a SHSMD report

# From If to When:
## New Strategic Realities in an Era of Creative Destruction

REPORT FROM AN EXECUTIVE DIALOGUE
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SOCIETY FOR
Healthcare Strategy & Market Development℠
of the American Hospital Association

# From If to When: New Strategic Realities in an Era of Creative Destruction

## Report from an Executive Dialogue

Two days after the re-election of President Barack Obama in November, as many in the country finally came to accept that the Patient Protection and Affordable Care Act (more commonly referred to as the ACA or Obamacare) essentially would be implemented as passed by Congress, senior healthcare strategy executives gathered in Chicago for the second annual SHSMD Executive Dialogue.

This program offers a special opportunity for strategic leaders of hospitals and health systems to come together with industry thought leaders and talk candidly and constructively about the most pressing strategy issues—in this case the apparently unstoppable drive towards cultural change, physician alignment, new payment models, and population health management.

This report gives SHSMD members a chance to listen in, retrospectively, and share in the insights and ideas that came out of that conversation.

SPEAKERS

**Arati Randolph**
Senior Vice President,
Director of Internal Communications
Wells Fargo & Company
Charlotte, NC

**T. Clifford Deveny, MD**
Senior Vice President,
Physician Practice Management
Catholic Health Initiatives
Denver, CO

**Brian J. Silverstein, MD**
President
HC Wisdom
Owings Mills, MD

**David B. Nash, MD, MBA**
Dean, Jefferson School of Population Health
Thomas Jefferson University
Philadelphia, PA

*The 2012 Executive Dialogue was moderated by Burl Stamp, FACHE, Principal with Pershing Yoakley & Associates. Our thanks to Mr. Stamp and his colleague, Christopher Wilson, JD, senior manager at PYA, for their help in developing this report.*

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## "This Time Feels Different"

The participants in the 2012 SHSMD Executive Dialogue were not tasked with coming to a consensus about every issue and did not always do so. But there was general agreement that recent initiatives and actions by federal and state governments, employers, and payers are as much a reaction to the economic realities facing the healthcare industry – and, indeed, the nation as a whole – as they are reflections of a shift in philosophy about how care should be provided. As one participant put it, "this time feels different from the managed care of the 1990s" because the imperatives are more pronounced and the demands by multiple constituencies to change are more resolute.

> *Hospitals must look in the mirror and honestly ask themselves if they have they capacity to truly change to the degree that will be necessary in the future.**

Hospital and health system strategists have been chasing a moving target since the passage of the ACA. While uncertainty and politics clouded decision-making for many organizations, private market and macro-economic factors were exerting pressure in ways that began to reshape the industry. Public and political consensus continues to solidify around the need to "fix" a broken system. This sentiment, the election results, and significant value-based purchasing developments by payers and employers have shifted the conversation from "if" the system will change to "when" it must.

Strategy executives categorized top issues into two primary categories based on time frame: near-term provider-centric issues and mid-to-long-term planning issues affecting how providers interact with payers and the rest of the economy.

**All pull-out quotes in this report are drawn from individual participants in the Executive Dialogue*

# Near-term Provider Centric Issues
## Developing Effective Communication Strategies

Hospital leaders continue to struggle to find ways to convey value in communicating with both internal and external audiences. Increasing complex and often divisive messages make communication especially challenging. As one person said, "the literature suggests that 30 percent of what we do is unnecessary or harmful. So we're facing a world where about one-third of our business arguably will be disappearing over the next five to ten years."

> *Taking smaller risks on pilots can help build knowledge and tolerance for change.*

Keynote speaker Arati Randolph faced similar challenges as Wells Fargo Corporation acquired Wachovia in 2008 during the largest financial crisis in the country since the Great Depression. "It was an incredibly difficult time for many people and for the industry — but we also knew that we were part of the solution. We had a compelling story to tell and we needed to tell it to all our audiences," Randolph said.

