BoardRoom Press

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Improve Outcomes and Lower Costs across the Continuum of Care—Invite a Nurse to Serve on the Board

Generating Value from Big Data and Digital Health Investments

SPECIAL SECTION

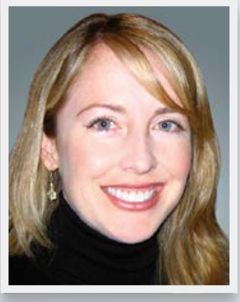
The Active Consumer: Delivering on Rising Expectations

Run to Risk: Making the Shift to Value-Based Payments on Your Terms

ADVISORS' CORNER

Driving Value through Strategic Alliances

We Will Carry On



We now know who will be President of the United States for the next four years. We don't yet know what that will mean for the ACA. For today the phrase is "repeal and replace," but what will be repealed and what will replace it?

Healthcare has been a divisive political issue for this country since the months leading up to the passage of the ACA in 2010. We understand why it is so controversial as opinions on how to "fix" it sit on opposite poles. But the past six years have given us some insights on what can work, if we are given the time to see things through.

I remember when we were wondering which way the Supreme Court would rule in 2012—whether the ACA would be upheld. We asked our faculty to weigh in on what would happen then. Most agreed that the market was moving healthcare in the direction of value and population health, away from fee for service, and that those forces were strong enough to take hold regardless of whether the legislation was in place. In the past four years we have seen that the ACA has helped move those forces more quickly than they might have moved without it.

So now, as we look back at what has happened this year and think about what might happen next year, the most important thing for us to do is to carry on. So many organizations have been implementing programs that help people at risk prevent developing chronic illness, help those with chronic illness better manage their care, and reducing or eliminating unnecessary and low-value care. Many of these things have been done despite lack of reimbursement because it is the right thing to do. Bundled payment programs are proving that they can work when implemented properly. Value-based contracts with private payers are taking hold and seeing success. We can continue to redesign our delivery system to provide patient-centered, high-value care; improve community health; and lower costs. We can do all of these things without federal legislation to support them. It might be harder, but it is still our responsibility to find a way to do them, because if we don't, no one else will. So as we continue to breathe day in and day out, we will find a way to breathe life into those in need, with compassion, joy, and a common purpose.

Kathryn C. Peisert, *Managing Editor*

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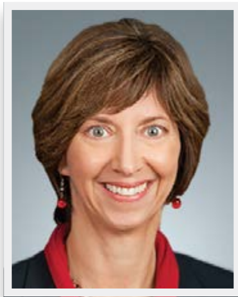
Improve Outcomes and Lower Costs across the Continuum of Care—Invite a Nurse to Serve on the Board

BY MARLA J. WESTON, PH.D., RN, FAAN, AMERICAN NURSES ASSOCIATION, AND LAURIE BENSON, NURSES ON BOARDS COALITION

Changes in the healthcare landscape dictate that what happens to patients after they are discharged is, increasingly, a hospital's concern.

The shift toward pay-for-quality, the rise of alternative payment models, and the emergence of penalties requires that hospitals and health systems take great care when referring patients to post-acute care facilities, such as rehabilitation centers, long-term care hospitals, skilled nursing facilities, and home health services.

But how can healthcare leaders determine with *which* post-acute care facilities they should partner? And how can hospitals ensure quality when patients transition across care settings? Inviting a nurse to serve on the board guarantees a valuable voice with expertise in care coordination who can help think through and make decisions around cross-continuum services and challenges.



Marla J. Weston, Ph.D., RN, FAAN
Chief Executive Officer, American Nurses Association

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Key Board Takeaways

As hospitals are increasingly being held accountable for what happens to patients post-discharge, leaders must establish reliable mechanisms to ensure high-quality continued care when referring patients to post-acute care services. Registered nurses are experts at managing transitions and coordinating patient care across settings and are best suited to evaluate post-acute care partners. Organizations with a goal of improving outcomes and lowering costs across the continuum of care should consider inviting registered nurses to serve on their board.

The Value of Care Coordination

Care coordination, "the deliberate synchronization of activities and information to improve health outcomes by ensuring that care recipients' and families' needs and preferences for healthcare and community services are met over time,"[1] is vital during transitions of care and when a patient moves from a hospital or health system to a post-acute care setting. Care coordination is an ideal way to lower costs and improve health, and is cited under the National Quality Strategy as one of six priorities that address the most common health concerns that Americans face. Since 2013, Medicare has provided payments for transitional care management aimed at reducing hospital readmissions by providing post-discharge care coordination.

The substantial cost of uncoordinated care is well-documented. According to a 2010 study, uncoordinated care patients represented less than 10 percent of patients, but accounted for an average of 46 percent of drug costs, 32 percent of medical costs, and 36 percent of total costs for the population.[2]

Nurses: Natural Leaders for Care Coordination and Transition Management

Care coordination has long been a core nursing competency. In *Nursing: Scope and Standards of Practice*, the American Nurses Association (ANA) outlines the competencies expected of every registered nurse. Included are core elements of care coordination, such as:

- Organization of care plan components
- Management of healthcare consumers' care to maximize independence and quality of life
- Assistance to healthcare consumers in identifying care options
- Communication with the healthcare consumer, family, and members of the healthcare system, especially during transitions in care
- Advocacy for delivery of dignified care by the inter-professional team
- Documentation of coordination of care

Advanced-practice registered nurses provide additional expertise, including leadership in the coordination of inter-professional healthcare in order to ensure integrated delivery of healthcare services.

A July 2016 article in *Hospitals & Health Networks* contends that the relationship hospitals have with post-acute care providers is taking on increased importance: "Post-acute care providers are no longer simply a downstream referral partner. They become an extension of the hospital's care delivery model and have a much more direct impact on a hospital's reputation and bottom line than they did before."[3] Nurses, who already possess care coordination expertise, are uniquely qualified to evaluate the quality of post-acute care providers and effectively manage patient transitions to new care settings.

