BoardRoom Press

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Conemaugh Health System's Journey

Bundled Payments Show Early Promise in the Payment Reform Mash-Up

SPECIAL SECTION

Aligning Physician/Provider Compensation Incentives for Not-for-Profit Integrated Health Systems

Igniting Innovation

ADVISORS' CORNER

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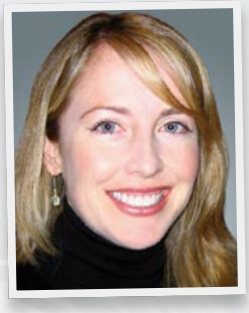

New Year, New Opportunities

2015 will be a year of looking at things in new ways for The Governance Institute. Based on your valuable member feedback, we have a number of changes to implement this year that will help readers navigate through our in-depth library and focus on educational priorities.

You will notice in this issue that we are now including a small sidebar on the first page of each article that keys up the topic—why it's important to the board—and main points to stimulate board discussion related to that topic. As you read through the issue, we hope these sidebars will help draw your attention to what your board's priorities and education needs are.

Meanwhile, we want to make things more accessible and easier to read in this age of information. If you prefer to read this newsletter on your mobile device or don't want to skip pages to the continuation of an article, be sure to download the ePub version rather than the PDF from our Web site. We are making ePub formats available for most of our publications—look for the links to download at www.governanceinstitute.com/epubs. They are also accessible on the board portal. Later this year we will be revamping both our Web site and board portal for easier access and navigation as well. We are excited to bring these important changes to our readers and look forward to continued feedback to ensure we are meeting members' evolving needs.

Kathryn C. Peisert *Managing Editor*

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LEADERSHIP CONFERENCE
The Ritz-Carlton, Laguna Niguel
Dana Point, California
March 15–18, 2015

GOVERNANCE TRAINING PROGRAM IN QUALITY & SAFETY
The Ritz-Carlton, Philadelphia
Philadelphia, Pennsylvania
April 7, 2015

GOVERNANCE SUPPORT CONFERENCE
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August 9–11, 2015

Please note: Conference expenses paid for by a board member can be claimed as a donation and listed as an itemized deduction on the board member's income tax return. Please consult your tax advisor for more information.

Conemaugh Health System's Journey: Transforming Care through Joining Duke LifePoint

BY SCOTT A. BECKER, FACHE, CONEMAUGH HEALTH SYSTEM

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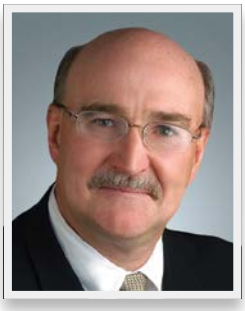
Leaders at Conemaugh Health System in Johnstown, PA, faced the same challenge as many other healthcare organizations: They wanted to be able to continue providing the best quality of care while at the same time thriving in a changing healthcare environment.

As CEO of Conemaugh Health System, I knew that healthcare was transforming, and we wanted to transform with it. But given our current capabilities and resources, it may have taken 10 years before we realized our full potential. This is why two years ago the board decided it was in the best interest of the community and the organization to expedite the process of becoming a transformative organization.



Scott A. Becker, FACHE
Chief Executive Officer
Conemaugh Health System

In 2013, we embarked on a journey to find an organization we could either partner with or that would acquire us. Though we were a financially sound and healthy organization, the board of directors understood that to continue to serve the community at a high level would require more than we currently offered. We needed to find a partner that could bring additional clinical and quality expertise to prepare us for population health and also provide access to capital that would give us the ability to quickly build and grow.

After a year-long search and competitive bidding process, last summer Conemaugh Health System became part of the Duke LifePoint Healthcare family of more than 60 hospital campuses across the country. Though acquired and no longer an independent, non-profit organization, Conemaugh Health remains a community-based hospital with its own advisory board of directors that is comprised of local leaders who support the same vision: *Excellence. Every Patient. Every Time.*

Key Components of a Successful Acquisition

Many hospital and health system boards are currently questioning and discussing their organization's future. They want to know how their hospital is going to continue to prosper in this changing environment. To get where Conemaugh Health is today, we thoroughly examined our operations and discovered that, with sluggish population growth in our service area, our only option to remain viable was through a partnership or acquisition.

Conemaugh Health has been part of Duke LifePoint for just six months, and I can say unequivocally the acquisition is remarkable for us and the community. A key element to this successful transition was entering the purchasing process from a position of financial and operational strength. We wanted to ensure we continued to be the preeminent player in our market. In turn, Duke LifePoint didn't want to acquire a hospital; it wanted to purchase a market. This was a market acquisition in which we are working together to strengthen and improve healthcare delivery and make our communities healthier.

Another contributing factor of the successful acquisition was a disciplined and controlled bidding process, which included using an investment advisory firm that served as the board's negotiating partner. The process involved taking a reality-based approach in that we knew whoever was going to purchase us—if that were to be the case—would want a fair amount of control of Conemaugh Health. But because we were negotiating from a position of strength, we negotiated to have the best of both worlds. As a result, we maintained a good deal of independence to manage our own marketplace and have capital to invest in the hospital and the community.

Through a request for proposal (RFP), our advisors invited 30 healthcare organizations known to be interested in partnering or acquiring hospitals to submit a proposal. Of those, 17 signed a bidding process confidentiality agreement, with seven submitting an initial offer. The board then reviewed each proposal and chose three finalists who submitted a final offer.

Each organization then visited Conemaugh Health as part of their due diligence, and during this time Conemaugh Health's eight-member integration team, which consisted of four board members, the CFO, two physician executives, and myself, visited each of the three finalists headquarters to conduct a reverse due diligence.

In addition, the integration team also visited a hospital that each of the finalists had recently acquired. In Duke LifePoint's case, we visited its main campus in Raleigh-Durham, NC, for the afternoon and the next morning flew to Marquette, MI, the location of one of its most recent acquisitions. There, our integration team, without Duke LifePoint representatives present, was able to ask questions of the hospital's board and senior management. Our main question was: Did Duke LifePoint live up to its promises? The answer was a resounding yes.

When the integration team returned, the three finalists had increased their proposals by 15 percent. We knew then we had

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Key Board Takeaways

Many boards are preparing for population health and considering what their hospital or health system might look like in the future. As Conemaugh Health System did this, leadership knew in order to flourish its best option was through a partnership or acquisition. As your board looks to the future, it should ask:

- How can we provide the best quality of care and prosper in this changing environment?
- Will we need to partner with another organization(s) to obtain resources and expertise that are essential to our success? If so, what is our vision for that partnership?

Bundled Payments Show Early Promise in the Payment Reform Mash-Up

BY DEIRDRE BAGGOT, PH.D.(C), M.B.A., RN, TORI MANIS, M.B.A., AND KIMBERLY HARTSFIELD, M.P.A., THE CAMDEN GROUP

Today, more than 2,000 organizations around the country are piloting some form of payment transformation, and that number will more than double within 2015.

One of the most promising elements of the Affordable Care Act (ACA)—that is, the *payment reform* provisions—offers our best chance at "getting it right" in lowering healthcare costs and improving quality. The concepts present a measure of what *New York Times* best-selling author Malcolm Gladwell describes as "stickiness," which determines whether a great idea succeeds or fails.[1]

Over the last two years, with the passing of the ACA, we have witnessed unprecedented interest in one of the "big ideas" of the ACA aimed at reducing healthcare spending. With more than 60 published studies on bundled payments, conceptually it is not new. Bundled payments is a pricing strategy (i.e., a fixed price for a set of predefined procedures/services) and in most cases, offers a "warranty."

Bundled payments aim to reduce cost and improve quality by reducing fragmentation and making medicine a team sport using payment reform as the lever. What we know for sure is that aligning financial incentives for hospital and physician providers can become, almost overnight, the impetus for care delivery transformation.

The Next Frontier of Bundled Payments

The skyrocketing interest among hospitals and physicians to test bundled payments has resulted in an expansion both in terms of episode length and also the types of healthcare services being bundled. Over the last 18 months, we have seen heightened interest among all sectors of the payer market to expand bundles to include outpatient procedures and infusion services such as chemotherapy, and to further expand post-acute bundles.

