

Forbes
INSIGHTS

GETTING FROM VOLUME TO VALUE IN HEALTH CARE

BALANCING CHALLENGES & OPPORTUNITIES



IN ASSOCIATION WITH:



Allscripts[™]

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OVERVIEW

“Value-based purchasing,” where cost and quality are each integral parts of the equation, is now widely seen as a replacement for traditional fee-for-service reimbursement. For senior hospital and health system executives, the challenge is getting from the-way-things-have-always-been to the-way-things-will-be without tumbling into a fiscal chasm because of the-way-things-are-now.

The goal is to get paid “for doing the best care, the most cost-effective care,” says Dr. Chalmers M. “Chal” Nunn Jr., president and CEO of Gastroenterology Associates of Central Virginia, former chief medical officer of Lynchburg, Va.-based Centra Health and a past president of the American College of Physician Executives. “We’re at the beginning of the journey.”

This report by Forbes Insights, in association with Allscripts, examines the responses to a survey of more than 200 chief executive officers, chief financial officers and chief medical officers who are charged with leading their institutions on that quest. (See Methodology, page 4.) While as a group they are cautiously optimistic and endorse the goals that value-based purchasing (VBP) seeks to achieve, they know that the path is neither straightforward nor obstacle free. The transition will require maintaining a delicate balance of opposing forces as well as a fine sense of timing.

KEY FINDINGS

An Imminent Shift: Nearly a third of the C-suite executives surveyed (30%) “agreed completely” that providers need to immediately begin shifting their focus from volume to value, while another 43% “somewhat agreed.”

Disruptive Potential of Value-Based Purchasing: Nearly four in ten respondents (38%) somewhat or completely agreed that VBP is likely to become a truly disruptive innovation. A whopping 41% are watching and waiting, neither agreeing nor disagreeing that disruptive innovation is nigh.

Key Milestone in Three to Five Years: Although only 12% of survey respondents believe that more than a quarter of their revenues will be derived from VBP-based reimbursement within the next three years, looking ahead five years, a striking 39% of respondents believe that at least a quarter of their revenues will be derived from VBP.

Crucial to Win Hearts and Minds: Fully engaging their doctors was seen by C-suite executives as the top barrier to VBP participation, selected by half of respondents.

A Warning on Consumer-Driven Health Plans: About two-thirds of executives believed that consumer financial incentives are key to making VBP successful (64%). However, about the same percentage (67%) also thought that consumers won't know when that success arrives, since they can't judge the value of medical care accurately. That's a flashing warning sign for those who believe that the high-deductible health insurance arrangements known as consumer-driven health plans will automatically drive value-based purchasing on the part of the patient.

VBP Will Require Seamless Communications: When asked their IT spending priorities for VBP over the next three years, nearly half of respondents chose system integration across all applications (49%) and health information exchange (47%). Translation: we need to be able to communicate quickly and seamlessly with our care partners and with other care delivery systems.

The Critical Role Played by Health IT in Both Financial and Clinical Preparedness: This can be seen by what C-suite executives single out as its most important uses, such as identifying patients who generate high costs within the hospital (66%) and in the ambulatory environment (56%); ensuring evidence-based protocols are available to nurses and doctors (61%); and getting complete and current information across the care continuum (58%).

Vital to Manage Chronic Disease: Asked to choose which three clinical, financial or patient engagement challenges are most important for a successful VBP transition, hospital executives most often picked “effective use of intervention strategies for chronic disease patients” (60%). Almost as many (55%) chose “improve patient education and engagement.”

METHODOLOGY

This report is based on a survey of 204 hospital executives and in-depth interviews conducted with eight health care executives. C-level executives accounted for 133 survey respondents, while the remaining executives held the title of executive vice president, vice president or director. The respondents work for all types of hospitals, with the biggest group (51) from for-profit health systems, followed by community hospitals that are part of a large non-profit health system (44) and independent community hospitals (41). The biggest group (112) of respondents came from hospitals situated in large cities, followed by small cities (45) and suburbs (34).

ACKNOWLEDGMENTS

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Dr. Larry J. Goodman, president and chief executive officer, Rush University Medical Center, Chicago, Ill.; **Dr. Robert Margolis**, managing partner and chief executive officer, HealthCare Partners, Torrance, Calif.; **Peter J. Holden**, president and chief executive officer, Jordan Hospital, Plymouth, Mass.; **Paul R. Goldberg**, chief financial officer, Liberty Health, Jersey City, N.J.; **Stuart Guterman**, vice president for payment and system reform at The Commonwealth Fund and executive director of The Commonwealth Fund's Commission on a High Performance Health System, Washington, D.C.; **Peter S. Fine**, president and CEO, Banner Health, Phoenix, Ariz.; **Dr. John Hensing**, executive vice president and chief medical officer, Banner Health, Phoenix, Ariz.; **Dr. Chalmers "Chal" M. Nunn Jr.**, president and chief executive officer, Gastroenterology Associates of Central Virginia, Lynchburg, Va., and past president, American College of Physician Executives.

