GOOD GOVERNANCE CASE STUDY

An Online Series by **The Governance Institute®**

Genesys Health System Tackles Pioneer ACO Challenge

PART TWO

By Elaine Zablocki, ***Staff Writer, The Governance Institute***

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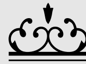

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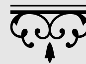

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ORGANIZATION PROFILED:

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Karen Aldridge-Eason, *Former Board Chair, Genesys Health System Board, and Foundation Liaison, Michigan Office of the Governor*
Mark Piper, *Board Member*
Marc Silver, M.D., *Cardiac Surgeon and Board Chair, Genesys Cardiovascular & Thoracic Surgery Associates*
Kenneth R. Steibel, M.D., *Former Medical Staff President*

Statement of Interest

The healthcare industry has never before experienced the degree of disruption and pace of change that the Affordable Care Act and industry events over the past few years have triggered. The CMS Innovation Center, created by the Affordable Care Act, is testing several new models for healthcare delivery and payment designed to realign payment incentives and promote high-quality, efficient care for Medicare beneficiaries—these models are known generally as accountable care organizations (ACOs). Pioneer ACOs are organizations that already have experience offering coordinated, patient-centered care, and already operate in ACO-like arrangements. In 2011, Genesys Health System and its physician partners applied for and were selected as one of 32 Pioneer ACOs, which are developing innovative models of population-based healthcare.

The Genesys story includes a number of remarkable initiatives. Since this story is rich in detail, and includes information and examples that will benefit other hospitals and health systems, this case study is divided into two parts. In Part Two, we look more closely at the system's relationship with its physicians, and how those special relationships prepared the way for Genesys' current role as a Pioneer ACO. (Part One focused primarily on new structures and processes the Genesys board has implemented within a remarkably short timeframe to prepare for changes in the healthcare delivery and payment system.)

Genesys Health System: Organization Profile

In 1992, Genesys, a member of Ascension Health, was created when four aging community hospitals agreed to form a new, integrated delivery system and build Genesys Regional Medical Center on a 478-acre campus, which opened in 1997. Today it is a teaching hospital with 250 medical students and 160 residents, home of Michigan's largest family practice residency.

The state-of-the-art, 410-bed hospital was designed as a healing environment, with a four-story atrium, decentralized nursing pods, and quiet space for patients. It is surrounded by forests and meadows, with four miles of walking trails and a 220,000-square-foot athletic/medical wellness center. This progressive, acute-care facility is augmented by an integrated continuum of care including hospice, home health, a skilled nursing facility, primary care locations, and several other outpatient/ambulatory sites located across a three-county region.

Genesys is one of the largest employers in the Flint/Genesee County region in Michigan, about one hour north of Detroit. The system created a joint-venture physician–hospital organization with 160 primary care physicians, and is designated by CMS as one of the nation's first Pioneer ACOs. Genesys focuses on culture and processes based on high reliability and Lean methodologies.

The name Genesys is based in part on the system's location in Genesee County, in part on its history of community leaders coming together to create a new beginning, and in part on its sponsorship as a Catholic healthcare ministry.

At the end of 2011, the CMS Innovation Center selected 32 organizations to participate in its Pioneer Accountable Care Organization (ACO) Demonstration Project. These organizations were chosen because they had previous experience maintaining health for a population of patients, and were prepared to move forward into the new world of fee-for-value and global payments.

"When the opportunity to become a Pioneer ACO surfaced, we were well prepared to take on that challenge," said Genesys Health System CEO Elizabeth "Betsy" Aderholdt. "CMS wants to move from a sickness model to one where improving outcomes is more financially sustainable and more holistic in nature. Those ideas were reflected in our health system's beginnings with our focus on primary care, in the architecture of our integrated continuum of care, and in our faith-based tradition."