This article proposes 10 new ways of looking at bundled payments, introducing the concept of "fusion reimbursement" as we are seeing emerge during this time of industry disruption.

1. Think "Fusion Reimbursement" Models

A common misperception in the industry today is that fee-for-service is dead. Fee-for-service is alive, although due to the fact that it drives over-utilization, we will see decreased reliance on fee-for-service in acute and post-acute environments. We should expect traditional fee-for-service to continue in some sectors of the industry such as rural healthcare. For acute and post-acute care, fee-for-service will not be replaced with a single payment construct; rather, it will be a fusion of multiple reimbursement models on the risk continuum, including bundled payments, accountable care organizations (ACOs), patient-centered medical homes, and others, all working synergistically based on the unique needs and economic risk associated with a population.

2. Not All Bundles Are Created Equal in Terms of Risk

Early tests of bundled payments have taught us that not all bundles are created equal from an economic standpoint. For example, orthopedic knee revisions are particularly challenging as patients present with knee hardware that may not be on formulary where an organization is getting preferred pricing. In this instance, an organization often pays retail rates for hardware. Any population with historically high readmission rates, such as with congestive heart failure, also pose more economic risk. Finally, any bundle in which patient behavior change is required represent heightened financial risk. Elective procedures have been well studied with bundled payments and work well. As patient complexity increases so does the economic risk, which must be accounted for.

Key Board Takeaways

The ACA's focus on reducing healthcare spending has led many hospitals and health systems to pilot some form of payment transformation, including bundled payments. As we enter into the next frontier of bundled payments, boards should keep in mind:

- Fee-for-service will not be replaced with a single payment construct; rather, it will be a fusion of multiple reimbursement models on the risk continuum.
- Not all bundles are created equal in terms of economic risk.
- Smart leaders will take a portfolio approach to payer contracting.
- Leaders need to find innovative solutions to eliminate waste and duplication.
- Regional partnerships with post-acute care providers bring opportunities for savings.

3. Demand Destruction

Inherent in any risk-based construct is the reality of demand destruction. Areas most affected by demand destruction will be high-end post-acute care such as inpatient rehabilitation, diagnostic testing, lab, and inpatient length of stay. The ability to manage and offset demand destruction is the "middle game" of payment transformation and likely cannot be offset by some sort of "volume play." New business development, partnerships, and innovative approaches to revenue growth are needed to manage the middle game.

4. A Portfolio Approach

As payment transformation unfolds, smart leaders will take a portfolio approach to payer contracting. Market factors and population health status demand a portfolio approach to reimbursement. We will see some markets more dominated by one payer strategy over another. We are already seeing variability among payers and employers when it comes to tolerance for risk, which will influence adoption rates

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1 This idea is presented in his book *The Tipping Point: How Little Things Can Make a Big Difference*, 2000.

Aligning Physician/Provider Compensation Incentives for Not-for-Profit Integrated Health Systems: Art, Science, or Both?

BY DANIEL K. ZISMER, PH.D., UNIVERSITY OF MINNESOTA, AND BOBBI DANIELS, M.D., UNIVERSITY OF MINNESOTA PHYSICIANS

The fully integrated model of health system design (integrated health system or IHS) creates a potential to gain greater control over operating economics and strategy versus the more conventional community health services delivery designs.[1] In an integrated model, physicians and other licensed providers serve as a principal point of financial and economic performance.[2] The production of a provider's unit of clinical effort (often described as a work relative value unit or WRVU) creates a relatively predictable production chain of services utilization and resource consumption events within the IHS operating model.

> If clinicians are focused on professional services unit production only, the resulting assumption is that all else (operating economics and financial performance) takes care of itself. This assumption should be questioned.

Based upon a number of internal operating dynamics and factors, the production chain model can create positive or negative operating economic effects (and related financial results) depending upon how clinicians direct their work schedules and related professional work efforts. In a simple example, two cardiologists each producing 8,000 WRVUs can create very different production chains and operating economic profiles within an IHS, based upon a range of dynamics and factors, including departmental plans, clinical subspecialty qualifications, professional interests, and incentives that derive from active internal compensation models. Provider compensation incentives can work at cross-purposes with IHS organizational missions and strategies.

It is these dynamics that call the question of *how can and should physician compensation plan designs align incentives between physicians and the operating economics and financial performance of an IHS?* This special section examines this question from several perspectives that are intended to provide a comprehensive view of the challenges and opportunities for integrated community health systems and academic health centers.

The Question Better Defined

The production chain in a fully integrated model encompasses operating revenue and expense production profiles across a spectrum of clinical services, typically referred to as "clinical service lines." For each "average" WRVU produced by a clinician within a clinical service line, there are service demand effects created for multiple diagnostics, therapeutic, and referral services within the IHS.[3] The aggregate of these production chains can be managed to varying levels of internal and external value for the IHS.

We will examine the pros and cons of varying types and levels of incentive alignment methods operating between clinician compensation plan incentives and IHS operating economics and financial performance. The overarching question relates to the methods by which a compensation design links clinicians' behaviors to the totality of the operating, financial, strategy, and mission performance of an IHS.

For example, many productivity-based compensation plans incorporate the WRVU as the operating definition of a clinician's unit of work effort. The most simple of these designs creates an internal value for a WRVU produced (e.g., $60 per WRVU produced by a cardiologist). Annual cash compensation paid to a cardiologist producing 8,000 WRVU is calculated by multiplying 8,000 x $60, producing total annual cash compensation of $480,000 (not including the accrued value of all allocated cash and non-cash benefits provided).

As cited above, cardiologists producing the same number of WRVUs annually can produce differing total productivity profiles for the IHS. Many compensation designs are indifferent to "downstream clinical services activities," under the theory that all WRVUs are equal. So, if clinicians are focused on professional services unit production only, the resulting assumption is that all else (operating economics and financial performance) takes care of itself. This assumption should be questioned by leaders and managers.

Connecting Cash Compensation Incentives with the Realities of Clinical Service Line Operations and Performance Incentives

IHSs exist as a portfolio of clinical service lines.[4] Each plays an important role in the composition of the totality of the clinical programming and services plan. Each clinical service line is affected variously by:

- Payer mix and IHS contracting strategies

Key Board Takeaways

To achieve success in aligning incentives with performance in an integrated health system (IHS), physician compensation design must link clinicians' behaviors to the totality of the operating, financial, strategy, and mission performance of an IHS. The proper role of the board is to ensure that physician/provider compensation models are designed and managed to best advance the mission, goals, and objectives of the IHS.

The conversation begins with a fundamental question posed by the board: "Does our compensation plan effectively align the incentives of integrated clinicians with the goals and needs of the health system today and into the future?"

1 D.K. Zismer, "Connecting Operations, Operating Economics, and Finance for Integrated Health Systems," *Journal of Healthcare Management*, Vol. 58, No. 5, September/October 2013; pp. 314–319.

2 D.K. Zismer and F.B. Cerra, *High-Functioning, Integrated Health Systems: Governing a "Learning Organization"* (white paper), The Governance Institute, Summer 2012.

3 For a list of considerations when linking cash compensation with clinician behavior potential, view the full PDF of this article at www.governanceinstitute.com/aligningcompensationincentives.

4 D.K. Zismer, "Physician Compensation in a World of Health System Consolidation and Integration," *Journal of Healthcare Management*, Vol. 58, No. 2, March/April 2013; pp. 87–91.

- Operating expense structures and trends
- Capital asset requirements and related and ongoing costs of capital
- Effects (and related costs of) clinical innovations
- Market effects on factors such as clinician compensation ranges and rates
- Program sizing and subspecialization strategies
- Effects of competitors' strategies and tactics

For example, the factors that affect the performance of IHS orthopedics, within a given period of time, will likely differ from those that affect the performance of cardiovascular services or general pediatrics. **Exhibit 1** provides a simplified demonstration of how three clinical service lines produce very different operating economics and, ultimately, financial performance for an IHS.

