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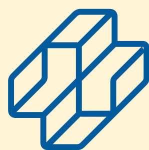
# Transforming Relationships to Transform Health Care

A REPORT FROM HFMA'S 10TH ANNUAL THOUGHT LEADERSHIP RETREAT

## PUBLISHED BY



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**TRANSFORMING RELATIONSHIPS TO TRANSFORM HEALTH CARE**

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# A Message from HFMA's President and CEO

**Dear Colleague:**

Thank you for taking part in HFMA's 2016 Thought Leadership Retreat. This year marked the 10th anniversary of the event, which was launched in 2007 as a forum for healthcare leaders to come together to discuss current issues facing our industry. Previous retreats have focused on such topics as payment reform, the transition to value, population management, and patient engagement. This year, we turned our focus to another timely topic: relationships and the opportunities they present to transform health care.

HFMA was honored to have the Alliance of Community Health Plans, the American Association for Physician Leadership, and the American Organization of Nurse Executives as our partners in the effort. Together, we convened a diverse representation of the healthcare industry to discuss new models for communication, collaboration, and consensus building. Participants included representatives from three of the most significant groups involved in delivering the care patients receive—something HFMA refers to as the "three circles"—hospitals and other providers, health plans, and physicians and other healthcare practitioners.

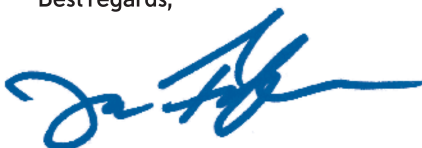
A major highlight of the retreat was the opportunity to hear industry leaders present their views on such topics as transforming relationships from both the employer and the health plan perspectives, managing the health of underserved populations, transforming the future of physician leadership and engagement, aligning stakeholders to take on risk, and transforming the patient experience.

Another highlight was the breakout sessions during which retreat participants broke into smaller—but still diverse—groups to discuss current challenges and potential solutions to a range of issues involved in efforts to transform our healthcare system. Participants discussed:

- The role of clinical leadership and strategies for successfully engaging clinicians
- The benefits and challenges of team-based care delivery models
- The barriers to identifying and addressing behavioral health needs and identification of successful models
- Issues related to accessing and using patient data
- Capabilities needed to effectively support risk management and the potential for shifting risk across the three circles
- Consumer needs and ways to improve their experience as they take on greater responsibility for the cost of care
- Identification of potential collaborations to improve the quality, affordability, and experience of patient care

This report summarizes those presentations and discussions. Thank you again for contributing *your* insights and expertise. We look forward to continuing the conversation as we explore and pursue new opportunities for collaboration. By joining forces and working together, we have the power to bring about the change needed to achieve a healthcare system that is truly committed to our shared Triple Aim goals.

Best regards,



**Joseph J. Fifer, FHFMA, CPA**
President and CEO
Healthcare Financial Management Association

# transforming relationships to transform health care

Providers and payers need to work together on models that deliver greater value to the patient while ensuring the financial sustainability of the system.

The U.S. healthcare system is moving toward new payment and care delivery models intended to improve the quality and cost-effectiveness of care. The success of this effort will depend in large part on the ability of the many stakeholders involved in care delivery and payment to collaborate on models that improve quality while controlling the growth in costs in the system.

During HFMA's Thought Leadership Retreat this past October, 100 thought leaders from across the healthcare industry shared ideas for how providers and health plans can identify challenges and potential solutions to a range of issues involved in efforts to transform the healthcare system.

## Clinical Leadership

Clinical leadership is seen as an essential component of any effort to transform care delivery. Peter Angood, MD, president and CEO of the American Association for Physician Leadership (AAPL), says emerging data has shown the value of physician leadership. For instance, data from the last four years on Medicare accountable care organizations (ACOs) consistently show most of the highest-performing ACOs are physician-led. Data indicated that performance on established quality metrics is 25 to 33 percent better in an enterprise led by a physician CEO, Angood says.[1]

The specific value of a physician leader as C-suite roles change in health care stems from the instinct to always put the patient first, says Thomas Higgins, MD, chief medical officer for Baystate Franklin Medical Center and Baystate Health Northern Region in Massachusetts.

"The true value of a physician in a leadership capacity is to take what you've learned in your four years of medical school, and residency, and however long your career has gone, and apply that in the business world," Higgins says.

Physicians can interpret for corporate leaders why an initiative may make sense economically but will hurt patient safety, quality, or the patient experience.

