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Moving up the Integration Pyramid

A Year in Review

The lead article of our February issue, the first of the year, detailed the experiences of one of our members who is participating in the Pioneer ACO program. In the months since, we have read in the news about organizations dropping out of CMS's Pioneer ACO program due to difficulties in meeting cost-reduction goals. Questions have been raised about whether this kind of project can be sustainable and ultimately successful in the future and, along with those questions, a myriad of others regarding how best to structure an ACO for future success.

Now with the results of mid-term elections in, we see more headlines about the potential to unravel Obamacare, possible collapse of Medicare expansion in some states, concerns about technical glitches and privacy issues for the exchanges' open enrollment period, and the Supreme Court set to hear a case regarding subsidies for those participating in federal exchanges.

We have all been hoping that the industry's uncertainty about what the future holds would diminish so we can all get back to the work of providing quality, low-cost care to our patients. Though it seems we must live through a bit more of this uncertainty, 2014 has brought with it a great movement of healthcare organizations towards delivering value in innovative ways, and we know that will only continue and accelerate. We hope this last issue of *BoardRoom Press* for the year 2014 will help further members' efforts to move forward with a bit more certainty.

Kathryn C. Peisert

Kathryn C. Peisert *Managing Editor*

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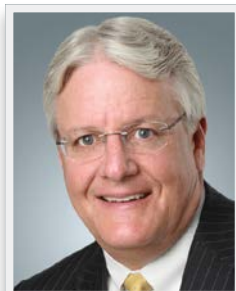*BY MARC D. HALLEY, M.B.A., THE HALLEY CONSULTING GROUP, INC.*

Our Move toward Integration

In response to healthcare trends our industry is consolidating. Health systems continue to merge or acquire hospitals and smaller systems. Hospitals continue to acquire medical practices and to employ physicians. Large medical group practices continue to grow larger by acquisition of smaller practices. Such consolidation in other mature industries is not uncommon, as competition increases and profitability declines.

Physicians, hospitals, and other providers of healthcare services are also attempting to integrate through a variety of methods, including consolidation. Factors driving integration include the need to collaborate across organizational silos in order to optimize clinical quality and service quality, while improving utilization and reducing costs in order to manage population risk.

Effectively managing an entire episode of care or improving the health of those with chronic ailments requires far more than a shared organizational structure. Board members and executive/physician leaders of integrated delivery systems—even those using merger, acquisition, or employment—are often frustrated that their organizations don't *act* like integrated systems. A key indicator of that dysfunction is referral leakage to competing organizations. Another common sign of dysfunction is the inability to hold individuals and organizations accountable for clinical quality, service quality, productivity, or financial viability.

Marc D. Halley, M.B.A.
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The Integration Pyramid

While we admire highly integrated healthcare delivery systems like Mayo Clinic, Geisinger Health System, Cleveland Clinic, and others, most community healthcare delivery systems are not and will never be structured like a Mayo or a Geisinger. Despite fact-finding trips or consulting contracts, our integrated cultures will not mirror those found in Rochester, MN, or Danville, PA. Most community healthcare delivery systems will continue to require collaboration among organizational silos including employed physicians, independent physicians, hospital departments, acute care settings, post-acute settings, and more. A key question for healthcare leaders today is how to achieve some level of collaboration when those silos have their own objectives and incentives to meet their own payrolls or budgets.

Again, many *structurally* integrated organizations don't *function* like integrated systems.[1] Despite great effort and identified best practices in the areas of clinical integration, organizations still find it difficult to inculcate evidence-based medicine across the various physicians, practices, departments, and facilities involved in an episode of care or serving the chronically ill. Differences in training and experience and incentives and culture often seem to stand in the way of agreeing on and consistently implementing the best way. Financial incentives (e.g., risk) will certainly help, but if past history is any indicator, financial incentives are not always adequate to change behavior. Consider how few traditional physician–hospital organizations (PHOs) or independent practice associations (IPAs) survived the managed care pressures of the late 1980s and 1990s.

Based on our experience and observation, we believe organizations need to go through a process to move from structural to functional to clinical integration in preparation for population risk management, and, ultimately, to support population health. The "Integration Pyramid" in **Exhibit 1** defines and illustrates the steps involved in moving from structural to functional and on to clinical integration.

As illustrated, structural integration (e.g., a medical staff is a loosely integrated structure) facilitates *coordinated* care from one silo to another. However, the silos remain independent and focused on their own payrolls and department budgets. The transitions from one silo to another look like traditional customer/vendor relationships

1   Marc D. Halley, "Integration: From Structural to Functional," *Healthcare Financial Management,* June 2012, pp. 74–77.

Exhibit 1: The Integration Pyramid

Population-Centered Care
- Personal accountability for healthy behaviors and lifestyle
- Population health management
- Chronic disease prevention and management
- Access and information = value
- Risk-based payment

Choreographed Care (Accountability)
- Improving *process and outcomes*
- Clinical quality commitments
- Transparent flow of clinical information across care continuum
- Managing an episode of care or chronic disease using clinical metrics
- Individual and joint accountability to live by established metrics

Collaborative Care (Trust)
- PCMH and "Choice" initiatives
- Vital behaviors ("We"/"Our")
- Service quality *extension* of referring provider's office
- *Information* lubricates the referral path
- Referral management

Coordinated Care (Silos)
- Basic form of integration
- Legal structure/organization chart
- Payroll silos ("Me"/"You")
- Referral leakage

PHM

Clinical Integration

Functional Integration

Structural Integration

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Palliative Care Is Person-Centered at Its Core

A Look at the Role of Palliative Care in the Transition to Value-Based Care

KATHRYN C. PEISERT, MANAGING EDITOR, THE GOVERNANCE INSTITUTE

Palliative care has been practiced informally for hundreds of years. A few years ago it was granted formal specialty status by the American Board of Medical Specialties. Palliative care consultations have been shown to improve quality of care, reduce overall costs, and sometimes increase longevity in patients with serious illness.[1] With the industry's current focus on efforts to provide the right care at the right time for every patient, along with reducing unnecessary or ineffective care and lowering costs of care at the end of life, palliative care deserves more focus by healthcare leaders. The consensus among palliative care practitioners interviewed for this special section is that palliative care is person-centered care, and it can play a key role in the healthcare industry's transformation from a fee-for-service focus to a value-based focus on improving quality and lowering costs.

However, many patients who could benefit from palliative care don't receive it, or receive it too late. Patients, families, and even physicians are not aware of what palliative care entails and how it differs from hospice care. According to a recent report from the Institute of Medicine (IOM), the number of palliative care specialists across the U.S. is still relatively small. The authors wrote, "One of the greatest remaining challenges is the need for better understanding of the role of palliative care among both the public and professionals across the continuum of care so that hospice and palliative care can achieve their full potential for patients and their families."[2]

This special section defines palliative care in the context of the overall healthcare industry transformation to value-based, coordinated, person-centered care; explores the experiences of palliative care specialists at two California hospitals; and presents implications and discussion questions for healthcare leaders and boards.

What Is Palliative Care?