When Genesys was formed, 160 independent family physicians joined with the health system to form a risk-sharing physician–hospital organization (PHO), a 50–50 joint venture taking full financial risk for its managed care patients. The system includes an exceptionally strong family practice residency program, and

primary care physicians have always been involved when their patients were hospitalized. "Our focus has always been on the primary care physician and their relationship with the patient, while also relying on specialist partnerships to provide the best level of care for our patient population," said Kenneth R. Steibel, M.D., past president of the medical staff. "This means we are able to provide coordinated care and effective transitions from the hospital back to the primary care setting."

In July 2009, Genesys formed three joint venture specialty co-management companies. The first company combines orthopedics, neurosurgery, podiatry, and anesthesia. The second company is the most diverse—the cardiovascular co-management company, which includes medical and interventional cardiologists, cardiac surgeons, vascular surgeons, hospitalists, anesthesiologists, and emergency services physicians. Finally, the surgical co-management company includes all the other surgical specialties: general surgery; ear, nose, and throat; OB-GYN; and urology. Together, the three companies have 64 physician investors and cover about 200 medical staff.

Fifty percent (50%) of each co-management company is owned by the physician specialists and the other half is owned by the hospital. The system pays the management company a set fee each year to manage that service line. This includes making decisions about which programs to develop or expand, equipment to purchase, policies and procedures, clinical guidelines, and strategic plans and budgets, including the capital budget. "The beauty of this model is that the physicians are right there at the table, part of the strategic and operational decision-making process, instead of inheriting someone else's decisions," Ms. Aderholdt said.

Half of the annual fee pays physicians to do the administrative work involved in developing guidelines and other processes. The other half of the payment is budgeted for "at-risk income." Each year, physicians and the system negotiate a range of eight to 12 indicators to focus on, typically including patient satisfaction, safety, and quality indicators. The "at-risk income" is paid to the physicians each quarter, based on improvements on the indicators. These indicators are carefully aligned to advance the health system's strategic plan.

> "There is a huge need for this in every community. Your organization could be the leader to drive the health of your community forward on a particular issue because you are looking for constructive solutions. Find partners and work together with them, monitor your results and learn from what you do."
>
> *—Kenneth R. Steibel, M.D.*

Each year, the co-management companies identify strategic objectives to pursue and essential equipment to support those objectives. "This is particularly helpful to me as a hospital administrator," Ms. Aderholdt said. "It requires complete transparency with the physicians. I show them how much money we have in the capital budget. We ask them, based on our mutually developed strategic plan, to set budgetary priorities. They understand why their favorite item may not make the final list, since they were an integral part of setting the strategy and budget priorities."

"The co-management companies are wonderful because they brought the specialists into the process of improving quality," said Dr. Steibel. "It is difficult for an organization to change physician behavior just by saying, 'We need to do something.' The co-management companies allowed us to incorporate input from physician leaders in defining which quality parameters could impact care in a positive way."

"The physicians, in partnership with the hospital, went through numerous 90-day quality improvement cycles, determining what our quality objectives would be," Dr. Steibel recalled. "In this way we were able to move change much quicker than I've ever seen before. The 90-day cycle improvement process slowly permeated how we do business." Genesys' co-management companies have improved CMS Surgical Care Improvement Project (SCIP) quality measures, patient fall rates, adoption and compliance with the World Health Organization surgical checklist, utilization of private consultation rooms, physician communication, patient satisfaction measures, OR first case start times, and OR room turnaround times.

Shared Savings and the Pioneer ACO Model

The CMS Innovation Center, created by the Affordable Care Act, is testing several new models for healthcare delivery and payment designed to realign payment incentives and promote high-quality, efficient care for Medicare beneficiaries.