A number of management-related decisions affect operating economics and financial performance of clinical service lines within IHSs, including the following factors:

- Size, scope, and subspecialization of clinical programming
- Strategy design (e.g., geographic outreach strategies)
- Emphasis of ambulatory or inpatient services
- Presence or absence of clinical research, teaching, and mentoring of medical students and post-graduate residents and fellows
- Special mission obligations (e.g., those of safety net hospitals)
- Prevailing economic effects of governmental payer programs (e.g., Medicare and Medicaid)
- Organizational costs of capital (e.g., costs related to external credit performance ratings)
- Effects of competition on operating costs, especially human capital

So, for an IHS to effectively manage the totality of its financial goals, it must effectively balance the operating economics of all clinical programs in relation to its own potential against that of all other individual programs and their economic, financial, and strategic contributions to the whole.

Now let's crosswalk this concept to compensation design, looking specifically at the cardiovascular services example in **Exhibit 2.**

Three initial observations regarding operating examples and financial performance of the principal component parts of the cardiovascular service line are obvious: 1) professional services (i.e., blended reimbursements for physician services) produce an operations professional loss "per unit of effort produced"; 2) contribution margin and net operating margin for inpatient and outpatient services varies with outpatient services providing greater net operating margin potential; and 3) payer mix affects financial performance to a substantial extent.

So, compensation plan designs for cardiologists must encompass and fairly consider a range of operating economics, financial characteristics, and related

Exhibit 1: Operating Economics Produced per WRVU for Three Clinical Service Lines within an IHS

Specialty	Physician FTE in IHS	Net Revenue per Average WRVU	Direct Expense per Average WRVU	Contribution Margin per Average WRVU	Net Margin per Average WRVU
Primary Care	56.3	$308	$232	$77	$(3)
Cardiology	18.6	$647	$440	$207	$73
Orthopedics	16	$553	$352	$201	$61

Notes:
1. All results reported per WRVU produced for an IHS service line assuming all provider WRVU production at the median of national standards. Results presented assume all accounted revenues and expenses for the designated service line (all inpatient, outpatient, and professional services).
2. "Net Revenue" is defined as "operating net revenue" (i.e., gross charges minus contractual adjustments).
3. "Direct Expense" is defined as all direct care-related expenses accounted across the designated service line.
4. "Contribution Margin" is defined as all net operating revenue for the clinical service line minus all related and accounted direct operating expense for the service line.
5. "Net Margin" is defined as contribution margin for the service line minus all accounted indirect expenses allocated to the service line.
6. All per-WRVU financial values are rounded to the nearest dollar.

Exhibit 2: Operating Economics for Cardiology Service Lines within an IHS: A "per-WRVU" Analysis

	Net Operating Revenue	Direct Operating Expense	Indirect Expense	Net Operating Margin
Professional Fees*	$103	$154	$39	($90)
Outpatient Services*	$244	$120	$38	$87
Inpatient Services*	$272	$166	$57	$49
Totals	$619	$440	$134	$45

*Per average WRVU.

Payer Mix Assumptions

(If all WRVU clinical activity was dedicated to a single payer class)

	All Medicare	All Medicaid	All Commercial
Total Operating Revenue per WRVU	$461	$390	$1,099

Notes:
1. All assumptions are based upon a simulated IHS with a blended payer mix and all providers operating at median productivity. All cardiology subspecialties are blended to create a mean per-cardiologist performance for an integrated cardiology service line within an IHS, providing a full range of cardiovascular clinical services (professional fees, outpatient services, and inpatient services).
2. Revenues, expenses, and margins are accounted based upon industry standards for clinical service lines within IHSs.
3. Payer mix assumptions (per category) were taken from the blended-rate case example.
4. Blended average ratio of cardiologist subspecialty FTEs within the sample practice were constructed from IHS examples used to build a simulated service line.

incentives. Three models for IHS compensation design are described below.

Model #1
All senior-level cardiologists are paid a salary at the same level, with an equal bonus opportunity payable as a percentage of total salary. Bonuses are based upon performance of the integrated cardiology service line. Junior-level physicians are paid a flat salary per year with increases available per year on a five-year progression to attained senior-level status.

With model #1, there is an active philosophy of team care and shared responsibility for departmental performance. Financial incentives are driven largely by market compensation rates, as well as the performance of the cardiovascular service line overall. Given the subspecialty nature of the composite clinical subspecialty services profile, it is assumed that a comprehensive, subspecialized array and scope of clinical services and programming is provided. Physicians are affected by incentives that favor the performance of the whole, with recognition of requirements for individualized performance expectations.

Model #2
The cardiology department is compensated, in the aggregate, based upon number of total WRVUs produced, multiplied by an IHS-determined internal value that meets applicable fair market tests.[5] Physicians in the department, at their election, choose to share the aggregate cash compensation pool on an equal share basis for all cardiologists with a minimum of four years experience with the group (for employment in the first three years, cardiologists are paid a salary with individual productivity targets available). If departmental financial and operating targets are met, the value of all WRVUs produced can be increased by 10 percent. All quality-of-care targets must be met to qualify for the bonus opportunity.

With model #2, the cardiologists have an incentive for clinical unit productivity, collaboration toward shared goals, accountability for quality and patient satisfaction, and the mentoring and management of new physicians in the group. Incentives also exist for innovation in interprofessional team care and economic "leverage" of the clinical care models applied.

Model #3
Physicians are compensated on an individual productivity model with a common value per unit of effort produced (e.g., common value paid per WRVU produced).

Under this model, there is no theoretical cap on individual physician earning potential. Physicians are not exposed to payer mix contractual adjustment differences or operating expense structures of the service line. Physicians are either advantaged or disadvantaged by the earning potential of their own clinical subspecialty (e.g., interventional cardiologists have greater earning potential over general non-procedural cardiologists operating under this model, and physicians are free to develop self-stylized practice models to best advantage their individual cash earnings targets).

Based upon the three compensation model designs presented, it is clear that each can have different effects on operating economics and financial performance of the clinical department. Thus, compensation plan designs matter in the operating economic and financial performance of "the whole"—each clinical department and the IHS overall.

Exhibit 3: The Aggregate Operating Economics and Financial Performance for 22 Clinical Specialties Caring for a Hypothetical Population of 100,000 from an IHS Structure

Description (IHS Simulation):
N=22 clinical specialties, producing 1.39 million WRVUs,
from 209 physician FTEs caring for a defined population of 100,000

Net Operating Revenue	$682,267,493
Direct Operating Expense	$468,468,030
Contribution Margin	$213,799,455
Indirect Expenses	$182,921,860
Net Operation Margin	$30,877,595 (4.5%)
Net Revenue PMPM	$568.56

Notes:
1. A fully formed and functioning IHS delivering primary, secondary, and tertiary care is likely to offer more than 22 physician specialties; this example is not intended to cover the full complement.
2. The simulation assumes all physicians operate at median productivity levels that are not likely to be accurate and reliable in practice, over time.
3. The simulation assumes the 100,000 population identified receives all care from the IHS for the clinical services identified.
4. The simulation assumes a payer mix typical of a large metropolitan area served.
5. The simulation identifies net operating revenues as gross charges minus contractual adjustments.

Returning to the Production and Value Chain Paradigm

As stated, for virtually every WRVU produced by a practicing clinician in an IHS, other units of clinical activity are produced, which bear upon operating revenues and expense performance of the IHS (see **Exhibit 3**).

These economic productivity profiles are affected by:

- Clinical specialty or subspecialty
- Clinical program assignments (e.g., a cardiologist assigned to a heart failure management program versus an alternative programmatic assignment)
- Provider experience, training, and professional interests
- Existence (or absence) of clinical pathways and protocols as promulgated by the IHS
- Clinical profiles of individual patients treated
- Management/leadership model of the departmental home of the clinician, including operating philosophy and culture of that clinical home (e.g., clinicians are free to self-stylize personal practice patterns, or the "collective we" operates as an integrated team)
- The IHS's approach to management and financial data transparency—especially reporting on how practice styles and

5 The IRS prohibits 501(c)(3) tax-exempt entities from operating other than for charitable purposes, and prohibits compensation payments to employed physicians in excess of fair market value. Fair market value (FMV) is generally defined as value paid according to an "arm's length" transaction (agreement); one that is consistent with demonstrated and documented market value paid under similar conditions and circumstances.

patterns vary across peers, affecting the operating economics and financial performance of the IHS

Based upon these factors, the total production and value chain of an individual clinician can vary significantly as compared with others practicing within the same specialty. Many times there are good reasons for observed variances, meaning the variances are expected and consistent with organizational or clinical service line strategy and best-practice care models (including expected contributions of individual clinicians to clinical models). However, variances may not always be productive for the IHS—provider compensation incentives can work at cross-purposes with IHS organizational missions and strategies.