Through research and dialogue with team members (all staff at Wells Fargo are referred to as "team members," not employees), the organization identified five principles to guide development and implementation of a more effective communication strategy:

- Predictable communication
- The ability to be ambassadors for the organization with concrete, positive messages
- Multimedia approaches
- Greater consistency
- Enhanced leadership communication

These provided a framework for coordinated, consistent, structured communication that emphasized both relevant, specific information and the emotional connection to the corporation's vision and values through storytelling. Multimedia messaging channels ranged from a weekly, integrated, news email to a breaking news channel and enterprise intranet. In addition, Randolph and her team focused on generating more effective communication directly from senior leaders, designed to meet the expressed needs of team members for:

- More frequent communication from executives
- Spontaneous, authentic messages
- Reinforcement of vision and values
- Sharing of information internally before leaders spoke externally

One of the most successful strategies has been company-wide broadcasting of Town Hall meetings with Wells Fargo Chairman & CEO John Stumpf, which also are available for later viewing via the company intranet. Stumpf encourages questions from team members both prior to and during the broadcast to achieve the spontaneous, authentic tone that team members said was essential.

The group agreed with Randolph that hospitals need to win back responsibility for health care "storytelling," a job that has been complicated by social media's blurring of the line between internal and external communication.

Summarizing both the substance and spirit of the dialogue on communication effectiveness, one participant concluded, "broadly speaking, I think this is as much a leadership issue as anything. Most of us come from organizations that have been extraordinarily successful playing by the old rules. As the rules change, developing a leadership model that is adaptive to a changing environment is really going to be the critical success factor."

## Pursuing Smart Physician Engagement and Alignment Strategies

Hospital-physician alignment has been a strategic priority for several years, and the ACA has only accelerated organizations' sense of urgency in developing the structure and approaches to engage physicians more meaningfully in quality and cost initiatives.

> *Strategy professionals must be ready and willing to take on new or expanded roles.*

Strategists must resist a one-size-fits-all approach, instead pursuing models that address the market- and organization-specific issues and opportunities identified through effective planning processes. Physicians, particularly those early in their careers, are looking for organizations that demonstrate a commitment to providing high quality, evidence-based, clinical care. It is therefore critical for health systems to develop approaches and cultures that embrace and promote that commitment to clinical excellence.

Executive Dialogue speakers and participants outlined the following best and worst practices in aligning with physicians.

## Best Practices

***Perform thorough (but efficient) financial, legal, and cultural due diligence on transactions.*** The days of acting on instinct and back-of-the-napkin agreements have past. Some of the best physician alignment processes have developed thorough physician on-boarding programs that promote agreements that make business, legal, and cultural sense. T. Clifford Deveny, MD, senior vice president of physician services at Catholic Health Initiatives (CHI), outlined one successful model implemented at CHI. Through a transparent set of contract terms and parameters, committees with checks and balances, template term sheets, and clear CEO expectations, CHI has developed an efficient approach to contracting with or hiring physicians that aligns strategy and culture while mitigating legal risk. Physicians must know during initial dialogues and negotiations what the rules and parameters are if alignment is to yield mutual long-term benefit.

***Build leadership structures that allow physicians to truly lead.*** Often organizations assume that autonomy is the top physician priority, when in fact it is often the ability to practice medicine and contribute to an organization in a way that has meaning. Physicians want to work for or with organizations that listen to their opinions and allow them to maximize clinical performance. So one key to successful physician alignment is to create governance and other organizational structures that allow physicians to lead in developing the clinical excellence required in a value-based environment.

> *Innovation must become more of a core competency.*

Physicians are 'A' students; given a goal or problem, they will usually figure out how to make things work. To address gaps in physicians' management experience, hospitals are now investing in physician leadership development programs and education. Identification of potential physician leaders is a priority. Sometimes the clinical leaders who hold the greatest promise may not be physicians, but rather nurses, pharmacists, or other clinical professionals.

In summary, as one executive put it, "there are often times when we just need to get out of the way and let physicians lead."

