INSIGHTS

from The Governance Institute's
Fall 2013 System Invitational

Balancing Mission & Margin in an Era of Accountable Care

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Preface

The Governance Institute's Fall 2013 *System Invitational,* held November 10–12, 2013, at The Ritz-Carlton, St. Louis, brought together a distinguished group of faculty with 28 representatives from 10 health systems across the U.S. to discuss critical issues facing their organizations in today's rapidly changing environment. The meeting represented The Governance Institute's sixth invitational focused on governance and leadership within integrated care delivery systems. Such meetings are held twice a year, with each session building on the previous one.

The inaugural *System Invitational* (held in the spring of 2011) focused on the unique and ever-changing business and governance needs of healthcare systems, featuring interactive plenary sessions and small-group discussions designed to prepare organizations for the future. After the meeting, The Governance Institute produced a white paper, entitled *System–Subsidiary Board Relations in an Era of Reform: Best Practices in Managing the Evolution to and Maintaining "Systemness."* This paper laid out concrete strategies for managing system–subsidiary board relationships, expanding on many of the themes and ideas covered in the meeting. The second *System Invitational* built on the first, focusing on promoting change and forging better relationships with key stakeholders, particularly physicians. The third gathering, held in the spring of 2012, continued this discussion, with an emphasis on the need to transition from volume- to value-based payments in partnership with physicians. The fourth meeting, held in the fall of 2012, focused on the need for constant or even accelerated innovation that simultaneously improves quality and reduces costs. The fifth meeting addressed how to respond to the realities of the Affordable Care Act (ACA), including the evolving role of boards in an era of reform. After each of these sessions, The Governance Institute produced proceedings reports like this one summarizing key messages.

This most recent *System Invitational* built on these previous conferences by focusing on how health systems grappling with the ACA can continue to balance a health system's core purpose—its mission—with the need to generate revenues in excess of expenses—the margin. This task has never been easy, even in the best of economic times, as CEOs and boards work to provide the highest possible quality of care to the community while simultaneously acting as worthy stewards of the financial resources entrusted to them. As the costs of healthcare approach 20 percent of the nation's annual economic output, all stakeholders agree not only on the need to spend fewer dollars, but also to spend them more wisely. This reality, combined with the ACA mandate for greater accountability, makes balancing mission and margin more difficult—and more essential—than ever before. To help attendees deal with this challenge, this *System Invitational* focused on the many issues that managing this balance entails for health system executives, boards of directors, and clinical leaders. As with the previous sessions, this report summarizes the presentations and discussions. Additional proceedings reports will be released after future meetings in our *System Invitational* series.

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The Governance Institute thanks the faculty of the Fall 2013 *System Invitational* for being so generous with their time and expertise.

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Executive Summary

The Governance Institute's Fall 2013 *System Invitational,* held November 10–12, 2013, at The Ritz-Carlton, St. Louis, brought together a distinguished group of faculty with 28 representatives from 10 health systems across the U.S. to discuss critical issues facing their organizations in today's rapidly changing environment. This most recent *System Invitational* focused on how health systems grappling with the Affordable Care Act (ACA) can continue to balance a health system's core purpose—its mission—with the need to generate revenues in excess of expenses—the margin. This task has never been easy, even in the best of economic times, as CEOs and boards work to provide the highest possible quality of care to the community while simultaneously acting as worthy stewards of the financial resources entrusted to them. This section serves as a high-level summary of the presentations and discussion that took place at the meeting; additional details can be found in the main body of the report, which follows this summary.

Leading with Vision

Howard Putnam, who served as CEO of Southwest Airlines in the late 1970s and early 1980s before leaving to take over struggling Braniff Airlines, reviewed the critical success factors that have made Southwest the world's most profitable airline:

- **The right leaders**: Southwest's success begins with having the right leaders in place. Southwest's board of directors is made up of only six individuals, all talented and involved people who speak their minds.
- **A clear, succinct vision**: The Southwest board laid out a clear and succinct vision and mission for the company, which sees itself as being in the mass transportation (not the airline) business.
- **A culture that puts people first**: Southwest's focus on people represents the single most important ingredient in the company's success. Founder and former CEO Herb Kelleher exemplified this with an anonymous quote, "If we take care of our people, they will take care of our customers, and everything else will take care of itself."

Mr. Putnam also shared lessons for succeeding during the turbulent times that inevitably occur in every industry. Turbulence can be a great opportunity to change things for the better. The key to success lies in being prepared to respond appropriately when the turbulence arrives. Other important lessons for succeeding during these times include the following:

- **Figure out the current "stage" of turbulence**: Turbulence has different stages and leaders need to figure out which stage they are in and how to respond accordingly.
- **Promote honesty and transparency**: Mr. Putnam's tenure at Braniff highlights the importance of honesty and openness in the face of turbulence and major challenges.
- **Start with "why" (not "what" or "how"):** Most companies start by thinking about "what" products and/or services to offer, and "how" to do so. Highly successful and sustainable companies like Apple, however, start with the "why"—that is, what is the purpose and passion of the company, and what inspires its employees and customers?
- **Consider selling an experience**: Companies offering products or services can quickly become commoditized. Companies that sell an experience often become successful brands.
- **Simplify**: Everyone worries during times of turbulence, so success depends on removing unnecessary complexity, which can be distracting.
- **Once on a sound course, stay there:** Success during turbulent times does not necessarily mean constant changes or abandoning one's strengths. Southwest has spent the last 30-plus years carrying out the same basic vision put in place in 1979 after deregulation.

When the Business Is Ministry

Two senior leaders at Ascension Health—Sister Maureen McGuire, executive vice president of mission integration, and Katherine Arbuckle, senior vice president and CFO—discussed how Ascension Health focuses on its mission as its core business.

The "no margin, no mission" mantra has, over time, been reinterpreted by some to mean that the organization's mission resides in its margin. For Ascension, that interpretation is not viable. Rather, Ascension focuses on financial stewardship as a way to fund the mission, which is the central focus for the whole business. The dedication to mission can be especially useful during challenging and turbulent times. Ascension has embarked on a number of major initiatives designed to take advantage of the challenges facing the industry today, with the goal of transforming the business in service to the mission:

- **Creating an organizational structure for the future**: As the inpatient business continues to downsize, Ascension is creating new business entities to support and even expand the mission. The goal is to reorganize for growth in new, nontraditional areas.
- **Moving to person-centered care**: Ascension is optimizing the provision of holistic, reliable, and safe person-centered care. To that end, Ascension is standardizing clinical processes and implementing safety protocols to enhance the patient experience and outcomes and reduce costs.
- **Consolidation and standardization**: In response to increased complexity and cost pressures, Ascension plans to consolidate and standardize so as to elevate the level of

expertise within the organization, better manage vendors, broaden the scale of operations, optimize investments, ensure use of best practices, and maximize the value of outsourcing.

- **Better operational management**: Ascension's integrated scorecard covers the top 12 to 15 mission-critical areas where leaders measure performance. All operating units become accountable for achieving performance targets in these areas, with a special emphasis on meeting the needs of the poor and vulnerable.
- **Managing resource disparities**: Ascension leaders expect that a range of operating margins will exist throughout the organization, with some ministries operating at breakeven or even losing money while others generate positive margins. The overall goal, however, is to generate enough cash to reinvest in the needs of the local communities being served. Leaders work diligently to avoid allowing one ministry to significantly deplete the resources of others.

Maintaining the Ascension ministry requires a community of inspired people—associates able to consistently provide healthcare that works, is safe, and leaves no one behind. To that end, Ascension's Model Community initiative represents the organization's commitment to its associates for their full flourishing, both personally and professionally, and, in turn, the associates' personal commitment to the ministry and one another, all in service to the mission. As part of this commitment, Ascension has made substantial investments in stewardship of talent and formation and development of leaders.

Key Takeaways and Implications for Health Systems

System Invitational attendees broke into small groups in which representatives from each system discussed the major implications of the material presented by Mr. Putnam, Sister McGuire, and Ms. Arbuckle. Key points include the need for the following:

- A simple, clear, and compelling mission statement
- Hiring and affiliation decisions based on the mission
- Innovation and transformation
- Population health management across the continuum
- Adequate size and scale to be relevant
- Reengineering of costs
- Appropriate metrics to measure success
- Clinical consolidation

Making the Toughest Choices in the Era of Accountable Care: Will Restructuring the Healthcare System Succeed?

Stuart Altman, Ph.D., the Sol C. Chaikin professor of national health policy at Brandeis University, discussed whether the current changes being made, including bundled payments, accountable care organizations (ACOs), and others, will be enough to meet external pressures for cost control and quality improvement. To date, two major strategies have been attempted to respond to these pressures:

- **Supply-side approaches**: The first strategy involves changing payment systems to give providers a fixed amount of money, letting them decide what care the patient needs. Both ACOs and bundled payments represent versions of this strategy.
- **Demand-side approaches**: The second major approach tackles the demand side of the equation by giving patients greater financial responsibility through high-deductible health plans (HDHPs) and/or high coinsurance rates, combined with limited provider networks and price and quality transparency.

While these two approaches can work together in complementary fashion, they also may work against each other. With both approaches, the key to success lies in offering high-quality primary care and in limiting post-acute care spending. Concerns do exist, however, about whether ACOs and bundled payments will work as currently configured. At present, most ACO and bundled-payment programs have adopted a shared-savings approach rather than giving providers fixed budgets that put them at full risk. In addition, patients have the right to opt out of the ACO network, making it harder for providers to control costs. At present, participation in ACOs and bundled payments remains voluntary, and many important organizations have chosen not to participate thus far. Those that are continue to struggle in the "never-never" land where some revenues are based on fee-for-service (FFS) contracts and other revenue comes from partial or full global payments. Not surprisingly, first-generation ACOs have only had limited success to date.

Looking ahead, Dr. Altman sees three potential paths for the U.S. healthcare system:

- **Status quo:** Under this option, the system continues on its current course, with spending set to reach $3 trillion and 20 percent of gross domestic product (GDP).
- **Demand and/or supply side reform:** This strategy involves restructuring of the payment system to reward lower costs and higher value through the aforementioned supply and/or demand side reforms.
- **Regulations:** This option features broad-based price and/or spending regulations at the federal or state level.

Most stakeholders have rejected the status quo option, as the U.S. healthcare system seems to have reached a "brown-out"

stage where money is no longer available to fund cost increases year after year. Most also do not like the idea of significant new regulations. For this reason, efforts to date continue to focus on demand and supply side reform, although there is no consensus on whether one is better than the other. For their part, employees (and their employers) continue to migrate toward preferred provider organizations that offer broader networks than do ACOs. If supply and demand side reforms end up working, growth in healthcare spending will moderate to levels in line with growth in GDP, and the likelihood of more draconian regulation diminishes. If these efforts fail and the status quo returns, however, regulations will be put in place that require tighter spending controls.

Changing Physician Behavior and Practice in a Value-Driven World: What Will It Take?

Robert M. Wachter, M.D., professor and associate chairman of the Department of Medicine and the chief of the Division of Hospital Medicine at the University of California, San Francisco (UCSF), discussed strategies for changing physician behavior and practice patterns as healthcare progresses toward a more value-based system.

Doctors are critical to the successful transformation of the system, and those attempting such reform need to understand how they act and think. Success depends on understanding and taking advantage of four key characteristics of physicians, as outlined below:

- **Competitive overachievers**: Physicians are used to getting straight "As" in school. Those trying to influence their behavior should recognize and take advantage of this fact. For example, physician "report cards" that compare performance with peers may be a way to catalyze action and behavior change.
- **Individualistic nature**: Doctors can no longer hold all the information they need to manage care effectively in their heads, nor can they master all the necessary skills. The system matters more than the individual doctor in terms of determining the patient's outcome. Physicians are beginning to accept this reality and see the value of standardization, and the advent of electronic medical records (EMRs) is accelerating this process. Going forward, the key will be to leverage EMR systems to provide decision support to physicians and support changes in their practices without sparking a revolt among physicians who still value their autonomy.
- **Not entirely economics**: Like all professionals, physicians are motivated by more than dollars. Consequently, the instinct to use money as a tool for changing behavior may not always prove to be correct. In some cases, social norms will prove to be more powerful than money.
- **Taught to care for individuals, not populations or systems**: Physicians have been trained and socialized to care and advocate for individual patients, not populations or systems. Malpractice fears reinforce this view, as do real-world experiences and emotions. The fundamental challenge, therefore, is to create structures to help physicians think about managing population health and not just individual patients.

Key Takeaways and Implications for Health Systems

System Invitational attendees broke into small groups in which representatives from each system discussed the major implications of the material presented by Dr. Altman and Dr. Wachter. Key points include the need for the following:

- Strong physician leaders
- Significant investment in physician change and leadership
- Changes to the medical school curriculum
- Investments in the workforce
- Appropriate quality improvement methodologies
- Creative use of incentives, including payments that reward quality and eliminate FFS medicine

New Scale and Margin Realities as Healthcare Consolidates

Mark Grube, managing director at Kaufman, Hall & Associates, Inc., discussed new realities related to scale and margins as health systems respond to external pressures to improve care and better serve local communities.

The healthcare industry finds itself at a second "inflection point" with respect to costs. (The first occurred around the time of the financial crisis in 2007 and 2008.) This inflection point is characterized by six trends:

- **Employer and insurance market transformation**: Employers and insurers are playing a key role in the transformation of the insurance market, moving employees into defined contribution plans (often with high deductibles coupled with health savings accounts), public and private health insurance exchanges, direct contracting, and Medicare and Medicaid managed care initiatives that rely on value-based rather than FFS payment systems.
- **Healthcare as a retail transaction**: Employers are shifting financial risk to employees, making them feel the economic consequences of their choices and become much more interested in having access to information on provider cost, quality, and customer satisfaction performance. In essence, healthcare is transitioning from a wholesale to a retail business, which has made consumers more responsible for their behaviors and choices and hence more interested in transparency.
- **Population health management as a business problem and opportunity**: Organizations are competing to become population health managers that coordinate and manage care to improve the overall health and well-being of a population of patients under a risk-bearing contract.
- **Flat-to-declining use of inpatient services**: Many states have experienced significant declines in discharges per 1,000 residents, even those with historically low rates of inpatient use. These declines appear to be the result primarily from structural factors within the healthcare system rather than recessionary factors. As a result, they will likely continue.
- **Mega-system formation**: Within the last few years many large organizations have formally merged, creating "mega systems" that compete locally, regionally, and nationally.
- **Emergence of new competitors**: Whenever major disruptions occur in an industry, individuals and organizations with

a different perspective often enter the market and address problems in a fundamentally different manner. Nowhere is the emergence of these new types of competitors more prevalent than in healthcare.

These trends all point to one large message for health system leaders—there is a critical need to become bigger. Additional consolidation (including larger deals) will be required to remain relevant, assemble the intellectual and financial capital required to succeed, and absorb and manage risk. The key question is how big is "big enough"? To achieve a predictable level of performance, provider systems need to cover at least 250,000 lives (equivalent to approximately $1.2 billion in revenue). Many systems, however, will not stop consolidating when they reach this size. Kaufman Hall anticipates that ultimately there will be between 200 and 400 integrated health systems (and perhaps fewer). Large markets will likely be home to three or four systems, while smaller ones will have just one or two. Most systems will generate between $4 billion and $8 billion in annual revenue.

Education, Patient Safety, and Reimbursement: Innovative Strategies for Maximizing Quality and Reimbursement in an Era of Accountable Care

Jeffrey D. Lowenkron, M.D., M.P.P., CEO of USF Physicians Group, reviewed innovative strategies for maximizing quality and reimbursement. He noted that too many health systems are still organized as "silos," with each department run separately and performance measured on a department-specific basis. Before Dr. Lowenkron arrived at USF, department heads acted as CEOs of their own companies. Organizations run in this manner need to experience a minor (or perhaps major) disruption. Dr. Lowenkron created such a disruption shortly after his arrival at USF through the following operational changes: streamlining management and encouraging innovation; requiring and enforcing non-compete agreements with physicians; developing business rather than funding plans; and revamping compensation systems to incorporate productivity, service, and quality.

He also began encouraging a new way of thinking about managing health, with a focus on early interventions to prevent declines in health status. Under his leadership, USF has embarked on several major initiatives designed to disrupt the current system and teach doctors and patients this new paradigm of early intervention:

- **New way of selecting and teaching medical students**: Most medical schools accept applicants in the 99th percentile academically, with little or no attention paid to interpersonal skills (e.g., level of empathy, ability to communicate) or creativity. This approach misses a fundamental truth, which is that the best doctors tend to be highly creative and empathetic and skilled at talking with patents. USF launched the USF Health MCOM SELECT Program in partnership with the Lehigh Valley Health Network (located 1,100 miles away in Pennsylvania). Under this program, the medical school considers a larger pool of candidates—anyone scoring in the 92nd percentile or above on academic criteria. Those meeting that hurdle are then screened for emotional intelligence, and those accepted are taught using a revamped curriculum.
- **Partnership to improve community health**: USF launched the America's Healthiest Hometown initiative in partnership with The Villages, the largest active living community in the country for those 55 and older. The partnership features a building dedicated to public health activities, two primary care centers (with three more opening soon), and a new specialty care center. A major insurer in the area recently introduced a Medicare Advantage plan that offers a $0 premium and $0 copayment for primary care visits to residents.
- **Simulation center**: USF developed the Center for Advanced Medical Learning and Simulation (more commonly known as CAMLS), which offers simulation technology, team training, research and innovation, and other evidence-based programs taught by experienced peers who help clinicians transition to the new value equation. The center also allows the field of medicine to investigate important questions that need to be answered to deliver high-value, appropriate, cost-effective care.