Exhibit 4: Compensation Plans for Health Systems with/without Academic Health Services

Integrated Community Health Systems:	Without Academic Health Services	With Academic Health Services
Clinical care productivity-related requirements exist at the individual provider levels	√	√
Need for collaboration among providers across system services components	√	√
Need to recruit and retain top talent	√	√
Need to ensure compensation plans are assessed as fair and equitable among providers based upon work and outcomes required	√	√
Non-cash benefits are fair and equitable (including the value of tenure for academic faculty)	√	√
Management of total costs of care based upon terms of third-party payer agreements	√	√
Defined roles, responsibilities, and accountabilities of clinical department/division leaders, including related compensation incentives	√	√

What Should Be Included in a Compensation Design?

In theory, there are a great number of opportunities, models, and methods to align operating economic, financial, and clinical care outcomes incentives between clinicians and the IHS:

- WRVU production targets and value paid per unit produced
- Utilization of IHS clinical resources and services (e.g., referrals to other providers, diagnostic services, hospital days, outpatient therapeutics)
- Total costs of care[6]
- Clinical outcomes produced
- Applications of accepted clinical pathways and patient-centered care protocols
- Patient satisfaction
- Clinical department performance (measured variously)
- Behaviors of practicing clinicians
- Performance of the IHS overall (measured variously)

The related questions of principal importance are:

1. What factors are productive and counterproductive to align?
2. How many factors are manageable within a compensation plan design?
3. Which factors should have financial incentives attached (vs. non-financial performance evaluation opportunities evaluated by an assigned clinical leader)?
4. How should factors affecting cash compensation (incentives) be valued and applied to clinician compensation?

Philosophies on where and how to link and align cash compensation incentives vary within IHSs. Philosophy drives design and design influences clinician behaviors. Clinicians will frequently report, "We work our pay plans." The big question is whether "working the pay plan" sufficiently and productively aligns the goals and objectives of clinicians with those required for the performance success of the organization?

Compensation design philosophy also drives considerations regarding the mechanics of how cash compensation is managed. As with almost any array of incentives that affect human behaviors at work, there is the potential for unintended consequences (good and bad). **Exhibit 4** provides an array of such design considerations gathered from "the field." A summary of experience with each is provided.

The big question is whether "working the pay plan" sufficiently and productively aligns the goals and objectives of clinicians with those required for the performance success of the organization?

6 Here, total costs of care is defined as total costs consumed by individuals who are identified as having a profile of clinical conditions affected by one or several related and intervening factors over a specified period of time.

Simplified, compensation design philosophies exist on a continuum. The range of philosophies can be described as one from the simplistic to the complex (see **Exhibit 5**).

As is the case with most management decisions, adherence to extreme positions on any operating philosophy or management theory can be counterproductive. The best answers often lie somewhere in between. But, getting the organizational philosophy clear is important because all else follows: incentives design, managerial mechanics, organizational behaviors, and performance results.

Exhibit 5: Continuum of Compensation Design Philosophies

Philosophy A		Philosophy B
The best design simulates how the incentives of "private practice" affect clinician compensation, including all inherent risks and rewards; a simulation of the "real world" (i.e., physicians being fully exposed to the vagaries of changing marketplace).	Variations on Themes	Clinicians are employees as are all others; they should be fully insulated from the vagaries of healthcare market dynamics and changing economic policies and regulations, and all dynamics they can't directly control. Physicians should not be exposed to that which they can't control.

Culture and Leading Professionals

When forming cash compensation design philosophy, there is a need to determine whether clinician behaviors are principally managed by cash incentives or the culture, influence, and direction of leaders, colleagues, and peers. IHSs, especially those in early stages of development, often search for the "magic" formula that doesn't require influencing the behaviors of physicians. As IHSs mature, most come to realize that mechanical formulae don't lead or manage people—leaders and managers do. So, the "big deal" in compensation philosophy is creating a design that strikes a healthy balance between the mechanics of a formula and behavioral management requirements derived from effective leadership.

One test of the potential for striking such a successful balance is to look at the job descriptions of clinician leaders. These must include the presence of clear responsibilities for the behaviors of clinicians working within clinics or clinical programs where the cash compensation designs and incentives apply. These position descriptions should clearly describe how leaders interact with clinicians to evaluate, coach, and influence the professional behaviors of clinicians working in their areas of responsibility.

Position descriptions of leaders (especially identified clinician leaders) should provide clarity on how the responsibilities and accountabilities of the positions tie to the broader approach to the leadership and management of the IHS, including the relationship ties of the goals and objectives of individual clinical departments (or divisions) to the greater physician/provider enterprise within the IHS and, ultimately, to the performance and success of the IHS overall.

Job description language must be explicit regarding goals and the interdependence of the clinical services, programs, and related obligations and accountabilities of the individual physician/provider working within the IHS. Such language also makes clear the responsibilities and accountabilities not provided for within the compensation design, including the implied covenants between the individual physicians/providers and the IHS.

The Role of IHS Governance in Compensation Plan Design

A strong argument can be made for an IHS governing body to stay out of the design and management of physician/provider compensation plans. However, a stronger argument can be made for proper involvement of IHS governance to the point of ensuring that physician/provider compensation models are designed and managed to best advance the mission, goals, and objectives of the IHS.

To this end, routine management reporting of IHS performance to the board should include both objective and subjective evaluations of the overall effectiveness of the physician/provider compensation plan set in the context of the IHS's mission, values, and goals.

How Does This Apply to Clinicians in Academic Health Centers?

The compensation design philosophy and models presented above are applicable to both community-based integrated health systems as well as academic health systems. The related question addressed here is: "Are the goals and objectives of academic health systems so different from those of community-based health systems that clinician compensation plan designs must, by design, be very different?" To answer that question, let's briefly explore how academic and community-based health systems are similar and different (see Exhibit 4) from each other to understand what factors might be necessary to best align providers with health system goals.

In general, the most successful academic health systems (AHSs) achieve alignment between the research, education, and clinical missions so there is synergy between and across all missions, as well as shared responsibility for the investments and performance of each. That interplay between the missions introduces additional factors that must be considered in establishing physician incentives, even for those solely related to clinical activity.

The incentives necessary to achieve the experience, cost, or outcomes in clinical care are arguably the same for all integrated health systems. Some believe the motives for physicians in AHSs may be more tilted towards research to the disadvantage of clinical care. In fact, there is much evidence the best medical schools, as ranked by Blue Ridge,[7] are often aligned with the best hospitals. Indeed, the concordance between medical school stature and the best hospitals in the *U.S. News* rankings is notable. Mechanisms for motivating clinicians and providing the environment in which to excel in clinical care delivery are essential in AHSs. In fact, the need to generate margins in the AHS clinical enterprise is even more critical given the need to support underfunded research and medical education from the various clinical revenue streams. Linking clinical compensation incentives to broad system goals is as reasonable with an AHS as with a community health system.

What considerations must be evaluated for the differences inherent in the AHS? The need to generate margins, a constant in both academic and community systems, can be even greater in AHSs that must generate the financial support necessary for ongoing investments in research as well as underfunded education and research activities. This would suggest an even greater need for efficient use of all resources.

Recruitment and retention in AHSs also introduces additional considerations. For highly specialized physicians, whether the specialization is clinical care or research, the market may be national or international. Moreover, compensation profiles generated by local market dynamics bear upon compensation plans for AHSs. So a broad understanding of both the priorities of the highly skilled clinicians and the benefits to the health system must be attained.

7 Blue Ridge Institute for Medical Research, NIH Funding to U.S. Medical Schools, 2006–2014.

While many of the potential metrics are similar to those of physicians in a community system, additional factors such as generating new clinical market share or new research funding may be incented.

