DECISIVE

MAKING DECISIONS IN AN UNCERTAIN WORLD

Insights from the
2014 Chairperson, CEO, & Physician Leader Conference

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THE GOVERNANCE INSTITUTE

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The Governance Institute

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Preface

The Governance Institute's 24th annual Chairperson, CEO, and Physician Leader Conference, held June 8–10, 2014, at the Boca Raton Resort & Club in Boca Raton, FL, brought together a distinguished group of faculty and attendees to discuss how to make better decisions in an uncertain world, including difficult and courageous decisions related to the following: the appropriate role for their organization in the overall industry and the local community; new business models that place value creation at the forefront; managing health rather than illness, both for patients and communities; and leading change across the continuum of care. This annual conference provides an opportunity for The Governance Institute to help its members exchange practical ideas with experienced faculty and with each other. An excellent faculty joined with approximately 75 health sector leaders from 18 states. This paper summarizes the presentations and discussions that took place during the conference.

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Faculty

The Governance Institute thanks the faculty of the 24th annual Chairperson, CEO, and Physician Leader Conference (listed in alphabetical order) for being so generous with their time and expertise:

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Guy M. Masters, M.P.A.
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Keith G. Myers
Chairman and CEO, LHC Group, Inc.

Barbara Tretheway, J.D.
Senior Vice President and General Counsel, HealthPartners

Robert M. Wachter, M.D.
Professor and Associate Chairman, Department of Medicine, University of California, San Francisco

1 Mr. Kett conducted a teaching session on the leadership transformation of Scripps Health, which is not included in this proceedings report. To download the related case study, *Building a Culture of Accountability from Within: The Transformation of Scripps Health,* visit www.governanceinstitute.com/research-and-publications/resource-library.

Executive Summary

The Governance Institute's 24th annual Chairperson, CEO, and Physician Leader Conference, held June 8–10, 2014, at the Boca Raton Resort & Club in Boca Raton, FL, brought together a distinguished group of faculty and attendees to discuss how to make better decisions in an uncertain world. This section of the report provides a brief summary of the presentations and discussions from the conference.

Decisive: How to Make Better Choices in Life and Work

Dan Heath, Senior Fellow at Duke University's CASE Center, discussed what psychologists have learned from decades of work about why people sometimes make bad decisions and what can be done to minimize the forces that lead to those decisions. In their book *Decisive: How to Make Better Choices in Life and Work*, Mr. Heath and his brother Chip outline four "villains" of bad decision making: narrow framing, confirmation bias, excessive focus on short-term emotions, and overconfidence related to how the future will unfold.

Awareness alone will not prevent these problems, you cannot "think your way" out of them. The authors present a four-step process known as WRAP, which incorporates conscious steps to avoid these traps:

- **Widen options**: Decision makers need to consider the full spectrum of possibilities. Yet too often narrow framing makes you miss options. How can you expand your set of choices?
- **Reality-test assumptions**: Many people convince themselves they are looking for the truth when in reality they are looking for reassurance that their views are correct, also known as confirmation bias. How can you get outside your head and collect information that you can trust?
- **Attain distance before deciding**: Decision makers often need some distance from the issue at hand before ultimately deciding, as short-term emotion can get in the way of the bigger picture. How can you overcome short-term emotion and conflicted feelings to make the best choice?
- **Prepare to be wrong**: The final component of the process is to avoid overconfidence and reassess decisions if necessary. How can we plan for an uncertain future so that we give our decisions the best chance to succeed?

Leadership Accountability for Creating Healthy Communities

Gregg Loughman, Vice President of Health System Strategy and Governance at The Governance Institute, presented key findings from The Governance Institute's 2014 Signature Publication, developed in partnership with the Institute for Healthcare Improvement (IHI), and profiled four partner organizations: LHC Group, HealthPartners, Genesys Health System, and Bellin Health. The publication reviewed how each of these four organizations has committed to achieving the IHI Triple Aim—reducing per-capita costs, improving care delivery, and managing population health. (The main report provides additional details on each organization's approach.) Key lessons from these four organizations include the following:

- Integrate community health into the mission and vision statement of the organization to guide future board decisions.
- Assess community health needs and assets at a broad level and focus initiatives on addressing these needs and meeting the Triple Aim.
- Recognize that healthcare and governance remain local even in an era of consolidation, and leverage local roots (e.g., patients, providers, business owners) and historical experiences to understand community needs and assets.
- Select a manageable number of objective measures of the organization's impact on community health, measure performance on these metrics, and share results with local partners. This process serves to create accountability for performance among board members and organizational leaders.
- Know how to use the organization's brand, including when to lead from the front and when to remain in the background and leverage the brand of partner organizations.

- Focus the board on fostering a culture that accepts change, promotes courage, and ensures alignment with the organization's mission, vision, and values.

Following his presentation, Mr. Loughman led a panel discussion with leaders of three of the organizations featured in the signature publication: Pete Knox, M.S., B.S., Executive Vice President and Chief Learning and Innovation Officer at Bellin Health System; Keith G. Myers, Chairman and CEO of LHC Group, Inc.; and Barbara Tretheway, J.D., Senior Vice President and General Counsel at HealthPartners. These panelists discussed the following issues: the appropriate role of the board in promoting community health; specific initiatives to improve community health; how to engage the boards of partner community hospitals; how to create an "improvement culture" where ideas take hold and last over time; overcoming challenges and pitfalls; the merits of owning an insurer and having access to claims data to guide resource allocation decisions; how to allocate board meeting time, including the appropriate division between backward- and forward-looking agenda items; and advice and guidance for organizations that have not yet started on the journey to managing population health.

Defining Your Position in the New Environment

Mark E. Grube, Managing Director of Kaufman, Hall & Associates, Inc., discussed the need to think differently about competitors, performance measurement, and the definition of success in the new healthcare environment. He began by reviewing the trend toward consolidation in the industry, noting that merger and acquisition activity continues at a rapid pace. Looking ahead, it seems reasonable to assume that more hospitals will become part of multi-hospital systems, with growth in such systems continuing at a steady pace. The degree of consolidation will likely be driven by the scale required to adequately manage population risk. Kaufman Hall estimates that systems need to manage at least 250,000 covered lives, as operating margins under full-risk contracts vary too much when managing smaller populations, thus creating a significant risk of financial losses. Extrapolating this figure across the nation, Kaufman Hall projects a future with 200 to 400 integrated health systems around the country, along with 100 to 200 freestanding academic medical centers, safety net hospitals, and children's hospitals. These systems will generally have $4 to $8 billion in annual revenues, although some will have even higher revenues.

The good news is that the industry seems to be experiencing the beginning of a reversal in historic cost trends. Kaufman Hall believes that this slowdown stems significantly from a fundamental transformation in the industry that is starting to take shape, a transformation that has major implications for providers.

Going forward, organizations need to map their path to a value-based model. This process begins with an assessment of the marketplace and internal capabilities, followed by development of a strategic plan and consideration of whether a partner will be necessary. These analyses help health system leaders determine how well they are positioned relative to the stage of market.

Getting to Total Cost of Care: Accepting the Challenges to Change

Guy M. Masters, M.P.A., Senior Vice President at The Camden Group, and Kimberly Hartsfield, M.P.A., Senior Manager at The Camden Group, discussed how health systems should respond to the radical changes taking place in the industry, including how to determine priorities, strategies to address those priorities, and the appropriate timing for any actions taken.

The key to success lies in being adaptable to the changes going on in the industry, particularly with respect to the transition from fee-for-service (FFS) to value-based reimbursement. Timing truly is everything when it comes to navigating this transition, as the critical success factors under FFS (building volume to maximize revenue) will not work under value-based reimbursement. Organizations that fail to accept the challenge to change will face significant consequences. They will not meet health plan requirements or differentiate themselves in the market. They will likely experience low patient satisfaction and provider and staff burnout, with patient care remaining uncoordinated and highly variable. They will also fall behind in preparing for health reform.

Rather than going down this path, health systems need to "bake" the Triple Aim into their strategic plans. Some organizations are well on their way to achieving this vision. For example, HealthCare Partners Medical Group in Southern California covers approximately 750,000 lives and generates $2.7 billion in annual revenues, 92 percent of which comes from full-capitation contracts. However, many markets are not like Southern California and not yet ready for full capitation. Even in these areas, however, some forms of risk-based contracts are becoming popular, particularly bundled payment initiatives.

Hospitals and health systems that participate in these initiatives have much to gain, including incremental volume, greater predictability in reimbursement, and the opportunity to leverage the program to push for additional care redesign and greater physician engagement.

To meet the Triple Aim and succeed under bundled payments, health systems need to put in place substantial infrastructure to support integration, including incentives, information technology, and real-time information to guide decision making. Transparency has been a "game changer" in some markets. Ideally, hospitals and health systems should have access to true cost and outcomes data, not what insurers pay. Organizations need to stay on top of this type of information, using it to inform contract negotiations with payers, benchmark performance versus competitors, and reduce variation internally by helping high-cost providers learn from their lower-cost peers. The ultimate winners will be those organizations that cover the full continuum of care (either through partnership or ownership) and that effectively manage and utilize data. Key elements for success include the following:

- Embrace transparency by sharing detailed, real-time physician- and procedure-specific data on a regular basis.
- Implement care protocols to standardize care and reduce variation.
- Reduce readmissions by investigating why patients end up back in the hospital and developing strategies to address identified problems.
- Reduce ambulatory care sensitive admissions and unnecessary emergency department visits by partnering with physicians to manage patient care proactively in the outpatient setting.
- Focus on quality and patient outcomes.

Physician Engagement: Insights to Smooth the Path from Aspiration to Reality

Two physician leaders at the University of California, San Francisco with a longstanding interest in physician workforce issues discussed strategies for engaging physicians in the reengineering of healthcare delivery, with each coming from a different perspective.

If Every Instinct Doctors Have Is Wrong, Then the Opposite Would Have to Be Right...Or Would It?

Robert M. Wachter, M.D., Professor and Associate Chairman of the Department of Medicine, described four areas where today's pressures for higher value and management of population health force providers and leaders to "do the opposite" of what they were trained to do.

- **Teamwork:** While teamwork and collaboration are critically important, Dr. Wachter emphasized the ongoing need for physician leadership. He worried that the movement toward teamwork may go so far that no hierarchy remains. Teams need leaders, and often (though not always) the physician needs to be that leader. Consequently, organizations need to invest in physician leadership development programs.
- **Sources for best practices**: Comparisons to outside organizations are often met with resistance, with key stakeholders claiming that their patients are different (e.g., older, sicker) and/or that the other organizations have more resources or a different history. In addition, comparisons to outsiders can be misleading, given that there are so many different rankings and relatively little consistency between them. By contrast, local comparisons provide a lot of value, often uncovering substantial variation between facilities within a given system and even more variation across units in the same facility.
- **Relative merits of money versus other policy levers**: Like everyone else, physicians are motivated by more than money. In fact, in some cases, use of money as a motivator can backfire. The jury remains out on whether financial incentives such as pay-for-performance (P4P) systems have a positive impact. Good leaders and policymakers need to be thoughtful, not doctrinaire, about their choice of tools, including P4P. They must understand the culture within the organization and figure out what will and will not work.
- **Focus on individual patients versus populations**: Physicians have been trained to focus on individual patients and generally continue offering services until there is no incremental benefit whatsoever to doing so, regardless of the cost. From a societal/population perspective, however, the provision of services on this flat part of the cost-benefit curve does not make sense unless everything else that offers a higher benefit/cost ratio has been provided to others in the population being covered. Advocates of this population perspective often face stiff opposition in the U.S., as Americans are not used to the concept of rationing care. For physicians, taking on the population perspective creates a dilemma, as they feel pulled in two different directions.

How Doctors Think: Implications for Creating a High-Performing Organization

Gurpreet Dhaliwal, M.D., Associate Professor of Clinical Medicine, offered a different perspective on physician engagement, focusing on how physicians think and what that means for those trying to create a high-performance organization.

Need for Performance Measurement

Increasingly, physicians will be faced with the following question: do they believe they can maintain their autonomy even as they cede accountability to everyone else? Physicians will not be able to have it both ways and increasingly they will need to be accountable for their performance on established metrics. Like all humans, they will not do so without the appropriate context and emotion. Financial incentives rarely work—they may produce short-term improvements, but they do not tap into more powerful psychological levers that deliver long-term results. Physicians are governed by social norms, and have a strong desire to be in sync with or ahead of those around them. Consequently, peer pressure remains a major driver of behavior change. Once scorecards become available—particularly if they measure processes or outcomes clinicians value—then

physicians talk about them and compete with each other to be the best.

Strategies for Engaging Frontline Physicians
Physician and administrative leaders need to get involved in engaging frontline physicians. Many physicians will not lead transformation efforts, but do want their voices to be heard and feel that their opinions matter. Financial incentives alone will not attract and retain top-notch physicians, as incentives do not create a sense of engagement and ownership. Instead, engaging physicians requires an appeal to their internal motivations, which include a desire for autonomy, mastery, and purpose.

The Unlikely Ally: Why the Healthcare Consumer Presents an Intriguing Growth Opportunity

Ryan Donohue, Corporate Director of Program Development at National Research Corporation, discussed opportunities that health systems have to engage directly with consumers by creating partnerships with patients and the general population being served.

Dominant View: Consumer as "Outsider" to System
Since 2012, National Research has conducted a "blue sky exercise" with consumers, conducting qualitative research on their views. By far, the single biggest finding from the most recent exercise is that consumers firmly believe that the healthcare industry has been built without them in mind. Rather, the system views consumers as "outsiders" who lack a basic understanding of—and do not pay attention to—healthcare. Recently, however, these "outsiders" have begun to realize they have more choices with respect to their coverage and care. As a result, consumers are a lot more motivated to become involved in their health and healthcare than in the past.

Barriers to Consumer Engagement
While consumers may want to become involved, barriers exist that prevent them from doing so:

- **Confusion**: Surveys suggest that confusion is the single biggest emotion consumers feel with respect to healthcare. Consumers try to understand the system and their options, but find it difficult to do so.
- **High costs**: High costs are the main reason consumers are confused and do not trust the system. Rightly or wrongly, consumers place most of the blame for rising costs on providers. In fact, they not only blame hospitals for high prices, but also see them as inconvenient. Even though all hospitals are not the same, consumers tend to lump them together due to a lack of familiarity with individual institutions.
- **Convenience**: Convenience still ranks well below quality and physician recommendation as drivers of provider choice, but its importance has risen markedly in a short time. Going forward, consumers will be drawn to provider organizations that make it easy and convenient to access care. For this reason, hospitals and health systems should be quite concerned about retailers such as Walgreens that are opening easily accessible clinics.

Lessons from Non-Healthcare Companies
Companies in many other industries have faced consumer revolutions and been forced to adapt, and those in healthcare can learn from their experiences. Key lessons include the following: the need to adapt to seismic change (as grocery stores have done in response to the trend toward healthy and organic foods), being open to new delivery methods (such as Netflix mailing DVDs and streaming videos to the home), and finding advantages in industries without a strong reputation (such as Southwest Airlines differentiating itself by not charging baggage fees).

Creating One-on-One Relationships with Your Consumers
How can hospitals and health systems build a strong alliance with consumers (as Southwest Airlines and Netflix have done)? The key is to build a one-on-one relationship by creating a brand they trust. Doing so, however, requires a simplification of the services offered. Healthcare brands today tend to be overly complex and nearly indecipherable to the average person. When it comes to healthcare services, consumers value the concept of "systemness," and branding the system as a whole (not individual components) helps to make it simpler for consumers.

Hospital and health system leaders need to be willing to launch a brand-building campaign to create awareness and differentiate the organization from the competition. They need to set goals related to brands as a defense against internal distractions, and create financial incentives to reinforce brand positioning. To that end, marketing leaders need to be given a seat at the "big-kid table" when major decisions are being debated, and feedback loops must be put in place to gauge the impact of all marketing, strategic planning, and business development activities.

Decisive: How to Make Better Choices in Life and Work

Dan Heath, Senior Fellow at Duke University's CASE Center, discussed what psychologists have learned from decades of work about why people sometimes make bad decisions and what can be done to minimize the forces that lead to those decisions.[2]

Flawed Decision Making

Business decisions are frequently flawed. One study of corporate mergers and acquisitions—some of the highest-stakes decisions executives make—showed that 83 percent failed to create any value for shareholders. When another research team asked 2,207 executives to evaluate decisions in their organizations, 60 percent of the executives reported that bad decisions were about as frequent as good ones.

On the personal front we're not much better. People don't save enough for retirement, and when they do save, they consistently erode their own stock portfolios by buying high and selling low. Young people start relationships with people who are bad for them. Middle-aged people let work interfere with their family lives. The elderly wonder why they didn't take more time to smell the roses when they were younger.

In his memoir, *Only the Paranoid Survive,* Andy Grove recalled a tough dilemma he faced in 1985 as the President of Intel: whether to kill the company's line of memory chips. Intel's business had been built on memory. For a time, in fact, the company was the world's only source of memory, but by the end of the 1970s, a dozen or so competitors had emerged.

Meanwhile, a small team at Intel had developed another product, the microprocessor, and in 1981 the team got a big break when IBM chose Intel's microprocessor to be the brain of its new personal computer. Intel's team scrambled to build the manufacturing capacity it would need to produce the chips.

At that point, Intel became a company with two products: memory and microprocessors. Memory was still the dominant source of the company's revenue, but in the early 1980s, the company's competitive position in the memory business came under threat from Japanese companies. "People who came back from visits to Japan told scary stories," said Grove. It was reported that one Japanese company was designing multiple generations of memory all at once—the 16K people were on one floor, the 64K people were a floor above, and the 256K team was above them.

Intel's customers began to rave about the quality of the Japanese memories. "In fact, the quality levels attributed to Japanese memories were beyond what we thought possible," said Grove. "Our first reaction was denial. This had to be wrong. As people often do in this kind of situation, we vigorously attacked the data. Only when we confirmed for ourselves that the claims were roughly right did we start to go to work on the quality of our product. We were clearly behind."

Between 1978 and 1988, the market share held by Japanese companies doubled from 30 percent to 60 percent. A debate raged inside Intel about how to respond to the Japanese competition. One camp of leaders wanted to leapfrog the Japanese in manufacturing. They proposed building a giant new factory to make memory chips. Another camp wanted to bet on an avant-garde technology that they thought the Japanese couldn't match. A third camp wanted to double down on the company's strategy of serving specialty markets.

As the debate continued with no resolution, the company began losing more and more money. The microprocessor business was growing rapidly, but Intel's failures in memory were becoming a drag on profits. Grove summarized the year 1984 by saying, "It was a grim and frustrating year. During that time, we worked hard without a clear notion of how things were ever going to get better. We had lost our bearings."

In the middle of 1985, after more months of fruitless debate, Grove was discussing the memory quandary in his office with Intel's Chairman and CEO, Gordon Moore. They were both fatigued by the internal deliberations. Then Grove had an inspiration:

> I looked out the window at the Ferris wheel of the Great America amusement park revolving in the distance, then I turned back to Gordon and I asked, "If we got kicked out and the board brought in a new CEO, what do you think he would do?" Gordon answered without hesitation, "He would get us out of memories." I stared at him, numb, then said, "Why shouldn't you and I walk out the door, come back in, and do it ourselves?"

This was the moment of clarity. From the perspective of an outsider, someone not encumbered by the historical legacy and the political infighting, shutting down the memory business was the obvious thing to do. The switch in perspectives—"What would our successors do?"—helped Moore and Grove see the big picture clearly.

