BoardRoom Press

A Bimonthly Journal of News, Resources, and Events for Today's Healthcare Boards

THE GOVERNANCE INSTITUTE ■ VOLUME 29, NUMBER 3 ■ JUNE 2018

GovernanceInstitute.com

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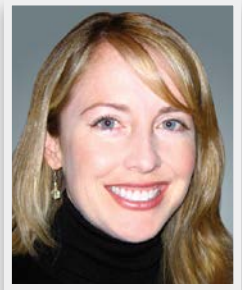

We often discuss "systemness" in the context of health systems specifically, whether it entails clinical integration, standardization of practices and processes, reducing unnecessary variation, or streamlining and aligning boards in a multi-tiered governance structure.

What happens if we put "systemness" into a different context all together, and apply it to all care settings? Can we apply it to board practices? In today's healthcare environment it is necessary to streamline and maximize efficiencies and put in place highly reliable processes across every level and at every opportunity. This is not limited to health systems, and we certainly don't want to pigeonhole these concepts into the operational frameworks of Lean or Six Sigma. What does high reliability mean at the governance level? How can a board become highly reliable to facilitate a culture of systemness throughout the organization? Having board-level processes allowing for reliable implementation of strategy, effectively structured board agendas to maximize time for necessary generative discussions, and building strong accountabilities for management to reliably achieve goals are some best practices to begin a strong foundation for any board, whether in a system or not, to help facilitate reliability and systemness across their organization.

This issue's lead article focuses on the board's role in achieving systemness through high-reliability concepts. Smooth executive transitions are an essential component to organizations' ability to maintain and further systemness. Streamlined efficiencies are critical for succeeding in value-based payment models. Finally, systemness in today's context requires an acute focus on the consumer and finding ways to redesign care to meet consumer expectations and build loyalty. We hope the articles in this issue provide essential resources for your board as you pursue the ultimate aim of systemness, from the board level all the way down.

Kathryn C. Peisert, *Managing Editor*

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Systemness: The Path to High Reliability

BY CHRISTINA M. FREESE DECKER, FACHE, SPECTRUM HEALTH

Christina M. Freese Decker, FACHE
Executive Vice President and Chief Operating Officer
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In a healthcare landscape ripe with mergers and acquisitions, consumerism, and non-traditional providers of care, continued success requires the ability to deliver value and compete in new and innovative ways. Our community and consumers expect our organizations to provide consistent, high-quality, and safe services. They also expect that we follow best-practice guidelines and excel at care coordination. This is what it means to be highly reliable for the people we serve.

At Spectrum Health, we strive to achieve high reliability in a complex health system. One of the key tenets for making this possible is "systemness": cultural and structural integration that serves as the cornerstone for high reliability.

Systemness has become a buzzword yet it represents an important concept and philosophy. It is imperative to provide value to the communities we serve and achieve the quadruple aim—better health; lower cost; improved experience, including outcomes; and joy at work and provider fulfillment.

There are certain common attributes of systemness that high-achieving organizations share or aspire to: a clear definition of the organization's identity and purpose; frictionless connections between people, physicians, caregivers, insurance providers, and health and wellness resources; and a focus on best practices and being highly reliable.

A Defining Moment

The pace of mergers and acquisitions in the healthcare industry has quickened over the past two decades. My own organization has significantly changed from a community hospital to a $6 billion integrated health system with a robust health plan, a talented multi-specialty medical group, and award-winning hospitals and service sites.

Most health systems face a defining moment. Ours involved declaring we were "One System, One Focus, One Experience." Previously, members of our system were proudly independent in their various locations and business units. To be successful in the future, we needed to be proudly integrated as one system.

To achieve our goals of being one system, we launched three initiatives: implementing one electronic clinical and financial platform across the entire system, establishing a streamlined structure to promote communication and collaboration systemwide, and executing high-reliability best practices.

Creating Board Champions

To launch these initiatives, we first had to ensure we had the full understanding and support of the board. Because systemness often is a new concept for board members, we invested time during the past year to educate board members across our hospitals on the topic. Additionally, we established clear metrics and prepared the board to anticipate and take action related to industry changes and market forces.

As part of our ongoing education with board members, we conducted several symposiums related to the role of community hospital boards and identified board members' top priorities as quality, community health, and philanthropy.

Last spring, the board symposium specifically focused on high reliability. Board members learned that high reliability involved quality and safety as well as reducing variation across all disciplines, such as process improvement, patient experience, and finance. They also came to understand the need for culture change and to prioritize this work.

Board members initiated discussions at their respective board meetings and quality committees about high reliability and how to shift the organizational culture. As board members and quality committees began to review and understand high-reliability organization (HRO) principles, they embraced the potential and were excited about the positive impact that systemness efforts could achieve. Board members have evolved to become champions of high reliability. They see the value in this work for our organization and the community, and are excited about our progress.

Key Board Takeaways

Boards at hospitals and health systems striving to achieve high reliability should take the following steps to ensure they are supporting efforts to create systemness:

- Become educated on systemness and identify board priorities for developing a high-reliability strategy. (Independent hospitals can benefit from a "systemness" assessment to ensure that clinical service lines perform using standardized processes and procedures across the organization, for example.)
- Be prepared to anticipate and take action related to industry changes and market forces.
- Ensure that the board recognizes the value for the organization and the community in striving to achieve high reliability.

A Common EHR Is the Beginning, Not the End

A single electronic clinical and financial platform for management and stewardship of all patient information is a building block toward systemness. Having one electronic health record systemwide is fundamental to removing technical barriers so we can deliver exceptional experiences and achieve the greatest level of coordination.

To begin the systemness effort, we implemented a consistent EHR throughout our 12 hospitals, 180 service sites, and 1,600-provider medical group. This multi-year effort has transformed care delivery at every location for every person.

Previously, extensive variation existed across our system, including 10 different EHRs, more than 1,200 order sets, eight processes for patient movement, 86 revenue-cycle add-ons for 38 vendors, and more than 20,000 setup protocols for surgery. As an integrated health system, we can create more value and ensure safer, higher-quality care when we have a tool that enables the different parts of our system to work in sync. For example, now we have approximately 400 order sets instead of 1,200, and 218 standard work documents. Systemness enables us to coordinate care for the optimal consumer experience and makes it more fulfilling to do our work.

