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This newsletter is designed to inform you about new research and expert opinions in the area of hospital and health system governance.

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Clinical and Technologic Innovation: Planning for Success

By Mark Dubow and John Harris, Directors, Veralon

Clinical and technologic innovations are fundamentally disrupting the healthcare market. Advances have already begun to change the interaction between patients and physicians, the location in which diagnostic and therapeutic services are provided, clinical protocols, and care management processes. Categories of innovation include:

- Consumer convenience: physician services by phone (e.g., Copper Queen Community Hospital); same-day/next-day care (One Medical)
- New forms of diagnostics: wearable and implantable devices for ongoing/home monitoring (Apple, American Well); non-invasive diagnostics (the smart contact lenses from Alphabet's Verily)
- New modes of clinical treatment: 3D printed tissues and skeletal structures (Organovo), exoskeletons (Ekso), stem cell therapies, immunotherapies, and pharmacogenomics
- Telehealth: remote diagnosis and treatment via physician kiosks; clinical support in rural hospitals (Banner Health)
- Artificial intelligence: algorithm-based diagnostics and machine learning for patient use (Babylon) and physician guidance (Alphabet's DeepMind)

Key Board Takeaways

In the boardroom directors should play a proactive role in helping their organization achieve success in innovation in the following six ways:

1. **Insight:** As representatives of the community, share their insight with the management team regarding where particular forms of clinical and technological innovation would enhance how the organization meets the value sought by local employers and community residents.
2. **Culture:** Reinforce a culture within the board itself and the management team of openness by the organization to an evolving role and informed risk-taking. The board should work with management to set the boundaries and guidelines for risk-taking.
3. **Education:** Set an expectation that management provides to the board periodic (e.g., semi-annually) profiles on the trends and implications specific to clinical and technologic innovation.
4. **Strategy and focus:** Require management to include goals and strategies specific to clinical and technologic innovation in the organization's strategic plan, establish focus (priority) in pursuing specific initiatives, and provide periodic reports to the board on the progress made on those initiatives.
5. **Champions:** Encourage the CEO to designate an individual or a dyad (administrative and medical staff member) to be the champion and accountable person for the organization's strategy(ies) specific to innovation.
6. **Partners:** Encourage the management team to selectively enter into strategic relationships with other organizations to gain critical expertise and resources (funds, staff, IT, other) that enhance the hospital/health system's likelihood of success in implementing innovation. The board should work with management to set guidelines for consideration of partners and play a role in evaluating and approving them.

Consumers and providers are propelling innovation to meet their needs, while payers are encouraging these changes with growing support for innovative care management and population-based healthcare. Entrepreneurs and major companies are investing in healthcare innovation because the industry is ripe for disruption.

In this environment, providers must address innovation or face the risk of becoming progressively marginalized. Hospitals and health systems should actively seek to apply innovation to control their future role, enhance the value they deliver, and maximize their competitive position and financial performance.

Many organizations see innovation as daunting and risky because it is significantly outside their traditional business model. Yet, many of these innovations are no fad, and as the work of innovation pioneers shows, they can be an effective component of strategy.

Headlines about innovation initiatives often convey a sense that they require "deep pockets" or critical mass. While organizations with these features are among the most active,[1] smaller regional systems (e.g., Bryan Health in Lincoln, NE, and Florida Hospital in Orlando/Tampa/Daytona Beach) and independent community hospitals are also applying the forms of innovation listed above in order to respond to market demand. Their initiatives are made possible through partnerships with innovation vendors (e.g., American Well), collaborative relationships with academic medical centers (AMCs), grant funding, and shared initiatives with other independent entities.

AMCs and large regional systems may be the natural parties to pursue the most complex forms of innovation (e.g., 3D organ printing, immunotherapies, and AI), but other forms require modest resource investment (e.g., Babylon) enabling community hospitals to participate. Increasingly where there is a will, there is a way to pursue innovation. Executive teams and their boards should turn their attention to making it happen.