While it is critical that the clinical goals and incentives for providers in an AHS are aligned and leveraged, consideration must also be given to aligning the performance of the research and education missions to achieve true differentiation for the AHS within a competitive market. For the sake of demonstration, at one extreme is a community health system with a university name on it—but without ownership or integration of the academic mission. At the other extreme is complete alignment between the clinical and academic missions—functionally and structurally, a fully integrated model. While many systems exist along this continuum, the greatest leverage of the academic mission—both to achieve business goals as well as to serve the community—is likely to occur with greater alignment and structural integration.

An Illustrative Case Example

Community Health System (CHS) is a large, community-based health system with regional reach and a multi-state and international referral draw for specific, complex clinical cases. The CHS model integrates employed, community service-focused physicians with an owned and controlled academic health center (AHC), which includes a medical school and broad research mission funded by a range of public and private research grants.

CHS competes in a "crowded" marketplace with worthy competitors. On the academic medicine "side of the house," there are internal and external competitors for at least 90 percent of the clinical care and programming provided.

CHS operates under a unified governing board (with employed physicians and leaders from the community services medical enterprise and the AHC, including the dean of the affiliated medical school and the CEO of the AHC physician practice plan) and a singular, unified senior management team. The CHS board recognizes that it should not be about the business of designing the compensation plan for clinical providers under the IHS's corporate umbrella. However, it believes it is responsible for defining the principles of the "universal" physician/provider compensation plan (i.e., principles that span plan designs for physician/providers employed to provide community-based care and those who serve the mission of the AHC component of the IHS). The theory is:

> *"Principles of the compensation plan serve the mission, vision, values, and required strategies of the IHS and leadership must create operative designs that effectively harmonize the incentives of the healthcare delivery policies and processes with the required goals and objectives of the whole."*

As a consequence of the implied mandate, CHS governance promulgates the following set of principles to guide compensation design across the various (and varying) operational components and sites of the IHS. The operating incentives of all active compensation plans must:

1. Ensure that the health and healthcare needs of patients are foremost and are well served above all else.
2. Patients are served by known and accepted, evidence-based clinical best practices as vetted by the best, most reliable clinical research with internal peer review and acceptance by the

organization's best-qualified clinical experts.
3. Total costs of care are well considered in the care planning and care plans for all patients.
4. The potential for the financial gain of individual clinical practitioners is never placed above the best interests of the health and well-being of patients and others served.
5. The patient services productivity of clinical services providers is designed consistent with the best interest of patients and where reasonable, the best interests of CHS, including interests that further the long-term viability of the organization.
6. The professional behaviors of practicing clinical professionals are overseen by an authorized peer(s) in a position of leadership authority who has as an assigned responsibility for the welfare of patients as well as the organization.
7. Senior leadership of the IHS believes that the active physician/provider compensation plan of the IHS can be successfully implemented to serve the guiding principles as defined.
8. The compensation of leaders and managers who operate the mission-guided services of the IHS is well aligned with the comprehensive mission and mission plan of the organization.
9. The research and teaching goals of the IHS are advanced and are sustainable.

These nine principles serve as examples of how an important connection is made between the responsibilities of governance of an IHS and the design and operations of a compensation design for an IHS, including those that span a strategy of community health services delivery and academic medicine.

What Might the Future Hold for IHS Clinician Compensation Plans?

If it is safe to assume that "pay plans" will continue to influence the behaviors of humans in the work setting for as long as humans are at work, then IHSs will likely be in a constant state of developing compensation plans for employed clinicians. As such, it's useful to look ahead in an attempt to identify the issues and dynamics that may define or at least influence compensation designs for future IHSs, including potential market disruptors:

1. Technological advances, (e.g., hand-held health status monitors and related devices), telehealth, self-care, and virtual care.
2. Genomics and the opportunities to customize prescriptive care plans, including preventive care plans tailored to individualized health risk profiles.
3. Moving from fee-for-service to value-based payer reimbursement schemes. With these, IHSs assume financial risk for defined populations, by contract with third-party payers.[8]
4. The "Watson Effect": computer-designed care plans; the eventual ability of supercomputers to map evidence-based, best-practice pathways to care planning and clinical pathway prescriptions.
5. Interprofessional team care models.[9]
6. Effective interaction and collaboration of clinicians and clinical programs within an IHS.
7. Health insurance plans that create incentives for "narrow network" clinical behaviors by clinicians and patients (i.e., incentives to retain care within a defined "system of care").
8. Physicians' interests in the security of employment relationships; the attraction from independent practice to the planned and managed "system" of care delivery and health management employment opportunities.
9. A need to encourage the ongoing development of professionals within organizations; creating an environment that supports professional development along a career path; providing benefits of career development and a tangible, valued benefit of the IHS.

8 D.K. Zismer, "How Might a Reforming U.S. Healthcare Marketplace Threaten Balance Sheet Liquidity for Community Health Systems?," *Journal of Healthcare Management*, Vol. 58, No. 3, May/June 2013 (pp. 168–172); and D.K. Zismer and C. Beith, "Free Cash Flow Productivity and Its Connections to U.S. Health System Financial Performance and Strategy in Current and Future Markets: A 'Macro View' of a Potentially Systemic Problem," The Governance Institute, February 2014.

9 D.K. Zismer, "An Argument for the Integration of Healthcare Management with Public Health Practice," *Journal of Healthcare Management*, Vol. 58, No. 4, July/August 2013; pp. 253–257.

Conclusion

As IHS design and function matures in the U.S., so should the compensation models for physicians and other clinical service providers who practice within them. IHSs will come to understand that the incentives set in motion by their compensation plans drive the behaviors of those operating under them. As such, the incentives at play affect the performance of the whole.

The ultimate goal in the design of provider compensation models is their ability to effectively serve temporal business plans while ensuring the longer-term reputations and sustainability of the organization; especially goals related to health services quality, value, customer service, and the ongoing pursuit of optimized best clinical practice and care.

Physician/provider compensation designs and plan management are fundamental to the ongoing mission and viability of any and every integrated health system. IHS leaders and boards must be mindful of how physician/provider compensation plan design and management affects the "greater whole" and the "greater good" of the organization. IHS boards are encouraged to test operating provider compensation plans against the sample principles offered above to begin the dialogue between the board and senior leadership.

The conversation begins with a fundamental question posed by the board: "Does our compensation plan effectively align the incentives of integrated clinicians with the goals and needs of the health system today and into the future?"

The Governance Institute thanks Daniel K. Zismer, Ph.D., Wegmiller Professor, Director, M.H.A. and Executive Studies Program, Division of Health Policy and Management, School of Public Health, University of Minnesota, and Adjunct Professor, Division of Medicine; and Bobbi Daniels, M.D., CEO, University of Minnesota Physicians, and Vice Dean Clinical Affairs, University of Minnesota Medical School, for contributing this special section. They can be reached at zismeo06@umn.edu and danieo03@umn.edu, respectively.

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Igniting Innovation

BY DAVID A. SHORE, PH.D., HARVARD UNIVERSITY AND UNIVERSITY OF MONTERREY (MEXICO), BUSINESS SCHOOL

When it comes to change, people reflexively fear the new. However, the rationales for this fear vary in healthcare delivery organizations.[1] More often than not a leading argument is some manifestation of the NIH ("not invented here") syndrome, which is a recurring affliction and a cause of fatigue in igniting innovation. Another familiar refrain when a change initiative is proposed is to take a "not now" approach. Rather than decide whether or not to invest, leaders and governing boards take on a "wait and see" attitude. I know of no better ways to extinguish ideas for future innovations than these two responses. In today's ever-changing environment, healthcare leaders need to be open to new ideas and create a culture where innovation is cultivated.