Key Lessons for CEOs and Boards

Dr. Lowenkron and other faculty members challenged health system leaders to similarly disrupt their own systems. To get started, these leaders need to ask themselves tough questions related to their organization's ability and readiness to succeed during the ongoing transformation in healthcare:

- What are you doing now as payment mechanisms change?
- From what data are you speaking?
- How will you know you are right?
- How much is it worth to be right?
- How much will it cost to be wrong in terms of quality, safety, service, or costs?
- How have you aligned your physicians and staff to welcome the change?
- How confident are you that when the door is closed, people are doing the work you really want them to do?

Leading with Vision

Howard Putnam served as CEO of Southwest Airlines in the late 1970s and early 1980s, before leaving to take over Braniff Airlines as it struggled financially. He played an instrumental role in turning Southwest into what many would call the most successful airline in the world. Beginning with three planes serving three Texas cities (Houston, Dallas, and San Antonio), Southwest is now the world's third largest airline as measured by passengers carried.

Critical Success Factors

Mr. Putnam laid out the critical factors Southwest used to achieve this success.

The Right Leaders

Southwest's success begins with having the right leaders in place. Southwest's board of directors is made up of only six individuals, all talented and involved people who speak their minds. By contrast, Braniff had a very weak group of directors unwilling to speak their minds. Rather, they acted as "puppets," giving in to an egotistical CEO's demand for substantial, rapid expansion after deregulation.

Boards will be critically important to the future of successful health systems. Effective board members bring skills and experience that fill a specific need within the organization, and speak honestly and openly when they disagree with the CEO or each other.

A Clear, Succinct Vision

The Southwest board laid out a clear and succinct vision and mission for the company, which sees itself as being in the mass transportation (not the airline) business. Southwest not only competes with other airlines, but also with automobiles, trains, buses, and even the living room (i.e., people who stay home), with the ultimate goal being to convince more people to travel and to choose a plane to do so. Success depends on offering safe, reliable transportation at very low prices.

For their part, health system leaders also need to figure out what business they are in—healthcare may be the product, but it likely is not the fundamental business in which health systems compete.

A Culture That Puts People First

With good leaders and a clear mission and vision in place, the next step is to develop a culture that supports the mission. At Southwest, that culture puts people first, and that focus on people represents the single most important ingredient in the company's success. Founder and former CEO Herb Kelleher exemplified this with an anonymous quote, "If we take care of our people, they will take care of our customers, and everything else will take care of itself."

The process of putting people first begins with hiring. Southwest's hiring strategy is different than that used by many other companies. Rather than being concerned with experience or skills, Southwest looks specifically for people with the right attitudes and with a passion for the work. Specifically, Southwest looks for people with cheerfulness, optimism, strong decision-making capabilities, a love of customers, team spirit, strong communication skills, self-confidence, the ability to be a self-starter, and a good sense of humor. Due to its reputation for investing in people, Southwest attracts many resumés and can afford to be very picky when hiring. In 2012, Southwest received 114,000 unsolicited resumés for employment, and hired only 2.5 percent of these individuals (making getting a job at Southwest harder than getting into Harvard).

> "We hire attitudes and develop skills."
>
> —*Howard Putnam*

After finding the right people, Southwest spends a lot of time and money training and preparing them. As Mr. Kelleher noted, "when the time to perform arrives, the time to prepare has passed." However, Southwest does not micromanage its employees. With the right attitude and training, they are free to experiment and innovate, and will not be reprimanded for making a mistake. (The only exception to this rule relates to passenger safety, as Southwest strictly forbids anything that could jeopardize safety. In its history, the airline has had only one crash that caused a fatality, when a plane skidded off the runway into a street in Chicago, killing a little boy who was a passenger in a car.)

Southwest seldom has to fire anyone. Most employees love their jobs and do not think of them as "work" they have to do. Rather, they enjoy what they do. In addition, the culture at Southwest creates a family-like atmosphere where peer

pressure and a sense of familial obligation encourage everyone to do their part. Southwest also started profit-sharing with employees very early in its history, giving everyone a financial stake in the company's success. Even though employees are unionized, little tension exists between the union and the company. While most airlines have suffered numerous strikes, Southwest has had only one—a brief machinist strike that ended after only a few days when other employees (i.e., the pilots) crossed the picket lines.

Succeeding during Turbulent Times

Like healthcare systems today, Southwest Airlines faced significant turbulence during the era of airline deregulation. Southwest leaders decided to stick with the company's core strengths as a provider of short-haul mass transportation services. They used these strengths to expand slowly over time to become the world's third largest and most profitable airline.

In the meantime, one of its major competitors—Braniff—lost its way by abandoning its strengths as a short-haul carrier and instead quickly trying to expand into the largest airline in the world. Highly successful under regulation, Braniff entered deregulation by borrowing $500 million to buy more planes. This strategy stemmed from the CEO, an arrogant individual who refused to listen to anyone who warned him of problems. The board of directors went along with the CEO for far too long, in part because he lavished board members with perks, such as first-class flights and free stays at his multiple homes around the world. The board eventually fired the CEO, but by then it was too late. The board initially replaced the CEO with one of his subordinates, only to get six additional months of the same ill-conceived strategy and excessive spending. In a move he now recognizes was a mistake, Mr. Putnam agreed to take over as CEO, intrigued by the challenge of turning the airline around. Together with the chief financial officer, Mr. Putnam left Southwest only to find an even bigger mess at Braniff than he ever anticipated. The information Braniff provided as part of his due diligence proved to be inaccurate and misleading. Spending had been even more rampant than he had been led to believe, and the company had only 10 days cash on hand ($175 million less than he had been told). Mr. Putnam took quick actions to address the situation, including weeding out all but two board members, eliminating 22 vice president positions, and getting rid of entire departments. But with $1 billion in debt, 18,000 unsecured creditors, and 10,000 employees to pay, these actions only delayed the inevitable. Braniff ran out of cash seven months after Mr. Putnam came on board, and had to file for bankruptcy protection.

As these stories make clear, Southwest and Braniff responded very differently to the turbulence created by airline deregulation. The same thing will likely happen in the healthcare industry in response to the ACA. While the turbulent times created by major changes such as deregulation or new legislation cannot be avoided, the negative consequences of such turbulence can be.

Turbulence can be a great opportunity to change things for the better. But the key to success lies in being prepared to respond appropriately when the turbulence arrives. As noted earlier, the preparation and training must come early, because it is too late once the situation presents itself. For example, Captain Sully Sullenberger was able to successfully land an Airbus 320 plane that had lost all power in its engines in the Hudson River only because he had prepared for such a situation. He had glider training early in his career and he and his co-pilot had routinely practiced crew resource management and hence treated each other as equal partners during the flight.

> "Turbulence is inevitable, but misery is optional. Something goes wrong every single day; the key is to make it work for you, not against you."
>
> *—Howard Putnam*

The Importance of Honesty and Transparency

Mr. Putnam's tenure at Braniff highlights the importance of honesty and openness in the face of turbulence and major challenges. Mr. Putnam became the victim of a lack of honesty when he came to Braniff only to find the situation much worse than he had been led to believe. While he could not prevent the company from going into bankruptcy, he did position it to emerge out of bankruptcy and operate again as a successful airline for many years. His ability to do that stemmed in large part from the decision he made to be open and honest with the company's 10,000 employees. Shortly after arriving at Braniff, he sent a one-page letter to each employee's home that honestly laid out the situation the company faced, including that it might not survive. In the letter, he asked for three suggestions on how Braniff could grow revenues, cut costs, and/or increase productivity. By writing directly to employees, Mr. Putnam reached their hearts and

minds, and helped improve their morale and trust in management, even in the midst of the horrible situation the company faced. At best, Mr. Putnam expected 500 responses to his 10,000 letters. He ended up getting six times that amount. In the original letter, he promised a personal response to everyone who wrote him back. It ended up taking him 45 days to honor this commitment, spending every spare moment he had writing the 3,000 personal responses. These employees had never before had any communication with senior leaders at Braniff, let alone have the CEO ask them their opinion.

Starting with "Why" (Not "What" or "How")

Sustainable organizations start with a "flight plan" that guides them through turbulent times. Most companies start by thinking about "what" products and/or services to offer, and "how" to do so. Highly successful and sustainable companies like Apple, however, start with the "why"—that is, what is the purpose and passion of the company, and what inspires its employees and customers? At Southwest, the purpose and passion was to get people to leave their cars, buses, trains, and living rooms and board planes as a mode of transportation.

Key Lessons and Takeaways

Mr. Putnam closed his presentation by reviewing the following lessons from his experiences at Southwest and Braniff:

- **Figure out the current "stage" of turbulence**: Turbulence has different stages and leaders need to figure out which stage they are in and how to respond accordingly.
- **Consider selling an experience**: Successful companies like Apple do not simply play the game; rather, they change it. Companies offering only products or services can quickly become commoditized and relegated forever to the role of vendor or supplier. Companies that sell an experience, however, often become successful brands.
- **Simplify, simplify, simplify**: Everyone worries during times of turbulence, so success depends on removing unnecessary complexity, which can be distracting. Mr. Putnam and his peers spent several days hammering out the company's vision statement focused on positioning Southwest in the mass transportation business. He then spent a lot more time hammering home this message to key stakeholders. Under the ACA, the business of health systems might change as well.
- **Create the right culture**: After determining the appropriate vision and mission, the focus turns to creating a culture that can support realization of that mission. A focus on safety, innovation, and transformation must come from above.
- **Once on a sound course, stay there:** Success during turbulent times does not necessarily mean constant changes or abandoning one's strengths. As authors Jim Collins and Morten Hansen note in *Great by Choice*,[1] Southwest has spent the last 30-plus years carrying out the same basic vision put in place in 1979 after deregulation. All of the turbulence and transformation that affected the industry did not mean Southwest had to abandon its core niche or change course every year. Rather, Southwest stuck with (and standardized) what worked well and got rid of what did not.

1 Jim Collins and Morten T. Hansen, *Great by Choice,* Harper Collins, 2011.

When the Business Is Ministry

Two senior leaders at Ascension—Sister Maureen McGuire, executive vice president of mission integration, and Katherine Arbuckle, senior vice president and CFO of Ascension Health—discussed how Ascension Health focuses on its mission as its core business.

Treating the Mission as the Business

The "no margin, no mission" mantra has, over time, been reinterpreted by some to mean that the organization's mission resides in its margin. For Ascension, that interpretation is not viable. Rather, Ascension focuses on financial stewardship as a way to fund the mission, which is the central focus for the whole business. The goal is to engage all key stakeholders to understand that the organization and the mission are one and the same. Reaching such an understanding can be quite powerful, as the Southwest Airlines story demonstrates. It allows for the financial strategy to be executed on behalf of the mission, with the mission driving the margin (not vice versa).

Once leaders begin to think of the core mission as the business (with no tradeoff between margin and mission), they can start to shape the experience of their customers and the employees who serve them and can make decisions related to creating new models of care delivery. As depicted in **Exhibit 1**, Ascension Health has embarked on a number of major initiatives shaped by the organizational mission, including a team that works on the delivery of holistic, reverent care designed to improve the experience of patients and a "healing without harm" initiative focused on safety and reliability.

Exhibit 1: Some Aspects of Care Strategy Shaped by Mission

Source: Ascension Health.

Once mission is understood to be the core business, leaders can embed systems within the organization to reinforce execution of that mission. For example, Ascension Health has long tied a portion of risk-based compensation to the provision of charity care and community benefit. This practice holds everyone accountable for increasing the resources allocated to the most vulnerable in the community.

Responding to Challenging Times

The dedication to mission can be especially useful during challenging and turbulent times, particularly for an organization like Ascension with a long history of pursuing the mission. During these times, Ascension leaders look back to those who began the ministry, which helps to instill a sense of courage and optimism in them, reinforcing their deep sense of conviction and purpose. As a result, Ascension leaders are able to follow Mr. Putnam's advice, viewing challenging times as an opportunity to build a better future for everyone. To that end, Ascension has created a vision that calls for the delivery of person-centered care, with an ongoing relationship with each person (including those who live in poverty and have complex needs) across the many and varied settings that make up the full continuum of care. That includes many settings beyond hospitals.

Without question, the healthcare industry is in the midst of challenging times. The watchword of the moment is

"unsustainable," a word that has been used to describe the size of the federal budget deficit, the annual increase in the amount of money spent on Medicare and state Medicaid programs, the proportion of gross domestic product (GDP) spent on healthcare (16 percent in 2011[2] and predicted to continue to rise), and the ongoing transferring of costs to employees and consumers.

As Ascension's founders did many years ago, Ascension's current leaders embrace these challenges as an opportunity to better provide for unmet needs. They recognize that opportunities to boost income through growth in inpatient care or increases in commercial insurance rates are quite limited. Rather, success must come from better management of population health and from fundamental changes in underlying cost structures. To become competitive with other developed nations, the U.S. healthcare industry as a whole will need to cut costs by 30 percent. Success will require a radical change in the basic care model, including relationships between hospitals, doctors, and patients. It will also require leadership in palliative and end-of-life care. This transformation must be achieved without undermining the ability of those who are poor to access the system.

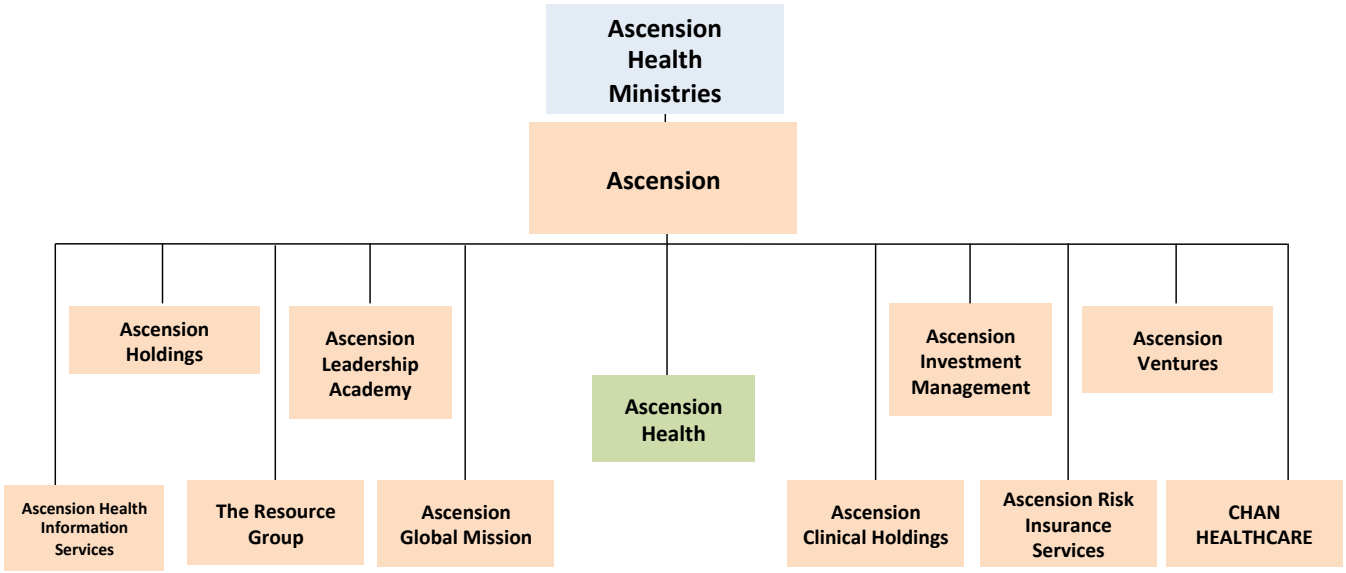
In 2011, Ascension leaders embraced this new, challenging reality by developing a "point-of-view" document that articulates how the organization will continue to meet its mission and the unmet needs of the communities it serves in a world of uncertainty and declining revenues. To that end, it lays out four key initiatives:

- **Meeting healthcare needs** by reconfiguring and redesigning how the organization works today, including its care delivery processes and cost structures.
- **Achieving high-quality, low-cost care** by creating a strong regional presence with integrated physicians and capabilities across the care continuum. As part of this effort, Ascension will partner with others or exit businesses in areas where it does not have an adequate presence.
- **Achieving sustainability** by developing a continuous, dynamic relationship (including risk-sharing) with purchasers. Thus far, Ascension has found that many payers still do not want to share the risk.
- **Health management for defined populations**, including rapid assessment of their needs and the assembly and development of the necessary capabilities to meet them.

