BoardRoom Press

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The Move toward Population Health

Price Transparency

SPECIAL SECTION

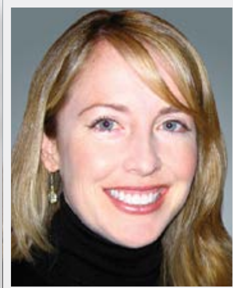
Building Population Health Capacity

Managing IT Vendor Relationships While Avoiding the Weeds

ADVISORS' CORNER

Local Markets Driving Adoption of Value-Based Care Delivery

Population Health, Community Benefit, and Patient-Centered Care



This month's issue contains articles on topics ranging from population health to IT vendor relationships to price transparency. But there is a common thread throughout—the customer, the patient, the person at the nucleus of our multi-faceted endeavor to change healthcare delivery.

Our lead article demonstrates that population health can be done in rural, smaller markets through innovative partnerships that recognize that "patients" are rapidly becoming "consumers" who are increasingly sensitive to price and access. The more "skin in the game," the more important it becomes then to have price transparency. The special section goes deeper on population health through a community benefit approach—using community benefit portfolios not just to "check the box" but to help build internal population health capacity. At the center of this community benefit approach is the understanding that the imperative is to move beyond episodic treatment and focus on the whole person. And as payment models continue to move towards value-based care, achieving the Triple Aim requires understanding how patients define value.

Kathryn C. Peisert *Managing Editor*

The Governance Institute is excited to announce the launch of our new Web site on June 2!

The new Governance Institute Web site will be your source for healthcare governance publications, resources, conferences, and advisory services tailored specifically to those focused on premier board performance. We invite you to discover all that the new Governance Institute Web site has to offer. Visit www.GovernanceInstitute.com often to stay up to date on all new offerings we provide to you as a part of your membership. Questions? Contact us at (877) 712-8778 or info@GovernanceInstitute.com.

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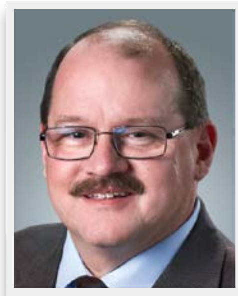
The Move toward Population Health: A Strategic Approach

BY STEVEN V. LONG, FACHE, HANCOCK REGIONAL HOSPITAL

America's healthcare system in its current form is nonviable. We are at our best when heroic interventions are required and people are rescued from the brink of disaster, but we are out of our comfort zone when confronted with the daily emotional, social, and environmental factors that are the root causes of those potential disasters.

Our business model is reliant on treating illness and injury after they occur, not on prevention and proactively improving health status. Financial success is linked more with heightened flu seasons, end-of-year deductible spending, and improved marketing than with the quality of life of the people we serve via better health; 80 percent of the factors that influence health status are non-medical, yet 80 percent of the dollars we spend on health in America are medical related.



Steven V. Long, FACHE
President and CEO
Hancock Regional Hospital

We have known for decades that the volume-driven, fee-for-service model of healthcare reimbursement was suboptimal. But we knew how to make a margin in that model: more volume and lower costs equaled success. Similarly, our colleagues on the payer side knew how to make a margin collecting premium dollars and controlling payments to providers. None of us knew how to make a margin in between those extremes, so we resisted change. But now it is clear that not only is change happening (for real this time), it is happening quickly so we need to figure out how to survive the transition.

At Hancock Regional Hospital in Greenfield, Indiana, our board has embraced the concepts of the Triple Aim (better care, better health, lower costs) and believes it offers guidance on how best to thrive in a new environment focused on value and population health. The first step in our journey was to fully understand what these two terms meant for a semi-rural hospital in central Indiana. We understood that, due to the prevalence of high-deductible health plans in our area, "patients" were rapidly becoming "consumers" and are increasingly sensitive to price and access. We understood that government and commercial health plans were requiring demonstrated value as part of their payment paradigm, and proof of exceptional clinical quality and patient experience were required. We also understood that consumers, employers, payers, and communities were all demanding improvements in health status for populations of people and this would require skills in care management and partnerships with community organizations far beyond our current scope and expertise.

While the magnitude of the change is daunting, our board knew we could adapt. It also knew that margin protection during and after the transition would be imperative and our past record of financial and operational success placed us in a great position. With this in mind, the board, administration, and physician leaders looked closely at the changing environment locally, regionally, and nationally. We then created a set of characteristics that described what we believed a robust organization operating in a value-based, population health-oriented environment in Greenfield, Indiana, would need to exhibit not just to survive, but to thrive. The resulting 10-item, one-page document included characteristics ranging from the importance of community members considering us their partner in healthcare (not hospital care), to developing approaches to proactively work with individuals in improving their health status via care management techniques, to partnering with community organizations to create healthy public and home environments.

One of the most important elements was embracing the new accountable care organization (ACO) we established in partnership with four other suburban Indianapolis hospitals.

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Key Board Takeaways

The healthcare industry is undergoing a complete transformation and hospitals, especially those in rural or suburban areas, are challenged with figuring out how to succeed in this new environment. As boards look to the future, they are asking: What do we need to do now to strategically position our organization for population health-based reimbursement models? Leaders at Hancock Regional Hospital had this discussion and decided to become a member of the National Rural ACO. This partnership has allowed the organization to:

- Act as its own ACO but utilize shared governance and resources in a regional consortium.
- Receive additional support for the chronically ill and use wellness promotion programs to improve outcomes and reduce unnecessary ED and inpatient utilization.
- Have revenue streams that are associated with the value of services, rather than the volume of services provided.
- Reduce per capita costs for Medicare beneficiaries in the region.

Price Transparency: What Board Members Need to Know

BY JOSEPH J. FIFER, FHFMA, CPA, HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

Although concern about healthcare prices is not new, interest has exploded in the last two years. In 2013, *Forbes* chose price transparency as the healthcare story of the year, trumping the launch of the Affordable Care Act's health insurance marketplaces.

Consumers have been voicing their frustrations on social media, including the public Facebook group "Paying Till It Hurts," hosted by *New York Times* medical correspondent Elisabeth Rosenthal.

Under the Affordable Care Act, hospitals and health systems are now required to disclose chargemaster prices, but compliance does little to achieve meaningful price transparency; the chargemaster doesn't reflect the prices consumers actually pay. How much more should healthcare organizations be doing? Debates on this topic are making for spirited discussions in hospital boardrooms across the nation. As you consider your organization's approach to price transparency, keep the following framework in mind.

