2018 CEO FORUM

Improving the Health of Communities Amid a Volatile Landscape

NAVIGANT

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FOREWARD

Spending time with my hospital and health system colleagues and friends is my favorite part of my job. Increasingly, such interactions have reinforced a less than pleasant reality: Being a healthcare executive has never been harder. Improving the health of communities is enough of a challenge unto itself — today's persistent political, financial, and competitive volatility has only made the mission that much tougher to complete.

We talked as a group about this and other pressing issues at Navigant's 2018 CEO Forum, graciously hosted by Texas Health Resources in Arlington, Texas. Similar to the 2017 Forum,[1] generating quality and financial returns from material investments in population health and technology still weighs heavily on the minds of executives. Additional topics that rose to the fore this year include enhancing payer-provider collaboration, reducing unnecessary variation, and addressing consolidation and scale.

Following are the collective insights, lessons learned, and best practices from CEO Forum executives and experts on overcoming current and future healthcare pressures.

RULON F. STACEY, PhD, FACHE
Managing Director, Navigant

PAYER-PROVIDER PARTNERSHIPS AT RISK

For close to a decade, healthcare leaders have expected fee-for-service payment to be replaced by a value-based movement centered on sharing risk with private and public insurers. While it's clear that a value-based **care** approach has gained in popularity, whether a broad-based transition to value-based reimbursement **models** is occurring depends on who you ask.

On one hand, the nation's largest private payers report that they're paying out approximately half of their reimbursements via value-based models.[2] Yet, a Moody's report[3] suggests less than 3% of hospital net patient revenue came from capitation and risk-based contracting in 2017, a statistic CEO Forum executives reinforced.

This gap exemplifies the divide between providers and payers, one that CEO Forum attendees discussed in the context of the imbalance between the supply of and the demand for risk arrangements in local markets nationwide.

Multiple provider CEOs noted that the acceleration of public payers moving to value models has not been matched by private payers, leaving them unable to find private payers to partner with on value-based models. As one executive suggested, "commercial participation is almost at a standstill in some markets, leaving organizations stuck between volume and value."

Likewise, attendees understood that payers have been met with varying levels of engagement on risk arrangements from the provider community.

Deciding on the right pace and trajectory to move from a volume to value environment is essential, particularly for providers. Executives agreed that the answer to that question lies much more in local market trends than national ones.

"Payer-provider collaboration is very geographic and organization-dependent," said Jack Lynch, FACHE, president and CEO of Main Line Health. "Some payers are more prepared and interested in sharing risk with providers than others, and vice versa."

Payer-provider collaboration is very geographic and organization-dependent. Some payers are more prepared and interested in sharing risk with providers than others, and vice versa.

JACK LYNCH
President and CEO,
Main Line Health

Access the video at nav.gt/CEOForumPayerProvider

Ultimately, closing the payer-provider divide requires a better understanding of why it is occurring, Navigant Managing Director and former health system CEO Rulon F. Stacey, PhD, FACHE, believes.

"I don't think hospitals understand how hard it is to be a payer, and I don't think payers understand how hard it is for providers to partner with them," he said. "We need to identify those areas where payers and providers can walk across that bridge and make collaboration happen, because opportunities clearly exist."

Sharing risk must be a collaborative pursuit, where payers and providers are properly equipped to take upside and downside risk together, suggested Joseph Swedish, former chairman, president, and CEO of Anthem, Inc. Having the proper technology underpinning is essential, he said.

"Payers and providers need to develop a support system that builds both confidence and trust," said Swedish. "Accelerating and scaling the sharing of data is going to be critical to that and overall success for all involved, most importantly the patient."

Swedish cited Vivity, a partnership between Anthem Blue Cross and seven Los Angeles-area health systems leveraging clinical and claims data to create a single, comprehensive record for each Vivity member. The partnership has resulted in a patient-centered approach promoting greater transparency into a patient's medical history and more effective care coordination across Vivity providers.

"Payers and providers need to develop a support system that builds both confidence and trust."

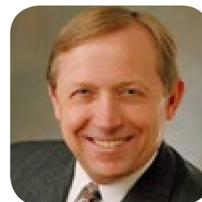
JOSEPH SWEDISH
Former Chairman, President, and CEO
Anthem, Inc.

EHRS, PRESENT AND FUTURE

Whether it's an implementation, conversion, or upgrade, health systems nationwide are enduring clinical and operational frustrations with electronic health records (EHRs). As Brent James, MD, a clinical professor at Stanford University School of Medicine, pointed out, those frustrations — along with the massive financial investments providers have already made — are likely to mount as the technology continues to evolve to better meet the needs of providers and patients.

"The EHRs that we have today aren't the ones that we'll have in 10 to 15 years. They aren't properly constructed for the core task of actually managing the delivery of clinical care."