Structural Alignment Paves the Way

A focus on structure is essential to ensure success and sustainability. As part of our

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Answering CEO Turnover: Do You Have a Plan?

BY LARRY R. MCEVOY, M.D., FACEP, LCI GROUP, LLC

Healthcare swirls with epidemics—opiates, clinician burnout, obesity, diabetes—and to this list you can add one more: CEO turnover. It's not just the occasional CEO that leaves—it's almost one in five, every year, and that number has held steady since a high of 23 percent annual turnover in 2008.[1] Given the impact of CEO stability on an organization's ability to address an increasingly complex set of challenges, CEO selection and retention must rise to the top of any board's list in governing a stable, evolving organization headed toward sustained high performance.

CEOs leave for a variety of reasons, but whatever the prompting conditions, the root cause is that alignment between the CEO and the organization is insufficient to prevent departure. To ensure their organizations can attract and support top talent, boards must take several steps that signal to potential and incumbent leaders: "We're in this for the long haul, we have a direction, and while the landscape may quake, we're solid."

Certainly the pieces of CEO attraction and support involve a competitive package and an appealing community experience for the CEO's family, but they also involve stability and continuity in the structures and functions so essential to CEO function: the board, executive team, physicians, strategy, and succession plans. A big part of this stability is the present state, but a process that continually and collaboratively renews strategy, leadership profiles, and succession approaches to all key leadership positions and bodies is an essential cornerstone. Particularly in multi-board systems, alignment of these pieces is key for CEOs to be able to pilot one organization while working as a supportive and seamless piece of the larger system.[2]

Once a board has established or reviewed these foundational pieces, the critical work of creating functional, high-performance relationships capable of meeting the challenges of CEO tenure begin. The problem, one health system CEO from an East Coast institution says, "is that it's not what you've done or not done before, it's the combination of challenges that *none* of us have really had to deal with that make the job so difficult." Another, who leads a multi-billion-dollar system, adds, "I think these jobs are becoming so complex we're going to have to think about how we design the jobs themselves, because they're becoming almost undoable."

Undoable? Consider that in 1993, management guru Peter Drucker observed that, "Large healthcare institutions may be the most complex in human history, and even small healthcare organizations are barely manageable." Today's CEO has to preside over an organization that must deal with acute care, post-acute care, primary care, and population health, often through a variety of business structures that are equal parts cooperation and competition; oversight of a merger-and-acquisition environment as the organization grows, either as an acquirer or an always-possible target; and consistency, reliability, and safety juxtaposed with flexibility, innovation, and evolution of care. There's also the move from fee-for-service to value-based reimbursement and its inevitable timing of political, regulatory, and payer winds. Then there are the people: those hundreds or thousands of around-the-clock professionals whose daily struggle through task-saturated workflow grind them toward higher percentages of burnout. Throw in the growth of mobile technology, artificial intelligence, and digital health, and the complexity a CEO has to navigate is formidable.

CEOs can't navigate these unknown waters singularly, no matter how deep their previous experience. In essence, the CEO's job is to multiply collective intelligence and action across a wide platform of people, topics, and challenges in a way that is unique to the complexity of the landscape and the organization. The job is to mobilize thought and action effectively against known and unpredicted circumstances—continually. What they've done before has not prepared healthcare as a sector for what we've never done before. Essential board work, then, is to help the CEO create new capacity in the organization—at the board, CEO, executive team, and physician levels.

Here are three areas of focus that can help an organization stabilize and optimize the CEO role.

Invest in "High-Stage" Leadership and Development

The data are starting to clarify what many have been suspecting—the best CEOs are not those who have "been there and done that," but those who have the capacity to mobilize people around previously un-encountered challenges. In their book, *Mastering Leadership*, authors Anderson and Adams demonstrate the data, which show that leaders with a higher "creative capacity" are most able to create abundant results—that is, to help complex organizations mobilize many people in the face of numerous complex challenges, new and previously encountered.[3] The good news? These kinds of executives are identifiable and developable. The bad news? They're very uncommon in the ranks of traditional corporate leadership.

Finding and selecting these kind of leaders is square one for stabilizing CEO tenure, but the board's and CEO's work begins, not ends, with selection. CEOs are not "done" when they start. In fact, only 28 percent of internally selected, and 38 percent of externally selected CEOs felt fully prepared for the job on selection according to a study by leadership advisory firm Egon Zehnder.[4] But with intentional development, CEOs

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Key Board Takeaways

- Set the table: Focus board work on aligning mission/vision/values, strategy, and leadership profiles, as well as overseeing active succession of positions and leadership pipelines.
- Build capacity: Invest in creating current and future leadership capacity at board, executive, and physician levels according to shared principles and approaches.
- Engage the work: Make this an iterative function of your board, not a one-and-done effort. "Are we governing for leadership capacity and stability?" must be a continual conversation in a turbulent environment.

1 ACHE, "Hospital CEO Turnover Rate Remains Steady" (press release), May 19, 2017.
2 *Strengthening Our Nation's Healthcare Leadership,* Yaffe & Company.
3 Robert Anderson and William Adams, *Mastering Leadership: An Integrated Framework for Breakthrough Performance and Extraordinary Business Results,* 2015.
4 Karen Talley, "Empathetic CEOs Said to Accomplish More: Reports," *FierceCEO,* April 26, 2018.

The 21st-Century Patient Is More Complicated but the Remedies Don't Have to Be: How Bundles and Other Innovations in Healthcare Payment Are Offering New Promise for Care Delivery

BY DEIRDRE M. BAGGOT, PH.D., M.B.A., RN

Principally inspired by the Affordable Care Act (ACA), in May 2018 United Healthcare announced its intent to expand its spine surgery bundled payments program from 28 markets to 37 markets. United Healthcare has seen a 22 percent decline in readmission rates, a 17 percent reduction in complication rates, and cost reductions totaling approximately $3,000 per case in the spine surgery population after implementing bundled payments. These findings are not unique, in fact they are very consistent with the growing body of literature to support bundled payments as a viable alternative to fee-for-service, which is costly and incentivizes duplication and waste. Additionally, later this year hundreds of hospitals and doctors will commence participation in the Centers for Medicare and Medicaid Services' Bundled Payments for Care Improvement Advanced program. Employer sponsored bundled payment programs continue to evolve with both national and regional employers.

Was the goal of the ACA to free up $1 trillion dollars for tax reforms? Was the goal to improve access to care by providing universal healthcare coverage for all Americans? Or was the goal to make healthcare better?