Price Transparency Is Not a Fad

With the increasing prevalence of high-deductible health plans, consumers are paying for a growing share of their healthcare expenses out of pocket. At the same time, healthcare is taking a bigger bite out of their paychecks because the gap between deductibles and wages is growing. Since 2006, wages have grown 23 percent while deductibles for single coverage have risen 108 percent.[1] There is widespread agreement that this shift is unlikely to reverse. Given that consumers have more "skin in the game," it's entirely reasonable that they want to know what they will be expected to pay for healthcare services. And the demand for price transparency today is just the tip of the iceberg. According to a study by the nonpartisan group Public Agenda, 57 percent of insured Americans (and 47 percent of the uninsured) are not even aware that physicians might actually charge different prices for the same services. It's noteworthy that those with higher deductibles are more likely to have sought price information: 74 percent of those with deductibles over $3,000 have tried to find price information before getting care, as compared with 48 percent of those with no deductible.[2]

Improving Price Transparency Offers Opportunities—Not Just Risks

In informal discussions with CEOs recently, it became clear to me that the risks associated with price transparency were top of mind for them. Some are concerned about the impact of greater transparency on their contract negotiations with payers. Others realize that their pricing structures are not transparency ready. And some are focusing on the logistical and technical challenges of providing accurate, timely price estimates. These are all valid concerns, but the opportunities associated with improving price transparency tend to be overlooked—and an understanding of those opportunities can make dealing with the challenges more worthwhile.

First, improving price transparency can strengthen community trust and patient loyalty. The financial experience is generally recognized as a potential dissatisfier but rarely as a contributor to overall patient satisfaction. Yet there is evidence to support a business case. For example, a benchmarking study Healthcare Financial Management Association (HFMA) conducted in 2012 found that 80 percent of patients at hospitals with high-performing patient financial services departments would "definitely recommend" their hospitals, while only 71 percent of patients at hospitals with "average" patient financial services operations would do so. In a time

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Key Board Takeaways

Healthcare consumers have become increasingly interested in the price of their care. As board members are thinking about their hospital/health system's approach to price transparency, they should keep this in mind:

- Price transparency is not a fad. It is being fueled by the shift toward greater cost sharing with consumers, a trend which is likely to continue.
- Although the industry tends to focus on the risks and challenges associated with price transparency, there are opportunities as well, including improving patient satisfaction, maintaining community trust, and leveraging efforts to improve costing and pricing capabilities in preparation for value-based payment.
- Collaboration with health plans and physicians is essential to improving price transparency—no one stakeholder group can do it alone.
- Don't let the magnitude of the task deter you. Start small, but start.

1 Drew Altman, "Why Low Growth in Health Costs Still Stings," *The Wall Street Journal,* April 8, 2015 (available at http://blogs.wsj.com/washwire/2015/04/08/why-low-growth-in-health-costs-still-stings/).

2 Public Agenda, *How Much Will It Cost? How Americans Use Prices in Health Care*, March 2015 (available at www.publicagenda.org/pages/how-much-will-it-cost).

Building Population Health Capacity: Issues and Opportunities for Board Consideration

BY KEVIN BARNETT, DR.P.H., M.C.P., PUBLIC HEALTH INSTITUTE

Proceeding in an Environment of Uncertainty: Population Health and Health Reform

Population health is a hot topic these days, as hospitals and health systems navigate the expansion in coverage and payment incentives begin to shift from volume to value. The pace of change varies substantially across the country, with states such as Massachusetts, Minnesota, Oregon, and Vermont moving rapidly towards global budgeting. Seventeen states have received funding through the Centers for Medicare and Medicaid Services State Innovation Model (SIM) initiative to support a variety of innovations linking healthcare reform and broader population health improvement. At the same time, a number of states in the Southeast, Midwest, and Mountain states continue to reject the federal Medicaid expansion. Associated financial pressures have contributed in some cases to closure of safety net institutions[1] and limit the ability of other hospitals to make strategic investments necessary to adapt to the changing environment (e.g., information systems development, systems redesign).

In states and regions where healthcare reform is advancing, there is growing imperative to move beyond episodic treatment of symptoms to focus on the whole person—to build an understanding of how people interact with their specific environments, and the positive or negative impacts of those interactions. This, in turn, leads inquiry beyond individual patients to how health and illness is manifested at the population level in the context of communities in which people live.

Coming to grips with these issues creates discomfort, since much of what drives health is outside of what can be done in clinical settings. Moving to a value-based system involves assuming financial risk for actions outside of the direct control of providers. An early step being taken by a growing number of healthcare organizations is to implement models of team-based care that include non-clinical members such as community health workers. These team members serve as important intermediaries between clinical service delivery and broader community health improvement. The redesign of clinical care models is an important part of a complex set of reforms that are needed in a rapidly changing environment. As such, most, if not all, provider organizations are on a steep learning curve.

Defining Population Health

Let's get on the same page about the meaning of "population health." In 1997, David Kindig offered a definition of population health as "the aggregate health outcome of health-adjusted life expectancy (quantity and quality) of a group of individuals, in an economic framework that balances the relative marginal returns from the multiple determinants of health."[2] The use of an economic framework was intended to highlight the fact that there are trade-offs in selecting options to address the multiple determinants of health. Given limited resources, those choices have consequences. Determining the correct choice is driven by how much improvement in a specific health measure is produced by alternative interventions (or sets of interventions). A more stripped-down definition of population health was offered by Kindig in 2003 as *"the health outcomes of a group of individuals, including the distribution of such outcomes within the group."* The qualifying phrase focusing on the distribution of outcomes was intended to encourage inquiry into factors that contribute to disparities. In a recent article, Kindig indicated that his 2003 revision was driven by a desire to give more focused attention to health outcomes in the allocation of resources.[3]

In 2007, the Institute for Healthcare Improvement (IHI) introduced the Triple Aim framework. The Triple Aim established three goals for healthcare: to 1) improve patient experience, 2) improve population health, and 3) reduce per capita expenditures. While the Triple Aim has served as a powerful tool to support a shift in emphasis from volume to value in the delivery and financing of healthcare, there has been a tendency among provider organizations to narrowly interpret the population health dimension of the Triple Aim as clinically defined populations, or panels of patients. Common groupings are patients with chronic diseases, and the focus is on the development of clinical management strategies to reduce the acuity of those conditions. In a recent IHI leadership blog, Ninon Lewis, Director of IHI's Triple Aim for Populations Focus Area, notes that some healthcare organizations have overlooked the

Key Board Takeaways

Board members should work with leadership to ensure there is a quality improvement approach to community benefit that helps to build internal population health capacity. Specific questions to think through include:

- Is programming informed by analysis of utilization data (e.g., the volume of preventable emergency room and inpatient visits among uninsured and underinsured patients)?
- Have we used geographic information systems to identify and focus resources in sub-county areas where health disparities are concentrated?
- Are we directing charitable resources towards proactive strategies that address key drivers of poor health in the communities?
- Are we building partnerships with external community stakeholders to align and leverage our resources?
- Have we set measurable objectives for programming, and are we monitoring progress to determine whether those objectives were achieved?
- Is there strategic coordination between community benefit, finance, and population health planning?
- What are the mechanisms for oversight and accountability for community benefit performance?