***Calculate return on investment (ROI) for physician alignment.*** It can be astonishing how few hospitals perform this calculation, more than one speaker said. And if they do perform it, their methodology often includes an unrealistic projection of downstream revenue based on referrals. Hoping for referrals isn't an alignment strategy and is risky in a value-based world. Counting on provider-based reimbursement is similarly over-emphasized, given its frequent targeting by public payers. Community need is difficult to

calculate in the ROI formula, but that is exactly what will drive returns in a value-based or population health environment.

***Offer flexibility in the branding of physician practices.*** Allowing physicians to maintain a practice brand with established goodwill and long-term equity, separate from a hospital brand, can offer a net marketing advantage. It may also allow physicians to retain some independent identity. As care shifts increasingly to ambulatory settings, hospitals should also consider branding these separately from the hospital.

## Worst Practices

***Don't treat doctors like commodities.*** Physicians are not all the same, but many feel this is how hospitals view them. Physicians want to be approached as unique entities in ways that recognize the value and meaning of their practice. If, at the end of the day, hospitals apply similar market values to all physicians equally, the hospitals may wind up in a bidding war without ever exploring how an individual practice aligns with their culture or vision.

> *Traditional M&A models and thinking will not be sufficient to truly integrate activities and increase value.*

***Don't blindly adopt an off-the-shelf model.*** Each physician alignment model should be localized. Simply because a model worked at one organization in one market does not mean it will work in all organizations or all markets. Nomenclature can compound a mistake in this arena: the label of a model at one facility, say "clinical co-management," may represent a completely different model at another facility. Hospitals and physicians need a thorough, shared understanding of goals and a common framework for implementation in order to make alignment strategies work.

***Avoid over-employment.*** Not all physicians should be employed. Employment without a solid strategy may just be adding an expensive W-2 and potential future problems. Many organizations are now setting out to right-size their employed physician enterprise. Some progressive health systems have employed physicians to develop clinical and operational skills, then "un-employed" them in favor of a continuing relationship built on a tighter alignment

***Think twice before putting a successful hospital manager over a physician practice.*** Hospital management staff are increasingly assuming manager roles over newly acquired physician group practices, often without the distinct skills, finesse, and experience group

practice management requires. To re-purpose hospital managers as physician practice leaders requires them to rapidly develop competency in key areas such as revenue cycle, ambulatory throughput, and marketing.

***Stop propping up aging physicians' aging business models.*** Perhaps too much emphasis is placed on keeping older physicians happy in contractual relationships suited for a fee-for-service payment structure. Hospitals preparing for value-based models of care should proceed with caution when contracting for services or employing physicians in a manner only viable under fee-for-service structures without any transition plans. Simply put, payment is changing, so hospital need to change the way they contract and align with physicians.

## New Care Systems and Insurance Models

Today, health care is a fee-for-service industry, and hospitals are the biggest fee generators. In a value-based world, how will hospitals and health systems adapt to structures promoting global cost-savings? Some argue that the industry is simply repeating the managed care mistakes of the 1990s. Others point out a number of important differences. First, payers and some provider organizations now have the data to analyze and stratify risk across a population; and second, managed care in the 1990s was principally focused around primary care and keeping healthy people healthy. Now, the focus is shifting to managing care more efficiently and effectively for high cost, high utilization patients.

*One of the key goals of communication strategies must be creating optimism regarding our ability to adapt to change—and dispelling skepticism that we really understand the problems facing us.*

But what is the right way to manage the complex transformational process? If organizations move too quickly, they could be leaving too much money on the table; moving too slowly may lead to noncompetitive costs and drops in market share. However, when markets do move, they can move seemingly overnight. Strategic planners need to build flexibility into their schedules to align their moves with the cadence of their local market.

## Building Bridge Models

Anticipating that population health management will fully take hold in the next few years, many progressive health systems are currently implementing "bridges" to new care models. Some bridge models, like the medical home, relate to how patient and provider interact and collaboratively manage care. Other models, such as the ACO, revolve around global financial arrangements and how hospitals share risk with the rest of the provider world.