In America the average life expectancy is 80-plus years, nearly 30 years longer than a century ago. Medical progress in the United States has been undeniable. We have reduced infant mortality rates twenty-fold and we tackled the biggest killer of women—child birth, virtually eliminating child birth-related deaths over the last century. Similarly in the area of payment reform, between 2012 and 2016 the percent of CMS payments to providers caring for patients in Alternative Payment Models (APMs) went from 0 percent to 30 percent, representing $200 billion dollars.[1] Despite this progress and paying nearly double than other wealthy nations for healthcare, in 2018 health outcomes are still unreliable at best. In fact, medical errors today represent the third leading cause of death in the United States after heart disease and cancer.[2]

While we are often quick to point to the complexity of the U.S. healthcare ecosystem as the root cause, it doesn't fix the fact that two million Americans will get a hospital-acquired infection this year. It also doesn't fix our lack of understanding as healthcare providers of just how addictive opioids are, which has been a major factor contributing to the opioid epidemic in America.

While there are major areas where we have made progress, the great opportunity today for board members and senior executives is to support and resource efforts that augment front-end discovery with systems innovation and the science of process engineering on the back end.

What Did We Learn from the Affordable Care Act?

As it turns out, what we have learned thus far is that having a regular source of healthcare, at about the five-year point, begins to have a significant and positive impact on reducing mortality rates, improving survivorship, and improving overall health. We learned that a consistent source of care is critical to how healthcare creates its value in the 21st century.

We also learned, thanks in large part to the ACA, the immediate positive impact of transparency and access to data that gives us the computational power to discover what we can do today from a health prevention standpoint that would benefit patients in five, 10, and 20 years.[3] As a result of the work of the Center for Medicare and Medicaid Innovation (CMMI), which was funded by the ACA, 30 percent of Medicare patients are being cared for by doctors and nurses who are incentivized to keep patients out of hospitals and emergency rooms. This represents a fundamental change from the traditional fee-for-service construct, which incentivizes unnecessary and sometimes harmful testing and treatment. Because providers had more access to patient data, early findings show that patients in value-based care models had lower readmission rates, lower mortality rates, and lower total cost of care. In addition, the level of patient engagement as a result of data transparency is unprecedented. Patients now represent the fastest-growing user group of electronic health records (EHRs) in the United States.

What is less clear today are the long-term consequences of high-deductible health plans and the choices patients in these high-deductible plans make to forego taking their medication and seeing their primary care provider. While seemingly a good idea for some (namely the 20-something healthy Americans), high-deductible health plans have surfaced a growing trend where a subset of patients have $2,000 to $3,000 deductibles and are limiting sometimes necessary and important care.

What's Really Going On?

In the United States, we have over 60,000 different diagnoses, more than 6,000

Key Board Takeaways

For board members, it is important to understand what a smart bundled payment strategy looks like which means asking better questions, such as:

- Do we have a bundled payment strategy?
- What evidence do we have that it is working? Is care delivery improving? Are costs going down? Are we making money?
- Are physicians leading the effort and engaged in the work?
- Do we have the technology to scale our efforts with employers and commercial payers?
- Are we getting better at managing total cost of care, and if so, how do we know that?
- What percent of our reimbursement portfolio should be comprised of new payment models?
- Are patients engaged?

1 Centers for Medicare & Medicaid Services (CMS), "Alternative Payment Models (APMs) Overview," 2017 (available at CMS.gov).
2 Martin Makary and Michael Daniel, "Medical Error—The Third Leading Cause of Death in the U.S.," *BMJ,* 2016.
3 Deirdre Baggot, "The Bundled Payments for Care Improvement Program: A Hospital Analysis," *Becker's Hospital Review,* February 2013.

drugs, and more than 4,000 surgical techniques and procedures that we are attempting to deploy regardless of one's ability to pay. In any given city, providers typically receive payments from as many as 60 or more payers all paying completely different. And for patients with a chronic condition, the current system is so administratively burdensome that patients report feeling overwhelmed with the number of bills they received each month.[4] Fee-for-service isn't just expensive and unreliable, it is exhausting—for patients, physicians, and nurses.

The Evidence

With a bundled payment, one single payment is made for all of the care and services related to a specific clinical episode or condition. While bundled payments as a viable alternative to fee-for-service has been under investigation for more than 30 years, most studies in this reimbursement model have been in the areas of cardiac and orthopedic elective procedures due to their high overall total cost of care.[5] Largely influenced by the ACA, over the last five years we have seen both private payers and employers broaden their interest beyond elective procedures to include oncology care, post-acute care, and chronic disease bundles.[6] There has also been an increase in the number of studies in chronic diseases such as diabetes, asthma, and congestive heart failure, as well as oncology, maternity, and pediatrics.[7]

Assessing Areas of Organization Vulnerability in the Run to Risk

The five most common areas of vulnerability for healthcare organizations include the following.

1. Physician Engagement

While many hospitals and health systems have very strong relationships with their medical staff, one cannot assume that this is the case. The quality of your relationships with physicians will predict your level of success with managing bundles, ACOs, or any APM. When physicians are not engaged, nothing changes and silos will continue to drive a care delivery model predicated on waste, duplication, and mediocre clinical outcomes.

2. Big Data and Complex Analytics Necessary to Manage Total Cost of Care

In April 2018, CMS announced that, in its continued efforts toward data transparency, it would be making Medicare Advantage data publicly available in much the same way it has over the last few years with Medicare fee-for-service data. CMS has released more data in the last three years than it has in the 30 years prior in an effort to help providers understand how to begin to manage populations over time. However, while the physical world is three-dimensional, most patient data remains trapped in two-dimensional pages and screens. This gulf between the real world and the digital world prevents doctors, nurses, and patients from exploiting the volumes of information now available to us.

In the near term, a lack of ability to provide physicians and other care team members with information to make decisions at the point of care is a gap for many healthcare organizations. For example, information regarding cost and clinical variation at a provider level is often a big ask for hospital analytics teams, and more than 90 percent of the time it's a manual data pull that may take weeks to complete. Like it or not, physicians today who are trying to do the right thing for their patients don't learn of the patient's outcome until many months after the patient has gone home. The feedback loop is typically one year in most cases. There are a number of vendors (some better than others) that, for a fee, may either sell you their solution or do knowledge transfer and help you build this competency. Giving physicians bad data is worse than giving them no data, so in this area it is better to go slow and get it right while you build this competency. The end game is building competency to predict and prevent clinical variation. Risk mitigation is not defined as having it all figured out—instead it is about clear progress in building competency over time.

