In light of the growing pressure to rein in costs and improve quality, delivery organizations are increasingly looking at population health management as a way to transition to what has been labeled a value-based payment model. The goal of population health management is to keep patients out of acute care settings, lowering overall costs and redefining "healthcare" as more than just "sick care." Unlike the current model, providers must coordinate treatments delivered across the entire care continuum—from preventative care programs to post-acute care settings. However, operating in this model will require many delivery organizations to make significant changes that run counter to established cultural norms. To complicate matters further, many of the pilot programs initiated by CMS incorporated improvement from historical baseline efficiency into payment, raising concerns for some that initiating change too early might actually penalize them.

Given that today's payment model is still predominantly FFS, many hospital boards and executives are scratching their heads and asking themselves two key questions:

1. When should we make the move to population health?
2. And where do we start?

When and Where to Get Started

Now is an opportune time for organizations to determine the direction they want to take, recognizing that the scale of operational and cultural change necessary in transitioning to a new business model requires time, and the clock is running. There are potential costs to being a leader, but there are also potential competitive advantages. And there are definitely potential costs in being a follower or a laggard. In any case, taking action now to prepare for population health is the only responsible choice for those with fiduciary accountability. In addition, the ability to manage variation in cost and quality that is central to population health can actually enhance margins in the current model while positioning the organization for competitive advantage going forward.

Developing bundled pricing for an acute procedure like hips and knees in the CJR bundle can be a reasonable starting point for transitioning to population health. Such an acute procedure has a clearly defined beginning, middle, and end. Once an organization develops the necessary infrastructure and builds the capabilities to manage variation in cost and quality, it can leverage that experience to tackle more challenging areas like the many chronic conditions that account for major care expenditures. Those that learn how to do this quickly can create competitive advantage in the marketplace and can leverage that position with payers, employers, and consumers. In order to provide hospital executives with appropriate guidance and support as they work to transition their organizations, boards of directors need to understand not only what population health is, but also what it will take to transition to a new model. Boards that understand the challenges and obstacles their organizations face will be better prepared to ensure success.

Indications are that CMS is determined to drive business model change in the industry, and that value-based approaches are increasingly on executives' minds. Yet there has been little data available to characterize the status of implementation. To address this, Numerof & Associates partnered with David Nash, M.D., Dean of the Jefferson College of Population Health on a multi-phase assessment of healthcare delivery organizations across the U.S. The first phase consisted of in-depth interviews with healthcare executives nationwide. A survey was deployed for the second phase to quantify the progress organizations have made in population health efforts. (For additional information about the methodology, see the sidebar "Numerof State of Population Health Survey: Methodology.")

Numerof State of Population Health Survey: Methodology

During the qualitative phase of the survey between January and June 2015, Numerof conducted 104 in-depth interviews with executives and key decision makers across healthcare delivery organizations nationwide. Special efforts were made to include a variety of viewpoints based on such factors as region, organization type, organization size, and individual role. Interviews were conducted via telephone using a structured interview protocol that explored areas including the definition of population health, state of progress, roadblocks toward implementation, and rationale for pursuing it.

In the quantitative phase between June and July 2015, Numerof developed an online survey to validate and further explore key insights gathered during the qualitative phase. Approximately 8,750 individuals were invited to participate. The target audience for the survey was defined as individuals working in U.S. provider organizations, including healthcare systems, hospitals, and academic medical centers at the executive or vice president level.

Numerof received 315 completed surveys, corresponding to a response rate of 3.6 percent of individuals and 11 percent of institutions. Respondents included C-suite executives across the entire U.S. in urban, suburban, and rural areas. They represented standalone facilities, small systems, and IDNs; for-profit and not-for-profit institutions; and academic and community facilities.

There were 305 responses that passed the inclusion criteria, which required that respondents work for a healthcare delivery organization or physician practice as well as have at least partial knowledge of their organization's current population health management efforts.

Going forward, Numerof and Dr. Nash have committed to conducting the quantitative survey on an annual basis in order to track the evolution of population health management over time.

Key Research Findings

Based on the results of both the qualitative interviews and quantitative survey, a series of key themes emerged that characterize the provider market with respect to population health management at this time.[1]

1. Definitions of Population Health Vary Greatly, with Implications for Pace and Prioritization of Initiatives

During the qualitative interviews, organizations provided various definitions of "population health." Some defined it more narrowly (e.g., primarily focusing on wellness), while others saw it as a much broader initiative that includes full accountability for patient populations in a given community. Several even reported multiple definitions being used internally, resulting in heightened confusion across the organization.

Talking about her recent struggles with achieving alignment, the senior vice president of a large health system said, "There are many different definitions of population health in the organization, and this is part of the challenge."

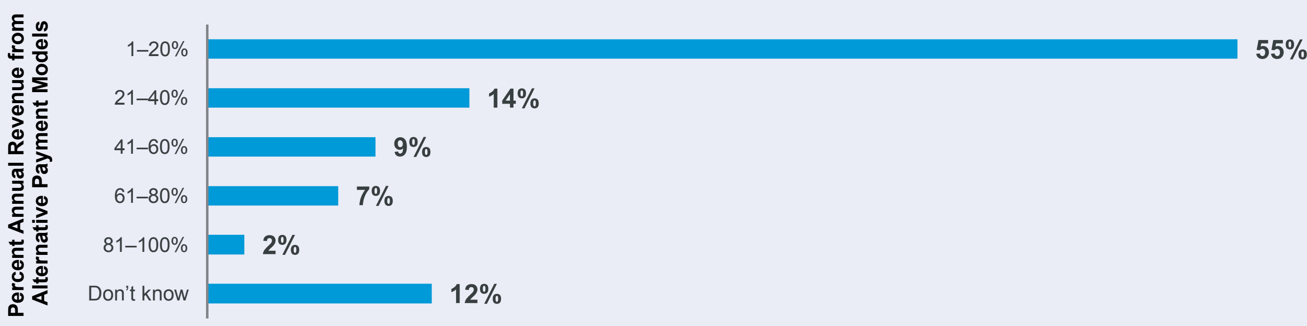
Overall, how population health is internally defined has real implications for the pace at which the organization can move forward on its value-based initiatives as well as what specific initiatives are prioritized over others. Not surprisingly, organizations with a clear and focused approach to population health management were generally much further along than those without clarity and focus.