***Clinical co-management.*** These arrangements with physicians are a popular choice as a bridge model. Typically, co-management arrangements compensate physicians for performing non-clinical tasks in the management of a service line, such as quality measurement and reporting, administrative duties, and education. Co-management can be a relatively simple, cost-effective transitional strategy that produces favorable results quickly, including tighter hospital-physician relationships, improved quality, and better utilization of capacity.

***Bundled payment relationships with payers.*** Arrangements in which hospitals, physicians, and other providers are paid a lump sum for a defined service also are increasing in popularity. Bundled payments, however, can be administratively burdensome and costly from a claims administration standpoint, and this complexity may slow adoption. On the other hand, patient-centered medical homes (PCMHs) do resonate with payers. PCMH programs have been proven to save significant costs from a global perspective, and payers are beginning to promote them with various "wrap-arounds" such as fee schedule increases for physicians, care management billing codes with significant dollars available, and shared savings models.

***Integrated clinical networks.*** With strained capital budgets, many hospitals are turning to the development of integrated clinical networks to contractually align with the full complement of clinical services needed to adequately serve a population. "Clinical integration" has multiple meanings, but it was originally a legal definition derived from antitrust laws that allow a network to collectively negotiate and contract with payers if it meets certain quality and efficiency standards. Some systems are mandating that hospitals develop their own local or regional clinically integrated networks, not only to drive efficiency and profitability, but to improve quality and lower costs stemming from their employees' health care needs and/or uncompensated care delivery. Robust data and care management systems are necessary for successfully integratation.

*Given changing incentives, it is essential that we redefine what marketing means and what its goals are.*

***Accountable care organizations.*** ACOs, in which providers contract with payers to take responsibility for the cost and quality of care for a defined population and then share the savings generated, are another link between fee-for-service and value-based delivery. However, if you have seen one ACO, you have only seen one ACO – even within the Medicare program. Benchmark setting will be critical to success for ACOs and shared savings models. For example, what method will be used to set annual cost savings targets and budgets? If providers are required to continually achieve more savings than the prior year, participation will provide a diminishing return: eventually providers will no longer be able to eliminate incremental global costs from the system – and will not want to incentivize mediocre performance by continual use of historical, easy-to-achieve targets.

The consensus among Executive Dialogue participants was that hospitals should not wait for payers to issue value-based mandates because there are often fee-for-services benefits available in the interim. But with so many models available, determining which ones will actually have an impact in a particular market is a challenge for hospital strategists. Regardless, change is inevitable and defining goals and mapping a path to those goals is critical.

individuals, however, because for many of them (e.g., those with certain cancer diagnoses or trauma) it may be too late to intervene to effectively manage costs.

In a population health management model, it also is important to link individuals leaving the hospital with social service/community organizations as well as continuing primary care. Often individuals in need of social services do not receive the economic or clinical support required to stay out of the hospital because of lapses in follow-up care such as medication refills.

*We must change our measures of success, and then monitor our performance against those measures and respond uncompromisingly.*

Speakers also pointed out that collaboration between provider and payer organizations is the only way to conduct accurate analyses and proactively develop strategies to manage care. Payer claims data can produce answers in a directional sense but cannot provide something as simple—and essential—as a body mass index (BMI). This is why integrated delivery systems like Kaiser Permanente integrate more than processes and care; they integrate claims and clinical data. Without clinical data analytics, it is impossible to be successful in a population health management world. "It's not the people that come in the office that you have to worry about," said Dr. Silverstein; "it's the people that don't come in the office."

# Meeting Reform Imperatives

***Care management.*** Organizations that hold the risk under new payment models will be the ones to potentially benefit most from care management. Clearly defining who provides that care management—and who receives the premium—will be critical. Providers, payers, and even large employers through some of the more sophisticated benefits brokers are making significant investments in developing care management and care-setting transition competencies. Consider that traditional risk-sharing insurance is no longer the majority of insurance companies' business. Today companies are accelerating investments in non-insurance services such as care management and analytics. In a future focused on eliminating costs, care management is where the opportunity—and the money—resides.