Innovation Pioneers

A number of healthcare providers have positioned themselves as pioneers in applying clinical innovation through the formation of innovation institutes and strategic relationships (see **Exhibit 1**).

1 "58 Hospitals with Innovation Programs: 2017," *Becker's Hospital Review*, August 24, 2017 (available at www.beckershospitalreview.com/lists/58-hospitals-and-health-systems-with-innovation-programs-2017.html).

Exhibit 1: Selected Innovation Pioneers

Organization	Selected Features of Innovation Program
Banner Health	Use of telehealth in multiple settings: • Banner iCare—in-home care with interaction via tablet • TeleICU and TeleAcute Care teams, with two-way audiovisual in every patient room • TeleBehavioral Health—for ED consults • Banner Simulation Medical Center (medical education simulation)
Intermountain Healthcare	• New ventures (strategic investing and partnerships) in mental health, genomics, outcomes, and specialty pharmacy • Business incubator and development with internal departments • Data insights, analytics, and industry-sponsored research • Healthcare Innovation Fund ($35 million) for innovative companies • Enterprise services—new enterprises and direct sales • Intermountain Simulation Center
Providence/St. Joseph Health	• Digital Innovation Group: software support for clinical care and technology partners (e.g., digital therapeutics for chronic disease prevention) • Consumer Innovation Group: new services and tools to support patients between episodes of care in areas like women's health and chronic disease management • Providence Ventures: funding technology advances and development of collaboration platform with early-stage companies

Sources: From the Web sites of each organization.

Embedding Innovation in the Organization

These pioneers and other organizations that are successful at innovation have specific cultural attributes:

- Innovation champions in the C-suite[2] (with titles such as Chief Strategy, Integration, and Innovation Officer)
- Openness to change and risk-taking, within boundaries set by the board and management
- Rewarding and recognizing innovation and new ideas even when they do not ultimately result in success[3]
- A management team and board willing to enter into strategic relationships with outside organizations to further the adoption and implementation of specific innovations
- Performance metrics and incentives that are relevant to risk-taking and innovation

Embedding innovation in the fabric of the organization also requires:

- Taking a long-term perspective (five, 10, and 20 years)
- Aggressively seeking relevant strategic relationships
- Creating a structure for pursuing innovation initiatives
- Learning to actively scan the environment to identify emerging trends and new forms of innovation that may be a fit with the organization
- Formalizing your innovation strategy[4]

2 Richard Lee, "Six Keys to Enabling an Innovation Culture," Presented at the Industrial Research Institute Meeting, October 2014.
3 John Epperson and Clayton Mitchell, "Four Strategies for Enabling Innovation in the Face of Risk and Compliance," Crowe Horwath, October 2017.
4 Mike Miliard, "6 Tips to Help Your Hospital Embrace Innovation and Collaboration," *Healthcare IT News*, June 15, 2018.

Innovation within Organizational Strategy

Incorporating innovation in organizational strategy is a "must"; the challenge is determining where to focus. There is no shortage of ideas for innovation initiatives. Clinical or other staff may propose ideas, as may vendors, and leaders may have their own ideas. Some of these will be appropriate for the hospital or health system, but the question is, which are worth pursuing? Providers must establish an innovation strategy, consistent with the overall organizational strategy, that provides the focus needed to answer that question.

There are four important steps to achieving focus:

1. **Determine the innovation vision.** Innovation requires a big picture vision for a cohesive program.[5] That requires determining the business goals that the hospital or health system wants to achieve. Is it seeking to improve organizational performance in quality of care, clinical outcomes, and patient satisfaction? Does it want to build capabilities related to strategic targets in clinical care? Does it want to strengthen its ability to engage and retain leading clinicians? Is it important to reduce operating costs? Or, is the hospital or health system seeking a role in a new business/sector of the industry, or targeting a new portion of the healthcare dollar (e.g., payer, pharmaceuticals, medical devices/equipment/supplies, big data)?
2. **Identify the forms of innovation that offer the most powerful response to the vision.** For example, Banner Health's many telehealth programs (see **Exhibit 1**) address the needs of the health system, which has numerous small and rural hospitals. The programs enable *enhanced clinical outcomes* through remote expertise, while *controlling operating costs* through centralization. Their simulation center trains clinicians and can *enhance system success in physician recruitment and retention*, while also *diversifying income sources and increasing net income*.
3. **Determine the priority form(s) of innovation the hospital or health system must address** versus those that are "elective" or even unsuitable. Precedence must go to innovations that are entering the mainstream in markets the organization serves, and that are consistent with the hospital or health system's strategy. Almost as essential are innovations that are becoming mainstream in other markets. Examples include innovations that address consumer convenience and control patient out-of-pocket costs, as well as mobile health and some types of telehealth programs.
4. **Assess innovations that could be beneficial but are not essential.** These are innovations that are emerging but not mainstream. These types of innovation will be pertinent to select organizations, often those that target a leading-edge position (e.g., AMCs, specialty hospitals, national/

5 Nora Zetsche, "Increasing the Speed of Innovation in Healthcare," *Forbes*, November 21, 2017.

The environmental trends are clear: Whether your organization is an independent community hospital, regional system, or AMC, it is crucial that innovation be incorporated in your strategic plan.

international "destination" institutes). These forms of innovation will include new diagnostics and modes of clinical treatment, and technologies that are likely to take a longer time to enter the mainstream, such as some forms of AI.

Making Innovation Initiatives Real

Success in innovation requires a well-structured and managed implementation process, including:

- Establishing leadership and accountability for the initiative(s)
- Building stakeholder commitment to adoption
- Assuring sufficient resources to support the initiative
- Using strategic partners to provide needed operational expertise
- Developing contingency plans, and leadership commitment to apply those plans and/or discontinue an initiative if the original enablers change.

The environmental trends are clear: Whether your organization is an independent community hospital, regional system, or AMC, it is crucial that innovation be incorporated in your strategic plan. Establishing the innovation capabilities and resources described in this article are key enablers for success. Get started now, or risk getting left behind.

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Merger Playbook: Best Way to Govern throughout the Process

By Jim Finkelstein, President and CEO, and Kellie Fielding, Senior Consultant, FutureSense LLC

How can you achieve the most efficient and effective alignment of governance as you navigate through the merger process? The new partnership is exciting, full of potential, and each side brings strengths and weaknesses to the relationship. The boards must be willing to embrace the strengths of each organization and utilize them to fill weaknesses of the other. As with any new venture, when two entities come together, it is natural for differences in process, procedures, and potential incompatibilities to exist. Accurately identifying these challenges and creating a proactive plan to overcome them is necessary to achieve successful integration. Examining cultural differences in both boards, and in the overall organizations, early in the relationship will assist in reducing cultural clashes that may be looming on the horizon.

For the combination to be successful, the vision and goals for the future must be aligned for all involved. Taking inventory in each of these recognized areas will allow the boards to build a prosperous synergy as they continue through the merger process.

Merger Basics

Although there are several underlying causes for failed mergers, some of the more common factors include:

the inability to reach agreements upon key elements, incapability to match and blend cultures and people, and poor integration planning and implementation. How can you avoid this from occurring? As you begin to strategize and envision your playbook, don't overlook the basic building blocks necessary to facilitate the success of your company's merger. In the article "Proper Governance Key to Mergers," authors

Key Board Takeaways

In order to be properly prepared for a smooth governance transition during any merger activity, boards should:

1. Transparently determine and agree on the reason(s) for the merger in order to determine the competencies required for a future board.
2. Assess knowledge, skills, abilities, and attitudes (KSAAs) of existing board members to determine appropriate role in transition (if any) aligned with the reasons for the merger.
3. Identify gaps in KSAAs for board integration team and fill the gaps.
4. Form a board integration team.
5. Work with management to maintain entity and local boards in transition to ensure communications and connections with constituencies.

Bill Ide and Crystal Clark state that the primary oversight responsibilities of healthcare boards can be grouped into six functional categories: culture, talent, strategy, compliance, risk, and governance.[1] Each of these areas must be scrutinized effectively to produce the desired goals. So, how do we accomplish this and why is developing a playbook important? Spending the time to create an innovative approach to the merger will provide a pathway to make sure it is successful.

