HEALTHLEADERS MEDIA

CEO EXCHANGE

Leadership for a Changing Future

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Leadership for a Changing Future at the 2012 CEO Exchange

The inaugural HealthLeaders Media CEO Exchange gathered 30 chief executives from leading hospitals and health systems around the country for an extraordinary two and a half days this fall at The Lodge in La Jolla, Calif. Representing different types of healthcare organizations, sizes, and geographies, these CEOs brought their decades of experience to bear on the most important issues they face today.

The Exchange model is peer-to-peer sharing in small-group sessions moderated by HealthLeaders editors. In lively and frank discussions, our CEOs debated physician alignment to achieve clinical integration, sustainable cost reduction, industry consolidation, the coming shift to population health–based reimbursements, the impact of reform, and leadership development for executives and physicians alike. These six key topics were chosen through surveys and pre-event conference calls between the CEOs and HealthLeaders editors. Here are highlights of the sessions.

Physician alignment for clinical integration

Hospitals and physician groups have been experimenting with new models for hospital-physician alignment with more urgency in recent years, in order to prepare for clinical care that is more integrated across providers. Despite all the effort, more work remains to find models that can work long-term, according to CEOs attending this session.

In a survey of CEO Exchange members, the leaders described the average breakdown of their physician staff as 52% independent affiliated physicians, 20% directly employed, 15% within a hospital-owned medical group, and 13% employed through an outsourced contract.

Chris Howard, president and CEO of SSM Health Care–St. Louis, says the four distinct markets of his multistate health system "are either moving towards ACO status or

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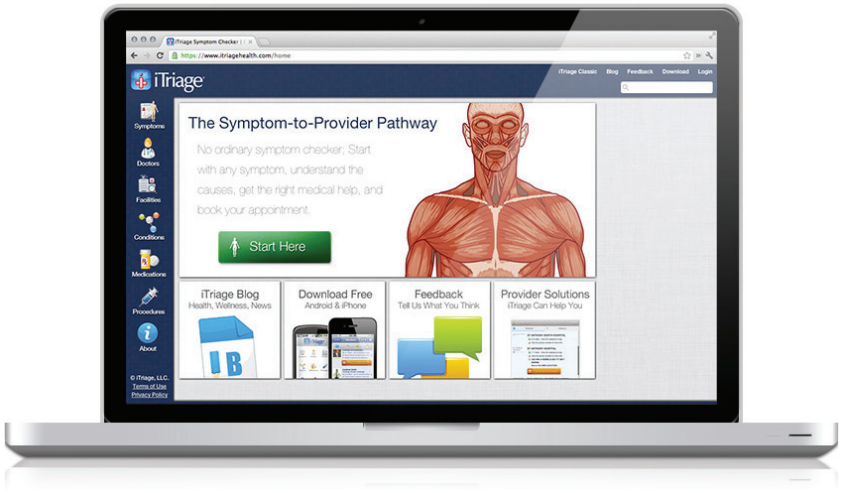

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ACO-like models." Despite the commonalities, SSM has not settled on a single satisfactory alignment structure. "We have gone from straight salary to RVU to cost-based to revenue-based, and we have just not found the right model yet, but we have made some improvements," he says.

Physician employment does not resolve all alignment issues, says Jeff Thompson, MD, CEO and chairman of the boards at Gundersen Lutheran Health System in La Crosse, Wis. Thompson—who remains a practicing pediatric intensivist himself—says the health system's physicians and hospital were separate entities until the 1990s, when they integrated. "The mindset of the hospital employing physicians never came to the mind of the physicians," Thompson says. "First of all, the clinic was bigger than the hospital. Our strategy was that regardless of who had the most money and the most power, we would all be better off long-term if the physicians felt part of the organization rather than as separate employees."

Physicians are integrated into the leadership of the Gundersen system, from the CEO's role to the physician board to departmental leadership, Thompson says. "Any lawyer looking at our agreements would say the docs are employed. [But] none of them feel employed because physician leadership in our organization is pretty clear."

Strategies for sustainable costs

Hospitals and health systems have long operated with low margins, and many have spent years honing their supply chain and revenue cycle expense management. But even greater cost savings promise to be gained from reforming and standardizing clinical practice patterns—never mind the demonstrated increase in patient safety and care that clinical practice reform can deliver. While reforming and standardizing clinical practice is a relative newcomer to the healthcare cost reduction imperative, the level of scrutiny surrounding clinical practice patterns seems poised only to ratchet higher in coming years, CEO Exchange members say.

Though modest operational efficiency gains remain to be found, many leaders feel that their organizations have completed the bulk of their work on traditional areas of cost containment such as the supply chain and revenue cycle. Now they seek to ingrain a culture of cost reduction among clinicians that is sustainable rather, than reactive and tactical.