There remains some confusion, both inside and out of the industry, about exactly what palliative care is. The IOM committee authoring the report mentioned above defined palliative care as "care that provides relief from pain and other symptoms, that supports quality of life, and that is focused on patients with serious advanced illness and their families."[3] While hospice is one type of palliative care they are not one and the same. It's also not "giving up." The primary distinction between the two disciplines is that palliative care should be provided to any patient with a serious illness, whose treatment could result in discomfort, diminished mobility and independence, distress, or other factors that could be helped by palliative care. These patients don't need to have a prognosis of six months or to be of a certain age—many palliative care patients are young cancer patients with much of their lives left to live. And most importantly, unlike hospice care, palliative care is provided in tandem with any other appropriate treatment. Its main purpose is to enhance the quality of life for a patient while they are undergoing any other treatments for their disease. And in some cases, it can help the patient fight the disease better than through treatment alone.

There are elements of palliative care that could be provided by any type of provider; others are more complex and require specialization. According to Drs. Timothy Quill and Amy Abernethy, "As in any medical discipline, some core elements of palliative care, such as aligning treatment with a patient's goals and basic symptom management, should be routine aspects of care delivered by any practitioner. Other skills are more complex and take years of training to learn and apply, such as negotiating a difficult family meeting, addressing veiled existential distress, and managing refractory symptoms."[4] The authors caution that while "many elements of palliative care

can be provided by existing specialists or generalist clinicians regardless of discipline, adding another specialty team to address all suffering may unintentionally undermine existing therapeutic relationships…if palliative care specialists take on all palliative care tasks, primary care clinicians and other specialists may begin to believe that basic symptom management and psychosocial support are not their responsibility, and care may become further fragmented."[5]

Palliative Care Benefits

Palliative care benefits have been shown both in improved patient outcomes and reduced costs. A study in 2010 at Massachusetts General Hospital involved 151 patients with stage IV lung cancer, which is not curable and which has a prognosis of about nine months with treatment. The patients were randomly assigned to one of two possible treatment approaches: one group received the usual oncology care and the other group received oncology care plus visits with a palliative care specialist, who discussed the patients' goals and priorities for if and when their condition worsened. The study showed that those who saw the palliative care specialist reported having a better quality of life, had less depression and less pain, stopped chemotherapy sooner, experienced less suffering at the

1   R.S. Morrison, J. Dietrich, S. Ladwig, et al., "Palliative Care Consultation Teams Cut Hospital Costs for Medicaid Beneficiaries," *Health Affairs,* Vol. 30 (2011), pp. 454–463.
2   Institute of Medicine, *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life,* National Academies Press, 2014, pp. S-1–S-2.

3   Institute of Medicine, 2014.
4   Timothy E. Quill, M.D., and Amy P. Abernethy, M.D., "Generalist plus Specialist Palliative Care—Creating a More Sustainable Model," *The New England Journal of Medicine,* Vol. 368 (March 28, 2013), pp. 1173–1175.

5   Quill and Abernethy, 2013.

end of their lives, and lived 25 percent *longer.*[6]

The University of California, San Francisco (UCSF) tracks financial outcomes data from its palliative care service (PCS) using the Web-based software program CaseMaker PCS, which was developed by UCSF. It has demonstrated direct cost savings and improved net margin. Between July 1, 2011, and June 30, 2012, care was provided for 546 PCS patients, through both early palliative care (within the first 24 hours of admission) and later palliative care (after the first 24 hours of admission). During this one-year period, the care resulted in a total of $3,712,736 in variable direct cost savings, $2,094,065 in improved net margin (defined as difference in average net margin for PCS cases compared to average net margin for comparable cases), and 1,229 avoided bed days, including 541 avoided ICU days.[7]

But to bring in palliative care requires a different kind of doctor–patient conversation, and approaching the topic of care choices with a patient can be difficult for physicians. In *Being Mortal,* Dr. Atul Gawande described a personal experience with a cancer patient who ultimately decided

to have an invasive operation with a chance of being successful but also with the potential for serious complications; the patient never recovered from the procedure although it was considered a success from a medical standpoint. "What strikes me most is not how bad his decision was but how much we all avoided talking honestly about the choice before him. We had no difficulty explaining the specific dangers of various treatment options, but we never really touched on the reality of his disease." Later, Dr. Gawande wrote, "We're good at addressing specific, individual problems: colon cancer, high blood pressure, arthritic knees, and various other ailments besides—an elderly woman at risk of losing the life she enjoys—and we hardly know what to do and often only make matters worse."[8]

So it seems clear that palliative care is necessary, but that it needs to be implemented in a thoughtful manner involving the right practitioners at the right times, in a coordinated care model. In addition, most physicians could benefit from education on palliative care and guidance on how to have those difficult conversations with their patients about the reality of their disease.

The IOM report provided the following recommendations to remove barriers to palliative and hospice care:
1. Government health insurers and care delivery programs as well as private health insurers should cover the provision of comprehensive care for individuals with advanced serious illness who are nearing the end of life.
2. Professional societies and other organizations that establish quality standards should develop standards for clinician–patient communication and advance care planning that are measurable, actionable, and evidence-based. These standards should change as needed to reflect the evolving population and health system needs and be consistent with emerging evidence, methods, and technologies. Payers and healthcare delivery organizations should adopt these standards and their supporting processes, and integrate

them into assessments, care plans, and the reporting of healthcare quality.
3. Educational institutions, credentialing bodies, accrediting boards, state regulatory agencies, and healthcare delivery organizations should establish the appropriate training, certification, and/or licensure requirements to strengthen the palliative care knowledge and skills of all clinicians who care for individuals with advanced serious illness who are nearing the end of life.
4. Federal, state, and private insurance and healthcare delivery programs should integrate the financing of medical and social services to support the provision of quality care consistent with the values, goals, and informed preferences of people with advanced serious illness nearing the end of life. In addition, the federal government should require public reporting on quality measures, outcomes, and costs regarding care near the end of life.
5. Civic leaders, public health and other governmental agencies, community-based organizations, faith-based organizations, consumer groups, healthcare delivery organizations, payers, employers, and professional societies should engage their constituents and provide fact-based information about care of people with advanced serious illness to encourage advance care planning and informed choice based on the needs and values of individuals.

6   J.S. Temel et al., "Early Palliative Care for Patients with Metastatic Non-Small Cell Lung Cancer," *The New England Journal of Medicine,* Vol. 363 (2010), pp. 733–42; as told by Atul Gawande, M.D. (paraphrased) in *Being Mortal: Medicine and What Matters in the End,* Metropolitan Books, 2014.
7   University of California, San Francisco, Palliative Care Service Financial Analysis FY2012. Case-Maker PCS is available as part of the Palliative Care Quality Network (see www.pcqn.org for more information).
8   Gawande, 2014.

Palliative Care in Practice

The Governance Institute recently spoke with palliative care specialists at two California hospitals to learn about their experience providing palliative care and educating physicians, patients, and healthcare leaders about the benefits of their work for individual patients and the organization as a whole.

Santa Clara Valley Medical Center is a county-owned public hospital service located in Santa Clara County near San Jose, CA. Shoshana Helman, M.D., Sub-Chief of Supportive Care Services and Continuum at Kaiser Permanente in Redwood City, CA, began her career as a primary care resident at Santa Clara Valley Medical Center in 1998. After attending a conference in 2000, where she met a number of clinicians in the palliative care field, she wrote a proposal for Valley Medical Center stating the need for an inpatient palliative care program there (this was a discipline considered to be relatively new at the time). The proposal was turned down initially because the CMO believed that palliative care was "everyone's work," and was concerned that by creating a sub-specialty, which tasked that work to only a handful of clinicians, other physicians across the medical staff would not learn how to do it well.