INTRODUCTION

The market for health care services seems to follow its own set of rules. In a seminal article explaining what makes health care different, economist Kenneth Arrow wrote: “It is clear from everyday observation that the behavior expected of sellers of medical care is different from that of businessmen in general...The social obligation for best practice is part of the commodity the physician sells, even though it is a part that is not subject to thorough inspection by the buyer.”¹

That article was published back in 1963, and Arrow would go on to win the Nobel Prize. Yet nearly a half-century later, trust in the doctor’s “social obligation” still lingers. At the same time, however, “thorough inspection” by buyers has burgeoned into a welter of employer and health plan requirements, publicly available report cards and government regulations. For example, providers who form a Medicare accountable care organization (ACO) have their payment tied to the scores of 33 different measures in four different domains.

At its most basic, value-based purchasing (VBP) asserts that buyers should hold providers of health care accountable for both cost and quality of care. As one widely used definition puts it:

Value-based purchasing brings together information on the quality of health care, including patient outcomes and health status, with data on the dollar outlays going towards health. It focuses on managing the use of the health care system to reduce inappropriate care and to identify and reward the best-performing providers.²

How quickly VBP will go from concept to contracts remains a crucial unanswered question. Perhaps the strongest signal of a new era is that hospitals’ largest customer, Medicare, wants to move in this direction. The Deficit Reduction Act of 2005, passed by a Republican Congress under a Republican president, authorized the Centers for Medicare & Medicaid Services (CMS) to develop a VBP plan for hospitals. In 2010, the Accountable Care Act (ACA), passed by a Democratic-controlled Congress under a Democratic president, used the word “value” 214 times.³ In early 2012, a senior CMS official announcing the latest ACO contracts declared that the agency was “on track to fundamentally transform” fee-for-service Medicare reimbursement.⁴

Meanwhile, Medicare’s Value-Based Purchasing program under the ACA goes into effect on Oct. 1, 2012, the start of the government’s FY 2013. Under the program,

Medicare will withhold a small part of hospital reimbursement each year and then redistribute it as incentive payments based on specific groups of quality measures.

Influential private-sector purchasers, including the largest national health insurers, have also joined the public sector in declaring their support for efforts to “speed payment reforms away from traditional volume-based payment systems so that most health payments in this country align better with quality and efficiency.”⁵

In an era when a Cadillac and a Camry can be compared with the click of a mouse, tough scrutiny of product quality, service and cost is old news in most industries. In health care, though, it still represents a profound change. A “cottage industry” mentality maintains a strong hold in a \$2.6 trillion business that accounts for one-eighth of the U.S. gross domestic product. The value of health care services is thought by many to be intangible and immeasurable—but, of course, schoolteachers and principals and university professors and deans would say the same thing about education.

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SPEED: HOW FAST A CHANGE?

A JOURNEY OF A THOUSAND MILES BEGINS...SOMETIME

Nearly a third of the C-suite executives surveyed (30%) “agreed completely” that providers need to immediately begin shifting their focus from volume to value, while another 43% “somewhat agreed.”

“It would surprise me if you could find too many people who would say they’re not working on something along this line,” says Dr. Larry J. Goodman, president and chief executive officer of Chicago’s Rush University Medical Center.

Still, those with responsibility for the bottom line understand that there can be missteps from changing revenue streams too early or too late. Call their approach “watchful waiting”: 19% of respondents neither agreed nor disagreed with the need for an immediate shift to value, 7% “somewhat disagreed” and 1% disagreed completely.

“ACOs ACCEPTED HERE”

Somewhat surprisingly, 63% of those surveyed are either participating in a Medicare ACO already or expect to do so eventually—though it’s unclear how long it will be before those “expectant” ACOers give birth to a fully formed risk-bearing entity. The majority of survey respondents also said they’d been approached by private payers and/or state and local payers regarding VBP.

For some, the ACO decision was easy: HealthCare Partners, a multi-state medical group based in Torrance, Calif., has long been a managed care trailblazer and easily became one of the Pioneer ACOs. These Medicare ACOs accept more financial risk than those in the Medicare Shared Savings Program (MSSP) ACO model. Notes Dr. Robert Margolis, the organization’s managing partner and CEO: “We are the only Pioneer ACO in multiple states”—California, Nevada and Florida.

Banner Health System in Phoenix also has a Pioneer ACO network and was the first to be accepted into that Medicare program in late 2011. The network includes affiliated physicians and 13 Banner hospitals.

At the other end of the country, 165-bed Jordan Hospital of Plymouth, Mass., joined the MSSP ACO despite being a standalone facility. Call it Pilgrim’s Progress: the hospital was losing money when President and CEO Peter J. Holden joined three years ago. The red ink has stopped, but the state’s largest private insurer, Blue Cross and Blue Shield of Massachusetts, is pressing

providers to accept an “alternative quality contract” whose provisions were one model for ACOs.

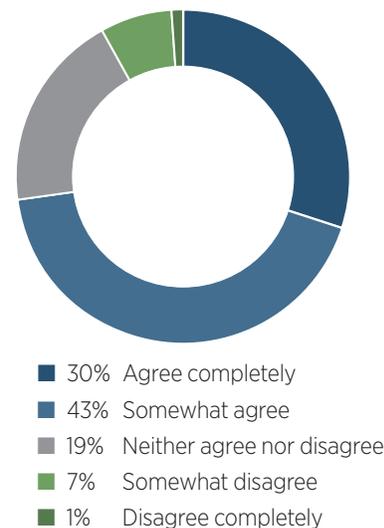
“Somehow, we’re going to have to manage within defined financial parameters,” Holden says. “And it will be population-based. So we have to learn how to engage the population and our citizens in a better lifestyle.”