2. Many Are Exploring Alternative Payment Models, but Most Are Still Waiting to Take Bold Action

Although a significant majority of organizations are actively exploring alternative payment models, overall progress thus far appears limited.

Nearly four in five respondents (79 percent) reported that their organization is in at least one agreement with a payer that includes either upside gain or both upside and downside gain/risk. For organizations engaged in these types of arrangements, approximately half were in upside-only programs, while the

1 Portions of this section are from *The State of Population Health: Numerof Survey Report* conducted by Numerof & Associates in collaboration with Dr. David Nash, Dean of the Jefferson College of Population Health, released in January 2016.



other half were participating in at least one agreement with both upside gain and downside risk.

However, regardless of the exact structure of these agreements, most organizations have limited exposure to them (see **Exhibit 1**).

Over half of respondents (55 percent) reported that 20 percent or less of their organization's revenues currently flow through these agreements. This suggests that many organizations are still focused on small experiments and/or pilot programs (e.g., CMMI pilots), a hypothesis that's strongly supported by the findings from the qualitative interviews.

Most interviewees described these programs as important business model experimentation. For instance, the Senior Vice President of Population Health at an academic medical center clearly laid out the impetus behind the move to risk. "With respect to bundles, we've done work in different areas to standardize care. This is a good opportunity—we haven't done an episode to include post-acute care, where the opportunity really is. CMS doesn't care too much from a cost perspective on how the DRG is managed—they just pay the DRG. So the real issue is the 90 days after that. We've done a lot of good work, but not outside our institution. Now we have an 'opportunity'—we *have* to do this and focus on our relationships with SNFs, home health, etc."

When we looked at the data in Exhibit 1 in terms of which organizations are farthest along in readiness for population health, we found that those organizations most confident of readiness, (i.e., Leaders; see sidebar "Defining Leaders, Followers, and Laggards" for definitions) are moving more of their revenue potential into at-risk models (see Exhibit 3 on the following page).

Defining Leaders, Followers, and Laggards

Through our in-depth qualitative interviews, we identified systems and processes that were consistently in place at hospitals engaged in population health management. We present the results here in three categories: Leaders, Followers, and Laggards.

Survey respondents were categorized into one of three groups based on their self-reported readiness for at-risk payment models on a seven-point scale, now and in two years, with one representing "Not At All Prepared" and seven representing "Completely Prepared." Leaders were defined as those reporting their current readiness as a six or seven (n=61); Followers were defined as those who reported their current readiness as a five or below and their readiness in two years as a six or seven (n=121); and Laggards were defined as those who reported their readiness in two years as a five or below (n=123).

In summary, Leaders reported that their organizations were ready to take on financial risk now, and felt that they had key components in place. Followers described their organizations as not ready for financial risk today, but expected they would be in two years. Followers are committed to working to make the transition and are in the middle of putting supporting structures in place throughout the organization. Laggards described their organizations as not ready for financial risk today, and also not ready to assume financial risk within the next two years. Although many Laggards have started the transition, they describe their organizations as being in the early phases of that work.

3. Culture Is Critical for Success

In the survey, respondents reported numerous reasons for engaging in population health, including better control of cost, quality, and outcomes; concerns about the viability of the current FFS model; and mission/cultural alignment. They were also asked to select the primary factor for pursuing population health from a list of reasons that were frequently cited in the interviews. Leaders most frequently cited mission/culture as a primary rationale (see **Exhibit 2** on the following page).

> Boards of directors need to understand not only what population health is, but also what it will take to transition to a new model. Boards that understand the challenges and obstacles their organizations face will be better prepared to ensure success.

In many ways, Leaders have made the most progress toward alternative payment models and population health management. Compared to others, these organizations are more likely to move significant portions of revenue to at-risk models (see **Exhibit 3**). Leaders also rate their ability to manage variation in clinical cost and quality significantly higher than others (see **Exhibits 4** and **5**).

These findings are consistent with the qualitative interviews. Discussing his organization's culture, the CEO of a leading medical institution said, "Historically, we've been a leader in addressing the challenges facing healthcare—it's part of our culture and mission statement." These organizations also reported facing fewer challenges in achieving clinician "buy-in" on population health management, since it's widely viewed as "the right thing to do." In some cases, organizations are even able to make significant strides toward value in markets still dominated by FFS. In the words of the CEO of one such system, "Currently, only a small percentage of revenue is driven by at-risk agreements—most of the market is still FFS…[but it's] part of our mission to provide the best care for patients."

Not surprisingly, culture can be a significant roadblock for organizations pursuing population health. Among survey respondents, two of the leading challenges/barriers to pursuing population health management are related to cultural issues (difficulty in changing the organization's culture and resistance/lack of buy-in from physicians) (see Exhibit 8 on page 10).

The importance of culture came up repeatedly in our interviews with executives. Those interviewed noted that without a strong existing culture focused on achieving quality outcomes in a team-based approach, modifying behavior can be very challenging, especially when the organization is still profitable under FFS. Talking about culture, the CEO of a large academic system said, "People will say 'We don't have time for a culture change!' Well, sorry, you can't just flip the switch!" On this same topic, another CEO stated, "Internally, people have to change their way of thinking, especially those who have been focused on filling beds for many years. The waste in the system is someone else's revenue."

4. Collaborations Are Key

Although some larger healthcare networks "own" the entire continuum of care, many of the organizations that participated in the interviews noted that they've opted for partnerships and collaborations instead. According to the CEO of a large healthcare network, "We can't be all things to all people!" A common theme among organizations making progress toward population health has been the ability to forge deep relationships with entities across the care continuum. These relationships have enabled the development of an infrastructure for monitoring and measuring the performance of these partnering facilities.