1 Nearly 50 rural hospitals have closed in the last four years; See Dionne Searcey, "Hospitals Provide a Pulse in Struggling Rural Towns," *The New York Times,* April 29, 2015.

2 David Kindig, *Purchasing Population Health: Paying for Results,* University of Michigan Press, 1997.

3 David Kindig, "What Are We Talking About When We Talk About Population Health?" *Health Affairs* Blog, April 6, 2015, (available at http://healthaffairs.org/blog/2015/04/06/what-are-we-talking-about-when-we-talk-about-population-health/).

population health dimension altogether, "focusing instead on quality, satisfaction, and costs, often in acute care settings."[4]

This more narrow interpretation (or avoidance) of the population health dimension is driven at least in part by the predominance of the fee-for-service, or "volume-based," payment system. In this context, while effective implementation of population health management may reduce patient suffering (and improve their health), it also contributes to reduced revenue for insured populations.

> Moving to a value-based system involves assuming financial risk for actions outside of the direct control of providers. An early step being taken by a growing number of healthcare organizations is to implement models of team-based care that include non-clinical members such as community health workers. These team members serve as important intermediaries between clinical service delivery and broader community health improvement.

In a recent commentary in *Trustee* magazine,[5] William Jessee called for hospital and health system board members to judiciously monitor investments in population health, demanding that leaders "make the business case" prior to authorization of resource allocations for the design of new delivery models, information systems, hiring non-clinical personnel, and community outreach. He noted that in regional environments where fee-for-service reimbursement is dominant, effective investments could create "a financial disaster" for hospitals in the form of reduced admissions, tests, and procedures.

Jessee acknowledged that many hospitals and health systems already engage in community outreach programs as part of returning benefits to communities in fulfillment of their tax-exempt obligations. It is important to note, however, that while these investments could (and optimally, should) yield some form of measurable outcomes for populations and communities, they are not expected to produce net financial returns for hospitals. On the contrary, hospitals and health systems are expected to make net investments of charitable resources that are at least equal to the financial value of their tax exemption.

At present, community benefit expenditures of most hospitals and health systems are primarily in the form of charity care and public pay shortfalls for Medicaid patients. A small portion of these portfolios include educational events such as health fairs and screenings, and a few strategic investments in community health improvement programs. The historical tendency has been to simply tally up and report these expenditures, giving little attention to whether they represent optimal stewardship of available resources. Rather than evaluating the relative effectiveness of alternative resource allocations, many hospitals have a compliance orientation that focuses primarily on whether the net charitable contribution meets financial targets aligned with their tax-exempt obligations.

A growing number of hospital and health system leaders are taking a closer look at current community benefit resource allocations and asking important questions, including the following:

- Does the current configuration of programs and services represent the most cost-effective use of our limited charitable resources?
- Can we point to measurable outcomes produced by our charitable resource allocations that demonstrate a commitment to improve community health?
- Are we building partnerships with external stakeholders with shared interests in improving community health to leverage our resources?
- In what ways are we aligning our community benefit resource allocations with our core business strategy to build population health capacity?

These leaders are shifting their emphasis away from a compliance orientation to community benefit, and towards a quality improvement approach to community health improvement. Rather than simply tally financial totals, they're asking critical questions about the relative value of alternative options. Of equal importance, they have recognized the opportunity for a more integrated approach that aligns community outreach, workforce development, the design of new care models, and information systems development.

In this context, community benefit portfolios can serve as an "investment pool" to help meet strategic goals such as building internal population health capacity. As addressed later in this article, there are effective strategies to pursue both in markets dominated by fee-for-service reimbursement and those that are shifting more rapidly to value-based payment.

> There is opportunity for a more integrated approach to community benefit that aligns community outreach, workforce development, the design of new care models, and information systems development. Community benefit portfolios can serve as an "investment pool" to help meet strategic goals such as building internal population health capacity.

Internal Alignment and Integration

A key step in the process of alignment and integration of efforts to build hospital population health capacity is to assess existing community benefit structures and functions. An early model for the assessment of internal population health capacity was employed in a multi-state demonstration

4 Ninon Lewis, "A Primer on Defining the Triple Aim," IHI Leadership Blog, October 21, 2014.

5 William Jessee, "Is Your Hospital Ready for Population Health?" *Trustee,* February 9, 2015.

project entitled Advancing the State of the Art in Community Benefit (ASACB).[6] Participating hospitals and health systems focused their assessment in three areas: staffing, reporting relationships/departmental links, and oversight structures.

Staffing

Key areas of focus include full-time equivalent (FTE) levels, scope of required competencies, and job responsibilities. Job descriptions should outline not only population health-related competencies (e.g., expertise in epidemiology, program design, evaluation, community engagement), but also responsibilities that delineate the elements of the larger community health improvement process and integration with internal structures and functions (e.g., finance, care coordination, primary care, strategic planning). Those responsibilities include specific accountability measures and FTE component allocations. A standard job description was developed and adopted by ASACB partners.

Reporting Relationships/ Departmental Links

In reporting relationships, supervisors of community benefit staff should have at least a basic knowledge of community health improvement, and accountability to ensure quality in the portfolio of charitable investments. If the supervisor is a member of the senior leadership team, part of their responsibilities are to ensure that there are

regular briefings on the status of relevant work. If the supervisor is not a member of the senior leadership team, their responsibilities should include regular reporting to that senior leader, with attention to alignment with other relevant department functions.

Other department leaders with relevant responsibilities (e.g., finance, strategic planning, data/information, quality, care coordination, human resources[7]) should also have specific language in their job descriptions and associated accountability to facilitate timely coordination of efforts with the community benefit/population health functions in the hospital. For example, finance and care coordination leaders should work with community benefit staff to link patient utilization data with geographic information system (GIS) coded demographic and related data that highlight common and distinct factors and support more precise targeted programs and resources. In order for this to occur, there needs to be specific expectations and reporting of findings from these analyses at the senior leadership and board level.

Finally, hospitals are beginning to think more about the role of their CEOs in the improvement of community health. In the process, more attention is being given to quality and outcomes, rather than simply financial totals. In the ASACB demonstration, partners developed revised language for the job descriptions of hospital CEOs that explicitly outlined their responsibility for community benefit. The inclusion of such language also ensured that these issues would be addressed in future searches and selections of successors. Some ASACB partners took an additional step, tying annual compensation of CEOs to specific strategic targets such as reducing preventable ED utilization for ambulatory care sensitive conditions.

Oversight Structures

Current IRS regulations call for hospital governing boards to formally approve community health needs assessments (CHNAs) and implementation strategies. In practical terms, however, most boards lack the breadth of competencies and dedicated time to offer more than cursory review and approval. The sheer scale and pace of change in today's environment demands attention of the board to a host of financial and legal issues related to quality, patient satisfaction, infrastructure development, and relationships with providers, vendors, and other healthcare organizations, to name a few examples. As such, the role of the board with CHNAs and implementation strategies is largely to provide legal authorization, rather than substantive review and oversight.