There were 27 MSSP ACOs as of April 2012, and Medicare says another 150 groups have applied for a July 1 start date. There are 32 Pioneer ACOs, and together the two ACO types now serve more than 1.1 million Medicare beneficiaries.

Still, many executives remain cautious. LibertyHealth’s flagship Jersey City (N.J.) Medical Center sees more Medicaid than Medicare patients, notes Paul R. Goldberg, chief financial officer. An ACO “is a huge infrastructure for a small number of patients for us,” he says. At Rush, Goodman is looking to minimize risk before taking on a VBP contract. “I first want to make sure the pieces we control we can do well,” he says.

The Speed of the Shift

Do you agree that providers need to begin shifting their focus from volume to value immediately?



FAD OR FUTURE? (“DO I DARE TO EAT A PEACH?”)

“In the room the women come and go/Talking of Michelangelo,” observes the hero of T.S. Eliot’s “The Love Song of J. Alfred Prufrock.”⁶ Had it been a health care conference room Prufrock was observing, he would have seen consultants come and go, talking of acronyms like “ACO.” ACOs, of course, shouldn’t be confused with ACAs (accountable care activities), and VBP is separate from, though related to, VBID (value-based insurance design) and VBBD (value-based benefit design). How CDHP (consumer-driven health plans) factors into the equation remains unclear.

Like Prufrock, hospital and health system executives wonder, “Do I dare disturb the universe...for decisions and revisions which a minute will reverse?” The change from fee-for-service to bundled payment is complex and difficult, a juggling act with financial benefits that are promised but by no means assured.

“You have to prepare for a future that has an unknown amount of validation,” says Rush’s Goodman. “I don’t think anyone can predict the pace of change.”

Fad or future? Asked whether VBP is likely to become a truly disruptive innovation, nearly four in ten respondents (38%) somewhat or completely agreed. Uncertainty about the magnitude of change VBP would

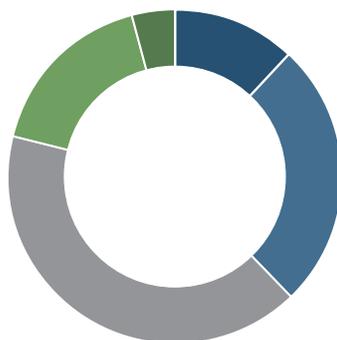
bring (“disruptive” is not a word you want to associate with actual care) may be what was bothering other respondents: 17% disagreed “somewhat,” only 4% disagreed “completely” and a whopping 41% are watching and waiting, neither agreeing nor disagreeing that disruptive innovation is nigh.

When asked straight out whether VBP is a fad without lasting impact, just 9% agreed completely, while 8% disagreed completely. Another 22% “somewhat” agreed, while 26% somewhat disagreed. Given the closeness of the tally, it’s no surprise the “undecideds” won, with 34% of respondents neither agreeing nor disagreeing that VBP would go the way of the hula-hoop and medical tourism.

For hospital executives who fear VBP might vaporize their profits, a prediction by Harvard Business School’s Regina Herzlinger may provide an odd kind of comfort. Herzlinger says ACOs will fail, because hospitals will use them to dominate their markets and raise prices. As a result, she predicts, antitrust regulators will step in.⁷

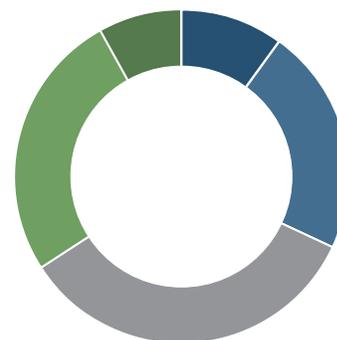
Disruptive Innovation or a Fad?

Do you agree that VBP is likely to become a truly “disruptive innovation”?



- 12% Agree completely
- 26% Somewhat agree
- 41% Neither agree nor disagree
- 17% Somewhat disagree
- 4% Disagree completely

Do you agree that VBP is one more fad that may not have a lasting impact?



- 9% Agree completely
- 22% Somewhat agree
- 34% Neither agree nor disagree
- 26% Somewhat disagree
- 8% Disagree completely

A DIFFICULT INDUSTRY TO DISRUPT

The nature of health care services and service providers makes value-based purchasing (VBP) complex. This is an industry at once highly competitive and highly regulated, one with national and local customers and with clearly delineated, standardized offerings balanced by highly individualized and uniquely customized services. It is, in other words, difficult to disrupt.

In 1980, a *Harvard Business Review* article asked, “Can Hospitals Survive?”¹ At the time there were about 7,200 acute-care hospitals. The end of Medicare reimbursing each hospital for its individual costs was near, and technological change was pushing more and more procedures to outpatient status. Between 1981 and 1988, had historical trends held true, inpatient admissions would have risen 10.2%. Instead, admissions fell 13.4%. On an adjusted basis, inpatient days plunged 28% from what otherwise would have occurred.²

Yet the vast majority of hospitals did survive. The numbers declined as guaranteed profits disappeared, but by the mid-1990s they had stabilized at about 5,200. The hospitals that remained, however, had evolved: the number of acute-care beds dropped, and the mix of services changed.³ The old ways were disrupted, but most of the old players remained.