There were several notable success stories from the interviews, including that of a provider organization primarily made up of a network of physician groups. Given

Exhibit 2: Primary Driver for Pursuing Population Health Differs in Leaders and Laggards

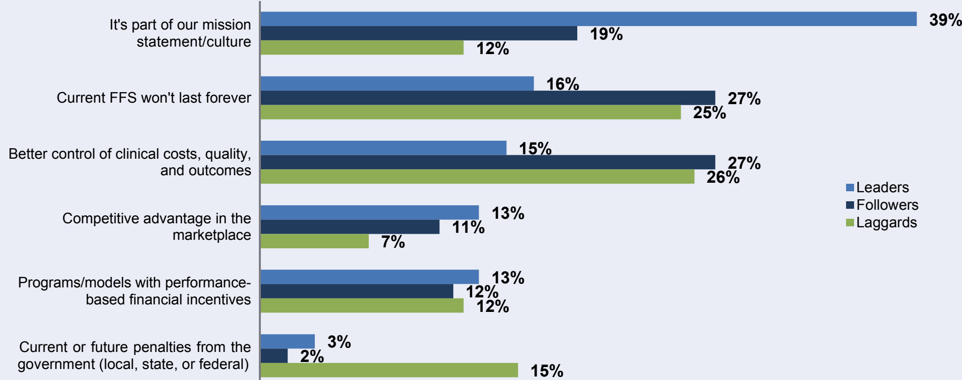


Exhibit 3: Leaders Are Moving Significant Portions of Their Revenue to At-Risk Models

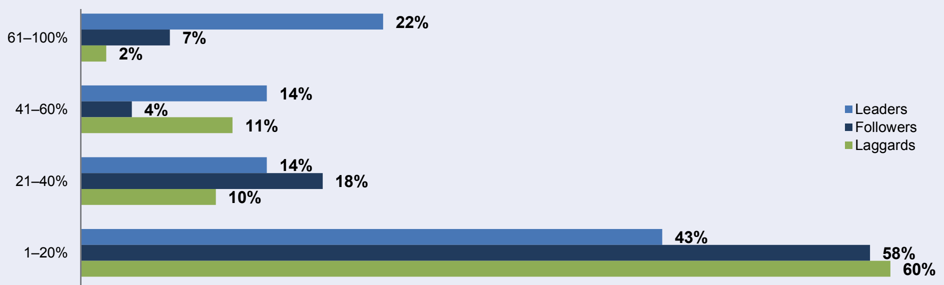


Exhibit 4: Ability to Manage Physician Variation in Cost

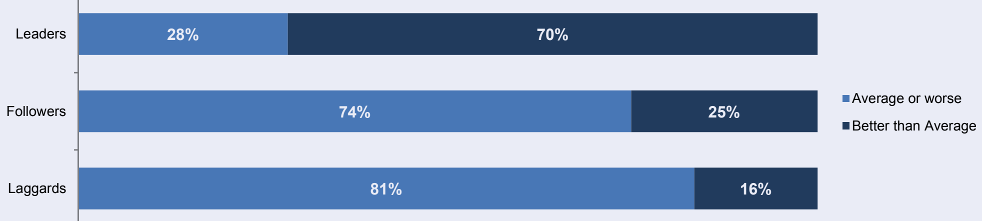


Exhibit 5: Ability to Manage Physician Variation in Quality

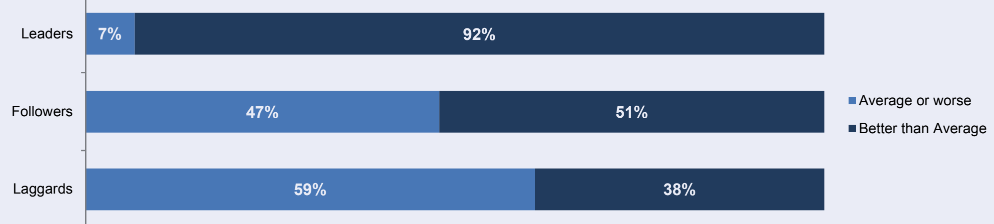


Exhibit 6: The Extent of Coverage across the Continuum: Ownership and Partnerships/Alliances

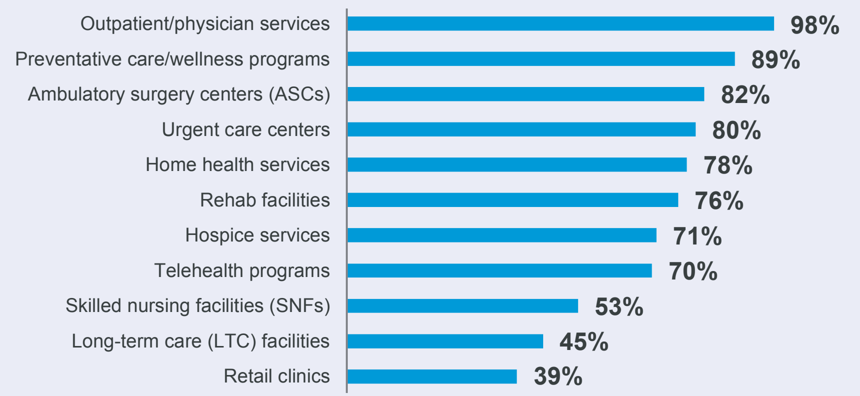
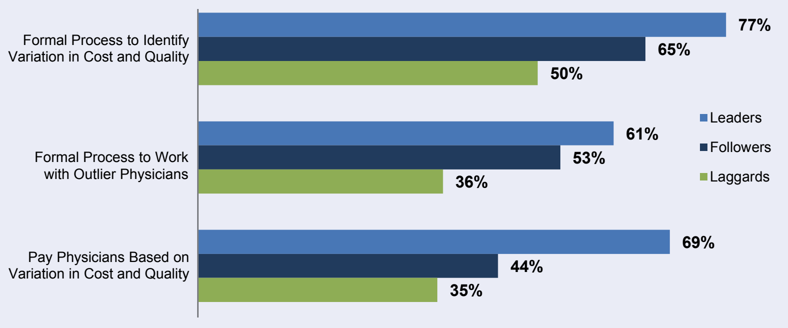


Exhibit 7: Leaders Recognize Importance of Formalized Process for Managing Variation



the organization's unique business model as well as its involvement in a very competitive market—where payers have moved aggressively to at-risk payment models—it has had to develop strong partnerships across the entire care continuum. This includes a joint governing structure with partner facilities in which key metrics are mutually developed and continuously tracked through comprehensive reporting. When partners don't meet their goals, the organization works directly with them to improve performance.