As she completed her residency, Dr. Helman was hired at Valley Medical Center as a primary care physician. She was given a half-day per week to spend time "doing" palliative care. "So I spent the first few years doing training, essentially, for the residents and other physicians, providing them with material from outside resources with skills related to palliative care," said Dr. Helman.

In 2005, Dr. Helman started a program at nearby O'Connor Hospital with the help and training from the Palliative Care Leadership Center at UCSF, through a contract with the county. While the county still wasn't willing to pay for its own hospital program at Valley Medical Center, the hospital's medical staff had relationships with other hospitals in the area that were understaffed. O'Connor Hospital wanted to start a palliative care program and needed a medical administrator, so Dr. Helman took on that responsibility. The program launched in October of that year, and it was very successful within just the first few months. By May 2006, Santa Clara revisited Dr. Helman's original proposal and decided to finally fund an inpatient palliative care program at the hospital.

> "The reason I wrote the proposal was that with palliative care, we were trying to align the treatment plans to the goals of the patient and the family. When I was an intern in the ICU, I would talk to the nurses at night about what they were seeing, and what families were telling them, it was very different from what I was hearing on rounds with the attending physicians during the day. There was a huge disconnect between what the attending physicians believed the patients and family wanted, and what the patients and family were actually telling the nurses."
> —*Shoshana Helman, M.D.*

Dr. Helman also emphasized the importance of placing specialty palliative care at the right practitioner level while ensuring that all providers perform primary palliative care (see sidebar) for all patients. "All of us need to have the skillset to some degree—we all need to be really good at primary palliative care, just like we all need to be able to treat hypertension and high cholesterol—but [it's important] to recognize that [palliative care is] a sub-specialty that

requires unique skills and individuals who can manage the more complex scenarios," Dr. Helman explained.

Representative Skillsets for Primary and Specialty Palliative Care

Primary Palliative Care

- Basic management of pain and symptoms
- Basic management of depression and anxiety
- Basic discussions about prognosis, goals of treatment, suffering, and code status

Specialty Palliative Care

- Management of refractory pain or other symptoms
- Management of more complex depression, anxiety, grief, and existential distress
- Assistance with conflict resolution regarding goals or methods of treatment:
  - » Within families
  - » Between staff and families
  - » Among treatment teams
- Assistance in addressing cases of near futility
- Addressing complex psychosocial and spiritual issues

Source: Quill and Abernethy, The New England Journal of Medicine, 2013.

According to Dr. Helman, a major barrier to more patients receiving palliative care who can benefit from it is the lack of recognition on the part of referring providers that they should involve palliative care sooner in the process. Much of this stems from the

incorrect assumption that palliative care is the same as hospice care. "We have an image problem," said Dr. Helman. "Our own fear as healthcare providers—our own lack of understanding—drives fearful behaviors and lack of understanding in our family members and patients. I had a patient in her 80s who was on dialysis, and she was a very sophisticated person. She said, 'I heard that they were calling for palliative care, and I thought, oh my God, it's the end.'"

> "When I went through my training, I didn't get a single class on pain management. If we don't start with the goals of the patient, it doesn't go anywhere. I think what's missing is really the patient-centered care focus, which needs to be taught early on."
>
> —*Shoshana Helman, M.D.*

Another challenge limiting palliative care is demonstrating value or cost-benefit. For now, most palliative care teams have to use the same quality indicators as the rest of the hospital, although those indicators seek different goals. At Valley Medical Center and O'Connor Hospital, a first step was to compare payer sources and how much revenue the palliative care team was generating against time spent with patients. "We realized that you can't really sustain the program just by generating revenue from physician visits," explained Dr. Helman. They found that palliative care providers were getting reimbursed an average $33.00 per hour of physician time spent at Valley Medical Center, compared with $110.00 per hour of physician time spent at O'Connor. But even $110.00 wouldn't have covered the full costs of the program, taking into account physician fees and benefits. So they had to look at it another way—whether palliative care can save money for the organization as a whole. "When palliative care has been involved with patient care, the cost per day goes down because we're a little bit more wise about how we utilize some of these routine tests and other things that are part of the normal process of care," Dr. Helman said. "We looked at costs per day, three days prior to the palliative care consult, and three days post, and compared those costs. We also looked at patients with a similar admission diagnosis that were not seen by our team, that were in the hospital at the same time, ideally with the same primary team providers. And we compared them to our patient base, and the bottom line was that when you consider the costs unique to each patient, we saved over $200.00 per patient per day."

At that point, the success of the palliative care program at Santa Clara was beginning to show on paper and they were able to recruit a second physician to the team, Dr. Gary Lee, who is now chief of Valley Medical Center's palliative care division.

Addressing Cultural Differences across the County

In 2006, the county received a grant from the California HealthCare Foundation to initiate a project that would improve culturally competent care in the county. "The [foundation] proposed that we look into building a program that was sensitive to the cultural background of the large number of Latino and Asian patients that come to our hospital," said Dr. Lee. Drs. Helman and Lee worked closely with the hospital's Language Services Department, planning and discussing implications of involving interpreters in the palliative care program. "When patients are dealing with terminal illness and decisions that they have to make at the end of life, [the need for] cultural considerations is particularly strong," Dr. Lee said. "In addition to interpretation and communication challenges, how do you talk to the

patient about their illness? What are their cultural beliefs and expectations coming to a medical center that provides Western medicine?"

In Dr. Lee's experience, due to the county-owned hospital patients' lower socio-economic status and varied cultural backgrounds, Valley Medical Center's patients also have different expectations: perhaps they came from another country expecting to receive better, more aggressive, or more curative care here; some patients worry that they won't receive the highest-quality care because of a fear that they will be discriminated against. Most of the palliative care patients seen by Dr. Lee and his team are in their 60s and are either uninsured or on MediCal (they have seen a reduction in uninsured patients due to MediCal expansion and Covered California, the public insurance exchange in the state). In comparison, palliative care patients at a private Catholic hospital in the same market are more likely to be 80–90 years old and on Medicare.

Program Structure

Today, the program consists of the inpatient consultation service (in place since 2006) and a new outpatient clinic that began in November 2013. The team's dedicated staff consists of two full-time physicians who are palliative care specialists (Dr. Lee and Dr. Thuy Pham, who began her residency at Valley Medical Center and then came on full time), a nurse practitioner, a case manager, and a psychology fellow. A social worker attends the palliative care interdisciplinary team meeting every week and acts as a liaison between the palliative care team and social workers on other units. Another social worker from the geriatrics division chooses to attend clinic sessions (they have two half-day clinics per week), simply because she has a strong interest in palliative care.

To enhance cross-communication and education, the palliative care team is invited to attend a burn unit interdisciplinary team meeting once a week, as well as a weekly meeting with the surgical ICUs. "Not every patient who needs palliative care gets palliative care," said Dr. Lee, so educating all staff on the importance of the program is key. "We're constantly trying to educate residents and the house staff because they have to be the first ones who recognize that a patient needs palliative care."