Of course, abandoning memory was not easy. Many of Grove's colleagues were furiously opposed to the idea. Some held that memory was the seedbed of Intel's technology expertise and that without it, other areas of research were likely to wither. Others insisted that Intel's sales force could not get customers' attention without selling a full range of products—memories as well as microprocessors.

After much "gnashing of teeth," Grove insisted that the sales force tell their customers that Intel would no longer be

2 This section is excerpted from Chip and Dan Heath, *How to Make Better Choices in Life and Work*, Crown Business, 2013 (used with permission).

carrying memory products. The customers' reaction was, essentially, a big yawn. One said, "It sure took you a long time."

Since that decision in 1985, Intel has dominated the microprocessor market. If, on the day of Grove's insight, you had invested $1,000 in Intel, by 2012 your investment would have been worth $47,000 (compared with $7,600 for the S&P 500, a composite of other big companies). It seems safe to say that he made the right decision.

The Four Villains of Decision Making

The first villain of decision making is narrow framing: the tendency to define our choices too narrowly, to see them in binary terms. We ask, "Should I break up with my partner or not?" instead of "What are the ways I could make this relationship better?" We ask ourselves, "Should I buy a new car or not?" instead of "What's the best way I could spend some money to make my family better off?"

Our normal habit in life is to develop a quick belief about a situation and then seek out information that bolsters our belief. And that problematic habit, called the "confirmation bias," is the second villain of decision making. When people have the opportunity to collect information from the world, they are more likely to select information that supports their preexisting attitudes, beliefs, and actions. Political partisans seek out media outlets that support their side but will rarely challenge their beliefs by seeking out the other side's perspective. Consumers who covet new cars or computers will look for reasons to justify the purchase but won't be as diligent about finding reasons to postpone it.

The tricky thing about the confirmation bias is that it can look very scientific. After all, we're collecting data. Dan Lovallo, Professor and Decision-Making Researcher, said, "Confirmation bias is probably the single biggest problem in business, because even the most sophisticated people get it wrong. People go out and they're collecting the data, and they don't realize they're cooking the books."

The third villain of decision making is short-term emotion. When we have a difficult decision to make, our feelings churn. We replay the same arguments in our head. We agonize about our circumstances. We change our minds from day to day. If our decision was represented on a spreadsheet, none of the numbers would be changing—there's no new information being added—but it doesn't feel that way in our heads. We have kicked up so much dust that we can't see the way forward. In those moments, what we need most is perspective.

The fourth villain of decision making is overconfidence. People think they know more than they do about how the future will unfold. A study showed that when doctors reckoned themselves "completely certain" about a diagnosis, they were wrong 40 percent of the time. When a group of students made estimates that they believed had only a 1 percent chance of being wrong, they were actually wrong 27 percent of the time. We have too much confidence in our own predictions.

The problem is that we don't know what we don't know. The future has an uncanny ability to surprise.

WRAP: A Four-Step Process for Dodging Traps and Making Better Decisions

We can't deactivate our biases, but we can counteract them with the right discipline. The nature of each villain suggests a strategy for defeating it. We present a four-step process for making better choices:

1. Widen your options.
2. Reality-test your assumptions.
3. Attain distance before deciding.
4. Prepare to be wrong.

Note the mnemonic WRAP, which captures the four verbs. We like the notion of a process that "wraps" around your usual way of making decisions, helping to protect you from some of the biases we've identified.

1. You encounter a choice. But narrow framing makes you miss options. So...

Widen your options. How can you expand your set of choices?

2. You analyze your options. But the confirmation bias leads you to gather self-serving information. So...

Reality-test your assumptions. How can you get outside your head and collect information that you can trust?

3. You make a choice. But short-term emotion will often tempt you to make the wrong one. So...

Attain distance before deciding. How can you overcome short-term emotion and conflicted feelings to make the best choice?

4. Then you live with it. But you'll often be overconfident about how the future will unfold. So...

Prepare to be wrong. How can we plan for an uncertain future so that we give our decisions the best chance to succeed?

The four steps in the WRAP model are sequential; in general, you can follow them in order—but not rigidly so. Sometimes you'll double-back based on something you've learned. For

example, in the course of gathering information to reality-test your assumptions, you might discover a new option you hadn't considered before. Other times, you won't need all of the steps. A long-awaited promotion probably won't require much distance before you accept and pop the champagne.

Occasionally some aspect of the WRAP process will lead to a home-run insight. More commonly, it will yield small but consistent improvements in the way you make decisions—and that's critical too. Think of a baseball player's batting average: if a player gets a hit in one out of every four at-bats (a .250 average) over the course of a season, he is mediocre. If he hits in one out of three (.333), he's an All-Star. And if he hits .333 over his career, he'll be a Hall-of-Famer. Yet the gap in performance is small: only one extra hit in every 12 at-bats.

To get that kind of consistent improvement requires technique and practice. It requires a process. The value of the WRAP process is that it reliably focuses our attention on things we otherwise might have missed: options we might have overlooked, information we might have resisted, and preparations we might have neglected. A more subtle way the WRAP process can help us is by ensuring that we're aware of the need to make a decision.

Governance across the Continuum: Leadership Accountability for Creating Healthy Communities

Gregg Loughman, Vice President of Health System Strategy and Governance at The Governance Institute, presented key findings from The Governance Institute's 2014 Signature Publication, developed in partnership with the Institute for Healthcare Improvement (IHI) and profiling four partner organizations: LHC Group, HealthPartners, Genesys Health System, and Bellin Health.

Background

Every two years, The Governance Institute takes an in-depth look at a specific area of importance to hospitals and health systems, with the goal of helping them transform healthcare through high-performing governance. This year's publication focused on what can be learned from organizations focused on community health, a topic of increasing importance as hospitals and health systems are being held accountable for more than just the provision of high-quality, safe, and cost-effective care. As reimbursement models shift from fee-for-service (FFS) to value-based, hospitals and health systems increasingly take on risk for the health of defined populations. Consequently, the "center" of the healthcare experience is shifting from the hospital to other settings, including primary care and community health. A number of organizations are achieving success in this area, but there is no "one size fits all" approach.

To launch the effort, The Governance Institute reached out to Donald Berwick, M.D., head of IHI and an expert in this area. The goal was to identify and examine organizations that have been successful in addressing rising costs while simultaneously improving access and quality, not by focusing on "bricks and mortar" (i.e., hospitals), but rather by partnering with community-based organizations (such as home health agencies, fitness centers, community alliances) to focus on population health. As part of this effort, the research investigated the appropriate role of the board in helping to shape the strategy, create metrics to gauge success, and hold managers accountable for performance on these metrics. In conducting this project, The Governance Institute and IHI had a clear desire not to look at the "usual suspects" for these kinds of research efforts, such as Geisinger and Intermountain. Too often, those who read about these organizations feel they are "not like them" and hence discount the lessons and experiences from these pioneers. Consequently, IHI and The Governance Institute focused on finding an array of organizations that reflect the broad spectrum in the market today.

The transition from FFS medicine to quality, safety, and ultimately population health has been underway for a long time. It began in 1999 with the publication by the Institute of Medicine, *To Err Is Human*, which launched the modern patient safety movement. In the mid-2000s, IHI's 100,000 Lives Campaign and 5 Million Lives Campaign sought to employ the lessons of IOM and other organizations in improving the safety of care. During this time, the collapse of Enron and other organizations led to passage of Sarbanes-Oxley, which made boards more accountable for and engaged in their fiduciary responsibilities. By the time the financial crisis and recession arrived in 2008, the focus had turned to curbing rapidly rising costs. Around the same time, a paper written by Dr. Berwick and colleagues called on healthcare organizations to achieve the Triple Aim—the simultaneous reduction of per-capita costs, improving healthcare delivery and quality, and improving the overall health of the population. Soon thereafter, accountable care organizations (ACOs) came into existence, as did value-based purchasing and the Affordable Care Act (ACA), all with the goal of furthering the Triple Aim by promoting the delivery of high-quality, cost-effective, accessible care. These efforts have all been designed with an eye toward preventing the U.S. economy from collapsing under the weight of healthcare costs, much as the former Soviet Union did after military spending hit 20 percent of gross domestic product (GDP). By 2011, healthcare accounted for 17.7 percent of GDP, a level dangerously close to that 20 percent "tipping point."

Four Organizations Focused on the Triple Aim

The Triple Aim is easy to articulate, but complex and difficult to achieve. When organizations assume responsibility for population health, hospitals are no longer at the center of the equation. Instead, primary care providers assume the role of "quarterback" and play a large role in determining success or failure. At the same time, providers of non-acute care, such as

home health agencies and assisted living facilities, play an increasingly important role in the continuum of care, something that is new to many hospital leaders and boards. In some communities, non-traditional care settings emerge, such as retail clinics opening by CVS, Walmart, and other large organizations that want to be at the center of community health.

It can be challenging to understand where to focus or how to measure success in such an environment, with the board of directors often playing a critical role. The first step is to identify and prioritize community health needs, weighing them against existing assets. This mapping exercise helps to identify potential linkages and new methods of collaboration and to unite disparate elements within a community towards the common goal of population health.

Local customs, cultures, demographics, and histories all play crucial roles in determining how an organization can best serve the community. Consequently, The Governance Institute and IHI identified four innovative, leading-edge organizations that are in the process of figuring out how to best serve their communities by responding to the ever-changing dynamics of their local markets.

HealthPartners

Founded in the 1930s, HealthPartners is the largest consumer-governed, not-for-profit healthcare organization in the country. It serves 1.5 million members in Minnesota and western Wisconsin through 1,700 providers (including 750 primary care physicians) and seven hospitals (six wholly owned and one joint venture). HealthPartners has two health maintenance organizations (HMOs), an insurance company, and a third-party administrator business. As a result, the organization has long had access to a wide array of data. HealthPartners also has a robust research organization, with research being used to inform efforts to improve both clinical and population health outcomes. HealthPartners also maintains a laser-like focus on the consumer, including having consumer representatives on the board who are elected by members.

Leaders of HealthPartners view the challenges they faced through the lens of the IOM's *Crossing the Quality Chasm* report (which focused on the need for revamping systems) and the Triple Aim, both of which created a "seismic shift" in the thinking of organizational leaders and provided them with a framework for moving forward. In addition, the personal healthcare experiences of HealthPartners' CEO Mary Brainerd compelled her to drive the organization to be more patient-centered from an operational perspective and to create a culture of continuous quality improvement. To that end, the board created the Health Transformation Committee, charging it with the following: establish goals related to care and transformation; develop appropriate measures of success; collaborate in learning with senior leadership; and embed the goal of system transformation into the culture of the organization. As Ms. Brainerd noted, "To hold a whole organization accountable for results, the board really needs to know—and have a role in determining—how we are making the changes."

Local boards have also played an important role in transforming the organization, and system-level board members and leaders make a concerted effort to leverage them, including aligning the local boards around the common mission and vision and bringing this vision into the local communities in which HealthPartners operates. In addition, these local boards bring experience and wisdom from the community. To reduce the potential for local resistance to change, system leaders stress the essential role of the local board in maximizing the health of the community. To that end, local directors are asked to assume greater levels of responsibility, including being accountable for performance on established population health metrics, in much the same manner as the system-level board. In essence, the system board and the local boards form a "listening-and-learning" partnership focused on executing the Triple Aim. The partnership includes various "inflection points" along the continuum of collaboration, with the local boards advocating for the community and the system board partnering with them to promote the health of these communities.

Genesys Health System

Serving Central Michigan, Genesys Health System came into existence as General Motors (GM) shrank in size from 80,000 employees to under 8,000. The system represented the consolidation of existing community health infrastructure, which had historically grown to keep pace with GM, by far the area's largest employer. As GM struggled, four community hospitals consolidated into one new facility (Genesys Regional Medical Center), which now serves as the anchor of a system that also includes home health, hospice, ambulatory care centers, an athletic center, and a physician–hospital organization. The organization's goal is to be recognized as "the premier, values-based healthcare system in the region by focusing on the needs of people in their pursuit of health and well-being."

For Genesys (which recently became a member of Ascension Health), it took the better part of a decade to absorb the impact of the traumatic change at GM and to commit to becoming a true health system rather than a collection of siloed parts. Creating this true community asset required the building of a common vision. To that end, representatives from the local

community joined with physicians and a few hospital executives to create a long-term (25-year) vision for and serve as stewards of this new shared asset. The system board and leaders work to disseminate this new vision across the system, with the goal of spreading understanding and alignment organically. To promote the vision beyond the four walls of the hospital, the board's view of its fiduciary responsibility have similarly expanded, moving "beyond the myopia of the hospital being the center of the health system." To that end, system and board leaders have increased provider engagement and representation on the board to enrich deliberation while simultaneously ensuring that community board members do not "abdicate" responsibility to the new provider board members. System leaders also created an Advocacy Committee made up of local leaders who really understand the needs of the community, including representatives of free clinics, federally qualified health centers (FQHCs), fitness centers, schools, and colleges. This committee took charge of developing a community needs assessment, analyzing data to understand local needs, and participating in or leading multi-sector alliances designed to address them. For example, the Greater Flint Health Coalition is tackling various community health issues, including efforts to curb smoking, reduce caesarean-section rates, and lower the incidence of diabetes. To that end, the coalition is working to deploy best practices and to manage costs, with a focus on boosting volume in FQHCs and patient-centered medical homes so as to reduce ED visits.

The Genesys case example illustrates the importance of being flexible and embracing the idea of reinventing the organization to focus on community wellness. As Betsy Aderholdt, CEO of Genesys Health System, noted, "Nobody here ever thought that GM could go bankrupt and yet that happened. So it sets this mindset of 'don't resist change, lead it,' because it can be devastating if you aren't paying attention to what's going on and aren't continuing to reinvent yourself."

Bellin Health

Bellin Health serves residents of Green Bay, Wisconsin, and surrounding areas, including approximately 600,000 residents living in communities as much as 150 miles north and 60 miles east and west of Green Bay. With just under $1 billion in annual revenues, the system offers inpatient services (through a 167-bed hospital); primary care services (through a 90-physician group practice); inpatient and outpatient psychiatric services; fitness, sports medicine, and rehabilitation services; home health; and urgent care (through Bellin Health FastCare).

Having set the goal of helping people in the area become the healthiest in the nation, Bellin leaders had a unique lens through which they viewed the organization's challenges. In 2000, the system was forced to cut services and staff due to increased competition in the local market. Several years later, local employers became quite concerned about rapidly rising healthcare costs, which were forecast to increase by 30 percent. Bellin leaders did not have a clear understanding of what was driving the cost increases, or of where opportunities for improvement might lie. As CEO George Kerwin noted, "We realized we needed to get better information about the way we were spending the dollars, and we also realized that people using their health benefits needed to be more invested in those benefits and in their own health."

To that end, Mr. Kerwin led the organization's first foray into managing population health, beginning with Bellin's own employees. The initial focus was on data, with the goal of providing direction to senior leaders, employees, and the board. The cornerstone of the effort was a health risk assessment (HRA) for every employee, with premium discounts tied to HRA scores and additional discounts offered to encourage employees and dependents to get needed screening tests and preventive services. To promote engagement, senior leaders held frequent conversations with system managers and employees to explain the importance of the program. The program worked, generating a 33 percent reduction in health costs within two years and an improvement in employee HRA scores. Over an eight-year period, the program yielded $13 million in cumulative savings.

Bellin leaders are working to spread this effective model throughout the community by helping local business owners manage their health costs. Known as "Business Health Solutions," the resulting model features a consumer-driven health plan, on-site services, HRAs, and employee incentives to promote the provision of needed preventive and screening services. To date, approximately 2,500 companies have partnered with Bellin on this model, and these employers' costs are 20 percent below the national average.

As part of this work, Bellin is working to build a strong board by focusing on experience and constancy. To that end, the "Bellin Corporation" was formed, made up of 60 members from a cross-section of the community, including providers and former Bellin board members. The corporation focuses on educating these individuals and elevating their ability to support the health system. The Bellin Corporation serves as a talent bench for and promotes longevity among senior leaders and board members, while simultaneously avoiding the potential for stagnation by providing continuous education. This creation of a "common past" facilitates the taking of risk by shifting the focus from short-term concerns to long-term gains. This shift can be seen in Bellin's approach to mergers and acquisitions. Despite facing financial pressure from increased competition and rising costs, Bellin leaders did not succumb to pressure to divest of system assets in a "fire sale." Instead, they took their time and made the right decisions for the long-term health of the community, including the decision to invest in an expanded primary care network.

Part of Bellin's success came from a conscious choice to evolve the composition of the board, particularly with respect to increasing representation from patients and family members. These board members are uniquely qualified to contextualize what a healthy community can be, to share strategies, and to design ways to link health assets to community needs. The board also includes several family physicians trained in how to manage patients and keep them healthy, along with members of the local business community who have a unique understanding of the impact of employee health on corporate

financial fortunes and on what is needed to improve the health of their workers.

Finally, Bellin has engaged in a conscious effort to increase the strength of its brand among employers, patients, and other partners, with the goal of associating the brand with wellness. As Kerwin noted, "15 years ago, having a good brand was important, but it was very much targeted to clinical services that were primarily hospital-based. Today, that's totally different… all the things you would want from any other retail product, you want increasingly from a health system."

LHC Group

Operating in 26 states, LHC Group's 8,500 employees offer home health, hospice, long-term acute care, and private duty services through 350 locations that are jointly owned with local hospitals and health systems. The company's lofty mission is to "improve the quality of life in the United States by transforming the delivery of healthcare services." The company began in 1994, operating out of one location (the CEO's house). It was founded by the CEO's wife, who left her job to provide care for four elderly individuals in the community who could not get care at home. From these humble beginnings as a home health company, LHC has expanded significantly into disease management, care coordination, and health coaching.

Like the leaders of the other organizations profiled in the publication, LHC leaders viewed the challenges they faced through a unique lens. The company was labeled as a provider of post-acute care, a label that was a relic of the hospital-centric, FFS model of care. Under the new value-based model, LHC needed to expand its focus beyond care after hospitalizations to care designed to prevent hospitalizations in the first place. To that end, the emphasis shifted to "everything" outside the hospital, with the company playing both an upstream and downstream role in assessing and managing quality, costs, and the patient experience. To succeed, LHC needed data to measure quality, including evaluation of new metrics such as readmission rates that serve as a proxy for how well the company does its job. LHC leaders choose metrics carefully and then share results with partner hospitals (including their boards) to demonstrate LHC's value and hence validate the hospitals' choice of LHC as a partner.

As part of this strategy, LHC leaders explicitly know when to lead the population health effort and when to support partner hospitals and health systems in these efforts. Because these organizations are well-known and respected within their local communities, LHC consciously places their brand names (which are a community asset) ahead of the LHC brand. Like Genesys Health, LHC is better served by being in the background, leveraging the brand of local partners that already have a reputation for promoting wellness and health. This "humility" helps to create better health and better business outcomes.

The dynamic nature of the markets in which LHC operates creates the need for greater efforts related to board education. To that end, LHC leverages expertise from both inside and outside the boardroom, bringing in experts in policy, politics, and business. This education reduces the risk that the board will overreact to market changes, and helps the board govern effectively in both FFS and population management models. LHC leaders are currently exporting this knowledge to the boards of partner organizations through LHC's participation in joint ventures and by focusing them on objective quality measures to gauge their success. The goal is to promote open and honest dialogue between board members and senior leadership. As Keith Myers, Chairman and CEO of LHC Group said, "What we're looking for from the board members on the hospital side is to guide us in a few areas. How are we perceived in the community in terms of quality and customer service? How are we perceived by other parts of the hospital? Are we responsive enough? What and where are the opportunities to do a better job? Really, I want them to tell us the things that no one else wants to tell us."