Living the Mission

Ascension has embarked on a number of major initiatives designed to take advantage of the challenges facing the industry today, with the goal of transforming the business in service to the mission.

Exhibit 2: Creation of New Business Entities to Support Ministries and Community



Source: Ascension Health.

2 Congressional Budget Office, "Federal Spending on the Government's Major Health Care Programs Is Projected to Rise Substantially Relative to GDP," September 18, 2013. Available at www.cbo.gov/publication/44582.

Area #1: Creating an Organizational Structure for the Future

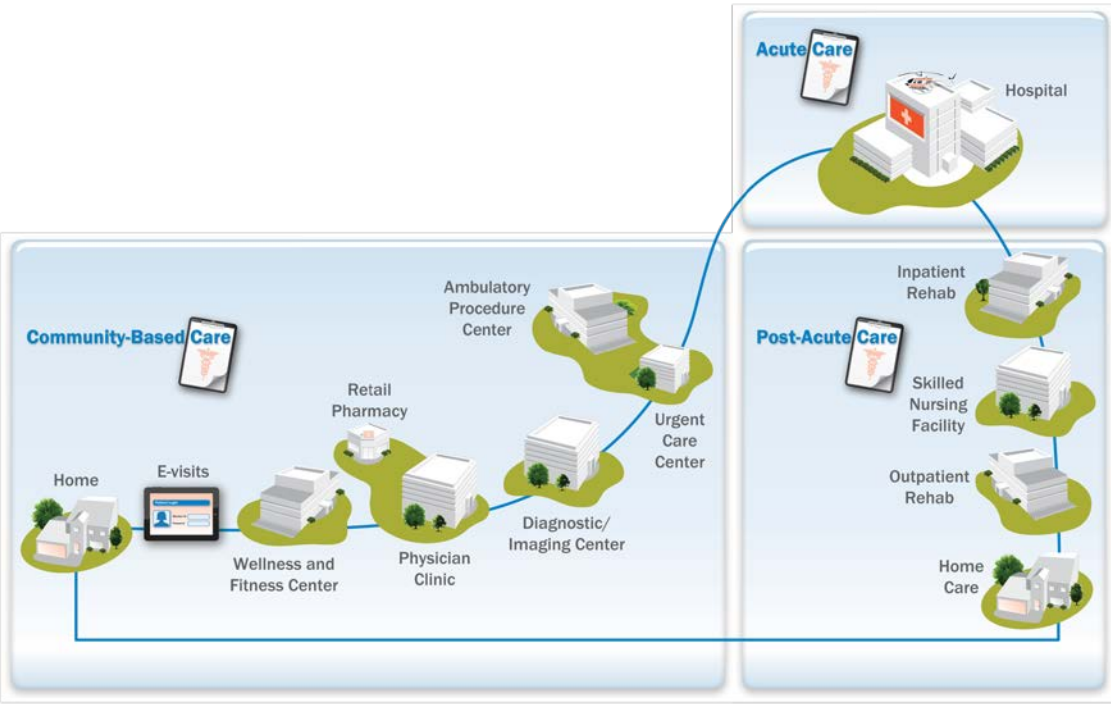
As the inpatient business continues to downsize, Ascension is creating new business entities to support and even expand the mission. The goal is to reorganize for growth in new, non-traditional areas. Recognizing that the organization's size brings scale, Ascension leaders are working to bring needed services to other systems, both inside and outside the healthcare arena. This strategy has allowed for the expansion of multiple services such as biomedical engineering, investment management, supply chain management, and others. As depicted in **Exhibit 2**, new business entities have been created and expanded to support Ascension's ministries and the greater community. New entities include a resource group that purchases on behalf of Ascension and other organizations; a central IT department that works to standardize IT systems across the entire organization (a very challenging task); a physician management company that serves Ascension-affiliated and other practices; an investment management firm; and Ascension Ventures, which focuses on identifying innovative start-up companies that have the potential to change healthcare in a fundamental way (e.g., through telemedicine). As part of this effort, Ascension has embarked on many more joint ventures than in the past, sometimes engaging in non-traditional partnerships.

As shown in **Exhibit 3**, Ascension is also working to redesign the delivery system to focus on the entire care continuum, including community-based, acute, and post-acute care. This system has helped to reduce costs by emphasizing prevention and wellness (rather than acute services), patients and populations (not providers), and a continuum of accessible care (not individual facilities).

Area #2: Moving from Patient Care to Person-Centered Care

Ascension is working to optimize the provision of holistic, reliable, and safe person-centered care, which its leaders view as fundamental to the organization's mission. To that end, Ascension is standardizing clinical processes and implementing safety protocols to enhance the patient experience and quality outcomes and reduce costs. Success requires collaboration with community stakeholders to identify and implement best practices. In some cases, implementing these practices

Exhibit 3: Sg2 System of CARE™



Source: Ascension Health.

might require the organization to sacrifice revenues in today's fee-for-service (FFS) payment environment. As depicted in **Exhibit 4**, this effort has worked well, with performance on many indicators of safety and quality above national averages.

Much of this success stems from the standardization of clinical processes in areas such as: early identification of sepsis, blood use after surgery, neonatal care, oral and intravenous drugs, palliative care, and hospice care. Historically, variations in clinical practices have led to wide variations in costs and outcomes. Standardization helps to provide patients and families with the best possible outcomes at affordable costs. To that end (and consistent with Ascension's mission), various groups with disparate interests and points of view have come together to identify, champion, and adopt best practices. Success has been driven by engaging the clinician community in this process.

Area #3: Consolidation and Standardization

In response to increased complexity and cost pressures, Ascension plans to consolidate and standardize so as to optimize the level of expertise within the organization, better manage vendors, broaden the scale of operations, optimize investments, ensure use of best practices, and maximize the value of outsourcing. Considerations during this process include the impact on associates and the benefits that will accrue to those the organization serves and their families, caregivers, and communities. While care strategies and collaborations will generally remain locally operated, some functional areas may be standardized and consolidated, including facility management, billing and collections, patient registration, staffing models (which are becoming more flexible), some clinical processes, physician practice management, and IT solutions. In all cases, changes are being made only after receiving collective input from key stakeholders about the best design and solutions.

As an example of the benefits that can be achieved through consolidation and standardization, Ascension Health is reorganizing 12 internal business offices for revenue cycle management (responsible for managing $7 billion in revenues across 26 sites), leading to faster and more accurate resolution of bills and lower costs due to use of shared technology, more rapid deployment of best-practice solutions, and creation of better backup systems. At the same time, department employees now have more opportunities for growth.

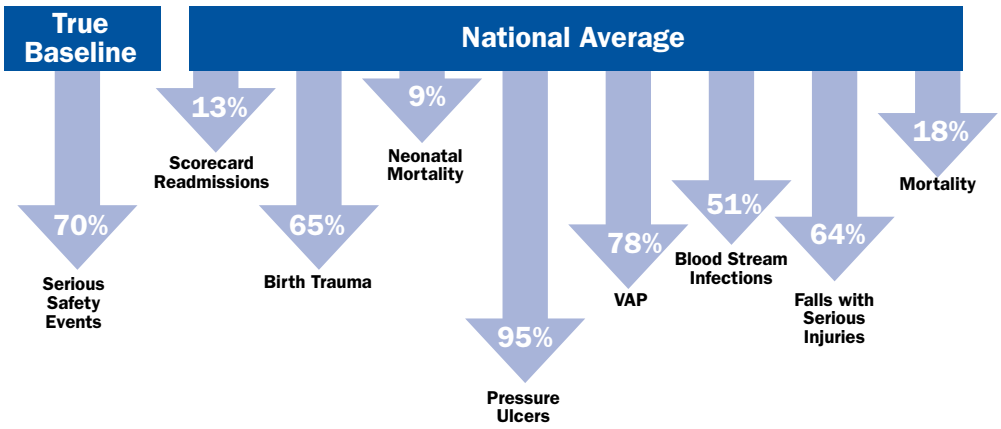
Area #4: Operational Management

The daily management of a complex enterprise requires the regular preparing of budgets, monitoring of performance, evaluation of leaders, and prioritization of investments and spending. As depicted in **Exhibit 5**, Ascension's integrated scorecard covers the top 12 to 15 mission-critical areas where leaders measure performance (including palliative care). All operating units become accountable for achieving performance targets in these areas, with a special emphasis on meeting the needs of the poor and vulnerable.

Area #5: Managing Resource Disparities

Ascension leaders expect that a range of operating margins will exist throughout the organization, with some ministries operating at breakeven or even losing money while others generate

Exhibit 4: Patient Safety



- **Sharing evidence and discussion, standardization has improved patient safety.**
- **Once positive results were demonstrated, adoption was faster.**
- **We championed these improvements with Medicare and others.**
- **We pursue safety despite resultant revenue losses.**

Source: Ascension Health.

positive margins. The overall goal, however, is to generate enough cash to reinvest in the needs of the local communities being served. To determine the expected level of margin, Ascension considers a variety of factors, including community need, available support, demographics, payer mix, and reimbursement rates. Some cross-subsidization occurs across ministries, but leaders work diligently to avoid allowing one ministry to significantly deplete the resources of others. They achieve this by applying their collective judgment and knowledge related to the ministries and the communities they serve, including historical factors that may be at work. Often a broad array of leaders will become involved in these discussions, and these leaders work hard to remain focused on the health ministry as a whole. In some situations, the decision may be made to downsize a particular service. For example, in one market, inpatient services may be downsized and will only serve Medicaid beneficiaries in the future. Decisions are being based on the collective judgment of where it is best to allocate scarce capital, since investments often represent "big bets" on the future of a market or service.

Other Examples of Business Decisions Grounded in the Mission

Countless other examples exist of Ascension leaders making business decisions grounded in the organizational mission. A few additional innovative examples include:

- Paying a living wage to associates in every location
- Adjusting the required contribution to health benefits for associates based on income
- Implementing person-centered facility standards that eliminate use of high-cost, inefficient space
- Committing to being "green"
- Offering discounts to the uninsured based on what insurers pay (not charges)
- Providing counseling, outplacement, and spiritual support when reductions in force become necessary

Building a Model Community for the Mission

Engagement, alignment, commitment, and accountability are the four pillars that have allowed Ascension leaders to instill a sustainable culture into the organization. Maintaining the Ascension ministry requires a community of inspired people—associates able to provide on a consistent basis healthcare that works, is safe, and leaves no one behind. To that end, Ascension's Model Community initiative represents the organization's commitment to its associates for their full flourishing, both personally and professionally, and, in turn, the associates' personal commitment to the ministry and one another, all in service to the mission. Every associate has a voice (for example, in reviewing critical incidents and safety events when they occur). As part of its commitment to building a

Exhibit 5: Our Highest-Level Accountability: The Integrated Scorecard

- **The scorecard addresses the most critical objectives of the mission.**
- **All operating units are accountable to these requirements.**
- **Special emphasis is called out in meeting needs of the poor and vulnerable.**
- **All elements further the mission of being a sustainable, growing organization that is identifying new needs for the communities served.**

Source: Ascension Health.

Model Community, Ascension has made substantial investments in stewardship of talent and formation and development of leaders, as depicted in **Exhibit 6**.

The effort began with senior executives and later expanded to management, with the goal of building a broad array of leaders capable of guiding the organization effectively into the future. For example, Ascension recently made a substantial investment in a Leadership Academy for top leaders. The Leadership Academy will equip these individuals to make often-difficult decisions about what to do and how to do it based on organizational priorities. These leaders learn an organized process of decision making that goes beyond looking at data to engage key stakeholders (e.g., the board, members of the local community) in evaluating all relevant considerations (including ethical ones). Leadership development programs embrace the integrated domains of learning and formative development, including theological, professional, organizational, spiritual, and psychological considerations, both for individuals and the community. Going through this process allows leaders to make wiser, more informed decisions when choosing among various options and to be "at peace" with their choices.

Ascension administers an associate engagement survey to gauge its performance in achieving the objectives of the Model Community. Results make it very clear that engaging associates and providing them with good experiences leads to better experiences for the patients and communities being served. Ascension will soon administer a new combined survey that will allow for more careful evaluation of the relationship between the Model Community components and clinical care outcomes, preventable conditions, patient perceptions of care, and business outcomes such as operating income. This information will help Ascension reach its goal of evidence-based leadership.

Integrating the Mission

At Ascension, responsibility for the integration of the business and the mission resides in every associate. To reinforce that responsibility, Ascension considers each chief executive officer to be the chief mission officer. These individuals are assisted by a "vice president of mission integration," a senior leader whose areas of collaborative responsibility include: values-based culture, formation, workplace spirituality for all associates, Model Community, ethics (clinical, corporate, and organizational), care of persons living in poverty (i.e., community benefit), spiritual care, palliative care, and church relations. Policies and processes that help to achieve the alignment between business and mission include:

- Ethical and religious directives for Catholic healthcare
- An organizational ethics discernment process that is widely used for major decisions
- A clinical ethics decision-making tool
- Ethical guidelines for major transactions
- A position statement on care of the dying

Exhibit 6: Talent Stewardship, Leader Formation, and Development Evolution

Source: Ascension Health.

- Guidelines for fostering justice through global sourcing arrangements

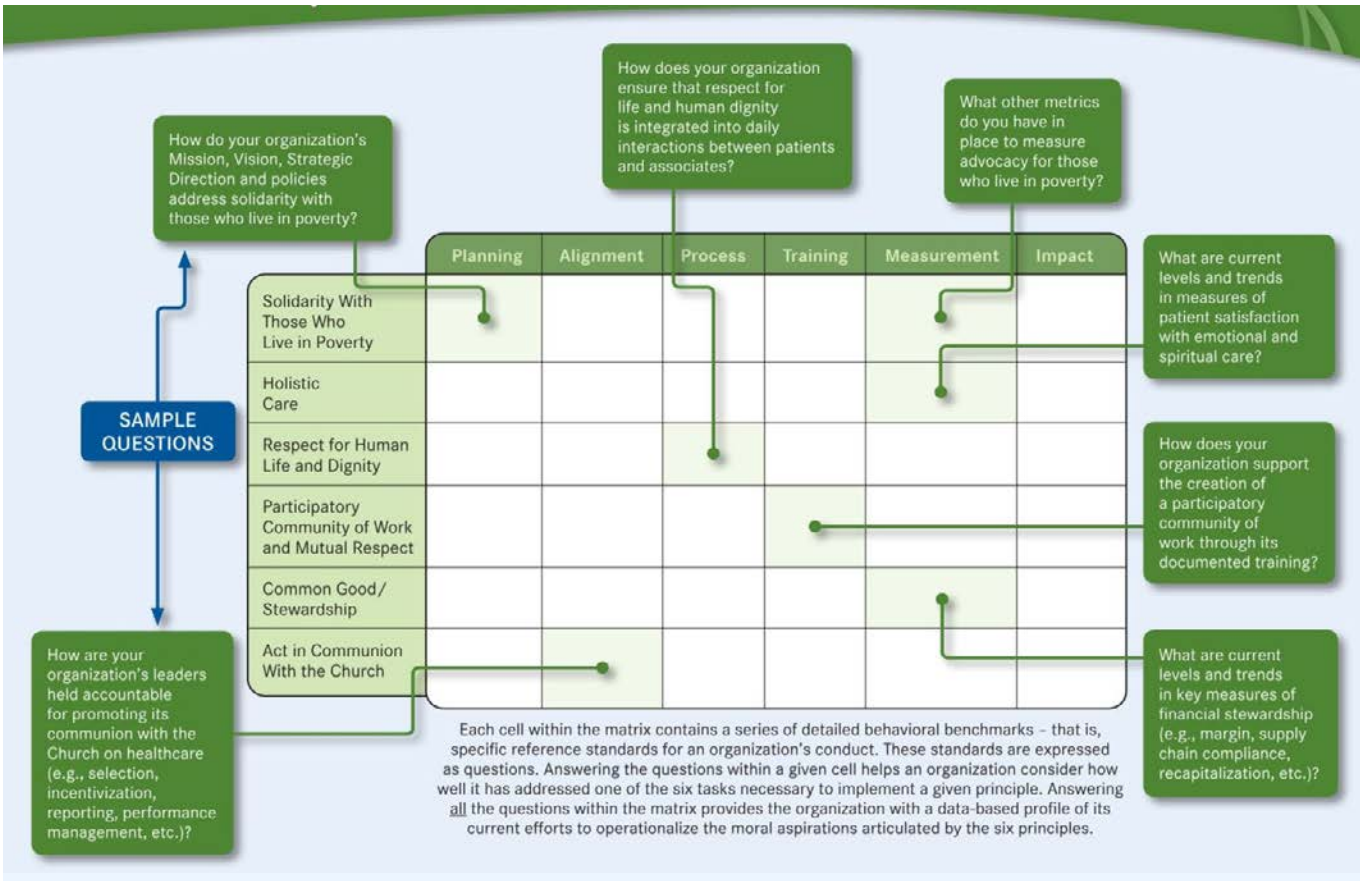
As shown in **Exhibit 7**, Ascension uses the Catholic Identity Matrix (CIM) as a tool to assess how well various components of the organization are integrated into the mission.