1. Goodall, A., "Physician-leaders and hospital performance: Is there an association?" *Social Science and Medicine*, Volume 73, Issue 4, August 2011, Pages 535–539.

At the same time, elevating physicians to leadership roles requires finding clinicians who are capable of shifting from traditional "captain of the ship-type" mindsets to a focus on team building—and who can "keep financial outcomes in mind too," says Donald Bradshaw, MD, vice president of clinical transformation for Evolent Health.

"Some physicians should be CEOs; some should certainly not," Bradshaw says.

For organizations, one key to improving the effectiveness of physician leaders is ensuring they are being paid for their leadership, says Napoleon Knight, MD, medical director of The Rural Alliance for Health Care Excellence for the Carle Health System and chair of the board of directors for AAPL.

"We recognized that we needed to pay people for their services," Knight says. "But not just pay them— we needed to make them accountable for the outcomes."

Physician leaders also are well-positioned to monitor the health of a hospital's physicians. Health systems need to ensure their clinicians have the time and resources to tackle problems without being exposed to the type of work-induced burnout that can hinder efforts to find new physicians.

Optimizing physician productivity in a pay-for-value world will require many different components.

"You just can't keep paying the same and expect a different outcome," Knight says. "But if you can change the way you pay me and value my services, and tell me that there's a goal that we have to achieve, I think that there's not a physician on the planet who wouldn't be willing to do that."

## Team-Based Care

Patient-centered medical homes and other team-based care delivery models have emerged as part of a renewed emphasis on primary care and chronic disease management. But making those new models work requires bringing together all of the affected providers to discuss how to

"You just can't keep paying the same and expect a different outcome."

implement them, says Maureen Swick, RN, PhD, CEO of the American Organization of Nurse Executives.

"With the evolution of the health plans and so much that is going on within health care and health systems, getting all of the stakeholders together when decisions are being made with regard to risk or whatever the protocols might be is key," Swick says.

The potential of team-based health was demonstrated in a presentation by Elizabeth Hale, chief clinical officer for the Lowell Community Health Center (LCHC) in Lowell, Mass. LCHC provides care for underserved populations in the Lowell area, 90 percent of whom have incomes of less than 200 percent of the federal poverty level and 45 percent of whom speak a primary language that is not English.

To meet the needs of this population, LCHC uses a team that tends not only to the immediate healthcare needs of its patients, but also includes community health workers who help to mitigate the impacts of social and economic conditions affecting patient health, health benefits coordinators who provide financial counseling and education about the healthcare system, and integrated behavioral health clinicians.

In one example, LCHC assembled nurse-supervised teams of community health workers who went into homes of pediatric patients with asthma to identify environmental triggers and provide education and action plans to help eliminate these triggers. As a result, asthma attacks in this population dropped by 76 percent and ED visits dropped by 81 percent.

"We need to adopt a more global approach to health care," says Hale. "This includes integrating social services, increasing awareness of available community resources,

and ensuring the cultural competency of those who work with patients. It's all about the relationships."

Another key to implementing team-based care is ensuring clinical coordination, care management, and performance accountability.

The development of effective team-based care delivery is necessary for managing patient health under risk-based payment models.

Michael Monahan, director of solutions enablement for GE Healthcare, saw the need for team-based approaches that incorporate various perspectives when he advised providers that were launching their own health plans. Providers were generally unaware of the particular requirements and needed the expertise of those with experience in that area.

"Where we are right now with respect to change, you can't necessarily do this by yourself, and you need to have the experience of others," Monahan says.

### Need for Collaboration

Angood says the healthcare industry is beginning to see "pockets of collaboration," especially among vendors, payers, and professional organizations.

"And yet, that is at the higher level," Angood says. "The challenge is how we drive that sense of collaboration down to our community level." That drive to collaborate locally for the good of the community was shown by two competitor community hospitals in Monterey, Calif., which overcame their distrust to find areas where they could work together, says James Gilbert, MD, president of the Monterey Bay Independent Physician Association. The fruits of their local collaboration included together convincing a local medical management company to cover for the first time a CDC-based diabetes prevention and education program to serve 150,000 local residents.

"And the reception so far has been phenomenal and the community has supported this stuff tremendously," Gilbert says.

"The challenge is how we drive that sense of collaboration down to our community level."

In terms of overcoming regulatory obstacles to collaboration, Laura Zehm, CFO of Community Hospital of the Monterey Peninsula, says her hospital learned that it could eliminate many antitrust concerns by working with an unaffiliated hospital through its health plan.