BRENT JAMES, MD
Clinical Professor
Stanford University School of Medicine



"The EHRs that we have today aren't the ones that we'll have in 10 to 15 years," James said. "They aren't properly constructed for the core task of actually managing the delivery of clinical care."

Main Line Health recently undertook a "big-bang" EHR system conversion, one that Lynch said posed some unexpected challenges.

"I don't know that we really understood the amount of training that would be required, the amount of change management it would take to get us through the process," said Lynch.

As Main Line Health looks to upgrade its EHR, Lynch worries the process is going to be another big-bang launch. "Maybe this is something we're just going to have to get used to over time with these new releases," he said.

Access the video at nav.gt/CEOForumEHR

But Lynch was quick to suggest there's no plan to go backward. "We believe we've got a better tool that will help us be safer, help us increase quality, help us identify and eliminate disparities, and help us make care more affordable," he said.

Barclay Berdan, FACHE, CEO at Texas Health Resources, also highlighted EHR benefits from the physician side. “Our physicians tell me they couldn’t live without the EHR, that they concentrate on what it does to help them and their patients as opposed to some of the burdensome parts,” he said.

Lynch also pointed out that providers shoulder some blame for not leveraging EHR benefits as they should, and he compared the situation to that of telephone technology.

“If we all use our smartphones the way we used a flip phone, we wasted a lot of money,” he said. “I think the real challenge for us is to take the EHR and optimize it to its fullest capabilities.”

Lynch believes collaboration among providers and EHR vendors is required to improve the situation.

“How do you take this very strong tool and utilize it to increase quality, identify and eliminate disparities of care, and make care more affordable?” said Lynch. “That’s the challenge that we’ve got in front of us, and I think we should look to the vendors that are putting these products out on the street to help us do that.”

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BARCLAY BERDAN

CEO, Texas Health Resources

USABILITY REVOLUTION NEEDED TO FIX THE EHR

A path exists for EHRs to become more useful partners in the care process, but doing so requires a significant overhaul of the current system, according to Navigant National Advisor and CEO Forum speaker Jeff Goldsmith, PhD.

As Goldsmith and University of California Department of Medicine Chair Robert Wachter, MD, wrote in *Harvard Business Review*,[4] a usability revolution is needed to transform EHRs into easy-to-use tools that liberate clinicians and paint a better picture of the patient. Specific changes Goldsmith and Wachter suggest include:

- **Typing and point-and-click must go.** Voice and gesture-based interfaces should replace the unsanitary and clunky keyboard and mouse as methods of building and interacting with the record.
- **AI is needed to make the clinical system smarter.** The existing, primitive state of artificial intelligence (AI) in EHRs is a major barrier to efficient care. Clinical record systems must become a lot smarter — reducing needless and duplicative documentation requirements is a key starting point.
- **Center the EHR on a portrait of the patient.** This is the central problem statement for the care team and a rallying point for their work, and it must include the patient's diagnosis, major clinical risks and trajectory, and the specific problems the team must resolve.

JEFF GOLDSMITH
National Advisor, Navigant

WEIGHING IN ON SCALE

Healthcare continues to see record-high hospital mergers and acquisitions intended to achieve such benefits as gaining economies of scale. Scale up, and you'll bring down costs.

Yet, research questions whether economies of scale truly exist in hospital operations:

- An analysis[5] of 104 health systems found no relationship between profitability and the size of the system, data authors believe "flies in the face of the conventional wisdom that has driven mergers."[6]
- Another perceived benefit of scale is that it helps lower purchasing costs through enhanced bargaining power. But a Wharton School study[7] found the average estimated supply chain savings for target hospitals in a merger of equals to be a fraction of what was expected. In some cases, acquiring hospitals experienced supply chain cost increases in certain areas.
- Consolidation was supposed to benefit patients through lower costs. But, a University of California, Berkeley, study[8] of the metropolitan areas with the highest rates of consolidation shows mergers have mostly raised hospital admission prices.

What's more, Fitch Ratings' Kevin Holloran told *Modern Healthcare*[9] that his firm is de-emphasizing size and scale in its not-for-profit hospital credit rating analyses. "Just because you're big doesn't mean you get a high rating," he said. "Just because you're on the smaller side doesn't mean you get a low rating."

The benefits of scale were on the mind of CEO Forum executives as well.

"Hearing from individuals that have been there and done that and reflecting back after reviewing the data, questions remain about whether scale really matters for most hospitals and health systems," said Carrie Owen Plietz, executive vice president and chief operating officer at WellStar Health System. "Does scale truly improve quality of care and reduce the cost of care?"

Still, conversations about generating scale through consolidation continue in every market, no matter the size or geographic location. And there are organizations with immense scale equipped for short- and long-term sustainability, Navigant Managing Director David Burik pointed out.

Burik referred to Kaiser Permanente, HCA Healthcare, and UnitedHealthcare, three distinct operating models that clearly leverage their vast scale in their success. But these organizations benefit from another essential factor beyond size: discipline.