3. Pervasive Need for Care Transformation

Often within the same medical group the process for prepping a patient for surgery can be radically different. There is a pervasive lack of understanding when it comes to systems innovation across healthcare. While technology, AI, telemedicine, apps, and other solutions will help, there are some very simple fixes that need to occur in terms of standardization that will enable your success, such as showing physicians their data compared with their internal peer group in an effort to reduce clinical variation, adding metrics to service line report cards related to cost and clinical variation, updating your order sets and protocol to reflect 21st-century medicine, being more prescriptive with discharge ordering, setting expectations with patients around post-discharge care, and patient engagement with respect to medication adherence and ER avoidance. Small fixes can net big returns.

4. Infrastructure and Competency in Managing Care Transitions

There are two major phenomena that make transitions of care challenging and risky both clinically and financially that most organizations are still trying to figure out. First, the post-acute care workforce is largely under-educated and we have not done enough to support their knowledge development. Second, EHRs are largely non-existent in the post-acute care environment, which at least in part contributes to unnecessary return visits to the ER. Add to that the fact that leadership roles historically turn over much more rapidly in the post-acute care environment as compared with acute care, which can impede systemic and sustainable change that is so needed in many post-acute care facilities. Making sure your post-acute care partners have the tools necessary to manage total cost of care is important to assess at the outset. If your post-acute network is still under construction, it may make sense to select a population with fewer or no care transitions at the outset and dial up clinical complexity as your network and infrastructure allow for.

4 Margarida Azevedo, "Pilot Program to Help CF Families Navigate Care Systems Reports Initial Success," *Cystic Fibrosis News Today,* April 29, 2016.

5 Deirdre Baggot and Cleo Burtley, "Bundled Payments: How Seemingly Small Innovations in Care Delivery Can Lead to Big Financial Rewards," *BoardRoom Press,* The Governance Institute, April 2013; Peter S. Hussey et al., *Bundled Payment: Effects on Health Care Spending and Quality: Closing the Quality Gap: Revisiting the State of the Science,* Evidence Reports/Technology Assessments, No. 208, Agency for Healthcare Research and Quality, August 2012.

6 CMS, APMs Overview, 2017.

7 Laura A. Dummit et al., "Association between Hospital Participation in a Medicare Bundled Payment Initiative and Payments and Quality Outcomes for Lower Extremity Joint Replacement Episodes," *JAMA,* September 27, 2016; CMS, "Notice of Proposed Rulemaking for Bundled Payment Models for High-Quality, Coordinated Cardiac and Hip Fracture Care," 2016 (available at CMS.gov); CMS, "Episode Payment Models: General Information," 2017 (available at CMS.gov); CMS, APMs Overview, 2017.

5. The Ability to Influence
This work requires administrative and physician leaders who are visionary and who have influence with their peers. All too often I see physicians for whom leadership is their "Plan B" volunteering to lead this work. You need senior administrative leadership who can remove barriers and break down silos and you need a physician who has broad influence (ideally still practicing) in the organization, as every department from IT to revenue cycle to care management will be critical to your success.

The purpose of identifying risks is to guide you in your planning so that you prioritize improvements in the five areas of risk identified above.

> "What does it even look like to be agile at scale with bundles or risk-based reimbursement?"
> *—CEO, Academic Medical Center, East Coast*

Implementing Bundles

Big Gains with Relatively Simple Fixes

Why is it that while some organizations seem to be drowning in the complexity of knowledge that exists today, others are making big gains with relatively simple fixes?

Since 2012 with the launch of CMS's largest test of bundled payments, hundreds of organizations have learned first-hand the powerful cultural shift that occurs as a result of implementing new payment models. Qualitative and quantitative analyses of programs succeeding with bundles reveals several key similarities among participating sites.

Keep it simple. The population, strategy, approach, plan, execution, and evaluation should be as straightforward as possible while you scale up your competency to manage clinical and actuarial risk. Keeping it simple also applies to the population under consideration. The most predictive factor in managing total cost of care for an episode or patient or population is the number of care transitions. Patients who are cared for at home pose much less clinical and actuarial risk as compared with patients who access post-acute care.

Take an accurate diagnostic of your organization's strengths and weaknesses. When it comes to managing clinical and actuarial risk, having a good understanding of strong and weak areas will inform your path forward. Most organizations think they understand where clinical and cost variation exists but struggle to get after the *why* of clinical and cost variation. The winning strategy is to deeply understand what your organization is good at or find out who is good at whatever it is that you aspire to be. The diagnostic informs what is needed or missing and ultimately informs the care model necessary to drive superior quality and ensure your success with APMs.

Be smart about the investment. Both over- and under-investing have their consequences. A strategic approach to outpacing Goliath requires smart investments, given the real truth that technology is not there yet and EHRs have not been the panacea we all thought we were buying. Having studied more than 60 value-based payment technologies and solutions over the last 10 years, my assessment is that most are still in the MS-DOS phase of their evolution. Telemedicine, apps, care redesign, and the infrastructure to manage big data tend to be the areas of investment most organizations make at the outset. Make sure your investment makes sense for the market and the population under consideration.

Consider strategic value partnerships. There are several areas today where strategic partnerships are the difference between rapid market entry and new revenue growth and the alternative. The number one cause of death both in the United States today and the world is high blood pressure. One billion people worldwide suffer from hypertension and yet only 14 percent of individuals with high blood pressure have it diagnosed and under control. The medications that control high blood pressure have been around for decades and cost pennies on the dollar. However, with few exceptions, our delivery system has one way in which you can control your blood pressure: make an appointment and go into a physician's office for an in-person visit with a provider. In most cases, this is the only way the provider will work with you. Does a doctor really need to be involved every few weeks or can a patient text with his or her nurse or health coach to manage this condition?

Evaluate your strengths and gaps with respect to managing total cost of care. For example, what partnerships are needed for your organization to better manage the cardiac population? What technologies, systems innovation, analytics, contract management, and care management solutions or partners would give you speed to market?