The Medicare Shared Savings Program (MSSP) provides incentives for ACOs that meet standards for quality performance and reduce cost. In this model, participating organizations benefit from shared savings, but are not responsible for sharing losses in years when spending is higher than expected. However, after the first three years the organization must share both savings and losses. At present, more than 250 ACOs are participating in the MSSP, and additional ACOs may join the program each January.[1]

The Pioneer ACO Model goes a step further. It was designed specifically for organizations that already had experience offering coordinated, patient-centered care, and already operated in ACO-like arrangements. Throughout 2011, CMS evaluated a large applicant pool through an open competitive process, and eventually chose 32 organizations as participants.[2]

This model is designed to test the impact of varying payment arrangements in achieving the goals of providing better patient care while reducing Medicare costs. It relies on the same quality measures as the MSSP. When it comes to payments, during the first two performance years the Pioneer model uses a shared savings/shared losses payment arrangement, with higher levels of potential risk and reward than the MSSP.

During the third year, Pioneer ACOs that have demonstrated savings over the first two years will be eligible to move to a population-based payment model. That means the ACO will receive a prospective monthly payment for each covered beneficiary, intended to replace some or all of the current fee-for-service payments.

Pioneer ACOs are required to develop similar outcomes-based payment arrangements with other payers and fully commit their business and care models to offering seamless, high-quality care. Full-risk payment arrangements may continue through optional years four and five.

1 For additional information, see www.cms.gov/sharedsavingsprogram.

2 For additional information, see http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/.

The Pioneer ACO: Winning Support from Stakeholders

When Genesys learned about the Pioneer ACO opportunity, it started out with three major assets: its successful primary-care-driven PHO, its specialist co-management companies, and a system with an integrated continuum of care. But the decision was not an easy one. Over several months, the board considered the issue and consulted with physicians and other stakeholders.

Early on there were concerns about who would be involved in governance of the ACO, and who might be excluded from the process. The system board of trustees established an *ad hoc* team of board members, which met several times to educate themselves about ACO issues. "As a result, when we met with the PHO leadership, we were ready to ask the right questions," recalled former board chair Karen Aldridge-Eason. "We wanted to check whether we had an inclusive process that represented all physicians, both primary care and specialists."

"The ACO model says you'll be rewarded for keeping people healthy. This puts tension into the process because if the health system or the primary care physicians or the specialists aren't on the same page and don't buy into the vision, that can jeopardize and undermine the whole decision," said board member Mark Piper.

Genesys worked over a substantial period of time to achieve buy-in from all players. "The governing body sent out a letter describing the model," Mr. Piper said. "You have to decide if you are going to accept downside risk, and who pays for what portion of that risk. Everybody wants to sign up for the reward side, but to move to the ultimate goal of global payments, you're also going to have to sign up for the downside risk."

"When we became a Pioneer ACO, we'd had co-management companies in place for almost four years, and that was incredibly helpful," Ms. Aderholdt recalled. "Our specialists know how to work together on quality improvement measures. Now we're partnering with primary care doctors to find ways to improve processes that go throughout the continuum of care, not just inside the four walls of the hospital. We are starting with an invaluable set of trained physician leaders, based on our previous experience."

When the ACO was first contemplated, Genesys primary care physicians and the hospital started out with a long-standing partnership and joint ownership of the PHO, which would be a major player in the ACO. Specialist physicians were concerned about their role in the emerging new organization. "As providers, you really want a partnership amongst all the providers involved," recalled Marc Silver, M.D., cardiac surgeon and board chair of the cardiovascular co-management company. "The primary care physicians had assumed a substantial amount of financial risk in building the structure that was already in place and then taking on the ACO."

The specialists had multiple meetings over several weeks with PHO administration, and then with the hospital board to raise points on why they thought there should be an essentially collaborative process between specialists, primary care physicians, and the hospital. At one point, an informal group of specialists met to educate themselves on how ACOs are structured and how they're

expected to work. "We didn't want to define the specifics of how the board would function, but we did want to see essentially equal representation on the ACO board," Dr. Silver said. "When we spoke with the health system board, they thought there was sound logic to that, and ultimately that such an inclusive governance structure would benefit all parties."