We need to be more thoughtful when considering scale and M&A activity, and ensure that it's truly being done to benefit the patients and communities that our health systems serve.

CARRIE OWEN PLIETZ
Executive Vice President and Chief Operating Officer, Wellstar Health System

"The benefits of scale won't simply be there unless you're organized and have the discipline to take advantage of it," Burik said. "It all starts with discipline."

Glancing inside these companies offers a view of how disciplined they are in using information to standardize, automate, and optimize operations and care delivery, Burik suggested.

"It's about knowing if there's a product or procedure that isn't of value or why ED visits are down, and using information to make necessary changes," he said.

According to Navigant's Stacey, "We have to focus on being more disciplined than we've been, learning from those that have made this work — both big organizations and small organizations."

Areas providers should target include executive compensation, unnecessary layers of management, and information technology outlays leading to higher, rather than lower, operating expense.

Plietz summarized the situation well, stating, "We need to be more thoughtful when considering scale and M&A activity, and ensure that it's truly being done to benefit the patients and communities that our health systems serve."

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DAVID BURIK
Managing Director, Navigant

TARGETING WASTE, UNNECESSARY VARIATION

EHRs, payer-provider partnerships, and greater scale were all supposed to address one of healthcare's long-standing challenges — reducing unnecessary variation or waste.

"Our ability to stay focused and disciplined around waste and clinical variation is something we can control, regardless of policy changes," said Gail Donovan, president of Health Services and chief operating officer at TriHealth. "Hospitals still have a long way to go, but we need to own it."

Stanford's James emphasized the significantly higher financial leverage from waste elimination compared to revenue growth. As he suggested, generating revenue or eliminating waste requires sound investments. If providers achieve a return on those investments that yields a 5% to 9% annual operating margin contribution, it's considered a win. On the other hand, it's common to attain a 50% to 100% return on waste reduction.

"The operating margin impact from reducing waste is much greater than the impact of increasing revenues," James said. "From the standpoint of pure value, both the quality and financial upside is stunningly massive."

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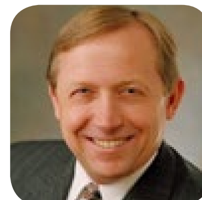

Our ability to stay focused and disciplined around waste and clinical variation is something we can control, regardless of policy changes or payer-provider partnerships. Hospitals still have a long way to go, but we need to own it.

GAIL DONOVAN
President of Health Services and Chief Operating Officer, TriHealth

Access the video at nav.gt/CEOForumVariation

According to Texas Health's Berdan, "Reducing variation is not a program but an ongoing part of an organization's overall culture and processes. We have to relentlessly pursue taking variation out of healthcare for financial reasons, and more importantly to provide a safer environment for our patients and our employees."

Collaboration is an essential ingredient in reducing waste, according to WellStar's Plietz. "We need close partnerships across clinical enterprises which can help take costs out of the system while moving the entire organization forward in their quality platform."

Navigant's Goldsmith points to the need for greater focus, saying hospitals need a "Serenity Prayer" moment. "I think what's really hurt this industry is a loss of focus. Instead of trying to imitate others and do 12 things poorly, let's focus on two things that are specific to your market and do them really, really well."

"Reducing variation is not a program but an ongoing part of an organization's overall culture and processes."

BARCLAY BERDAN
CEO,
Texas Health Resources

MAIN LINE HEALTH SAVES $46M THROUGH PERFORMANCE IMPROVEMENT EFFORTS

In 2017, Main Line Health set an ambitious goal: eliminate disparities and preventable harm while achieving top-decile performance around quality and performance, reduce costs through more informed operational decisions, and improve the patient and employee experience.

Main Line Health partnered with Navigant on the initiative, “Performance Excellence 2020,” applying the Baldrige performance excellence framework to change their culture and build new capabilities to achieve their operational goals.

EXAMPLES OF PROJECTS UNDERTAKEN INCLUDE:

Reduce variation in throughput and care coordination through standardized care progression tools and processes to ensure patients receive timely and appropriate care from admission to discharge. Examples include care progression rounds, a physician escalation process, standardization of care coordination roles and responsibilities, and ensuring discharge to appropriate care settings.

Enhance care for complex patients with congestive heart failure by implementing standards of care and therapeutic pathways for emergency departments, observation units, and inpatient units. Also, coordination with outpatient providers to ensure appropriate care is provided across settings.

Create a culture of accountability by clarifying leadership and work group roles, and strengthening organizational goal-setting, measurement, and performance review.

THROUGH THE INITIATIVE, MAIN LINE HEALTH:

Saved **$46.7M in FY 2018**, exceeding its target by $13M

Projects a **$109.7M savings opportunity** to date, tracking toward a **$120M goal** by FY 2020

ENDNOTES

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