Given these practical realities, many hospitals establish board subcommittees to provide a more in-depth form of oversight. Rather than being presented with a final version of a community health needs assessment or implementation strategy, they have the opportunity to review and provide input at earlier stages of the process. In this way, they can facilitate a more deliberate, quality improvement approach that emphasizes both internal integration and alignment and leveraging resources through strategic alignment with external stakeholders. In the ASACB model, hospitals form committees with board representatives, but with a majority of external stakeholders with relevant competencies. Formal written charters are developed that

6 The Advancing the State of the Art in Community Benefit demonstration was sponsored by a consortium of foundations between 2002 and 2006 and administered by the Public Health Institute, in collaboration with over 70 hospitals and three health systems in four western states.

7 Human resource departments can play an important role in supporting the development of health career pathway programs (e.g., internships and shadowing) for youth in proximal low-income communities who are underrepresented in the health professions.

outline the specific areas of oversight. This specificity signals to staff that they will need to be prepared for a critical review process and signals to committee members that they have substantive roles to ensure optimal quality.

> Many hospitals establish board subcommittees to provide a more in-depth form of oversight. Rather than being presented with a final version of a community health needs assessment or implementation strategy, they have the opportunity to review and provide input at earlier stages of the process.

External Alignment: Hospitals as One Player—a Balanced Portfolio of Investments

As a provider in a value-based payment system in a larger environment where most of what creates health is outside the clinical setting, there is an imperative for hospitals and health systems to align their efforts with a broad spectrum of stakeholders. Hospitals that have taken steps towards the kind of internal alignment described above have a distinct competitive advantage. First and foremost, they have dedicated staff with the competencies, the time and resources, support from leadership, and an oversight structure to ensure a quality improvement approach to community health improvement. In practical terms, they have the space to conduct outreach, build working relationships, assess health-related needs and identify community assets, and work together with diverse stakeholders to design and implement comprehensive strategies that help to effectively address both the symptoms and underlying causes of poor health.

They recognize that "going it alone" practically ensures the perpetuation of the status quo in communities where health disparities are concentrated. The sheer complexity of the interactions between individual behavior, family, culture, and social, physical, and political environments requires intensive focus in targeted geographic areas, alignment of multiple stakeholder investments, agreement on a common set of metrics, and perhaps most importantly, an infrastructure that facilitates, monitors, builds trust, and cultivates an ethic of shared ownership. Stakeholders must move beyond what child psychologists would refer to as "parallel play," delivering services, implementing programs, and taking actions that are not coordinated in a manner in which they can be mutually reinforcing. This includes competing hospitals—while they are expected to compete for patients in providing high-quality clinical services, their long-term viability will be driven in part by their ability to come together and address the drivers of poor health in communities.

Expanding Our Scope

There are a "new" set of players in communities that have not been viewed by most in the healthcare and broader health sector as key partners in improving community health. Truth is, they have been there all along; we just haven't taken advantage of the opportunity to align our respective efforts. Approximately $130 billion dollars in loans are made each year to support community development in low-income communities, a significant proportion of which is provided by financial institutions in fulfillment of their Community Reinvestment Act (CRA) obligations.[8] Another $26 billion are allocated by the federal government in the form of tax credits[9] and community development block grant funding. This funding supports a variety of efforts, including but not limited to affordable housing, grocery stores, child care centers, charter schools, and federally qualified health centers. Four years ago, the Federal Reserve Bank of San Francisco began to convene a series of meetings at district Federal Reserve Bank offices, bringing together representatives of financial institutions and the public health community to discuss the intersection between health and community development, and to explore ways in which public health agencies may

8 The Community Reinvestment Act (1977) authorized federal regulatory agencies to take into consideration investments made by financial institutions in areas of concentrated poverty in their review of proposed mergers and acquisitions. Investments by banks in affordable housing and other forms of physical infrastructure, as well as services such as building financial literacy were intended to help reverse the negative impact of decades of "redlining" practices that concentrated African Americans and other ethnic minorities in low-income neighborhoods with limited access to services, job opportunities, and functioning schools.

9 Low-Income Housing Tax Credit and New Markets Tax Credit programs incentivize investments.

collaborate with the community development community to better align programs, services, interventions, and investments.

The same low-income communities that are the focus for CRA-related investments are also the focus for community benefit resource allocations by tax-exempt hospitals. There is immense opportunity to optimally leverage the resources of both sectors. With this in mind, the initial discussions convened by the Federal Reserve Bank have now been expanded to include the healthcare community to explore ways in which to align the resources of the health and community development sectors.

The field has responded quickly to this opportunity, thanks in part to targeted support from private philanthropic organizations such as The Kresge Foundation, the Robert Wood Johnson Foundation, the Annie E. Casey Foundation, and the MacArthur Foundation. A number of national community development financial institutions (CDFIs) such as The Reinvestment Fund (TRF) and the Low Income Investment Fund (LIIF) have also provided leadership in facilitating dialogue and planning processes. There are approximately 1,000 CDFIs across the country, mostly local non-profit organizations that help organize and aggregate investments from financial institutions and other entities to support development in low-income communities. There are also a number of national initiatives that have been launched to foster intersectoral alignment, including The Way to Wellville, Alignment for Health Equity and Development (AHEAD), the BUILD Health Challenge, and the Build Healthy Places Network.

Finally, there are a small number of health systems[10] that have been working in this intersection for some years, carving out a small percentage of their larger investment portfolios to provide low-interest loans for community development; often at the pre-development phase, when smaller loans are needed to support the planning phase, securing permits, and infrastructure development. These loans serve as a critically important financial bridge that enables CDFIs to develop a risk reduction strategy that will increase the potential for securing larger-scale loans from financial institutions and other investors for development projects in low-income communities.

> The same low-income communities that are the focus for Community Reinvestment Act-related investments are also the focus for community benefit resource allocations by tax-exempt hospitals. There is immense opportunity to optimally leverage the resources of both sectors.

Voluntary Leadership in the Field

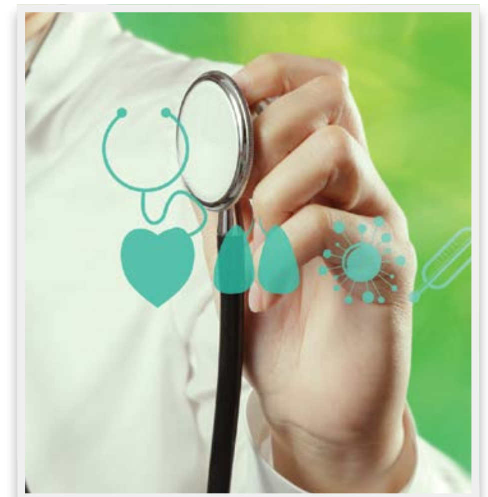
In recognition of the need for support to accelerate innovation across the country, two national initiatives have been launched to support collaborative learning processes.