When Medicare stopped “cost-plus” reimbursement, “everyone thought it was the end of the world,” recalls Paul R. Goldberg, chief financial officer at LibertyHealth in Jersey City, N.J. VBP “is not going to be the end of the world. We’re going to adjust to this or to anything else that comes down the pike.”

One reason is that economic efficiency is not the sole—and sometimes not even the primary—goal of either buyers or sellers of health care services. “Disruptive innovation”—a term coined by Harvard Business School’s Clayton Christensen—is trumpeted in theory, but often tamped down in practice.

The politician who denounces rising health care costs reflexively defends those hospitals providing access (and jobs) to his constituents, whatever the cost reports may say. The benefits manager who boasts he’ll treat providers like any other vendor blanches at a network that doesn’t include the CEO’s wife’s gynecologist. And patients who complain about rising insurance premiums cry out against “rationing” should any desired treatment or drug be deemed unnecessary.

On the other side of the equation, hospitals have missions that transcend the bottom line, including medical education and community service. The mixed messages from both the

supply and demand sides are reflected in ever-changing reimbursement rules. As one researcher put it:

“Public payment rates are set through a complex and changing process based on, among other factors, the evolving judgment of rate setters, imperfect adjustments for hospital markets’ demographic and geographic characteristics, and the political strength of interested parties. Private payment rates result from complex negotiations and relative bargaining power.”⁴

Under those circumstances, what might normally be disruptive innovation can misfire.

The Early Bird Gets No Worms

So, for instance, when Harvard Business School’s Michael Porter and Elizabeth Teisberg were writing about the need for providers to embrace high-value care in the mid-2000s, Seattle’s Virginia Mason Medical Center was doing just that. Using the quality improvement methodology pioneered by Toyota, Virginia Mason found it could get the same clinical outcomes in back pain patients at far less cost by starting directly with physical therapy rather than a neurology consult and MRI. The medical center’s reward for reducing per-case revenues but dramatically improving efficiency was to become part of one national insurer’s “high-value network.” Its innovation also received national publicity.

Here’s what didn’t happen: Virginia Mason’s back pain treatment protocols were not imitated by other providers in its area, did not cause other local insurers to “carve out” back pain business for Virginia Mason and did not cause all national insurers to demand that providers nationwide copy Virginia Mason’s innovation.

A similar scenario held true for Geisinger Health Systems’ ProvenCare program, which offered bypass surgery at a set price that included no-additional-cost treatment of any complications that occurred within 90 days. Like Virginia Mason, the initiative at Danville, Pa.-based Geisinger attracted national attention, but it did not inspire either an outpouring of imitators or an overwhelming economic reward.

Signs of an Innovator's Spring

What is different today is not that innovative hospitals are suddenly driving less-innovative competitors out of business. Rather, public and private payers are beginning to harmonize their incentives so as to force a general change in business practices. Innovators who were "early movers" to demonstrably higher value should be the first to benefit.

While nothing in health care moves in a predictable straight line, there are indications VBP could be set to bring about disruptive innovation based on the criteria in *The Innovator's Prescription*, by Christensen and co-authors Dr. Jerome H. Grossman and Dr. Jason Hwang.⁵

"Business model innovation," the first of their three "agents of transformation," refers to the ability to profitably deliver new and simplified solutions. In health care, that means being rewarded for value rather than volume.

Stuart Guterman, vice president for payment and system reform at The Commonwealth Fund and executive director of The Commonwealth Fund's Commission on a High Performance Health System, puts it this way: "It's like, 'first, do no harm.' First, get the payment system out of the way so it doesn't punish you for doing the right thing."

The "technological enabler" of disruptive innovation, a second agent of transformation, stems from health information technology allowing the sophisticated measurement and management of clinical and financial processes. When Medicare tells accountable care organizations to measure 33 domains of care, some may dispute the measures' necessity; however, the technical ability to assess many hospital and physician actions at a granular level is no longer in doubt.

That same technology can provide competitive advantage for those who conduct a detailed self-assessment. For instance, Geisinger used its electronic health record (EHR) for checklists and automated order sets; to prompt medical personnel to either adhere to the care elements or document justification for non-adherence; and to highlight gaps in care to be swiftly addressed. Phoenix's Banner Health found that

instituting standardized processes in an all-electronic environment enabled it to reduce average length of stay by 7.1%, nurse turnover by 15.8%, pharmacy costs by 17.8% and adverse drug events by a stunning 84.3% when compared with a weighted average of similar hospitals without an electronic medical record.⁶

Together, changes in incentives and in technology contribute to the third agent of transformation, a "value network;" that is, a commercial infrastructure where innovators support each other. In health care, that infrastructure is just starting to form, as insurers explore health IT or buying provider practices, providers dip their toes into taking on risk and non-health care companies seek new alliances to enter the field.

Banner Health, for instance, has become a major technological partner of Aetna. Meanwhile, dialysis services provider DaVita, Inc., recently announced an agreement to pay \$4.42 billion to buy Torrance, Calif.-based Health-Care Partners, which *The Wall Street Journal* called "the largest U.S. operator of physician groups and networks," and an organization "that seeks to oversee nearly all of its patients' health needs, including primary care, specialty care as well as coordinating other services like hospital visits."