"If we take certain kinds of risk through that health plan, then it's a shared risk and so lot of these antitrust questions go away," Zehm says. "So it actually provides us a way to do it without violating antitrust rules."

### In Search of Quality Data

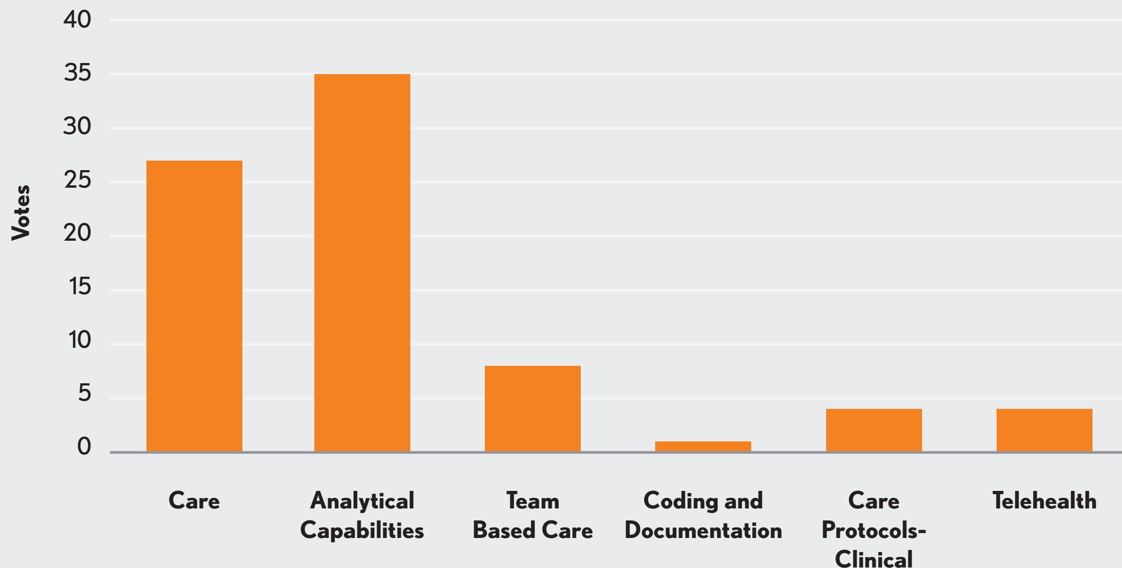
In an on-site poll, Thought Leadership Retreat attendees deemed optimizing analytic capabilities the highest investment priority for their organization.

As stakeholders across the industry have become aware, gathering and curating data is not an ultimate objective. Knowing how to apply that data is every bit as vital in efforts to improve the quality of care.

Says Mary Mirabelli, Chair of the Board of Directors of HFMA, "Do we understand causation? That part is equally important to just getting access to the data and doing predictive analytics with it. It's also about understanding what makes a difference."

As an example, GE Healthcare's Monahan notes that tracking down heavy users of healthcare services may reveal a correlation between utilization and issues such as a lack of access to food. A cost-effective response in a population health management scenario might be to provide food cards to needy patients.

"It's those kinds of things that match the data to action," he says.




Collaboration between providers and health plans is vital to ensuring optimal use of data, various conference speakers say.

Mary Ann Jones, CFO of Priority Health, part of Spectrum Health, says the plan's recent evolution in its strategic approach to risk sharing and provider collaboration has arisen in part from the way it deploys data.

For example, the plan shares data with key providers every month "to let them know what their members are seeing in terms of the total cost of care, as well as how care is being contained within their own system, but then also where there is leakage," Jones says.

Michael Sautebin, chief actuary, Security Health Plan, part of Marshfield Clinic Health System, cites data visualization tools as a development that has helped in terms of "getting to that total cost of care, gaps in care, last visit, next visit, [whether patients] have all the immunizations. So it really helps us all to head toward our mission."

Certainly, some data collection tools and processes need to be refined.

For example, Mirabelli notes that during the breakout discussion sessions among attendees at the conference, a consensus emerged that health information exchanges have significant potential value. Yet "some people are questioning that value because they have some limitations as well, the way they are currently constructed, the way it is expensive to get data out of the system."