Palliative Care Triggers for Valley Medical Center

Intensive Care Unit Trigger Tool:
- Stage IV malignancy
- Presence of two or more life threatening comorbidities (dementia, ESRD, CHF, COPD, etc.)
- Actively dying or withdrawal of life support
- Poorly controlled physical symptoms
- Prolonged length of stay in ICU (>7 days) without evidence of progress
- Readmission to ICU during the same hospitalization
- Patient/family considering tracheotomy and/or feeding tube placement
- Team/patient/family needs help with complex decision making and determination of goals of care

Med/Surg Palliative Care Consult Trigger Tool:
Any serious or life threatening disease including though not limited to:
- Metastatic or locally advanced incurable cancer
- Advanced pulmonary, cardiac, renal, or liver disease
- Progressive neurological illness (e.g., ALS, dementia)

AND at least one of the following:
- Unacceptable level of pain and/or other symptom(s) of distress > 24 hours
- Team/patient/family needs help with complex decision making and determination of goals of care, which can include PEG/trach decision

- Greater than two hospital admissions or ER visits for the same diagnosis in last three months
- Patient/family needs assistance with illness understanding and/or treatment decisions including hospice decision

The following conditions fall outside palliative care's scope of care:
- Chronic non-malignant pain with no serious/life limiting illness
- Substance abuse disorder

Outpatient Clinic Consult Trigger Tool:
Any serious or life threatening Illness including though not limited to:
- Metastatic or locally advanced incurable cancer
- Advanced pulmonary, cardiac, renal, or liver disease
- Progressive neurological illness (e.g., ALS, dementia)

AND at least one of the following:
- Advance care planning
- Patients/family need assistance coping with life threatening illness
- Frequent ED visits/hospital admissions
- Hospice referral/discussion
- Illness understanding and treatment decisions
- Symptom management

The following conditions fall outside the clinic's scope of care:
- Chronic non-malignant pain with no serious/life limiting illness
- Substance abuse disorder

Dr. Lee's team has developed a set of palliative care triggers for the intensive care unit, medical/surgical unit, and also the outpatient clinic (see sidebar). In the ICU, the nurses are first to recognize that a patient has palliative care needs. Having explicit triggers empowers them to recommend palliative care to the attending physician. Other nurses throughout the hospital will contact the team when they think a patient qualifies, and then the palliative team will contact the primary team to discuss the patient's case and the potential benefits of adding palliative care. But difficulties arise with some physicians who worry that palliative care will "take over," so it has to be approached carefully and diplomatically. "Most of the time the [primary] team says, 'No, I think we have everything under control,' but maybe 20 percent of the

time, they'll agree that they could use our help with their patient," said Dr. Lee. "We say we have spies all over the hospital who are kind of looking out for who might need our services."

Dr. Lee's team now receives a daily report from the hospital's EMR system that will indicate when a patient that has been seen by the palliative care team in the past has been admitted to the hospital. Having that advance notification allows the team to review the patient's chart and offer services if it looks like they may be needed.

According to Dr. Lee, the biggest barrier to expanding awareness and therefore the number of patients receiving palliative care at Valley Medical Center is underfunding. Without a full-time chaplain or full-time social worker, it becomes a delicate balance of determining how much or how

often to offer services, and then risk being overwhelmed with the amount of work generated. "The biggest struggle is being able to communicate with people higher in our organization about what we're capable of doing—how we're capable of helping patients and helping the organization, and how more resources would be helpful," Dr. Lee said.

Despite the growth and success in the program, the outpatient palliative care clinic does not yet have its own staff—for now staff comes from the discharge clinic (for patients discharged from the hospital who don't have a primary care doctor). The team is still faced with the need to show increase in patient numbers, both in the outpatient clinic and inpatient program. But palliative care is not about numbers. "It takes us much longer to have these full care discussions," explained Dr. Pham. "To do symptoms, to address all these things in one meeting—we can't possibly do it in a 15- or 20-minute slot. It's really about building trust and preventing hospitalizations and ICU stays. And that's how you provide quality care for patients, continuity of care."

Dr. Pham's biggest challenge during this journey has been trying to help people understand that the concepts behind palliative care are a very different way of thinking about caring for patients and their families. "It does require kind of a culture shift—you can't think of it as very differential divisions," said Dr. Pham. "How do we collaborate so that we can provide comprehensive care? How do we do it using multiple disciplines? How do we incorporate that in the hospital setting so that things are well communicated and understood?"

Dr. Lee believes that palliative care needs to play a central role going forward as the industry moves to a value-based business model and increases efforts to improve quality and lower costs. "What we can do is offer patients the treatment they want, and most of the time, that treatment is going to cost less than what usual care will be," Dr. Lee said. "We can help them receive care outside of the hospital, and avoid coming back to the hospital at the time of death and dying in an intensive care unit."

"Palliative care is really about the whole person. And I think that healthcare's focus has been so much on just the medical aspect of patient care that we forget that there's so much more to a person. Suffering is not just physical. When you see that you can see the mission of palliative care—respect for human life, and how to provide dignity. It's very different for each person. But how do you know if you don't even attempt to try to know?"

—*Thuy Pham, M.D.*

Kristyn Fazzalaro, a clinical social worker by trade, supervises the palliative care program at Hoag Memorial Hospital Presbyterian in Orange County, CA. The program, which began in 1999, is known as the CARES program. Hoag's Web site states, "Palliative care is a specialty that focuses on improving the quality of life of individuals facing serious illness through medical management and emotional support. Any individual who suffers an illness that is likely to limit life expectancy can benefit from palliative care. Palliative care consultations provide a team approach to advance healthcare planning and counsel on symptom management. Palliative care is not a hospice program, nor is it a program for the terminally ill."

The Hoag palliative care team is comprised of 1.5 physicians (board-certified palliative care specialists), one clinical nurse specialist, an inpatient-dedicated social worker, and an outpatient-dedicated social worker. Hoag has a clinical pastoral education program, so the palliative care program utilizes the chaplain interns, who are assigned to the team on a rotational basis.

The program started as a result of the efforts of one social worker who worked with a physician champion to create an end-of-life pathway to ensure that people weren't suffering during the dying process. They created a standardized order set and focused on ensuring that pain and symptoms were well controlled by the primary physicians—either the hospitalist or the primary care physician from the community. The standardized "best practice" order set was created for the benefit of the physicians so that they didn't have to wonder if they were doing the right thing.

Then in 2008, the social worker resigned and a clinical nurse specialist was recruited, who came to Hoag with over 20 years of experience working in palliative care in the U.K. She is still on the team today and has gradually brought the program away from solely an end-of-life focus into more of a medical palliative care model. In the beginning, Hoag physicians were reluctant to have doctors on the palliative care team because they didn't want other doctors telling them how to take care of their patients. But the medical staff physicians were comfortable with the advisory role of the clinical nurse specialist.

A physician was first brought on to the team in 2009. A part-time physician was added in 2013 to meet the growing hospital census. Similar to Valley Medical Center, up until 2013 Hoag's palliative care program was 100 percent inpatient-focused. Due to increasing need for palliative care in the outpatient setting, they launched a physician-led outpatient clinic in February of 2013.

