ROUNDTABLE

Catalytic Leadership

The healthcare provider industry is ever shifting. Rarely, however, does it truly change. A combination of economic pressure to reduce costs and healthcare reform efforts have led to a new recognition that the underlying volume-based business model of healthcare may finally have cracked, and along with it the style of leadership it created. HealthLeaders Media convened a panel of health system leaders to share their insights on how they plan to guide their health systems to meet a new way of doing business based on coordination and value.

PANELIST PROFILES

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Roundtable Highlights

HEALTHLEADERS MEDIA: *Do you feel like the combination of forces from healthcare reform, the consumer, and the economy are truly causing the underlying fundamentals of the healthcare business model to shift?*

CRAIG SAMITT: Absolutely. This is a fundamental change, and there's no going back. The question is, where is there to go back to? We all know that the realities of healthcare really dictate a total paradigm shift in the way we provide care delivery. We've all been on a treadmill where we presume we can just generate more units despite the fact that unit cost reimbursement is going down and we're spinning off all of these excess ancillary initial costs that drive up the total cost of care. Accountable care is a delivery system objective. If we're going to reform healthcare, we need to reform it from the inside out. We need to change the business model so that we are focusing on value and not volume. There are some parts of the U.S. that presumed that managed care would never come to them, and it never did. I don't see the same will be true of the evolution from volume to value.

PETER FINE: Yes, I do. If I put my global cost of healthcare hat on, then the direction we are going in is unsustainable because the country can't afford the cost. But if I'm just running a healthcare organization providing services when people hit our door, behavior changes must occur to offset the unsustainable direction. These behavioral changes have to be put in place from a reimbursement perspective. You have to change the methodology. The reimbursement system is an incentive system. If you create a certain incentive, you will likely get that outcome and so you have to change that incentive system. We've yet to see whether that incentive system is actually going to change, therefore causing a change in behavior, but I think it is inevitable.

MICHAEL DOWLING: If we want to promote health instead of just providing medical care, we have got to change the business model, which means changing how we get paid. While we call ourselves "health" systems, we have to be honest: We primarily take care of people medically when they get sick, instead of focusing on prevention and wellness. Overall, efforts to curtail cost will not be really successful until this change occurs. Cost growth results primarily from environmental and lifestyle issues. This is not, of course, meant to avoid being more efficient and productive in how we do things currently.

MICHAEL COHEN: So part of the challenge right now is that there's recognition by many as to what the edge of the horizon starts to look like. How do you time the transition? The cliché right now is how do you live in two worlds at once? Leading organizations at this point are trying to take smart steps toward employer direct contracting, for instance. Trying to create pools where you can have some gain share where if you accept some risk, you can share in that benefit. You see some isolated pockets here in Illinois and in other markets where you have commercial payer health system partnerships trying to forge new arrangements where there's some level of increased risk around quality, but also some inurement for the benefit. There's a strong appetite on the employers' side to figure out a new model, along with some level of frustration for employers that the commercial insurance sector isn't adapting to changes as quickly as it needs to.

Craig Samitt, MD
CEO
Dean Health System

FINE: If you have commercial insurers who are just looking to offset their risk and dump it on provider organizations that have not been used to managing risk, or organizations that don't have a significant and large base of physicians tightly linked to them, that provider is going to fail miserably and take us back to where we were 20 years ago. So the incentive change has to be done carefully.

SAMITT: What Peter just described is an area that I hope we don't relive. One of the primary reasons why managed care failed is that there was a big difference between facilitating the management of risk and dumping risk; managed care was all about health plans dumping risks on providers that weren't ready. There was no assistance.

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There was no data. Managing risk is sophisticated. If you want to make the move from volume- to value-based care, that's a culture change. There are many steps to that. You can't just take a capitation and presume that you're going to do well without building the infrastructure. That's how we have to play it differently this time.

HEALTHLEADERS: *Do scars from the managed care era still contribute to a hesitance on the part of some health systems to jump back in to risk?*

DOWLING: Failure, in and of itself, is not bad. It can be a valuable learning experience. Many previous efforts to take risk, including our own, were unsuccessful because we did not have proper alignment between our hospitals and physicians. Though not at all perfect, it is now much better. In my situation, for example, there has been a major expansion in the number of full-time staff physicians. This development helps.

