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INSIDE EDGE

CEO Roundtable
Creating Partnerships for New Models of Health

Dr. Nicholas Wolter, Kevin Lofton, Dr. Laura Forese, Ken Paulus, Amir Dan Rubin

Introduction

It's not often you get the mix of healthcare-CEO firepower in one place that we did at the recent 22nd Annual Scottsdale Institute Spring Conference, April 30 to May 1, 2015 at Scottsdale's Camelback Inn. Our Executive Roundtable and Open Forum, moderated by SI Chairman Don Wegmiller, featured:

» Laura Forese, MD, President, NewYork-Presbyterian Healthcare System

» Kevin Lofton, CEO, Catholic Health Initiatives

» Amir Dan Rubin, President & CEO, Stanford Health Care

» Ken Paulus, CEO, Allina Health

» Nicholas Wolter, MD, CEO, Billings Clinic, and Board Member, Scottsdale Institute

These top executives, leaders of major health systems across the country —literally "from sea to shining sea"—tackled the issues that keep them awake at night as they navigate the uncertain passage from volume to value. Each one offers particular insight into how American healthcare institutions are responding to the most challenging and yet the most exciting time in healthcare by developing innovative partnerships while engaging consumers and the underserved in bold new ways—and using IT innovatively to connect globally while acting locally. Time and space limitations make it impossible to do justice to the rich content of these unique presentations. For access to more of the content—including a lively Executive Roundtable with audience interaction—SI members can access complete audio and slide presentations at http://www.scottsdaleinstitute.org/

Laura Forese, MD, President NewYork-Presbyterian Healthcare System
http://nyp.org/

NewYork-Presbyterian is just a teenager—17 years old—with six campuses including two academic medical centers: Columbia and Weill-Cornell, both in Manhattan. "We don't employ the physicians and that's a significant factor in developing partnerships,"

NewYork-Presbyterian
The University Hospital of Columbia and Cornell

said Forese. "They're all employed by the medical schools."

After 15 years without hospital acquisitions, two years ago this most urban of health systems began exploring acquisition of community hospitals. It now has three in the boroughs and suburbs, and expects to add another in Brooklyn this year, which will bring NewYork-Presbyterian up to 4,000 beds.

While New York has lagged the rest of the country in hospital consolidation, in the past 24 months that trend has reversed itself. "Everybody [health-delivery systems] wants to be in Manhattan," she said.

Adding the community hospitals signaled NewYork-Presbyterian's new emphasis on becoming an integrated delivery system, a challenging task considering it encompasses markets ranging from the one of the nation's most affluent areas—Westchester County—to its most diverse and densely populated area—Queens. Integration involves three major strategies:

- Meshing the community hospitals and physician practices with the core academic medical center;

- Integrating outpatient services like surgicenters, radiation oncology centers, skilled nursing facility, home health and hospice;

- Focusing on post-acute care.

NewYork-Presbyterian's approach is to put its name on the door on day one, giving it the look and feel of the NewYork-Presbyterian brand. Despite its focus on post-acute care, whether the health system retains ownership of or partners in all its new service lines such as home health or long-term care is uncertain.

Only in New York

"The nursing home business in New York is challenging," Forese said, and while the health system is not interested in operating nursing homes, it wants to find quality partners in that market. New York has also shown "very little uptake in hospice, a quirk in the region." One thing is certain, she said: NewYork-Presbyterian has no current intention of becoming an insurer.

Cost is another factor "keeping us up at night," Forese said. "We know we are high cost for a litany of reasons, including the fact that we train more residents and fellows than anybody in the country." Despite such logical causes, however, NewYork-Presbyterian recognizes the unsustainability of the cost curve and has launched several cost-cutting initiatives, including benchmarking revenue cycle of its two academic medical centers against each other, standardizing the clinical supplies and resources that providers use and eliminating unnecessary testing.

Given that salaries account for 60 percent of its budget and half its workforce is unionized, "there's a lot of pressure on other parts" of the cost equation, she said. "Perhaps community hospitals can be incubators" for cost-cutting and quality programs that can be rolled out to the whole health system, Forese said. "It's not just about the dollars. We also focus on care redesign."