10 There are three health systems that have provided leadership in this arena: Bon Secours Health System, Dignity Health, and Trinity Health.

In 2012, the Health Systems Learning Group was established through the leadership of Gary Gunderson and Teresa Cutts at Methodist Le Bonheur Healthcare in Memphis, Tennessee. A network of over 30 health systems (with a core of 10 sponsoring systems) have participated in a series of regional and national meetings in the last three years, most recently at the White House in mid-April.

A team of leaders from these systems developed a monograph released in April 2013 which staked out a three-part agenda: 1) to build more in-depth working relationships with diverse community stakeholders, 2) to more strategically invest charitable resources to reduce preventable utilization and readmissions, and 3) to focus more explicitly on addressing the social determinants of health. The Department of Health and Humans Services' Center for Faith-Based and Neighborhood Partnerships has played a critical role in helping to coordinate these meetings and holding a series of national Webinars to highlight specific innovative practices. Under the new title of Stakeholder Health, this learning collaborative has initiated work on a second monograph for release in 2016.

In the past year, IHI, in partnership with organizations such as Communities Joined in Action and Community Solutions, launched the 100 Million Healthier Lives campaign. The 100 Million Healthier Lives campaign is also a collaborative learning model that views communities as the core focus of a larger transformational process involving the full spectrum of stakeholders with a shared interest in improving community health. In a few short months, there are already over 500 organizations that have joined the campaign. With funding



from the Robert Wood Johnson Foundation, the SCALE (Spreading Community Accelerators through Learning and Evaluation) initiative was launched under the auspices of 100 Million Healthier Lives to provide funding for 24 communities that have demonstrated commitment to comprehensive approaches to health improvement.

The leadership team of 100 Million Healthier Lives will facilitate technical assistance, documentation and dissemination of innovations, and evaluation processes that help illuminate key elements and lessons to support the broader field. There are a series of both content and geographic "hubs" being formed to support dialogue among leaders in the field; identify, document, and disseminate exemplary practices from across the country; and provide targeted technical assistance to support acceleration and scaling of innovations.

Putting It All Together

Returning to Jessee's commentary in *Trustee*, it is appropriate to be thoughtful about making investments to build population health capacity. At the same time, there is an equal imperative to avoid confusing prudence with inaction. As is demonstrated on a daily basis by leading-edge hospitals and health systems across the country, there is much that can be done, even in environments where payment systems are firmly in fee-for-service mode.

As stated previously, community benefit offers an investment pool to build population health capacity—hospitals have an obligation to make net contributions (if you get a financial return on these investments, that return must be subtracted from the net total reported in fulfillment of your tax-exempt obligations). As such, the more important consideration is how to strategically invest these resources in a way that represents optimal stewardship. Does it produce measurable improvements in health status? Does your approach enable you to provide tangible benefits for a larger number of people? Does it create conditions that help your primary care providers do a better job? Does it help build expertise that will help your hospital thrive economically in a new financial environment?

For hospitals and health systems in predominantly fee-for-service environments, the initial focus for investments of community benefit dollars and building population health capacity should be on

uninsured and underinsured populations, developing proactive strategies that make better use of limited charitable resources. Many of these payment environments happen to be in states that continue to reject the Medicaid expansion—as such, they have a much larger pool of patients for whom investments in population health represent a prudent business practice; you reduce high-cost preventable ED and inpatient utilization, achieve savings (in the form of reduced charity care) that can be reinvested for further capacity building, and build experience with innovations that can be more readily scaled as value-based payment systems emerge.

For hospitals and health systems in environments that are moving more rapidly towards value-based payment, it is time to more explicitly integrate community benefit functions and knowledge into the core business practices. Investments in building GIS capacity and developing team-based care models must be complemented by the development of working relationships with diverse community stakeholders, fostering an environment of shared ownership for health, and focusing strategically in communities where health disparities are concentrated.

Let's be clear: there will be winners and losers in the midst of such profound and rapid change in the field. There will also be mistakes made every day in hospitals across the country—in some cases expensive mistakes. It is important that we learn from these mistakes, make appropriate adjustments, and keep moving forward. Now is not the time to stand on the sidelines.

As for my fellow hospital and health system board members—yes, ask the hard questions—demand that attention be given to prudent business practices, but make sure that your leadership recognizes and is acting on the imperative for fundamental change in the way we deliver and finance healthcare. It is time to move well beyond the four walls of our acute care facilities.

The Governance Institute thanks Kevin Barnett, Dr.P.H., M.C.P., Senior Investigator, Public Health Institute, for contributing this article. He can be reached at kevinpb@pacbell.net.

The Move toward Population Health...

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Becoming an ACO and Preparing for New Reimbursement Models

In January, Hancock Regional Hospital signed on to be part of the National Rural ACO, which works with rural healthcare providers across the country to help prepare them for future payment models, increase local market share, and increase patient and provider satisfaction. Each member acts as its own ACO, with its own benchmarks and goals, but utilizes shared governance and resources in a regional consortium. This network enables small healthcare organizations to qualify for shared savings programs, allows aggregation of lives to support other value-based payment models, and fosters a peer learning network. The National Rural ACO follows evidence-based processes to improve the health of its communities and position its health systems for financial success using the framework, waivers, and data supplied by the Medicare Shared Savings Program. It also provides additional support for the chronically ill and uses prevention and wellness promotion programs to improve outcomes and reduce unnecessary ED and inpatient utilization.

The ACO model provides valuable learning in the areas of care management, data analysis, and an orientation on prevention. We believe it can teach us methods to maximize margins under the new value-based reimbursement models while also improving care for our community. One outcome of our activities with the ACO has been a subtle shift in thinking of our organization not as a community hospital that operates physician practices, but as a broad-based regional healthcare company.

Our charge with the ACO is to reduce per capita costs for Medicare beneficiaries in our region. Our first task is to identify patients with multiple chronic conditions who are also heavy users of healthcare resources and come alongside them in their healthcare journey, maximizing their health status and providing early interventions when their disease process begins to worsen. Interestingly, as we keep these folks in their homes and out of high-cost locations such as hospitals and skilled nursing facilities, we reduce the traditional volume-based, fee-for-service encounters that were the recipe for success in the past. On first blush, this may seem irrational, but we know it is better for the patient and it forces us to re-evaluate our processes to become ever more efficient and to be proactive about developing revenue streams that are not associated with acute care volumes, but rather with the health status of those we serve.

We are hopeful that by embracing the techniques learned in the ACO we can remain an independent, community-owned and operated organization. We believe this status helps us better meet the needs of our region in ways that we could not if we were owned by a larger health system. That said, we have also come to realize that smaller organizations cannot operate on an island, and partnerships are required to provide our patients with access to the complete continuum of care in the future.