Making the Case for Nurses on Boards

Given nurses' ability to ensure patients receive coordinated care across the continuum, they are well positioned to advise boards about partnering with post-acute providers. However, nurses are vastly underrepresented on hospital and health system boards. Despite being the largest health profession at 3.6 million strong, less than 1 percent of hospitals and health

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1 National Quality Forum, *Priority Setting for Healthcare Performance Measurement: Addressing Performance Measure Gaps in Care Coordination,* August 2014.

2 Institute of Medicine, *The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary,* Washington, D.C.: National Academies Press, 2010, pp. 109–140.

3 Michael N. Abrams and Gordon Phillips, "Why Post-Acute Care Partners Are Critical to Hospitals' Future," *Hospitals & Health Networks,* July 2016.

Generating Value from Big Data and Digital Health Investments

BY SHAILLEE CHOPRA, PMP, AND DANIEL J. MARINO, M.B.A., M.H.A., CAMDEN GROUP, A GE HEALTHCARE PARTNERS BUSINESS

Healthcare organizations are making substantial investments in digital health technologies and analytics aimed at improving coordination, delivering optimized care at a reduced cost, and finding new and innovative ways to engage, educate, and retain consumers.

Developing an effective, efficient digitally empowered care delivery system from which to identify and drive profitability under value-based contracts remains of utmost importance. However, developing population health capabilities, especially a big data framework to support strategic initiatives, continues to be a struggle for leadership as they consider current and future investments, return on these investments, and revenue implications from shifts in utilization.

Big Data and Digital Health Is as Good as the Value It Delivers

True success of any investment in digital health technology lies in the ability of analytics to measure results and begin to predict additional outcomes based on certain capabilities, actions, and activities. Similarly, there is no immediate benefit to big data analytics unless it produces actionable insights. Insights translate to tangible knowledge if they are executed upon under well-defined care models and care management services that leverage best practices, methodologies, organizational structures, and embedded workflows.

Build a Value-Based Framework to Measure Effectiveness and ROI

High-performing organizations are creating analytics-based value models that enable them to quantify risk, evaluate impacts to changes in utilization, and predict future trends and outcomes that require intervention. These models also allow organizations to measure, track, and predict return on investments (ROIs) in population health capabilities including digital health technology and staffing resources associated with programs aimed at improving health outcomes.

Healthcare organizations that have successfully developed a value-based framework have incorporated best practices that focus on building a strong information management framework, establishing value-driven needs and requirements, and creating actionable information that drives knowledge enablement and strategic success. Some of these best practices are listed below.

First Things First: Begin with the End in Mind

The key to establishing a value framework that drives decision making and actions is to begin with the end in mind and develop a clear understanding of your goals. Questions for consideration include:

- What key objectives do you want to achieve from your digital health initiatives?
- Are there clearly defined use cases driving technology implementation and alignment?
- Is your organization aiming to capture market share by offering competitive services to consumers?
- Do you need to leverage data-driven insights to improve your agility to react quickly to changes in the market?
- How will you predict performance outcomes associated with high-risk patients and the associated resources and care management protocols?

Succinctly outlining end goals guides what problems need to be solved and helps conceptualize a knowledge framework that will assist with decision making.

Place a Premium on Data Governance

It is important to identify early on key consumers of digital health and big data initiatives within your organization. Understanding the information needs of users, their level of data literacy, and the ability to act on information determines the pace at which your organization can successfully adopt these technologies and realize a tangible value against your investment.

Building and leveraging digital health platforms and managing the new "data culture" is what harnesses the power of information. Data governance structures focused on master data management is critical to realizing your information potential. Important elements to consider in establishing effective data governance include:

- Clearly defined objectives that begin the shift to an aligned, data-driven organization
- Guidelines for managing the quality of data being leveraged across the continuum
- A roadmap to incrementally building data literacy within consumers of digital health and analytics
- Keeping the board informed regarding information management and digital strategy, as well as cybersecurity and compliance plans

Multidisciplinary data governance ensures that investments in big data and digital health initiatives support strategic initiatives. It becomes an important mechanism in establishing data integrity, alignment of technology platform criteria, and measurement of value.

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Key Board Takeaways

Building a value-based framework for digital health and big data initiatives allows healthcare organizations to optimally invest resources and dollars towards programs that generate outcomes and value in alignment with strategic goals. Best practices include:

- Begin with the end in mind and develop a clear understanding of goals to accomplish.
- Set up a multidisciplinary and operations-led data governance framework that serves as a mechanism to establish data integrity, alignment of technology performance criteria, and measurement of value.
- Build a value-based information blueprint that vendor partners must deliver against.
- Think big, start small, and go fast—continually build for scalability and sustainability.

The Active Consumer: Delivering on Rising Expectations

BY RYAN DONOHUE, NATIONAL RESEARCH CORPORATION

Healthcare consumers are increasingly paying attention to everything from the quality, cost, to delivery of care. Once passive patients, consumers are now active participants in their health and want to receive care and interact with healthcare organizations and providers in the most convenient, cost-effective way—and they aren't afraid to look elsewhere to find care that meets their needs.

Key Board Takeaways

The consumer point-of-view will drive strategic decisions and priorities going forward. As healthcare boards plan for the future, they should consider the following:

- The number one emotion consumers feel at the outset of a healthcare journey is confusion. Most consumers lack the requisite knowledge to successfully navigate basic healthcare experiences.
- Consumers are looking for more than the traditional acute care provider in the future, and becoming a provider of health and healthcare means investing differently and putting the consumer first.
- Savvy providers will see price transparency as an opportunity to display value and use price as a competitive differentiator.
- Rebuilding programs around the consumer will require a fully transparent approach.
- Consumers are searching for a one-on-one relationship with a trusted partner—be bold and seize the role.