The high price, concluded the *Journal*, represents a wager "that American health care is changing significantly—moving away from a fragmented world in which individual doctors and hospitals get fees for each service, and toward large integrated providers that coordinate all patients' medical needs and get paid in ways that reward quality and efficiency."

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—STUART GUTERMAN
Executive Director,
The Commonwealth Fund's
Commission on a High
Performance Health System
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¹Jeffrey C. Goldsmith. "The health care market: can hospitals survive?" *Harvard Business Review*. 1980 Sep-Oct; 58(5): 100-12.

²William B. Schwartz and Daniel D. Mendelson. "Hospital cost containment in the 1980s: Hard lessons learned and prospects for the 1990s." *NEJM* 1991; 324(15): 1037-1042

³Declining capacity in acute care hospitals may indicate problems. HFMA. http://findarticles.com/p/articles/mi_m3257/is_6_61/ai_n19311763/

⁴Jill R. Horwitz. "Making profits and providing care." *Health Aff* 2005; (24)3:790-801

⁵Clayton M. Christensen, Jerome H. Grossman and Jason Hwang. *The Innovator's Prescription: A Disruptive Solution for Health Care*. (New York: McGraw-Hill, 2009).

⁶Maureen McKinney. "Looking at the big picture. Banner Health's Fine set the course for standardized, systemwide IT rollout." *Modern Health Care*. June 14, 2010. Accessed at: <http://www.modernhealthcare.com/article/20100614/MAGAZINE/100619988#>

SCOPE: HOW FAR-REACHING WILL THE EFFECTS BE?

“SHOW ME THE MONEY”

The real balancing act C-suite managers face is figuring out what part of their revenues will be coming from VBP, what part from traditional sources and how fast they've got to traverse from one to the other. Just 12% of survey respondents believe that more than a quarter of their revenues will be derived from VBP-based reimbursement within the next three years.

“This is such a huge part of the U.S. economy, it's just not going to shift quickly like that overnight,” says Peter S. Fine, president and chief executive officer of Banner Health, whose facilities stretch across seven states. “The cultural issues are so great, I think it's a slow process regardless of whatever incentives are created to make it move faster.”

“These days, even with all the talk about VBP, you're still better off if you bill for volume than anything else,” says Stuart Guterman, executive director of The Commonwealth Fund's Commission on a High Performance Health System. “It's still a fee-for-service system.”

Indeed, asked about the biggest barrier to VBP implementation, 46% of respondents pointed to the difficulty of balancing the unpredictable impact of VBP-based contracts.

Still, looking ahead five years, a striking 39% of respondents believe that at least a quarter of their revenues

will be derived from VBP. One indication they may be right is that the percentage of large employers embracing value-based benefit design—varying employee payments based on cost and value of services—is set to surge from 15% in 2012 to 34% in 2013, according to a recent survey by Towers Watson and the National Business Group on Health. Meanwhile, insurers such as Aetna, UnitedHealth and WellPoint are all pressing for ACO-type contracts with their provider networks.

Despite Herzlinger's prediction that ACOs will boost hospital profits, just half of the C-suite respondents believe profitability will increase in the next three to five years. A quarter said it will decrease, and a quarter said they didn't know. That assessment may be heavily influenced by what individual executives see when they look out their window.

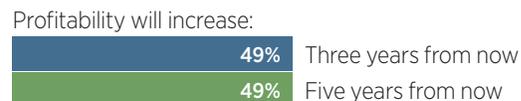
LibertyHealth's Goldberg sees the Manhattan skyline in one direction and Ellis Island and the Statue of Liberty in the other. The Jersey City Medical Center serves transplanted Wall Streeters sipping cappuccinos and working-class families struggling to put food on the table. The state's Medicaid budget is drum-tight. “When you look at everything that's coming down the pike, it will be tougher for us for a few years until we really understand what the impact is going to be for us and regroup,” Goldberg says.

VBP Revenue Growth

What percentage of your total revenue do you expect to be based on VBP?



VBP Impact on Profitability



But in Southern California, where capitated payment has long been a way of life, the local health care scene is a land of opportunity, and VBP represents an opportunity to capitalize on years of hard-won operating knowledge. “If we do our job right and we’re more efficient than everyone else, finance will work itself out,” says HealthCare Partners CEO Margolis. (Shortly after that interview with Forbes Insights, HealthCare Partners announced it was being acquired by for-profit dialysis chain DaVita for \$4.42 billion.)

While the finances settle into place, preparing for the transition will require a breadth of activities that cut across the usual organizational barriers.

“SEE ME, FEEL ME, TOUCH ME, HEAL ME”: ENGAGING THE DOCTORS

Any hospital that wants to successfully transition from volume to value knows it has to have its physicians committed to reaching the same destination. Fully engaging their doctors was seen by C-suite executives as the top barrier to VBP participation, selected by half of respondents. Of course, “fully engaging physicians” might be selected by hospital executives as the top challenge for virtually any major change. But in replacing fee-for-service with VBP, physician relations are especially delicate. One man’s inefficiency is another man’s income, and savings seem as likely to come out of surgical volume as supply chain management.

“The medical staff is always the hard part of the process,” says LibertyHealth’s Goldberg. “Doctors aren’t seeing anything [economic] on their side related to this.”