The Semmelweis Reflex

An exploration into the challenge of change in healthcare and the consequences of not changing would not be complete without exploring the Semmelweis Reflex case. The Semmelweis Reflex (or Semmelweis Effect) is a metaphor for the reflex-like tendency to reject new evidence or knowledge because it contradicts established norms, beliefs, or paradigms. This was named after Ignaz Semmelweis, a 19th century Hungarian obstetrician whose perfectly reasonable hand-washing recommendations were ridiculed and rejected by his contemporaries. As you read the following story, I invite you to reflect on this question: If physicians found it so difficult to grasp as intuitive and straightforward a prophylactic practice as hand washing, how challenging is it for healthcare professionals today to embrace innovations where the evidence is far less clear, the ROI is far less certain, and the potential adverse consequences far more personal?

Dr. Semmelweis worked at the generally well-respected Vienna General Hospital. However, the mortality rate among women on his ward was one in 10. Its reputation was so bad that many women preferred to give birth on the street and *then* go to the hospital. It is estimated that 2,000 women died each year in Vienna alone from Puerperal fever. Patients at Vienna General Hospital pleaded to be transferred off of Dr. Semmelweis's ward and onto a second section of the maternity ward where the mortality rate was (only) one in 50.

Dr. Semmelweis became consumed by the disparity on the two wards and attempted to control all factors (i.e., birthing positions, ventilation, diet, venue for laundry). He noticed there was one glaring distinction between the two sections. His section was attended by physicians, while the other section was attended by midwives. As a teaching and research hospital, physicians split their day between research on cadavers in the morning and treatment of patients in the afternoon. Midwives were neither required nor allowed to perform autopsies. Dr. Semmelweis concluded that "particles" from cadavers and other diseased patients were being transmitted to healthy patients by the hands of physicians. He experimented with various cleansing agents and eventually instituted a policy requiring all physicians to wash their hands thoroughly in a chlorine and lime solution before examining any patient. The death rate precipitously fell to one in 100.

In 1848, the mortality rate in Dr. Semmelweis's division went from 18.27 percent to 1.27 percent. Yet, the doctor was *not* rewarded for his discovery and changes in protocol. In fact, the following year, he was dropped from his post at the clinic and turned down for a teaching position. In 1861, he published a book; however, his doctrine continued to be roundly rejected by the medical community. A few years later, he suffered a nervous breakdown and was admitted to a mental hospital, where he was routinely beaten by asylum personnel and died at the age of 47. It was 14 years later that his discovery was accepted after Louis Pasteur revealed the presence of Streptococcus in the blood of women with child fever.[2]

Key Board Takeaways

Higher-performing hospitals and health systems all have one thing in common: the ability to ignite innovation. Too often leaders fear what is new and different and end up dismissing or pushing off innovative ideas. Healthcare delivery organizations need people in leadership positions to be agents of change, capable of igniting innovation and realizing benefits from these efforts. Boards should evaluate their own organization's tolerance and capability for change:

- Do we have the capacity and infrastructure to ignite innovation?
- Are leaders effectively managing organizational change?
- Is innovation encouraged at all levels of the organization?
- What can we do to stimulate and sustain a culture of change?

Being Right Isn't Good Enough

The Semmelweis case reminds us of Voltaire's warning, "It is dangerous to be right in matters on which the established authorities are wrong." It further reminds us that the human mind often treats a new idea the same way the body treats a strange protein, it rejects it and often tries to destroy it.

Had Dr. Semmelweis received training in "soft" or non-cognitive skills his efforts to introduce change might have met with a more positive response. Indeed, with regard to the selection of healthcare leaders (both clinical and non-clinical) there is currently a tradition of measuring these non-cognitive factors in an effort to predict

1 David A. Shore, *Launching and Leading Change Initiatives in Health Care Organizations: Managing Successful Projects*, San Francisco: Jossey-Bass, 2014; David A. Shore and Eric D. Kupferberg, "Preparing People and Organizations for the Challenge of Change," *Journal of Health Communication*, Vol. 19, No. 3, 2014, pp. 275–281.

2 The Semmelweis story is drawn from multiple sources including: The Arbinger Institute, *Leadership and Self-Deception: Getting Out of the Box*, San Francisco: Berrett-Koehler, 2002; Ignaz Semmelweis (translated by K. Codell Carter), *The Etiology, Concept, and Prophylaxis of Childbed Fever*, Madison: University of Wisconsin Press, 1983; K. Codell Carter and Barbara R. Carter, *Childbed Fever: A Scientific Biography of Ignaz Semmelweis*, Westport: Greenwood Publishing Group, 1994.

success.[3] Generally, healthcare leaders have responsibilities that can be grouped into three main domains:

1. **Managing up:** relationships with CEO, board, and dean
2. **Managing across:** relationships with other members of the leadership team
3. **Managing down:** relationships with division chiefs and chairs, etc.

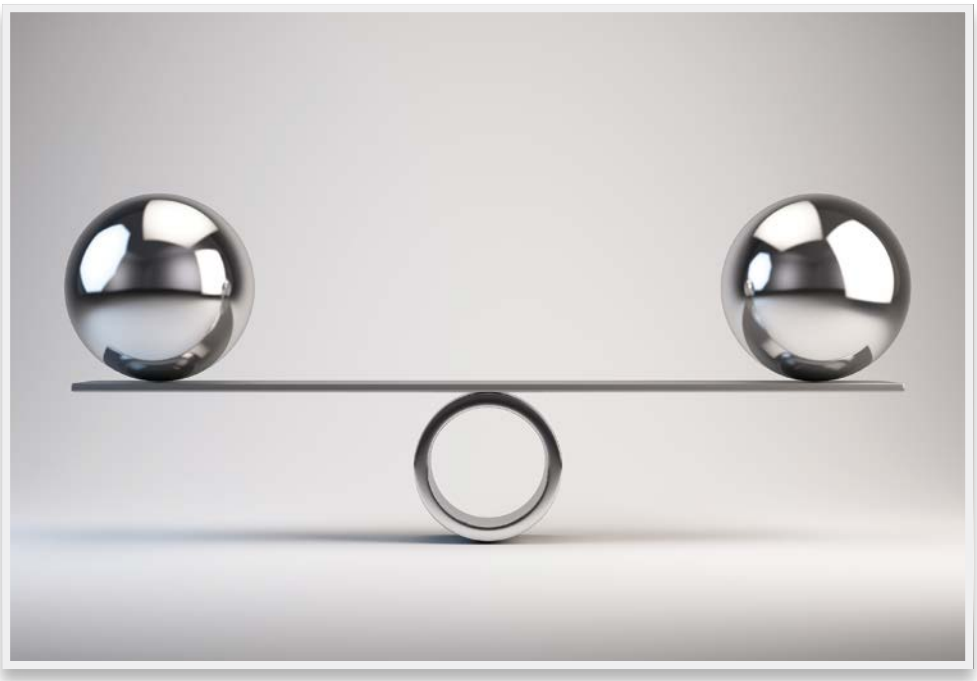
Despite the growing importance of personal and social skills, most healthcare organizations have a long way to go in assessing these critical management skills. The task becomes all the more pressing when we add a requisite fourth category: *managing change*.

The Big Five Personality Trait Taxonomy

In contrast to the past, there now exists a reasonable degree of consensus that personal characteristics that impact job performance cluster into five main domains, often referred to as the "big five."[4] The big five personality trait taxonomy includes:

1. Extroversion
2. Agreeableness
3. Conscientiousness
4. Emotional stability
5. Openness to experience

The first four traits might be thought of as the "usual suspects" and therefore perhaps of little surprise to most. It is the fifth trait we so desperately need in our leaders: *openness to experience*. Openness to experience includes the degree of intellectual curiosity, creativity, and a preference for novelty and variety. This trait also refers to the extent to which a leader is "imaginative, independent, adaptable, and *change oriented*."[5] In other words, healthcare delivery organizations need people in leadership positions



to be agents of change—serial innovators, capable of igniting innovation and realizing benefits from these efforts.

I am currently working with the leadership team of a service delivery organization in which managing organizational change has been identified as one of a handful of core competencies (i.e., communication, team leadership, business acumen, and functional performance effectiveness). We have established evaluation criteria along three classifications—questionable fit, solid performer, outstanding—each with a narrative that describes and defines the criterion. When we started six months ago, the leadership team gave itself high marks on the other core competencies, but when it came to managing organizational change there was consensus that is was a "questionable fit." Now, halfway through a year-long executive education and consultation period, the group self-assesses themselves as "solid performers" en route to "outstanding." The goal is to create inside entrepreneurs or "intrapreneurs"—acting and behaving like entrepreneurs while working inside the organization. After all, how could you expect anything less of management and boards when 60 percent of CEOs list innovation as their company's primary focus?[6] There is one important caveat, and that is that these internal change agents do so without incurring the risks often associated with entrepreneurs.