In addition to being a member of the National Rural ACO, Hancock Regional Hospital also participates in the Suburban Health Organization (SHO), which is composed of 11 central Indiana hospitals that work together to promote quality, efficiency, and patient access in the communities they serve. The SHO supports our organizations and communities through the development of strategic initiatives and shared services, sharing best practices for quality improvement and joint physician recruitment to managed care contracting and a shared risk retention group.

Everything is changing, and if, as a board member, you are thinking that your organization can ride out this new "phase" in healthcare in hopes that it will go away, you are placing your organization in high risk. Population health and value-based reimbursement are quickly becoming the "new norm." Our job as leaders is to learn how to succeed in that environment. Creating an ACO is a great first step for our organization, but it is just the beginning of how we serve our communities in a value-based world. As a hospital CEO, I am thrilled with the idea that we are finally beginning to be paid for helping people have a better quality of life via better health, rather than caring for them after they are already sick. Having a high-functioning board that is ready to engage in strategic dialog around these critical issues is imperative to succeeding in these transformational times.

The Governance Institute thanks Steven V. Long, FACHE, President and CEO of Hancock Regional Hospital, for contributing this article. He can be reached at slong3@hancockregional.org.

Managing IT Vendor Relationships While Avoiding the Weeds

BY MICHAEL L. DAGLEY AND BRITTAIN W. SEXTON, BASS, BERRY & SIMS

Information technology (IT) is an inextricable fixture of the modern healthcare landscape. As such, healthcare executives and board members are often called upon to make informed decisions about IT strategies, products, and services that will have a substantial impact on their organizations.

Most healthcare leaders are not IT experts, and they do not want to be. But expertise is not required for informed and deliberate decision making or executive oversight. If you are already an IT expert, this article is not for you. Rather, this article will set forth some strategies for non-expert executives and board members called upon to make high-level, though important, decisions about their healthcare organization's IT infrastructure.

Strategies for Working with IT Vendors

While some large healthcare organizations may develop their own "homegrown" software, most small-to-midsize organizations must rely on IT vendors. That is not necessarily a bad thing. It allows hospitals and health systems to focus on what they do best—provide healthcare—and places the responsibility for implementing and maintaining IT into the hands of specialists. Even so, the arrangement requires the organization's management team to properly vet potential IT vendors, ensure that vendor contracts are tailored to fit the organization's needs, and ensure that the relationship with the vendor is appropriately managed. Below are strategies to help healthcare leaders in these efforts.

Understand "Best of Breed" vs. "Single Vendor"

One of the first major decisions that an organization must make is whether it should follow a "best-of-breed" or "single-vendor" strategy. It is important for board members and executives to understand which approach the organization follows and the risks associated with each because that will affect nearly every other IT decision.

In general, under the "best-of-breed" approach the organization selects the most appropriate offering for each application area, and under the "single-vendor" approach the organization will give preference to a particular vendor's offerings. Both approaches have benefits and pitfalls. With "best of breed," the organization will select the most appropriate software (in terms of quality and price) regardless of the vendor, but that approach may result in an overall software infrastructure that is less integrated, less uniform, and possibly more cumbersome to maintain. In contrast, the single-vendor approach may increase overall integration among various systems, but the organization may accept risks associated with certain software systems that are less developed, more expensive, or that have fewer features.

Vendors often push for the single-vendor approach because it ultimately means more business for their organization if they are selected, but it is important that the healthcare organization make an independent, thoughtful determination about which approach is most aligned with its needs and goals.

Key Board Takeaways

Most healthcare board members and executives are not IT experts, yet they still have to make IT decisions that will have a major impact on their organization. Following these thoughtful strategies will help them make informed decisions and properly manage the relationship with IT vendors:

- Understand the difference between "best-of-breed" and "single-vendor" approaches and the risks associated with each.
- Consider forming a steering committee to make recommendations about IT decisions.
- Ensure management is asking vendors the right questions and documenting their responses.
- Independently investigate the vendors (e.g., speak with current and former users, review published resources, and enlist IT experts to vet the software).
- Engage experienced attorneys who can provide valuable insight.
- Pursue remedies for IT problems that caused operational and/or financial harm.

Consider Forming a Steering Committee

The board may form a steering committee to make recommendations about IT decisions. This committee can include senior members of the IT team, who will have more familiarity with the organization's existing systems, and other senior personnel who will oversee the ultimate end users of the product after implementation (and, therefore, may have the greatest incentive to ensure an optimal implementation). The committee can do much of the hands-on work when vetting vendors, though the larger board and executive team will ultimately approve the committee's work and recommendations.

Interview the Vendors
When an organization is seeking to implement a new software system, it will find no shortage of vendors that will solicit its business. But keep in mind that the vendor's representatives are ultimately salesmen and, therefore, may be less forthcoming with information that, while material to the organization's interests, might compromise the sale.

Accordingly, management must be prepared to ask the right questions, such as:

- Has this product been successfully implemented for the same purpose at a similar institution?
- Can the product be interfaced with other existing products used by the organization?
- What standard reports come with it?
- How long is the standard implementation time in a comparable setting?

Healthcare organizations can pose these questions through a formal "request for information" or through more informal questions posed to the vendor's representatives. In either case, the vendor's responses should be documented in a way to accurately record the vendor's commitment and the organization's expectations.

The board may form a steering committee to make recommendations about IT decisions. The committee can do much of the hands-on work when vetting vendors, though the larger board and executive team will ultimately approve the committee's work and recommendations.

Independently Investigate the Vendors
Considering that the information provided from the vendors must be taken with a grain of salt, the organization should also consult independent sources for information about software products. For example, it may speak with current and former users of the system. There are also published resources, such as the KLAS report, which provide data from end user satisfaction surveys about particular products. Further, healthcare organizations may enlist in-house or third-party IT experts—including the CIO, supervisor-level end users, or outside consultants—to vet the software closely.

Engage Attorneys with Expertise
Experienced attorneys can provide valuable insight about what provisions should be included in a contract, insist upon detailed disclosures that limit surprises, and ensure that the client receives what it bargained for. For example, they may be able to negotiate contractual concessions that mitigate risk to the healthcare organization, such as benchmarks that must be met before the implementation team can leave the site, requirements that the vendor conduct rigorous testing before the product goes live, or appropriate disclosures in writing that define roles and responsibilities of the vendor and the organization's respective implementation teams.

Large IT vendors have developed strategies to gain the most leverage possible when negotiating software licensing contracts, and having an experienced advocate on the hospital/health system's side can level the playing field. Further, after the contract has been signed, your attorneys can be powerful advocates to ensure that the vendor delivers what was promised.

Pursue Remedies for IT Problems
When a hospital or health system implements a problematic software product that causes it operational and/or financial harm (such as lost revenue from billing errors or loss of operational efficiency due to frequent errors or lost functionality), the board and executive team may seek to hold the vendor accountable.