Another example further illustrates the importance of partnerships—especially with at-risk vulnerable populations. Coordination and alignment with internal and external partners are critical components of success for a Midwestern system. Externally the organization has formalized partnerships with food banks, homeless shelters, and faith-based nursing homes. These partnerships enable it to ensure that when patients leave its system, they have a place to go to continue their healing. Ensuring a successful transition is also part of its internal focus. A group of RNs, social workers, and care coordinators work collaboratively to ensure care transitions occur with minimal disruption to care. Finally, the organization trains its physician partners to recognize the "doorknob moment"—that point when he or she is about to exit the room and asks the patient if there is anything else they should discuss. It's at this point that patients often share additional factors (like something happening at work or within the family unit) that might be contributing to the symptoms they had been discussing.

No matter the approach, most organizations, regardless of if they are Leaders, Followers, or Laggards, have extensive coverage across the entire care continuum (see **Exhibit 6**). In addition to traditional areas of focus like outpatient/physician services, a significant majority of respondents reported that their organization either owns or has partnerships with urgent care centers (80 percent), home health services (78 percent), rehab facilities (76 percent), hospice services (71 percent), and telehealth programs (70 percent). Nearly four in 10 (39 percent) respondents cited retail clinics as part of the mix, which we expect will be more prevalent over time.

5. Managing Variation in Cost and Quality Remains a Significant Hurdle

Respondents generally feel that their organization has room for improvement in managing variation. About two in three respondents (68 percent) rated their organization's ability to manage variation in cost at the physician level as "average" or worse, while more than two in five (44 percent) consider their organization's ability to manage variation in quality similarly in need of improvement.

Although it appears that many organizations are taking steps to manage variation in cost and quality, Leaders recognize the importance of managing variation and are more likely to have established a formalized process for doing so (see **Exhibit 7**). In addition, they are more likely to have a formalized process for addressing outliers and structure physician pay based on variation in cost and quality.

Although interviewees didn't typically identify the challenge of managing variation in cost and quality spontaneously, further exploration identified it as a critical roadblock for most. When prompted to discuss how well they were performing in this area, many organizations stated that progress had thus far been slow.

In discussing this topic, a senior vice president of a well-known health system said, "[Managing variation] is at a stage of infancy, and we're just starting to do some of this work within treatment areas.... Traditionally, we've been inpatient focused. Yet even here, we've struggled to understand variation in cost and quality." In addition, some interviewees specifically indicated that their organizations hadn't yet expected physicians to control cost and quality, even when they might have the data to do so. According to the CMO of a regional health system, "The biggest challenge [in managing variation in cost and quality] is getting actionable data to folks and getting people to understand the value [of this data]."

6. Having the Appropriate Systems, Platforms, and Benchmarks Represents a Significant Roadblock

In the survey, respondents identified issues with internal systems (e.g., IT, tracking, management) as the leading challenge/barrier to pursuing population health management (see **Exhibit 8** on the following page).

These findings are consistent with the results from the qualitative interviews, which found that many organizations struggle with acquiring the data necessary

for supporting their population health management initiatives. Of particular note are problems with accessing data outside of the "four walls" of the provider organization. According to a senior vice president at a regional academic medical institution, "We have good data to show what happens within our walls, but we have a hard time accessing data in the post-acute setting. Seventy percent of the utilization is occurring in places we don't have much data about."

However, even when data is available, it can be difficult for providers to create actionable insights. In discussing this topic, a senior vice president at a leading academic medical center said, "There are registries going back 20 years with quality data, risk scores, etc. However, it's been difficult to create actionable information."

7. Organizations Are Struggling with When to Make the Transition from the Current Model

From both the interviews and survey, it's clear that executives and decision makers increasingly believe that the current FFS model won't last forever, but there's also significant hesitancy in how—and when—to move forward. Among survey respondents, two of the leading challenges/barriers to pursuing population health management were concerns over potential financial losses and the timing of the transition (see Exhibit 8).

Exhibit 8: The Primary Challenge/Barrier in the Pursuit of Population Health

During the interviews, some talked about "bad memories" from previous healthcare reform efforts, and how these are influencing organizational receptivity to change. According to a vice president at a nationally recognized academic medical center, "We're in the early stages of our population health efforts…however, we're hesitant given previous experiences with capitation. In the 1990s, we aggressively pursued capitated payments, resulting in about $200 million in losses."

This reluctance was especially common in markets where there hasn't been the regulatory "push" to transition to value-based models of care or where organizations are still financially successful under the current FFS environment. There was also the feeling among several interviewees that some long-serving executives—especially those nearing retirement—aren't interested in enacting comprehensive change.

In the words of the CMO of a large health network, "Some executives are saying, 'I just hope that the changes don't happen until I retire!' The fee-for-service model has been profitable for a long time, and population health goes against this." However, given the rate at which the market is currently evolving, a "wait-and-see" approach is a potentially dangerous strategy for providers.

We heard one anecdote that illustrates an important source of the underlying ambivalence that delivery organizations have regarding the adoption of a population health model of care, and the values that drive early adopters to move to action. In our interview about their progress toward population health, the CEO of a regional health system shared her successes in targeting a specific chronic disease subpopulation—diabetic expectant mothers—and taking steps that cut the cost of care. By working with community support organizations, families, patients, and primary care physicians, she had saved the community over $2.5 million compared to the expected cost of caring for these patients. Unfortunately, in doing so, she had cost her own institution over $600,000 in foregone acute care revenue. She had done so knowing that she would incur a cost because, as an institution driven by religious values, it made sense to take steps to mitigate the pain and suffering that accompanies diabetes when it's not adequately managed.