## Collaborating to Take on Risk

Hospitals, physicians, and health plans share risk in alternative payment models, ensuring that all parties have a financial stake in improving the quality and efficiency of care. Yet the different stakeholders vary in their access to financial resources, patient data, and other capabilities that are needed to manage risk successfully.

"What we try to do is to tailor the financial arrangements within the specific providers," Priority Health's Jones

says. “What their risk appetite is, what’s their makeup, do they have a lot of primary care, a lot of specialists? To figure out what the right arrangement is, and how we’re going to make it a value-based program.”

If a provider doesn’t have at least 10,000 attributed lives, Jones says, a risk arrangement may not be advisable due to the potential for disruption by a few outliers.

Once a shared-risk arrangement goes into effect, care coordination becomes more vital than ever. Keynote speaker Kathy Davis, senior vice president and chief experience officer with Presbyterian Healthcare Services, says such a function helps the organization take patient engagement to the highest possible level.

“We have care managers in our hospitals and our clinics,” she says. “A layer above that, we have care coordinators that help patients navigate across the system. Especially where we’re fully at risk with our health plan, that’s the integrated function in terms of assisting the patient and member.”

Health systems with a provider-owned health plan have easy access to a resource that comes in handy in risk-sharing arrangements.

“We can bring some knowledge on the insurance side that’s really important if you think about information from a clinical perspective, and that’s because we own the entire premium dollar,” says Kurt Wrobel, CFO and chief actuary, Geisinger Health Plan. “I think this is a big distinction between other risk arrangements that may not give you that same clarity.”

Meanwhile, provider-owned plans benefit from their ability to cultivate risk practices internally and then implement those practices with a broader provider base.

Sautebin notes that such an evolution came in handy at Security Health Plan with respect to prior authorizations.

“We’re able to take some of the risk practices that we have inside our integrated system to external provider

> “What we try to do is to tailor the financial arrangements within the specific providers.”

systems,” Sautebin says. “Because [Marshfield Clinic was] was taking risk, for the first time in our organization, we were able to take a protocol and embed it in a practice and we could see it happen, and we could study the data.”

Wrobel adds that the most effective risk arrangements tend to be the simpler ones.

“To create very complex risk arrangements, I think it’s rarely worthwhile to do that,” he says. “Keep it simple, have people understand the risk they’re taking, and create that long-term partnership.”

## Consumer Needs

Nearly three-quarters of employers surveyed say they will not offer healthcare benefits to employees 10 years from now, says David Lansky, PhD, president CEO of the Pacific Business Group on Health, a coalition of 50 large employers that is based in California and focuses on improving the affordability and availability of health care.[2]

These data indicate a seismic shift in thinking as employers reassess their roles and the costs associated with employee benefits and healthcare purchasing in the future, Lansky says.[1] Whether or not the predictions from employers will become reality in a decade is largely unknown, but such data indicate employer cost fatigue when it comes to rising costs of health care. Many experts predict a continued shift toward high-deductible health plans that call on consumers to shoulder a growing share of healthcare costs.

“It is a sentiment that employers are feeling: It is simply unsustainable and their businesses will exit the health insurance space in the course of our careers,” Lansky explains.

Employers, Lansky says, face increasing financial challenges when it comes to providing comparable, competitive

[2] Lansky, D.; “19th Annual Towers Watson/National Business Group on Health Employer Survey on Purchasing Value in Health Care (2014);” HFMA’s 10th Annual Thought Leadership Retreat; 2016.

benefits and healthcare access to employees. According to a 2016 survey by Kaiser Family Foundation and the Health Research & Educational Trust, more than half of employees at small firms (3-199 workers) and large firms (200 or more workers) are enrolled in a health plan with an annual deductible of $1,000 or more for single coverage.

"It now costs $18,000 a year to provide healthcare coverage to a family in America," Lansky says. "It wasn't so long ago when that was a good living for a family in America."

Hospital costs and drug prices are two key areas of concern for employers, he says. "And I will emphasize the word 'price.' It has been a slow dawning to employers that price is the elephant in the room."

According to HFMA's Health Care 2020 report on consumerism (free download available at hfma.org/healthcare2020), two key drivers are influencing purchaser trends—increased cost sharing by consumers and a shift to outcomes-based payment. Both trends are creating a need to make more information accessible to consumers, engage key stakeholders to better collaborate, and look for opportunities to decrease costs and improve outcomes.

Lansky's message from employers: "What we are doing now is not working. [Employers] are not looking just to turn up the dial a little bit on some of the traditional mechanisms like employee cost sharing or high-deductible health plans. That is not the solution."