No longer is growth and cost efficiency the panacea for organizational strength. Providers have successfully wrung out

operational efficiencies using productivity systems and benchmarks for labor, and innovative contracting methods for supply chain and other necessary services. What is needed now is leadership that focuses on a deeper dive into the operations of healthcare in the United States with the goal to improve quality while driving out waste in all aspects of the healthcare continuum.

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>
> JEFFREY E. THOMPSON, MD
> CEO AND CHAIRMAN OF THE BOARDS
> GUNDERSEN LUTHERAN HEALTH SYSTEM
> LA CROSSE, WI

Shifting the definition of healthcare

The shift from a reimbursement model based on fee-for-service to one based on risk and population health is perhaps the most profound change to the business of healthcare since Medicare. The assembled CEOs agreed that a move away from a sick-care model to one based on health is the right direction for healthcare, but the mystery is in how fast to get there.

"We are moving incrementally into population health because we believe that is the only future," says Chris Van Gorder, president and CEO at Scripps Health in San Diego. "I often get myself in trouble for saying this, but I think accountable care organizations are a fad, because it's still episodic care payment for the most part. What we're moving towards is full risk capitation again, but we want to do it in a risk-adjusted model."

Britt Berrett, president of Texas Health Presbyterian Hospital Dallas and executive vice president of Texas Health Resources in Arlington, Tex., says that "the name of the game now is outside the walls of this hospital." Under the fee-for-service model, there has been little incentive for hospitals to manage post-discharge medication reconciliation or navigation, but that is changing. "We [are] forced to do something we should have been doing in the past. We have an obligation to identify what the needs are, where before we just didn't worry about it."

Van Gorder says that to succeed, hospitals must recognize that the shift to population health changes more than just a business model; it also creates a new relationship with patients. "I asked my people the other day, 'What is it we really sell? Is it healthcare?' I said we sell relationships, and yet we really haven't cared much about the relationships."

M&A and other affiliations

Shifting reimbursements and looming capital needs are driving healthcare mergers and acquisitions at record levels across the country. To position themselves financially and operationally for the future, hospitals and health systems must control costs while still offering quality services, attract and retain physicians, find their niche among competitors near and far—and consider the right

The Power of Analytics:
Creating Real-World Solutions

At the recent HealthLeaders Media CEO Exchange, a panel of senior executives shared their thoughts and offered insights on the most pressing needs for hospital leadership in the coming years. The discussion focused primarily on Physician Alignment and contracting. Various contracting, governance, and employment options were discussed, including models to address the evolution from fee-for-service to population-based care under the health reform act. But whatever the structure of the hospital-physician relationship, the panel members were unanimous in their agreement on one key point: analytics will play an essential and significant role in creating, monitoring and measuring the effectiveness of a successful physician alignment.

The Power of Analytics

In today's healthcare, analytics is no longer just a buzzword. For hospitals seeking to successfully navigate the challenges and uncertainties of healthcare reform, analytics has become a critical and compelling resource. These hospital leaders understand that creating a physician network that delivers high quality services in a cost-effective manner requires making a host of tactical and strategic decisions based on internal dynamics and performance as well as external market influences.

There are many questions to be answered:

- How many physicians are needed? In what specialties? Where are they needed?
- What medical services does the community need now? In five years? In 10 years?
- How is the medical staff performing compared to their peers? What are appropriate benchmarks?
- What contracting and/or employment models best fit with an individual hospital's optimal medical staff structure?
- How can medical decision-making and governance challenges be effectively addressed under different medical staff employment and contracting models?

Only the information available through a wide range of data sources can serve as the foundation for making the smart decisions that will separate the winners from the also-rans. Hospital executives must examine cost, quality and operational factors internally, as well as comparing physician performance to peers and competitors.

The new way of organizing strategic information allows a user to perform complicated analysis in minutes instead of weeks. New technologies allow users to maintain continuity between the detail information and the overall view of the organization. Complicated analyses, requiring significant time and effort, are simplified.

Analyses such as:

- Location (master planning of assets)
- Alignment of providers across the continuum of care
- At-risk scenario planning (bundled payments)
- Cost/quality as it relates to physician population and population health planning

Often these data components are not aligned or structured to work in harmony because of investments in independent legacy platforms. Clinical data is separate from financial and strategy data. At iVantage, we have streamlined and integrated these disparate analytics to help you quickly discover the relationships between these data.

This integration is the basis for the iVantage product suite. Our goal is to deliver timely, meaningful information in simple to use dashboards which interface to a GIS mapping platform. Combining market data with the myriad of data from legacy platforms in your organization allows disparate information to come together to provide a complete picture. No piece of information is left behind.

In this ever-evolving industry, the right strategy depends on the seeing all the intricacies of your organization in the context of your market and responding quickly to a rapidly changing environment.