A 2018 survey by Grant Thornton revealed that most M&A deals fail to exceed expectations due to lack of cultural alignment. Only 14 percent of all respondents felt that deals exceeded their initial expectations.[2]

Identifying the Meaning behind the Merger

What is the real reason for the merger? This is the first question that needs to be answered and will set the stage for effectively creating your playbook. The board must be willing to accept the purpose of the merger and conduct themselves accordingly. Knowing the true meaning behind a merger opens opportunity to thought-provoking questions and sets the foundation for developing a strategic plan for the future. In a recent Deloitte survey of over 1,000 corporate executives and private equity investors, "key strategic drivers for mergers and acquisitions included technology acquisition, expanding customer bases in existing markets, diversifying and expanding products and services, digital strategy, and talent acquisition."[3] In a 2017 study by Charles River Associates, interviews with hospital executives identified benefits of hospital mergers as cost reduction, scale-related savings (including supply chain, IT, and back office), capital access and avoidance, clinical standardization to reduce cost and improve quality, clinically integrated networks, and other operational items.[4]

However, we have found that the principal reason for a merger can generally be classified in one of three ways, and each comes with its own obstacles and challenges and potentially unique playbook and/or alignment of the boards:

1. **Survival.** It may simply be out of a necessity to survive as the healthcare industry continues to evolve and is characterized by a board from the stronger entity dominating the new board.
2. **Merger for scale.** Perhaps the transaction would be classified as a merger of "equals" in order to create scale in revenues and cost control. This requires the highest and best use of talent on the board as entities combine.
3. **Innovation and advancement.** The merger intention may be the creation of new and innovative possibilities to accelerate future growth.

Once you have clearly and transparently identified the merger's purpose, it's time to focus on the development of the new board structure.

Creating the Future: A Playbook for Organizing the Board

Are you finding yourself in a situation where the boards are being combined? At this stage, board members may feel protective about preserving the company's legacy. However, it is essential to be proactive—not reactive—throughout the process. Adapt the philosophy to *abandon* old processes, *choose* to combine the best practices of each company, and *create* new approaches to drive the future.

Boards, like executive and staff teams, must first be tasked with the objective of discovering the highest and best use of each board member consistent with the purpose of the merger. Perhaps there is a strong need to add talent to the team, or an organization is interested in advancing into unchartered territories and these goals will require additional board resources to achieve them. Or, the board needs to be shrunk and simplified as operations are combined and reduced.

When planning for the post-merger, non-profit strategy expert David La Piana explains that strategy, people, program, and systems are the four focus areas to achieve full integration. He states that, "post-merger integration is where a merger succeeds or fails. This critical effort is often viewed as an afterthought and is typically under-resourced."[5] Knowing this in advance allows governance to better prepare and achieve a well-executed integration implementation strategy. For example, if you are seeking innovation and advancement, instead of just having an Integration Management Office (IMO), consider an Advancement Management Office (AMO). The name itself encompasses a 360-degree view of the new company's ambitions and a motivator to strive for a brighter and more interesting tomorrow.

Another option is to create a board integration team that is both the overseer and ambassador for the board integration process. This team should stay in place for at least six months following the merger.[6]

1 Bill Ide and Crystal Clark, "Proper Governance Key to Mergers," *Healthcare Finance*, August 27, 2014.
2 "Defining What Is Vital for Deal Success," Grant Thornton, May 2018.
3 *The State of the Deal: M&A Trends 2018*, Deloitte.
4 Monica Noether, Ph.D., and Sean May, Ph.D., *Hospital Merger Benefits: Views from Hospital Leaders and Econometric Analysis*, Charles River Associates, January 2017.
5 David La Piana, "After the Merger: Getting to 'Yes' Is Only the Beginning," Stanford Social Innovation Review (SSIR), June 22, 2018.
6 "Bring the Boards Together," Nous Group and Whitelion.