The volume of knowledge and skill in healthcare and medicine today has exceeded human capability. You simply can't know it all, which is why the role of Alexa, AI, and other emerging system innovations offer new hope for improving health outcomes in America. While technology continues to emerge, doctors, nurses, social workers, and health coaches—who figured out long ago that computer systems don't break down silos—are identifying their gaps, finding partners, and quietly dividing and conquering, causing a revolution along the way.

Make sure patients are empowered and accountable co-creators of their health experience. Measuring and delivering what an empowered patient truly wants and needs hasn't been something providers have been very good at historically. In any value-based care model, the ways in which providers have engaged (or *not* engaged) with patients in the past makes for an untenable path forward. A hospital in Boston, against the guidance of its legal counsel, pioneered the concept of "Open Notes" whereby patients were allowed full access to read and edit their medical record. The findings have surprised many administrators and providers. Patients are more engaged, and these highly engaged patients have assisted in the reduction of medication and other errors in their EHR.

Put in the hours and follow the evidence. For several years, I have written about the importance of following the evidence when it comes to bundle selection. Programs that are succeeding first and foremost are doing so because they have committed the time and resources to building the muscle necessary to manage total cost of care for a bundle. Selecting bundles and APMs that have been well studied and are well supported will ensure that your move to risk-based care delivery won't break your organization.

Recently I read an article where the author categorized several disease conditions based on "high risk" and "high reward." The author put forth, for example, that sepsis is an episode of care that is both high risk and high reward. But sepsis is only high risk given its low price point, relatively small sample size for most organizations, and the complexity of the patient. In addition, the literature to support that bundles work in the sepsis population is nearly nonexistent. Alternatively, the impact of primary care on reducing unnecessary readmissions in the congestive heart failure

population is clear. Make certain that your approach to new payment models is evidence-based.

Manage big data. We will see our biggest area of system innovation over the next 10 years as a result of new access to information and better tools with which to make clinical decisions. Big data's impact is undeniable in value-based care and building the competency to manage big data is a strategic imperative today. One huge benefit of participating in pilots with public and private payers is the unprecedented access to data and the ability to get smart about managing risk. While there are many vendors that will sell you a solution to manage big data, with few exceptions, most are still in the MS-DOS phase of evolution.

Trust the algorithm. Underpinning every successful bundle is an algorithm. A checklist. A playbook for delivering a reproducible cost and quality outcome. Organizations that are succeeding with bundles and/or population health management are *not* doing so by "trusting their gut." They are evidence-based, protocolized, highly reliable environments where the patient's voice is heard the loudest.

Demand destruction. Yes, it's true, we are getting better at readmission avoidance and getting better at avoiding duplicative testing and treatment. Yes, there will be demand destruction, but if we are really honest, it is not revenue we want anyway. We want revenue from taking the best care of patients and giving them only what they need and nothing that they don't need for their whole life. Demand destruction will hit skilled nursing facilities, inpatient hospitalizations, inpatient procedures, diagnostics, and therapeutics the hardest. Smart leaders don't have their head in the sand, they are facing demand destruction head on. They are planning for it, budgeting for the revenue loss related to continued outmigration of orthopedics and backfilling the revenue loss with a value-based business model that brings new value to a marketplace. Payers don't actually care where you reduce cost or waste; that is for your team to determine and get after.

Prioritize and Focus

The board needs to understand that the only way to succeed with managing total cost of care is with adequate focus. Healthcare organizations that are thriving are doing so because leadership has given this the priority and focus that it deserves. Organizations that have not done well with managing total cost of care have not committed to the work at hand. Payment reform offers the opportunity to reconceive your business model.

The healthcare landscape today poses both complex challenges and tremendous strategic opportunity to pioneer new ways of delivering healthcare value. If industry transformation requires anything of board members and senior executives, it is focus. The onus is on you to help your hospital or health system make strategic decisions that best enable a future where your organization is able to manage total cost of care for a population and do it well. What those hospitals and doctors who signed on to test bundles with CMS and other payers have found is that by narrowing their focus, breaking down the problem into manageable parts, and getting help where needed they are perfectly capable to tune their systems to get better results and it doesn't have to be some complex remedy.

The Governance Institute thanks Deirdre M. Baggot, Ph.D., M.B.A., RN, Healthcare Payment Policy Expert; Former Lead, Acute Care Episode (ACE) Demonstration, St. Joseph Hospital in Denver, Colorado; and Former Expert Reviewer, Bundled Payments for Care Improvement (BPCI), Centers for Medicare and Medicaid Services, for contributing this article. She can be reached at Deirdre.Baggot@ucdenver.edu.

The APM No-Go Zone

While I acknowledge the research and innovation necessary to scale Alternative Payment Models, having implemented new payment models in more than 200 organizations with employers, commercial payers, and public payers over the last 10 years, I believe we have an obligation to be smart with how we go about investigating alternatives to fee-for-service. My no-go zone includes:

- **Small populations.** It doesn't matter how interesting the idea is. If you don't have enough of a sample size to distribute the risk, everyone loses. Ideally a population of no less than 150 patients per year is my threshold for ensuring adequate consideration of the actuarial risk, and in chronic disease the number of cases necessary may be even higher.
- **Gaps in clinical performance.** Given the retrospective nature of data, gaps in quality performance take 12–18 months to fix, no matter if the root cause is process or outcome related. So while you may believe you have resolved your high readmission rates in a particular population, you must plan for payers to not see it for up to a year or more in many cases. A better strategy is to put the population on an evidence-based protocol and validate that indeed the gap in clinical performance is a thing of the past and only *then* take risk.
- **Low price point.** Taking clinical and financial risk will require investments in care redesign, telehealth, care navigation, claims analysis and reporting, etc. This is not about a race to the bottom. Taking on financial risk assumes that you can provide not only a better clinical outcome but also a better cost outcome. Building agile models to scale requires the courage to move beyond historical cost-shifting exercises and be willing to pay for and value the importance of gold-standard care redesign and care management. If payers aren't willing to pay for care management, most chronic disease DRGs, for example, will likely be too low a price point for a bundle and would be better managed in a per member per month (PMPM) construct.
- **Unnecessary actuarial risk.** Doctors don't like to lose clinically or financially. Particularly early on, it is mission critical that care teams are able to be successful both financially and clinically. Most executives and clinicians believe that they can "do better" than their historical performance and better than their competitors. If the population is losing money today, go fix that problem first. In my experience, hospitals and doctors have a low tolerance for losing money or owing money. Therefore, make sure that you are stacking the deck in your favor at the outset as much as possible. You can always scale up complexity once you have a foundation of success from which to build on.
- **Lack of physician support.** New payment models should be a tool to further integrate clinically with your medical staff. The work necessary to drive the clinical redesign is real and requires physician leadership, enthusiasm, and engagement. You can't scale care redesign without real physician engagement.