Key Takeaways and Implications for Health Systems

System Invitational attendees broke into small groups in which representatives from each system discussed the major implications of the material presented by Mr. Putnam, Sister McGuire, and Ms. Arbuckle. Key points from this discussion include the need for the following:

- **A simple, clear, and compelling mission statement:** Health systems need clear and compelling mission statements that motivate and guide behavior every day. To that end, Alameda Health System leaders rewrote the organization's mission statement last year, reducing what previously had been a 150-word statement to five words: "caring, healing, teaching, serving all." They also changed the accompanying vision statement and are now trying to align all aspects of the organization with the mission and vision. The system's leaders are intrigued by the way Ascension integrates the mission and vision into the organization, including the explicit use of the term "mission" in the job titles of senior leaders.
- **Hiring and affiliation decisions based on the mission**: System leaders need to have clear conversations with anyone considering joining their organization about what is expected of them. For example, a ministry of Ascension will choose not to partner or otherwise affiliate with physician practices that are not willing to take care of Medicaid beneficiaries and the uninsured.
- **Innovation and transformation**: Health systems need to be at the forefront when it comes to innovation and transformation of the delivery system. Alameda Health System (which is much smaller and more geographically concentrated than Ascension) recently created a transformation center focused on innovation, including through new types of partnerships and ventures. For its part, Ascension recently brought a group of its leaders to Silicon Valley to learn more about innovation and transformation, and Ascension leaders spend significant

Exhibit 7: Catholic Identity Matrix (CIM)



Source: The enhanced Catholic Identity Matrix is a product of a collaboration between Ascension Health and the Veritas Institute at the University of St. Thomas, with support from the John A. Ryan Institute for Catholic Social Thought at the University of St. Thomas, St. Paul, MN, and the Gonzaga Institute of Ethics at Gonzaga University, Spokane, WA.

time educating associates on these topics. In recent months, these efforts have led to the identification of several opportunities for growth, including in the retail pharmacy arena.

- **Population health management across the continuum**: Even safety net systems need to focus on maximizing and optimizing population health across the continuum of care, including being in a position to provide prevention and wellness services to everyone and high-quality palliative care to those with a terminal illness. With respect to palliative care, systems need to involve family members and caregivers long before a crisis situation arises. Ideally, these discussions should begin as soon as the patient is diagnosed with a terminal illness.
- **Adequate size and scale to be relevant**: Health systems need to have an "essential presence" in every market in which they operate. To that end, the board at Alameda Health System has embarked on a strategic planning journey aimed at establishing such a presence in its local markets. The strategy focuses on development of provider networks in each market area, in some cases through hospital acquisitions. (More information about the need for scale can be found later in this report.)
- **Reengineering of costs**: Health system leaders should no longer expect sizable increases in reimbursement year after year. In fact, payments may be flat or even decline in some areas. As a result, costs must be taken out of the system. To that end, a central component of Alameda Health System's multi-year effort to boost margins involves a reconfiguring of its cost structure.
- **Appropriate metrics to measure success**: All systems need appropriate metrics by which to gauge their success. Ascension's leaders ended up creating some new metrics because existing ones were not adequate for their needs, particularly in areas such as palliative care. Ascension also created the aforementioned CIM tool to assist with the measurement and assessment process.
- **Clinical consolidation**: In large systems, it often does not make sense to offer every major clinical service line at every facility. Yet standardizing and rationalizing services can be challenging, as doing so requires the difficult choice of closing service lines in some facilities. In some cases, local and system boards are rightly reluctant to close certain service lines, particularly if no other organization in the area provides the service to some or all of the population. For example, Covenant Health in Tennessee is the only behavioral health provider serving a large region.

Making the Toughest Choices in the Era of Accountable Care: Will Restructuring the Healthcare System Succeed?

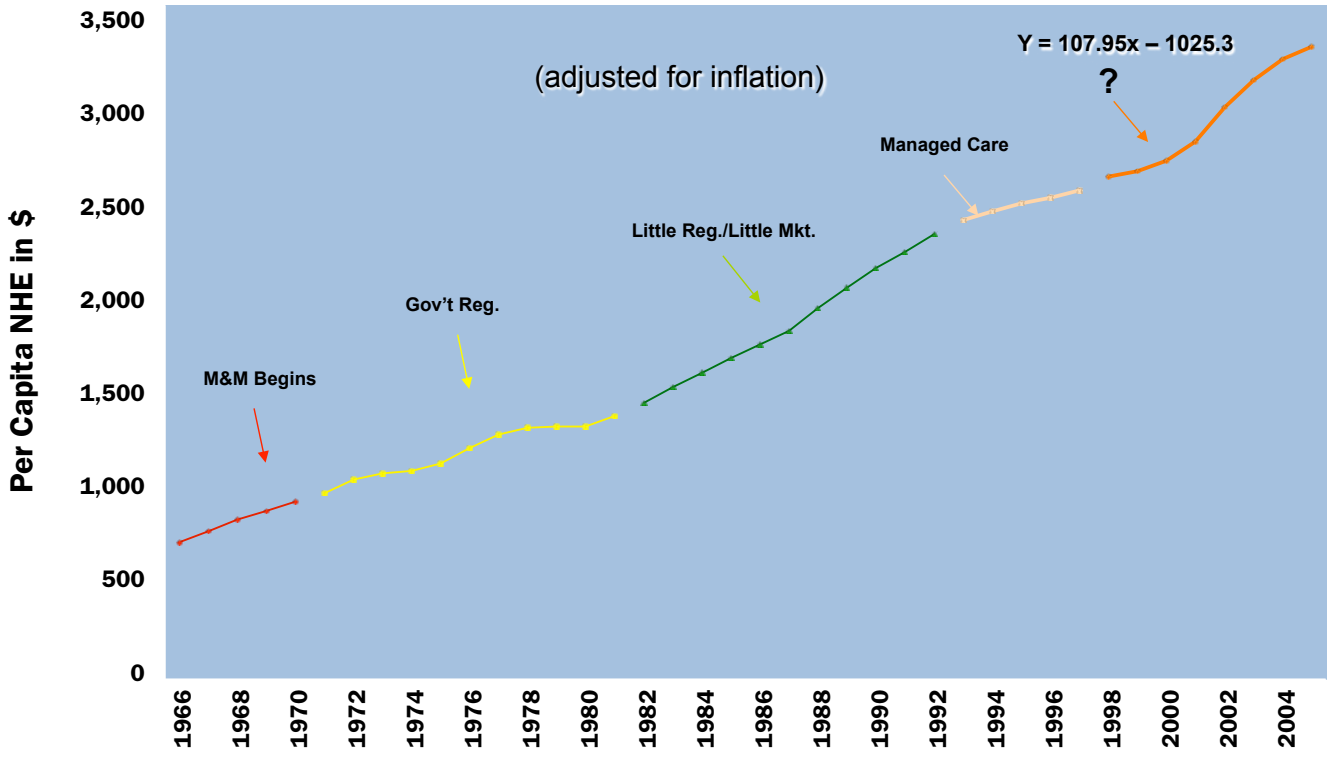
Stuart Altman, Ph.D., the Sol C. Chaikin professor of national health policy at Brandeis University, discussed whether the current changes being made, including bundled payments, accountable care organizations (ACOs), and others, will be enough to meet external pressures for cost control and quality improvement (QI).

A History of Cost-Control Efforts, Followed by Return to Old System

The unrelenting growth in healthcare spending that occurred in recent decades has forced the U.S. to seek a more efficient system, and the pressures to become more efficient will not go away anytime soon. In the last 40 years, spending on healthcare in the U.S. has risen 36-fold in nominal terms, from $75 billion to $2.7 trillion. Over the same time period, the proportion of the nation's GDP spent on healthcare has more than doubled, from 7.5 percent to over 16 percent. Earlier, dire predictions of what would happen if healthcare spending continued to rise have largely not come to pass. In 1971, for example, experts predicted that the economy would collapse if healthcare accounted for more than 8 percent of GDP. Nonetheless, serious problems exist that need to be addressed.

The U.S. has been in this situation before, and it remains to be seen if the response this time will be different. As illustrated in **Exhibit 8**, the U.S. has embarked on multiple efforts to control spending, beginning with the Economic Stabilization Program in 1971 (which followed a period of rapid growth in spending fueled by the introduction of Medicare and Medicaid). A lull in spending ensued, only to resume again after the program ended in 1974. As the economy grew rapidly, the 1980s ushered in a period of major increases in spending, to the point that large employers such as Ford and General Motors found that health coverage had become the single biggest expense involved in manufacturing a car. After the failure of the Clinton administration to pass reform legislation, the managed care era began. Cost growth slowed significantly, but consumers and providers rebelled against the restrictive nature of provider networks and the tendency to allow insurance companies to "second-guess" providers. After the press and politicians spoke out adamantly against managed care, the era came

Exhibit 8: U.S. Has Tried to Control Healthcare Spending Growth in the Past



to an end in the late 1990s, ushering in a period of even more rapid growth in costs than had occurred in the 1980s.

In short, history seems to be repeating itself. The nation has gone through multiple periods where healthcare costs rise rapidly. This growth leads to major actions to curb spending (e.g., regulation, managed care, consumer initiatives), which work for a few years before facing backlash and repeal, leading to a reversion to the old system of unfettered access to care and rapid growth in costs.

Key Question: What Happens Next?

Regardless of the fate of various key provisions of the ACA, it remains clear that government will be a major, growing force in healthcare. If projections hold true to form, the number of individuals enrolled in Medicare will have doubled in the 40-year period between 1990 and 2030. Over the same time period, the number of Medicaid beneficiaries will also increase significantly, even if many states remain unwilling to expand coverage under the ACA.

What remains unclear, however, is how government will play that role. Will government serve to promote more effective market-based activities, such as development of new payment policies that promote value rather than volume? Or will it take a more regulatory approach, such as in Maryland and Vermont, as well as other developed nations, where government sets the rates for all services?

Two Major Approaches to Address Current System Concerns

The key is for government to promote policies that address the many major concerns that exist about the current system. Even in the best health systems today, care is often delivered in an uncoordinated and fragmented way, with people "falling through the cracks" due to the failure to share information, which in turn leads to duplicative testing, poor care coordination, and mismanaged care transitions. Other big problems include the limited consideration given to "cost-effectiveness" when making decisions on the use of and payment for services, lack of pricing constraints for new drugs and devices, and a medical malpractice system that continues to add unnecessary costs. With respect to this latter problem, Dr. Altman noted that health economists generally dismiss the notion that the malpractice system significantly adds to the costs of healthcare. Yet health system leaders believe that it does. While malpractice liabilities and the associated premiums paid by providers represent a very small portion of overall healthcare costs, "defensive medicine" (i.e., providers doing things they know do not add value to protect against a possible lawsuit) represents an estimated 4 to 10 percent of all costs. Health economists are generally skeptical even of the low-end estimates for defensive medicine, because states that have changed their malpractice systems have generally not seen any impact on costs. Over time, however, as a new crop of physicians comes along that no longer has such large concerns about legal liability, it is possible that practice patterns will change and costs will come out of the system as the practice of defensive medicine becomes less common.

To date, two major strategies have been attempted to address these problems—the first is a supply-side approach where payment systems change to give providers a fixed amount of money, letting them decide what care the patient needs. Both ACOs and bundled payments represent versions of this strategy, with ACOs providing a fixed amount for all care and bundled payments giving fixed amounts for a defined episode of care. The second major approach tackles the demand side of the equation by giving patients greater financial responsibility through high-deductible health plans (HDHPs) and/or high coinsurance rates. While these two approaches can work together in complementary fashion, they also may work against each other.

Supply-Side Approaches: ACOs and Bundled Payments

Proponents of ACOs and bundled payments note that they help to do the following:

- Allow providers (not regulators or payers) to make decisions on appropriate care.
- Reward care that is less fragmented and that minimizes duplicative and wasteful services.
- Permit providers to pay for services not traditionally considered part of healthcare, such as buying an air conditioning system for a homebound senior who regularly comes to the emergency department (ED) due to heat exhaustion and dehydration.

To succeed, these strategies need to avoid the errors made with similar kinds of initiatives (e.g., provider capitation) in the past. In particular, providers (both physicians and hospitals) cannot be asked to take on more financial risk than they understand or can afford. At the same time, individuals cannot be forced into plans they did not choose and do not like, including plans that appear to be more concerned about cost control than providing high-quality care. (In the 1990s, no one knew how to measure quality, so all the focus turned to costs. Consequently, people quickly came to view the "managed care" era as the "managed cost" era.) In addition, bundled payments should not be as narrow as they have been in the past. The Medicare diagnoses-related group (DRG) payment system was the first major attempt at a bundled payment, but it only covered hospital services and Medicare beneficiaries. The original strategy of expanding DRGs to cover other services and payers never came to fruition.

Fortunately, the current ACO and bundled-payment programs have been designed to avoid many of the problems of these earlier initiatives, as outlined below:

- **ACOs:** Under current ACO programs, providers assume limited downside risk through use of a shared-savings system where each participating group does not lose as long as it stays at or below current spending levels. Over time, providers will take on more risk as they get better at managing care across the continuum. The ACO programs also do not lock patients into delivery systems they may not

trust. While Medicare patients must sign up with a primary care physician (PCP) when they enroll in the ACO, they can change PCPs and also go to other providers without penalty. This aspect of the program may create problems for providers participating in the ACO, as it essentially asks them to be financially responsible for the care of a patient but does not give them control over where that patient seeks care. Finally, to address quality concerns, the eligibility of ACO providers to receive shared-savings payments depends on their meeting or exceeding clear quality standards. While debate continues as to which quality measures should be used, the ability to incorporate appropriate measures has improved—and will continue to improve—over time.

- **Bundled payments:** The Medicare bundled covers inpatient care as well as physician services and post-hospital care. (It does not include pre-hospital care.) Medicare is also encouraging (but not requiring) providers to offer non-Medicare patients the opportunity to be part of bundled payment systems.

With both approaches, the key to success lies in offering high-quality primary care and in limiting post-acute care spending. As depicted in **Exhibit 9**, post-acute spending for major DRGs often accounts for as much or more of total spending as does the initial inpatient stay.

Concerns do exist, however, about whether ACOs and bundled payments will work as currently configured. At present, most ACO and bundled-payment programs have adopted a shared-savings approach rather than giving providers fixed budgets that put them at full risk. In addition, as noted, patients have the right to opt out of the ACO network, making it harder for providers to control costs. At present, participation in ACOs and bundled payments remains voluntary, and many important organizations have chosen not to participate thus far. Those that do continue to struggle in the "never-never" land where some revenues are based on FFS contracts and others incorporate partial or full global payments. Not surprisingly, therefore, first-generation ACOs have only had limited success to date.

Despite these problems, these efforts can and should continue, as governments need to be active participants in promoting new delivery systems. FFS payments need to end, as they perpetuate a splintered system that promotes the unnecessary use of high-cost services. At the same time, government needs to limit the regulatory hurdles placed on providers and provide financial assistance to systems that are financially stressed due to an unfavorable payer mix. In addition, state governments need to play a more prominent role in revamping payment systems. As Medicaid enrollment swells, states will find private payers increasingly unwilling to cross-subsidize the state's low payment levels. In other words, all payers—including the private sector, Medicare, and state governments—are being pushed to the limit with respect to healthcare spending.

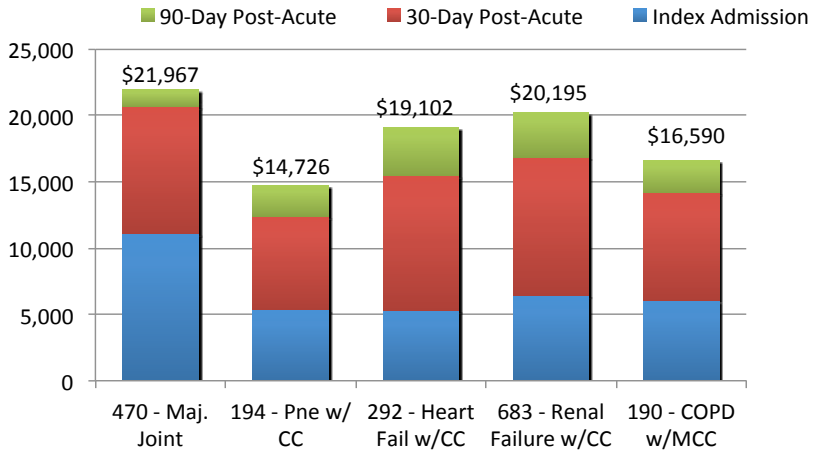
Three Potential Paths Forward

Dr. Altman laid out three potential paths forward:

- **Status quo:** Under this option, the system continues on its current course, with spending set to reach $3 trillion and 20 percent of GDP.
- **Demand and/or supply side reform:** This strategy involves restructuring of the payment system to reward lower costs and higher value through supply and/or demand side reforms, including global payments, bundled payments, and consumer incentives and initiatives, such as HDHPs, limited provider networks, and price and quality transparency.
- **Regulations:** This option features broad-based price and/or spending regulations at the federal or state level.