As an initial matter, the board and executive team must evaluate the root cause of the problems. If the vendor shifts blame to the organization's IT personnel or other vendors, the organization may want to engage an independent party (such as an outside consultant) to determine whether it is actually the vendor's personnel or products that are causing the issues.

If the leadership team determines that the vendor is at fault, they should then ascertain the healthcare organization's rights and responsibilities. Legal counsel can evaluate the contract, the representations of the vendor during the selection process, the vendor's ultimate performance, and the applicable law to advise the board and executive team about its options.

Finally, if appropriate, the board and executive team may work with legal counsel to pursue dispute resolution or other avenues to pressure the vendor. Such measures may compel the vendor to commit resources that will resolve or mitigate ongoing issues and to compensate the organization for harm caused by the software.

Healthcare leaders need not be IT experts to make important decisions about a healthcare organization's IT infrastructure, but they do need to consult with experts and employ strategies to manage vendor relationships. The tips outlined above constitute some of the high-level strategies that healthcare leaders can use to avoid the weeds while still making informed decisions.

The Governance Institute thanks Michael L. Dagley, Member, and Brittain W. Sexton, Associate, of Bass, Berry & Sims in Nashville, Tennessee, for contributing this article. They can be reached at mdagley@bassberry.com and bsexton@bassberry.com.

Price Transparency…

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when patient or customer experiences routinely circle the globe on social media, the value of creating good financial experiences is amplified. Making it easier to get price information is an important element of a good experience.[3] Second, many hospitals and health systems are delving into costing and pricing as they prepare for contracting under value-based payment models. There are opportunities to leverage the synergies between transparency and value-related costing and pricing analysis efforts.

Hospitals Are Not in This Alone

Collaboration is the watchword of the new era, and that's especially true when it comes to improving transparency. What consumers pay out of pocket is largely governed by their benefit plan design and by individuals' progress toward meeting their deductibles. Health plans are in the best position to have this information. That's why a multi-organizational task force convened by HFMA last year recommended that health plans take the lead in providing price information to their members.[4] Of course, health plans can also help consumers comparison shop; hospitals and health systems don't have information about competitors' prices. Healthcare organizations should ensure that health plans have accurate and up-to-date information to give their members. From a community relations standpoint, being proactive about price transparency makes sense for hospitals even when health plans are the primary conduit for price information. In today's consumer-driven environment, a commitment to price transparency is essential to maintaining community trust. (It's important to note that price information should always be paired with quality information so consumers can assess the value of what they're purchasing.) The task force also recommended that hospitals and health systems serve as the primary source of price information for consumers who are uninsured and for those who are seeking services out of network.

Physicians Will Take Their Cues from Hospitals

Physician thought leaders like Neel Shah, M.D., Founder of Costs of Care, and the Duke Oncologist Yousuf Zafar, M.D., have drawn attention to the negative effects that high medical costs can have on patients. Dr. Zafar recently told a journalist, "If we want to have an informed discussion with patients, we need to consider the benefits, the physical toxicity, and the financial toxicity of treatment."[5] Long-standing attitudes that equate discussing costs with rationing or denial of care are changing—among both physicians and consumers. In a recent *New York Times* survey, 80 percent of consumers said that their doctor should discuss the cost of recommended medical treatment with them ahead of time.[6] As the gatekeepers of price information, hospitals are the linchpin in the transparency equation. If hospitals and health systems don't facilitate physician access, they are not only signaling their attitude toward transparency; they are putting up roadblocks to achieving it.

In conclusion, don't let the perfect be the enemy of the good. There are thousands of items on the average hospital chargemaster. The prospect of overhauling it can be daunting. But the chargemaster need not be your starting point. It makes sense to focus your initial efforts on your hospital's most frequently performed procedures. For example, in March, Seattle's Virginia Mason Medical Center began posting estimated prices for its 100 most common outpatient surgical procedures online.[7] This is not a new approach; Michigan-based Spectrum Health has posted average prices for its 200 most commonly done medical procedures since 2009. But until recently, this approach has been slow to diffuse through the industry. If you start now, there is still time to be in the vanguard for price transparency.

The Governance Institute thanks Joseph J. Fifer, FHFMA, CPA, President and CEO, Healthcare Financial Management Association, for contributing this article. He can be reached at jfifer@hfma.org.

3 HFMA has developed best practices for financial communications to help hospitals and health systems improve the financial experience for their patients. See Healthcare Financial Management Association, "Best Practices for Patient Financial Communications" (available at www.hfma.org/communications).

4 Healthcare Financial Management Association, *Price Transparency in Health Care: Report from the HFMA Price Transparency Task Force*, 2014 (available at www.hfma.org/transparency).

5 Timothy Gower, "Should Doctors Consider Medical Costs?" *Boston Globe*, April 13, 2014 (available at www.bostonglobe.com/ideas/2014/04/12/should-doctors-consider-medical-costs/GPJM1h30qtz6zpfzrxQGoL/story.html).

6 Elisabeth Rosenthal, "How the High Cost of Medical Care Is Affecting Americans," *The New York Times*, December 18, 2014.

7 Anthony Brino, "Virginia Mason Medical Center Embraces Price Transparency," *Healthcare Finance*, April 6, 2015 (available at www.healthcarefinancenews.com/news/virginia-mason-tries-embrace-price-transparency).

Local Markets Driving Adoption…

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groups have created the Health Care Transformation Task Force with the mission of moving 75 percent of their businesses to a value-based payment and delivery model for achieving the Triple Aim of improving the patient experience of care, improving the health of populations, and reducing the per capita cost of healthcare.[5]

But a patient who describes value in healthcare may not see it just as cheaper care or more positive procedural outcomes. Rather, patients may see it as care that keeps them healthy, or living independently, or working to full capacity, and that is where the real disruptive strategy comes into play for a board member who is involved in the direction of a health system. Care delivery no longer stops at the walls of the acute care hospital or the ambulatory clinic, and a value-based delivery system does not begin with a patient's entry into the system for treatment or a surgical episode and end with the completion of the chart. The value-based system is also focused on maintaining the health of a population and eliminating unnecessary hospitalizations, treatments, and diagnostics. Michael Porter described the value-based care that will change the delivery of care as treating patients in Integrated Practice Units (IPUs) through which "a dedicated team made up of both clinical and non-clinical personnel provides the full care cycle for the patient's condition. IPUs treat not only a disease but also the related conditions, complications, and circumstances that commonly occur along with it—such as kidney and eye disorders for patients with diabetes or palliative care for those with metastatic cancer."[6]

The gain for an innovative healthcare provider that is able to move from a capability to meet the expectations for value-based purchasing to a fully developed value-based delivery system will be leadership in the national healthcare system, market leadership for its services, and possibly a broader geographic reach through its proven excellence. Walmart has named six health systems that will be the designated locations for any of its employees to have heart, spine, or transplant surgeries due to the value that these systems provide for those conditions and procedures.[7] While the loss of volume in any market specific to this employer is likely to be small, the real impact will come from more employers translating this type of benefit design to more clinical conditions and segmenting providers in a local market. In geographies where there are shortages of providers or capacity, the effect is likely to be minimal. However, in markets with excess capacity there can be dramatic movements.