Ms. Aderholdt recalled that Dr. Silver and other specialists came to talk with the board about their concerns about forming the ACO. As a result, the board looked for additional ways to embrace physician voices. "Dr. Silver now serves as a Genesys representative on the PHO board, and also on the Genesys Health System board finance committee, where he gives another physician perspective to our decisions," she said.

The Board's Continuing Oversight of ACO Progress

"The board felt a tremendous amount of responsibility in deciding to participate in the demonstration project, since Medicare accounts for 55 percent of our book of business," Ms. Aderholdt said. "Board members are committed to act as responsible stewards of our resources, and to be actively involved in monitoring this transformational process. There is no blueprint for this; no one has ever done this before."

The board and top health system leaders worked together to develop a detailed list of each board committee's specific responsibility for monitoring the ACO process, including specific objectives, how those objectives will be measured, relevant timeframes, and an executive lead person with responsibility for each objective. For example, the audit committee is responsible for budget review and internal controls for data transfer. The finance committee is responsible for reviewing service agreements, monitoring and achieving financial targets, and monitoring the adequacy of the provider network. The quality committee is responsible for achieving targets for all cause readmission rates, avoidable emergency department utilization, clinical intervention alignment, and impact on targeted improvements. The board of trustees as a whole is responsible for reviewing continuing engagement and satisfaction of stakeholders such as physician partners, health system administration, Ascension Health, continuum of care service providers, and the board itself.

"This monitoring process means that in board committees we can do deep dives to make certain each aspect of the ACO is on track, while at the full board level we review the big picture," Ms. Aderholdt said. "This well-defined process clarifies the governance oversight required, and that everyone has a role to play. We have made certain that this isn't one of those situations where the board says 'okay, sign the three-year contract and we'll monitor the financials.' This is a process that will transform our healthcare delivery system, and the board will guide and govern all aspects of the change."

Population-based health, caring for the health needs of a community, has many ramifications. It means doing a systematic community health needs assessment, prioritizing community needs, and fully integrating that list of priorities into the health system's strategic plan. The Genesys board uses its advocacy committee to focus on community health needs and solicit information and viewpoints from a wide range of community players.

Accurate Information and Community-Wide Alliances

To manage a population of patients, any healthcare system needs coordinated electronic medical records. Genesys is using Allscripts in the hospital and also in 97 percent of PCP offices, and it has achieved Meaningful Use Level One. Within 18 months, all of its care delivery sites will be fully integrated and at Meaningful Use Level Two.

"In the past, healthcare systems were only set up to take care of a patient in an episodic fashion," Ms. Aderholdt reflected. "But as we move to the ACO model, we're responsible for your care anywhere you access care—your doctor's office, at urgent care, or in your home when receiving home health services."

Genesys plans to implement dbMotion software (a data integrator) so it will be able to access a complete health record, even if some of the sites are not using their Allscripts platform. "This is important so we can view the patient's complete current record, and also so we can lean out unneeded and redundant testing," she said.

Through the support of parent company Ascension Health, Genesys will also implement Humedica software (a report writer) as an IT tool to capture patient data in a broad, extensive database. This means the health system will be able to identify groups of patients with special needs and monitor ongoing trends. "How can we design better services to help those individuals stay healthy or at least not get worse?" Ms. Aderholdt asked. "Do we have adequate services for diabetic patients? Are those services located where they are most needed? In the past, we had only fragments of information. Now, we will be able to target our resources in the most effective way."

In addition, as Genesys works to support population health within its community, it benefits from a number of community-wide alliances. The three health systems in Genesee County are working together to create a public health information exchange, called Michigan Health Connect. This summer, Genesys has been loading lab and radiology results and continuity of care documents, which are patient care summary documents that can be shared among healthcare providers. Genesys and the other health systems will next work with Michigan Health Connect to store advance directives. Creating this health information exchange means even when a patient receives care from a different health system, the systems will still be able to share information. "I am particularly excited about this initiative," Ms. Aderholdt said. "It

will mean that when someone has an advanced directive, that information can be accessed from any location. So many times, in the absence of information about a patient's wishes, the health system's default is to do everything possible. We want to create a system that is more patient-centered than that, one that respects our patients' important life choices."