Lessons Learned

Mr. Loughman shared the following key lessons from The Governance Institute's 2014 Signature Publication:

- Integrate community health into the mission and vision statement of the organization to guide future board decisions.
- Assess community health needs and assets at a broad level and focus initiatives on addressing these needs and meeting the Triple Aim.
- Recognize that healthcare and governance remain local even in an era of consolidation, and leverage local roots (e.g., patients, providers, business owners) and historical experiences to understand community needs and assets.
- Select a manageable number of objective measures to gauge the organization's impact on community health, evaluate performance on these metrics, and share results with local partners. This process serves to create accountability for performance among board members and organizational leaders.
- Know how to use the organization's brand, including when to lead from the front and when to remain in the background and leverage the brand of partner organizations.
- Focus the board on fostering a culture that accepts change, promotes courage during uncertain times, and ensures alignment with the organization's mission, vision, and values.

Panel Discussion: Overseeing Health and Healthcare across the Community

Following his presentation, Mr. Loughman led a panel discussion with leaders of three of the organizations featured in The Governance Institute's 2014 Signature Publication:

- Pete Knox, M.S., B.S., Executive Vice President and Chief Learning and Innovation Officer at Bellin Health
- Keith G. Myers, Chairman and CEO of LHC Group, Inc.
- Barbara Tretheway, J.D., Senior Vice President and General Counsel at HealthPartners

Question #1: What Is the Role of the Board in Promoting Community Health?

Ms. Tretheway stressed the need for boards of not-for-profit organizations to conduct community needs assessments as part of their fiduciary obligations. She reminded board members to view senior managers within the organization as partners, since they have the expertise and knowledge about the industry and hence can provide the context and information necessary for boards to understand community needs and the organization's ability to meet them. Senior managers can also educate the board on complex healthcare issues, including sharing research on the social determinants of health. This research shows that only 20 percent of overall health status is driven by clinical care, with the remainder being a function of behaviors, the environment, genetics, and socioeconomic conditions. Understanding this paradigm helps the board figure out where to focus resources. For their part, boards have to educate management about the needs of large employers, advocacy organizations, and other stakeholders. To that end, the board should be diverse enough to bring these unique perspectives and expertise to the table.

Question #2: What Initiatives Have You Undertaken to Focus on Community Health?

Bellin Health's community health efforts consist of seven "rings of influence." Once these have been fully deployed, Bellin will have the capacity to manage population health and achieve the Triple Aim. The seven rings are outlined below:

- **Primary care network**: Bellin has a primary care network that cares for 400,000 people, which is making an ongoing transition to team-based care.
- **Employer partnerships**: Bellin offers on-site primary care services at 100 employer sites throughout the region, and has signed at-risk contracts with 15 additional partners. Unlike its competitors, Bellin has not required a narrow provider network.
- **Focus on care experience across continuum**: In managing various chronic conditions, Bellin is "blowing up" traditional boundaries by focusing on prevention and management across the continuum of care.
- **Accountable care/clinical integration at local and state level**: Bellin participates in the state's high-value network initiative, and has differentiated itself from other systems on both costs and quality. Bellin has distinguished itself as the best in the country in Medicare's Pioneer ACO program, with the lowest costs, highest quality, and best patient experience ratings. Bellin also has put in place risk-based contracts with Medicare Advantage plans and is working with the state Medicaid program to manage care for those with disabilities. On the commercial side, Bellin has shared-savings and value-based programs with UnitedHealthcare and other regional payers.
- **Community initiatives**: Bellin serves as the lead player on some initiatives, including a partnership with the Green Bay school district looking at the link between health and academic performance, and with the Green Bay Packers to improve community health. Bellin also participates in several community initiatives spearheaded by others, including efforts focused on improving dietary habits and reducing alcohol and substance abuse.
- **Healthiest community**: Bellin has partnered with a small community 30 miles from Green Bay, helping it to become the healthiest community in the state. (It now ranks 15th.) This effort involves working with schools, small employers, and other community resources, and includes creation of a small business collaborative that will ultimately offer employees health insurance through a private exchange. Bellin now has a unique shared-savings arrangement with these employers, with a third of the savings going to Bellin, a third to the employers, and a third back to the community.
- **State and national policy**: Bellin is working to influence policy at both the state and federal level, leveraging its success with the Medicare Pioneer ACO initiative.

LHC Group plays a supporting role to hospital partners that serve as the engine for community health initiatives. These hospitals enjoy much higher brand recognition and awareness than LHC, and consequently are better able to connect with community residents. To support the hospitals, LHC is converting to real-time, point-of-care data, including providing information from the home setting to hospital-based physicians. Having access to this information leads to better clinical outcomes and lower costs. For example, by reducing

duplicate testing and other inefficiencies, the system has led to a 2 percent decline in costs. LHC's data systems now allow for dynamic stratification of patients on a weekly basis, something that could not be done a few years ago. LHC manages care for 36,000 active patients, providing home services for a defined period of time based on their needs. Roughly 4,000 of these patients need intense support through home visits and telemedicine. The typical patient receives some contact from LHC every 36 hours, with some getting support much more frequently. This approach has reduced hospitalization rates, often to the lowest levels in the community.

> "Patients should get care when and where they need it, not when and where we schedule it."
>
> *—Keith G. Myers, Chairman & CEO, LHC Group, Inc.*

Question #3: How Do You Get the Boards of Partner Community Hospitals to Adopt Aggressive Goals and Methods?

HealthPartners works with six hospitals, each of which is different. The key is to sit down with the leaders of each to make sure that all parties are aligned culturally around the Triple Aim. For example, one of the system's hospitals serves as a safety-net facility that cares for a large Somali population (the largest concentration of Somalis outside of Somalia). These residents speak 158 different languages. HealthPartners worked with leaders of this hospital to help them carry out the critical mission of being a safety-net facility in an urban environment. Part of this effort focused on shoring up the hospital's financial situation and working to reduce huge backlogs in the ED and on the inpatient floors. To address these issues, HealthPartners and the hospital established a mental health roundtable, engaging representatives of the police department and local social service programs. Over several months, these partners established programs to address critical issues and developed measures to monitor their success, with a focus on enhancing access to mental health services. With other hospitals, HealthPartners has focused on different areas. For example, the system's three critical access facilities are working on enhancing access to dental care and mental health services, and on addressing rising health disparities. HealthPartners assists them with analyzing the data and deciding on appropriate metrics and related goals.

Question #4: How Do You Create an "Improvement Culture" Where Ideas Take Hold and Last Over Time?

For LHC Group, the key to ensuring the sustainability of ideas lies in data and performance measurement. To that end, LHC focuses on a few initiatives at a time, with a handful of measures used to evaluate their success. Having large dashboards with many measures does not work, as improvement tends to stagnate over time. The better approach is to have a sustained focus on a few important metrics; for LHC Group, reducing readmissions remains the top priority.

Aware of research showing that 70 percent of strategies fail, Bellin Health leaders focus on execution. Many organizations are good at planning things, but then do not execute them in a disciplined manner. Good execution often comes down to knowing when to say no, as it often becomes too easy to say yes to everything. Bellin, for example, focuses on three breakthrough initiatives. These initiatives cascade throughout the entire organization, so that everyone is focused on the same things. The approach seems to work, as Bellin has an 80 percent success rate for strategy implementation.

Question #5: What Challenges and Pitfalls Exist? What Would You Do Differently if Starting Over Again?

Like other organizations represented on the panel, HealthPartners' leaders sometimes find it difficult to say no and hence tend to get involved in too many things at once. To avoid this problem, the board, leadership team, management, and frontline staff all need to focus on the same things. Consequently, organizational leaders pick a handful of important areas and then put in place projects to address each of them. Leaders also communicate with frontline staff to make sure they understand how it all fits together. These efforts often require the creation of partnerships with local organizations in a position to help, such as those able to enhance access to mental health services. For these initiatives to work, key stakeholders must come to the table and be involved in the planning and development process. Each stakeholder will have a unique point of view and a unique funding stream. Each will need to understand its role and have a set of metrics for evaluating their performance. This process becomes especially important when there is a fixed pool of money available, and each stakeholder is worried about getting their piece of that pie.

LHC Group is focused on developing stronger working relationships with administrative leaders and boards at its partner hospitals. In 1998, LHC formed its first joint venture with a hospital. LHC leaders saw the hospital CEO only once, during the upfront negotiations. Today, however, LHC works to forge closer relationships with hospital executives, with the goal of engaging them in an ongoing effort to reduce readmissions.

Question #6: Does Owning an Insurer Change How Resources Are Allocated?

HealthPartners has paid claims for 60 years, and hence has the capability to analyze data by employer or community. These data allow it to identify areas with a high rate of alcoholism, cancer, and other problems, thus helping to determine where initiatives may be needed. Since part of the Triple Aim relates to affordability, HealthPartners is working to bring down per-capita costs. Claims data helps with that, showing where the healthcare dollar is currently being spent. The organization's goal is to be one or two percentage points below the market

average, which should be enough to attract incremental lives to the system.

For its part, Bellin Health is working to get into the insurance business and hopes to have access to data that will help the organization take on risk for managing population health.

Question #7: How Often Does Your Board Meet and How Is Time Allocated between Forward- and Backward-Looking Agenda Items?

HealthPartners' board meets four times a year for a full day. Half of each meeting reviews the past, and the other half looks to the future. Meetings often include conversations with outside experts, such as quality improvement experts from IHI. The Bellin Health board meets three times a year (every 120 days), with each meeting assessing progress on its three major initiatives. Meetings also focus on making sure directors have the skills and knowledge they need to make well-informed decisions.

Question #8: What Advice Do You Have for Those Who Have Not Yet Started on the Journey to Population Health?

Mr. Myers urged these organizations to start the journey immediately, as he believes that most markets will soon reach the point where at least half the population is in a full-risk contract and the other half is in some sort of modified risk arrangement. Ms. Tretheway urged leadership teams to be imaginative and curious, laying out a vision for the community in which they want to live and understanding what challenges the community faces today and what it will take to reach that vision. She also highlighted the importance of remaining focused and unrelenting, not trying to do too much at once, and demanding accountability for measurable results. Mr. Knox emphasized the importance of providing high-value services to customers by understanding the issues they face and figuring out how to address them.

Defining Your Position in the New Environment

Mark E. Grube, Managing Director of Kaufman, Hall & Associates, Inc., discussed the need to think differently about competitors, performance measurement, and the definition of success in the new healthcare environment.

Consolidation: What Is Driving It? Where Is It Going?

Consolidation continues at a rapid pace in healthcare. According to *Health Leaders Media*, 78 percent of hospital organizations are currently involved in or actively exploring merger and acquisition (M&A) opportunities, with some being in parallel discussions with multiple potential partners. The most important reason to pursue M&A activity—cited by 65 percent of those involved—is to shore up the organization's position in existing markets by building scale and increasing influence within a geographic area. Other important reasons include acquiring physician practices (59 percent), with some organizations acquiring practices for defensive reasons despite the potential for these acquisitions to place stress on the bottom line. Most of the interest (64 percent) centers on primary care physicians (PCPs). Entities that do not end up acquiring physician practices and/or employing doctors are generally looking to align with them in some other way.

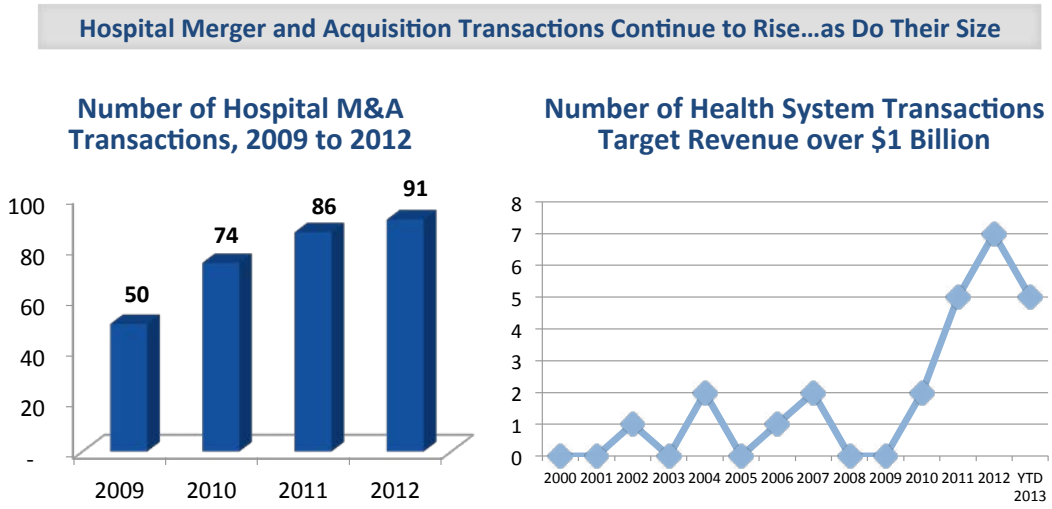
Many M&A discussions do not come to fruition, however, with 58 percent of survey respondents having terminated an M&A transaction in the past 12 to 18 months. Typically, only 20 to 30 percent of discussions lead to a formal partnership. The most common reasons for ending discussions include cultural differences that become clear as conversations continue (cited by 49 percent of those who terminated an M&A discussion); political/governance issues, including how many representatives will be on the board from each side (41 percent); and differences of opinion on the financial value of the entities being merged or acquired (39 percent).

Despite these problems, the number of hospital M&A transactions continues to rise, as does the size of those transactions, with a growing number of deals worth $1 billion and higher. (See **Exhibit 1.**)

The nature of consolidation in other industries provides some interesting lessons for the healthcare industry. As in healthcare, in many cases the driver of consolidation has been a major disruption in the prevailing business model, such as the following:

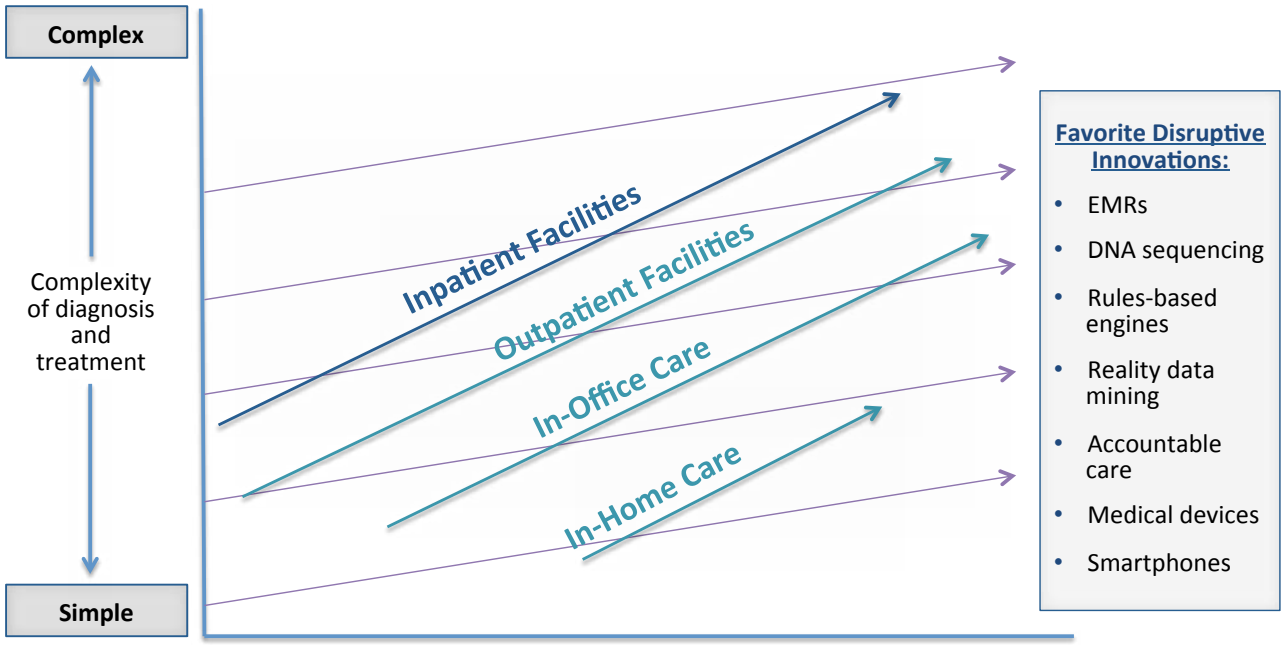
- **Response to a change in the revenue model**: Retail pharmacy used to be a cash business between the local pharmacist and the customer. However, insurance coverage of prescription drugs has changed the economic equation, creating an imbalance in negotiating power between the independent pharmacist and large insurers. Regional and national chains of pharmacies formed to benefit from this imbalance, effectively driving independent pharmacists out of business. A similar phenomenon is occurring with hospitals and health systems that face the need for increased size and negotiating leverage

Exhibit 1. Provider Consolidation



Source: The Health Care M&A Deal Search Online, Irving Levin Associates, Inc.

Exhibit 2. Disruption amongst Healthcare Institutions Is Well Under Way



Source: Adapted from Clayton Christensen, "The Innovator's Prescription: How Disruptive Innovation Can Transform Health Care," Innosight Institute, December 11, 2009.

related to risk contracting. Without a sizeable network to offer payers, small organizations are at a significant disadvantage.

- **Need for more sophisticated information technology (IT):** The banking industry faced increasing demands for faster transactions, creating the need for more sophisticated IT systems that could be leveraged across a broader base.
- **Innovation/evolution in the production/service delivery process:** New delivery processes for products and services commonly lead to consolidation, as organizations seek to leverage the process across a larger base.
- **Change in competitive dynamic/new market entrants**: Consider what happened to independent book stores when Amazon entered the business of bookselling. Healthcare has seen a number of new entrants in the primary care space, including large retail companies like Walmart, Walgreens, CVS Health, and others.
- **Aggregation "domino" effect**: As markets consolidate, a reaction is triggered among the remaining independent organizations that do not want to be left behind. In many cases, a "feeding frenzy" ensues, with consolidation essentially becoming a self-fulfilling prophecy.

As shown in **Exhibit 2**, the healthcare industry faces multiple disruptions that are having an impact on the pace of consolidation.

Current themes related to consolidation in the healthcare industry are described below.

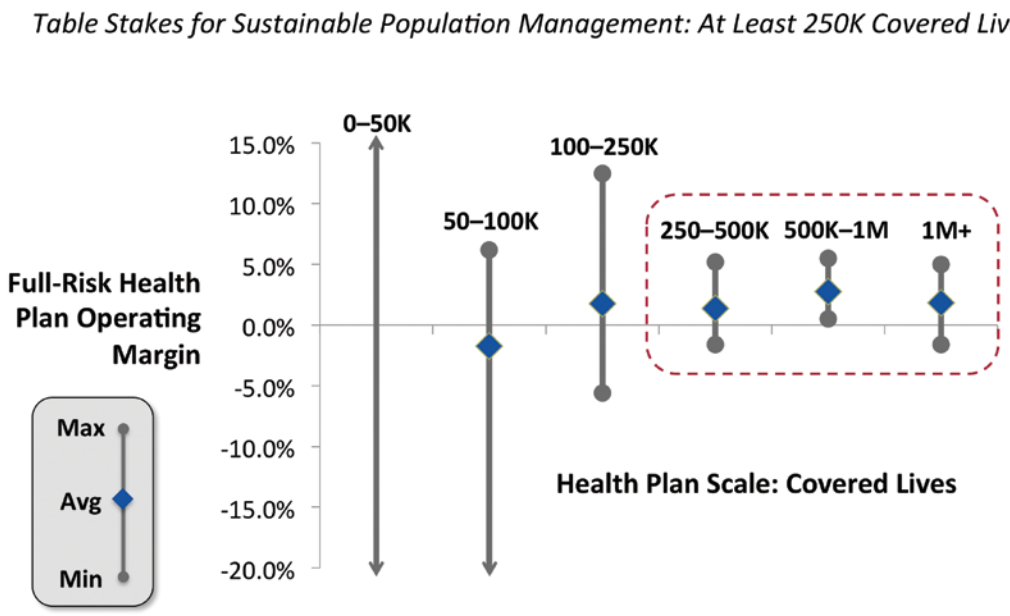
Recognition of a Financial and Intellectual Capital Gap

Organizations (particularly smaller ones) are worried about how large they need to be to assume and manage risk. Unlike in the early 1980s and 1990s, strategic considerations are driving current transactions (rather than organizations in financial crisis looking for a partner to help them survive and achieve operational efficiencies). In many cases, smaller entities are looking for a larger partner.