Multi-State Health Systems: On Their Way at Last

BY BARRY SAGRAVES, JUNIPER ADVISORY

Five years ago, we wrote an article for The Governance Institute predicting that there would be an increasing number of health system mergers across state lines, creating new multi-state, super-regional systems that would have the benefits of scale, and not just size.[1] We pointed out that there were at that time only about five non-profit, non-Catholic systems formed in that way, and detailed the historical impediments to such developments. The systems we identified as meeting these criteria were Banner Health, Carolinas HealthCare System, Essentia Health, Mayo Clinic Health System, and Sanford Health.

We boldly predicted there would soon be many more cross-border combinations across the country—using the term "soon" advisedly, as change is usually slow in such a fragmented, conservative, and highly regulated industry. There have been few such transactions in this period; however, the conditions are increasingly ripe for these deals. In this article, we describe why this is the case, and double down on our prediction that such combinations will in fact begin to occur—soon.

Thar She Blows! A Textbook Example of This Trend

The recently completed combination of Advocate Health Care of Chicago and Aurora Health Care of Milwaukee is an example of this kind of transaction. They are of almost equal size, serve contiguous geographies, and have complementary areas of expertise. These systems also will gain size, but probably remain below the threshold where size becomes counterproductive.

The combined company will provide others contemplating such tie-ups with a number of criteria to consider when evaluating, negotiating, and structuring similar combinations. The key elements are:

- It is a "good-to-good" combination. The majority of transactions continue to involve a larger, stronger system taking on a smaller individual hospital or system. The "seller" typically has challenges of financial performance, capital access, or cost structure. Both Aurora and Advocate are successful, reasonably large regional systems with good positions in their markets. It is a more appealing task to make strong organizations stronger than to forge a turnaround of one of the partners.
- The "industrial logic" is strong. The service areas are not only directly contiguous, but are converging economically. As more businesses and residents move out of Illinois into southern Wisconsin, a health system that can cover both areas should find significant growth. In addition, both organizations are committed to physician integration, population health, and risk-bearing, so there is strong strategic alignment.
- They "punted" on just enough social issues. The key impediment to combinations such as this are the social issues of management control and board composition. Many such discussions fail to gain traction over who gets to be CEO and the number of board seats each organization will fill. In this case, the parties agreed to co-CEOs, dual headquarters, equal board seats, and rotating chairmanships. None of these "fudges" is efficient, or long term, but they help to "get the deal done," which makes business sense.

Why Haven't There Been More?

There are a number of reasons why this multi-state trend has been slower to take off than expected. One, as mentioned above, is simply the nature of the industry: fragmented, conservative, and highly regulated. Many attorneys general remain concerned about the possibility of charitable assets being moved or controlled by an out-of-state entity, and the social issues of management and control remain as potent as ever.

This is in a context of the overall number of transactions being down somewhat from its recent peak in 2015. While activity is still brisk, the individual hospital market is presently tilted toward systems filling out local markets with acquisitions or sellers with financial challenges or capital needs.

There are several reasons that transaction activity has declined among individual hospitals:

- Margins are up. While it is somewhat challenging to identify a large number of individual hospitals that are more profitable than they were a few years ago, aggregate figures indicate that the average operating margin of hospitals has increased slightly over the past several years. This is primarily due to reduced bad debt thanks to Medicaid expansion. With less imminent financial distress, individual hospitals are less likely to need to find a partner.
- There are fewer buyers. Consolidation among investor-owned systems as well as Catholic systems have occupied their time and resources, as well as reducing the number of buyers.
- Turnarounds are harder. It is becoming easier and faster for a hospital to fail. Losing a key contract, a sudden change in reimbursement, or similar events have led to discontinuous drops in performance, and systems are increasingly unwilling to take on these situations.
- Many geographic markets have become largely consolidated.

Future Growth of Multi-State Transactions

The patterns above, which tend to depress partnering of individual hospitals, should accelerate the trend of system-to-system consolidation. As mid-size systems seek growth and meaningful scale, the

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Key Board Takeaways

Boards of healthcare organizations considering multi-state partnerships can take the following steps:

- Assess your own situation to see what you need and what you have to offer. By defining your strengths, needs, and objectives as clearly as possible, you will be in the best position to initiate conversations with others.
- Assess potential partners to get an idea of how well they might meet your needs, and whether their culture might be compatible with yours.
- Determine and quantify the benefits of the combination. If they are significant, and achievable, this will inform the structure and your negotiating approach to the relationship.
- If you identify a potential "good-to-good" partnership, be prepared for an atypical negotiation. Whereas in most transactions it is imperative to agree on many details before closing, in these it may be better to "fudge" some things to finalize the deal.

1 Barry Sagraves, "Multi-State Non-Profit Health Systems: Why There Are Not More, but Soon Will Be," E-Briefings, The Governance Institute, September 2013.

Systemness…

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systemness initiative, we are aligning both clinical and administrative functions across the enterprise to ensure we are improving quality and reducing cost. Spectrum Health's rehabilitation department is garnering superlative results as the first area to implement this alignment.

The project started by addressing span of control to achieve consistency and eliminate overlap. Managers in different sites were working in comparative silos, with different standards and expectations. Because patient demand wasn't spread across the system, productivity, efficiencies, and consumer convenience were suboptimized. As the initiative took hold, employees identified solutions to create consistent standards and expectations across all sites. The solutions included standardizing the branding and dress code to being very clear about job responsibilities and pay rates. Traditionally, these inconsistencies contributed to animosity and low morale among staff and low patient experience scores.

A well-developed leadership structure overseeing more than 10 sites and supervisors working side by side with therapists has led to less variation and more coordination of services. This effort resulted in significant improvement in operational metrics within 18 months of implementation at each site. We have achieved the following results over the past five years:

- Productivity has risen by 21 percent.
- Growth increased by 28 percent.
- Patient experience improved by 7 percent.
- Team engagement increased by 77 percent.
- We achieved a cost savings of 18 percent or nearly $600,000.