All of this is forcing healthcare leaders to reevaluate the inner workings of their organizations and ensure that the consumer perspective is being heard and driving strategic plans and priorities. This article offers insight into the rising needs and expectations of consumers and the expanding role of the healthcare organization.

The Confused Consumer

Ask consumers how they feel about healthcare and they will tell you. They'll share their expectations, disappointments, and hopes for the future. Consumers have a lot to say about healthcare, but it's a world they largely don't understand. National Research Corporation has embarked on a nationwide examination of the psyche of today's healthcare consumer through its Market Insights survey.[1] Since 2012, over 500,000 customers were polled and more than 200 customers discussed perceptions face-to-face in an ongoing effort to understand the point-of-view of the healthcare customer. Strikingly, most consumers lack the requisite knowledge to successfully navigate even the most basic healthcare experiences. Three in five consumers are not familiar with their local options. In many markets, one in five consumers simply couldn't name a local hospital at all. Most consumers don't experience healthcare frequently and when they do they are often overwhelmed with choices they don't understand and frustrated by processes they didn't design.

When asked about the emotions they feel during a healthcare experience, consumers cite confusion as the most prevalent. A growing maze of information, expanding alternative care options, and lack of price transparency has created a moving target for even the most informed consumers. Where do I go? Who do I talk to? How long will I wait? What will this cost me? These are questions that rattle around in consumers' heads as they transition from their daily lives into "patienthood." Even the simplest of healthcare encounters can dent the confidence of average consumers.

As a result, consumers often defer to the most convenient, simplistic options when possible, and as they travel through experiences they are preoccupied with the pending cost and the ultimate impact on their lives. Some consumers defer their healthcare altogether. Three in 10 consumers are currently delaying "necessary medical treatment." That's nearly a third of the country that is not coming in for care they *need*. The reasons are unsurprising: "perceived cost" is the top reason cited for deferment and "willingness to manage on my own" was a distant second, but it does point to a consumer who is making hard choices about their healthcare and taking their medical future into their own hands.

The Rise of DIY Healthcare

When asked who is responsible for their care, seven in 10 consumers said they feel personally responsible for managing their own health. Consumer disposition toward the mentality of do-it-yourself health is influenced by the rejection of healthcare's status quo and its unbearable costs and inconveniences. If healthcare is a confusing maze, why not do everything in your power to never enter?

For all its inspiring qualities, the do-it-yourself mentality isn't creating healthier consumers. Sixty-eight percent of U.S. adults are overweight or obese. Record numbers are battling diabetes, high blood pressure, heart disease, cancer, and so on. Consumers may be well-intentioned in taking healthcare into their own hands, but they desperately need support—perhaps

1 The data referred to in this article is from National Research Corporation's Market Insights survey, 2012–2016.

even a healthcare hero—to ensure they get healthy and stay healthy. But who? In 2015, National Research Corporation conducted a unique study, The New Payer, where it polled more than 3,000 consumers specifically on their emerging purchase patterns in healthcare. On the issue of health responsibility, the study asked consumers to extricate themselves from the responsibility equation and attribute responsibility to a larger healthcare stakeholder (see **Exhibit 1**).

While healthcare's traditional cast of characters are well represented in terms of consumer-assigned responsibility, less healthcare-centric stakeholders are on the consumer radar. Grocery stores, gyms, and even churches register as players in health and well-being. Grocery stores even edge hospitals in the eyes of consumers. Physicians and hospitals still play a prominent role, but it's clear consumers see their health as a team effort and the players they've eyed don't all fit healthcare in the traditional sense.

Rising to the consumer challenge is critical to dispel confusion and lift the consumer and patient experience, but there is another reason to raise the bar: consumers expect more from healthcare than any other industry. Eighty-two percent of consumers expect healthcare to meet or *exceed* their expectations—11 percent higher than expectations of the next closest industry, financial services. When consumers notice other industries providing stellar experiences—everything from a seamless trip for coffee to purchasing a new iPhone—they don't exclude healthcare from the equation. In fact, because their own health is second to none, they expect more from healthcare and those expectations are only going up.

Rising to the consumer challenge is critical to dispel confusion and lift the consumer and patient experience, but there is another reason to raise the bar: consumers expect more from healthcare than any other industry and those expectations are only going up.

The Virtual Consumer

Consumerism is pushing the care experience outside the confines of the often-frustrating traditional healthcare environment and into the places consumers live and work. Consumers no longer need to don a gown to receive care. This emerging idea of virtual care is made possible by the digital transformation of consumer behavior. The Web is the first stop for a consumer detecting a health issue. Market Insights found more consumers rely on health-related Web sites (45 percent) for the necessary resources and support to keep themselves healthy than even family members (36 percent). The Web isn't the only surging source of information. Consumers flock to social media sites—especially Facebook, YouTube, and Twitter (in that order)—to find information, seek council from other consumers, and share their experiences. Consumer connectivity has changed how we make decisions. To consumers, the world of traditional, physician experiences and the world of non-traditional, virtual experiences form a single whole.

The Rise of the "Silver Surfer"

While it's true younger consumers shifted to digital tools first, the tech game is graying. More than half of consumers 65 and over use online ratings and reviews to purchase products and services. Even in healthcare, the average age of consumers who use social media to make decisions is 48 years old—the same age as the household decision maker for all healthcare services. Hardly a coincidence given social media's immense popularity in all other corners of consumer life. In fact, the adoption of digital means to inform and communicate is outpacing the aging process itself—just three short years ago the average age was 42 years old. Moving forward, the digital learning curve will continue to flatten and older consumers will increasingly go digital. As consumers of all ages stake their lot online, healthcare brands must build new front doors for care—and those front doors will likely be screens.