Population-based health, caring for the health needs of a community, has many ramifications. It means doing a systematic community health needs assessment, prioritizing community needs, and fully integrating that list of priorities into the health system's strategic plan. The Genesys board uses its advocacy committee to focus on community health needs and solicit information and viewpoints from a wide range of community players.

"We are currently working with Ascension Health to continue to evolve our thinking about regional and national decision making," Ms. Aderholdt said. "One of the things we have learned is how essential it is for the local board to have an advocacy committee to do this sort of work. This is where our health ministry connects directly to our communities, where the board brings the community voice to the strategic planning process to ensure we focus on community needs in relation to health."

The population-based health model allows a healthcare organization to step forward and take the lead on a particular issue. "There is a huge need for this in every community," Dr. Steibel said. "Your organization could be the leader to drive the health of your community forward on a particular issue because you are looking for constructive solutions. Find partners and work together with them, monitor your results and learn from what you do."

Genesys is particularly fortunate because a community-wide health coalition has been in place in Genesee County for more than 20 years. Called the Greater Flint Health Coalition, it includes the three health systems, physician groups, academic institutions, employers, organized labor, and government. The coalition works together on gathering data and on community-wide public health issues. "We use the coalition as a venue to share what we're doing, where there may be gaps or where there may be opportunities for improved collaboration," Ms. Aderholdt said.

Evaluating Pioneer ACOs after the First Year

In July, CMS announced that nine of the 32 Pioneer ACOs had decided to drop out of the program since they had not achieved savings during the first year. Seven of the nine will participate in the Medicare Shared Savings Program instead, which means they will share gains, but will no longer be responsible for shared losses.

According to CMS, data from the first year of the Pioneer ACO program showed that all 32 participating organizations improved the quality of patient care. Costs for approximately 770,000 beneficiaries in the Pioneer ACOs grew by only 0.3 percent in 2012, while costs for similar beneficiaries who were not in the Pioneer ACOs grew by 0.8 percent during the same period. Thirteen out of 32 Pioneer ACOs produced shared savings with CMS, generating a gross savings of $87.6 million. Pioneer ACO savings were driven, in part, by reductions in hospital admissions and readmissions.[3]

"We are through year one, and CMS has yet to give us our final data. While we significantly bent the historic cost curve for our population, we are close to breaking even on the shared savings model with CMS," Ms. Aderholdt said. "Our challenges have been the impact of the national cost index on our targets, managing to cost targets that change on a quarterly basis, and the newness of the data reporting that has delayed CMS in providing us information critical to population health management."

> "How can we design better services to help those individuals stay healthy or at least not get worse? Do we have adequate services for diabetic patients? Are those services located where they are most needed? In the past, we had only fragments of information. Now, we will be able to target our resources in the most effective way."
>
> *—Elizabeth "Betsy" Aderholdt*

Genesys stakeholders are still evaluating their own experience under the Pioneer ACO program. Those who have participated closely in the process describe it as an ongoing challenge. "We have learned a great deal," Dr. Steibel said. "The first thing is to be extremely patient in making critical decisions at this level. When you decide to take your whole organization into a population care model that potentially changes how every physician will be reimbursed in the future, there is a huge impact. This is not a decision to make lightly."

During preparations for the ACO, the Genesys board considered both best case and worst case scenarios. Dr. Steibel advises organizations to be prepared for both. For example, during 2012 the early Genesys data looked very favorable, but then the second set of numbers looked like a break-even scenario, and then at one point it looked like they might be losing money. "It's a roller coaster ride, and you just have to hang on," Dr. Steibel said. He found working with CMS an interesting challenge. "You don't get data when you think you'll get data, and you can't always make decisions as quickly as you think you should," he said.