Exhibit 9: Designated Leadership Plays a Role in Population Health

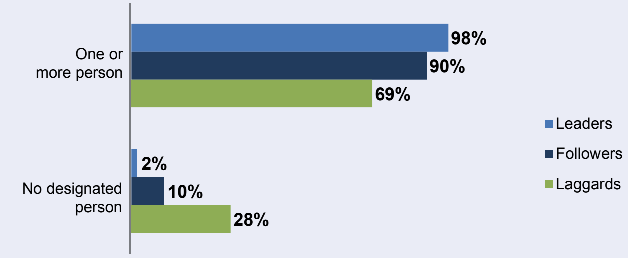
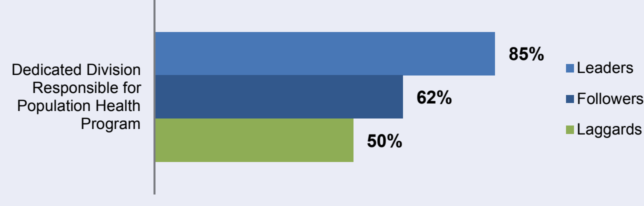


Exhibit 10: Creating a Division for Population Health Helps Organization Focus



She also saw the project as a learning exercise, and reaped important lessons. But, she cautioned, her freedom to make societal contributions at the expense of her own organization was limited. She had not yet found ways to recoup the acute care revenue she had foregone, and would need to do so if she was going to apply what she had learned more broadly.

8. Clear Accountability for Population Health Initiatives Is Associated with Progress

Although most organizations have established at least some form of leadership structure around their population health management initiatives, individual approaches appear to vary greatly. Almost all of the Leaders and 90 percent of the Followers have at least one person responsible for population health management (see **Exhibit 9**).

Similarly, Leaders recognize the importance of giving visibility to population health initiatives and frequently create a division focused on population health initiatives (see **Exhibit 10**).

Although it's difficult to directly attribute leadership structure as a key determinant of achieving progress, findings from the qualitative interviews do provide support for this idea. In discussing the leadership for their population health management initiatives, interviewees with multiple individuals leading these efforts tended to describe it as a loose arrangement between executives, rather than a formal structure with defined responsibilities. Given this observation, it's not unreasonable to expect that organizations with someone who is formally in charge of population health management generally will be further ahead than those in which accountabilities are dispersed across multiple individuals and potentially not clearly defined at all. As in other areas of business, clear accountability for results tends to yield better results.

Implications for Boards of Directors

The survey results reinforce the conclusion that building a model for population health is a significant undertaking. Organizations need to think now about what it will take to be successful in this environment. Boards and executive teams need to work closely together to ensure their organization is prepared and able to succeed in current models while also planning for the future environment.

For organizations that have not yet started the transition, Medicare's CJR presents a great opportunity to begin to operate in a population health environment. Since rates will be established on a regional level, if current costs are higher than average, time and effort need to be spent on reducing costs—and the sooner, the better. This will have implications across the board for operations. However, if an organization's costs are lower than average, there might be a competitive advantage that can be leveraged in today's environment while working to gain favor with key stakeholders like payers and employers.

For organizations with pilot programs in place already, it's time to evaluate those programs, make necessary improvements, and consider expanding into new areas, like chronic care management.

Based on our own experience and the results of the survey, we've identified five key ways in which boards of directors can help position their organizations for success in population health.

1. Ensure Development of a Clear Vision for Population Health and Plan to Operationalize It

Organizations need to develop a clear and consistent definition of value-based care and population health as these become critical organizing principles for priority setting, communications, and operationalizing the vision. Population health is more than a set of competencies; it represents a different delivery model in which ensuring that the right services are delivered by the right people at the right site of care is a core consideration. It is this transformation of the care delivery model that is at the heart of value-based care and population health. A clear vision that is established, agreed upon, and understood by the board, leadership, and executive staff will help focus and accelerate the journey.

2. Communicate the Vision Broadly

Once the vision has been defined, organizations need to develop an umbrella communications and deployment approach so that internal stakeholders understand the new direction. Population health requires more than tweaking current models; it will require functions and individuals to develop new competencies and processes to support the delivery of care and health services across the care continuum. A coordinated communication plan can help to reduce complexity for the organization and decrease the likelihood that people will be overwhelmed during the transition.

The communication plan should also address what this means for external stakeholders like payers, employers, and consumers. Defining what's different about the new model and "connecting the dots" to what the changes mean for these stakeholders will help to create differentiation in their eyes. The more they understand how the new model will enable them to achieve their objectives of better health outcomes and lower costs, the more value they will

see in a particular system. This could have long-term implications for the prices organizations can charge.

> Population health represents a different delivery model in which ensuring that the right services are delivered by the right people at the right site of care is a core consideration. A clear vision that is established, agreed upon, and understood by the board, leadership, and executive staff will help focus and accelerate the journey.

3. Allocate Resources to Develop Necessary Capabilities

The ultimate goal of population health management is to improve the health of a population by engaging patients as consumers in making better choices about their own health, by supporting wellness, and by providing the right care at the earliest practical time at the most cost-effective point in the care continuum. This is a significant departure from current operations at many health systems, and will require developing new clinical, analytic, and coordination capabilities.

At the clinical level, providers will need to develop and implement care protocols based on best practices, clinical guidelines, and peer-reviewed literature. New analytic capabilities will be required to support implementation of new clinical practices and goals, identify opportunities to manage variation in cost and quality, and facilitate alignment of incentives across the organization. In addition, a new approach to financial analytics should tie new cost accounting capabilities to relevant clinical units, putting information about the cost ramifications of different clinical behaviors into the hands of those who will be held accountable. Also, processes for ensuring care coordination across the continuum will be required.

Boards need to take a critical look at resources to ensure that funds are directed toward those activities that will enable them to build effective and sustainable capabilities. In addition, serious consideration should be given to requests to add space for more acute care beds. In light of the move to providing care at the lowest cost possible, a better decision might be to repurpose acute care beds for long-term care, rehab, observation units, and other points of care along the continuum.