> **"Perhaps community hospitals can be incubators for cost-cutting and quality programs that can be rolled out to the whole health system."**

While the New York area remains mostly fee for service, NewYork-Presbyterian is testing the waters of value-based care. For example, it entered into partnerships with local community and religious leaders as part of a regional population-health collaborative that managed 6,000 patients with chronic diseases like diabetes, asthma and CHF. After three years, the collaborative cut ED visits and hospitalizations by nearly 30 percent each and 30-day readmissions and average LOS dropped about 37 percent and 5 percent respectively. Patient satisfaction scores also rose. "It's proof of what you can do with data," she said. (See *Health Affairs* article http://content.healthaffairs.org/content/33/11/1985.abstract?sid=1666675d-3299-4cfe-b36d-f19b835998a6).

Kevin Lofton, CEO, Catholic Health Initiatives
http://catholichealthinitiatives.org/

"We represent healthcare in America," said Lofton in reference to CHI's aggregate scale and diversity: 105 hospitals in 19 states, 13 clinically integrated networks, 10 insurance plans and 30 critical access hospitals. Fifty-four million people, or 17 percent of the U.S. population, live within 60 miles of a CHI hospital.

While CHI has $2-billion medical centers in six states, it also owns facilities in tiny towns like Baudette, Minn., that call for innovative approaches to health and wellness. For example,

an analysis of mortality rates in Baudette, a town of 1,000 people on the Canadian border, found it had a high rate of highway deaths because teenagers were driving to other towns in the dead of winter to see first-run movies. As part of an internal corporate-grants program, CHI built a movie theatre and gave it to the town.

Such scale and diversity present formidable obstacles to data sharing. "The IT challenge," he said, "is we can't have just one IT platform. We must manage multiple platforms from a single operations center. We have to have flexibility for each location. Healthcare is local, but we also have national service lines. On the corporate level we focus on using our size and scale to position CHI for the future."

In the transition from volume to value CHI is taking a clinical-integrated network approach to population health, said Lofton. "We're reaching out to consumers before they become our patients." By 2020 CHI expects to derive only 35 percent of its revenue from inpatient acute care and is pursuing a diversification strategy involving partnerships with other companies that offer care management, consumer engagement, pharmacy and lab services. Last year CHI did $900 million in charity care, so care management and consumer engagement are key strategies going forward.

A stake in the company

CHI has set up an internal research engine called CIRI, for CHI Institute for Research and Innovation, to develop and implement emerging technologies that can be applied toward cancer, increasingly managed as a chronic disease. CHI takes care of as many cancer patients as some of the leading U.S. cancer centers, he said, and "we can bring cancer clinical trials to small communities, as well as virtual care using teleradiology and telepharmacy." Innovative partnerships are the watchword. "We'll do

outsourcing, but also want a stake in the company."

"Transition is not easy. There can be a lot of unexpected repercussions," said Lofton, noting that CHI recently acquired an Arkansas-based health insurer and ended up losing $20 million to $30 million a month in out-of-network costs, partly because of CHI being dropped by another major insurer in another state who now viewed it as a competitor.

Positioning for the future includes a focus on the entire patient experience starting with CHI's own workforce. CHI Healthy Spirit, an initiative that brings together health coaches and 1,100 physicians to manage 90,000-plus of its nearly 160,000 employees and dependents, has generated $193 million in cost avoidance over the past four years and a projected saving of $10 million in prescriptions and $400,000 in medical-plan administration fees in 2014.

Successful examples of value-based payment and delivery models include the Mercy Health Network in Des Moines, Ia. and UniNet in Lincoln, Neb. that provides soup-to-nuts healthcare in a joint venture funded with a $10-million grant from CMMI. In the first year the model has achieved a 14 percent drop in readmissions and 9 percent drop in ED visits by implementing a comprehensive coordinated care program. Another initiative, Colorado Health Neighborhoods in Englewood, Colo., partners with community organizations and an Anthem ACO to cover 124,000 people under full-risk programs using 17 neighborhood clinics. While it's too early to quantify results, the program, which uses health coaches and outreach, has generated a reduction in unnecessary hospital visits.

> **"We don't have to own everything."**

Partnering with other organizations has become a CHI mantra. "We don't have to own everything," said Lofton.

Amir Dan Rubin, President & CEO, Stanford Health Care
https://stanfordhealthcare.org/

Stanford Health Care's service vision to "view new models of care through the lens of the patient and create the best patient experience anywhere" is paying off: The medical center has achieved the 95th percentile in patient satisfaction and is number one in HCAHPs in the entire San Francisco Bay Area. Rubin is quick to note that distinction includes great patient outcomes as well, including in cancer: For stage 4 colon cancer patients Stanford has achieved a 55-percent survival rate compared to a national average of 31 percent.