In my experience, what distinguishes higher-performing organizations from the rest is the chronic failure of most organizations to ignite innovation. When we ask CEOs, boards, and leadership teams what keeps them up at night, "failure to innovate" is regularly referenced as a challenge that haunts them. Imagine how history may have been different if our protagonist, Dr. Semmelweis, had the training and toolbox to be rated "outstanding" in managing organizational change. It is time to remedy our healthcare culture in which the Semmelweis Reflex is a common affliction. How about adding this as a goal to next year's strategic plan?

The Governance Institute thanks David A. Shore, Ph.D., former Associate Dean of the Harvard University School of Public Health, and current faculty of Harvard University and Adjunct Professor of Organizational Development and Change at the University of Monterrey (Mexico), for contributing this article. Dr. Shore is also on The Governance Institute's faculty. He can be reached at dshore@fas.harvard.edu.

3 F. Lievens and P. Sackett, "The Validity of Interpersonal Skills Assessment via Situational Judgment Tests for Predicting Academic Success and Job Performance," *Journal of Applied Psychology*, Vol. 97, No. 2, 2012, pp. 460–468; Fredrick L. Oswald et al., "Developing a Biodata Measure and Situational Judgment Inventory as Predictors of College Student Performance," *Journal of Applied Psychology*, Vol. 89, No. 2, 2004, pp. 442–452.

4 Murray R. Barrick and Michael K. Mount, "The Big Five Personality Dimensions and Job Performance: A Meta-Analysis," *Personnel Psychology*, Vol. 44, 1991.

5 *Ibid.* (italics added)

6 PricewaterhouseCoopers, Global CEO Pulse Survey, 2013.

Bundled Payments Show Early Promise…

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of new payment methodologies such as bundled payments.

5. The Confidence Quotient

Confidence is the single most important ingredient to being able to run to risk. Risk can be described as the gap between opportunity and success, and without it the greatest opportunities your organization holds may not have the possibility to develop and flourish. For many healthcare leaders and providers, the risk terrain is nerve-racking, but it does not have to be. Confident executives with an eye on the long view will enable their organizations to get smart about the nuances of payment reform and make strategic risk decisions that make sense for their market and patient population, both in the short-term and the long-term.

6. The World's Best Athletes Need Coaches and So Do You

The best athletes in the world have someone behind them observing their every move and telling them how they could be better. The ability to execute change is not inherent among all leaders, and with payment reform comes a new playbook. The difference between good leaders and great leaders is that great leaders know what they know and seek outside expertise to guide them through the "risk" terrain.

7. Your Worst Failure Is Your Greatest Success

Managing "fusion" reimbursement models requires an understanding that innovation is the hardest work to do, and failure is not failure at all; rather, it is just a data point on the journey to transformation. Failure cannot be personalized, and future leaders understand the need to "roll with it" and move quickly through tests of change. In order to effectively compete in a time of industry transformation, the really great leaders, those capable of transforming organizations, will demonstrate a high degree of failure tolerance.

8. Upending Orthodoxies and Traditions

Healthcare and the practice of medicine are steeped in tradition, which often slows us down. New payment models will drive demand destruction; therefore, we must be willing to ask better questions and find innovative solutions to eliminate waste and duplication. Put yourself in the shoes of your patients, their families, and your staff and begin to ask better questions. What are the irritants of a physician's day? What is it like for a patient to navigate your organization? Speaking truth to orthodoxy and tradition is the birthplace of care delivery transformation upon which payment transformation is predicated.

9. Now Is the Right Time to Lock In Your Post-Acute Care Strategy

In 2012, Medicare spending on post-acute care exceeded $62 billion, with post-acute care representing the use of home health services, skilled nursing facilities, rehabilitation facilities, long-term care hospitals, and hospices.[2] While research has demonstrated that Medicare beneficiary spending varies greatly among the 306 Dartmouth hospital referral regions (HRRs), the largest driver of overall variation can be attributed to spending on post-acute care, with skilled nursing facilities and home health as key drivers. Bundled payments have the potential to improve care coordination and quality of services, rationalize service use, and lower potentially avoidable readmissions.[3] Through regional partnerships, opportunities for savings include lower total cost of care through the reduction of waste and clinical variation, service line efficiencies through enhanced care redesign and resource allocation, increased transparency through data and analytics, and improved operational performance through lower average length of stay and readmissions.

10. The Innovation Imperative

Healthcare transformation is heavy lift, and payment transformation will only get us so far. It is estimated that bundled payments may offer Medicare approximately 5.4 percent reduction in spending growth.[4] It is estimated that 25 to 35 percent of what we do today adds no value. To reduce even half of the waste in our system requires ubiquitous access to health information and significant process reengineering. Healthcare organizations must build an innovation engine if they are going to compete tomorrow. Innovations in care delivery, smart partnerships, and new products and services will enable healthcare leaders to remain strong leading into the unknown.

Closing Thoughts: Taking the Long View

Payment reform is still evolving. First generation transformation is not the end game; however, this does not give us a "pass" to do nothing. Healthcare in the United States is *still* the most expensive in the world with an estimated price tag of $3.5 trillion for 2014, representing nearly 20 percent of the U.S. economy. Of the 11 wealthiest nations in the world, the U.S., once again in 2014, comes in dead last on average life expectancy, infant mortality, and efficiency.[5]

So while we continue to pay more—more than double the highest-performing countries—we don't get more. If we know anything, it is that while fixing healthcare is complex and highly political, there is no nation and no group of leaders more capable. Humility, failure tolerance, innovation, and smart execution will guide leaders as they make the run to risk. The run to risk includes embracing accountability for the care that we provide. We can, and we must do better, and while payment reform is not the end game, it is a critical step toward world-class healthcare in the United States.

The Governance Institute thanks Deirdre Baggot, Ph.D.(c), M.B.A., RN, Senior Vice President, Kimberly Hartsfield, M.P.A., Vice President, and Tori Manis, M.B.A., Senior Manager, from The Camden Group for contributing this article. Ms. Baggot is the Former Lead for the CMS Acute Care Episode Demonstration and CMS Reviewer for Bundled Payments for Care Improvement Initiative and is the Bundled Payment Practice Leader for The Camden Group. They can be reached at dbaggot@thecamdengroup.com, khartsfield@thecamdengroup.com, and tmanis@thecamdengroup.com.

2 Larry H. Bernstein, "Post-Acute Care—Driver of Variation in Healthcare Cost," Leaders in Pharmaceutical Business Intelligence, February 21, 2014.

3 Report to the Congress: Medicare and the Health Care Delivery System (MedPAC Report), June 2013.

4 Peter S. Hussey et al., "Episode-Based Performance Measurement and Payment: Making It a Reality," *Health Affairs*, Vol. 28, No. 5, September/October 2009, pp. 1406–1417.

5 K. Davis, K. Stremikis, C. Schoen, and D. Squires, *Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally*, The Commonwealth Fund, June 2014.

Conemaugh Health System's Journey...

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generated a great deal of interest; they liked what they saw in us. We would have been exceedingly fortunate to have chosen any of the three finalists. The board ultimately decided in March 2014 to go with Duke LifePoint, with the deal closing August 31, 2014.

Because we call ourselves a professionally managed, physician-led organization, our physician involvement was critical to the acquisition process, as their input carried a great deal of weight as to which organization we eventually chose. Their involvement was important to the ongoing success of Conemaugh Health; they felt actively engaged in the process. While Duke LifePoint had a solid reputation as an academic and teaching organization, it also brought additional competencies in operating small hospitals. Our physicians saw this firsthand during our reverse due diligence. They were excited about bringing those clinical parameters like evidence-based protocols and population health to our community.