Most stakeholders have rejected the status quo option, as the U.S. healthcare system seems to have reached a "brown-out" stage where money is no longer available to fund cost increases

Exhibit 9: 2008 Medicare Acute and Post-Acute Payments for Inpatient-Initiated 90-Day Episodes



Source: RTI Inc., Post-Acute Care Episodes: Expanded Analytic File, June 2011.

year after year. Most also do not like the idea of significant new regulations. For this reason, efforts to date continue to focus on demand and supply side reform, although there is no consensus on whether one is better than the other. For their part, employees (and their employers) continue to migrate toward preferred provider organizations that offer broader networks than do ACOs.

Lessons from the Massachusetts Experience

Massachusetts—the first state to pass comprehensive reform legislation—may offer some useful lessons for those trying to figure out the appropriate path forward, including the best way to structure supply and demand side reform initiatives. Under the Massachusetts' legislation, the private sector (both insurers and providers) has joined with the government to reform the system. Nothing was "forced" on providers, and the private insurance sector plays an expanded role within the new system.

Developers of the Massachusetts reform legislation made the explicit decision to tackle coverage first and cost containment second. (The crafters of the ACA did the same.) In August 2012, the Massachusetts legislature passed cost-containment legislation that represents a compromise position that stops short of price regulation. Rather, the state set limits on premium increases (typically below the underlying historical trend), leaving insurers to figure out how to live within those limits by restructuring payment models, introducing limited and tiered network plans, and increasing use of HDHPs. To date, roughly 22 percent of Massachusetts residents have enrolled in plans that feature global payments. In response to changes from insurers, provider systems have embarked on major delivery system reforms.

A new, 11-member Massachusetts Health Policy Commission has been created to oversee this effort, including administering a $135 million fund to support distressed hospitals and promoting payment reform (with $11.5 million allocated to this task). Major issues confronting this commission include the following:

- Completing a required assessment of the market impact of all provider restructuring and consolidation
- Administering a grant program to assist community hospitals in developing more efficient delivery systems
- Establishing a certification program for patient-centered medical homes (PCMHs)
- Assuring adequate transparency with respect to insurance options

The commission does not function as a regulatory body, and ultimate responsibility still lies with the private sector. The goal, however, is to align the incentives on both the supply and demand sides of the equation so as not to continue pulling providers in multiple directions.

Where Will We Likely End Up?

If supply and demand side reforms end up working, growth in healthcare spending will moderate to levels in line with GDP growth, and the likelihood of more draconian regulation diminishes. If these efforts fail and the status quo returns, however, regulations will be put in place that require tighter spending controls that limit growth in healthcare spending to levels below GDP growth, likely in line with inflation.

The good news is that healthcare spending growth has slowed in the last few years, and there is some evidence that the slowdown may not be temporary this time. Small, positive changes at the delivery system level seem to be keeping the growth in costs in check, including reductions in healthcare-associated infections and readmissions. In addition, insurer-initiated reforms such as increased cost-sharing and greater use of limited and tiered provider networks seem to be having an impact. It remains to be seen, however, whether this slowdown remains permanent, or whether the current predictions of actuaries—that healthcare spending will hit $3 trillion and consume 20 percent of GDP—come true.

Changing Physician Behavior and Practice in a Value-Driven World: What Will It Take?

Robert M. Wachter, M.D., professor and associate chairman of the Department of Medicine and the chief of the Division of Hospital Medicine at the University of California, San Francisco (UCSF), discussed strategies for changing physician behavior and practice patterns as healthcare progresses toward a more value-based system. Those seeking to transform the system need to understand how doctors have been trained and how they organize themselves. Physicians have their own way of speaking, and engaging them requires breaking down barriers by speaking their language.

Pressures to Change the Current System

As discussed by other presenters, huge pressures exist to create a system that delivers higher-value care. The current system fails to deliver on both the numerator and denominator of the value equation—i.e., quality remains subpar while costs are too high. Ample evidence suggests that quality remains well below where it should be. The Institute of Medicine (IOM) released its landmark report *To Err Is Human* in 1999; this report launched the modern quality movement with estimates that between 50,000 and 100,000 people die in hospitals each year due to medical mistakes. A few years later, Elizabeth McGlynn, Ph.D., a researcher at the RAND Corporation, found that the healthcare system delivers evidence-based care only a little more than half the time (54 percent). This level of reliability (roughly 1.5 sigma in a world where six sigma represents near-perfection) would put any other industry out of business quickly. In addition, patients remain unhappy with the system, and wide disparities in the costs continue to exist across geographical areas and even units of the same organization. These variations are completely unrelated to outcomes or clinical need. Key stakeholders—government, payers, employers, and patients—will no longer tolerate this poor performance, and hence most policy initiatives are designed to force the industry to offer less expensive, higher quality, more reliable care.

Why Doctors Are the Key to Successful Transformation

Doctors are critical to the successful transformation of the system, and those attempting such reform need to understand how they act and think. When it comes to changing the system, however, physicians do not seem to understand their role. A recent survey of 2,500 practicing physicians found that the vast majority believe that multiple other stakeholders have more responsibility to reduce costs than they do. In fact, physicians believe that trial lawyers have the most important role to play in reducing costs (likely the result of an overestimation of the importance of defensive medicine), followed by insurance companies, drug and device manufacturers, hospitals and health systems, patients, and the government. Physicians rank themselves seventh and professional medical societies eighth, with only employers having less responsibility for costs in physicians' minds. Physicians are not alone in their view that they bear little responsibility for the costs of care. In fact, most major policies and programs being launched to improve value have been targeted at hospitals and systems, not individual physicians.

While this view may be understandable, it is, quite simply, incorrect. The cost curve within healthcare cannot be fundamentally altered without fundamental changes in what physicians do and how physicians think. Doctors, not hospitals or health systems, decide which patients to see; how often to see them; which patients to hospitalize; what tests, procedures, and surgical operations to perform; what technologies to use; and what medications to prescribe. These facts are not lost on health system and hospital leaders, who in a recent KPMG/Harris study[3] highlighted the importance of aligning with their physicians in clinical redesign efforts, QI activities, health IT deployment, and other areas. System boards and CEOs increasingly recognize that their "old" job—to treat doctors as the customer and keep them happy—no longer applies. In this old world, physicians brought in the patients, making hospital leaders reluctant to admonish them for problematic behavior, even if such behavior proved disruptive, unnecessarily expensive, or indicative of poor quality. Instead, they catered to physician needs by purchasing new technologies and offering various perks, such as convenient parking. They also tolerated the policies of the self-governed medical staff, where any individual physician could veto a controversial decision.

3 KPMG Healthcare & Pharmaceuticals, *Transforming Healthcare: From Volume to Value,* New research on emerging business models, KPMG, LLP, September 2012. Available at www.kpmginstitutes.com/healthcare-life-sciences-institute/insights/2012/pdf/transforming-healthcare-volume-value.PDF.

This old-world strategy, however, simply is not viable in today's world. It can survive only in a world where hospitals and physicians face absolutely no pressure to provide the highest quality, safest care at the lowest possible cost. Over the past decade, this pressure-free world has eroded, thanks to a variety of strategies and initiatives that have created immense pressure to perform. This new reality has exposed the fatal flaws in the traditional hospital–medical staff relationship, which results in hospitals being governed by two parties that are at best collegial but highly wary of each other. To address this issue, hospitals and health systems need not necessarily purchase physician practices. But they cannot continue with the current lack of alignment with the doctors who practice in their facilities.

Understanding and Leveraging Four Key Facts about Physicians

Once incentives and motivations become aligned, the key is to understand and take advantage of four key characteristics of physicians: they are competitive overachievers; individualistic and tend to value their autonomy; not entirely economic animals; and taught to care for individuals, not populations or systems.

Competitive Overachievers

Physicians are used to getting straight "As" in school. Those trying to influence physician behavior should recognize and take advantage of this fact. For example, physician "report cards" that compare performance with peers may be a way to catalyze action and behavior change. When Medicare's Hospital Compare rankings first came out, UCSF Medical Center did not score that well on certain measures (e.g., administering pneumococcal vaccinations to patients with pneumonia), even though it had always ranked highly in less scientific rankings, such as those released by *U.S. News & World Report*. This new Medicare ranking—along with others consistently showing that while UCSF might be a "top 10" hospital in a reputational survey, it probably was not if the ranking hinged on hard data—served as a major catalyst for change.

The underlying lesson is that those seeking to influence physician behavior should take advantage of their competitive nature by sharing data highlighting areas of underperformance versus the competition. Because culture and performance tend to be local in nature, the best benchmarks are often in the same institution. Within a given hospital, the culture related to safety and quality often varies significantly from unit to unit. In fact, as shown in **Exhibits 10a** and **10b**, safety performance varies more across units within a hospital (from 20 to 100 percent) than across hospitals (40 to 75 percent).

Individualistic in Nature

As Atul Gawande wrote in *The New Yorker* in 2011, "the organization of healthcare and medicine emerged during a time when doctors could hold all the key information needed in their heads and manage everything themselves . . . doctors

were craftsmen . . . and the nature of the knowledge lent itself to prizing autonomy, independence, and self-sufficiency."[4]

Today, however, doctors can no longer hold all the information in their heads, nor can they master all the necessary skills. The system now matters more than the individual doctor in terms of determining the patient's outcome. Physicians are beginning to accept this reality and to see the value of standardization. However, many still want medicine to be standardized "their way" rather than according to evidence-based best practices.

The movement to standardize around these best practices has begun in some systems. The advent of electronic medical records (EMRs) is accelerating this process. Going forward, the key will be to leverage EMR systems to provide decision support to physicians and support changes in their practices. Some organizations pushing this approach have met with resistance from physicians. The key leadership challenge will be to use decision support and other systems to engage physicians in change without sparking a revolt. Success will be driven by the degree to which the system has achieved true integration with its physicians and convinced them of the need for better performance through standardization.

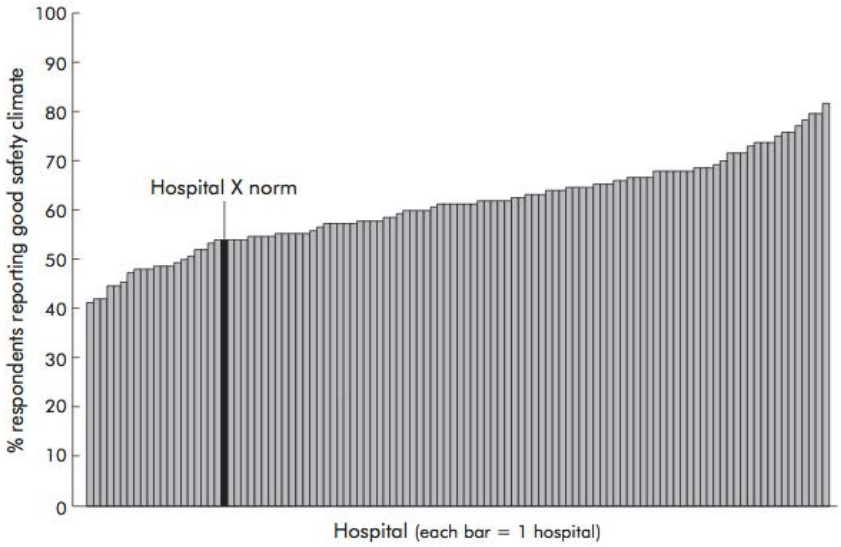
Not Entirely Economic Animals

Like all professionals, physicians are motivated by more than dollars. Consequently, the instinct to use money as a tool for changing physician behavior may not always prove to be correct. In some cases, social norms will prove to be more powerful than financial incentives. A great example of this comes from the experience of a daycare center in Israel, recounted by Ariely in his book, *Predictably Irrational*.[5] Once or twice a week, staff at the center ended up having to stay late (usually

4 Atul Gawande, "Cowboys and Pit Crews," *The New Yorker* (online blog) and commencement address at Harvard Medical School, May 26, 2011.

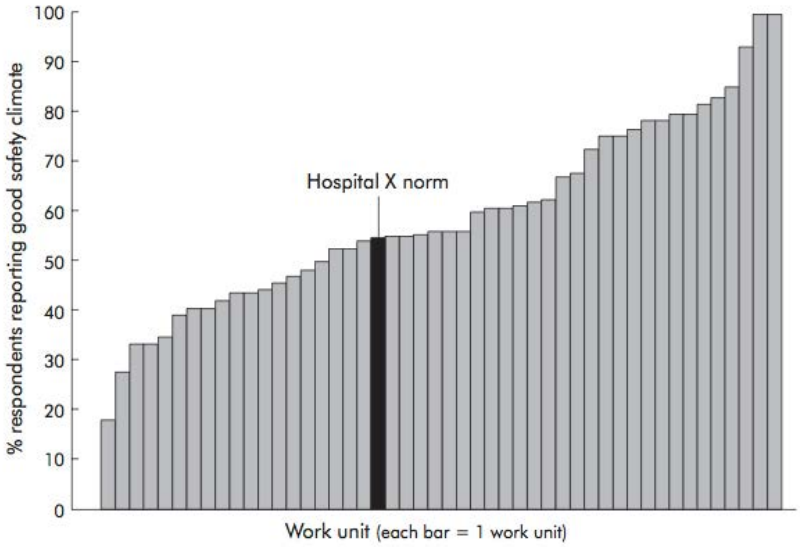
5 Dan Ariely, *Predictably Irrational: The Hidden Forces That Shape Our Decisions,* Harper Perennial, 2010.

Exhibit 10a: Culture Is Local: Safety Climate across 100 Hospitals



Source: P. Pronovost and B. Sexton, "Assessing Safety Culture: Guidelines and Recommendations," *Quality and Safety in Healthcare,* Vol. 14, No. 4, August 2005, pp. 231–233.

Exhibit 10b: Culture Is Local: Safety Climate across 49 Units in One Hospital



Source: P. Pronovost and B. Sexton, "Assessing Safety Culture: Guidelines and Recommendations," *Quality and Safety in Healthcare,* Vol. 14, No. 4, August 2005, pp. 231–233.

about 20 minutes or so) because one or a few parents would fail to pick up their child by the established deadline of 6:00 p.m. The problem persisted despite multiple attempts to get these parents to arrive on time. Consequently, the center's board decided to institute a new policy that would impose a fine (a per-minute charge) for parents who arrive late. To the surprise of the board and center leaders, the number of parents showing up late increased significantly after the fine went into place. In hindsight, this result should have been expected. By instituting the policy, the center essentially made the pick-up time a "market" rather than "social" transaction. More parents came late and paid the fine because they felt like they were paying for an additional service—having someone watch their children. Prior to the policy being put in place, the vast majority of parents picked their children up on time because they viewed doing so as a social norm (i.e., the right thing to do so as not

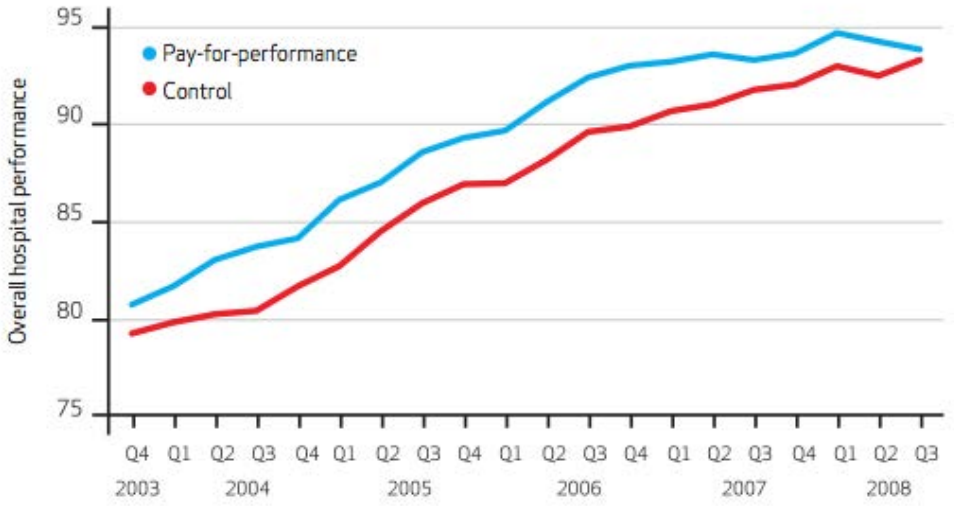
to abuse a privilege and take advantage of teachers and staff at the center). With the fine established, however, it became acceptable to come late and pay for the extra time. After a few months, the board reversed the policy and ended the fines. However, parent behavior did not change very quickly and the late pick-ups continued because the social norm had gone away, and bringing it back was not easy.