Why is that not the solution? Employers surveyed believe they have maxed out the value of asking consumers to pick up more costs.

## Ways to Shift

The core question for employers is: How can employers help improve the healthcare system in a way that helps all boats rise and that assures employees they will have access to a reliable level of high-quality and affordable health care?

"That is a difficult question," Lansky says. "Part of our job, on their behalf, is to influence the infrastructure of the healthcare system so it becomes better and more affordable for everyone."

As the market continues to shift, Lansky says there is shared interest from healthcare purchasers to work together in a kind of "informed forum to influence what the entire healthcare market is doing."

"We need a relationship where we are actively communicating about strengths, opportunities, and how to get things done together," Lansky says.

"We think that delivery system redesign is paramount. It is about really working with [healthcare organizations] to rethink what is the healthcare model that is going to work for more people in this country," Lansky says.

While there's no one solution to solve these complex challenges, there are many ways to address them. Payment reform is just one component, he says.

### Challenges to Value-Based Purchasing

**Corporate culture**

- Unwillingness to disrupt employees' relationships
- Loyalty/continuity with incumbent payers, TPAs, vendors

**Provider culture**

- Provider discomfort with non-process measures (span of control, methods, accountability)

**Consumer culture**

- Low consumer engagement with decision-making tools
- Consumer desire for "choice"—large networks

**Business issues**

- Provider resistance to data disclosure
- Uniformity of large, blended health plan networks
- Low patient volume with individual purchasers
- Regulatory pressure for "network adequacy"

**Technical issues**

- Poor HIT and HIE infrastructure
- Difficulty of aggregating data across settings, across time
- Difficulty of acquiring data from patients

"We need a relationship where we are actively communicating about strengths, opportunities, and how to get things done together."

Employers believe, Lansky says, that the most effective interventions will include:

- Payment change
- Better consumer education and incentives
- More information on costs and outcomes
- Clinical redesign and quality improvement

Here are some areas employers are pursuing to address these challenges:

- Selective contracting with high-performing organizations
- Pay-for-performance to reward services or behaviors that are valuable
- Total cost of care: Employers are less interested in episode costs or partial costs, but they do want to understand who's accountable for the total spend
- Patient experience: Companies like Apple and Disney live by the customer experience. "They cannot fathom why that would not be equally true for health care," he says. Patient experience is highly valued and highly weighted in many pay-for-performance programs, for good reason

Collaboration between stakeholders—including healthcare finance, medical providers, health plans, and consumers—is critical to successfully rebuilding health care to improve outcomes and lower costs, Lansky says. Everyone has a stake in health care's sustainable transformation, and collaboration and vision will be required to reposition the industry for the future. ■

### 10 Takeaways From the 2016 Thought Leadership Retreat

- As health care moves toward value-based models, it will require greater collaboration on the part of key stakeholders in healthcare finance, clinical medicine, and health plans to improve quality and control costs.
- Clinical leadership is a critically important component of efforts to transform care delivery. Clinicians can provide crucial information on why an initiative can make sense economically or will hurt safety, quality, or the patient experience.
- Team-based care can be very effective. One example is how Lowell Community Health Center in Lowell, Mass., mobilized nurse-supervised teams of community health workers to go into the homes of pediatric patients to identify environmental triggers and create action plans to reduce asthma attacks. As a result, emergency department visits dropped by 81 percent and asthma attacks in this population were reduced by 76 percent.
- Effective team-based care is also necessary for managing patient health under risk-based payment models. A key to success is ensuring clinical coordination, care management, and performance accountability.
- Health systems and hospitals have access to a vast stream of clinical and financial data. Successful systems in the future will harness new methodologies to apply data to improve the quality of care.
- Ensuring optimal use of data will also require collaboration between providers and health plans.
- Hospitals, physicians, and health plans share risk in alternative payment models. The different stakeholders vary in their access to financial resources, patient data, and other capabilities that are needed to manage risk successfully. Success hinges on finding the right arrangement and creating a value-based program.
- Because of the escalating costs of health care, employers are reassessing their role as healthcare purchasers. Both employers and consumers will take a much more active role in opportunities to decrease costs and improve outcomes.
- Employers believe the most effective interventions will include payment change, better consumer education and incentives, more information on costs and outcomes, clinical redesign, and quality improvement.
- Employers are less interested in episode costs or partial costs, but they do want to understand who's accountable for the total spend.

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