Telehealth: Return of the House Call

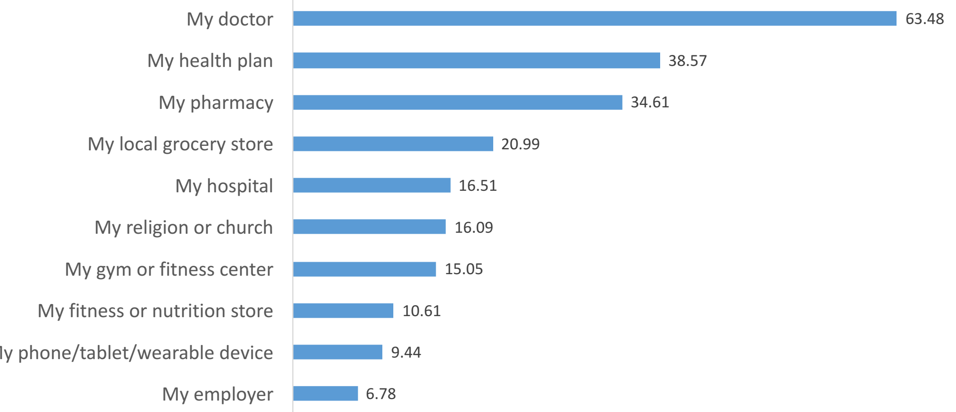
Consumers ask, "If I go online to find information, why can't I take the next step and talk to someone…online?" In our personal lives we increasingly utilize video conference services like Skype, FaceTime, and Google Hangout to connect with just about anyone, except a medical professional. Only one in 10 consumers report having a virtual or telehealth experience in the past year. Nonetheless, consumers gush over the prospect of widespread telehealth:

- 58 percent of consumers found it important that their current physician add telehealth as a resource in the near future.
- 37 percent would take a telehealth visit *if their provider offered it.*
- 12 percent were brave enough to declare they would switch hospitals if their preferred brand did not offer telehealth.

The Price-less Consumer

If consumerism is a car, the cost of healthcare is its engine, and the engine is revving. According to CNN Money, healthcare costs for an average U.S. family of four—with commercial insurance—have doubled. In fact, consumers have become the fastest-growing payer of healthcare services. This fact is not lost on consumers, who have noticed their wallets getting thinner as hospital bills get larger. And while overall healthcare costs have gobbled increasing chunks of GDP, it's out-of-pocket costs that are keeping consumers up at night—even in the reform era, where a record 86 percent

Exhibit 1: Which of the Following Play an Important Role in Your Health and Well-Being?



Source: The New Payer study, National Research Corporation, 2015.

of Americans lay claim to health insurance. Being covered and being able to afford healthcare are two different situations. According to Market Insights, less than half of insured consumers (36 percent) report a deductible of under $1,000, meaning there are more consumers with high deductibles than ever before. One in 10 consumers reported a deductible hike in the last year as well as a budget-busting individual or family deductible exceeding $4,000. No wonder nearly half of households (41 percent) feel a "significant burden" when considering how they'll pay for healthcare expenses. A growing number of consumers simply cannot afford healthcare at all.

How are consumers responding to the fiscal squeeze? As mentioned above, some are choosing to opt out of healthcare altogether. In 2012, the National Research landmark study on customer-centric care revealed the main driver of consumers putting off care is the perceived cost. *Perceived*, not actual, because little pricing information is available before a healthcare experience. Only one in 10 have visited price comparison sites for healthcare. The desire is there: more than half of consumers (53 percent) would be likely to visit in the future. Inside the hospital there is little being done to shift from fee-for-service pricing models that were built to tie volume to revenue. Value-based purchasing is stretching administrators' ability to not only adjust their financial models but to understand their own costs. It's not a surprise that in an industry dominated by not-for-profits, seven in 10 consumers actually believe the majority of hospitals are for-profit. Simply put: if hospitals and health systems don't have a grip on their own cost drivers, how can they hope to break out of negative associations and embrace price transparency?

Market forces may make all the difference. Affordability is primed to become a new competitive differentiator in healthcare. With money on their minds, one in three consumers would consider visiting a new provider who is *not associated* with their preferred hospital or physician *if* that provider offers more affordable services; 37 percent would choose a hospital that shares its prices upfront over a hospital that does not.

The Amazon Effect

One of the few allies consumers have in the battle for more price transparency is the almighty Internet. It's an angry driver and the top source of frustration for consumers. They've grown comfortable with making purchases entirely online and will rely on recommendations from complete strangers. Blame Amazon and its ability to tout convenience over all other factors. For most consumers, it's no longer worth it to take time out of a busy day to drive to stores in search of a product. Not when that product and countless reviews of its value are just a few clicks away. And one of the most popular clicks is to sort-by-price. Not so in healthcare. Only a sliver of consumers (8 percent) find it easy to compare cost and quality online, yet *three in four* desire to see this information before a visit.

A few deft providers have begun sharing certain prices online. St. Luke's University Health Network in Bethlehem, Pennsylvania, has unveiled a "price checker" feature on its Web site that provides information to consumers shopping around for a procedure. The Surgery Center of Oklahoma in Oklahoma City has been posting prices online since 2009, and isn't afraid to back up its prices with facts around its high-quality care to boot. These examples are surprising and powerful for consumers who feel neglected on price transparency, but they are few and far in between, leaving most consumers unable to determine value before a healthcare experience.

Value, after all, is the harmony between price and quality, and even healthcare's newest, shiniest offerings won't matter much if consumers cannot afford them. If we follow the money, we see consumers primed to use cost as a pivot to take control of their healthcare. But as of now, the potential remains entirely untapped.