***Keeping people out of the hospital.*** Payers have long been focused on reducing hospital costs through traditional methods of utilization review and decreased payment rates. But today, most payers have shifted their thinking on how to effectively reduce inpatient cost and are pursuing new, more straight-forward strategies. Brian Silverstein, MD, shared two examples. First, many insurers are less concerned with the absolute level of their contracted hospital rates as long as they are competitive with what the providers are offering other insurance companies. Insurance brokers do comparative analysis of insurance companies' network rates as one factor that can influence which carrier to recommend to employers. Second, insurers are paying primary care physicians more. Relative to hospitals and specialists, even doubling rates to primary care physicians is not a significant cost in global terms, considering that primary care payments typically account for only about five to six percent of costs for commercial insurers and just less than (or around three percent for Medicare. Eliminating a handful of high costs hospitalizations can pay for such increases and yield dividends by reducing the total cost.

***Population health management.*** As Dr. Silverstein put it, the key question in population health management is 'who needs to be managed?' As risk shifts and providers increase their role in population health management, the first step is to stratify the population to identify the greatest opportunities for improvement.

Focusing exclusively on disease prevention in large populations will not significantly reduce overall cost, at least in the short run. This is because, aside from things like vaccines, the ROI on much of the diagnostics in the primary care practice setting is notoriously difficult to measure—and because the return will not be realized for three to five years. Experts favor a focus on the top of a risk stratification pyramid, where the highest cost diagnoses and procedures, pertaining to a relatively small number of individuals, hold the greatest promise for cost reduction. It is important to not focus exclusively on the highest cost

# "No Outcome, No Income"

As the closing keynote speaker, Dr. David Nash brought together and commented on many points made during the Executive Dialogue, introducing additional concepts that are significant under reform and providing context for the sometimes overwhelmingly complex challenges facing all healthcare organizations today.

*Organizations must select, develop, and nurture individuals to be the colleagues they would want caring for their own families.*

Dr. Nash's memorable dictum, "no outcome, no income," effectively captures the harsh reality contained within the more abstract catchphrase, "from volume to value." Simply put, providers must produce superior results in clinical quality, quality-of-life outcomes, and efficiency to be favored and competitively paid by insurers in the future.

The six domains of excess cost identified in the Institute of Medicine's 2011 report, "The Healthcare Imperative: Lowering Costs and Improving Outcomes," show why the move to pay only for superior results is inevitable.

| OPPORTUNITY | ESTIMATED COST |
|---|---|
| Unnecessary services | $210 billion |
| Excess administrative costs | 190 billion |
| Inefficiently delivered services | 130 billion |
| Prices that are too high | 105 billion |
| Fraud | 75 billion |
| Missed prevention opportunities | 55 billion |

To effectively change the current cost and quality trajectory, Dr. Nash said, the industry must rely on four underlying concepts of cost containment through payment reform:

- Tying payment to *evidence and outcomes* rather than to units of service
- *Bundling payments* for physician and hospital services by episode or condition
- Reimbursement for the *coordination of care* in a medical home
- *Accountability for results* using patient management across all settings

Both Drs. Nash and Silverstein emphasized that from a payer's viewpoint, the most significant, straightforward way to reduce overall and per-beneficiary spending is by reducing inpatient utilization. All speakers also acknowledged that the most difficult aspect of managing this transition will be synchronizing the shift from fee-for-service with the evolving stages of population health reimbursement.

## Creative Destruction

The strength of the Executive Dialogue format lies in its capacity to both offer answers to immediate challenges and generate the right strategic questions to help organizations navigate through stormy waters ahead. At the close of the conference, comments suggested that the straightforward presentations and spirited dialogue had affected the thinking of the strategy professionals who attended.

In particular, participants seemed to feel that the concept of creative destruction was going to be critical to their success going forward: that simply retooling old ways and ideas would no longer suffice, that change must come from the inside—for organizations and individuals—rather than from regulators, and that hospitals and health systems must bring their different constituencies together to create a new organizational culture.