4. Identify Where Partnerships Are Needed

One of the key factors for success in a population health model is the ability to manage transitions and variation in cost and quality. This requires working across the entire care continuum—from preventative care programs to post-acute facilities. Boards need to work with staff to identify which partnerships will add the most value across the care continuum to their population health offering. Based on these insights, they can then work to structure appropriate partnerships. Ownership of these partners is one option, but not a requirement for population health. Instead, strong relationships can be built and processes designed to ensure appropriate monitoring and performance measurement. Whether the partner is owned or based on a performance agreement, boards should ensure that specifics of the partnership, including expectations and metrics, are clearly defined in advance and progress is monitored.

5. Hold Staff Accountable for Implementing the Organization's Plan and Achieving Results

Implementation of a plan for population health will not happen on its own; it will require a well-orchestrated effort across a disparate group of stakeholders. The board should work with the executive leadership team to define the desired results and key milestones that need to be accomplished. Information should be made available to the board on a regular and timely basis so it can track progress and determine if results are being achieved. When goals aren't being met, leadership should be accountable for explaining why and for developing countermeasures in order to meet targets.

Population health is a comprehensive solution. When properly implemented, it can reduce overall healthcare costs, improve the quality of care, and create a source of differentiation for a healthcare delivery system. Getting to this new model will require a coordinated effort by board and executive leadership. Given the rapidly evolving market and the acceleration of value-based payments, adopting a wait-and-see approach has become exceedingly risky. In our opinion, the time to act is now.

The Governance Institute thanks Rita E. Numerof, Ph.D., President, and Michael N. Abrams, M.A., Managing Partner, at Numerof & Associates, Inc. for contributing this article. They can be reached at rnumerof@nai-consulting.com and mabrams@nai-consulting.com. The authors would like to thank Kimberly White, Eric Abrams, and Kelsey Tinkum for their contributions to this piece.

Leading an Organizational Turnaround

BY KEVIN J. MILLER, FACHE, RHIA, MILLER HOSPITAL CONSULTING & INTERIM MANAGEMENT

U.S. hospitals and health systems today are increasingly finding themselves in the throes of financial and operational crisis.

MedPAC's latest *Report to the Congress* stated that in 2014, hospitals' aggregate Medicare margin was -5.8 percent.[1] In 2011, MedPAC reported that 64 percent of hospitals lost money on Medicare patients. And, according to the American Hospital Association, "In 2013, two-thirds of hospitals lost money providing care to Medicare and Medicaid patients and nearly one-fourth lost money overall."[2]

Recognizing that Medicare and Medicaid make up more than half of the typical hospital's patient revenue, our nation's healthcare organizations have a serious and escalating problem.

Common Reasons Behind a Failing Organization

What's causing healthcare organizations to fail? In my experience, the answer usually goes well beyond the issues of declining reimbursement and increasing costs.

Dunn and Bradstreet's research showed that 96 percent of businesses in America fail due to managerial incompetence.[3] Research done by Jessie Hagen of U.S. Bank revealed several common reasons why businesses fail:

- Poor cash flow management skills and understanding
- Lack of a well-developed business plan
- Being overly optimistic about achievable sales, money required, and what needs to be done to be successful
- Not recognizing, or ignoring, what they don't do well and not seeking help from those who do
- Minimizing the importance of promoting the business properly
- Insufficient business experience
- Inability to delegate properly—micromanaging or over-delegating and abdicating important management responsibilities
- Hiring the wrong people

After having led four successful hospital turnarounds, I would add a few more reasons:

- Lack of adequate controls and/or processes to contain expenses and/or increase productivity
- Inadequate knowledge of operations by management and leaders
- Lack of accountability and monitoring
- Overstaffing and absence of productivity benchmarking

Key Actions in Implementing a Turnaround

When I'm engaged as a CEO in a hospital or health system turnaround there are a few things I normally do. First of all, it takes a different type of leader during an organizational turnaround. The turnaround CEO must be very willing to change things, people, processes, and ideas. This is no time for unguarded sentimentality. I remind myself and my management team, on a daily basis, to look for the "homerun hits." I don't apologize for micromanaging during a turnaround. I become paternalistic. As a turnaround leader, it is important to control as many activities as possible. I do my best to eliminate unnecessary bureaucracy and extreme or long analysis of information before making decisions.

The board should require the CEO to give it a turnaround plan and regular updates on significant issues, but refrain from getting into operations. One sure way for a turnaround to fail is to have the organization run by committee. I cannot emphasize this point enough.

Below are key actions that a CEO should take when leading a turnaround:

- Immediately meet individually with the top 20–25 physicians as determined by volume of business, leadership position, respect from their peers, etc. Be sure to include physicians who are the loudest critics. Ask each physician for the top two to three things they would do first if they were serving as CEO. Also, ask them for their single biggest frustration with the organization.
- Tighten down the entire purchasing process. Both the CEO and CFO should sign off on all purchase requests. By doing so, they will quickly determine the people who require additional oversight as well as the baseline for what departments need versus what they desire. Keep this up for no less than six months. Most leaders are shocked by the automatic reduction in expenses when the staff knows that the CEO is reviewing all requests.
- Require the purchasing department to inform the CEO whenever someone wants to purchase outside of the GPO contracts at a higher price.
- Closely monitor purchased services. I always insist that no one in the organization engage legal counsel and/or consultants without my prior written approval.
- The majority of a healthcare organization's expenses are salaries, wages, and benefits. Immediately require all new or replacement position requests be approved by the CEO.
- Use an external productivity benchmarking system in order to make objective staffing decisions. Personally, I strive to be at the 35th percentile of staffing in each hospital department compared to its peer group. Generally, the bulk of your cost savings in a hospital will be found here.
- Reduce overtime hours to no more than an average of 3 percent hospital-wide and significantly reduce, if not eliminate, agency or temporary staff utilization.

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Key Board Takeaways

All healthcare organizations are being financially challenged. If this issue is complicated by other factors, it can easily and quickly threaten the organization's survival. These "other factors" usually fall into the general categories of ineffective leadership; a lack of accountability, monitoring, and controls; and absent or ineffective routine business practices. Some of the most important steps to consider or take when a turnaround is necessary include:

- Determine if the current CEO can lead a turnaround or if you need someone with turnaround expertise.
- Immediately put controls in place to get a handle on all forms of expenses, including labor.
- Determine, objectively, if the organization is overstaffed.
- Seek input from key physicians, managers, and line staff.