> Consumers will continue to push for better price transparency and providers will be hard pressed to remain price-less. In fact, savvy providers will see price transparency as an opportunity to display value and use price as an actual differentiator to boost their brand over lower-quality or higher-priced competitors.

The More You Pay…

One of the main beliefs of consumerism is when it comes to purchasing: the more you pay, the more you expect in return. Whether buying a smartphone or choosing a financial advisor, consumers tend to make purchases based on what they value most—and they determine value by fusing the cost of services with the quality of the experience. If quality doesn't measure up, it's not worth the money. If it's too expensive, it voids a great experience. We can again look to other industries to see this impact. For example, in the food industry, the quality of a "convenient experience" is powering Chipotle, Panera Bread, and other

"fast casual" upstarts, leaving traditional, often-slower sit-down restaurants with empty tables. In electronics, the iPhone's quality is in its seamless marriage of form and function. Other phones can do what iPhone does for less, but they aren't iPhones so consumers often pass.

What if healthcare became price transparent? Other than the painstaking effort it would take to turn a price opaque industry around, is there any downside? The top worry is upfront pricing will hypothetically cause consumers to flock to only the lowest-cost providers. But this is only true if quality remains flat across all options in the eyes of consumers. When quality is defined and a valuable relationship begins, then higher costs can be justified. Why do we pay more for Coca-Cola when the off-brand soda is cheaper and nearly identical in recipe? Because Coca-Cola is better. As long as healthcare organizations can convince consumers they are better they will be able to charge more. It's the central idea behind consumer-based value. For those brands that aren't better but certainly charge more, the race to the bottom may become a reality. Consumers will continue to push for better price transparency and providers will be hard pressed to remain price-less. In fact, savvy providers will see price transparency as an opportunity to display value and use price as an actual differentiator to boost their brand over lower-quality or higher-priced competitors.

Healthcare's Invasive Species

As healthcare organizations wrestle over issues like price transparency, it's important to zoom out and see how important it is to appeal to consumer demands. Consumer's sudden affinity for non-traditional healthcare providers has opened the door for the likes of Walgreens, CVS Health, Target, and Walmart to offer a host of healthcare services, all tucked within their cozy retail environs. Consumers openly embrace these offerings:

- For basic preventative measures (flu shot, blood pressure check, etc.) nearly half of consumers (48 percent) would go to Walgreens or a similar pharmacy. However, even more consumers (51 percent) would go to Walmart.
- For moderately advanced procedures (MRI, sinus infection treatment, etc.) four in 10 consumers would go to Walgreens if the services were offered, and a significant but slightly lower amount of consumers (38 percent) would go to Walmart.

Yes, nearly four in 10 consumers would get a Walmart MRI. It seems odd to say and is surprising to many traditional healthcare players but it underscores the wily, unpredictable nature of consumers. Especially consumers who are fed up with the current industry. And considering these consumer appetites for convenient, non-traditional care settings, and the size and scale of the retailers they find downright appealing, it appears the definition of healthcare could be entirely rewritten. For those hoping to get ahead of the challenges of consumerism, they would do well to discover the consumer point-of-view and include it in their strategic thinking. And no issue ranks higher on consumers' minds than the cost—and *their* cost—of care.

Takeaways

Addressing the wants, needs, and even demands of local consumers is critical to success in the new consumer-centric world. Today's savvy healthcare consumer is better informed, less patient, and laser-focused on quality and cost. Customers have high expectations and are not afraid to find care elsewhere and look to non-traditional avenues if they feel undervalued and unsatisfied.

Healthcare leaders will need to think through how their organizations can build a solid one-on-one relationship that keeps consumers engaged. Creating loyalty with consumers will be key and require proving that they are the top priority, providing a consistently positive experience, creating personalized care, and offering perks that other providers may not have (e.g., shorter wait times, loyalty programs, expedited check in, telemedicine, etc.). As consumers take their health into their own hands, hospitals and health systems should find ways to transcend healthcare's traditional confines and create a lasting relationship with consumers built on health and well-being. By expanding their traditional role, healthcare organizations can deliver on rising expectations and play a larger part in the consumer's healthcare journey.

Watch for a complementary special section on using local population health data to shape strategy in an upcoming issue of BoardRoom Press.

The Governance Institute thanks Ryan Donohue, Corporate Director, Program Development, National Research Corporation, for contributing this article. He can be reached at rdonohue@nationalresearch.com.

Run to Risk: Making the Shift to Value-Based Payments on Your Terms

BY RACHEL BIDGOOD, ANNA HENKEL, AND DEIRDRE BAGGOT, PH.D., ECG MANAGEMENT CONSULTANTS

CMS's recent announcement of a new mandatory bundled payment program for heart attacks and cardiac bypass surgery is the fourth major announcement coming out of the Center for Medicare and Medicaid Innovation in 2016 related to bundled payments. This suggests it is continuing to push forward on its goal of tying 50 percent of Medicare fee-for-service (FFS) payments to alternative payment models (APMs) and 90 percent of traditional Medicare payments to quality and value by 2018. And as goes Medicare, so goes healthcare; a national task force composed of providers, employers, and major private payers has declared its intention of transitioning 75 percent of its members' business into contracts with incentives for health outcomes, quality, and cost-management by January 2020.[1]

This shift to value-based payment (VBP) models is often met with resistance. We see seemingly smart leaders unable to make decisions because they are paralyzed by the "silent killer" of fear. Such anxieties are not completely unfounded; while FFS has been abysmal for the economy, many have profited from over-testing and over-treatment. Further, earlier tests of value-based models, including the first-generation ACO model, saw underwhelming financial performance.