Culture Change Drives High-Reliability Behavior

To be highly reliable, we must implement the principles and best practices across our system. These practices are embedded in our quality and safety work, as well as our culture. We launched an initiative called "At Our Best," which set expectations for employees to be curious, ask the next question, and participate in finding solutions. Our people are vital to making this transformation a reality. We are people caring for people—our colleagues as well as the people we serve. Our employees must be enabled and empowered to be at their best, providing high-quality, safe care every day. A culture of high reliability is the imperative to deliver the value proposition we have promised to our communities.

Conclusion

Many of us work for multifaceted organizations comprising delivery systems, medical groups, insurance carriers, and the entire continuum of care from prenatal to hospice. Layers of complexity make high reliability a challenge.

But, it is possible to be highly reliable. By achieving systemness, the principles of high reliability become central to operational effectiveness and excellence. Functioning as a true system differentiates organizations and enables long-term sustainability. The first step begins with the courage and conviction to declare it as a goal—to be one system focused on delivering the exceptional, affordable, and highly reliable services our communities deserve.

The Governance Institute thanks Christina M. Freese Decker, FACHE, Executive Vice President and Chief Operating Officer of Spectrum Health in Grand Rapids, Michigan, for contributing this article. She can be reached at Christina.Freese@spectrumhealth.org.

Multi-State Health Systems…

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most effective way to achieve this will be system combinations, and these will include those across state lines.

The overall industry drivers will only intensify. The limits of Medicaid expansion are in sight as funding responsibility shifts back to the states, changes toward population health, and increasing competition from disruptors (e.g., CVS-Aetna, Berkshire/JPMorgan Chase/Amazon) will maintain pressure to reduce costs as well as develop new capabilities and business models. Finally, as individual markets reach a consolidated equilibrium, further growth will have to come from combining with organizations in other, preferably contiguous, markets.

Most of the system mergers to date have arguably been more about size than scale. *Size* connotes the ability to buy in bulk, to centralize some functions and spread overhead. *Scale* adds the ability to operate more effectively as well as efficiently, improving an organization's ability to execute as the industry changes. This might be by combining skills or relevant markets that provide additional strategic or financial value. A number of studies have indicated that there is significant additional value created by the integration of partners over and above that derived from merely combining.

So, why will there be more multi-state mergers? To paraphrase the bank robber Willie Sutton, that's where the partners are. In many states, either the partners have consolidated or the remaining mergers would face antitrust issues. Thus, the availability of partners and the ability to gain approval will drive systems to look across state lines. The prime markets for this type of activity probably divide into two types: metropolitan areas spanning state lines and rural states where dominant systems either within or contiguous to would find scale benefits in addition to size alone.

Conclusion

Systems looking for significant growth will need to look at a range of transaction strategies. Adding additional hospitals, groups of physicians, and new services will generally be the basis of growth. But they should also consider whether there is a partner a bit further afield that might be able to help them vault to the next level of effectiveness and success.

We believe that the formation of Advocate Aurora Health Care is indicative of a trend that will accelerate in the coming years. There may be a similar opportunity—or competitor—coming to your market, you guessed it, "soon."

The Governance Institute thanks Barry Sagraves, Managing Director at Juniper Advisory, for contributing this article. He can be reached at bsagraves@juniperadvisory.com.

Answering CEO Turnover…

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can become markedly better at improving their leadership capacity.

Take an Ecosystem Approach to Developing Collaborative Capacity and Connection

The CEO's relationship with the board, physicians, and the executive team are critical to moving the organization. According to a white paper by the Center for Creative Leadership, most CEOs see their executive teams as comprised of skilled individuals who have significant learning to do in enterprise thinking as a team and in handling conflict.[5] Many physician leadership programs are aimed at "helping the doctors catch up" and are not experientially grounded in working with other parts of the organizational ecosystem. Building wide leadership capacity means taking a coherent approach to all these key stakeholders simultaneously.

Endorse "Safe Harbors" for Both Support and Development

CEOs will tell you that one of their challenges is finding places to learn, exchange ideas and unsolvable problems, and tap collegial support. What they can't necessarily find in their formal in-organization relationships or in educational conferences can often be found in small affinity groups, where executives can connect with non-competitive colleagues for learning, development, and trusted "hot line" consultations that provide invaluable outside-in perspective and empathy from people in like positions.

By putting in the essential cornerstones around governance, mission, vision, values, strategy, succession, and leadership capacity, boards optimize their organization's ability to attract talent, to support it, and stabilize the organization during transition periods. While there may be no magic trick for decreasing CEO turnover to zero, thoughtful board guidance around high-capacity leadership efforts, ecosystem thinking across key constituencies, and a safe place for CEOs themselves to continue to develop optimizes your organization's chances of landing and keeping the CEO of the future.

The Governance Institute thanks Larry R. McEvoy, M.D., FACEP, Past CEO of Memorial Health System in Colorado Springs, CO, President and CEO of LCI Group, Founder of PracticingExcellence, and Executive-in-Residence at Center for Creative Leadership, for contributing this article. He can be reached at larry.mcevoy@practicingexcellence.com.

5 Alice Cahill, Larry McEvoy, and Laura Quinn, *Are You Getting the Best Out of Your Executive Team?,* Center for Creative Leadership, 2017.

The Relationship Era…

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Over the past decade their use has undeniably skyrocketed, but what do these words mean to consumers and patients?

Quality: Ask 100 consumers to define quality and you'll get 100 answers. There is little to no consensus on what quality means, making it a vague and difficult concept to convey to patients. Most cannot discern medical quality and default to more obvious signs of quality—a clean environment, efficient processing, even a smile from the front desk. Consumers will often assume medical quality is generally the same across different organizations and look to convenience and compassion as proxies for quality.

Satisfaction: Consumers have a better grasp on what it means to be satisfied but don't often feel it during a healthcare experience. Blame sky-high expectations: 82.3 percent of U.S. consumers expect healthcare organizations to meet or exceed their expectations. That's over 10 percent higher than any other industry. With such lofty expectations it's difficult to see how consumers can feel complete satisfaction with their care, creating a void that becomes especially vexing when CAHPS places such emphasis on being satisfied.