Michael Dowling
President and CEO
North Shore-LIJ Health System

HEALTHLEADERS: *Mike, do you see that health systems are trying to acquire that skill set to be able to manage populations, to carry risk, to avoid repeating the experiments from 15, 20 years ago?*

COHEN: It's top of mind for every organization. Organizations that have a health plan or have some of that capability are actually very focused on how to make it a differentiator in their market. Those that don't have a health plan are asking themselves whether they should try to acquire a health plan or otherwise acquire the skills to do it. The larger conundrum is how to manage the behavior of the patients or the communities that you're serving and how to put in physical assets and human assets to really change behavior over time. I don't think most people have really gotten to the point of understanding what predictive analytics really mean to their organization. How many people in the market right now are really thinking about advanced epidemiology and how to look at a population and understand how disease prevalence will change over time? You can start to do things like put patients into medical home networks and put nurse navigators into the community, and those are all very logical foundational steps.

HEALTHLEADERS: *Your mandate still has to be, in a business sense, to grow in some way, to expand, however you define it. Has that definition changed? Do you view growth differently?*

SAMITT: If we believe that we will truly see this shift in paradigm from volume to value, growth takes on a whole new meaning. Growth is no longer more buildings, more beds, more facilities, and more specialists. It's more patients and a larger population. The growth is going to be in healthier populations. The growth is going to be in effectively managing the total cost of care as opposed to reaping margins from highly lucrative services. We're thinking of it in that context, so we're investing in the infrastructure that we talked about that reduces the total cost of care and grows our population. We're investing much more in primary care than we are in specialty care. We're investing much more in outpatient facilities than we are in inpatient facilities. The ideal growth scenario for us is five years from now we have triple the number of patients, each generating half the number of prior services that they generated previously.

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COHEN: There are really two elements to success going forward. One is you have to figure out a way to manage a margin in a budgeted care environment, and that means doing things around population health to manage your costs so that they align with the budgeted amount of revenue you're going to get for that population. Organizations also have to find the 10% of revenue that's going to provide a 10% margin. And that may be a different set of businesses than they are in today. I'm not talking about fitness spas and life spas and the traditional way we've thought about health and wellness, but getting into the lines of business where you can segment parts of your population who may be willing to pay more for certain kinds of services or value-added wraparound services that you can tie in to the delivery over time. Traditional margins on business, even if managed effectively, are not going to allow capital to be replenished year over year. The numbers just don't work.

FINE: I'll pick a contrary view. I think there is space for organizations that are very good and very efficient living within their space. It's hard to be all things to all people, so Banner isn't getting into 20 different new lines of business. We're trying to be very efficient and effective at what we do. Our overhead for our organization hovers around 7% of our revenue. We do think we're going to have to live with a Medicare rate in the future, and so we've geared the organization to manage the business at a Medicare level of reimbursement. We're not trying to supplement the loss of revenues by bringing in new lines of business that are relatively foreign to the organization, because we don't think we can be good at it. We'll find out 10 years from now whether that's a right decision or not, or whether becoming the best in your space is the better option.

HEALTHLEADERS: *How far do you push this envelope of being out on the edge of innovation without risking current performance?*

FINE: Any organization that gets too big a head and starts believing its own press is doomed to failure. You have to demonstrate caution associated with things that you want to do that significantly change the direction you're moving towards or change the essence of what you are as an organization. Take a pyramid and say the bottom third of the pyramid is 75% and the middle third is 20% and the top point of the pyramid is 5%. It's okay to take that 5% of your business and focus on creating networks, or focus on creating new methodologies of working with insurance companies, or focus on specialty areas that you want to take risk on. If you flip that pyramid around and you want to take the 75% and put it at the top of the pyramid where all the risky changes are occurring, then you're creating such a huge level of disruption and an unrealistic level of risk.

HEALTHLEADERS: *We've talked about new relationships and capabilities, but behind all of those are investments. Are there some common investments—human and real capital—that should be made as a hedge against the future?*

SAMITT: I'd probably say that our investments are falling into four categories right now. One is some physical plant investments, but we're being prudent about that. Our newest facility is in a brand-new market where there is a tremendous opportunity for us to grow. The second and biggest of them all is really investing in capabilities to deliver value. So it's the investments in enhanced technologies. We made a big play in Lean process improvement. We're going to be making a big investment in the data analytics space, things that will really further our progress to move in an even more accelerated fashion toward value. The third is a regulatory investment. We've got the burden of ICD-10 and some very major price tags that go with some things that are must-do. And then the fourth is investment in diversification, like the creation of joint ventures with other organizations that want to get into the risk business or create their own health plan.