Emergence of Super-Regional Organizations

Some organizations with revenues of $1 billion or more are looking to establish geographical leadership and to offer a broad network to payers and insurers. Examples include the coming together of Baylor Health Care System (a hospital system with $4+ billion in annual revenues) and Scott & White Healthcare (a physician clinic practice that branched into the hospital and managed care business, with annual revenues of $2+ billion). Early talks failed due to the inability to agree on proportionality of representation on the board, but about two years later, Baylor agreed to 50/50 board representation. (Board representation should not be a sticking point, given that governance structures typically change over time and often look very different within a few years after the merger.) Other examples of this approach include Advocate Health System (Illinois) and Iowa Health System. Some experts forecast development of two or three dominant regional systems in each state.

Exhibit 3. What Level of Scale Is Required in the Future Business Model?



Source: Kaufman Hall analysis, Citi Research 2011 Commercial Risk Analysis, "A Good Lawyer Knows the Law. A Great Lawyer Knows the Judge," January 28, 2013.

Reconsideration by Academic Medical Centers
Academic medical centers (AMCs) may be in a precarious position in a value-based world due to their high cost structure. These organizations are reconsidering their networks and developing partnership relationships with other providers.

Reconfiguration and Consolidation among Catholic Systems
Several Catholic systems have come together to create very large organizations, including Catholic Health East and Trinity Health, now CHE Trinity Health.

Scale and Scope of Services to Manage a Population
As noted, many organizations are looking for partners to give them adequate geographic coverage and breadth of services to assume risk through contracts with insurers.

Creating (and/or Fear of) a Narrow Network
Some organizations are joining larger ones to avoid being locked out of narrow provider networks that are increasingly preferred by insurers and consumers due to financial incentives of such networks.

Creation of Mega Systems
Trinity Health and Catholic Health East came together through full integration of assets to form a $15 billion organization that covers much of the Midwest and East Coast. The two organizations do not serve contiguous markets, meaning that the merger is more of a move to increase scale than a bid for regional dominance. The goal is to attract better talent and enhance intellectual capital, and then spread these assets throughout the organization.

Non-Asset Transactions
Some organizations are coming together on a collaborative basis without merging assets, including the BJC Collaborative (a group of four health systems in the St. Louis area) and the Mayo Clinic Health Network. In most cases, these transactions involve the creation of a new entity, with the old entities remaining intact as well. Examples include the following:

- **Stratus Healthcare**: A group of 29 hospitals and 2,000 physicians in Central and South Georgia came together to form Stratus Healthcare. With no large insurers in the area, these organizations are not yet interested in an asset-based transaction. Instead, they are focused on developing shared business services, coordination of regional specialists, a regional ED and hospitalist program, a common IT platform, data exchange and warehousing, and regional protocols and quality measures. Over the long term, the partners may develop an insurance product and a regional clinical integration network.
- **AllSpire HealthPartners**: This organization consists of seven systems in New Jersey, New York, Maryland, and Pennsylvania that collectively own 22 hospitals (including long-term acute care and rehabilitation facilities) and generate more than $8 billion in revenues. They are financially strong systems, and each organization has contributed $1 million in seed money to focus on investments related to managing population health, including insurance analytics, electronic

health records, and financial support. The goal is to offer self-insured employers direct contracts.

- **Granite Healthcare Network (GHN):** This organization is a joint venture of five small, independent health systems with $1.5 billion in combined revenues in New Hampshire. The systems have been working together since early 2011 to transform the delivery of care in their communities, with a clinical focus. The chief medical officers (CMOs) of the five systems agreed to a common set of core principles for establishing the patient-centered medical home model across their 150+ practice sites. In addition, the network is actively engaged in understanding ways to provide better care to patients with behavioral health issues by identifying services, best practices, and programs that can be shared across the system. The CMOs have also developed a patient-centered, data-driven process to optimize clinical and financial outcomes. The process includes care management strategies, enhanced physician and patient engagement, and sharing of evidence-based practices. As part of this effort, GHN established a partnership with an outside company to develop the business intelligence and analytic capabilities necessary to inform clinically based strategic priorities and improve provider performance. GHN partners also agreed to use the services of one common reference laboratory for tests not performed on-site, and four of the five participating systems formed a captive insurer that has significantly reduced liability insurance costs.

Where Might Consolidation Go from Here?

In 1990, 39 percent of hospitals were in multi-hospital systems, and by 2010 that figure had grown to 56 percent, with most of these systems being relatively small (four or five hospitals). Looking ahead, it seems reasonable to assume that more hospitals will become part of multi-hospital systems, with growth in such systems continuing at a steady pace. The degree of consolidation will likely be driven by the scale required to adequately manage population risk. As depicted in **Exhibit 3** on the previous page, Kaufman Hall estimates that systems need to manage at least 250,000 covered lives. Operating margins under full-risk contracts vary too much when managing smaller populations, creating a significant risk of financial losses.

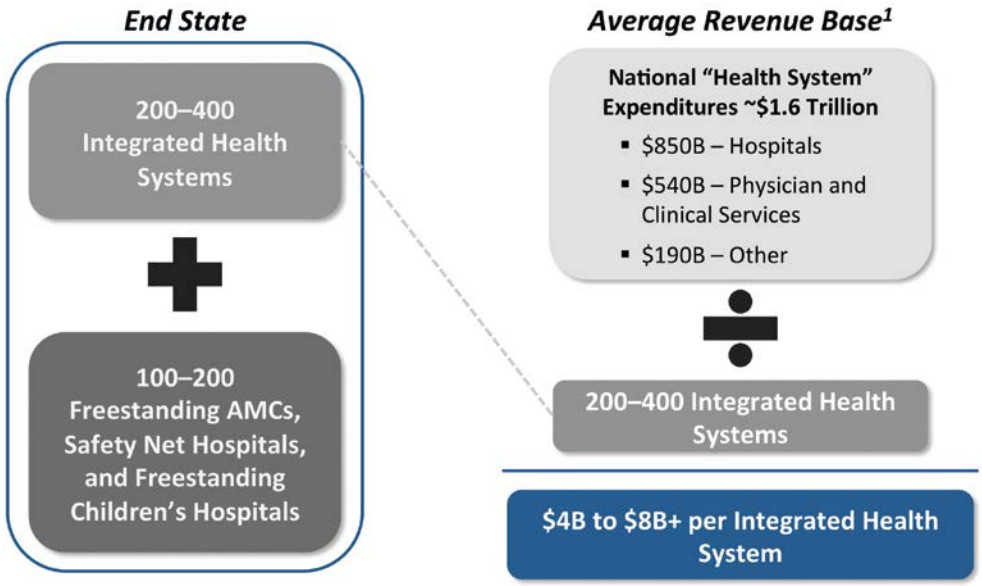
Extrapolating this figure across the nation, Kaufman Hall projects a future with 200 to 400 integrated health systems around the country, along with 100 to 200 freestanding AMCs, safety net hospitals, and children's hospitals. These systems will generally have $4 to $8 billion in annual revenues, although some will have even higher revenues. (See **Exhibit 4** for more details.)

Inflection Point 2.0: Kaufman Hall's Latest Thinking about Healthcare Markets

Rapidly rising costs are the driving force behind the effort to change America's healthcare system. As **Exhibit 5** indicates, total healthcare costs will eventually reach 80 percent of GDP if current trends continue.

The good news is that the industry seems to be experiencing the beginning of a reversal in historic trends. In 2012, real per-capita spending on healthcare services grew by only 0.8 percent, below the growth in GDP. Between October 2012 and October 2013, healthcare prices rose just 0.9 percent, the lowest

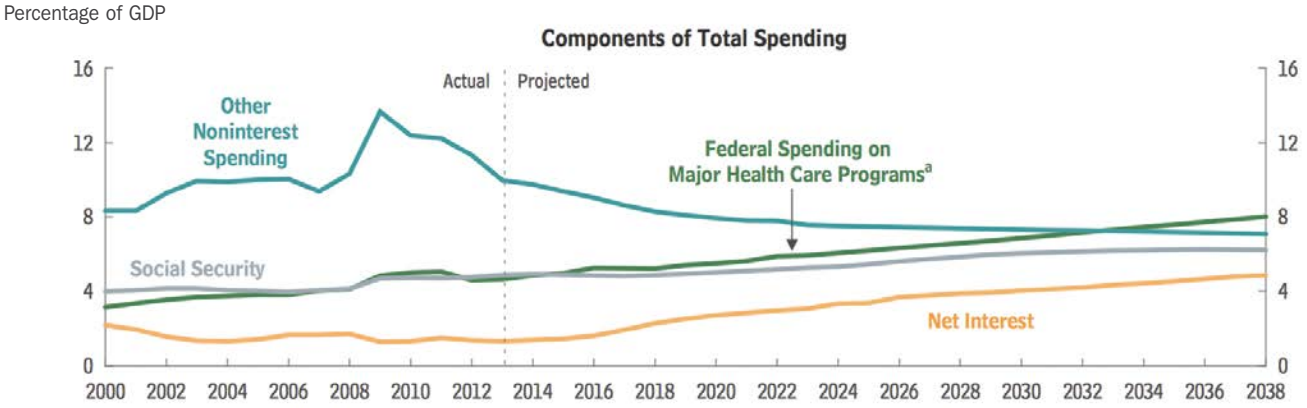
Exhibit 4. Summary of KHA Analyses from Several Perspectives: Potential Future State



[1] Based on 2011 Total Health System Revenue.

Source: 2011 National Health Expenditures data, www.cms.gov (accessed October 25, 2013).

Exhibit 5. CBO Long-Term Projection of Federal Spending on Major Healthcare Programs



[a] Spending on Medicare (net of offsetting receipts), Medicaid, the Children's Health Insurance Program, and subsidies offered through new health insurance exchanges.

Source: Congressional Budget Office, Long-Term Budget Outlook, 2013.

increase in the more than 50 years for which these data are available. For six consecutive months, healthcare prices have grown more slowly than economy-wide prices. And between 2010 and 2012, Medicare spending per beneficiary grew at a rate of 1.7 percent annually, well below historic growth levels.[3, 4, 5]

Kaufman Hall believes that this slowdown reflects more than the economy and the recession. Rather, it stems significantly from a fundamental transformation in the industry that is starting to take shape, a transformation that has major implications for providers. Key components of this transformation include:

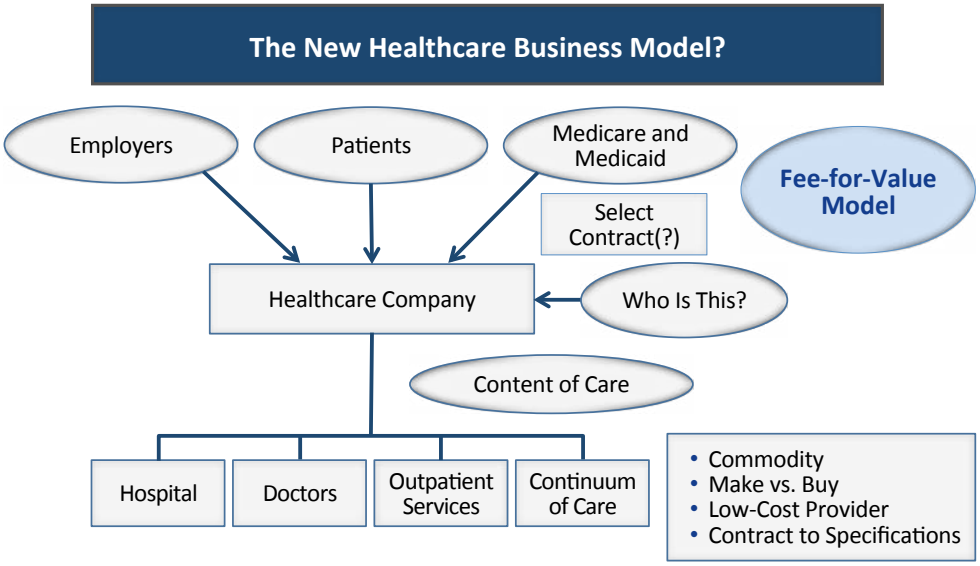
- **Insurance market transformation:** High-deductible plans (HDHPs) are becoming increasingly common, with such plans now enrolling 20 percent of workers, up from 4 percent just a few years ago. Growth in these plans is expected to double to 40 percent by 2015. These plans create very different financial incentives for enrollees, encouraging them to be much more aware of prices and costs. At the same time, enrollment in Medicare Advantage plans has continued to grow, with such plans enrolling 27 percent of seniors in 2013, more than double the rate of 13 percent in 2006. To date, more than 8 million individuals have enrolled in public exchanges, while a number of high-profile large employers have shifted to defined-contribution models, giving employees a fixed amount of money and letting them choose among plans on a private exchange. For example, Walgreens' 168,000 employees purchase plans on a private exchange that offers 29 different plan options. Darden, Sears, and other big companies have put in place similar arrangements. Kaufman Hall's analysis indicates that employees under such arrangements tend to "buy down" (i.e., they accept narrower networks and higher cost-sharing to save money on the monthly premium). The same transition from defined benefit to defined contribution took 10 to 20 years to play out for pensions, but most experts think it will occur more rapidly with healthcare benefits.
- **Healthcare as a retail transaction:** Consumer decision making will matter more than ever as the industry moves from a wholesale to retail construct, with public and private payers giving individuals a fixed-dollar benefit and providing them with data to help them choose plans and providers. (Castlight is a private company that helps employers provide this information to employees, including how much it will cost to go to a particular provider based on the coverage employees have.) Under these arrangements, individuals select a health plan and bear the incremental cost above the fixed-dollar benefit. In most cases, individuals have a broader selection of plans from which to choose, but face more limited provider networks and/or bear the economic consequences of going to an out-of-network provider. As a result, individuals have an incentive to actively work with their physician in choosing treatment options and providers.
- **Emergence of new competitors:** The blurring of traditional lines between for-profit and not-for-profit entities is creating opportunities for new, pragmatic competitors. Entrants into the provider space include health insurers; retailers such as Walgreens, Walmart, and CVS Health; and non-traditional competitors such as DaVita (which previously focused exclusively on services related to dialysis). In addition, some large companies such as Lowe's and Walmart have entered into direct contracting arrangements with providers.
- **Declining inpatient utilization; mixed changes in outpatient services:** Between 2007 and 2012, 88 percent of a sample of 20 states experienced 5 percent or greater declines in use of inpatient services, with some seeing double-digit

3 D. Blumenthal, K. Stremikis, and D. Cutler, "Health Care Spending—A Giant Slain or Sleeping?" *The New England Journal of Medicine,* Vol. 369 (December 26, 2013), pp. 2551–2557.

4 Altarum Institute, Center for Sustainable Health Spending, "Price Brief," December 10, 2013.

5 Centers for Medicare & Medicaid Services, "Trustees Report Shows Reduced Cost Growth, Longer Medicare Solvency," Press Release, May 31, 2013.

Exhibit 6. Pursuit of "Population Health Manager" or "Healthcare Company" Model



Source: Kaufman, Hall & Associates, Inc.

drops. While some analysts believe these declines are tied to the downturn in the economy (and thus likely temporary), Kaufman Hall believes they stem from a fundamental shift in how care is being delivered. This transformation has only just begun, and hence further, significant declines in inpatient utilization are likely. The decline will be driven in part by significant growth in the number of physicians accepting risk contracts, as these physicians often dramatically reduce use of inpatient services. For example, in Chicago, physicians affiliated with Advocate Health with incentives that align the hospitals and doctor groups under performance- or risk-based arrangements have reduced use of inpatient services by twice as much as physicians in the area who are not in aligned financial programs. Overall, Chicago experienced a 13 percent decline in inpatient use between 2010 and 2012. Declines also are being driven by increased use of observation beds and the avoidance of admissions for ambulatory care-sensitive conditions (which still account for 15 percent of all admissions). Going forward, Kaufman Hall expects an additional 15 to 25 percent decline in inpatient utilization over the next several years as risk contracting continues to grow. This decline will have significant implications for health systems as they make decisions related to capacity planning, resource allocation, and market positioning.

- **Delivery model dislocations:** Dislocations in the delivery model are underway, with the movement from inpatient to ambulatory-centric models representing the first stage, and the move to Web-/mobile-centric models being the second stage. This transition has huge implications for value creation, delivery capacity, customer connectivity, human resource requirements, and IT needs.
- **Population health manager/healthcare company model:** As shown in **Exhibit 6**, the new business model in healthcare centers around an entity that will serve as the broker between those purchasing care (individuals, employers, government) and those providing such care. Much like a cable company acts as the intermediary between consumers and content developers by organizing packages of services, this entity will perform similar tasks in the healthcare arena.

What Does This Mean for Hospitals and Health Systems?

The trends being seen in leading-edge markets have profound implications for hospitals and health systems:

- Business as usual is out the window, as the focus will shift to a new problem—how to manage population health and justify prices.
- More and bigger consolidation will be necessary to remain relevant, assemble the intellectual and financial capital required to succeed, and absorb and manage risk.
- Many organizations will attempt to position themselves closer to the premium dollar.
- Big investments in IT and care management will be essential.
- Core competencies will need to evolve along with the market.

Roadmapping to a Value-Based Model and Evaluating Stage of Market Development

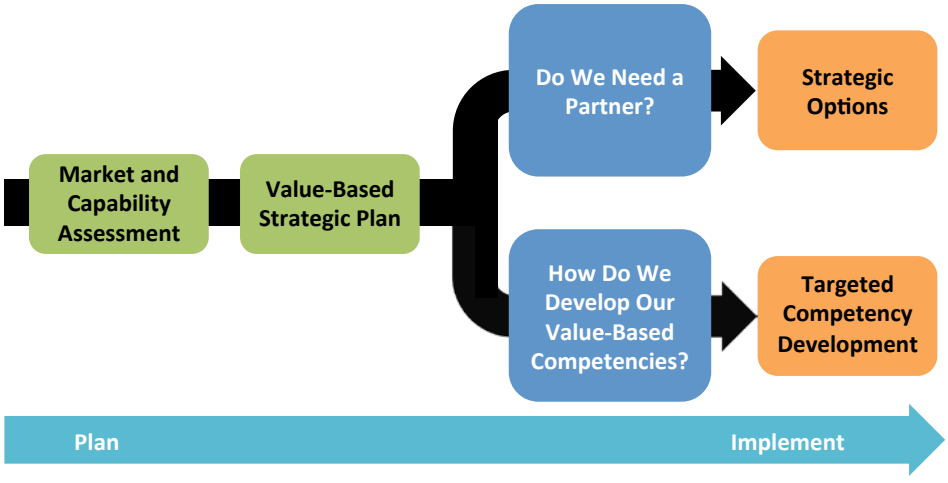
As **Exhibit 7** illustrates, organizations need to map their path to a value-based model, with the path being driven by the stage of development within the local market. This process begins with an assessment of the marketplace and internal capabilities, followed by development of a strategic plan and consideration of whether a partner will be necessary. If a partner is needed, key questions center on what the partner should bring to the table and on various strategic options related to partnering. If a partner is not needed, the focus turns to developing value-based competencies internally.