3 Centers for Medicare & Medicaid Services, "Pioneer Accountable Care Organizations succeed in improving care, lowering costs," (press release), July 16, 2013. Available at www.cms.gov/Newsroom/MediaRelease-Database/Press-Releases/2013-Press-Releases-Items/2013-07-16.html.

Accountable Care Organizations: 33 Measures of Quality

Performance Year 2013

Patient/Caregiver Experience

1. CAHPS: Getting Timely Care, Appointments, and Information
2. CAHPS: How Well Your Doctors Communicate
3. CAHPS: Patients' Rating of Doctor
4. CAHPS: Access to Specialists
5. CAHPS: Health Promotion and Education
6. CAHPS: Shared Decision Making
7. CAHPS: Health Status/Functional Status

(CAHPS = Consumer Assessment of Healthcare Providers and Systems)

Care Coordination/Patient Safety

8. Risk-Standardized All Condition Readmission
9. COPD or Asthma, Older Adults, Admissions
10. Heart Failure Admissions
11. Percentage of PCPs Who Successfully Qualify for EHR Incentive Program Payment
12. Medication Reconciliation after Discharge from an Inpatient Facility
13. Falls: Screening for Future Fall Risk

Preventive Health

14. Influenza Immunization
15. Pneumococcal Vaccination
16. Adult Weight Screening and Follow-Up
17. Tobacco Use Assessment and Cessation Intervention
18. Screening for Depression and Follow-Up
19. Colorectal Cancer Screening
20. Breast Cancer Screening
21. Blood Pressure Screening and Follow-Up

At-Risk Population

Diabetes Composite—Five Measures on an All or Nothing Basis

22. Hemoglobin A1c Control (<8 percent)
23. Low-Density Lipoprotein Control
24. Blood Pressure Control
25. Tobacco Non-Use
26. Daily Aspirin or Anti-Platelet Medication Use

Diabetes

27. Hemoglobin A1c Poor Control (>9 percent)

Hypertension

28. Blood Pressure Control

Ischemic Vascular Disease

29. Complete Lipid Profile and LDL Control
30. Use of Aspirin or Another Antithrombotic

Heart Failure

31. Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

Coronary Artery Disease Composite—Two Measures on an All or Nothing Basis

32. Drug Therapy for Lowering LDL Cholesterol
33. ACE Inhibitor or ARB Therapy for Patient with CAD and DM and/or LVSD

Source: CMS Quality Measures and Performance Standards—2013 ACO Quality Documents (www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality_Measures_Standards.html).

Implications of the Pioneer ACO for Genesys Physicians

"Your metrics change," Dr. Steibel said. "There are 33 defined quality measures that we need to address, and they are tracked on a much higher level than previously, especially in an ambulatory setting. When the data starts flowing to you, it can be eye-opening to realize there are segments of your population you believe you're caring for very well, but the initial data doesn't demonstrate it." Over time, Dr. Steibel believes he will use the data to develop processes that ensure higher-quality care, and that services are documented more accurately.

> "You have to be courageous. As part of Ascension, we are aware of national objectives, but when those objectives don't move your local community, then it isn't possible to bring physician leadership into the fold. You have to find a way to marry the needs of your community with broader goals."
>
> *—Kenneth R. Steibel, M.D.*

Specialist physicians continue to be somewhat uncertain about their ultimate role within the ACO. "Inherently we can see that one aspect of the ACO could mean lower specialist utilization, which of course means potentially less income, so every specialist has concerns about that," Dr. Silver said. "Ultimately, when you look at the services specialists provide, and the quality and efficiency we bring to the system, I think specialist physicians will continue to play a strong role." He added that in a fully functioning ACO, primary care physicians would rely on specialists to create clinical pathways, adopt quality measures, and take various steps to reduce costs and adopt best practices.