Yet a focus on near-term economic hurdles to VBP can hide a more optimistic long-term view about forming physician partnerships. At Rush, CEO Goodman, who trained in infectious disease at the Rush medical school, says: “You’ve got to ask them something that makes sense. Focusing on outcomes that are based on best evidence and working to get unnecessary cost out of the system makes sense.” At HealthCare Partners, CEO Margolis, who trained in internal medicine and oncology, agrees: “Get them all working towards best patient care and physicians respond.”

Jordan Hospital’s Holden also made clear the doctors’ personal stake in the transition to a new practice style: “I told them front and center that if you don’t learn and you don’t embrace and you don’t exert influence on what’s coming, you could be one class away from painting houses.”

Meanwhile, Banner Health’s executive vice president and chief medical officer, Dr. John Hensing, suggests that the trajectory of a physician’s career predicts the reaction to change. “If you’re 60 years old, ride it out. If you’re 50

years old, fight it. If you’re in your early 40s, you say what does the future hold for me, and what am I going to do about it?”

And if you’re just starting out, you may say, “That’s the way things have always been.” An *Annals of Internal Medicine* article last September that attracted considerable interest proposed that cost-consciousness and stewardship of resources become part of the general competencies all medical residents must demonstrate in accredited training programs.⁸

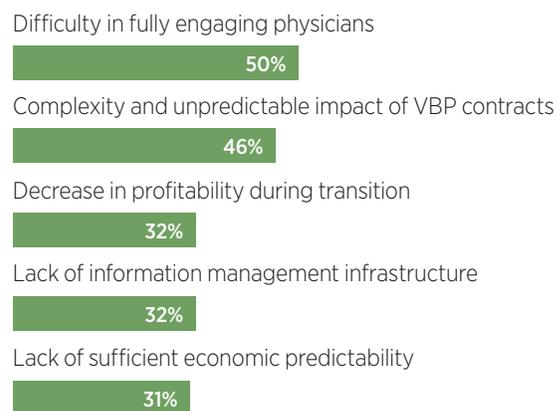
“WITH THIS RING...”: PROMOTING PATIENT ENGAGEMENT

Three-quarters of all health care expenses can be attributed to chronic disease care. The percentage is even higher for the elderly on Medicare and typically goes up with age. The more chronic disease, the more cost: from an average of \$7,000 for Medicare patients with one chronic condition in 2005 to \$15,000 for two conditions to \$32,500 for three.

That may be why hospital executives asked to choose which three clinical, financial or patient engagement challenges are most important for a successful VBP transition most often picked “effective use of intervention strategies for chronic disease patients” (60%). Almost as many (55%) chose “improve patient education and engagement.” Not coincidentally, both areas are part of the quality measures to undergo Medicare scrutiny for FY 2013 reimbursement.

The Barriers

Which of these barriers to adoption of the VBP model are most important to your organization? (Top Five)



As a result, when looking at important VBP measures, “improve patient/family experience and satisfaction” garnered almost half the votes (47%), while “improve transitions of care through better coordination” was close behind (45%).

About two-thirds of executives believed that consumer financial incentives are key to making VBP successful (64%). However, about the same percentage (67%) also thought that

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 “I told [the doctors] front and center that if you don’t learn and you don’t embrace and you don’t exert influence on what’s coming, you could be one class away from painting houses.”
 —**PETER J. HOLDEN**
 President and CEO,
 Jordan Hospital

consumers won’t know when that success arrives, since they can’t judge the value of medical care accurately. That’s a flashing warning sign for those who believe that the high-deductible health insurance arrangements known as consumer-driven health plans will automatically drive value-based purchasing on the part of the patient. The plans are increasingly popular among employers, but only some include specific elements to encourage value-seeking behavior.

“I don’t think the public has a clue [yet],” says Jordan Hospital’s Holden. “When you talk about changing ‘culture’ with a big ‘C,’ this whole thing is going to be

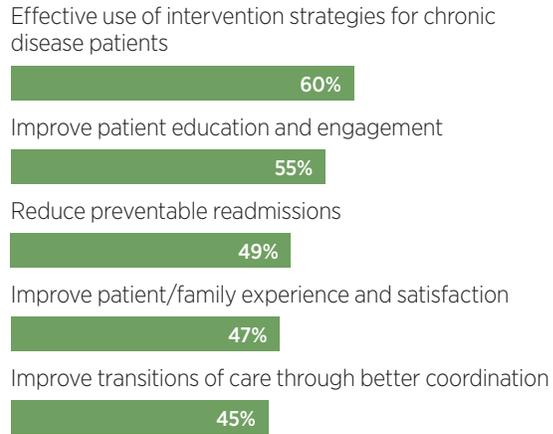
dependent upon being able to educate the community.”

“We have to proactively reach patients,” says Banner Health CEO Fine. Part of that effort means “using technology in chronic disease management and identifying improvement opportunities in the ambulatory care space.”

“Reduce preventable readmissions,” a complicated task that involves clinician and hospital changes as well as patient engagement, was selected by 49% of respondents. Which leads directly to the problem of care coordination.

The Challenges

Which of these clinical, financial or patient engagement challenges are most important for your organization’s successful transition to VBP? (Top Five)



SYNCHRONIZATION: HOW TO COORDINATE ALL THE MOVING PARTS?

WELL, IT'S COMPLICATED

Perhaps because of health care's idiosyncratic business practices, less than half of surveyed executives saw the experiences of other industries as applicable to them. After all, Medicare is forbidden by law from dropping them for anything other than gross quality violations, and in some locales the Big Name Hospital and affiliated Big Name Doctors are as important to local insurers as vice versa.