Another key to success of the acquisition was the similar cultures at Conemaugh Health and Duke LifePoint. Staff members at both are used to being actively engaged and enjoy the transparent nature of leadership. This was an important factor in our decision to select Duke LifePoint.

As part of the acquisition terms, Conemaugh Health maintains an advisory board of directors in which a representative from Duke LifePoint is a member. The majority of the board continues to include local leaders and physicians, and the board is very much a part of physician credentialing, patient safety, and quality aspects of the organization; they in a sense serve as ombudsmen for the community to Duke LifePoint.

Because we were a non-profit, we were concerned that the switch to for-profit now meant changing how we serve the community. Some for-profits have a reputation of turning away patients; we accept all patients. There were no changes to our charity care policy. In fact, Duke LifePoint has made our policy theirs.

Though we are now part of a larger organization, there is only one major difference now that we are a for-profit healthcare organization—we pay taxes. This is exciting and very positive for our community. Beginning January 1, 2015, the community benefits to the tune of $3 million to $4 million in tax revenue each year that was not available when we were a non-profit.

From recruiting physicians to investing in new technology and expanding services, being part of Duke LifePoint provides us the resources we need not only to survive in the evolving healthcare landscape but to thrive. It was a deal our board believed was well worth pursuing.

The Governance Institute thanks Scott A. Becker, FACHE, Chief Executive Officer of Conemaugh Health System, for contributing this article. He can be reached at sbecker@conemaugh.org.

Invigorating the Board Quest...

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Healthcare has already established this policy). This assumes, of course, that the system itself is operating on an appropriate platform. It also requires that this condition be prospectively stated (a requirement for three to five years out) so that physicians have time to plan for the transition.

There are approximately 800 physician office EHRs. We don't know what the right number is (three to five?), but we're certain that even 100 is far too many for a system to support. Working with their IT executives, boards must identify the office platforms that are compatible with the system.

Step 3. Link Physician Compensation to Quality Outcomes

One of the primary roles of any board is the oversight of the physician compensation program. Typically, compensation is tied to quality, but unfortunately most boards don't demand quality *outcomes*. Rather, the requirement tied to compensation is usually just that the physicians and management are working on quality processes.

Today, it is not enough to demand that processes be followed. High-performing boards must focus and incentivize physicians (in a meaningful way) on documented quality outcomes that show improved clinical, operational, and financial performance. Boards should set the tone that it is no longer acceptable for physicians to just be productive. In today's environment, physicians not only need to be productive (which is not just WRVU generation) but must also be following protocols, achieving clinical outcomes, and focusing on managing patient populations rather than individual patient encounters that maximize their productivity.

Step 4. Increase Oversight of Quality in Physician Offices

Every hospital utilizes its MEC to assist in evaluating the quality of inpatient care. A similar group must oversee patient care in the employed physician offices. Boards retain responsibility for the quality of care in these offices just as they do for inpatients. If the equivalent of the MEC for these practices doesn't exist, it needs to be established quickly.

By taking the steps outlined above, boards will ensure that quality improvement is real, and send a clear message to the medical staff that its oversight is diligent and vigorous. Finally and most importantly, these steps will help the board and medical staff work together, at the appropriate levels, to create an ideal care environment for every patient.

The Governance Institute thanks Don Seymour, Executive Vice President, INTEGRATED Healthcare Strategies, and Governance Institute advisor, for contributing this article. Chad Stutelberg, Executive Vice President and Practice Leader, was also a contributor to this article. They can be reached at don@donseymourassociates.com.

Invigorating the Board Quest for Quality Improvement

BY DON SEYMOUR, INTEGRATED HEALTHCARE STRATEGIES

For at least two decades, the Dartmouth Atlas has proven that there is great and unexplained variability in clinical practice across the country.

Dr. Glenn Steele, a surgeon and the CEO of Geisinger, has stated that patient care in U.S. is suboptimal 50 percent of the time (where optimal consists of right time, right place, right diagnosis, right treatment, and right price).

The relationship between the board and the medical staff is a key component in the quest for quality improvement. But board and medical staff relationships have gone stale in too many organizations. Little has changed since 1950 and it's time for boards, together with their MECs, to rejuvenate this critical relationship. While most physicians are willing and anxious for this to occur, the ball is in the hands of the board.

Since the Greatest Generation returned home, boards have delegated responsibilities to the MEC for three core functions: credentialing, privileging, and peer review. With one exception (requiring physician specialty board accreditation), boards have allowed their oversight responsibility to largely be reduced to a retrospective, frequently pro-forma review of MEC recommendations in these three core functions. This needs to change.

The Mandate for Change

The American Board of Medical Specialties (ABMS) recognizes 24 distinct specialties (cardiology, neurology, gastroenterology, etc.). Each specialty has at least five areas of subspecialty (ABMS recognizes 148), and many of these physicians treat patients in four distinct venues: emergency room, ambulatory, inpatient, and office. That means there are well in excess of 300 areas (i.e., strategic business units) in which boards are required to exercise policy setting and oversight. Complicating this, most physician/patient encounters are considered a "just in time" event. That is, while an arthroscopic procedure may not technically vary greatly from patient to patient, there are multiple nuances involving each patient, physician, and other clinicians—factors contributing to the clinical variation occurring now.

Providers know that something has to change, and we believe that change should take place at the individual system/hospital level on a specialty-by-specialty (subspecialty) basis.

Every board we know of is working diligently through its quality committee and its MEC to improve clinical outcomes—which can be a complex and often frustrating endeavor. But it doesn't have to be this way. This article describes several steps boards can take to proactively raise the bar in quality improvement and medical staff oversight. These steps will improve outcomes in quality, safety, satisfaction (patient, physician, and employee), and efficiency. They will lead to improved clinical and financial outcomes in all three methodologies by which providers are currently paid: traditional fee-for-service, acute care performance (narrow network), and capitation (HMO and Medicare ACO). Finally, these steps will lead to a rejuvenation of the relationship between the board and medical staff.

Step 1. Enhance the Board Quality Committee's Approach

The first step is to refocus the work of the board quality committee at the appropriate level (i.e., governance, not operations). This means adopting a standard continuous quality improvement approach, which keeps the board focused at the right level: structure, process, and outcomes. In order to be effective, the effort must be led by someone with experience in such an endeavor. This certainly can—but doesn't have to—be a physician. Board members with such experience come from a variety of backgrounds including banking, manufacturing, hospitality, retail, and education.

In addition, boards, working with their executives and MECs, need to revise their approach to granting of privileges and peer review to include utilization of proven best practices and clinical protocols. Physicians must be allowed to exercise clinical judgment and to make decisions outside the bounds of the protocols, but this should occur infrequently. The challenge is to set a standard set of expectations (usually via board policy). Norton Healthcare in Louisville, Kentucky, is an example of one system that has already adopted this approach as a requirement for practice on their staff.

Key Board Takeaways

The board and medical staff must work together proactively to ensure continuous improvement of quality, safety, satisfaction, and efficiency. The following are key steps to take to ensure the board and medical staff relationship is both appropriate and effective:

- Enhance the board quality committee's approach through continuous quality improvement, and establishing standard clinical protocols for privileging/credentialing.
- Use the electronic health record as a quality determinant.
- Link physician compensation to quality outcomes.
- Increase oversight of quality in physician offices.

In some specialties they have adopted national best practices, and for other specialties, physicians have come forward to establish their own.

Step 2. Use the Electronic Health Record As a Quality Determinant

While EHR implementation can be time consuming, costly, and frustrating, we know that in time these systems will simultaneously improve quality, safety, satisfaction, and efficiency. Thus, this is an important area of focus for the board's quality improvement quest.

But IT implementation is just the first step. If boards are to monitor quality improvement, they must also oversee progress in its utilization.[1]

Boards and their executives, together with their MECs, should also require, as a condition of privileging, that physicians utilize an EHR that is interoperable with the system and other physicians (again, Norton

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1 The Healthcare Information and Management Systems Society has provided a tool for this, the HIMSS EHR adoption model, which is available from HIMSS Analytics (see www.himssanalytics.org/emram/emram.aspx) and establishes standards for eight stages of adoption. Boards, through their executives, need to work with their medical staffs to establish an approach to reaching the final stage.