Now, Hoag physicians actually prefer that a palliative care physician is the first

responder with the nurse or the social worker, and there is a much greater understanding of the need for an interdisciplinary model. The program functions as a full consultation-based practice, so it does not take over the care of the patient. "We require a physician order to come in to consult, just like any other consultants do in our hospital," explained Fazzalaro. "It is an ongoing educational process with physicians and hospital staff to help them understand the difference between palliative care and end-of-life care." The program hosts continuing educational events for medical and nursing staff, as well as case managers, chaplains, and other disciplines throughout the hospital. "We also recognize that our bedside nurses are really our best advocate in recognizing the need for palliative care and then bringing it to the doctor," Fazzalaro said.

While there has been significant movement in palliative care to outpatient settings, Fazzalaro believes there will always be a place for inpatient palliative care. "You'll always have those patients who are in a symptom crisis, who need crisis management and goals-of-care defining, which comes with critical illness in a hospital setting," she explained. "But I do think there's a shift toward moving palliative care upstream and into the outpatient arena to try to help keep patients out of the hospital and yet be able to manage their symptoms. In a perfect world, palliative care would be engaged at the time of diagnosis for anyone with a serious illness."
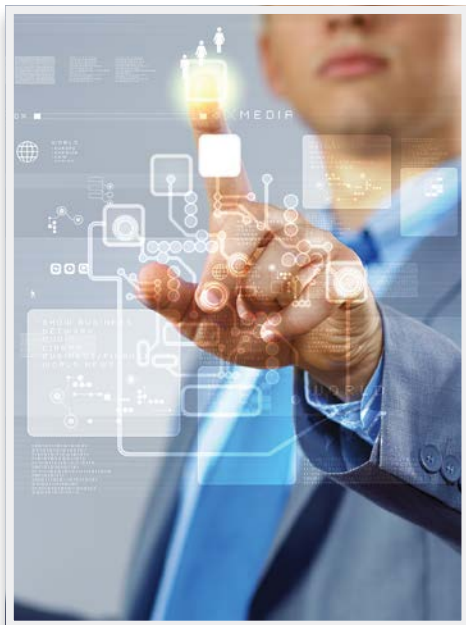
> "Our main purpose is to help advocate for patients who are struggling with serious illness to ensure that they have the treatment and the quality of life that they want. So the benefit of a palliative care team, beyond all of the medical and symptom management and the things that our physicians can bring to patients, is the perspective of the interdisciplinary team. We look at the whole person and everything they're dealing with. If its pain, we ask if it is physical pain or existential pain? Is it emotional pain? Is it spiritual pain? Is it fear? What is it beyond the physical pain?"
>
> —*Kristyn Fazzalaro, LCSW, ACHP-SW*

Cancer patients provide a great example of how palliative care can benefit patients. While going through chemotherapy or radiation, palliative care helps these patients manage the nausea, vomiting, shortness of breath, sleeplessness, and depression that can come with chronic illness. In addition, palliative care helps these patients define what their personal values are and where their limits might be. "For whatever reason, whether it's just because they're very invested in healing the patient or curing the cancer or helping them live with their congestive heart failure, it's very hard for the treating specialist to say, 'enough is enough,'" said Fazzalaro. "And I think no doctor really wants to bear that burden…." So the palliative care specialists and social workers can step in and talk with the patient and family about core values and goals that should drive their care plan. It empowers the patient to be the one to determine when the symptom burden is outweighing the burden of the treatment.

Hoag's board and senior leaders have been very supportive of the palliative care team's needs. "We're very fortunate that our senior leaders really understand the benefit of palliative care to the patients," Fazzalaro said. "I think they agree that it's the right thing to do for the patients, and they are starting to recognize that, in addition to being the right thing to do, it may positively impact some of the value-based metrics

that we're being held accountable for, such as reducing readmissions, interventions, length of stay, and critical care bed days." In 2010, the Hoag board of directors created a document mandating the availability of palliative care to all Hoag patients who were interested. This action means that if a patient or family requests palliative care, a physician cannot refuse it.

The palliative care team often debriefs both physician and nursing staff on challenging cases. In addition to consulting with the patient and family, they also provide the staff and treating team with support and an open communication channel, to help guide them through difficult situations whether it may be cultural issues, family dynamics, or advocating for the patient's desires. "A lot of the work that we do to support the staff really helps the hospital overall because it helps to reduce that compassion fatigue and burnout that easily comes with taking care of very sick patients," Fazzalaro said.

> "Palliative care is really the foundation of population health. If you're trying to manage a population, the most important thing is finding out what's important to those people and where their limits are, because we see patients come in and out of the emergency room all the time, and they realize they didn't want to be there—but nobody asked. I think that's the place where we can make the biggest impact as the healthcare industry changes. If ever there were a key time for palliative care, it's now."
>
> —*Kristyn Fazzalaro, LCSW, ACHP-SW*

Palliative Care Quality Network Helps Further Efforts

Both Valley Medical Center and Hoag Hospital are part of the Palliative Care Quality Network (PCQN). Started in 2009, the PCQN is a continuous learning collaborative committed to improving the quality of palliative care services provided to patients and their families. PCQN and its members use shared data collection and analytic strategies

to drive quality improvement initiatives, identify and disseminate best practices, and foster a professional community that contributes to the growth and future direction of palliative care.

The Valley Medical Center and Hoag palliative care teams are currently participating in PCQN's quality improvement project for pain management. PCQN provides them with data from a broad set of other California hospitals including public and private, enabling participants to compare themselves against others, see what others are doing, and determine what can be implemented in their own institutions. Networking with peers has been a valuable resource for the Valley Medical Center team in particular, given the grass-roots nature of their efforts. "The nice thing about having these [PCQN] meetings is that everyone shares what's going on in their program. And I think palliative care is still growing so much that we get ideas from other programs," said Dr. Pham. The information provided by PCQN is also providing the Valley Medical Center team with evidence to take back to the hospital leadership, to help make the case for growing the program.

Drs. Lee and Pham record their patients' daily pain, nausea, and shortness of breath scores, and then PCQN analyzes the scores. "We haven't done a lot of quality improvement things on our own—we were tracking things like the percentage of patients with an advanced directive, or the percentage of patients on a bowel regimen—but to be able to have somebody pushing us along the road to actually ask ourselves, how are we doing with pain management and what kinds of things can we do better, and getting it down to a meaningful level, has been really helpful to us," said Dr. Lee.

The Hoag team has benefitted greatly from PCQN biannual meetings and collaboration with peers in the network, which has enabled them to start setting benchmarks for best practices. "We knew we were doing the right thing for the patient and doing great work, but we didn't have any way to tell our leadership that we're doing it and show them our outcomes—there was no basis of comparison," said Fazzalaro. The PCQN has provided Hoag with a benchmark to determine outcomes on a particular metric against how the rest of the network is performing. "We keep real-time data, and we keep it entered into the [PCQN] database as real-time as we're able to. And we report out on it every month at our staff meeting," said Fazzalaro. "And then, we do quarterly reports to our direct leaders and annual reports to senior leadership and the board of directors to show them where we are, where there are opportunities for growth, and how the rest of the network is doing, to set the stage of what we think is best practice. If we're doing X right now, what do we want to see in the future? What would we expect as improvement? And what's reasonable to expect as improvement based on what other teams are doing?"