The parallels that executives do perceive tend to pop up in non-clinical areas. The largest group of respondents saw customer service improvement (44%) and operational improvement (43%) as places where the health care field could benefit from other industries' experiences. That may explain why the Disney Company consults to hospitals on creating happy patients and why hospital operations executives routinely trumpet Japanese terms like *kaizen* ("change for the better") as part of efficiency improvement initiatives.

Reflecting either an ability by hospital executives to bark out orders and have everyone jump to follow them or wishful thinking, Jack Welch-type management was seen as applicable for health systems by the largest group of respondents (38%).

MANAGEMENT DEMANDS DATA

Because C-suite executives may fret as much about what they don't know as what they do, respondents were bullish on the ability of health IT to help them bring together disparate parts of the care continuum and produce a more-or-less organized system of care. You don't want to walk a tightrope with your eyes closed, and a full three-quarters of respondents agreed that greater measurement and analytics will improve care and cost effectiveness.

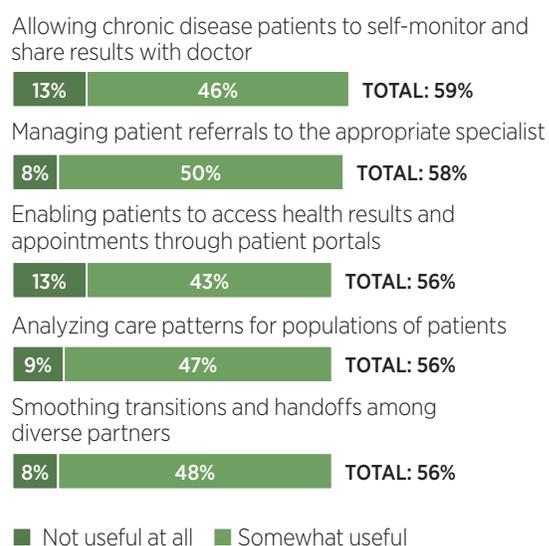
Banner Health, for example, was recently recognized by the Health Information Management Systems Society for having 17 of its 23 hospitals certified as

The Uses of IT

Information technology today is very useful for:



And less useful (not at all or only somewhat useful) for:



“Stage 7,” HIMSS’s highest level and a status obtained by only 1.2% of all hospitals nationally. That HIMSS certification measures not just adoption, but actual utilization of IT applications. (The “implementation thing” was why HIMSS had to add a “Stage 0” when it discovered Stage 1 was too tough for many institutions.)

“Our meaningful use of enhanced electronic medical records is integrated into our patient care processes and even targeted to help our clinicians proactively recognize and treat specific and dangerous disorders such as sepsis and delirium,” says Banner Health CMO Hensing.

However, even the largest and most aggressive systems don’t yet feel they have all the technology to do VBP right. When asked their spending priorities over the next three years, nearly half of respondents chose system integration across all applications (49%) and health information exchange (47%). Translation: we need to be able to communicate quickly and seamlessly with our care partners and with other care delivery systems. Waiting days for information to transfer won’t do it.

The critical role played by health IT in both financial and clinical preparedness can also be seen by what C-suite executives single out as its most important uses: identifying patients who generate high costs within the hospital (66%) and in the ambulatory environment (56%); ensuring evidence-based protocols are available to nurses and doctors (61%); and getting complete and current information across the care continuum (58%).

Boiled down to its essence, it means senior management at hospitals and health systems knows that health IT tools are central to the systemic changes needed to turn operational success in a fee-for-volume environment into success in an environment where care processes and outcomes must be measured, monitored and improved.

“Information is absolutely necessary to manage the population, and we feel it’s a distinguishing property we have developed over the years,” says HealthCare Partners CEO Margolis. Using a highly facilitated health record that feeds into a sophisticated data warehouse, HealthCare Partners employs predictive modeling to “understand the population and create programs that deal with different population segments based on their needs and risks.” Those programs include “e-visits,” group visits, care management follow-up and home visits.

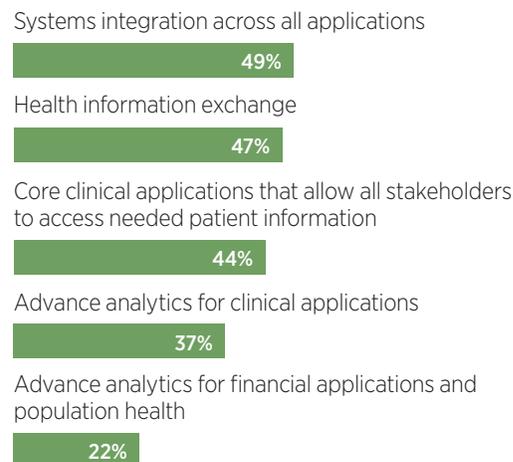
Information technology was also seen as somewhat less useful for allowing chronic disease patients to self-monitor and share results with their doctor (59%), managing patient referrals to specialists (58%), smoothing transitions and handoffs (56%), enabling patients access to test results and appointments through patient portals (56%) and analyzing care patterns for populations of patients (56%).

Those responses seem to reflect a recognition that engaging patients as partners with providers requires more than a technical “fix.” Still, Rush CEO Goodman is optimistic.