Patient experience and transparency go hand in hand. "We publish patient ratings and comments of our providers on our website, their pet peeves," said Rubin, adding that Stanford employs Lean and design thinking (using resources in the university's design school) to analyze its processes, including consumer engagement. That approach has made management aware that one size does not fit all. "We're all supposed to have the same strategy for every customer segment," he said, and that's not the case.

The need for deeper understanding of customers led Stanford to develop its C-I-CARE ("See, I care.") initiative that includes soliciting feedback from 150 patients on various advisory councils. The initiative is proactive. "We asked, 'Can we watch you?' We even asked to follow them into their homes and work. When you start observing people you notice things about them," said Rubin. "In addition to wanting the leading edge of care, patients also said, 'I want you to know me.' Help show me the steps. Can you help coordinate my care? Can you own the complexity of care for me?'"

> **"We asked, 'Can we watch you?'"**

C-I-CARE's design elements are applied to processes, strategies and even physical design of facilities in four key strategic domains:

» Complex care (e.g. tertiary care),

» Network of care (regionalization, outpatient care),

» Accountable care (population health),

» Virtual care (digital health).

It helps that Stanford is a truly integrated system, with its 1,800 physicians aligned as part of a single clinical enterprise. In the area of complex care, Stanford is one of the first to offer clinical genomics service, whole gene sequencing. "This is not inpatient or outpatient. A specimen is sent to lab, he said, and now I'm going to have a discussion that might go like this: 'Amir, over the next seven years you have a 23-percent chance of getting this disease. Here's a procedure that has a 63-percent success rate. What do you want to do?'"

Genomic counselors wanted

Rubin foresees such testing and analysis eventually being performed by a big testing company, while the health system will provide people with new skill sets for test reporting and counseling of patients in this very complicated new area.

Also, a survey of patients with complex care said they want to have transparent care plans and curated question lists to help them in discussions with clinicians. Stanford has built a "Patient Experience Platform" on its EHR aimed at engaging patients over a long period of time for chronic disease, including many cancers.

"Design matters" at Stanford, partly due to the influence of Silicon Valley neighbors like Apple, famous for designing technology from the inside out with consumers in mind. C-I-Care design elements have been incorporated into both the health system's new clinical architecture and workflow. In a new co-located model, physicians and staff offices are together in a bullpen instead of separate silos.

The new spatial arrangement not only provides on-stage/off-stage areas for patients and staff but also allows pushing work down to the most appropriate level of care. That has cut total patient turnaround time in the clinic from 50 minutes down to 30 minutes and reduced physician documentation time from 60 or 90 minutes down to only 15, the latter helped by redesigned workflow that has nurse and staff assume more of those duties.

Stanford is offering a new model of primary care for its corporate partner program care. Recognizing that many younger people in Silicon Valley "just want advice" about their health, Stanford offers a special program so any employee of Cisco or Intel can call the health system at any time about any healthcare-related question.

Ken Paulus, CEO Allina Health
http://www.allinahealth.org/

After 10 years at the helm of Allina, a 14-hospital, 2,000-physician (half are employed), 15-retail clinic health system based in the Twin Cities, Paulus had just retired at the time of our Spring Conference, but was gracious enough to join our executive panel. "This is a distinguished and very diverse group," he said, "but most of us in this room are fairly unprepared" for risk, value-based, accountable care.

"We [as a U.S. health system] have stunning levels of overcapacity, overutilization, MRIs, DME, lab facilities, beds. The country can't afford us. The next president will probably oversee an economic recession and a lack of resources. We'll have the choice of declining reimbursement or we can go at risk. We're in this incremental stage and feeling good about ourselves, but we're going to be surprised. All of the CEOs I talk with say if we have to choose I need to be in the risk business," says Paulus.

"When health plans look at us they see us as the problem. When we look at health plans we see opportunity. Over the next 10 years health plans and providers will merge. We will try to get into risk, but we have no idea how to do it. When we get past this we will become a mature industry that delivers value and efficiency. We're at this crossroads. Are we in an evolution that will take 10 years or will we hit a wall and turn into a revolution?" he said.

With margins under pressure, Paulus said he met with every health insurer in Minnesota, but none wanted to joint venture with Allina. Finally Blue Cross agreed to go 50/50 with Allina on a joint venture that would take on risk. Neither partner will run it, both will be funding partners. "We don't know how to run a health plan, let's let the new company flourish and we can" then successfully navigate the shift to risk.