Conclusion and Discussion Questions for Boards and Healthcare Leaders

Palliative care has enormous potential to enhance quality of care and patient experience through improved communication and care coordination, along with a focus on what the patient wants and needs rather than just doing "more medicine" without fully considering those implications. Furthermore, the palliative care practitioners profiled in this special section all overwhelmingly believe that, beyond doing what is right for the patient, palliative care can reduce waste, unnecessary care, and readmissions, thus reducing organizational costs. It can be provided in both inpatient and outpatient settings. Studies are showing that patients receiving palliative care have better quality of life and may live longer. In this context, it becomes apparent that palliative care is a key player in providing coordinated, person-centered care across the continuum.

With that in mind, the following list of questions can assist healthcare leaders and board members in assessing the role of palliative care in their own institutions:

1. What is the status of palliative care at our organization? Is it treated as a priority? Do we have the resources in place to provide high-quality palliative care to all patients who could benefit from it? If not, what is the business case for investing in palliative care?
2. How significant should the role of palliative care be in our population health efforts?
3. How should it be incorporated into our organization's quality improvement and patient experience strategy? What are some ways to include aspects of palliative care into our overall person-centered care approach?
4. How can we support more coordinated care efforts between patients' initial care teams and the palliative care team? What are the needs of each care team and are they being properly addressed?
5. What standards can we implement across the organization (such as clinician–patient communication, advance care planning) that are measurable and evidence-based? Are we tracking palliative care effects on outcomes, prevention, readmissions, costs, etc.? How can we help the palliative care team demonstrate its effectiveness through data?
6. What should the board's role be in providing education to physicians and nurses on the importance and benefits of palliative care? ◉

The Governance Institute thanks Steven Pantilat, M.D., Professor, UCSF School of Medicine, Founding Director, UCSF Palliative Care Program, and Principal Investigator, Project Director of the Palliative Care Quality Network, for reviewing drafts and recommending organizations to interview. He can be reached at stevep@medicine.ucsf.edu to answer questions about Palliative Care Leadership Center training, PCQN membership, or financial analysis of palliative care services. We also thank James Bennan, Executive Director, Financial Operations, UCSF, for providing financial data.

Three Datasets Should Drive Governing Boards

BY RULON F. STACEY, PH.D., FACHE, FAIRVIEW HEALTH SERVICES

Throughout my 30-year career in healthcare administration, I've had the privilege to serve under the direction of a diverse complement of boards—from rural, critical access hospitals to a fully integrated academic health system. Each board for which I've served has provided tremendous learning and growth opportunities for me and my management teams.

Across the healthcare industry, each board is unique in how they determine priorities upon which to focus. Some focus on financial performance, while others may focus on clinical quality. In my experience, I've come to believe the highest-performing boards pay equal attention to both financial performance and quality outcomes.

The most effective boards track a broader set of data than just operating margins, days cash on hand, and return on investment. Rather, they track clinical outcome measures and three datasets that are leading indicators of quality—employee, provider, and customer satisfaction. This article takes a look at each of these datasets and why they are important for boards to track.

1. Employee Satisfaction Data

One of the most important datasets for boards to pay close attention to is employee satisfaction data. In healthcare, employee satisfaction drives every aspect of organizational success, which is why I feel so strongly that board members should be paying more attention to this data. Employees who feel valued, know their opinions matter, and are recognized for their contributions are more likely to go the extra mile for patients and families, as well as medical staff members. That all translates into better outcomes and experiences for everyone on the healthcare team.

Put another way, boards that do not pay attention to employee satisfaction data risk employee alienation in the workplace that can negatively impact quality. Tracking employee satisfaction is a critical upstream step to ensuring quality outcomes for your patients.

Board members should expect to receive, at least annually, quantifiable employee satisfaction/engagement results with associated action plans for improvement. There are many effective survey tools on the market from which to choose—just be sure the tool/vendor your organization works with can provide comparative data so you can see how your organization compares to others.

In my experience, high-performing organizations also ensure data is collected at the individual manager level. The relationship between manager and employee is key to satisfaction. You will find that the number one impact on employee satisfaction is the relationship with the individual's supervisor. For this reason alone, the employee satisfaction monitoring and action planning process is critical.

When reviewing employee satisfaction data, a few key questions to ask include:
- What are the satisfaction trends of the organization overall and of major divisions/units?
- How do we stack up within our industry nationally?
- How do we compare to our local/regional competitors?
- Where are our greatest opportunities for improvement?
- What action plans is the management team putting in place in response to the feedback?
- What process is in place for lower-performing managers to learn from higher-performing managers?

2. Physician and Advance Practice Provider Satisfaction

A second dataset to pay close attention to is physician and advance practice provider satisfaction. While employee satisfaction surveys assess how well managers are meeting the needs of employees, satisfaction surveys for physicians and other providers assess how well all hospital employees—managers and frontline staff—are meeting the needs of this critical group. Physicians and other providers rely on hospital employees to have effective and efficient processes in place for them to practice and to create a positive environment for employees to work, providers to practice medicine, and patients to receive care.

While the same survey tool may be able to be used for both employees and physicians, it is important to analyze and act on physician and other provider satisfaction data separately. The drivers of satisfaction for this critical group may vary greatly from employees, especially if you have a diverse medical staff comprised of employed, independent, and, when applicable, faculty providers. This special focus on physicians and providers gives an understanding of their unique needs and enables the development of separate action plans to drive improvement.

An effective board will also be keenly aware of physician and advanced practice provider satisfaction and related action plans for improvement. These data and plans also should be gathered no less than annually, and the action plans monitored regularly.

3. Customer/Patient Satisfaction

The third dataset to closely monitor is customer/patient satisfaction. Because healthcare is a service industry, customer/patient satisfaction is directly affected by how satisfied employees, physicians, and other providers are with your organization—these are the key drivers of customer satisfaction. Their alignment with organizational mission, vision, and goals and commitment to your organization will drive overall performance.

By measuring, monitoring, and systematically taking action to improve both employee and provider satisfaction, you are setting

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continued from page 3

with the patient as both prize and pawn in the process. Each silo provides services to patients according to its own processes and preferences, and creates its own revenues. Patient referrals are based on relationships, ease of access, effective communication, and prior patient experience. Frequent referral leakage to other providers and systems is a classic indication of structural integration.

Functional integration is collaborative care. The term "collaborative" connotes silos working together to ensure a seamless experience for the benefit of "our" patient. Functional integration is driven by excellent service quality to our patient and to each referring provider along the referral path comprising a particular episode of care. Demographic, clinical, and financial information is the lubricant required to smooth the transitions from one silo to another, with each subsequent provider looking like an extension of the previous provider's office (just down a different hallway). "We are expecting you!" is the message to the patient from the subspecialty office, the ancillary services department, or hospital registration desk. Functional integration encourages collaboration to develop service commitments and joint accountability for achieving them. It is often focused on a service line or chronic disease where there is common interest among the various service providers. Developing, measuring, and achieving those service commitments creates trust among the providers as they collaborate to improve service quality to each other for the benefit of their patients.

As collaboration and trust build, the functionally integrated partners are ready to face a more significant challenge—examining how they provide their clinical care. Talk of "cookbook medicine" can quickly kill clinical integration initiatives if the players lack the trust necessary for introspection, innovation, transparency, and joint accountability. Improving processes and outcomes brings the partners face-to-face with the challenges of organizational change. Seeing ourselves clearly is the beginning of wisdom, but only the beginning. Physicians and other knowledge workers cannot be *bossed*—even if they

are on the payroll.[2] Instead, they must be *engaged* in developing the "recipes" that will define how they will work together and with others to ensure consistent clinical quality and appropriate utilization. Choreographing an episode of care while allowing for the variability inherent in individual patients, many with comorbidities, is a challenge requiring our best "integrated" selves.