The underlying lesson here is that social norms can often be more effective and less expensive than money-based market transactions. In the healthcare arena, the laws of economics may not always work, particularly when it comes to changing physician behavior. In fact, some pay-for-performance (P4P) pilot projects have shown the limits of financial incentives. As illustrated in **Exhibit 11**, Medicare's public reporting initiative stimulated performance improvement by hospitals, as the competitive nature of physicians kicked in after the release of comparative performance data. (The performance of hospitals subject to public reporting is illustrated in the "control" group line on the graph.) Hospitals participating in both public reporting and P4P (the line labeled "pay-for-performance") initially performed a bit better (roughly one to two percentage points) than those involved only in public reporting, although it is not clear if the marginal difference in performance justifies the extra expense and political complexity. More importantly, the differences evaporated after five years, suggesting no long-term incremental benefit to P4P on top of public reporting. This finding does not mean that there is no place for P4P incentives, but it does call into question the often-used assumption that money and incentives are always the right answer.

Taught to Care for Individuals, Not Populations or Systems

Physicians have been trained and socialized to care and advocate for individual patients, not populations or systems. Malpractice fears reinforce the view that everything possible should be done for an individual patient, without consideration to the impact that such care might have on the resources available to others. Real-world experiences and emotions, moreover, reinforce this view. For example, about 20 years ago, the state of Oregon created a policy in which bone marrow transplants for children would not be covered by Medicaid, with the goal of freeing up resources to pay for prenatal care and other important preventive and screening services that

Exhibit 11: Does P4P Work Better Than Simple Transparency? The Jury Is Still Out

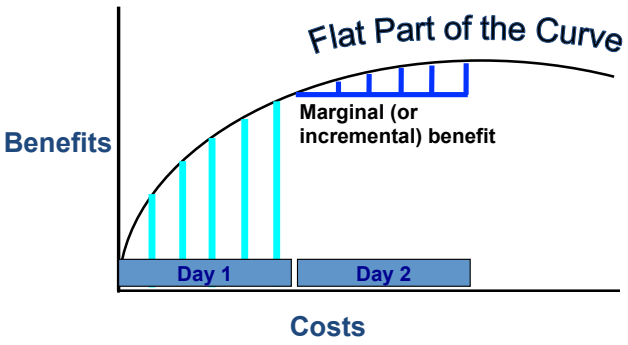


Source: R. Werner, et al., "The Effect of Pay-for-Performance in Hospitals: Lessons for Quality Improvement," *Health Affairs,* Vol. 30, No. 4, 2011, pp. 690–698.

could save many more lives. However, the state backpedaled in the face of widespread negative publicity and mounting public pressure when a child with leukemia actually needed the service. That child was very real and evoked great sympathy and support; by contrast, the children that could have potentially been saved through better prenatal care did not yet exist and hence were only statistical lives, not real ones.

This tension between care for the individual and care for populations and systems is illustrated in **Exhibit 12**, which graphs the benefits of a hospital stay over time. Benefits tend to be quite large on the first day and generally continue to rise modestly during the second day, after which they tend to flatten out. Costs, meanwhile, continue to grow at a fairly steady pace. In other words, the first day or two represent substantial "bang for the buck," after which the costs often begin to outweigh the benefits. In wealthy nations like the U.S., the debate tends to center on the flat part of the curve, when the marginal or incremental benefits may no longer be considered "worth" the money.

Exhibit 12: Costs vs. Benefits: The Big Picture



For physicians, the challenge lies in what to do when patients reach this flat part of the curve. Their training tells them to act on behalf of the individual patient and offer any service that provides any level of net benefit. From a societal or population perspective, however, services that offer only marginal benefit should be provided only after services with higher benefit-cost ratios have been provided to everyone else. These two perspectives represent very different ways of looking at the world. As the healthcare system migrates toward maximizing population health, physicians will face conflicting objectives. In the U.S., the notion that someone should be denied any type of care (even one that offers little or no marginal benefit) so that someone else can get care that has the potential to add more value has little resonance, and efforts to deny such care generally meet with stiff resistance. In other developed nations, this concept has much more support; for example, the United Kingdom's National Health Service has an office that deals with these types of rationing-related issues.

For policymakers hoping to address this issue, the fundamental challenge is to create structures to help physicians think about managing population health and not just individual patients. Past efforts to create such structures (such as through managed care and provider capitation) did not work, as physicians and patients rebelled. Part of the problem with managed care was that too much money left the system, going instead to Wall Street investors or organizational leaders, rather than being repurposed for other patients within the organization. While ACOs presently have some protections against the problems that ultimately doomed the widespread growth of managed care, they still work the same basic way (i.e., they give clinicians and delivery systems a pot of money to manage the health of a population of individuals each year, leaving system leaders and clinicians to determine the appropriate allocation of resources). To make this work, services that offer little or no value will have to be taken away from certain individuals, with the resulting savings being used for higher-value services needed by others. It remains to be seen if such actions will be accepted this time around.

Critical Success Factors

Successfully changing physician behavior requires new organizational arrangements that align incentives and promote a population perspective. Physicians need to learn new skills related to QI and safety, including how to do the following: be an effective leader, use Lean or other established improvement methodologies, work effectively as a team, and use IT as a positive force for change. The sharing of clinically meaningful comparative performance data at both the group practice and individual physician level can support this process. For the most part, comparisons of local providers (including units and/or departments within the same organization) will be more meaningful and effective than comparisons with outside organizations. Structured care protocols and forcing functions within IT systems can help in promoting standardization around best practices. Success, however, will not occur unless physicians are engaged and buy-in to the process from the beginning. In addition, physicians must view participating in and leading this type of effort as a path for success within the organization. Finally, carefully structured incentives likely have a role, as long as they do not serve to extinguish professionalism and/or undermine teamwork.

Key Takeaways and Implications for Health Systems

System Invitational attendees broke into small groups in which representatives from each system discussed the major implications of the material presented by Dr. Altman and Dr. Wachter. Key points from this discussion include the need for the following.

Strong Physician Leaders

Many of the systems that have been most successful in aligning with physicians and promoting value-based, accountable care have a physician CEO. While the CEO need not be a physician

(and having a physician in this position is no guarantee of success), it sometimes helps. Moreover, the chief medical officer should be a highly respected, visible doctor capable of making tough choices and convincing his or her peers that it is in their interest and that of their patients to practice differently than in the past.

Significant Investment in Physician Change and Leadership

The most successful systems invest heavily in physician leadership development. For example, one system routinely takes between 30 and 40 physicians off-site four times a year to work on leadership, QI, and change strategy. These doctors spend up to 10 days every year focusing on these issues. The sessions engage the doctors in depth, teaching them a new way of thinking about their role as system leaders.

Changes to the Medical School Curriculum

Medical schools need to incorporate training on systems, quality, patient safety, and the patient experience into their programs. Many schools and residencies have done so in response to pressures from the Accreditation Council for Graduate Medical Education and other accreditors. However, the degree to which these changes are real and effective depends on the quality of the faculty and school leadership. UCSF leaders and faculty care a great deal about teaching these skills, and consequently residents spend six weeks learning the basics of QI, safety, systems, and leadership. The biggest challenge is finding qualified faculty to teach these concepts, along with time in the curriculum to do so. For their part, medical students and residents greatly enjoy these topics, and often do not understand why they have not been taught in the past.

Investments in the Workforce

Successful transformation is predicated on having an enthusiastic and engaged workforce. Providers are being asked to do everything they have done in the past and to learn many new skills, including how to use EHRs. Once the transformation has been completed, the resulting jobs will be more interesting and engaging. The danger in the meantime, however, is that clinicians and staff will burn out, causing morale to suffer and potentially exacerbating workforce shortages.

Appropriate QI Methodologies

Lean and other comprehensive QI methodologies are appropriate for tackling complex processes such as discharge planning and care transitions. Improving these areas often requires a comprehensive mapping of current processes to identify bottlenecks and other problems. However, these methodologies may be "overkill" when tackling simpler problems such as overuse of diagnostic imaging tests. These "smaller" problems can often be addressed more easily, by first documenting and publicizing the gap between current performance and best practices and the costs of this gap to the organization in terms of quality and costs. Once physicians understand and accept the problem, simpler solutions, such as education, forcing functions built into EHRs, and/or incentives, will likely work.

Creative Use of Incentives

While economics and incentives do not always drive behavior, they can still be quite important. Often the biggest problems come when financial incentives work against desired behaviors. More specifically, there is a need for payments that reward better quality and end FFS medicine, as described in more detail below:

- **Payments that reward quality**: Thus far, providers have generally not been able to extract a higher price for providing high-quality care. Instead, factors such as reputation and market power seem to determine the price a provider receives. In fact, under current systems providers are more likely to be penalized for poor quality than rewarded for high quality. Over time, however, more payers are starting to reward quality, generally through P4P incentives rather than higher prices. For example, Blue Cross Blue Shield of Massachusetts developed an "alternative quality contract" program that pays significant bonuses to providers that achieve high levels of performance on established quality metrics. As a nation, however, no clear consensus yet exists as to whether to pay more for higher quality care. To address this issue, payers and the public at large need to be engaged in how to evaluate quality and educated on the need to reward the best-performing providers.
- **End of FFS medicine**: Many health systems still receive a substantial portion of their revenues from FFS payments. As a result, they lose substantial revenues when they treat patients with evidence-based protocols that reduce length of stay and eliminate unnecessary tests, consultations, procedures, and treatments. For example, Ascension lost money as a result of its efforts to reduce early elective inductions.

New Scale and Margin Realities as Healthcare Consolidates

Mark Grube, managing director at Kaufman, Hall & Associates, Inc., discussed new realities related to scale and margins as health systems respond to external pressures to improve care and better serve local communities.

Downward Trajectory in Revenue and Expense Growth

Prior to 2008, health systems could count on consistent revenue growth of 6 to 7 percent each year. Today, however, annual growth has slowed to approximately 4 percent, and increases of 2 percent or less may be possible in the years ahead. As shown in **Exhibit 13**, health system leaders have thus far succeeded in modifying underlying cost structures in response to these rate pressures. As a result, expense growth has largely tracked revenue growth and margins have been maintained at reasonable levels. But in 2012, expense growth exceeded revenue growth.

Going forward, health system leaders face significant challenges in continuing to curb costs enough to maintain margins, particularly as revenue growth decelerates further. The kinds of cuts that organizations have put in place thus far, such as supply chain changes and productivity enhancements, will likely no longer suffice.

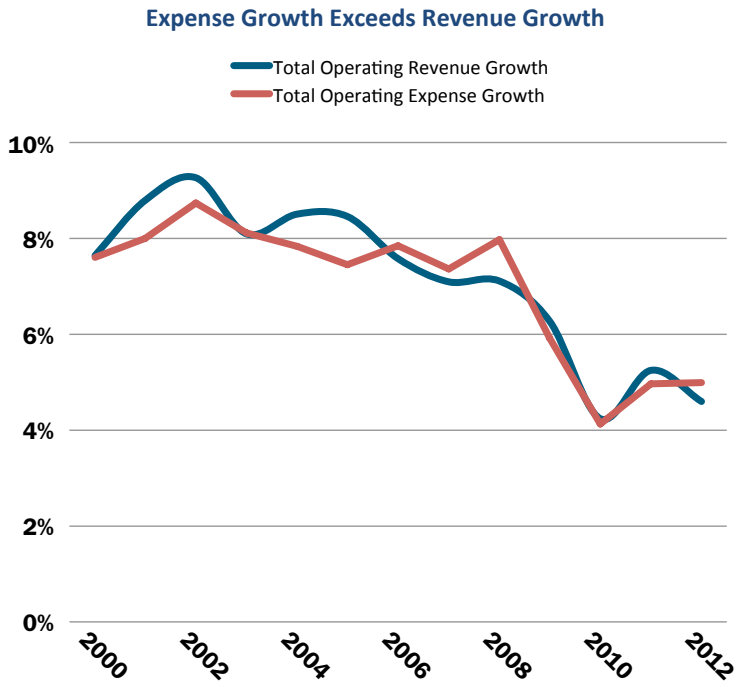
An Inflection Point for the Industry

The healthcare industry finds itself at a second "inflection point" that will pressure margins goings forward. The first inflection occurred around the time of the financial crisis of 2007–2009, with the subprime mortgage crisis, auction-rate securities meltdown, and the deepening credit crisis. The first inflection was driven by escalating federal and state fiscal problems, including healthcare costs that had reached unsustainable levels. In most of the country, the industry now finds itself at a second inflection point, one characterized by six key trends, as outlined in the paragraphs below.

Trend 1: Employer and Insurance Market Transformation

Tired of unpredictable and increasing health benefits costs, employers are playing a key role in the transformation of the insurance market. They are moving employees away from defined benefit plans and into defined contribution plans (often with high deductibles coupled with health savings accounts), public health insurance exchanges or marketplaces,

Exhibit 13: Revenue Growth Spirals Downward Pressuring Margins



Source: Moody's Investors Service.

private exchanges, direct contracting, and Medicare and Medicaid managed care initiatives that rely on value-based rather than FFS payment systems.

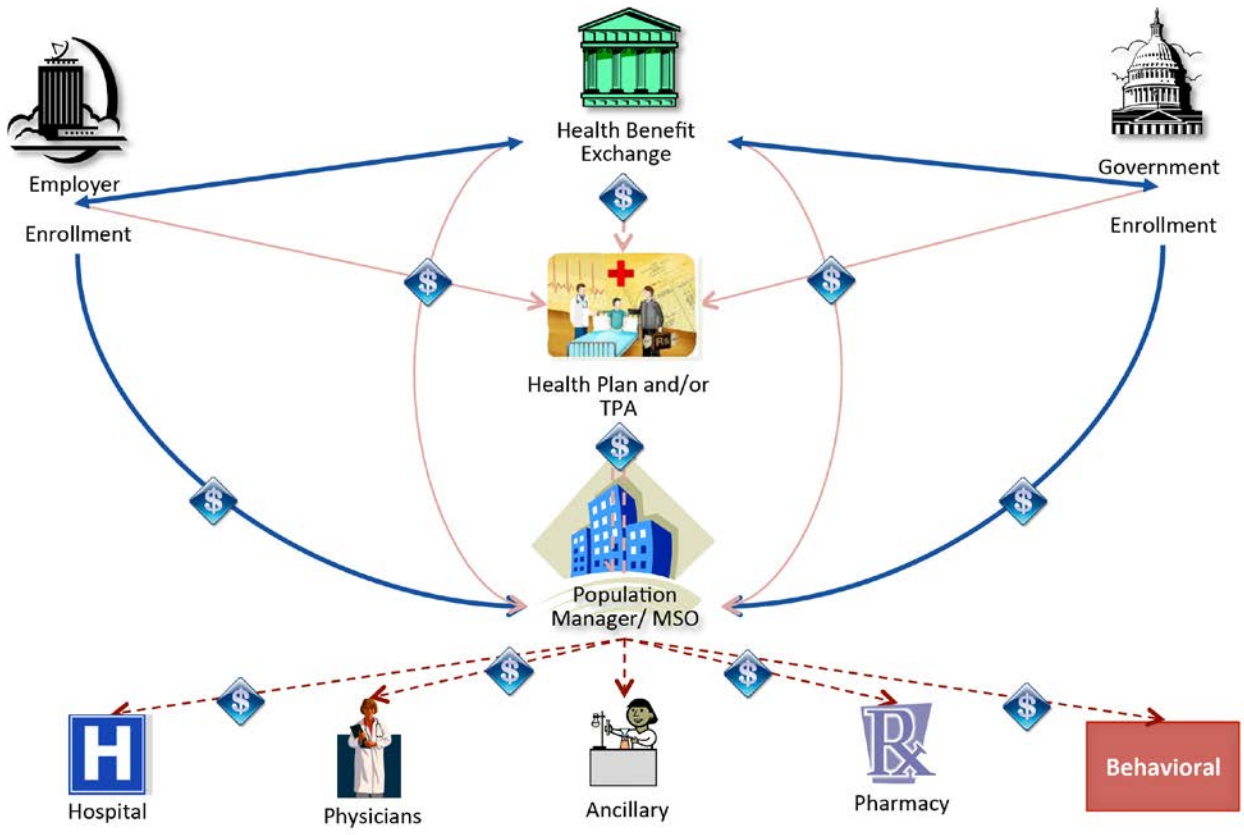
Several large employers are migrating employees to private exchanges. At Walmart, for example, all 16,000 employees will soon be purchasing coverage through a private exchange, with the company providing a fixed contribution for that coverage. (Previously, Walmart had offered a defined benefit plan.) Other large employers are doing similar things, and small employers will likely follow their lead. This change has resulted in employees having a broader array of coverage options from which to choose. Walmart employees, for example, can now choose from approximately 25 different plans that vary by network size, level of deductibles and copayments, and other factors. Research suggests that these exchanges are driving a fundamental shift in how consumers select coverage, with price being the predominant factor. In fact, a recent simulation exercise conducted by Blue Cross Blue Shield of Rhode Island found that monthly premium was the number-one driver of plan selection, with only 3 percent of consumers citing the providers offered in the network as their primary concern. The average participant spent only nine minutes choosing a plan on the exchange, and most expressed a willingness to change PCPs if offered a $15 or greater difference in the copayment for an office visit. Private and public exchanges are contributed to a narrowing of networks and public policy is supporting this movement.