While the integration team is being formed and prior to the final combined board being established, it is also critically important to maintain "local" presence. There may be the need for multiple boards/teams with different responsibilities:

- **Board integration team:** integration management, including focusing on the new board culture
- **Final combined board:** ultimate fiduciary responsibility, including focusing on strategy executive selection
- **Legacy entity board:** legacy board(s) with strong relationships to the transitioning executive and staff teams—for continuity purposes; eventually they will be either decommissioned or turn into advisory boards, depending on the structure of the deal
- **Community board:** strong ties to the local community and donor bases, which ultimately may become local financial development and community relations boards or committees

As with any new venture, when two entities come together, it is natural for differences in process, procedures, and potential incompatibilities to exist.

Creating the Future: A Playbook for Board Members

Although we would prefer to describe ourselves as a population that ambitiously accepts change, human behavior tends to resist the unknown, retreat to the comfort of our current foundation, and cling to the process flow that we have grown to rely upon. Transitioning your mindset as a board member is a critical component to embracing the possibilities of this new journey. Perhaps your role is to assist with the facilitation process, through the transition phase, but you aren't planning on continuing as a member of the governance post-merger. Or perhaps you shouldn't continue on because of a lack of appropriate skills. As board members are asked to change their roles, it is critical that they understand why their roles are changing and why their new role is in the best interest of the new company. Over-communication on this point must be emphasized, with ample opportunity for board members to voice their concerns and feel that they are being addressed.

In conclusion, there is no one-size-fits-all universal playbook that can be referenced or built. Each merger includes unique components that must be accounted for during the process. A successful outcome requires you and your board to begin building your merger playbook early, with both short- and long-term new company goals being aligned and assessing and identifying the best board talent to make it all happen. And ultimately, boards must decide who can best serve the new organization by stepping away from the board or stepping up to build the playbook and execute against it.

The Governance Institute thanks Jim Finkelstein, President and CEO, and Kellie Fielding, Consultant and Director of Client Success, of FutureSense, LLC for contributing this article. You can learn more about their company and work at www.futuresense.com or contact them at jim@futuresense.com and kellie@futuresense.com.

Advanced Alternative Payment Model Bundled Payments for Care Improvement-Advanced (BPCI-A), October Launch

By Deirdre Baggot, Ph.D., M.B.A., RN, Former Lead, Acute Care Episode Program, St. Joseph Hospital, Denver, Former Expert Reviewer, Bundled Payments for Care Improvement Program, CMS

On October 1, 2018, the Centers for Medicare and Medicaid Services (CMS) will commence the next Alternative Payment Model (APM)—an unveiling that's among the year's biggest events in value-based payment. While the value agenda has been a bit ambiguous over the last 18 months, it is important to remember that the Medicare Access and CHIP Reauthorization Act (MACRA) passed with overwhelming bipartisan support suggesting no lack of commitment on CMS's part to test and scale new payment models.

MACRA was signed into law on April 16, 2015, and created the Quality Payment Program that:

- Repeals the sustainable growth rate formula
- Changes the way that Medicare rewards clinicians for value over volume
- Streamlines multiple quality programs under the new Merit-Based Incentive Payment System (MIPS)
- **Gives bonus payments for participation in eligible APMs**

What Is a Bundle?

With a bundled payment, a payer (CMS in this case) remits a single fixed payment for all of the care and services related to a specific patient condition over a predetermined time period. If doctors and hospitals provide care that is less costly than the predetermined price, doctors, hospitals, and post-acute providers may get paid more than they are historically paid under fee-for-service. If doctors, hospitals, and post-acute providers deliver care that is more costly than the bundle price, doctors and hospitals may be paid less.

BPCI-A and MACRA

BPCI-A is a voluntary bundle with two-sided risk, which qualifies as an Advanced APM under the MACRA law thereby allowing individual providers to potentially qualify for bonus payments by participating in the program. In BPCI-A there will be only one risk track and the episode will be 90 days in duration. BPCI-A includes 29 inpatient and three outpatient episodes. Payment under BPCI-A will be tied to performance on quality measures.