COHEN: There is going to be a sea change where you're going to go from very large customers to many individual customers. The ability to make the investments to allow for adaptation to a small individual and small group client base are not going to be the biggest dollars you're going to spend, but they are going to be some of the most important.

FINE: What you're really describing is the movement toward a retail market.

COHEN: Yes.

Peter Fine
President and CEO
Banner Health

FINE: I think that's a major sea change for most of us. Moving to a retail market isn't just changing how you put a billboard up. It's a whole different dynamic. We've convinced ourselves that if these health exchanges really take hold, and if employers will be motivated and incentivized to push their employees into health exchanges, then those health exchanges become a giant retail market. So it's not about convincing the benefit manager of a company to have an insurance plan that has your particular organization; it becomes a real value equation from a choice perspective for the individual.

HEALTHLEADERS: *On the physician and organization alignment side, it seems the integrated delivery system structure is getting renewed attention. Craig, do you think the structure like you have at Dean is a model that can or should be copied?*

SAMITT: Not everyone wants to be like us, and I don't think you need to

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have the structure to deliver the function. I've facilitated groups of doctors that are part of an IPA, part of a PHO, are an integrated delivery system that's not for profit, and a for-profit owned medical group. And there's envy around the table. They all kind of want to be each other, and the reality is that there isn't nirvana in any of those settings. It's not about structure that drives performance of a provider group; it's really leadership, incentives, data. There are tools of influence, and the groups that use those tools of influence—no matter what their structure is—drive performance.

DOWLING: Again, it depends on circumstance. If you start with the premise "I want to provide the best quality and the best service, and I want to coordinate care," then you've got to figure out

Michael Cohen
Principal
Deloitte Consulting LLP

those mechanisms that make people align around those goals. It's pretty simple. Making it work on the ground is, of course, more difficult. As mentioned earlier, increasing the number of full-time, employed physicians can make it easier.

FINE: That's to protect their incomes.

DOWLING: In part, yes. But I believe that there is growing acceptance of the desirability to work in an interdisciplinary way to improve overall quality and the experience of care. Our task is to maximize that reservoir of professionalism and commitment.

FINE: We have over 800 employed physicians. We actually think we're going to have 2,000 over the next few years. But it still will be a small component of the total number of physicians that work with the organization. We just built the Banner Health Network for our Arizona market. It has over 2,500 physicians in it. Less than 30% of those are actually our employed physicians. The rest are independent physicians who are banding together with us to be able to accept risk contracts and in many cases are either part of our PHO or are part of the physician group that serves our Medicare Advantage plan. So whether physicians are employed or independent in the Banner Health Network, we're building a base of closely aligned physicians linked together in some economic model that aligns our interests.

HEALTHLEADERS: *We know that leadership in healthcare will have to be more dynamic in the near future. We've talked about investments, relationships, and capabilities. Do you have a final piece of leadership advice to tie these strings together?*

COHEN: The thing I always encourage my clients to do is not to adopt the strategy of another organization that's very successful. Adopt a strategy that meets the needs of the future but builds from the strengths of who you are. You can certainly learn from the experiences of others, but you have to be true to who you are, first and foremost. And I think one of the things that makes each of these organizations very successful is they're building strategies from their position of strength and strategies that meet the unique demands of their markets.

FINE: I would say don't try to be more than what you're capable of being. Focus on excellence in whatever you decide is your area of business or expertise. Too many organizations in a time of disruption try to latch on to, "Well, I'm going to go after this and this and this and this," and they're not excellent in any of them. In a time of disruption, narrowing your focus is much better than expanding your focus.

"Adopt a strategy that meets the needs of the future but builds from the strengths of who you are."

DOWLING: I think it's a great time to be in healthcare. You have to be transformational if you want to be called a leader. We'll be different—not because it has to be different, but because it needs to be different. The second point I want to make is that leadership is not just the C-suite. The best leadership comes from the bottom. If you get the people at the bottom acting as transformational leaders in their own units and their own divisions and let it percolate from there up as well as from the top down, then you will change the culture of the organization.

SAMITT: While we're all in different markets and we all have unique circumstances, there are several ways that we're all the same: We're taking offensive strategies, not defensive strategies; we're focusing on the fact that leadership matters; we're changing our organizations through cultural change; and we're being optimistic, not pessimistic, about what the future can offer. Those who look forward and take advantage of the blue sky and lead their organizations optimistically to a better place will be the ones that will succeed.

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