Effective governance is the key to successfully navigating the process of moving up the Integration Pyramid. We discuss two types of governance. Vertical governance occurs within distinct organizational silos (e.g., a hospital, department, practice, etc.). Horizontal governance connects multiple silos—some of which may reside in the same legal entity and others not.

Vertical Governance
Vertical governance occurs within silos and is responsible for the success of the individual silo. Effective vertical governance is critical to functional integration, since an integrated delivery system is only as strong as its weakest link (silo). In its simplest form, vertical governance derives its authority from the owners. For example, a private small group medical practice is likely "governed" by its members who sit in council with one another in order to make decisions. The owners assume the risk of their decisions and provide (or borrow) any required capital to support their decisions. They then support their manager to implement their decisions and hold that person accountable to do so effectively. In properly functioning silos, the owners also hold each other accountable to support their decisions publicly.

In more complex organizations vertical governance starts with a formal board, an elected or selected body, which represents the "owners" (e.g., tax payers, shareholders, etc.) and protects their interests. "Fiduciary" governance is *strategic oversight*. For our purposes, we define fiduciary governance as the process of developing and approving strategy, sponsoring policy to support that strategy, providing or

2   Peter F. Drucker, *Peter Drucker on the Profession of Management* (Boston: Harvard Business Review), 1998, pp. 122–125.

approving resources, overseeing regulatory compliance, and establishing accountability for performance. In larger organizations, the fiduciary board hires the chief executive officer and holds him or her accountable as the chief implementer for the organization.

Horizontal Governance
Horizontal governance is essential to the integration process and fundamental to moving up the Integration Pyramid. Some organizations have tried, unsuccessfully, to ignore organizational silos in an effort to promote an "enterprise" or integration philosophy. Failing to acknowledge silos, however, does not negate their existence and their influence (positive or negative) on the integration process. Instead, integrators should acknowledge the reality of silos and spend their energy effectively connecting them.

Horizontal governance connects multiple silos in the pursuit of a common objective (e.g., across an episode of care). Some of those silos may be independent medical practices, while others may be hospital-employed physicians. Ancillary departments may be involved, as well as acute and post-acute facilities. These silos often have different ownership structures or distinct fiduciary boards. Consequently, horizontal governing bodies derive their authority through common consent. In essence, each silo agrees to meet certain requirements as a condition of participation or

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membership. Members are "governed" by those commitments as long as they choose to participate (a vertical choice). Failure to do so results in expulsion from the integrated body.

Successful horizontal governance requires the following:

1. **A common interest:** A service line or a chronic disease provides a great forum for gathering members that have a common interest and incentive to participate in improving clinical quality and service quality while reducing cost and utilization.

2. **A clear and compelling vision:** Engaging members in developing a clear vision for their common interest provides the glue to engage the silos in a common cause. That vision must be compelling enough to keep the members together during the inevitable disagreements over tactics.

3. **Shared tenets:** Tenets are the ground rules that govern how the members agree to filter and make decisions. The following filters are commonly employed by decision makers who ask: Does the proposed policy or decision:
   - Maintain or enhance clinical quality as defined by our physicians and evidence-based medicine, where available?
   - Maintain or enhance service quality as defined by our referring providers and their patients?
   - Reduce inappropriate utilization?
   - Reduce overall cost?
   - Maintain or enhance care coordination?
   - Maintain or enhance the productivity of our member physicians and other providers of care?
   - Maintain or enhance efficient operational processes?
   - Maintain or enhance financial viability of all members?

   Decisions that cannot pass the selected filters are tabled until they are modified, or do not receive further consideration. Because horizontal governance authority is derived from the membership, decision filters become very important when there is disagreement among members over specific tactical

decisions. Otherwise, the hospital plays the capital card, the physicians play the referral card, and everyone—especially the patient—loses.

4. **Working together:** Clarity around how the silos will work together involves addressing the following:
   - Individual silo roles and responsibilities (vertical governance)
   - Shared commitments (horizontal governance)
   - Performance targets (horizontal governance)
   - Performance management (vertical governance)
   - Individual accountability and performance reporting (vertical governance)
   - Joint accountability, meaning rigorous and transparent performance reporting (horizontal governance)
   - Appropriate incentives and rewards (horizontal governance)

5. **A culture of accountability:** Critical to the success of horizontal governance and the integration effort is the development of a culture of accountability. Members cannot be allowed to violate terms to which they have committed, and still remain in the integrated service line, nor can sole community providers be allowed to hold other members hostage without the risk of being replaced. The authors of *The Oz Principle: Getting Results through Individual*

and Organizational Accountability make the following statement:

> "It's worth repeating: An attitude of accountability lies at the core of any effort to improve quality, satisfy customers, empower people, build teams, create new products, maximize effectiveness, and get results. Simple? Yes and no. It's a simple message, but it takes a tremendous investment of time and courage to make accountability an integral part of an organization."[3]

The message is simple. *Paying* for performance (a common tactic in our industry) will only get an organization part way up the Integration Pyramid. Only individual and joint accountability will take us to the pinnacle.

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Managing population health is certainly a worthy objective. Achieving that significant objective will require that we include a healthy—and potentially disinterested—population in preventive efforts to maintain their health. (It is difficult enough to engage even the chronically ill in managing their health.) While preparing for that challenge, healthcare providers must "get our own act together" by effectively connecting our silos as we move up the Integration Pyramid. Successful *integration*, by its nature, requires that clinical experts and business experts work together *in partnership* to balance clinical quality, service quality, productivity, and financial sustainability. Neither will physician-led nor will executive-led integration move organizations up the pyramid. Only a partnership based on a compelling vision, shared tenets, and a culture of accountability will be equal to the task. ⬡

3 Roger Connors, Tom Smith, Craig Hickman, *The Oz Principle: Getting Results through Individual and Organizational Accountability* (New York: Penguin Group), 2010, p. 16.

yourself up to be more successful when it comes to customer satisfaction, as well as all other performance objectives you set.

The process by which each board and management team monitors and acts on these datasets varies, but there are a few best practices I've come to appreciate:

- **Annual retreats** where board members have time to "dig deep" into the data, ask critical questions of management, and drive higher performance expectations.
- **Balanced scorecards** showing current performance on all key datasets—quality, employee satisfaction, physician/provider satisfaction, customer satisfaction, and financial performance. Dashboards should be distributed at each board meeting to ensure current performance is always front and center.
- **Regular review of progress on action plans by the appropriate board committees** to ensure actions plans to improve performance are being executed as planned.
- **Online, real-time access to performance data** to ensure transparency not only for board members but for the entire healthcare team.

The exact rhythm, processes, and tools will vary from organization to organization. What's important is making this a regular cycle and routine part of how your board operates.

If you are on a board that isn't reviewing employee satisfaction, provider satisfaction, or customer satisfaction data on at least an annual basis, you may be losing sight of what actually drives organizational performance and sustains the core purpose of your organization.