For example, the premiums paid under Medicare Advantage allow insurers to offer various types of limited network plans at a profit. The proportion of Medicare beneficiaries enrolled in these types of plans has risen from 10 percent in the late 1990s to 30 percent today, with half of beneficiaries enrolling in some areas of the country. With respect to Medicaid, 46 states have some form of comprehensive managed care plan that covers all enrollees, typically either a primary care case management program or a risk-based, capitated plan. These models help to ensure beneficiary access to care while also providing structures to measure and improve quality, reduce costs, and promote other important health objectives.

Trend 2: Healthcare as a Retail Transaction

As defined benefit plans give way to defined contribution plans, employers are shifting financial risk to employees. As a result, employees feel the economic consequences of their choices and become much more interested in having access to information on provider cost, quality, and customer satisfaction

Exhibit 14: Population Health Management: A New Strategic Construct



Source: Kaufman, Hall & Associates, Inc.

performance. In essence, healthcare is transitioning from a wholesale to a retail business, which has made consumers more responsible for their behaviors and choices and hence more interested in transparency.

Under the old wholesale model, employers chose plan options for their employees, with most offering access to a broad spectrum of providers. For their part, Medicare and Medicaid established benefit plans and set payment rates for providers. Individuals had limited choice of plans but most plans offered access to most providers at the same cost to the consumer. Under the new retail model, employers offer a fixed dollar amount per employee or family. Individuals select a health plan on their own or through a private or public exchange and bear the financial burden if the price of the "healthcare they consume" exceeds the fixed dollar benefit. Individuals have broader health plan choices, but in most cases these plans offer more limited provider networks and/or impose additional fees for going out of network. Over time, consumers may switch plans after they get a better understanding of how their plan works. Some may decide to shift the balance and be willing to pay more for a plan that offers access to a broader network.

The move to a retail transaction shifts the focus of provider competition to the consumer, with brand, access to care, convenience, customer satisfaction, IT connectivity, and the ability to offer consistent quality, service, and price becoming of paramount importance. Health systems and other provider organizations have not historically excelled in these areas, but other potential competitors from outside the industry have.

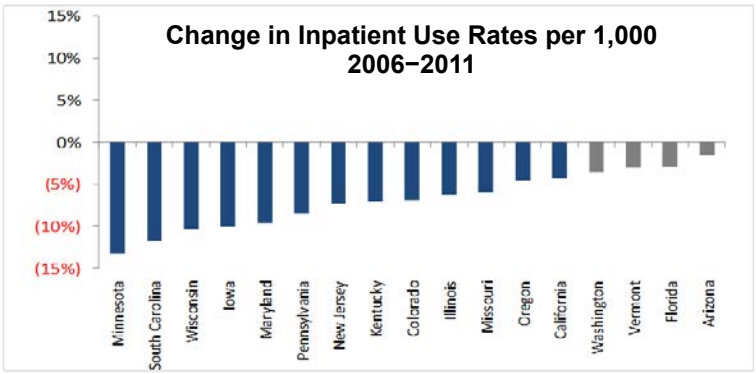
Trend 3: Population Health Management as a Business Problem and Opportunity

Population health management refers to when a healthcare system or provider network works in a coordinated manner to improve the overall health and well-being of patients across all care settings under a risk-bearing arrangement.[6] As depicted in **Exhibit 14**, an entity takes on the role of population health manager, coordinating and managing the care provided to enrollees.

The type of organization serving as population health manager varies throughout the country. In Southern California, for example, large independent practice associations (IPAs) are playing this role, taking on capitated risk from payers and

Exhibit 15: Shift in Risk to Providers Incents Elimination of Unneeded and Low-Value Care

State-by-State Use Rate Change Comparison



2011 Use Rates per 1,000
U.S. = 112

Age Group Use Rate Change Comparison

Weighted Average Change in Use Rates per 1,000 2006–2011

Age Group	United States
0–17	(7.1%)
18–44	(8.0%)
45–64	(5.4%)
65–84	(12.1%)
85+	(8.9%)

Notes: Weighting based on state population as percentage of total sample size population; discharges exclude normal newborns.

Source: Analysis by Kaufman, Hall & Associates, Inc.

6 G. Hill, G. Sarafin, and S. Hagan, *Population Health Management: Hill's Handbook to the Next Decade in Healthcare Technology,* Citi Research, May 14, 2013.

organizing a network of providers to provide care, often through subcontracts with hospitals and specialists. With a glut of hospital and specialist capacity in the market, the IPAs often negotiate very aggressively, paying only 75 to 80 percent of traditional Medicare FFS rates. Not surprisingly, hospitals and specialists are struggling to sustain margins, leading to major disruptions in the marketplace. Similar stories have begun to unfold in other parts of the country as well. In some areas, health systems have taken on the role of population health manager. For example, Advocate in Chicago has signed a capitated contract with Blue Cross Blue Shield to cover its 250,000 lives. Advocate has some employed physicians, but relies primarily on a group of independent, affiliated physicians to provide care through a provider network. As necessary, Advocate subcontracts for services not available in the network. In other areas, health plans have stepped into the role of population health manager.

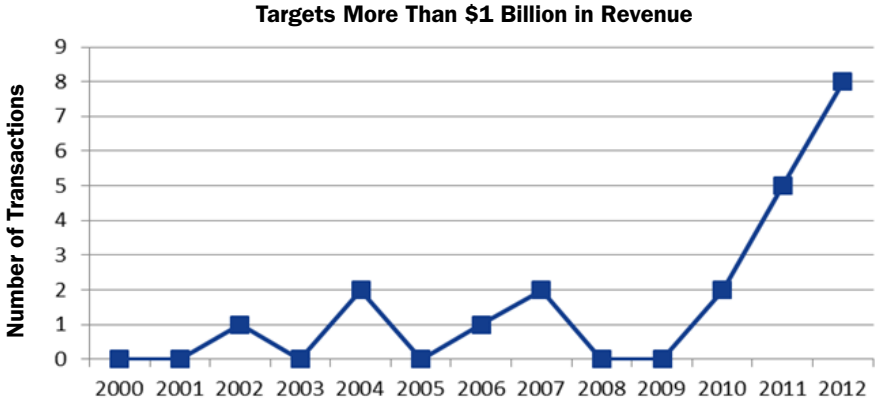
Regardless of who plays the role, the key is to organize a delivery network and then proactively manage the health and coordinate the care of individual enrollees. To that end, each of Advocate's 11 hospitals operates its own physician–hospital organization (PHO), which have been aggregated into a "super PHO" that contracts with every health plan. Once individuals ("lives") have been enrolled, physicians and hospitals both benefit financially if they control costs and improve quality, and get penalized if they do not.

A separate subsidiary (Advocate Physician Partners) supports physicians by developing tools to help them manage care, including clinical protocols and pathways and sophisticated IT systems that provide information on their performance. This physician-led subsidiary also polices physician behavior. Initially, 4,000 physicians were part of the super PHO, but over time the panel has narrowed as doctors that did not conform have been asked to leave by their peers. The self-policing approach stands in contrast to the traditional command-and-control approach still used by other providers. Under the command-and-control approach, a health system sets a single way of doing things that is believed to be the best approach for managing patients in a given situation. (Typically scientific studies and other evidence are used to develop these standards.) Physicians who deviate from this approach must explain why. By contrast, Advocate sets targets for physician performance and leaves it up to the doctors to decide how to reach those targets. The command-and-control approach tends to be more predictable, but in many markets the physician community simply will not accept this perceived intrusion on their autonomy. The appropriate strategy, therefore, depends on local circumstances.

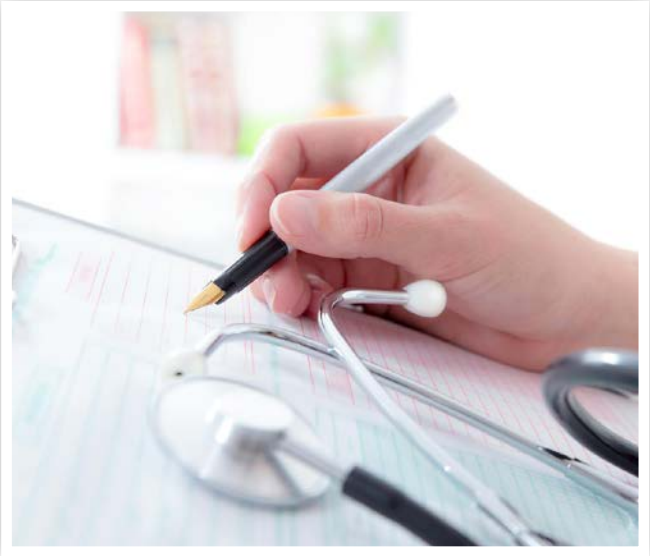
Trend 4: Flat to Declining Utilization

Inpatient utilization grew in the 1990s, leveled off in the early 2000s, and then began to decline in the mid-2000s. As shown in **Exhibit 15** on the previous page, many states have experienced significant declines in discharges per 1,000 residents over the last five years (although wide variations exist across states). The recent declines seem to reflect a national trend, even in states with historically low rates of inpatient use. In fact, the level of decline seems to be greatest in states such as Minnesota where managed care has been around for a long time. Payers in these markets are moving quickly to put in place shared savings and other risk-based arrangements with providers. Physicians in these markets already know how to

Exhibit 16: Acceleration of Number of Large Health System Transactions



Source: Kaufman, Hall & Associates, Inc. proprietary database.



eliminate wasteful and unnecessary care (which accounts for a third of all care, according to the IOM), and hence are moving aggressively to do so.

Utilization declines appear to result primarily from structural factors within the healthcare system rather than recessionary factors. Health economists do not expect a rise in utilization as the economy recovers. Rather, inpatient use will continue to decline due to the following factors:

- A shift to value-based reimbursement in many markets
- Focused work to reduce readmissions
- The transition of patients to observation status
- Increased use of case managers outside the hospital walls
- Development and adoption of medical homes
- Improved ability to transmit test results between providers, which reduces the need for repeat work

Given this underlying trend, health system leaders should carefully consider any new investments in inpatient facilities. While some organizations will still need to replace aging facilities, most new investments should likely focus on improving ambulatory care infrastructure.

Trend 5: Mega-System Formation

Within the last few years many large organizations have formally merged, such as Baylor Health Care System joining with Scott & White Healthcare and Trinity Health merging with Catholic Health East (one of several mergers involving Catholic systems). Some systems have embarked on "partial integration," such as BJC Healthcare joining with Cox Health, Memorial Health System, and St. Luke's Health System to form the BJC Collaborative, which focuses primarily on shared savings opportunities and joint contracting. Similar collaboratives have been formed in New Jersey and Georgia. As depicted in **Exhibit 16**, transactions involving organizations with more than $1 billion in total revenue have accelerated significantly since 2009.

Trend 6: The Emergence of New Competitors

Whenever major disruptions occur in an industry, individuals and organizations with a different perspective often enter the market and address problems in a fundamentally different manner. Nowhere is the emergence of these new types of competitors more prevalent than in healthcare, where Walmart, DaVita, Walgreens, Highmark, UnitedHealthcare, and others are seeking to fundamentally change the nature of the provider industry. For example, leaders of Walgreens have publicly announced the goal of making the company the largest provider of healthcare services in the world. Walgreens has a nearly unmatched retail presence, with a store located within 15 minutes of 90 percent of Americans. Walgreens already offers primary care in store-based clinics, and the company is aggressively moving into chronic disease management by leveraging its sophisticated IT system.

Walgreens and other new competitors could be a major disruptive force in many local markets. Health system leaders need to think beyond other health systems and providers as their only competition, recognizing that the main competition may be from untraditional competitors, particularly large retailers.

Key Implications for Health Systems: The Need for Scale

The six trends outlined above have significant implications for health systems:

- Revenue will be under significant pressure over the next several years; leaders will have to decide with whom to contract and under what terms.
- Business as usual will no longer work; the key challenge will be learning to manage population health effectively.
- 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.

These five implications all point to one larger message for health system leaders—there is a critical need to become bigger. Additional consolidation (including larger deals) will be necessary to remain relevant, assemble the intellectual and financial capital required to succeed, and absorb and manage risk. Scale is already bringing financial benefits in an FFS world, with large organizations generally enjoying slightly higher margins (one or two percentage points) than smaller ones. While this difference may seem small, it allows large organizations to invest 25 or 30 percent more each year in critical areas such as IT and care management.

The necessary level of scale varies by market. In the FFS world, the required scale depends on the size and nature of the relevant providers, payers, and employers in the area. However, in general, the data suggest that systems with more than $1 billion in revenue tend to have superior (and less variable) performance, including significantly higher revenue growth, operating margins, and levels of capital spending, along with better balance sheet ratios. The benefits of scale, moreover, increase

as revenue grows beyond $1 billion. In fact, there appears to be a virtuous cycle that comes with getting bigger. Systems with more than $4 billion in revenue generate five times as much cash as those with between $1 billion and $2 billion in revenue.

In addition to sustaining performance today, scale can help ensure a smoother transition to the future. Scale supports organizational development, helping providers play "catch up" on the ambulatory front and allowing for significant capital investment in IT, care delivery redesign, physician network development, and other infrastructure and expertise needed to manage care for a fixed price. Scale also helps providers become more relevant to purchasers. Providers cannot lead the transition to the new business model without the participation of the purchasers. To activate this change and drive new partnerships, providers need enough scale to be relevant and important to purchasers.

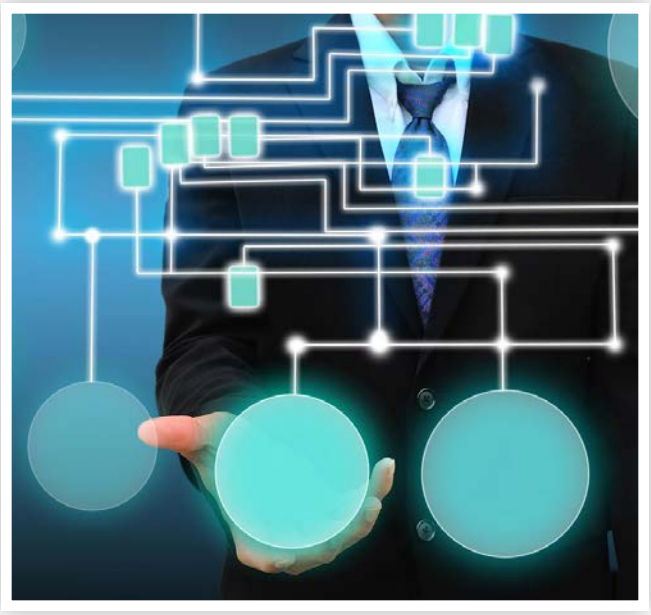
The key question, therefore, is how big is "big enough"? To achieve a predictable level of performance (i.e., relatively little variation in operating margins), provider systems need to cover at least 250,000 lives. This size allows the system to spread the risk of disease incidence and cost over a large enough base to ensure relatively stable finances. Assuming annual healthcare spending of just under $5,000 per individual, the 250,000 lives translate into roughly $1.2 billion in revenue at a minimum.

What Level of Scale Is Required?

- Required scale in the fee-for-service business model varies depending on the size and nature of the relevant provider, payer, and employer markets.
- The financial data provide direction as to preferred scale and where the competition is headed:
  - » **Systems with more than $1 billion in revenue** show superior and less variable performance.
- In general, systems with more than $1 billion in revenue achieve:
  - » Significantly higher **revenue growth**
  - » Increased **operating margins**
  - » Better **balance sheet ratios** and consistently higher **capital spending ratios**
- Scale's virtuous cycle: Systems with *more than $4 billion in revenue* generate **five times as much cash** as those between $1–2 billion.

Source: Kaufman Hall analysis, Proprietary Moody's medians data, Moody's Investors Service (date received: October 23, 2013).