The Run to Risk

What's easy to forget is that in many ways, healthcare reform is still in its earliest stages. Reducing costs and improving quality isn't easy. Healthcare is part of a much broader and complex ecosystem; transforming it is hard work and will take years of cross-collaboration among numerous sectors of the economy.

Even though payment reform is still evolving, the financial future of any healthcare organization rests squarely on the early and earnest adoption of the right VBP arrangement for its unique situation. With the commitment from CMS, employers, and payers to tie payment to value, it is not a matter of if but a matter of *how* organizations go about planning for transformational change. Organizations that enter into value-based arrangements on their own terms and select the models that make the most sense for them will be able to capitalize on early learnings and get paid for what they already do: providing high-quality, appropriate care for patients. Below are five principles that healthcare leaders should be mindful of as they navigate the journey to value-based reimbursement.

Key Board Takeaways

As healthcare organizations navigate the journey to value-based reimbursement, boards should be mindful of these principles:

- Early adopters will have more time to gain the experience necessary to prepare for the shift to predominantly value-based reimbursement.
- During this shift, providers are likely to operate simultaneously under different reimbursement models.
- Incentives from FFS and VBP contracts will need to be organized to maximize the value from each type of contract.
- Organizations that delay their entrance into VBP run the risk of allowing other players to capture attributed patients before their own models are initiated.

1. Early Adopters Win the Day

Providers that have embraced VBP models are already gaining important experience in the transition toward outcomes-based reimbursement. Over the next decade, the markets will shift to predominantly value-based reimbursement, and those not ready will be left behind and find it impossible to operate profitably.

Regardless of profitability under value-based systems as presently constituted, providers need to develop capabilities now to provide cost-effective, outcomes-based care. While some providers still experience financial stability under the FFS model, profits will continue to erode as public and private payers move continually toward reimbursement based not on the quantity but the value of services delivered.

Waiting to move toward value-based models will come at a cost as competitors continue to forge ahead with efforts to operate under different types of reimbursement models. Early adopters have time on their side as they become savvy in the intricacies of VBP, gain a head start on articulating their value under these new arrangements, and subsequently corner the market with favorable payer and employer contracts.

2. Get Comfortable Living in a World of "Fusion" Reimbursement

Value-based care models and FFS reimbursement are not canceling each other out. The options under value-based care fall into a vast continuum, from upside-only risk associated with retrospectively reported quality measures to full-risk models in which providers deliver care under a fully capitated agreement. The wide variety of risk tolerances and reimbursement models in the value-based continuum should ease concerns surrounding future financial instability.

During the transition to a payment approach that deemphasizes FFS, providers are likely to operate simultaneously under different models. At least for the time being, this fusion approach allows providers to gain valuable experience while mitigating the effects of taking on large amounts of risk in a short period of time.

3. Organize Incentives to Maximize Value

Transitioning a greater proportion of payments into value-based contracts can feel like a dicey move. There may be a period of time in which total revenue decreases, because the pressure on FFS revenue will increase faster than it can grow through value-based reimbursement. To mitigate this revenue impact, savvy organizations must fuse incentives from FFS and VBP contracts into gainsharing and co-management agreements that maximize the value from each type of contract. Given that most organizations will have both FFS and VBP contracts with payers at different points along the continuum, operationalizing this information is no small effort. However, since both reimbursement types will be the new reality for years to come, it will be well worth any struggle.

4. The Master Class in Patient Attribution Begins Now

One of the fundamental tenets of VBP is provider and payer accountability; because of it, parties have a strong financial incentive to closely monitor patient care and outcomes across the full care continuum. Providers care for a group of "attributed"

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1 Health Care Transformation Task Force, "Major Health Care Players Unite to Accelerate Transformation of U.S. Health Care System," January 28, 2015.

Improve Outcomes and Lower Costs...

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systems reported that they have nurses as voting members on the board in The Governance Institute's 2015 biennial survey.[4]

Hospitals that include nurses at the highest levels reap the benefits. Institutions that have achieved Magnet® recognition have lower costs and better nurse and patient satisfaction scores as well as superior patient outcomes. A full 85 percent of those named to *U.S. News & World Report's* 17 Best Hospitals Honor Roll were Magnet facilities. To receive this prestigious credential, hospitals and health systems must empower nursing leaders "in the organization's highest governing, decision making, and strategic planning body."[5]

Nurses themselves know the value they bring to boards. "As a nurse serving on the board of a non-profit healthcare program, I often raise the clinical care aspects of the program at the board level. As someone with a clinical background, I see aspects of data and reports that have implications for care that can be missed by other board members," said Barbara Blakeney, M.S., RN, FNAP, Innovation Advisor, Center for Medicare and Medicaid Innovation, and Innovation Fellow, Institute for Patient Care at Massachusetts General Hospital. "I'm able to ask questions that highlight both best practices as well as deficiencies that others may not see or fully appreciate. Equally important, I can help other board members appreciate the skill and knowledge required by clinical staff to provide optimal care."

Having registered nurses at the decision-making table allows the board to see the full picture. "When it comes to understanding how the quality and cost of our healthcare system can be improved with effective care coordination, nursing is right at the top of the list of all clinician disciplines," said Mary Jo Jerde, B.S.N., RN, M.B.A., CCM, CNAA, Senior Vice President, UnitedHealth Group Center for Clinician Advancement. "Nurses often have a diverse perspective and insight on many issues, and that can be a great asset when serving on a board. The overall professional makeup of a nurse, from bedside care, community care, and/or business, includes key elements of leadership that will often benefit the decision-making process of the board."

Nurses as the Key to Improved Outcomes and Lower Costs

The evolving healthcare landscape dictates that hospitals and health systems have a vested interest in ensuring patients experience smooth transitions post-discharge. Registered nurses can contribute invaluable insight into how best to manage such patient transitions and help evaluate post-acute care partners. If a hospital or health system is looking to improve outcomes and lower costs across the continuum of care, its leaders would be wise to invite a registered nurse to the decision-making table.