Core competencies within an organization need to evolve with the stage of the market. The relative maturity of these core competencies (versus the level of evolution within the local market) will drive the appropriate approach to both strategy and operations (see **Exhibit 8** on the next page).

To assess the stage of market evolution, Kaufman Hall evaluates seven dimensions: the level of provider organization, the dominant healthcare benefit model being used (i.e., where major employers are with respect to HDHPs and other innovative benefit models), level of vertical collaboration, market demand, market supply, sophistication of managed care products, and the pricing and regulatory environment. As shown in **Exhibit 9** on the next page, an organization needs to assess each dimension in terms of where it falls on the continuum from a traditional to a value-based market. In many cases, the assessments of various dimensions will tend to cluster around a similar spot (i.e., all dimensions of the market often migrate to a value-based model at a similar pace).

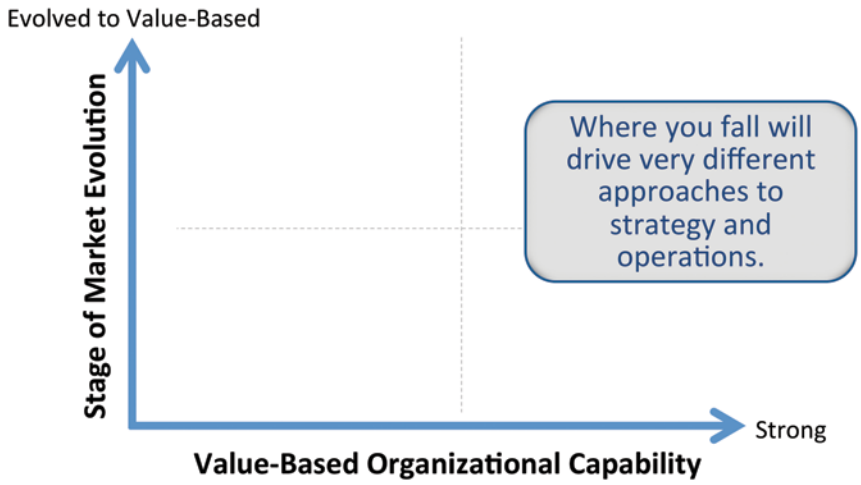
To assess core competencies, health systems need to evaluate their capabilities in nine areas that are central to success in the new era: network robustness (the quality, breadth, and geographic scope of the provider network), clinical alignment (particularly among physicians and post-acute providers),

Exhibit 7. Roadmap of the Migration to a Value-Based Model



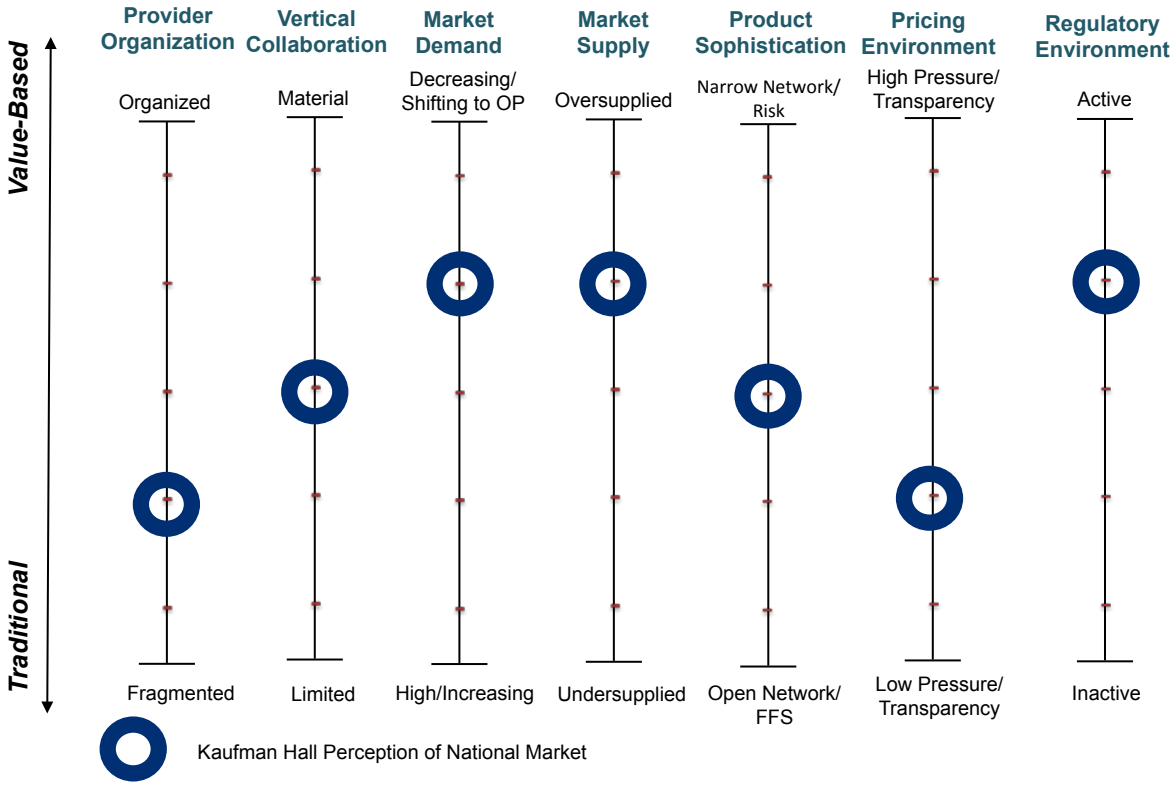
Source: Kaufman, Hall & Associates, Inc.

Exhibit 8. Core Competencies Will Need to Evolve with the Market



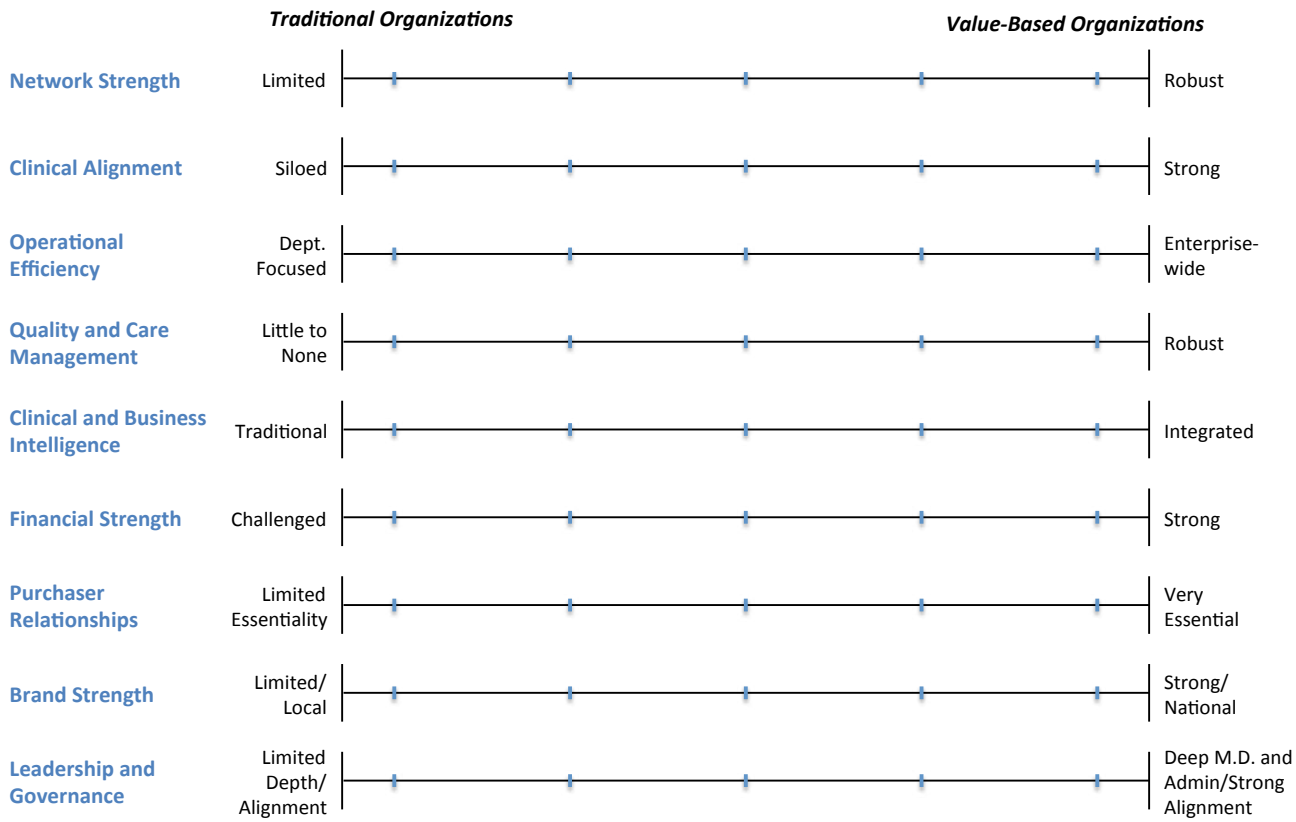
Source: Kaufman, Hall & Associates, Inc.

Exhibit 9. Market Evolution Framework



Source: Kaufman, Hall & Associates, Inc.

Exhibit 10. Organizational Capability Framework



Source: Kaufman, Hall & Associates, Inc.

operational efficiency/cost position versus competitors (including freestanding facilities), quality and care management, clinical and business intelligence (including sophistication of IT systems), financial strength (e.g., access to capital), purchaser relationships, brand strength and reach, and leadership/governance. Organizations need to assess capabilities in these nine areas along the continuum from a traditional to a value-based organization (see **Exhibit 10**). Unlike with the market-stage analysis, organizations often exhibit greater levels of variation across the competencies, with some being well developed and others not. This analysis can help organizations identify those core competencies that need the most work.

> "Now, more than ever, strong governance and leadership is required to guide the transition to the very different healthcare world of the future."
>
> *—Mark E. Grube, Managing Director, Kaufman, Hall & Associates, Inc.*

These analyses help health system leaders determine how well they are positioned relative to the stage of market. As depicted in **Exhibit 11** on the next page, those in the upper left quadrant (i.e., those with competencies characteristic of a traditional organization that are operating in a value-based market) face a tough situation and likely need to figure out how to remain relevant, which may mean finding a partner. By contrast, those in the lower left quadrant (competencies characteristic of a

Exhibit 11. How Is Your Organization Positioned? What Are You Doing to Improve Your Positioning?

Source: Kaufman, Hall & Associates, Inc.

traditional organization operating in a traditional market) need to start positioning themselves for the transition to a value-based market, something that can occur quite quickly if one large player shifts the market. Organizations in the lower right quadrant are out front of the market, with core competencies characteristic of a value-based organization even though the market is still traditional. These organizations may have redesigned care delivery processes, but not negotiated at-risk contracts. As a result, any cost savings generated accrues to the payers rather than the health system. These organizations need to try to move the market, perhaps by starting with a small insurer. Finally, those in the upper right have strong capabilities and are operating in a value-based market, and hence they are succeeding in the new value-based era. Unfortunately, only about 10 percent of health systems are in this category, with the remaining 90 percent being in one of the other three.

Summary of Key Lessons

While it is tempting to cling to the old business model (particularly for leaders of high-performing organizations in less-evolved markets), doing so creates vulnerability. Those who currently are succeeding in the FFS environment could fall behind quite quickly if they do not take action soon. The ways in which leaders evaluate the market and the organization's position in it need to be very different than in the past. Establishing a solid "fact base" relative to the stage of market evolution and organizational capabilities provides the foundation for development of effective strategies. Skipping this step is very risky and can lead to big miscalculations. Every roadmap will be unique, however, as there are no cookie-cutter solutions.

Getting to Total Cost of Care: Accepting the Challenges to Change

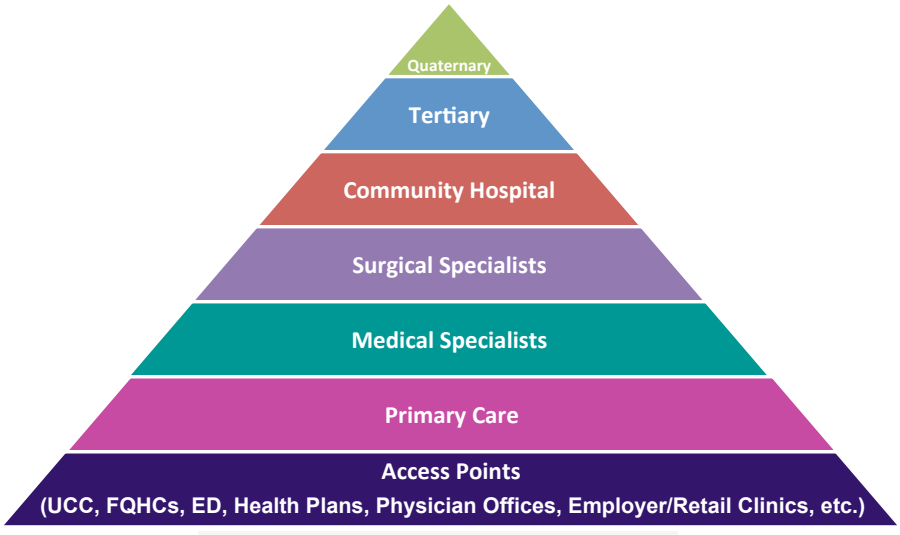
Guy M. Masters, M.P.A., Senior Vice President, and Kimberly Hartsfield, M.P.A., Senior Manager, The Camden Group, discussed how health systems should respond to the radical changes taking place in the industry, including how to determine priorities, strategies to address those priorities, and the appropriate timing for any actions taken. Like their colleagues at Kaufman Hall, they stressed that there is no "one size fits all" strategy, as the best course of action and the timing of that action depend on the characteristics of the local market and the organization. In fact, some health systems had their best financial year ever in 2013, while others are struggling.

Adapting to Change

The key to success lies in being adaptable to the changes going on in the industry, particularly with respect to the transition from FFS to value-based reimbursement. Timing truly is everything when it comes to navigating this transition, as the critical success factors under FFS (building volume to maximize revenue) will not work under value-based reimbursement, where the "name of the game" is to move care to the lowest-cost setting. Most organizations will have to live in both worlds for a period of time. Doing so can be difficult, as it generally does not work to ask physicians to practice differently based on a patient's coverage. The key to success is to "follow the money" by knowing what proportion of revenues come from FFS and value-based contracts. Once value-based reimbursement hits a certain threshold of revenues (likely 35 to 40 percent), it becomes time to change care delivery systems and processes to focus on managing risk.

Organizations that fail to accept the challenge to change will face significant consequences. They will not meet health plan requirements or differentiate themselves in the market. They will likely experience low patient satisfaction and provider and staff burnout, with patient care remaining uncoordinated and highly variable. They will also fall behind in

Exhibit 12. Clinical Integration Pyramid for Success



Source: The Camden Group.

preparing for health reform. These problems, in turn, will have profound implications, including loss of revenue and volume, higher costs, suboptimal teamwork, high staff/provider turnover, poor performance on quality metrics, and loss of market position. Rather than going down this path, health systems need to transition their organizations to operate under a payment system that rewards value and good health outcomes. They need to embrace the IHI Triple Aim, striving to simultaneously optimize care delivery, manage population health, and control per-capita costs.

Managing Population Health and Bundled Payments

Health systems need to "bake" the Triple Aim into their strategic plans. They need to set aggressive goals related to managing the health of a large population through a network featuring a broad array of access points, supported by adequate capacity to handle the population's need for primary care, specialty, tertiary, and quaternary services (see **Exhibit 12** on the previous page).

Some organizations are well on their way to achieving this vision. For example, HealthCare Partners Medical Group in Southern California covers approximately 750,000 lives and generates $2.7 billion in annual revenues, 92 percent of which comes from full-capitation contracts to manage the health of commercial, Medicaid, Medicare Advantage, and "dual-eligible" enrollees ("dual eligibles" qualify for both Medicare and Medicaid). Recently sold to DaVita for more than $4 billion, HealthCare Partners has little bad debt and accounts receivable on its capitated business. Predictable revenue comes in on a monthly basis, and the entire system is set up to make money on these full-risk contracts.

As discussed earlier, many markets are not yet ready for full capitation. Even in these areas, risk-based contracts are becoming popular, particularly bundled payment initiatives. For example, the state of Tennessee is spending millions of dollars to put a statewide bundled payment program in place. Arkansas put in place a similar statewide program for Medicaid beneficiaries several years ago, with the goal of addressing the following problems: the poor health status of Arkansans, difficulties in navigating the system, misaligned incentives, and rapidly rising costs that threatened the state budget. A joint initiative of Medicaid, Arkansas Blue Cross Blue Shield (BCBS), and QualChoice (a commercial payer), this program got up and running in less than a year. Preliminary results suggest it has had a major, positive impact on quality and costs, including the following:

- Better compliance with established guidelines
- Less antibiotic use for upper respiratory infections
- Significant cost savings for episodes involving attention deficit hyperactivity disorder and oppositional defiant disorder
- Reduced use of inpatient rehabilitation services

The initiative has also encouraged providers to practice at different (lower-cost, higher-quality) hospitals, and led to better communication and collaboration between payers, physicians, and hospitals.

Private companies are also embracing bundled payments. For example, Walmart and Lowes have partnered with Health Design Plus to create a centers-of-excellence strategy under which 1.5 million covered members can travel to low-cost, high-quality facilities for certain orthopedic and cardiac procedures. The members pay nothing out of pocket, including travel expenses for the patient and a companion. The goal of the program is to eliminate unnecessary utilization through rigorous pre-procedure screening and to reduce costs by sending patients to high-quality, efficient providers. Other employers are embarking on similar strategies.

Hospitals and health systems that participate in these initiatives have much to gain, including incremental volume, greater predictability in reimbursement, and the opportunity to leverage the program to push for additional care redesign and greater physician engagement. As one hospital executive noted about bundled payments, "It's a 'win-win-win' for patients, employers, and the hospital. The patient has no out-of-pocket responsibility, employers have a better long-term financial result, and we get new patients."

> "Transparency must be actively managed, as information can be your best friend or your worst enemy. You must manage information proactively on the front end before it ends up in the newspaper."
>
> *—Guy M. Masters, M.P.A., Senior Vice President, and Kimberly Hartsfield, M.P.A., Senior Manager, The Camden Group*

The Need for IT Infrastructure and Greater Transparency

To meet the Triple Aim and succeed under bundled payments, hospitals and health systems need to put in place substantial infrastructure to support integration, including incentives, IT, and real-time information to guide decision making. Many organizations invest in infrastructure, but too often do not realize enough benefits from it, as they do not have the right people in place or the right information available at the point of care. In addition, some organizations have not properly aligned financial incentives or moved to a new level of transparency. Transparency has been a "game changer" in some markets, including in Arkansas where the aforementioned multi-payer, statewide bundled payment initiative was set up based on comparative cost information.