1 *Report to the Congress: Medicare Payment Policy*, MedPAC, March 2016.
2 "Hospital Billing Explained," American Hospital Association, March 2015.
3 Critical Care Companies, "Step 1: Why Do Businesses Fail and What You Can Learn from These Failures."

Baptist Health Lexington...

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are available to consult on potential red flags).
- Conduct a safety assessment.
- Help the patient connect with needed community-based services such as meals, transportation, and respite care.
- Assure follow-up appointments.
- Coordinate with home health.

Patients are invited to participate in the program based on their risk score. They are seen at home, as well as in rehab/skilled nursing facilities. The hospital pays health coaches on a per-patient basis for identified high-risk patients to offer support 30 days post-discharge.

This program is one example of the way hospitals can network with other community organizations to support patient health. In one typical story from the early days of this collaboration, a nurse called a discharged patient to check their medication list. This patient had been given new medications while in the hospital, but didn't understand he was supposed to stop taking his previous medicines. Unintended double doses of similar medications could have led to negative results. In this case, a pharmacist was able to review all the medications with the patient and explain exactly which ones to take.

During the first 18 months of the project, the hospital compared patients in the pilot program to similar patients who did not receive these services. Those in the pilot program had an 8.5 percent readmission rate, while those who were not in the program had a 14 percent readmission rate. Because it has been so successful, the program was recently expanded to cover post-stroke patients as well.

Hospital Board Supports a Culture of Excellence

Our board is strongly committed to quality and we spend a significant percentage of time in board meetings discussing quality issues. The board asks difficult but appropriate questions, and we appreciate the way it challenges us to improve.

Ultimately, our goal is to do the right thing for our patients. This shows up in something like the new atrial fibrillation center, mentioned above, which in 2014 became the first accredited atrial fibrillation center in the United States. Similarly, we've been named a Magnet hospital for nursing three times, which is quite an unusual achievement.

Because of consistency in leadership, it has been possible to build a level of confidence and trust over time as part of our culture. Maintaining a consistent vision gives everyone an understanding about what's important. Everyone who works at this hospital understands that our culture is about offering every patient excellent care. This philosophy is working. We've been profitable and able to expand our facilities. At the same time, we are careful with our resources so we can use them in a way that yields the maximum benefit for our patients and the communities we serve.

The Governance Institute thanks William G. Sisson, FACHE, President at Baptist Health Lexington and Regional Executive for Baptist Health System, East Region, for contributing this article. He can be reached at bsisson@bhsi.com.

Leading an Organizational Turnaround

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- Hire an external employee benefits consultant and have her/him recommend benefit cost savings and renegotiate your benefit plan and costs with carriers. There are always savings to be had.
- Review the highest dollar value vendor contracts. Determine and eliminate ones that are no longer necessary and for those contracts that you must keep, attempt to negotiate a lower price.
- The management team should meet as a group to compile a list of ideas for expenses reduction and revenue enhancement. Turn these ideas into a written plan with due dates and persons responsible. Update it regularly.
- Review the management structure and, if possible, streamline it. This will send a very important message to staff that the management team is not excluding itself from position eliminations.
- Schedule specific hours each week to round on departments and staff. This will allow the opportunity to ask staff for their input on expense reduction and revenue enhancement.
- Review the organization's array of services/products and determine which, if any, lose money and/or don't directly support the organization's mission and should be eliminated.
- Materials management staff should verify that the organization does not keep excessive inventories, have a significant loss history, have a large amount of outdated supplies, etc.
- Reduce corporate credit cards to a very few.
- Slow down and require CEO approval of any out-of-state conference attendance and/or travel.
- Closely monitor all travel and expenses reimbursement requests for excessive use.
- Create a challenging business plan that will ensure organizational survival.
- Communicate frequently and transparently to all internal audiences regarding the progress of the turnaround plan.

Closing Thoughts

When I see an organization in need of a turnaround it is almost always in crisis from both a financial and an operational standpoint. There is, oftentimes, a significant lack of adequate leadership. I, therefore, caution boards to not only focus on the more easily identifiable financial shortcomings. The board should also require an in-depth review of operations and, most importantly, the culture and leadership of the organization.

The Governance Institute thanks Kevin J. Miller, FACHE, RHIA, President, Miller Hospital Consulting & Interim Management, for contributing this article. He can be reached through his Web site at www.millerhospitalconsulting.com or at KJMiller77@aol.com.

What Healthcare Boards Need to Know About Nursing

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acute care setting. The neonatal care nurse practitioner focuses on the population of those infants born prematurely. Note that these populations do not align with a medical specialty focus. As a matter of contrast, physician assistants are trained specifically in the medical model, with rotations through the same as medical practitioners.

The majority of nurse practitioner sponsors for hospital credentialing are physicians. It is not uncommon for a medical specialist—using cardiology as an example—to enrich a medical practice with a nurse practitioner. If a FNP is used in this cardiology practice, it must be done with training beyond that provided in an FNP program (which is a primary care across-the-lifespan training emphasis). Training can be achieved through experience (work in a cardiac unit) and continuing education in the clinical management of cardiac patients. The challenge for hospital credentialing committees is to understand that nature of population-based education and ensure that the education aligns with the role requested. If the advanced education does not "fit" with the medical specialty, then there should be evidence of additional training and experience to ensure safe and effective advanced practice care.