> "*Most of us are fairly unprepared for risk.*"

No longer center of the universe

A second key point to understand, Paulus said, is that "acute care has been the center of our universe forever. We're a problem yet to be solved." Recognizing this reality, Allina management dropped its traditional reluctance to deal with post-acute care firms. Allina's approach was that it did not want to run post-acute care businesses but preferred to co-own them with existing firms already doing it well. "Now we're building five or six transitional-care units, 60-bed facilities spread around Minnesota—and they are hugely successful with hip and knee replacements, making an 8 percent margin versus 3 percent for hospitals."

Finally, he said, despite all the hype about creating clinically integrated organizations, "we're all in the patient business. At the end of the day, what we're really in is the relationship business."

Paulus contrasted his experience with setting up his Wells Fargo banking account when he moved to Minnesota. The apps on his cellphone were easy to use and created a sticky relationship that made it difficult to change to another bank. When he signed up with a primary physician at Allina, however, he didn't hear anything for three years, not even when he turned 50 and would likely need a colonoscopy.

"We have no idea how to relate, no idea how to segment, we don't predict, don't promote, don't prevent." And yet as a health system, the mission is to bring people together: "We are matchmakers, putting caregivers and patients together to relate. We've been remiss as an industry."

Nicholas Wolter, MD, CEO, Billings Clinic, and Board Member, Scottsdale Institute
http://www.billingsclinic.com/

Based in Billings, Mont., Billings Clinic is Montana's largest health-delivery organization, serving most of Montana, northern Wyoming and the western Dakotas. Billings Clinic is a physician-led, integrated multispecialty group practice with a 285-bed hospital, Level II trauma center and a 90-bed skilled nursing and assisted living facility.

Wolter, a veteran member of the Medicare Payment Advisory Commission (MEDPAC), said the four-year process of merging the physician group practice with the hospital in itself was so difficult that the organization developed cornerstone principles for any such future venture or partnership. The framework of those cornerstone principles was inspired by a June 11, 2009 article in the New England Journal of Medicine (Fisher & Berwick) on how to design care in microsystems across silos of care.

Half of the clinic's patients come from outside the county, so Billings Clinic has developed close affiliations with 10 critical access hospitals, including providing board governance and quality measurement and

development. The clinic's strategy is to employ community physicians whenever possible, in keeping with its identity as a multispecialty group practice.

Billings Clinic recently entered into partnership with Regional Care, a Nashville-based for-profit hospital company with eight hospitals. The new joint venture just completed its first acquisition of a community hospital in Missoula, which it successfully converted into a for-profit hospital. In the partnership, Billings Clinic is responsible for quality, patient safety and physician leadership. "It's a good value fit, especially for access to needed capital," said Wolter.

> **"Collaboration with a Disney executive has greatly advanced our culture of patient experience."**

A single EHR

Billings Clinic has had a long-standing and fruitful partnership with Cerner, which provides its single EHR platform for its hospitals, clinics and critical access hospitals. "The EHR really supports knowledge across the health system and allows us to be beta developers for Cerner," he said.

The clinic has also developed a population-health application called Healthe Registries, the result of IT collaboration with Caradigm and White Cloud. "Doctors like using the Healthe Registries' quality metrics of patients as opposed to doing chart reviews," Wolter said.

Some other partnership nuggets:

- Core collaboration with a former Disney executive has "greatly advanced our culture in the area of patient experience."

- Using Lean Six Sigma, which has become heavily embedded in the clinic's culture, Billings Clinic has been able to take $10 million to $12 million of cost out of the budget annually.

- A former hospital executive, Curt Lindberg, has become an expert on complexity theory and now works for Billings Clinic half time, helping the organization use complexity theory to, for example, cut MRSA rates in the ICU.

- A "Relational Coordination" initiative led by Jody Gittel at Brandeis University has helped improve clinical outcomes.

- Billings Clinic is very committed to physician leadership training and over eight years has certified eight cohorts of 12 individuals each, half doctors and half executives.

- Billings Clinic has joined Brookings' physician-led ACO Learning Network, a collaborative that provides member organizations with tools and other resources to solve practical issues facing ACO development and operation.

- Billings Clinic is entering into a population health collaborative with Geisinger this fall. "Geisinger has done well with their insurance arm," Wolter said.

Conclusion

As our CEO Panel so eloquently described, SI member organizations are well on the journey to value-based care. And Ken Paulus put it succinctly: we're not sure if this journey is evolutionary, or if it is revolutionary. But we can be sure of one thing: You cannot walk this path alone. Partnerships are critical. The margins are better when shared.

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