For non-profit hospitals, focusing solely on financial performance and not on the people performance—employees, providers, and customers—puts our very mission and purpose at risk. As a service industry, it is equally, if not more, important that we monitor how well our organizations are serving our people as ensuring financial viability.

We make money to stay in business, but we are in business to serve our communities and that's why these datasets are so important for boards and management teams to pay attention to. They speak to the very health of our healthcare organizations. ◉

and then providing or contracting for the needed services. CVS Health used non-physician clinicians to treat minor medical complaints in its 900 walk-in clinics. Companies such as MDLIVE offered prompt video consultation with physicians for non-emergent conditions.

Gaining market share during the decade, these companies offered low-intensity services at low costs and high levels of convenience and customization. Many consumers bypassed expensive, inconveniently located hospital facilities, preferring their care through Web-based e-visits or in urgent care centers and convenience clinics closer to where they live, shop, and work. Hospital emergency departments, outpatient centers, and physician offices lost volume or were at significant risk of doing so in many communities.

Strategies for Success
Some organizations could carve out a strategy to deliver high-end services only, but for most hospitals and health systems, an effective outpatient and virtual strategy would be critical to continued market relevance. Successful hospitals and systems invested early in such a strategy, focusing on a retail approach to service delivery. The approach commenced through in-depth analysis of the hospital's market and competitive environment. A strategic plan quantified the organization's vulnerability in the low-intensity space and identified opportunities to develop a sustainable presence in an increasingly retail-driven market.

The plan also identified the infrastructure required for a robust delivery system that would firmly position the organization in the ambulatory sphere, and determined how and where those pieces would be assembled. Leaders recognized that the existing hospital chassis would not likely have the right assets in the right geographies for cost-conscious customers.

Use of virtual and mobile diagnostic and treatment modalities also were an important competitive strategy, particularly for healthy patients and those with chronic diseases. The organizations invested in employees with technology, marketing, and service know-how to meet the changing needs of activated consumers.

Force 4: Consolidation and Partnerships Continue to Accelerate
The level of merger and acquisition activity among hospitals and systems accelerated as organizations sought to attain the financial, operational, and clinical synergies required to manage population health. Additional consolidation (including larger deals) was required for organizations to remain relevant, assemble the intellectual and financial capital required to succeed, and absorb and manage risk.

Strategies for Success
Vigorously pursuing partnership options was perhaps the most important activity in which a hospital or health system's board and management team engaged during the past decade. Partnerships were an imperative, in fact, for fulfilling fiduciary and management responsibilities.

Forward-thinking healthcare executives and directors in 2014 envisioned their organization's role in the disrupted business environment, and moved rapidly while there still was time and flexibility to gain the intellectual capital, human resources, and infrastructure to be an ongoing force in their communities in 2024. ◉

Metrics for Success:
As Four Forces Disrupt Healthcare, Hospitals Deployed New Strategies for 2024

BY MARK E. GRUBE, KAUFMAN, HALL & ASSOCIATES, INC.

Imagine that it's December 2024. The past decade was a period of high urgency for the nation's hospitals and health systems, but also a period of great opportunity. What major forces were reshaping the industry and what strategies did providers deploy in 2014 for success in 2024 and beyond?

This article is part of our "Metrics for Success" series, which looks at how the hospitals and health systems of 2024 will measure their performance.

Force 1: Healthcare Moves toward a New Business Model

As a result of its unsustainable costs and inordinate share of gross domestic product, the U.S. healthcare system rapidly moved during the decade toward a new business model to improve health, enhance care access and outcomes, and lower costs.[1]

This model transforms the delivery system from hospital-centric *sick* care to an outpatient and Web-centric system that emphasizes community-based *health*care. The new model puts consumers, employers, and payers at the top of the system, able to select a "Health Company" to manage and provide care for them under value-based arrangements. These purchasers select a company based on its ability to guarantee a specific level of performance at a specific cost for services in all settings.

Strategies for Success

Leaders of successful hospitals and health systems in 2014 understood the new business model, the disruption it would bring to hospital business during the next decade, and the need for transformational change. Committed whole-heartedly to the new view of healthcare, they recognized that not all hospitals would be able to assume financial and clinical risk for service provision, playing a role as the controlling hub of healthcare delivery in their communities. Instead, some organizations would play a supporting role as a niche provider or major participant that provides a single service or portfolio of services within a delivery network.

Based on the role they envisioned for their organizations, executives and directors developed a comprehensive, go-forward strategic plan—one that would ensure sustainable transformation. The plan was grounded on an accurate assessment of core organizational and leadership competencies and competency gaps, a clear strategic direction, and realism about the scale necessary to succeed in a delivery system focused on service value rather than volume. The leaders knew that inaction or inadequate action could impair the organization's ability to effectively reposition itself for the longer term, so they worked aggressively to move their organizations toward the new model.

Force 2: Managing a Population's Health Becomes the Decade's Top Business Challenge and Opportunity

Population health management (PHM) is the care management function of the Health Company. It occurs when a health-care system or network of providers works in a coordinated manner to improve the overall health and well-being of patients across all care settings under a risk-bearing financial arrangement.[2]

Managing the health of a population, and assuming the financial and clinical risk for doing so, represents a profoundly different model of care delivery and financing. Under 2014's traditional fee-for-service model, most hospitals and health systems focused on providing patients, on a person-by-person basis, with the best care possible from the best clinicians available through the organization's facilities.

In contrast, the new model for 2024 requires organizations to reach into the community to meet the populations' health promotion, maintenance, and care needs at home and in other settings. Attention is on keeping consumers well and managing the problems that may develop—particularly chronic conditions. Care teams provide needed services in the least-intensive setting possible.

Strategies for Success

Early in the decade, leadership of successful provider organizations answered the question, "What role(s) do we want to play in PHM and which population segment(s) do we think we can most effectively serve ourselves or through partnerships with other organizations?" They understood that PHM opportunities were not equally attractive. Patient populations and market opportunities could be defined or segmented in many ways.

To answer this question, the leaders therefore thoroughly assessed the clinical and business environments of their specific hospitals, and market, payer, plan, and organizational realities. Based on their desired role and target population(s), they determined the scope of services to be provided, and the delivery network that would maximize wellness and minimize illness for the targeted population(s). They moved quickly to shape that network and to "right-size" the distribution of services across the network.

Arrangements with payers and employers would provide the financial backbone for an organization's PHM initiatives. Leading providers thus moved their contracts with payers to value-based arrangements as rapidly as feasible. They gained early experience in managing risk and the health of a defined population, and applied that experience to new contracting arrangements as the decade progressed.

Force 3: Non-Traditional Competitors Emerge, Targeting and Depleting Hospitals' Low-Intensity Business[3]

Attracted by the new business model and increased consumerism in healthcare, a wave of new competitors emerged. Retail companies such as Walgreens vied to be the Health Company enrolling patients in their regions, capturing the revenue stream,

1   M.E. Grube and K. Kaufman, "Inflection 2.0—The Real Change Begins," *Kaufman Hall Point of View,* August 2013 (available at www.kaufmanhall.com).

2   G. Hill, G. Sarafian, and S. Hagan, *Population Health Management: Hill's Handbook to the Next Decade in Healthcare Technology,* Citi Research Report, May 14, 2013.

3   K. Kaufman, "The Growing Attack on Hospitals' Low-Intensity Business," *Healthcare Finance News,* August 8, 2014.