One vision for ACOs suggests that as preventive care is improved, people will be healthier and will therefore use less inpatient hospital days and fewer specialist services. Dr. Silver pointed out that maintaining health is not a simple process. "I don't think we're going to start doing some new type of preventive care and all the sick patients will go away. That's just not realistic," he said. He does see considerable prospects for more efficient care that aligns incentives and limits redundancy and unneeded tests.

Dr. Silver emphasized that the ACO is an evolving entity. "We absolutely have not worked out all the details," he said. "You start off with the idea that an organization will take a certain level of risk but still basically be on a Medicare fee-for-service schedule, with potential shared savings. Over time this is expected to shift to full capitation, where essentially the government writes one big check to the ACO, and the ACO decides how to manage that money."

In this scenario, there are a number of different options for how an organization might get from here to there. Different ACOs will choose different ways to function within this "global payments" structure, Dr. Silver suggested. Some will continue to use a fee schedule since it is familiar, and they can modify it to meet their needs. Other systems will shift to an employment model,

and yet others will do something in between. "At present, that aspect of the ACO is not fully defined, not for us and probably not for anyone else," Dr. Silver said. "As we move toward capitation, all parties are going to have a huge interest in seeing what type of reimbursement protocols will be available, what their system will adopt, and how it will impact their practice."

Genesys Pioneers: Risk-Taking Is in Our DNA

What have Genesys stakeholders learned from the Pioneer ACO process? According to Dr. Silver, "Betsy Aderholdt has been an essential ingredient in our having a chance of success at this. She isn't the sort of person who says 'I'm the CEO, this is the structure. I'm going to create and you can all do what I say.' Instead, she pulls the right people together."

He described Ms. Aderholdt's work in finding people who have real expertise and practical working knowledge in a specific area, giving them an opportunity to look at other systems to educate themselves, and encouraging them to come up with novel ideas and create a process that will function well. "That's really been a tremendous talent of hers, to encourage people who are going to work within the system and hold an area of expertise to be a core part of the design team," Dr. Silver said. "This applies to all the different components that actually make the system work. For us it is a co-management company, but for the PCPs it would be the ACO workgroups, and the same principles apply to developing a care pathway or best practices, or revamping an entire clinic. This is key. If you don't have someone like that, it will be difficult to succeed."

"You have to be courageous," Dr. Steibel said. "As part of Ascension, we are aware of national objectives, but when those objectives don't move your local community, then it isn't possible to bring physician leadership into the fold. You have to find a way to marry the needs of your community with broader goals."

Stepping forward as a Pioneer ACO is a challenging process, with twists and turns in the road. When you ask Genesys board members about the decision, they are clearly aware of risks and uncertainties in their commitment as a pioneer. For the Genesys board members, being a pioneer means that you are going to an unfamiliar place, you can't predict the exact challenges you'll face, but you have confidence you will cope effectively with new situations.

Dr. Silver methodically laid out the pros and cons of participation as a Pioneer ACO:

> "Two years from now we may look back and say this was blunder. We may take a financial loss; absolutely we have that concern. On the other hand, all the payers are looking at ACOs and deciding whether to build their own, and Medicare appears very motivated to move this forward. We are in a position where we have a reasonable chance of success at creating the ACO, hitting the cost savings we want to achieve and ending up ahead of the curve.
>
> "One way or the other, the ACO model will become a reality for all health systems. Rather than waiting for it to come down as a policy from Medicare, or just a financial reality everyone has to face, our hope is that by jumping in now and starting to build our structure, we'll have a good, functional system in place so we can be successful when the time comes."

One reason Genesys decided to take on the Pioneer ACO challenge is the community environment in which the health system has its roots. "No one here ever thought GM could fail, and yet we've seen that happen," Ms. Aderholdt said. "Our leaders have developed the mindset of looking ahead to find new ways to meet future needs. This is a community that recognizes life can change dramatically, and we must look forward to create an innovative, sustainable model. We have risk-taking in our DNA."

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