At iVantage Health Analytics, we embraced this new thinking several years ago. We know the healthcare reality of today requires hospital executives see all the moving parts in a market. Using internal benchmark data and evaluating that information in the context of the market, planners can identify all factors that may impact a physician's performance. For example, the traditional approach to running a physician demand report for recruitment or counting the number of physicians in the market for supply are no longer sufficient to remain competitive.

Traditional 'splitter' analysis (identifying where physicians are sending some or all cases to a competing hospital) would indicate that if a physician is splitting admissions, you want to stem that flow; new physician planning requires an examination of the cost/quality performance to determine if the physician needs be 'wooed or shooed'.

Using Integrated Business Intelligence to Get the Whole Picture

Using iVantage Health's integrated business intelligence tools, healthcare executives can now identify the true underlying causes of poor physician performance.

For example:

Physicians, especially hospitalists, often do not have control of patients coming through the emergency department. Thus, either through lack of early intervention, poor coordination of care, or lack of social safety net services, patients often come to the ED sicker and are sent back into an environment where care is limited. By combining the market data with the physician performance, iVantage helped one hospital client identify a physician who might be viewed as a poor performer in the market place, when, in reality, population health planning was the problem.

iVantage™ Health Analytics

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partner to work with. Potential affiliates include other hospitals and health systems, physician practices, and post-acute care facilities. Executives must be able to look beyond day-to-day responsibilities to an uncertain future, say CEO Exchange members in this session.

The strategic needs for affiliations are now shifting. Population health approaches will change the types of alliances seen in the near future, our CEOs predict. While scale will remain important, many organizations are likely to make moves to build or protect positions in local markets. Agreements with partners across the care continuum will aim to protect cost and quality.

Unusual affiliations, such as between nonprofit and for-profit entities, are showing up. Nontraditional competitors are entering the industry. Leaders expect consolidation to continue unabated for many years. But regional supersystems, touted by some industry observers as the ultimate outcome, are unlikely, say our CEOs. Instead, consolidation to a small number of leading players is already taking place within many large metropolitan markets.

Board expertise is a bigger consideration than ever, CEO Exchange members say. At multi-hospital systems, board members tend to have broad experience and perspectives, but the boards of community hospitals are often lacking. Those hospitals risk being left out in the cold.

Charting the effect of reform

The Supreme Court's ruling on the Patient Protection and Affordable Care Act was a judicial highlight, yet many healthcare executives said beforehand that the decision—pro or con—would change little in what they must do. Healthcare reform was driven in part by economic necessity, and many hospitals and health systems have moved independently toward reform goals.

But the devil is in the details, CEO Exchange members say. Hospitals and health systems may find themselves facing an influx of new patients—with or without Medicaid reimbursement. Some organizations are launching or joining ACOs, while others hold back. Competitive differences among markets mean that no set of responses applies to everyone.

Healthcare organizations are scrambling to put the pieces in place for the new healthcare reality. Technology investments take center stage, our CEOs say—to standardize processes, to ensure clinical care, and to track costs.

But the CEO attendees of this session are bracing themselves and their organizations for a period of upheaval, calling the next couple of years a "killing zone" for weaker competitors caught in a zero-sum game. The healthcare industry will soon see change on a massive scale. Organizations must attempt to predict risk and prepare for disruptive innovations in the delivery of healthcare. Deep cuts in costs, changes in the doctor-patient relationship, and changes in doctor-hospital arrangements are just a few of the massive shifts ahead.

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Executive and physician leadership development

CEOs agree that the healthcare industry is experiencing a dramatic shift in key competencies with the advent of new incentives and requirements. Sharpened skills are needed to handle risk management, case management, and medical informatics, among other needs. What's more, thinner margins mean that organizations can no longer afford to allow senior leaders who are not getting the job done to linger in their positions. Even top executives such as CMOs, CFOs, COOs, and CEOs themselves will have to broaden their capabilities and serve as a bridge between clinical and financial needs.

Yet leadership development is not a new concept at hospitals and health systems, note CEO Exchange members. MemorialCare Health System in southern California has enrolled 20 business-side executives and physician leaders in its Leadership Academy each year since 1997. SSM Health Care, headquartered in St. Louis, operates an Emerging Leaders program for high-potential leaders.

Physician leaders need business skills, just as business-side leaders must understand the ins and outs of clinical care. The increasing need for physician alignment and for physician leaders puts a premium on leadership development for physicians. Gundersen Lutheran Health System in La Crosse, Wis., tries to get business and physician leaders on the same page by conducting joint performance reviews, with each side responsible for the other.

Will programs like these be sufficient? The changing dynamics of healthcare make it difficult to come up with a reliable playbook, our CEOs say. ■

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*Leapfrog's 2013 Hospital Survey launches April 1; the first reporting deadline is June 30. Survey closes Dec. 13.

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