“This is where the consumer becomes a major player,” he says. “They’ll have their own numbers, and they’ll understand those evidence-based things that are important for their own health and be able to recognize and prioritize the things that are most important to their personal health.”

Information Technology Investment

What are your priorities for IT investment for VBP over the next three years? (Top Five)



CONCLUSION: STRATEGIES

At about the same time Henry Ford was introducing the assembly line to the auto industry, a Boston surgeon named E.A. Codman decided that hospitals, too, had a product: patients who were cured. Codman called on the businessmen who sat on hospital boards (employers didn't offer health insurance back then) to support measurement of patient outcomes in order to improve hospital "efficiency." He even suggested hospitals publish their outcomes so patients could go where treatment was best.

To no one's surprise but Codman's, his quixotic End Result Idea went nowhere. He blamed providers' being too concerned about their incomes. "For whose interest is it to have the hospital efficient?" Codman wrote. "Strangely enough, the answer is: No one...There is a difference between interest and duty. You do your duty if the work comes to you, but you do not go out of your way to get the work unless it is for your interest."⁹

Nearly a century later, hospital executives confront a similar quandary. "Change before you have to," General Electric's Jack Welch bluntly advised. But how much before? GE didn't abandon conventional light bulbs the instant it began manufacturing energy-saving ones.

The Commonwealth Fund's Guterman estimates that about 10% of Medicare reimbursement today is aligned with the goal of providing cost-effective, high-quality care. "In five years, my hope is it will be up to 30% to 50% for the whole health care system," Guterman says. "Folks understand there's a change coming, and they need to know how to deal with it."

The experience of the respondents to the Forbes Insights survey and the management and medical literature on VBP suggest three executive strategies:

1. INVEST IN KNOWLEDGE ACQUISITION.

Information is not power; knowledge is. Consistently producing measurable, high-quality, cost-effective outcomes for a defined population across the care continuum demands an enormous amount of information synthesis, often in real time.

Having advanced analytics serves a reactive and proactive purpose. Insurers, consultants and others are constantly analyzing and comparing different providers on quality and cost metrics. "If you don't know what your physicians and group are doing and are not able to track your performance, your future will never be in your control," advises Dr. Robert Nesse, CEO of the Mayo Clinic Health System. "You will be victimized by new payer contracts and pilloried by public displays of your performance data."¹⁰

Proactively, the mantra "You can't manage what you can't measure" remains more valid than ever. Without the right clinical information tools and dashboards, a diabetic patient who bounces among hospital, specialist visit and nurse coaching may be retroactively assigned to an episode of care but will not truly be part of any organized process of care.

There's another kind of knowledge acquisition that's also important: financial. Different markets have differing payer mixes and approaches to VBP. Massachusetts and Montana both have Blue Cross and Blue Shield plans and state Medicaid programs; the demands made by those payers are very distinct.

2. DISTRIBUTE RESPONSIBILITY.

While senior management can accumulate one kind of knowledge through IT, there's an equally important type of knowledge no printout can provide. "Engaging" physicians and patients can be a euphemism for, "Get with the program." But though shared goals are a necessity, care processes ultimately cannot be improved unless those in the front lines are given

explicit authority to use their practical experience to do so and are provided with the tools to carry out that mandate.

Front-line teams can be any combination of clinicians, staff and patients. In one example of that mixture, University of Pittsburgh Medical Center won national recognition for a six-step patient- and family-centered care improvement process used in its orthopedic surgery program. The process involves all stakeholders affected by each change that is made and has improved effectiveness, efficiency and patient satisfaction.¹¹

3. LEAD CULTURE CHANGE.

Ultimately, the alternative to preparing for VBP is not prospering under the status quo. The Medicare physician fee schedule and prospective payments to hospitals are failing to keep pace with medical inflation and will fall even further behind in an era of budget austerity. More and more private employers are cutting back or even abandoning health benefits. “The system cannot and will not pay what it has in the past,” says economist Michael Chernew, a professor of health care policy at Harvard Medical School. “The boat is sinking.”¹²

As that happens, it is the responsibility of senior executives to lead their organizations to safety. “There are no great men, only great challenges that ordinary men are forced by circumstances to meet,” said famed World War II Adm. William F. “Bull” Halsey. And there may be no greater challenge than taking a health care organization whose clinicians, staff and managers have all grown up with the autonomy and economic rewards of visit-based, fee-for-service medicine and helping those people change the working assumptions of their professional lives.

In every interview conducted for this report, the issue of commitment to community repeatedly surfaced. Senior executives at Banner Health may have expressed this view best.

“Our heart and soul is not a mission of financial value,” said Banner Health CEO Fine. Added CMO Hensing: “Technology is a vehicle. But this, in fact, is about commitment, mission, governance, organizational design, clinical leadership. It’s about a culture that embraces performance as a measure of its success.”

The balancing act is complex, but those who’ve made their way to the top jobs in hospitals and health systems are used to that. The challenge they face is to walk steadily forward to a new era without stumbling or losing the shared sense of mission and values that have bonded together managers, staff and clinicians in the past. That demands not just skillful managers, but leaders.

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¹¹Harris Meyer, “Innovation profile: At UPMC, Improving Care Processes to Serve Patients Better and Cut Costs,” *Health Affairs* 2011; 30(3): 400-403.

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