As current activities make clear, however, many systems will not stop consolidating when they reach 250,000 lives or $1.2 billion in revenue. Looking ahead, Kaufman Hall anticipates that ultimately there will be between 200 and 400 integrated health systems (and perhaps fewer). Large markets will likely be home to three or four systems, while smaller rural markets will have just one or two systems. Most systems will generate between $4 billion and $8 billion in annual revenue, enough to allow for investments in IT, care coordination, intellectual capital, and other areas needed to meet the cost and quality requirements of the new marketplace. (Each market is different and understanding the scale required for effective competitive positioning over the long term requires a thoughtful assessment of the local, regional, and national environment.) In addition, roughly 100 to 200 freestanding academic medical centers, safety net hospitals, and children's hospitals will likely be a part of this "end state." The challenge for the leaders of these large systems will be to remain "high touch" and offer broad access to ambulatory care while still maintaining the infrastructure needed to compete on costs and quality.



Education, Patient Safety, and Reimbursement: Innovative Strategies for Maximizing Quality and Reimbursement in an Era of Accountable Care

Jeffrey D. Lowenkron, M.D., M.P.P., CEO of USF Physicians Group, reviewed innovative strategies for maximizing quality and reimbursement in an era of accountable care, including efforts to revamp medical education and manage health in a senior community.

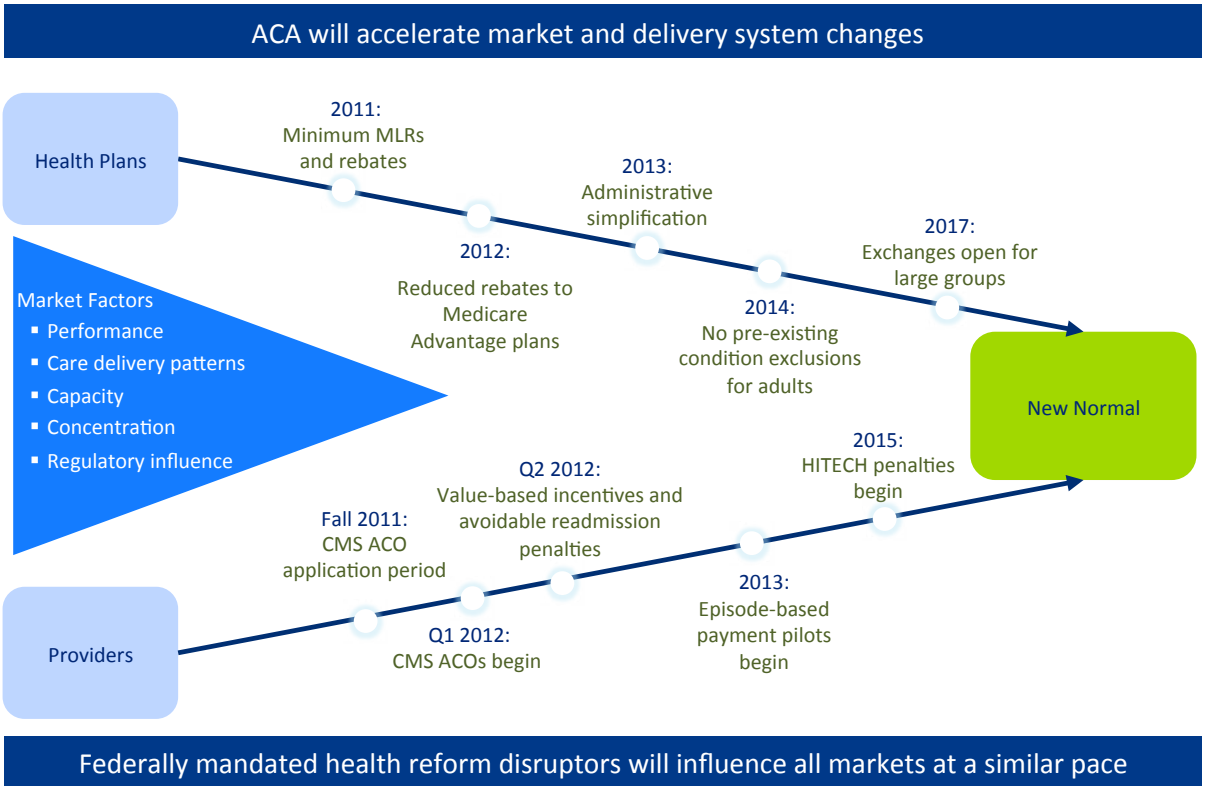
As illustrated in **Exhibit 17**, a variety of market and federally mandated factors are driving rapid change in the industry, with pressures increasing as health plans and providers consolidate.

End of the Status Quo

These changes mean that the traditional "value" equation (the ratio of benefits to price) is being replaced with a new one: quality outcomes combined with patient safety and service, all divided by cost. Payments may go up or down depending on performance in any of these four areas. This change means that "business as usual" will no longer suffice. Going forward, providers can look forward to the following "sure bets":

- **Reimbursement and payment structures:** Cost, quality, and service will drive the level of payments to providers. Hospitals will be held accountable for the care provided to patients, and hospitals and physicians will increasingly take on collective risk for their performance. Medicaid payments will decline over time due to iterative changes to payment structures and states becoming accountable for a portion of the costs of the Medicaid expansion. Increases in Medicare payments will be negative, non-existent, or very small. Prosecutions for fraud and abuse within Medicare and Medicaid will increase, and the penalties for not having an EMR will outweigh the rewards. Even as they are forced to absorb declines in reimbursement from public payers, hospitals and physicians will have less of an opportunity to shift costs to commercial payers.
- **Compensation and workforce:** The decline in reimbursement means that physician compensation will not keep pace with inflation. Specialist compensation and office-based ancillary service utilization and payments will be under heavy pressure. As a result, the number of physicians seeking income stabilization through employment from hospitals, insurance companies, and larger multi-specialty groups will increase at an accelerating rate. Hospital-owned physician networks will be restructured. In addition, physician shortages will occur, including a projected shortage of approximately 45,000 PCPs and 46,000 medical and surgical specialists over the next

Exhibit 17: The ACA: Market and Federally Mandated Factors Driving Rapid Change



decade. These shortages will lead to increased use of physician extenders.

- **Competition:** Payers will push hard to be the organizers of new delivery systems by leveraging existing relationships with employers along with their significant data capabilities and substantial financial resources. Only peak-performing health systems will have access to the capital they need to compete effectively, which will lead to more consolidation among organizations looking to achieve scale and more closures among those unable to do so.

Faced with an environment where there is less "food" (i.e., money) available, "table manners" will likely deteriorate among physicians, multi-specialty group practices, and hospitals, with each party increasingly fighting for a larger share of a shrinking pie.

The Need for Disruption

Too many health systems are still organized as "silos," with each department run separately and performance measured on a department-specific basis. Before Dr. Lowenkron arrived at USF, department heads acted as CEOs of their own companies. Organizations run in this manner need to experience a minor (or perhaps major) disruption. Dr. Lowenkron created such a disruption shortly after his arrival at USF through the following actions:

- **Streamlining management, encouraging innovation**: In his first six months, Dr. Lowenkron removed an entire level of administration, and made it clear to those on the front lines of care (who generate 90 to 95 percent of all good ideas) that he welcomed their thoughts and would support trying new things. He emphasized the need for an early detection system so that the ideas that work would be augmented and spread throughout the organization, and those that did not would be refined or shut down. Either way, he made it clear that USF would pay for the test, and that no negative repercussions would result from proposing an idea that proves ineffective.
- **Requiring and enforcing non-compete agreements**: He insisted that management abide by existing policies—have newly recruited physicians sign a restricted covenant preventing them from leaving to compete with USF. Historically, physicians routinely got out of these agreements just because they preferred not to sign them. Now they must sign except in two specific cases—when they join USF with their own existing practice and when they are jointly hired by USF and a partner hospital.
- **Developing business (not funding) plans**: Dr. Lowenkron ended the organization's practice of developing "funding plans" that raised money to support the hiring of individuals to fill specific positions, instead moving to creation of "business plans" based on the competitive marketplace. As a result, USF new hires have expectations for performance into the future, which can be compared to the business plan used to justify the new hire.
- **Revamping compensation system**: USF leaders designed a new compensation plan to incorporate productivity. Reflecting the realities of the marketplace, physician income under this system could initially only remain the same or go down. Within a year changes were made to allow income to go up or down based on performance. Over time, USF will add service and quality components to the system likely defined by the payers, thus allowing for the alignment of incentives with outcomes. Under this system, physicians can now earn more money than before by performing well on the established metrics.
- **Encouraging a new way of thinking about managing health**: Dr. Lowenkron spearheaded an effort to think differently about when and how to intervene in a person's health. Rather than waiting for an individual's health status to decline to the point that he or she needs to be hospitalized, the goal is to intervene earlier by monitoring ongoing health, identifying the point where things go downhill, and then intervening to prevent the initial hospitalization. This change does not come naturally to either patients or physicians. Patients who feel healthy generally do not want to change their behaviors. For their part, physicians find it challenging to change patient behaviors and see little financial reward for doing so. To change this dynamic, both parties need to work together under a system with the appropriate incentives.

Specific Programs Designed to Disrupt the System

USF has embarked on several specific initiatives designed to disrupt the current system and to teach doctors and patients this new paradigm of early intervention.

A New Way of Selecting and Teaching Students

The first initiative targets physicians during their training. Most medical schools look for students with great grades and

standardized test scores. They want smart, hard-working individuals, and consequently focus primarily on students in the 99th percentile academically, with little or no attention paid to interpersonal skills (e.g., level of empathy, ability to communicate) or creativity.

This approach misses a fundamental truth, which is that the best doctors tend to be highly creative, empathetic, and skilled at talking with patients. Believing that its medical school might be able to admit better future physicians, USF launched the USF Health MCOM SELECT Program in partnership with the Lehigh Valley Health Network (located 1,100 miles away in Pennsylvania). Under this program, the medical school considers a larger pool of candidates—anyone scoring in the 92nd percentile or above on academic criteria such as grade-point average and test scores. Those applicants meeting that hurdle are then screened for emotional intelligence, including creativity, empathy, and communication skills. This change has resulted in the acceptance of a different type of student. Once the students arrive, moreover, USF teaches them using a new curriculum designed to give them the skills needed to succeed under the new paradigm.

A Partnership to Improve Community Health

USF launched the America's Healthiest Hometown initiative in partnership with The Villages, the largest active living community in the country for those 55 and older. The Villages has 95,000 residents, with 10 new homes being sold each day.

Two years ago, USF and The Villages conducted the largest public health survey ever administered to seniors. In total, 88,000 surveys were sent out, with 33,000 returned, translating into a 38 percent response rate. (Most such surveys garner a response rate of only 1 or 2 percent.) After reviewing the survey results, The Villages created a primary care model built around a patient-centered medical home (PCMH), with USF handling specialty care. USF is also dedicated to public health activities in The Villages and hosts various speakers and a wide array of activities. In addition, two primary care centers have opened, with three more scheduled to open by March 2014. Each center can care for 10,000 patients, using eight PCPs, two nurse practitioners, social workers, an audiologist, and other staff. Thus far, there have been no problems attracting PCPs, with 34 doctors having been hired in the last year, 26 of whom came from outside of the area. A new specialty care center recently opened, and a major insurer in the area (UnitedHealthcare) recently introduced a Medicare Advantage plan that offers a $0 premium and $0 copayment for primary care visits. This plan should eventually attract between 60 and 70 percent of residents. Surveys show that residents are with the community although they are eager to have a more coordinated healthcare system. The public health survey results showed that while they have physical ailments similar to others of the same age, residents have a much greater sense of social connectedness. This is a result of how the community is designed; for example, benches are placed around centralized mailboxes to facilitate social interaction when residents get the mail.

Center for Advanced Medical Learning and Simulation

USF developed the Center for Advanced Medical Learning and Simulation (more commonly known as CAMLS), which offers simulation technology, team training, research and innovation, and other evidence-based programs taught by experienced peers who help clinicians transition to the new value equation by practicing and perfecting techniques in their specialty and learning teamwork and collaboration. It also allows the field of medicine to investigate important questions that need to be answered to deliver high-value, appropriate, cost-effective care. Examples include the following:

- **Heart attack care**: The simulation center is being used to investigate questions that will inform the delivery of optimal heart attack care, such as:
  - » How long does it take to get the patient to the catheterization laboratory?
  - » Are only the right people coming into contact with the patient?
  - » Is the existing chest pain protocol efficient?
  - » Does it cost more or less to have a door-to-needle time of less than 30 minutes (versus the old standard of 90 minutes)?
  - » Does the reduced time yield better or worse outcomes? (Doctors may make more mistakes when faced with increased time pressures.)
- **EMR implementation, including best-practice alerts**: EMRs do not always save physicians time, particularly right after implementation of a new system. At Kaiser in the mid-Atlantic states, for example, EMRs initially added 1.5 hours to most doctors' days, although some doctors saved time. By bringing together physicians who saved time with those who lost it, Kaiser was able, over time, to teach all physicians to use the EMR in a way that, at worst, cost them no additional

time and in some cases saved them significant time. The simulation center can help health systems with the process of implementing EMRs by simulating their use. For example, it is being used to test whether and how physicians incorporate EMR-generated best-practice alerts into their workflow, including issues such as:

  - » Workflow when the door is closed and only the patient and physician are present
  - » Signs of "alert fatigue" among physicians
  - » The potential for someone other than the physician to handle the alert in real time
  - » How to make the right thing to do as easy as possible through automation
- **Surgeon proficiency**: Measuring a surgeon's proficiency (e.g., with robotic surgery) can be quite a challenge. It has historically been done through peer review, which has generally proven ineffective in identifying problems. The simulation center can be used to evaluate a surgeon's technical skills, including comparing performance with others to identify those who can act as peers to under-performers. CAMLS can also be used to track performance over time to gauge improvement and to test the effectiveness of corrective actions when required. The center can also simulate negative safety events, such as a medical error or near miss, including the quality of follow-up actions after such events. Finally, it can be used to test improvement strategies, such as what might be required to reduce surgical risk by 90 percent for a given procedure.
- **Primary care productivity**: The simulation center has been used to understand how to improve productivity in primary care without making the patient feel as if he or she is being rushed. In the future, it will be used for similar purposes in other settings, including ambulatory surgery centers, labor and delivery, and EDs. The goal in primary care is to figure out how caregivers can see four patients an hour instead of three, but have it still feel to patients as though the time with the caregiver has remained the same. To that end, testing in the center has focused on answering the following questions:
  - » Are all the team members in the right place, and doing the right things?
  - » Would team members continue to do what they are doing if they could see themselves?
  - » How can alignment be achieved around the idea of seeing more patients each hour?

As more people go through CAMLS, USF will build a database that will allow for the calculations of means and standard deviations around performance in many areas. This information will be used to identify best practices related to safety and quality and to assess current performance with respect to these practices.

Conclusion

As this report makes clear, the ACA and other external factors are ushering in an era of accountable care where health system leaders will be challenged to live up to their mission and vision while still maintaining an adequate margin to ensure the organization's survival over the long term. Success will require a fundamental restructuring of the care delivery system, with the goal of effectively managing population health under capitation and other risk-sharing arrangements. Executing this transition likely requires sufficient size and scale to spread the risk of disease incidence and allow for significant investments in IT, care management, and other necessary infrastructure. It also requires an accompanying culture change within the organization, with providers coming together to work as part of multidisciplinary teams organized to deliver standardized, evidence-based care, including proactive preventive care, screening, and monitoring to identify patients whose health status is at risk before they require hospitalization. The Governance Institute's Fall 2013 *System Invitational* highlighted many strategies and actions necessary for organizational leaders to succeed in these efforts, and laid out key lessons that can help ensure that success. As always, other Governance Institute tools and resources are also available to support member CEOs and boards in this work.

Key Questions for CEOs and Boards

Dr. Lowenkron and other faculty members challenged health system CEOs and boards to disrupt their systems. To get started, leaders should ask themselves tough questions related to their organization's ability and readiness to succeed during the ongoing transformation in healthcare. Key questions include the following:

- **What are you doing now as payment mechanisms change?** System leaders cannot afford to wait until the transition to value-based payments is complete. Actions must be taken today to prepare for that future.
- **From what data are you speaking?** Executing change is hard, even when it makes incredible sense to do so. Data can help identify what needs to change, convince others of the need for those changes, and determine which changes do and do not work.
- **How will you know you are right?** Systems need to take a balanced approach that considers various types of metrics, including those related to quality, safety, costs, productivity, cost-effectiveness, and patient and employee satisfaction and engagement.
- **How much is it worth to be right? How much will it cost to be wrong in terms of quality, safety, service, or costs?** Sometimes the upside may be limited, but the potential downside to not taking action may be quite large.
- **How have you aligned your physicians and staff to welcome the change?** Without alignment of the workforce, system leaders often resort to driving change from the top down, which seldom works.
- **How confident are you that when the door is closed, people are doing the work you really want them to do?** People's behavior when no one is watching becomes the true test of whether the culture has changed and true alignment exists.