Main Points for the Board

With this primer, I hope that governing boards will understand several things:

- Modern nursing is science-based and encompasses training across the lifespan, in multiple settings, with a focus on individuals, families, and communities.
- The NCLEX-RN examination is an entry-level examination based on field-based applied nursing knowledge. It is used for graduates of associate, diploma, and baccalaureate programs because it is entry-level.
- The medical and nursing model is different, yet complementary to each other.
- The U.S. is falling behind the international standard of the B.S.N. for entry-to-practice and clinical outcomes are enhanced with more B.S.N.-prepared nurses. This year, the national number of nurses graduating with the B.S.N. is higher than that of other programs.
- APRNs add needed workforce, particularly in primary care. With proper education and training, nurse practitioners and other APRNs can enrich hospital and ambulatory programs through credentialing mechanisms that encourage all providers to practice to the top of their scope of practice.
- Credentialing bodies must appreciate the population-focus of the nurse practitioner and not confuse the medical specialty which they may embody in their employment.
- States vary in their regulations. Know your state practice act and certifying requirements.

In summary, an understanding of how nurses are educated at the basic and advanced level can clear up misunderstandings about the levels of their contributions as healthcare employees or as licensed independent practitioners. Board initiatives to support the advancement of nursing contributions to quality and safety are needed; this primer supports communication with nurse and other clinical executives.

The Governance Institute thanks Michael R. Bleich, Ph.D., RN, FAAN, President and CEO of NursDynamics, for contributing this article. He can be reached at mbleich350@gmail.com.

The Volume vs. Value Scale...

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continuum ranging from better nutritional counseling, improved medication management, better monitoring at home, and of course, improved access to the doctor's office.

While it is clear what we should do, the way we pay for healthcare does not support those actions and in fact actually works against us. Over the years, we have become masters at being able to deliver and bill for services and somewhat oblivious as to what is going to get the most bang for the buck. Although we can shift incentives to align the patient's needs with the provider's economics, we do not operate in a single-payer system so changing contracts is not like flipping a switch. Also, when you move the money without changing the care model or infrastructure most systems have failed to get the results they sought. In addition, shifting from one care model to another turns out to be much more difficult than people anticipated.

Transitioning to Value-Based Care

Fortunately, we know what does and does not work. We also now understand the steps required to operationalize a value-based delivery model while still successfully operating a fee-for-service business. All healthcare is local and all successful value-based delivery transformations account for those local market dynamics. Do you have a dominant commercial payer or several payers? Do you have excess specialty capacity or shortages? Are your ORs and beds full? What about ambulatory surgery center (ASC) capacity? Is your cost of care (total and by episode) high or low relative to regional benchmarks? What about your unit pricing and actual costs relative to competitors?

A big part of being successful during this transition is to approach your value-based activities as a separate business. Trying to change the entire system incrementally all at once is a recipe for mediocrity. Better to focus efforts on a specific area or two and fully transition the clinical and economic model. This will allow you to properly align incentives, set up the right metrics, and truly understand just how well you are solving the affordability problem in your market.

The Governance Institute thanks Brian J. Silverstein, M.D., Managing Partner, HC Wisdom, and Governance Institute Advisor, for contributing this article. He can be reached at briansilverstein@hcwisdom.com. The author would also like to acknowledge Rick Weil, Ph.D., Partner, HC Wisdom, for his contributions to this article.

The Volume vs. Value Scale: What Is the Tipping Point in Your Market?

BY BRIAN J. SILVERSTEIN, M.D., HC WISDOM

A prerequisite to participate at the board level of a hospital or health system in the United States is the ability to be comfortable with what appear to be major contradictions. Seemingly simple questions can appear to have wildly different and contradictory answers.

For example, when asked the question "How much of our revenue in three years is expected to be *value*-based and how much will be fee-for-service?" a perfectly acceptable response is "We expect our revenue to be 60 percent value-based in 2019 and 90 percent fee-for-service." Another example is looking at the upcoming board meeting agenda where the topics of how to increase service line volume and how to reduce hospitalizations via population health management will be discussed back-to-back. Psychologists tell us that when presented with such contradictions, humans are highly motivated to reduce the discomfort by selectively ignoring information and/or actively avoiding situations where such topics are discussed—neither of which makes for good governance.

The Current Challenge

How is it that the future of value-based care can seem so clear at the national level—with CMS ahead of its stated goal to migrate 90 percent of Medicare payments to value and 50 percent to so-called alternative payment models (i.e., risk-based models) by 2018—while at the same time being so murky within your market? This contradiction is at the heart of why it is so challenging today to sit on a management team or board of a hospital or health system in the United States. To resolve this apparent contradiction, it is important to start at the root of the problem.

Acute healthcare in the United States is the best in the world. However, only a small portion of people need those services in any given year. Yet, we have designed our delivery system around sophisticated treatments and our payment system has evolved to reward high volumes of those treatments. To bend the cost curve, those who pay the claims have steadily ratcheted down the price per unit. Predictably, providers responded by increasing productivity and efficiency.

A consequence of the above is that though there are fruitful avenues left to pursue to improve both productivity and efficiency, we are nearing the limits of what they can achieve and neither is sufficient to solve the affordability problem. Adding insult to injury, we have materially under-invested in prevention and management of disease resulting in significant variability in cost and quality of care. The prototypical illustration of the current state is the person who has congestive heart failure. This condition is marked by the heart pumping blood inefficiently resulting in fluid backing up in the lungs and the patient feeling short of breath. Changes in diet, minor infections, and deviations from their complex medical regimens can exacerbate their symptoms and tip the balance away from stability toward a health crisis. Fortunately, the process is correctable when caught early. In the early stages of the shift, these patients experience shortness of breath. When this happens most patients call their doctor for an appointment. Unfortunately, it is all too common that their doctor's schedule is full (since they are maximizing productivity) and they cannot be seen for several days when it is too late.

So what happens? Once the patient is in enough distress, we can send an ambulance right away to take the patient to be immediately seen in the emergency department and even given a place to stay for a couple of nights until they are again stabilized. Sometimes we send them to a skilled nursing facility until they are back on their feet. Though the acute care received by the patient is top-notch, all of this could have been avoided at multiple points along the

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Key Board Takeaways

Value-based care is clearly the way of the future, but making decisions related to the transition away from volume is no easy task for the board. Two important pieces for the board to understand are that successfully knowing how and when to migrate from volume to value is:

- Largely dependent on local market dynamics, not national trends
- Necessitates thinking about your value-based business as an entirely new business, not an extension of your existing operations