Costs often vary significantly by provider, and it is important for health systems to evaluate their performance versus the competition, and to assess the relative cost of physicians

Exhibit 13. Sample Cardiac Surgery Performance Metrics

Provider-Level Cost and Variation Transparency

SAMPLE Health System
Open Heart Summary Performance Metrics
January to November 2012

	All Payers								
			DIRECT OPERATING ROOM COSTS (Per Case)			DIRECT ANCILLARY COSTS (Per Case)			(Per Case)
Surgeons	Cases	30-Day Readmission Rate	Implant Cost	OR Time and Team	OR Supplies	Lab	Pharmacy	Imaging	Total Direct Costs
Valves (MS-DRGs 216-221)	**71**	**15%**	**$6,081**	**$7,206**	**$2,316**	$3,888	$1,463	$970	**$37,683**
Doctor 1	34	12%	$6,936	$7,648	$2,285	$3,827	$1,889	$1,020	$41,483
Doctor 2	36	19%	$5,306	$6,783	$2,347	$3,912	$1,071	$905	$33,866
Doctor 3 (1)	1	0%	$4,946	$7,400	$2,247	$5,113	$1,082	$1,594	$45,857
CABGs (MS-DRGs 231-236)	**129**	**9%**	**$427**	**$6,067**	**$2,089**	$1,871	$1,108	$419	**$26,245**
Doctor 1	68	6%	$468	$6,466	$1,938	$1,514	$1,028	$450	$26,944
Doctor 2	60	13%	$386	$5,606	$2,254	$2,200	$1,206	$387	$25,463
Doctor 3 (1)	1	0%	$97	$6,568	$2,425	$6,376	$688	$254	$25,661

Indicates surgeon with the highest cost (or readmit rate) during the baseline period. This is highlighted to illustrate opportunity for savings.
(1) Surgeon only had one case; therefore that surgeon was not included in the comparison of highest cost (or readmit rate).

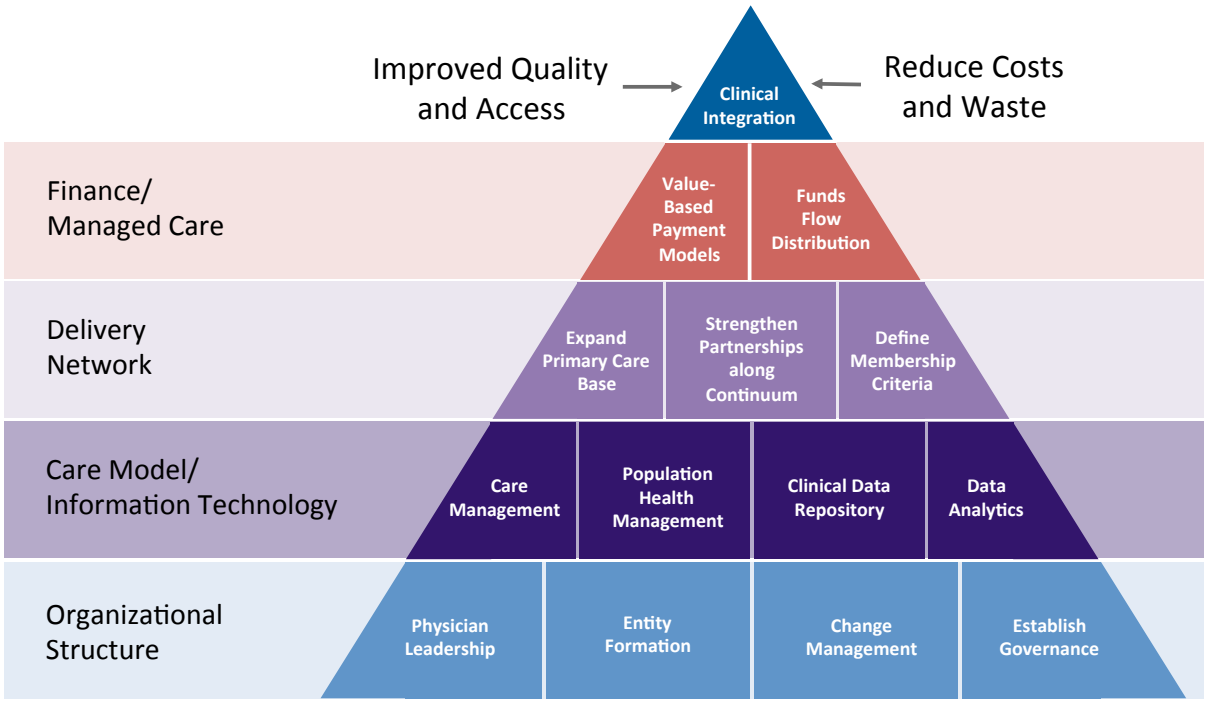
Source: The Camden Group.

and facilities within the system. Insurers already track this information to inform their contracting and payment decisions. For example, data from the BCBS consumer cost tool found that the cost for total knee replacement varied significantly in the Boston area, with the highest-cost provider being $18,782 more expensive than the lowest-cost one. This type of information is readily available throughout the country, as it must be submitted by all Blue plans nationwide. As a result, high-cost providers may quickly find themselves priced out of the market as insurers adopt narrow networks and/or tiered-network strategies that require higher payments by enrollees who choose to go out of the preferred network. To help employees make their choices, companies often provide shopping tools to help identify low-cost providers, and may even give them a positive financial incentive for going to these providers. In addition, physicians who have a financial incentive to control costs will steer their patients to lower-cost providers. Most physicians know which patients require routine care at a community hospital and which need specialized care at a high-cost tertiary institution, and they will steer their patients accordingly.

Arkansas BCBS is also active in publishing performance information. On a quarterly or semi-annual basis, the insurer publishes risk-adjusted cost information for the top five episodes each physician treats. ("Costs" are measured as what the insurer pays for the procedure.) Relatively few providers actively use this information, but it can potentially be used to help physicians improve their performance.

Ideally, health systems will have access to *true* cost and outcomes data, not what insurers pay. To that end, **Exhibit 13** shows a sample of performance metrics related to cardiac surgery. This kind of information can be shared with providers, so that they can see how they compare to their peers on costs, readmissions, and other key metrics. Some organizations begin by sharing this information only with individual surgeons

Exhibit 14. Clinical Integration Building Blocks



Source: The Camden Group.

to give them a chance to improve; over time, the audience can be broadened.

Pioneering organizations in more advanced markets have become more aggressive with the sharing of information. For example, HealthCare Partners shares non-blinded, physician-specific data with their providers. By 2015, the organization plans to make data available to clinicians at any time on any device or system, anywhere in the world, with sub-second response times and inclusion of the appropriate clinical context for the information. This kind of information can be used at the bedside to inform clinical decisions and hence drive improvement.

Health systems need to stay on top of this type of information, using it to inform contract negotiations with payers, benchmark performance versus competitors, and reduce variation internally by helping high-cost providers learn from their lower-cost peers. Those that do will reap the rewards, as evidenced by the following examples:

- **Brooks Rehabilitation**: Located in Jacksonville, FL, Brooks Rehabilitation has been a pioneer in bundled payments, which has led to reductions in admissions and the overall costs of care. Keys to success include using care navigators for the entire episode, developing IT infrastructure and analytic capabilities, and changing the organizational culture.
- **Geisinger Health System**: Geisinger participated in a bundled payment initiative for bypass surgery, which led to a 0.5-day reduction in length of stay (LOS), a 50 percent drop in post-acute care costs, and a 44 percent decline in readmissions. Outcomes improved as well, including better compliance with established best practices (which rose from 59 to 100 percent within six months) and reductions in complications (21 percent) and wound infections (25 percent).
- **Camden Group client**: One (unnamed) health system reduced costs by $2,000 to $3,000 per case in its cardiac service line. The decline came from significant reductions in supply costs, time spent in the catheterization laboratory, LOS, and

readmissions. At the same time, on-time starts in the operating room increased by 29 percent, which led to higher physician satisfaction.

Critical Success Factors and Lessons Learned

As depicted in **Exhibit 14**, health systems need to put the building blocks for clinical integration into place, starting at the bottom and moving to the top. Part of this effort includes changing the metrics by which performance will be judged. Rather than focusing on volume and occupancy rates, hospitals leaders need to be concerned with admissions and readmissions per 1,000 covered lives and LOS.

The winners will be organizations that cover the full continuum of care (either through partnership or ownership) and that effectively manage and utilize data, including integrating today's disparate data sources to bring together information on costs, operational metrics, reimbursement (by payer), and benchmark/best-in-class performance. In most cases, external data from payers must be added to provide insight as to what happens outside of the system and to allow measurement of the total costs of care. (Health systems with an in-house insurer may already have this information.) Key elements for success include the following:

- Embrace transparency by sharing detailed, real-time physician- and procedure-specific data on a regular basis.
- Implement care protocols to standardize care and reduce variation.
- Reduce readmissions by investigating why patients end up back in the hospital and developing strategies to address identified problems.
- Reduce ambulatory care sensitive admissions and unnecessary ED visits by partnering with physicians to manage patient care proactively in the outpatient setting.
- Focus on quality and patient outcomes.

Action Checklist: What You Must Do Now

- Evaluate the payment transformation strategy within the organization and determine where it lies on the continuum.
- Use data strategically, as information is a prerequisite to a successful transition to a value-based world.
- Assess the degree of physician alignment within the organization, and figure out what it would take to double it and the resulting effectiveness.
- Count the number of items and cost variations within the supply chain management system. Evaluate each service line and figure out how to cut by 25 percent.
- Become knowledgeable about the information available about your facility and physicians, and figure out how to manage it more proactively.
- Use bundled payments as a lever to begin the work of managing the total cost of care.

Physician Engagement: Insights to Smooth the Path from Aspiration to Reality

Two physician leaders at the University of California, San Francisco (UCSF) with a longstanding interest in physician workforce issues discussed strategies for engaging physicians in the reengineering of healthcare delivery, with each coming from a different perspective.

If Every Instinct Doctors Have Is Wrong, Then the Opposite Would Have to Be Right…Or Would It?

Robert M. Wachter, M.D., Professor and Associate Chairman of the Department of Medicine at UCSF, noted that physicians are now being asked to think and act very differently than during their training. Concerns about patient safety, runaway costs, poor patient experiences, and huge variations in care (not associated with evidence) have led to tremendous pressure to improve the value of healthcare services in the U.S. This pressure incorporates both aspects of the value equation—the numerator (higher quality and patient satisfaction) and the denominator (lower costs). In essence, physicians are being told that everything they learned in training is essentially wrong and hence they need to do the opposite.

Four Major Areas Where Physicians Are Being Asked to "Do the Opposite"

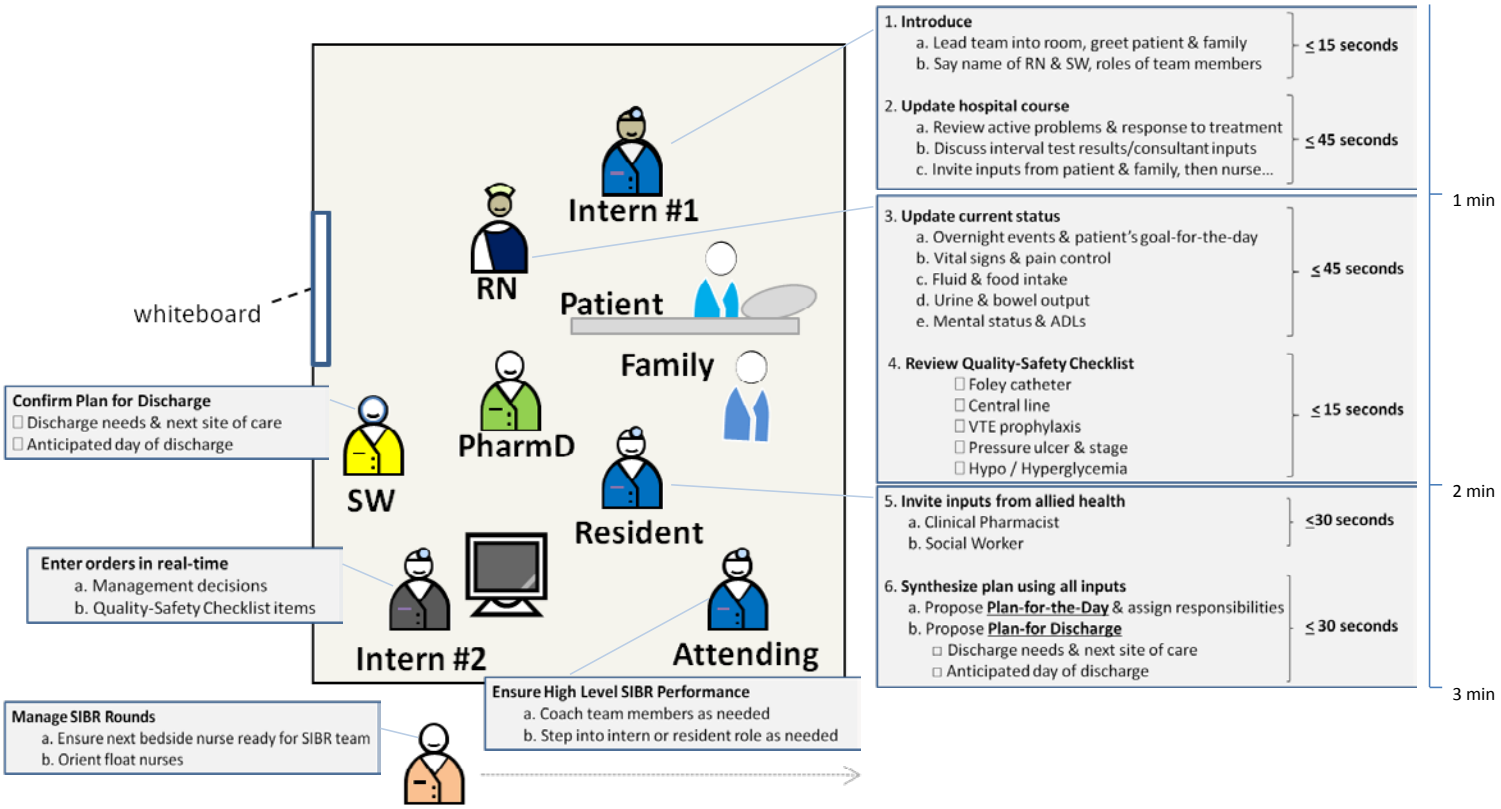
Dr. Wachter described four areas where today's pressures for higher value and management of population health force healthcare providers and leaders to "do the opposite" of what they were trained to do.

Area #1: Teamwork

The traditional view portrays physicians as being individualistic, incapable of "playing well" with others, and not thinking about systems. The opposite view that dominates today is that healthcare is a "team sport" and that improving systems is the key to delivering high-value care. Substantial evidence exists that teamwork is beneficial. For example, the Veterans Administration developed a medical team training program

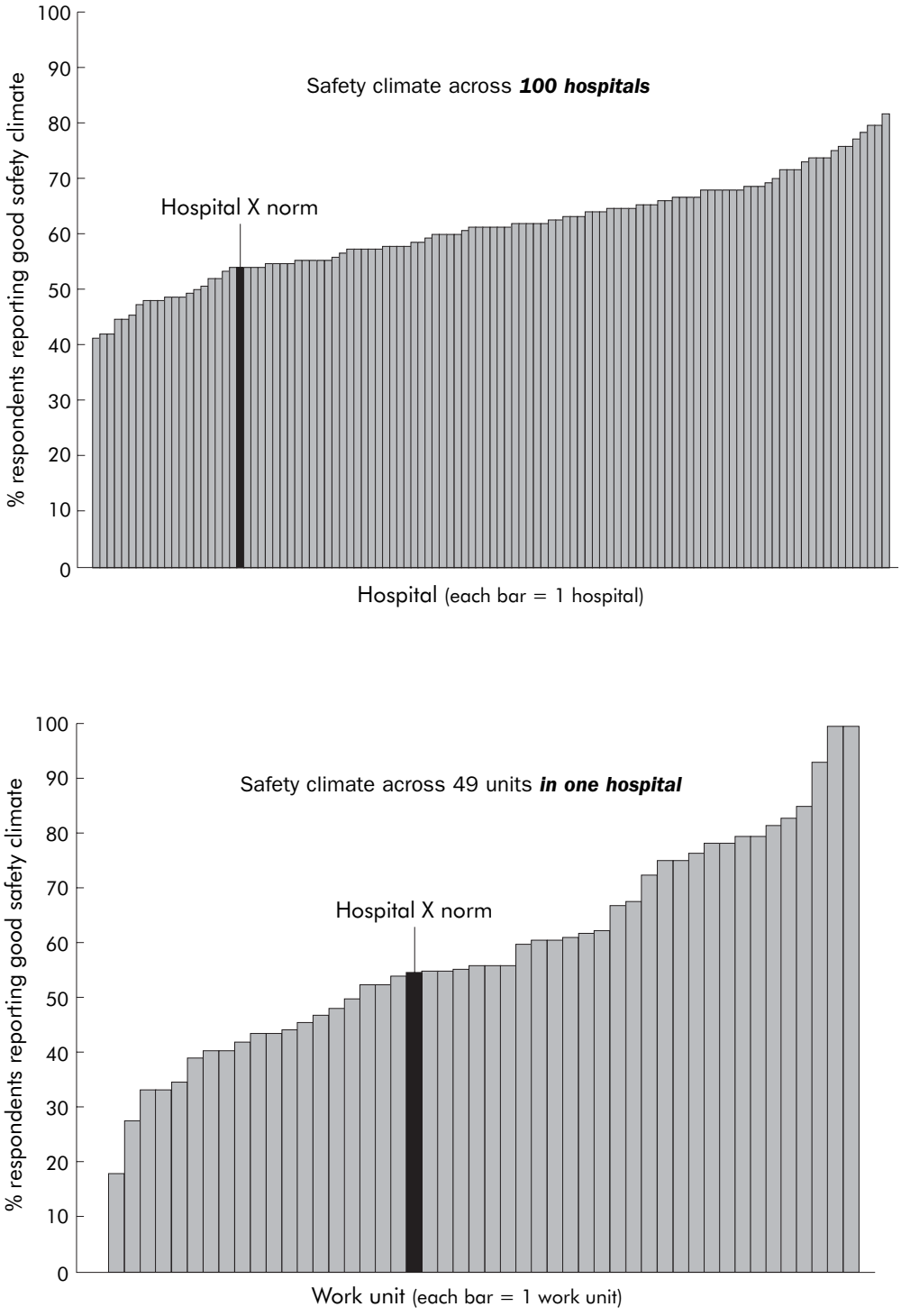
Exhibit 15. Structured Interdisciplinary Bedside Rounds: Roles and Process

This diagram proved extremely helpful in getting all the members of the interdisciplinary team involved in an "accountable care unit" at Emory University Hospital to have a shared understanding of the standard approach they should use in communicating and coordinating patients' care.



Source: Jason Stein, M.D., SFHM, Associate Vice Chair for Quality, Department of Medicine, Emory University School of Medicine.

Exhibit 16. Culture and Performance Are Local



Source: Pronovost/Sexton, *QSHC* 2005

in 70 hospitals that helped to reduce post-operative mortality rates.[6] As depicted in **Exhibit 15** on page 33, new organizational models are being developed, such as structured interdisciplinary bedside rounding programs (rather than having nurses, physicians, and case managers all round separately). Implemented at Emory, this highly structured and choreographed approach improves efficiency, quality, and the patient experience, as patients like seeing their caregivers talk with one another and act like a team.