The Governance Institute thanks Marla J. Weston, Ph.D., RN, FAAN, Chief Executive Officer, American Nurses Association, and Laurie Benson, Executive Director, Nurses on Boards Coalition, for contributing this article. They can be reached at marla.weston@ana.org and laurie.benson@ana.org.

4 Kathryn C. Peisert, *21st-Century Care Delivery: Governing in the New Healthcare Industry,* The Governance Institute's 2015 Biennial Survey of Hospitals and Healthcare Systems.

5 American Nurses Credentialing Center, *Getting Started: An Overview of the ANCC Magnet Recognition Program® and Pathway to Excellence® Program*, 2013.

Generating Value from Big Data...

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Build a Value-Based Information Blueprint to Guide Delivery and Implementation

With clearly defined strategic initiatives and targeted outcomes and capabilities in mind, building an information management framework for the organization provides the blueprint to achieving results. The framework helps identify what *type* of data is required from varied sources (clinical, financial, sociodemographic, community, retail, etc.), what *form* the data needs to take to appropriately harmonize (structured, unstructured, text, multimedia, data from devices, etc.), and at what *frequency* the data needs to be submitted and updated (real time/dynamic or retrospective). This framework is a valuable tool in understanding the pace at which the organization can build capabilities and create actionable reports. It helps identify value levers (cost of revenue) that can be leveraged to achieve desired outcomes.

Think Big, Start Small, and Go Fast: Build for Scalability and Sustainability

Often digital health and big data initiatives become too complex too fast, and they lack the ability to produce any measurable value. Information produced from analytics platforms might identify a problem, but an established operational framework is needed to *solve* the problem. The usability of digital health technology is closely tied with an integrated workflow that ensures a seamless and cohesive flow of information. Organizations that have successfully built action-oriented value-based frameworks for digital health and big data initiatives have started small, often around a "proof-of-concept," and gradually expanded based on the strategic and operational requirements of the organization.

Convergence of digital health and big data initiatives comprises an increasingly large component of the capital and operating budgets. As a board member, understanding and posing questions to understand the value expected from these investments is critical. Utilizing a value model allows your organization to optimally invest resources and dollars towards programs that generate outcomes and value in alignment with strategic and financial goals.

The Governance Institute thanks Shaillee Chopra, PMP, Senior Manager, and Daniel J. Marino, M.B.A., M.H.A., Executive Vice President, Camden Group, a GE Healthcare Partners business, for contributing this article. They can be reached at shaillee.chopra@ge.com and daniel.marino@ge.com.

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patients—to whom their VBPs are directly tied—and are held responsible for those patients' outcomes. Organizations that delay their entrance into VBP run the risk of allowing other players to capture attributed patients before their own models are initiated, inadvertently forgoing future business and revenue opportunities.

In addition, providers' responsibility for patients across the care continuum calls for stronger partnerships with post-acute care organizations. Early adopters are already working with post-acute care organizations to standardize care based on their care protocols, and more aggressive organizations are thinking about buying or building post-acute assets. Waiting too long may lead to missing the opportunity to partner with the most beneficial post-acute partners.

5. There Is a Time and Place for FFS

A common misperception of VBP models is that they encourage providers to do less, often at the expense of a patient's care needs. Similarly, this logic encourages the flawed perception that FFS models only incentivize providers to do more, through potentially unnecessary services. VBP models are actually built on the principle that improvements in tools and technology better enable providers to give patients the care they need while avoiding unnecessary treatment. And while FFS models have earned a bad reputation, there may continue to be scenarios in which FFS payments are more appropriate, such as unavoidable ER visits and ensuring patient access in areas with a provider shortage. By embracing a fusion approach, organizations can equip themselves to operate under a variety of reimbursement models and appropriately respond to patient needs.

Implications for Board Members

Good patient care is good business. Healthcare executives willing to step up and make the necessary changes to their care models will transform care on their terms. In doing so, their organizations will lead markets and become places where doctors want to practice and patients want to receive care. Board members, executives, providers, and payers must commit to building communities where doctors are rewarded for giving high-quality care that is cost-effective.

Modeling the courage and transparency necessary to improve healthcare is a legacy worth leaving. Putting the interests of patients above those of every other stakeholder group is a conscious decision leaders make every day. Our patients and their families deserve nothing less.

The Governance Institute thanks Rachel Bidgood, Senior Consultant, and Anna Henkel, Senior Consultant, ECG Management Consultants, and Deirdre Baggot, Ph.D., Former Expert Reviewer, BPCI Initiative, CMS, and Principal, ECG Management Consultants, for contributing this article. They can be reached at rebidgood@ecgmc.com, ahenkel@ecgmc.com, and dbaggot@ecgmc.com.

Driving Value through Strategic Alliances

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Anthem customers.[2] In most such partnerships, parties share data and resources to ensure patients efficiently obtain the preventive services, care, and education they need. Examples abound in every state.

Provider–Community Alliances

While less likely to attract national attention, provider–community alliances drive value locally by coordinating the continuum of care, moving past a hospital-centric focus, and addressing social determinants of health. Patients, as people first, come from home or homeless situations that may support or impede their health. Community organizations and agencies that address housing, heat, nutrition, public health, wellness, mental health/substance abuse, and other social needs can and should be essential partners in improving community health.

Addressing the social determinants of health is a "wicked problem," that is, one that is particularly difficult (or even impossible) to solve. Without attending to the thorny issues patients face, hospitals and systems cannot realize their full potential to achieve the Triple Aim. Addressing these requires collective impact: the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem.[3] More than a simple collaboration, these relationships should be viewed as strategic alliances.