BPCI-A will be an Advanced APM as of the first day of the Model Performance Period, which is October 1, 2018. Eligible clinicians who meet the patient count or payment thresholds under the model may become Qualifying APM Participants (QPs) and be eligible to receive the 5 percent APM incentive payment. The first date for QP determination will be March 31, 2019. (See **Exhibit 1** for the BPCI-A timeline.)

While BPCI-A has many similarities to BPCI-Classic, there are a number of new and noteworthy design features. **Exhibit 2** on the following page illuminates a number of key differences among the two programs.

Key Board Takeaways

1. Have a clear understanding on where your organization stands on the path to becoming a high-value provider. Recently CMS leadership articulated a desire to banish fee-for-service. The most important area of focus for providers should be in the area of becoming high-value providers.
2. Support smart investments in managing total cost of care. New payment models aren't going away and the infrastructure needed to manage total cost of care is not the same as fee-for-service. Becoming a high-value provider means actively investing in strategies such as hospital at home, patient monitoring apps, and call center capability to name a few, in an effort to get after closing care gaps.
3. Make smart IT investments in managing populations. EHRs have yet to be the panacea many had hoped for in terms of mitigating cost and clinical variation at a provider level. A middle game with respect to analytics will be necessary in order to be successful with new payment models.
4. Engage physicians in BPCI-A. Similar to BPCI, with BPCI-A, which operates under a Stark waiver, hospitals and conveners are able to share savings with physicians that result from efforts that reduce cost.
5. Remember that BPCI-A qualifies as an advanced APM under the MACRA law, which means physicians may be eligible for a 5 percent bonus for participating in BPCI-A.

Exhibit 1: BPCI-A Timeline

Source: CMS, 2018.

Exhibit 2: Comparison BPCI-Classic versus BPCI-Advanced

BPCI	BPCI-Advanced
48 inpatient (IP) clinical episodes	29 IP and 3 OP clinical episodes
Not an Advanced APM since lacking CEHRT requirement and quality not tied to payment	Model is an Advanced APM
No quality measures required for payment purposes	Quality measures are reportable and performance on these measures will be tied to payment
Excludes cost of care associated with services according to 13 unique exclusion listings of "unrelated" care	Limited exclusions; excludes the part A and B costs associated with ACH readmissions qualifying based on a limited set of MS-DRGs
Model 3 includes PAC providers triggering episodes in the post-discharge period	No equivalent for model 3; design is similar to model 2 with PGPs and ACHs as EIs; PAC providers, and other Medicare-enrolled, as well as non-Medicare-enrolled entities can participate as convener participants
Risk corridor of 20% of spending above the upper limit of the selected risk track	One risk track Risk is capped at +/-20%
Target prices provided at reconciliation	Preliminary target prices provided prospectively before the start of each model year

Source: CMS, 2018.

Why Does BPCI-A Matter to Providers?

In the area of payment reform, between 2012 and 2016 the percent of CMS payments to providers caring for patients in APMs went from 0 percent to 30 percent, representing $200 billion.[1] Over the last two years, fee-for-service payments only accounted for 37.2 percent of provider reimbursement and that number is expected to drop to 26 percent by 2021 only to be replaced by APMs.

With traditional fee-for-service each provider is paid separately based on the claims that they submit, which leads to over-testing and over-treating. Under a bundled payment, doctors, hospitals, and post-acute providers are incented to provide care that is more efficient and more effective.

Where to Begin with BPCI-A?