Value: Another loose and overused word, value provides the starkest contrast in meaning between healthcare leaders and consumers. While the industry uses value to describe the movement toward accountable care and shared savings—a concept most consumers support—there is little understanding of this meaning among consumers. For them, value means quality proportionate to cost. If I pay more, I expect more. If I pay less, I expect less (within reason). Since consumers don't know cost upfront and have little to no idea of quality they are unable to calculate value in healthcare. Use of the word is rendered meaningless by the quality and price opaqueness of the industry.

greatest regret is losing sight of why we did it: for the person behind the numbers—the consumer who is desperate to know what makes us the best choice but unable to comprehend a system of measurement that excludes their personal insights in favor of industry terminology and comfort-driven complexity.

It's not as though quality, value, and satisfaction aren't important. They are. But our core metrics haven't created much clarity. How we approach their improvement seems to be off. If we hope to improve our standing among our most important stakeholders, we must realize those stakeholders aren't in the boardroom or the executive lounge. They sit at home, in cubicles, and in cars, and they've been largely unable to decipher what we're telling them—leaving them without sufficient information to make good decisions.

In the next decade, let's hope we can consider the consumer point-of-view in measurement or any matter that requires their buy-in or benefits from their insight. In the world of healthcare, everything is riding on the relationship we build with our consumers. It's time to stop talking, start listening, and form our goals with our most important ally: the people we serve.

The Governance Institute thanks Ryan Donohue, Corporate Director, Program Development, NRC Health, and Governance Institute Advisor, for contributing this article. He can be reached at rdonohue@nrchealth.com.

The Relationship Era: Why Satisfaction, Quality, and Value Aren't Enough to Win Over the Consumer

BY RYAN DONOHUE, NRC HEALTH

It's been a decade since the first public reporting of HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) and you don't have to go far into healthcare to see its impact. Ask an executive whose compensation is based on their organization's HCAHPS results or the nurse manager who coaches soon-to-be-discharged patients how to complete their follow-up survey. And that's just the hospital setting. Primary care? Long-term care? Home health? There's CAHPS for those settings, and seemingly everything.

After such a prolific and prolonged period of use, what does HCAHPS and the larger patient experience measurement movement tell us? Before we get to the statistics, it's interesting to examine the anecdotes. In speaking with hundreds of healthcare executives since 2012, it seems the fruits of our labor never bloomed. I hear constant mentions of compassion fatigue, survey frustration, and confusion over which metrics to track and what they are telling us—a serious and often undiagnosed medical condition I call "data disorientation." I especially hear frustration in CEO voices as they cut costs and remain uncompensated for millions of dollars in cost but find their CAHPS numbers unimpressive. This cycle creates an immense burden. "We need to fully appreciate the burden that measurement places on professionals, and minimize it," opines Dr. Robert Wachter, a fellow Governance Institute faculty member.[1]

The anecdotes are unkind to CAHPS and so are the numbers. Irene Papanicolas of the London School of Economics and Political Science examined CAHPS scores for over 3,000 U.S. hospitals, comparing hospitals that adopted value-based purchasing (VBP) programs to reduce costs and boost patient experience and hospitals that didn't.[2] Improvement in overall hospital rating among VBP hospitals was 1.51 percent between 2008 and 2014 and 1.28 percent among non-VBP hospitals over the same timeframe. Considering over a billion dollars were spent to improve the patient experience and VBP hospitals focused uncountable energy toward improvement, those gains are particularly unimpressive.

Addressing Loyalty and Advocacy

Overall ratings aside, the CAHPS movement also pursued patient loyalty with great passion. Perhaps a minimal increase in hospital ratings would be overshadowed by a boost in patient loyalty and advocacy? NRC Health, The Governance Institute's parent company, examined patient "willingness to recommend" at the onset of HCAHPS in 2008 and found a massive 33 percent of patients were unwilling to recommend the hospital or health system they recently visited. After nearly a decade of money and energy burned, NRC Health found the lack of recommendation fell to 28 percent—a modest improvement toward patient advocacy but hardly the loyalty boon originally hoped.

In fact, with all the focus on quality, satisfaction, and even value there still seems to be little penetration into the consumer psyche. Nearly every overused healthcare word seems to have little effect on consumer audiences and often needs translation. When consumers describe patient experience in their own words, terms like "frustration," "confusion," and "fatigue" were mentioned far more often.[3] The call for a better "relationship" with a "convenient" and "trustworthy" provider was loud. Those terms—raw, unfiltered, commonplace in living rooms—don't get uttered much in the boardroom.

Connecting with Consumers

Perhaps solving the riddle of patient experience requires the industry to connect with consumers, to listen to consumers in their own words as they describe how they measure a successful experience. For example, consumers will often describe "access" far differently than healthcare executives. Consumers begin with a question: where can I find you? They ask not about physician efficiencies or nurse ratios. Instead they look for the easiest path. The kindest caregiver. The doctor who will sit down with them. These simple, straightforward attributes contrast sharply with the overly complex industry efforts to improve quality, satisfaction, and value.

In keeping with the consumer view, it's important to know what actually drives consumers to become patients. Being in-network and having a physician referral are helpful but they are number two and three on the list of reasons consumers will choose a healthcare organization. The organization's reputation is number one.[4] Our reputation is who we are, what we stand for, and the feeling consumers have when they think about us. We've spent countless resources playing the measurement game and perhaps our

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Key Board Takeaways

To win over consumers, healthcare organizations need to ensure they are building solid relationships with consumers and always considering their point-of-view. Board members must:

- Understand and monitor what drives consumers to become patients and what happens to them when they leave. CAHPS doesn't cut it—the patient experience is critical but it's only a piece of the larger consumerism puzzle.
- Be vigilant in requiring consumer-friendly communication, and clearly communicate the organization's value to consumers. Healthcare organizations often use mysterious or insider-only words to describe themselves. Consumers desire straight talk and evidence to support why they should use and trust the hospital.
- View themselves as essential proxies for the consumer point of view—having one foot in and one foot out of the organization, board members are in a unique position to understand the plight of the consumer.

1 Robert M. Wachter, "How Measurement Fails Doctors and Teachers," *The New York Times*, January 16, 2016.
2 Irene Papanicolas, José F. Figueroa, E. John Orav, and Ashish K. Jha, "Patient Hospital Experience Improved Modestly, But No Evidence Medicare Incentives Promoted Meaningful Gains," *Health Affairs*, January 2017.
3 Market Insights survey, NRC Health, 2016.
4 Market Insights survey, NRC Health, 2016.