Examples of such community alliances range from a consortium of area hospitals committing time and money to ensure adequate affordable housing, to hospitals/systems investing in school partnerships to encourage potentially at-risk students to focus on careers in healthcare, to the BUILD Health Challenge,[4] which strengthens partnerships between local non-profit organizations, hospitals/systems, and local health departments to support interventions in low-income urban neighborhoods to improve community health.

Moving forward, most hospitals—whether independent or part of a larger system—will be participants in multiple partnerships or alliances focused on driving value. These types of relationships require cultivation and the investment of tremendous management time and energy. Therefore, the board should be open to such alliances but very careful to approve only those that hold the greatest likelihood of enhancing your mission and strategy.

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2 Brett Brune, "How Anthem's Vivity Venture Is Faring in Southern Calif. Showdown with Kaiser," *Modern Healthcare,* October 23, 2015.

3 John Kania and Mark Kramer, "Collective Impact," *Stanford Social Innovation Review,* Winter 2011.

4 For more information on the BUILD Health Challenge, see http://buildhealthchallenge.org.

Driving Value through Strategic Alliances

BY MARIAN C. JENNINGS, M.B.A., M. JENNINGS CONSULTING, INC.

Physician offices, hospitals, and health systems have long been synonymous with "healthcare," under a system in which payers essentially exchanged payment for services rendered.

Driven by our nation's largest payer, Medicare, and enhanced by our growing ability to collect and analyze data about the care we provide, the industry is shifting from a model of "healthcare" to one of "health" that encompasses the overall wellness of populations, locates interventions in their most appropriate and cost-effective settings, and measures how effective a job we are doing.

This "new normal" of moving from *volume* to demonstrated *value* is far more than a semantic change. Twenty-five years after the Institute for Healthcare Improvement introduced the Triple Aim ("applying integrated approaches to simultaneously improve care, improve population health, and reduce costs per capita"), recent changes in payment models have focused providers of all types on managing the quality, quantity, and cost of care. Regardless of size, hospitals and systems are now challenged to respond. To succeed, most must address the first clause of the Triple Aim: to use "integrated approaches" in partnerships comprising other providers, payers, and community-based organizations, as well as potential industry disruptors.

Although rapid consolidation through hospital mergers is well-documented and expected to continue unabated, it is unlikely that ever-larger health systems will resolve the issues facing our industry. We expect strategic alliances—partnerships short of merger—to proliferate as organizations pursue the Triple Aim and recognize more fully the impact of the social determinants of health (poverty, education, housing, and other environmental factors) on their ability to reduce readmissions, deliver a cost-effective "bundle of care," and effectively manage population health under ACO or global budget payments.

How might such strategic alliances fit into your organization's approach?

What Is a Strategic Alliance?

By definition, an alliance is a relationship in which parties agree to work together around areas of common interest. Such alliances may be contractual, joint ventures, management services agreements, or affiliation agreements short of merger or acquisition. Because members must agree on common goals and will naturally place their own interests before those of the alliance itself, these relationships can be difficult to manage and may be less sustainable long term than fully integrated structures. However, they are often the only or best way to meet the objectives of the Triple Aim.

Key Success Factors for Strategic Alliances

For alliances to have any chance for long-term success, they must include:

- Trusting relationships—there is no substitute for trust.
- A clearly articulated statement of purpose. Generally, the more focused the mission, the more likely the success. Avoid overly broad statements of purpose.
- A clear, agreed-upon vision statement and measures of success for three years.
- A clear, practical action plan with specific resource commitments for each party.
- Delineation of roles, responsibilities, and expectations for each member and what authorities, if any, will be delegated to the alliance.
- A structure sufficiently strong to deliver the desired outcomes.
- Anticipation of potential obstacles, so that if they occur, they do not unnecessarily derail the relationship.
- Dedicated alliance staff and committed hospital/health system leaders.

Provider–Provider Alliances

Myriad provider–provider alliances exist both statewide and nationally. Typically, these focus on creating a "super-brand" or the critical mass to become a narrow provider network capable of managing population health. The Mayo Clinic Care Network is now a 40-member international strategic alliance. MD Anderson Cancer Center and the Cleveland Clinic, among others, have similarly leveraged their expertise and brands to enhance service offerings locally, while gaining exposure and attracting quaternary care cases from local markets.

Key Board Takeaways

To succeed in developing and participating in strategic alliances, the board must:

- Recognize that any partnership or alliance is the board's call.
- Remember alliances are a means to an end, not an end in themselves.
- Understand the why of any proposed alliance and how your organization should measure its success in driving value.
- Understand what you will "give to get" in any proposed alliance.
- Anticipate at the outset the potential for sunsetting the alliance.
- Choose alliance partners carefully—and make sure your organization would be a desirable partner.

Another provider–provider alliance, the Midwest Health Collaborative comprises six major Ohio health systems, including the Cleveland Clinic. The common interests of the strategic alliance members are typical of most such networks: to increase value to the communities they serve and to their collective organizations through:[1]

- Creating a statewide provider network
- Exchanging best practices
- Sharing resources
- Reducing costs
- Developing innovative ways to deliver care across large populations
- Reducing care variation

Provider–Payer Alliances

These relationships, while contractual, differ from traditional payer contracts in that the common interest is to enhance value to their shared beneficiaries and create competitive advantage. Often they are structured as narrow provider network arrangements. Vivity, for example, is an integrated network of seven highly competitive Southern California health systems, including Cedars-Sinai and UCLA Health. In partnership with Anthem Blue Cross, this narrow network in its first year signed on 13 large employers, including seven that were not previously

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1 "Leading Ohio Health Care Systems Launch a Collaborative Effort to Improve the Value of Health Care" (Press Release from Midwest Health Collaborative), January 14, 2015.