In this time of tumultuous consolidation and affiliation in the industry, boards need to be delving deeply into strategic questions around what challenges their organization will have to surmount to stay competitive and understand the likely pace of change in their market regarding value-based healthcare delivery. In some cases, it may mean giving up a service line because the system does not have enough cases to provide the efficiency and quality that value represents. In other circumstances, it may mean closing or relocating clinics or having smaller hospitals focus primarily on ambulatory care or emergency services, which has an impact on communities, but supports the overall value proposition for the health system's population. In many situations, health systems will need to invest precious resources in the infrastructure needed to develop ACOs or CINs to ensure that patients will receive coordinated care at every point of entry in the delivery spectrum. The local market dynamics determine how quickly a system can and should travel along the value-based delivery curve. For boards, the focus is on ensuring that the organization's strategic plan accounts for these issues and includes specific goals and deadlines for achieving the necessary steps along the journey to providing value-based care.

There is no question that the healthcare system today demands value, but it is up to those who deliver the care to supply that value. The leaders who continually move the bar up and find cost-effective and innovative options for delivering real value-based care will be the initial winners, but there is a clear place for those who observe, note, and put into place the leading best practices that will eventually move the entire healthcare system forward.

The Governance Institute thanks Brian J. Silverstein, M.D., Managing Partner, HC Wisdom, and Governance Institute Advisor, and Anne Carter, Consultant, HC Wisdom, for contributing this article. They can be reached at briansilverstein@hcwisdom.com.

5 Emily Rappleye, "20 Major Health Systems, Payers Pledge to Convert 75% of Business to Value-Based Arrangements by 2020," *Becker's Hospital Review*, January 28, 2015.

6 Michael E. Porter and Thomas H. Lee, "The Strategy That Will Fix Health Care," *Harvard Business Review*, October 2013.

7 "Company's New 'Centers of Excellence' Program Is First-of-Its-Kind Partnering with Six of the Nation's Foremost Health Care Systems to Provide Better Care," Walmart, October 11, 2012.

Local Markets Driving Adoption of Value-Based Care Delivery

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

The alarm went out long before the government threw its weight behind value-based purchasing. Economists held forth on the damage that the rising cost of healthcare was having and would continue to have on the economy, and various employer and payer organizations began considering how to dampen the growing provider and patient enthusiasm for more technologies, procedures, and treatments.

The U.S. is buying the wrong healthcare services resulting in the need for more healthcare. The word "value" began ascending into the conversation about healthcare delivery, and large employers were quick to embrace it through the Leapfrog Group and other coalitions focused on quality and patient safety. And the race was on for moving value-based purchasing of healthcare into the broad spectrum of the delivery system.

The National Business Coalition on Health's Value-Based Purchasing Council defined value-based purchasing as "a demand side strategy to measure, report, and reward excellence in healthcare delivery…[which] involves the actions of coalitions, employer purchasers, public sector purchasers, health plans, and individual consumers in making decisions that take into consideration access, price, quality, efficiency, and alignment of incentives."[1] Michael Porter of the Harvard Business School simplified the definition by describing value in healthcare as: "Value = Patient Health Outcomes per Dollar Spent."[2]

As market forces took hold and CMS instituted its value-based purchasing policies with their commensurate reimbursement impact, providers reacted by focusing on reducing readmissions, decreasing hospital-acquired conditions, and enhancing patient satisfaction, all of which created value. Payers began to follow CMS's lead, and employers soon began to shift costs to their employees through the use of consumer-driven health plans with high deductibles. Currently, 41 percent of all U.S. workers are in high-deductible health plans and over 80 percent of consumers purchasing insurance on the healthcare exchanges chose plans with high deductibles, providing consumers with the incentive to utilize services only when absolutely necessary and to seek out services that were lower priced, but offered good quality.[3] Suddenly, in markets that have high adoption of these insurance products, consumers were shopping for healthcare providers on the Internet as if they were choosing a restaurant on Yelp, looking at star ratings and cost information, and determining what they judge to be value. But have they been misled? And how does a health system rise above the Web site evaluation to establish the true value of the care it delivers?

Value-based purchasing, the demand side of our healthcare economics equation, does not always guarantee value-based care delivery, the supply side, and many providers are caught between the two. A health system with excellent CMS-defined quality indicators for a hip replacement rarely takes into account the bottom line for the patient, which is how well the patient functions after leaving the system provider—how well do they feel, how soon can they return to work, and how free of pain or discomfort are they over what period of time? Providers are judged on low costs by major payers and self-insured employers, but do they really know their costs? Hospitals have utilized charges for billing purposes, which have no relationship to true costs, and few systems have a true cost accounting system.

However, the train has left the station, and most healthcare providers that do not book a seat will be left behind. Bundled payments for a total episode of care are under testing by CMS, and it has stated that it would begin moving 30 percent of its payments into non-fee-for-service models by the end of 2016, and 50 percent by the end of 2018.[4] CMS has also indicated that it will tie 85 percent of fee-for-service payments to quality or value in some fashion by the end of 2016 until value-based payments are responsible for 50 percent of all government reimbursement. The recent elimination of the Medicare Sustainable Growth Rate (SGR) included the requirement for physicians to be reimbursed through payment models focused on value versus volume. A new coalition of providers, payers, purchasers, and patient advocacy

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Key Board Takeaways

The healthcare system is quickly moving toward value-based payment and delivery models. As boards think strategically about how to stay competitive and provide value-based care in their own markets, here are a few items for consideration:

- The healthcare system is currently delivering a lot of "sick care," but not enough healthcare. Moving forward, the focus will be on population health and eliminating unnecessary hospitalizations, treatments, and diagnostics.
- Payers (Medicare and employers) are moving the country towards value-based care delivery by modifying payment.
- Patient engagement is driven by insurance plan design. Many patients now have high-deductible health plans, causing them to be much more interested in the price and quality of healthcare services.
- Local market factors will determine the timing of value-based care delivery opportunities.

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2 Harvard Business School, Institute for Strategy & Competitiveness, "Value-Based Health Care Delivery" (see www.isc.hbs.edu/health-care/vbhcd/Pages/default.aspx).

3 Kaiser Family Foundation, "2014 Employer Health Benefits Survey," September 10, 2014.

4 Sylvia Mathews Burwell, "Progress Towards Achieving Better Care, Smarter Spending, Healthier People," U.S. Department of Health & Human Services, January 26, 2015.