While teamwork and collaboration are critically important, Dr. Wachter emphasized the ongoing need for physician leadership. He worried that the movement toward teamwork may go so far that no hierarchy remains. Teams need leaders, and often (though not always) the physician needs to be that leader. Consequently, organizations need to invest in physician leadership development programs.

In addition, individual performance still matters. The logical extension of today's thinking is that everything revolves around teams and systems. While the focus on fixing systems is correct, taking it too far leads to the conclusion that the quality of the physician no longer matters. However, physician quality does matter, particularly with respect to diagnostic acumen. Today's quality measures almost always assume the initial diagnosis is correct. But it may not be correct. Physicians have been trained to solve the diagnostic riddle, and today's measures generally do not capture this aspect of their work. Consequently, physicians may look good on paper, but not actually be doing a good job in diagnosing patients. If the diagnosis is wrong, then it does not matter how well the treatment phase goes, since the treatment may be unnecessary or, worse yet, cause harm.

Physician quality also matters when it comes to technical skills, particularly for surgeons. Technical skills often vary, and these variations affect outcomes. For example, two University of Michigan physicians (John D. Birkmeyer, M.D.,[7] and Jonathan F. Finks, M.D.) conducted a study of jejunojejunostomy, the surgical creation of an opening or passage between two portions of jejunum (a part of the small intestine). This procedure tends to be quite tricky, particularly when done via laparoscopy. In their study, the two physicians asked surgeons to send in videotapes of their favorite examples of them performing the procedure, and then had 10 surgeons rate each tape on five dimensions, using a scale of one to five. The surgeons found large variations in the technical skills of the surgeons, with the top quartile averaging a score of 4.3 across the 10 dimensions and the bottom quartile averaging 2.7. More importantly, patient outcomes correlated highly with technical skills, with the patients of more skilled surgeons having a lower risk of infection, readmission, and death. In fact, technical skills predicted patient outcomes more so than any other factor, including years of experience and training. In other words, if a patient could know only one thing before choosing a surgeon, this technical score would be most important, as no other factor better predicted his or her ultimate outcome. (Only historic case volume—the annual number of procedures performed—came close as a predictor of outcomes.) Every hospital has both low- and high-rated surgeons when it comes to technical skills. Nurses probably know which surgeons are technically sound and which are not. However, the CEO and members of the board probably do not.

Area #2: Sources for Best Practices

Under the traditional view, the best ideas come from somewhere else, typically from well-known, highly respected organizations like Mayo Clinic or Cleveland Clinic. The opposite view holds that many of the best ideas can be found within an organization. Comparisons to outside organizations are often met with resistance, with key stakeholders claiming that their patients are different (e.g., older, sicker) and/or that the other organizations have more resources or a different history. In addition, comparisons to outsiders can be misleading, given that there are so many different rankings and relatively little consistency between them.

Local comparisons provide a lot of value, often uncovering substantial variation between facilities within a given system and often even more variation across units in the same facility (see **Exhibit 16**). As shown on the bottom chart, the safety climate varied dramatically across 49 units in the same hospital.

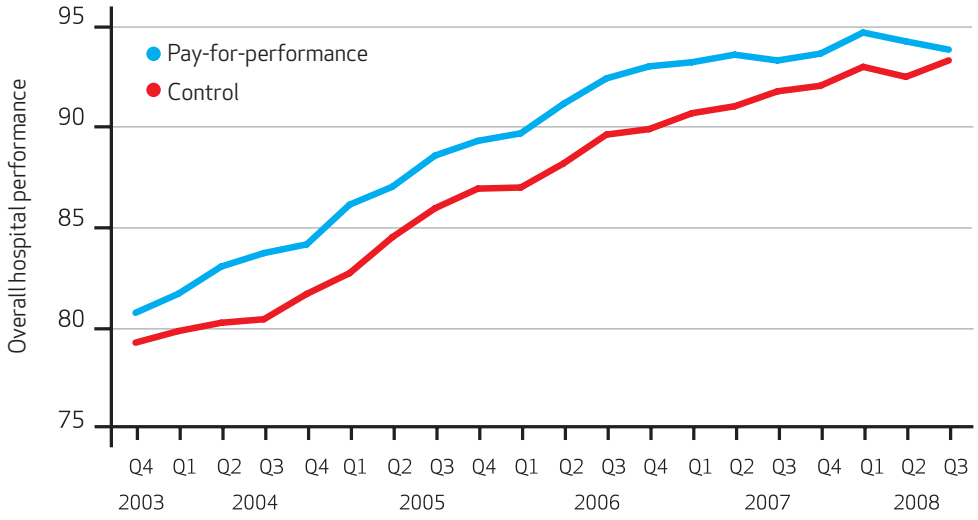
> "Your hospital doesn't have a safety culture. Rather, individual units have one, such as labor/delivery, the ED, and the step-down unit. In fact, differences within an organization tend to be greater than differences across organizations."
>
> *—Robert M. Wachter, M.D., Professor and Associate Chairman, Department of Medicine, UCSF*

Using in-house comparisons to benchmark performance tends to reduce if not eliminate many common objections about the data, as everyone is dealing with the same patients and the same organizational resources. Leaders can share facility- and unit-specific performance data broadly, and let those performing poorly learn from those who perform well. These local comparisons tend to be more powerful than comparisons to state or local averages or to "best-practice" institutions around the country. For example, UCSF found itself stuck at relatively mediocre performance with respect to adhering to hand-hygiene protocols. After leaders decided to share unit-specific performance data, the leaders of low-performing units got tired of being singled out and figured out how to improve.

6 J. Neily, et al., "Association between Implementation of a Medical Team Training Program and Surgical Mortality," *Journal of the American Medical Association,* Vol. 304, No. 15 (October 20, 2010), pp. 1693–1700.

7 Dr. Birkmeyer is now at Dartmouth-Hitchcock.

Exhibit 17. Does P4P Work Better Than Simple Transparency? The Jury Is Still Out



Source: R. Werner, et al., *Health Affairs,* Vol. 30 (2011), pp. 690–698.

UCSF is now considering how to use physician-specific data to promote improvement, but are proceeding carefully so as to avoid pushback.

As a caution to the movement toward local comparisons, Dr. Wachter noted that there are lessons to be learned from outside organizations, including those outside the U.S. and/or in other industries. However, there is a tendency to underestimate what can be learned internally, and hospitals and health systems leaders will likely be well served by focusing more on internal than external comparisons.

Area #3: The Relative Merits of Money versus Other Policy Levers

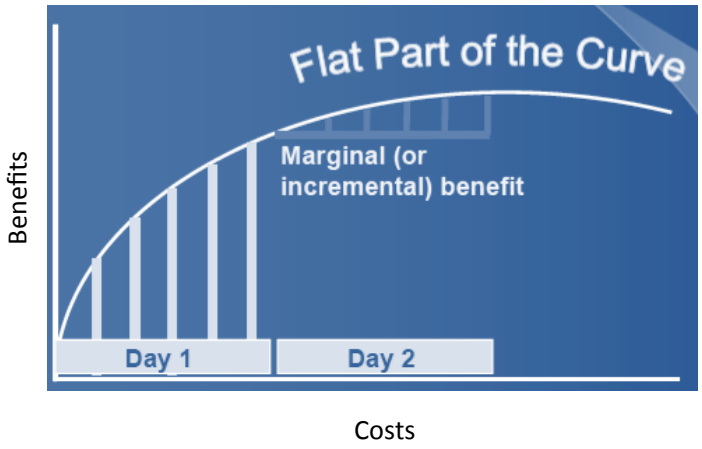
The traditional view holds that pay-for-performance (P4P) systems and other financial incentives will be the dominant mechanisms to engage physicians and get them to change their behaviors as the industry transitions from a volume- to value-based system. The opposite view holds that other, additional levers, such as appeals to professionalism, will be important as well, perhaps even more so than money.

Like everyone else, physicians are motivated by more than money. In fact, in some cases, use of money as a motivator can backfire. For example, the board at an Israeli day care center decided to introduce a fine for parents who picked up their children late. The policy was adopted in response to what the board perceived as too many parents coming a few minutes late to pick up their child. The fine, however, ended up having the opposite of the intended effect, as late pickups skyrocketed. This counterintuitive result, however, makes complete sense. The board essentially made what historically had been a social transaction into a market transaction. Parents now equated coming late with paying the center to watch their children a little longer. In the past, they felt bad about being late, as they were violating a well-established social norm to be on time for pickup. Now, however, parents viewed coming late as a perfectly acceptable commercial transaction. After the board reversed the decision and ended the fine, late pickups continued, as they had become the new, accepted norm.

The jury remains out on whether financial incentives such as P4P have a positive impact. As illustrated in **Exhibit 17**, hospitals that received bonus payments and had their performance reported publicly did not improve any more over the long run than did those participating in public reporting alone. In other words, public reporting on its own seemed to be just as effective as combining it with P4P. Implementing public reporting, moreover, is a lot easier than implementing P4P systems.

Dr. Wachter cautioned that evidence exists on both sides related to P4P—some studies suggest it does have a positive impact, while others suggest it does not. In addition, some experts interpret the negative studies (i.e., those finding no impact from P4P) as an indictment on how the system was set up rather than on the concept itself. For example, the size of the financial incentive may have been too small or it may have been implemented poorly. In some cases, provider organizations may be receiving the P4P payment, but individual physicians may not be getting them. Looking ahead, it seems safe to conclude that P4P programs will continue to be used, unless more vigorous, robust data show that they do not work. Good leaders and policymakers need to be thoughtful, not doctrinaire, about their choice of tools, including P4P. They must understand the culture within the organization and figure out what will and will not work.

Exhibit 18. Costs vs. Benefits: The Big Picture



Area #4: Physician Focus on Individual Patients versus Populations

The traditional view depicts physicians as having a laser-like focus on individual patients and thus being incapable of making hard decisions about resource allocation. The opposite view holds that physicians can assume a population perspective and consider tradeoffs with respect to resource allocation among patients.

As shown in **Exhibit 18**, healthcare services often provide a large initial benefit, but that benefit tends to flatten out over time even as costs continue to rise. For example, in the intensive care unit, the first day of care tends to provide significant benefit at a high cost, as the patient benefits greatly from the intensive treatment and monitoring. By day two or three, the benefit begins to flatten out, even as the costs continue to rise. The key question becomes, what should be done along this "flat part" of the curve?

Physicians have been trained to take the individual perspective and hence generally continue offering services until there is no incremental benefit whatsoever to doing so, regardless of the cost. From a societal/population perspective, however, the provision of services on the flat part of the curve does not make sense unless everything else that offers a higher benefit/cost ratio has been provided to others in the population being covered. This societal perspective is as reasonable and ethical as the individual perspective, and in many other countries it has been accepted as the norm.

ACOs are an attempt to get physicians to take a societal/population perspective. Like HMOs did in the past, ACOs give physicians the job of optimizing care for a group of patients, within the constraints of a fixed pool of dollars. Under this model, decision makers, including physicians at the bedside, may need to reallocate dollars from those on the flat part of the curve to others within the population who are on the steeper part (i.e., where incremental benefits more clearly outweigh incremental costs). Under this approach, a patient may not receive $100,000 palliative chemotherapy that provides only a marginal benefit until everyone else in the panel has received lower-cost services that provide greater benefit, such as evidence-based screening tests.

Advocates of this population perspective often face stiff opposition in the U.S., as Americans are not used to the concept of rationing care. For physicians, taking on the population perspective creates a dilemma, as they feel pulled in two different directions. They have been trained to do everything possible for an individual patient, yet doing so may prevent them from providing highly beneficial services to others for whom they also are responsible.

The leaders of various organizations pushing for the movement to a population perspective have tried to find the right words to use to engage physicians and the public in this approach, and hence avoid a quick degradation in the quality of the debate (such as occurred during debate about ACA, when efforts to pay for and hence encourage counseling about palliative care turned into accusations that "death panels" were being created). Various terms have been used, including stewardship, parsimonious care, taking a population perspective, patient-centered care, reducing waste, value-based care, lean care, reducing harm from overuse, and quality. Several organizations have helped move this discussion forward in a productive way. For example, as part of ABIM Foundation's Choosing Wisely initiative,[8] specialty societies have come up with lists of five services that, in certain situations, add little or no value (and in some cases cause harm). A small group of specialty societies first came up with their lists, and now many more have signed on as well, and come up with their own lists. In addition, the authors of a recent article in the *Journal of the American Medical Association* furthered the discussion by noting that care delivered on the flat part of the curve (such as an

8 See www.choosingwisely.org.

Exhibit 19. Self-Reported Responsibility and Enthusiasm for Various Means of Reducing Healthcare Costs among 2,556 U.S. Physician Survey Respondents

	No. (%)[a]		
	Major Responsibility	Some Responsibility	No Responsibility
Entities with potential responsibility to reduce cost of healthcare			
Trial lawyers (n = 2,433)	1,449 (60)	630 (26)	353 (15)
Health insurance companies (n = 2,446)	1,439 (59)	923 (38)	84 (3)
Pharmaceutical and device manufacturers (n = 2,445)	1,377 (56)	938 (38)	129 (5)
Hospitals and health systems (n = 2,439)	1,373 (56)	1,037 (43)	29 (1)
Patients (n = 2,439)	1,265 (52)	1,124 (46)	50 (2)
Government (n = 2,440)	1,073 (44)	1,186 (49)	181 (7)
Individual practicing physicians (n = 2,438)	889 (36)	1,448 (59)	101 (4)

[a] Percentages not all based on denominator of 2,556 because of missing responses to some survey items.

Source: J.C. Tilburt, et al., *JAMA,* 2013.

imaging test for low-back pain) may cause financial harm to the growing number of patients facing high copayments and/or deductibles.[9]

Even as physicians are encouraged through new organizational arrangements and payment systems to consider the population perspective, they will continue to be socialized to see life through a one-patient-at-a-time lens. This perspective may be correct, as one cannot ignore other factors driving the "individual trumps population" perspective, including malpractice concerns, standards of care, patient demands, and the physician's moral responsibility to act as an advocate for the patient. This challenge—how to advocate for individual patients while simultaneously managing population health—will likely be the single biggest challenge that physicians face during the rest of their careers.

> "It doesn't matter if a physician didn't want to be measured in the first place. If social pressures are applied correctly, what was originally seen as a hassle eventually becomes a habit."
>
> *—Gurpreet Dhaliwal, M.D., Associate Professor of Clinical Medicine, UCSF*

How Doctors Think: Implications for Creating a High-Performing Organization

Gurpreet Dhaliwal, M.D., Associate Professor of Clinical Medicine at UCSF, offered another perspective on physician engagement, focusing on how physicians think and what that means for those trying to create a high-performance organization.

The essence of doctoring is the ability to diagnose a patient with clarity, accuracy, and confidence. When a patient walks into a clinic, the physician begins a search within his/her mind to figure out what might be wrong. Once a set of potential diagnoses emerges, that triggers a second round of questions, a cycle that continues until the doctor settles on a particular diagnosis. If the doctor gets it right and treats the patient for what he or she actually has, that doctor is likely providing high-value care. If the doctor gets it wrong (which happens roughly 10 percent of the time), that is an instance of low-value care, with money being spent unnecessarily to produce a poor outcome.

Need for Performance Measurement

Getting physicians to care about costs and population health involves a reprogramming of their professional identity. Physicians must lead the effort, as doctors generally follow the lead of other doctors they know and trust. Every organization must assess the degree to which its affiliated physicians are ready to embark on this transition. For now, the picture remains mixed, as many physicians are reluctant to accept responsibility for the costs of care (as depicted in **Exhibit 19**).

Increasingly, physicians will be faced with the following question: do they believe they can maintain their autonomy even as they cede accountability to everyone else? Physicians will not be able to have it both ways and increasingly they will need to be accountable for their performance on established metrics. Teachers face a similar challenge, as they are also in the throes of the accountability movement. While the temptation may be to resist these initiatives and hope they will fade away, the better approach is to become engaged in and attempt to shape the effort. Teachers in North Carolina took this approach, working with other stakeholders to decide what measures to use, how measurement should occur, and what would

9 C. Moriates, N.T. Shah, and V.M. Arora, "First, Do No (Financial) Harm," *Journal of the American Medical Association,* Vol. 310, No. 6 (2013), pp. 577–578.

be done with the resulting information. This approach tapped into the teachers' identities as experts in their field. It helped to reprogram their professional identities, instilling the notion that being a professional means constantly trying to do a better job.

A promising method when it comes to creating accountability lies in a bottom-up approach that engages physicians in the task of finding the right metrics and measurement approaches. However, even when physicians participate in these efforts it still may take time for them to change behaviors. Like all humans, they will not do so without the appropriate context and emotion. Financial incentives rarely work—they may produce short-term improvements, but they do not tap into more powerful psychological levers that deliver long-term results. Physicians are governed by social norms and have a strong desire to be in sync with or ahead of those around them. Consequently, peer pressure remains a potent driver of behavior change. Like Dr. Wachter, Dr. Dhaliwal believes that performance data from local peers will be much more powerful than comparisons to national or state averages. Performance data should be shared semi-publicly among physicians' peers, such as through a group email or semi-private bulletin board. The goal of such efforts is not to place blame or shame on any physician, but rather to send a strong signal about the importance of improvement over time. Once scorecards become available—particularly if they measure processes or outcomes clinicians value—then physicians talk about them and compete with each other to be the best.

Performance data help to change the organization's culture and create a sense of shared purpose where everything is done in the interest of the patient. Once this shared purpose has been established and all physicians are working toward the same goal, financial incentives can be introduced. A shared-purpose organization is a precondition for using financial incentives, but financial incentives will never build a shared-purpose organization.

Initial Target: Reducing Waste

Improvement efforts must also be focused on eliminating waste. Too much testing is done on patients "just to be sure," which then becomes the community norm. Since malpractice cases have to be defended against the community standard, widespread use of this type of testing spreads in a self-reinforcing cycle driven by malpractice fears. FFS payment systems also encourage waste, as physicians have an incentive to do more rather than less. However, the evidence shows that overuse is not only wasteful, but also can be harmful. For example, unnecessary use of imaging tests and antibiotics can harm patients.

As Dr. Dhaliwal suggested, the Choosing Wisely campaign is one of the best initiatives focused on eliminating waste, with specialty societies highlighting five tests that are frequently wasteful and sometimes harmful. To get started, healthcare systems should pick a specific area, such as imaging tests for low-back pain or use of antibiotics for a sore throat, and set a specific target for reducing unnecessary use. Such an initiative requires the coordination of multiple stakeholders, including leaders of the business office and the legal department, who must accept the new standard of care, including its potential to reduce revenues and/or increase legal liability. In addition, patients must be educated on the new standard of care; for example, many clinics now have posters in waiting and examination rooms that discuss the dangers of antibiotic overuse.

> "The next generation of physicians will focus on everything that 'should' be done and not on everything that 'could' be done."
>
> *—Gurpreet Dhaliwal, M.D., Associate Professor of Clinical Medicine, UCSF*

Strategies for Engaging Frontline Physicians

Physician and administrative leaders need to get involved in engaging frontline physicians. Many physicians will not lead transformation efforts, but do want their voices to be heard and feel that their opinions matter. Consequently, leaders need to provide the opportunity for such input, such as by hosting regular lunch meetings and/or providing access to leaders. One CEO has an open-door policy that invites physicians to voice their concerns—as long as they also come with a plan to resolve the issue, not just a complaint.