Mastering the competencies associated with becoming a high-value provider is the most important goal for you and your organization over the next five years in BPCI-A. Consider the following as you begin your BPCI-A journey:

1. **Early success matters *a lot.*** Keep it simple and win early. If you look both at BPCI-Classic organizations that dropped bundles and also at the nearly 25 percent of Pioneer ACOs that dropped out, much of that attrition was likely related to an overly ambitious strategy out of the gate. Losing money, dropping out, and "re-grouping" doesn't sit well with doctors; they like to win and moving your organization to competing on value is pretty important. Early failures kill morale and lead to provider fatigue. Many C-suite executives and boards do not appreciate just how important it is culturally for providers to see early success if you are ever going to hope to get to scale with value-based payment.
2. **Resource adequately.** A common mistake is under-resourcing the project, particularly in year one. While I do not recommend adding FTEs long term, year one of BPCI-A should yield more than adequate savings to cover the upfront cost of analytics, care management, and physician leadership support. Under-resourcing the project tells the team that they don't matter, which is predictive of mediocre results or worse. Be reasonable, don't over-invest but certainly invest adequately.
3. **Smart execution.** We can call this exercise "BPCI-A launch," but for any of the organizations that I have worked with over the last several years, this journey ultimately becomes "the way we work." Many organizations around the country are still very deep into their EHR implementation along with countless other initiatives. Healthcare is a culture of "nice." We don't say no and then we wonder why our implementations are suboptimal. Conduct a diagnostic on where you are with respect to competing on value and in the operational readiness quadrant, spend some time developing the perfect pace that fits your circumstances. Re-read number two above—what

1 CMS, "Alternative Payment Models (APMs) Overview," 2017 (available at CMS.gov).

Top Five Most Commonly Selected Clinical Episodes in BPCI-Classic

Clinical Episodes (CE)
1. Major joint replacement of the lower extremity (MJRLE)
2. Sepsis
3. Congestive heart failure
4. Chronic obstructive pulmonary disease, bronchitis, asthma
5. Simple pneumonia and respiratory infections

Source: CMS, 2018.

matters most is that you are building positive momentum around your new identity as a high-value provider, so honor your teams and launch smart. Better sequencing improves learning and ultimately will be a contributing factor to your ability to scale multi-payer and commercial or employer APMs.

4. **Smart episode selection.** Related to number one above, one way in which organizations set physicians up to win is with smart episode selection (see sidebar "Top 5 Most Commonly Selected Clinical Episodes in BPCI-Classic"). There is no reason to lose money with BPCI-A. It kills morale among physicians and performance improvement teams. Play to your strengths out of the gate, make money, and share savings with those providers who helped create the savings. That is a foundation from which to build and scale a value strategy. CMS has allowed for a one-time, no risk retrospective review in March 2019, when providers will be able to drop episodes that are not performing well economically. Use this opportunity to withdraw from episodes that aren't successful at that time.
5. **Analysis to action.** It is impossible to build, scale, and sustain high-value care without the technology and tools necessary to do so. Telling physicians three months after the fact that it was their patient that was the readmission is not helpful. Over the last three years, CMS has made public more data than the 30 years prior. While it is unfortunate that EHRs have yet to realize their potential, the middle game will require transparency at a provider level in as close to real time as possible. It is not 100 measures; it is likely something closer to 10 measures, mostly outcome related, that physicians will need in order to manage total cost of care in BPCI-A. Too much data or inaccurate data is counter-productive. Multi-disciplinary, cross-setting teams should select the measures (make sure at least one measure is related to patient experience). Process measures and qualitative study are helpful when needing to conduct root cause analysis; however, for day-to-day performance, typically outcome measures work the best. Be practical and share data at the provider level in an effort to illuminate major areas of cost and clinical variation. What I have found time and again is that sharing the right data with physicians will cause immediate positive change and markedly reduce unnecessary cost and clinical variation.

Signing up for risk that an organization is not ready to manage is not a formula for success. Make sure that the episodes you ultimately take risk on are ones that your organization demonstrates the highest level of quality, cost effectiveness, and patient engagement with. Success at the outset is critical if your organization is going to scale beyond BPCI-A so get it right out of the gate.

The Governance Institute thanks Deirdre M. Baggot, Ph.D., M.B.A., RN, Former Lead, Acute Care Episode Program, St. Joseph Hospital, Denver, Former Expert Reviewer, Bundled Payments for Care Improvement Program, CMS, for contributing this article. She may be reached at Deirdre.baggot@ucdenver.edu or (720) 376-8881.