Some organizations have set up more formal mechanisms to elicit physician input. For example, Scripps Health created a Physician Leadership Cabinet that has made many recommendations, virtually all of which have been accepted and implemented. Scripps also focuses on training physicians through its leadership academy. The goal is to create a "pipeline" of leaders—almost like a sales force—that represents, engages, and motivates frontline staff.

Physicians have historically been trained in the biomedical sciences. However, medical schools are coming to realize that their goal should not be just to create smart physicians, but also to improve the health of patients and populations,

something that requires a completely different kind of doctor. Financial incentives alone will not attract and retain top-notch physicians, as incentives do not create a sense of engagement and ownership. Instead, engaging physicians requires an appeal to their internal motivations, which include a desire for autonomy, mastery, and purpose:

- **Autonomy**: Long prized by physicians, autonomy is slipping away from doctors. That autonomy should not be replaced with new policies, but rather with new structures and systems that make it easier to do the right thing.
- **Mastery**: Physicians will always focus on the mastery of their craft. The key is to create metrics and systems to evaluate their degree of mastery on things that matter to clinicians and patients, such as use of antibiotics or providing evidence-based screening tests.
- **Purpose**: Some physicians and systems have lost sight of their original reason for going into the field—to help patients. They now must get back to that purpose. The key to engaging a physician in any change is to make a compelling case that this approach is good for the patient.

The Unlikely Ally: Why the Healthcare Consumer Presents an Intriguing Growth Opportunity

Ryan Donohue, Corporate Director of Program Development at National Research Corporation, discussed opportunities that health systems have to engage directly with consumers by creating partnerships with patients and the general population being served.

Who Is the Healthcare Consumer?

More than just an economic term, a "consumer" is anyone who consumes. When it comes to healthcare services, therefore, everyone is a consumer, since everyone will need these services at some point in their lives. Health system and hospital leaders need to look beyond the walls of their facilities when thinking about consumers, as current patients represent just a small portion of all consumers. Consumers include anyone at any point in his or her "care journey," including former, current, and future patients.

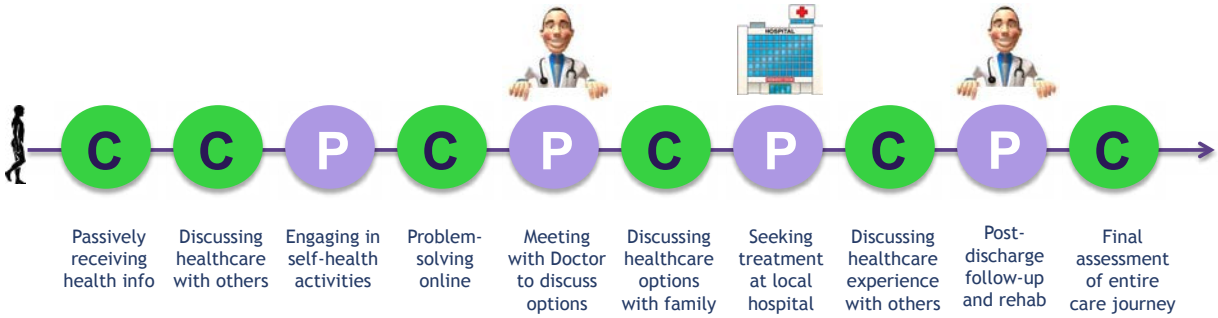
Defining the Care Journey

Consumers see the "care journey" differently than those in the healthcare industry. For consumers, the journey begins with the passive receipt of information (e.g., seeing a logo or advertisement) and continues through a series of steps (such as self-care, problem-solving, discussions with physicians and others about options, treatment, follow-up) that culminate with a final assessment (see **Exhibit 20**).

Surprisingly, many people consider themselves to become patients when they first engage in self-care activities. Once a problem arises, many individuals begin by going online to search for information. In fact, two-thirds of consumers go to sites like WebMD before seeing a doctor. In some cases, this step will be the first time the person engages with a hospital or health system, assuming that he or she goes to a provider-sponsored site. For this reason, the most important frontline "staff" for an organization may be that Web site, which for many consumers is their first interaction with the hospital or health system. Many organizational leaders do not think of the healthcare journey in this manner, instead viewing the

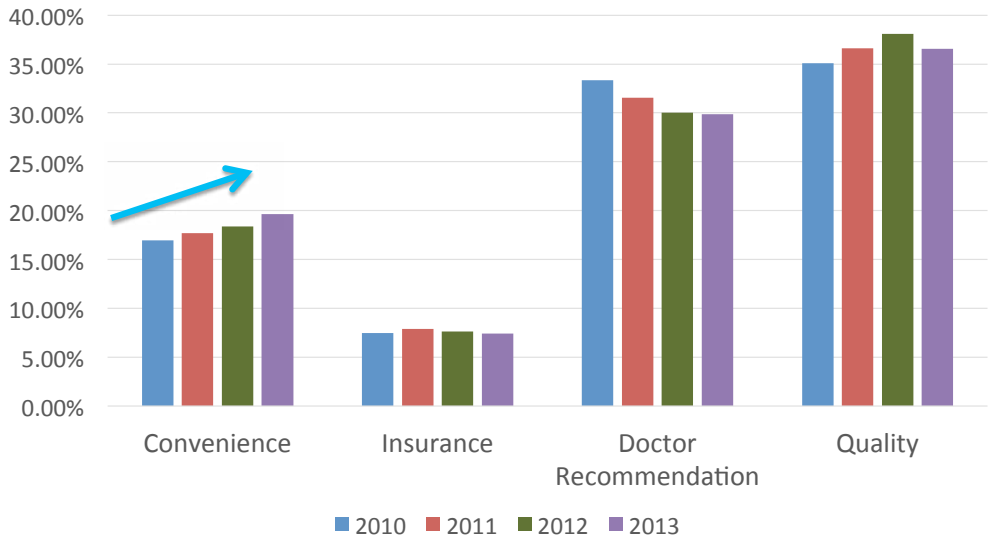
Exhibit 20. Treating Today's Consumer

*Unlike most of our care continuum interpretations, in the eyes of the consumer the **"care journey"** is much simpler.*



Source: National Research Corporation, Blue Sky Exercise, 2012–2014.

Exhibit 21. Hospitals Are Part of the Problem



patient coming to a care setting as the first interaction. But in the patient's mind, that may be step number six or seven in the journey.

Dominant View: Consumer as "Outsider" to System

Since 2012, National Research has conducted a "blue sky exercise" with consumers, conducting qualitative research on their views. In the most recent exercise, 111,488 consumers were polled in a national survey and focus groups were conducted with 176 consumers in 48 states. The Governance Institute subsequently produced a white paper that details key findings from this research.[10] By far, the single biggest finding is that consumers firmly believe that the healthcare industry has been built without them in mind. Rather, the system views consumers as "outsiders" who lack a basic understanding of—and do not pay attention to—healthcare. In the consumer's mind, the system excludes them from their own care decisions. Not surprisingly, consumers feel confused about the care journey, including not knowing how much care will cost (the single biggest point of confusion). Consumers feel they have no control of the situation and consequently have become entirely fed up with the healthcare system.

Recently, however, these "outsiders" have begun to take a closer look at the healthcare industry. Consumers have recently begun to realize they have more choices with respect to their coverage and care. In addition, rising out-of-pocket (OOP) costs have forced them to focus more on healthcare than in the past. The wellness movement has begun to change the care paradigm, and various changes in the industry (e.g., transparency) are shifting the balance of power towards consumers. As a result, consumers are a lot more motivated to become involved in their health and healthcare than in the past.

Barriers to Consumer Engagement

While consumers may be motivated to be more engaged, many barriers still exist that prevent them from doing so.

Confusion

Surveys suggest that confusion is the single biggest emotion that consumers feel with respect to healthcare, more so than anger, apathy, and delight. Being confused suggests that consumers are trying to understand the system and their options, but are finding it difficult to do so.

Many people hoped that the health insurance exchanges would help to clear up at least some of this confusion. They expected the exchanges to offer a seamless, intuitive, online shopping experience, much like Amazon.com. Yet as has been well documented, the rollout of the exchanges went quite poorly and consequently this opportunity to show consumers that the system is not broken ended up reinforcing the notion that it is. Overall, 43 percent of consumers now feel even less confident about the healthcare industry due to exchange-related fallout. They partly blame providers for these problems, since they are part of the system.

High Costs

The cost of healthcare services continues to rise at an unsustainable pace, and these high costs are the main reason that consumers are confused and do not trust the system. In the past 50 years, healthcare costs have tripled as a share of GDP. Medical payments account for nearly 15 percent of all

10 Ryan Donohue, *Considering the Customer: Understanding and Influencing Healthcare's Newest Change Agent* (white paper), The Governance Institute, Summer 2013.

consumer spending, and OOP costs doubled between 2002 and 2012. Even with the ACA, OOP costs are projected to double again in the next 10 years. Soon, health insurance will become the number-one household expense, higher than the average monthly mortgage payment or spending on food.

Rightly or wrongly, consumers place most of the blame for rising costs on providers (hospitals and health system) rather than other stakeholders, including insurers, pharmaceutical companies, malpractice lawyers, and the government. Providers dismiss much of the criticism that comes their way, but ignoring it is likely a mistake. Overall, 62.7 percent of consumers do not believe that hospitals are upfront and transparent about the prices of the services they provide. At the same time, roughly two-thirds of consumers indicate that knowing the upfront price of a service is important to them, even for major life-threatening surgery. Consumers want to know what something will cost, because they need to be sure that the bill will not be financially debilitating to them. Nearly one in five consumers (19.4 percent) has delayed necessary medical treatment over the past year due to costs. (This figure is down from 27 percent in 2008, the height of the financial crisis.)

Consumers not only blame hospitals for high prices, they also see them as inconvenient. And even though all hospitals are not the same, consumers tend to lump them together due to a lack of familiarity with individual institutions. In the past five years, the public's trust in both hospitals and physicians has declined, in part due to perceptions about high prices and high costs. The proportion of the public that trusts or highly trusts hospitals has fallen from 72 percent to 66.7 percent in the last five years; a similar decline occurred for physicians, from 74.4 percent to 68.4 percent. Individual hospitals need to take steps to address this decline in trust, so as to avoid being lumped together with other hospitals.

> "To regain our trust, consumers need to know who we are, what we do well, and how to find us. We need to build a one-to-one relationship with the consumer that makes us 'future-proof.' At your next board meeting, imagine that a consumer is sitting in and listening to what you are saying. Are you doing something that will help this consumer?"
>
> *—Ryan Donohue, Corporate Director, Program Development, National Research Corporation*

Convenience

As depicted in **Exhibit 21**, the importance of convenience as a factor when choosing providers has risen in the last few years, more so than whether the insurer includes a particular provider in the network and what provider the physician recommends.

Convenience still ranks well below quality and physician recommendation as drivers of provider choice, but the importance of convenience has risen markedly in a short time. Going forward, consumers will be increasingly drawn to provider organizations that make it easy and convenient to access care. For this reason, hospitals and health systems should be quite concerned about retailers such as Walgreens that are opening easily accessible clinics.

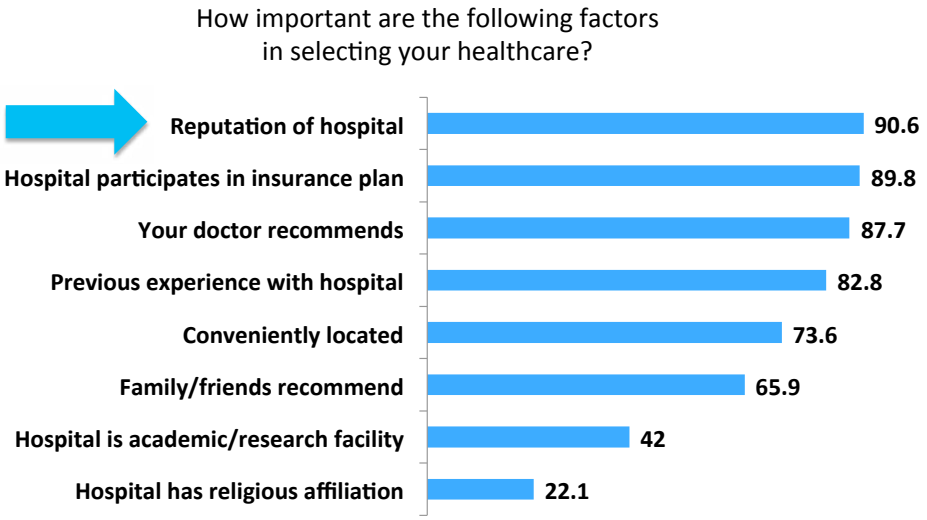
It is dangerous, moreover, for hospital and health system leaders to believe they can rely only on a good reputation and image. While reputation is important, what it takes to build and maintain that reputation is quite different than in the past. Perceived quality is used to drive brand image. But as consumer habits have shifted and attention spans shortened, hospitals must adapt to focus on what consumers now say is important, which includes both costs and convenience.

Lessons from Non-Healthcare Companies

Companies in many other industries have faced consumer revolutions and been forced to adapt, and those in healthcare can learn from their experiences. Consumers use products from other industries more frequently and consistently than they do healthcare services, and they expect to have a very good experience when dealing with service providers. The same will be true in healthcare as the consumer revolution takes shape. The following lessons from other industries have significant implications for healthcare providers:

- **Adapt to seismic change**: In response to the trend toward healthy and organic foods, grocery stores had to recognize this seismic change in consumer eating habits and find new ways to make such foods available, including changing operational models and developing new delivery methods to ensure the availability of fresh offerings.
- **Be open to new delivery methods**: Leaders must understand the importance and power of convenience, and look for new ways to offer it. If not, they could face extinction. For example, the leaders of Blockbuster once had a chance to purchase Netflix for relatively little money. But they failed to see the power of offering greater convenience to consumers by mailing DVDs or streaming videos directly into the homes. They remained too wedded to the idea that people would be willing to travel to a retail location. They also did not appreciate the greater convenience offered by Redbox kiosks, which allow consumers to pick up videos at a grocery store, gas station, or other frequently visited location without the need for a separate trip to a video store. Provider organizations need to look for partners who can help enhance the convenience of their service offerings, including investigating the potential for online and virtual care. These services may create new revenue opportunities. On a cautionary note, however, there will always be some cases where an in-person visit is needed.
- **Find attrition advantages**: Some organizations find ways to differentiate themselves in industries that do not have a

Exhibit 22. Brand Is #1 Factor in Healthcare Selection



Source: National Research Corporation, Market Insights national database, 2011, n size=278,824.

strong reputation with consumers. For example, Southwest Airlines separated itself from its competitors by building a brand around the idea of no baggage fees. Consumers despise these fees, and Southwest has gained market share by not having them, even as they raised fares at or above those of competitors. Southwest is no longer the low-cost/low-fare provider, but the company still enjoys a great reputation with consumers and reaps financial dividends as a result. The lesson is clear—organizations can win by doing things differently in an industry with a negative reputation.

Creating an Alliance with Your Consumers

So the question becomes, how can hospitals and health systems build a strong alliance with consumers (as Southwest Airlines and Netflix have done)?

Building a One-on-One Relationship with Consumer

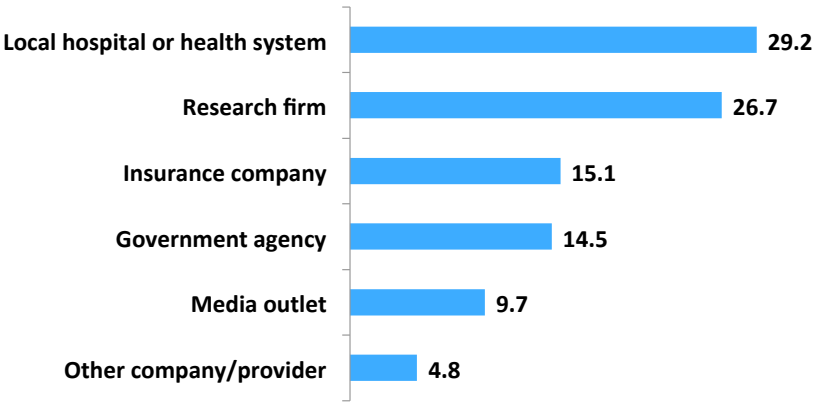
The key is to build a one-on-one relationship with consumers by creating a brand they trust. As shown in **Exhibit 22**, a hospital's reputation (i.e., brand image) remains the single most important factor in selecting a provider.

Creating a one-on-one branding relationship, however, requires a simplification of the services offered. Healthcare brands today tend to be overly complex and nearly indecipherable to the average person. Unlike those in other industries, healthcare organizations have one natural branding advantage, which is the potential to build an emotional connection with consumers. But if the brand is perceived as convoluted, confusing, or cold, it will turn consumers off.

When it comes to healthcare services, consumers value the concept of "systemness." In fact, roughly two-thirds (65 percent) are more likely to choose a hospital that is part of a system. Consumers like the idea of going to simple, scalable health resources oriented around their needs, and systems get credit for being a comprehensive provider able to provide those resources. Branding the system as a whole (not individual components) helps to make it simpler for consumers.

To create a brand, system leaders need to be willing to launch a brand-building campaign to create awareness and differentiate the organization from the competition. They need to set goals related to brands as a defense against internal distractions, and create financial incentives to reinforce brand positioning. To that end, marketing leaders need to be given a seat at the "big-kid table" when major decisions are being debated, and feedback loops must be put in place to gauge the impact of all marketing, strategic planning, and business development activities.

Exhibit 23. A Transparent Industry



Source: National Research Corporation's national consumer survey, July 2013, n size=22,717.

Embracing Transparency

Like it or not, healthcare is becoming a much more transparent industry, and this movement will continue regardless of whether hospitals and health systems willingly participate. Consumers will have access to various sources of information on the relative price and quality of healthcare services in the area, including some tools created by consumers themselves. Hospitals and health systems should readily participate in these initiatives and provide as much information as possible. In other words, as consumer-centric organizations, they should embrace price and costs as external differentiators and internal bellwethers of performance. Consumers should not have to rely on others to find such information. Transparency, however, is more than a pricing paradigm. Consumers need information on the entire payment process, including their various options. To that end, providers should consider developing and promoting the availability of payment plans/options and loyalty programs.

Consumers cannot determine the "value" of services, however, without information on both price and quality. As shown in **Exhibit 23**, moreover, they want to receive this information from hospitals (more so than from other entities).

At present, it is too easy for consumers to lump all hospitals into the box of providing "sick care" and forgetting about them until an acute problem arises. To most consumers, all hospitals are pretty much the same, and consequently the industry faces a challenge due to the perceived parity of providers. Hospitals are losing the ability to differentiate themselves, and as a result the strength of their brands continues to decline. Even as hospital brands sag nationally, those in local markets should continue to look for "bright spots." Brands can be built around high quality and convenience to the consumer, particularly when reinforced by sound strategies related to IT, virtual medicine, and price and quality transparency. In doing so, hospitals can move beyond being seen just as providers of "emergency care" and physicians can be seen as more than just providers of "routine care." As noted, the goal should be to create a one-on-one relationship with the consumer through a brand that emphasizes value and the provision of health (not just healthcare).

Consumers seem to be receptive to this type of personalized messaging. They value wellness activities as an access point to the system, including educational content, activity-based clubs, health fairs, online resources, and other programs. They also value access to telemedicine, which can be an effective way for organizations to form relationships with consumers early in their care journeys.

Consumers are sending providers across the country a strong and unmistakable message—what is important to them is changing. The leaders of hospitals and health systems must recognize these changes and adapt accordingly by changing their own views about what is important. Part of that effort involves changing how they portray themselves to the consumer.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