

# Executive Dialogue



## EXECUTIVE INSIGHTS

What's Top of Mind for Health System CEOs

Health system leaders are rapidly redesigning their businesses to position their organizations better in an environment that requires higher value, care coordination, integration and risk assumption. Health Forum convened a panel of health system executives Oct. 16 in Phoenix to discuss how their organizations are navigating the transformation from volume to value, with a focus on IT, leadership development, the rise of consumerism and process improvement. Health Forum thanks Siemens Healthcare for sponsoring this event.

**MODERATOR** (Maulik Joshi, Health Research & Educational Trust): What are the biggest issues you face today with the transition from volume to value?

**CONSTANCE HOWES** (Care New England Health System): Regardless of strategy, we all need to focus on cost reduction. That's a huge initiative for our system right now, and one that will have a direct payoff. Reducing costs will have a positive impact on our bottom line, giving us more capital to make the investments we need to succeed under value-based care.

**MICHAEL EESLEY** (Centegra Health System): We have three hospitals in the Chicago area, and our biggest challenge is duplication of services. How can we minimize duplication of services to reduce costs and enhance quality? We consolidated orthopedics earlier this year into one facility. Since then, we've seen an increase in volume, as well as outcomes.

**ROBERT CURRY** (Citrus Valley Health Partners): That's been a focus for us, as well. We have one certified stroke center, for example, and we've centralized all cardiac care and obstetrics. It's an important part of the Triple Aim — reducing the per capita cost of health care. It also enhances the patient experience, because it builds efficiency and effectiveness.

**TOM KEARNEY** (Siemens Healthcare): How does this process work? How do you go about the decision-making?

**HOWES**: It's mostly done with the help of outside

consultants. We brought in consultants to help us benchmark across the entire country and identify what has worked in other places.

**MELINDA ESTES** (Saint Luke's Health System): We started our cost-reduction journey about three years ago, and we brought in a consultant in the beginning for about nine months. We have since built up our internal capacity and we are now doing the work ourselves. It's become ingrained in our culture, and not viewed as something that was imposed from an external source.

**CURRY**: It's important to involve all stakeholders in the process. We are working to centralize our orthopedics. We've sought input from the stakeholders, letting them decide what's the best way to consolidate. It builds support and trust.

**EESLEY**: That's been our experience as well. When we began the orthopedic consolidation process, we had about 17 orthopedists. We put two orthopedists in charge of the unit, and then let them select the staff. It's helped to build acceptance for our initiative. And it became an honor, of sorts, to work in that area.

**MODERATOR**: Let's get back to the Triple Aim, reducing the total cost per capita of health care. Where are your organizations today in meeting this objective?

**HOWES**: Well, this is something we've been working on for a while now, and we still have a long way to go.



One of our challenges involves cost accounting. It's being able to understand our costs. And that's difficult to achieve.  
Michael Eesley

# PANELISTS

Moderator  
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President, Health  
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**Melinda Estes, M.D.**  
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**Robert Curry**  
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**Michael Eesley**  
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Vice President, Strategic  
Accounts  
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Malvern, Pa.



**EESLEY:** One of our challenges involves cost accounting. It's being able to understand our costs. And that's difficult to achieve.

**CURRY:** That's a challenge for us, too. About 85 percent of our reimbursement is government-funded. We're in survival mode; we have to get costs down. For the past five years, we've had an aggregate 2 percent increase in total costs. Getting the cost increase down to that percentage required a lot of blocking and tackling. But, for us, it's a mandate.

**ALAN WATSON** (Maury Regional Health System): From the cost of providing care, we found that post-acute care is the biggest driver of costs. There's an expectation in our market that the patient will go to the hospital for a few days and then transfer immediately to post-acute

care. That realization was a wake-up call for us. We had always been focused on cost — what it's costing us to provide care. But with the shift toward value-based care, we've expanded our focus to include utilization outside of the hospital.

**KEARNEY:** What, if any, low-hanging fruit exists when it comes to cost reduction?

**EESLEY:** The supply chain and physician utilization remain two areas that provide good opportunities for cost reduction.

**HOWES:** Another area is standardization and consolidation of services, as has been discussed so far today. These practices reduce duplication of services and enhance quality and patient safety.



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Melinda Estes, M.D.



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Alan Watson

**MICHAEL UNGVARY** (Siemens Healthcare): What opportunities remain for cost savings under the supply chain?

**ESTES:** Mostly commodity pricing, and trying to drive as much scale as we possibly can from a price perspective. It's also base logistics. Gone are the days of six month's worth of anything on the shelf. We have a just-in-time strategy.

**HOWES:** I would add outcomes, too. Value-based purchasing shows what equipment delivers better outcomes, such as lower infection rates. This is important because we're looking to improve both costs and outcomes.

**ESTES:** It's a long process, and without physician input, it would go nowhere. Value-based purchasing requires a significant amount of physicians' time. But it is also effective, and has a good return on investment.

**EESLEY:** We share physician performance data, so our physicians can see how their performance compares with their peers. It's had a significant impact; our physicians are on the same page with what we're trying to do. We're also placing physicians in key positions in our organization, leading quality and clinical effectiveness. Their input is essential.

**WATSON:** If we're going to lower the cost of total care, we need to take on all of the utilization pieces. Medicare data are 16 to 18 months old by the time we receive them, so they are not useful in helping us to drive utilization down. They are not helpful.

**HOWES:** One way to address utilization is through the adoption of evidence-based medicine and protocols, and building them into an electronic health record. After initial pushback, we've found physicians to be supportive. They respond to data, and they want the best results for their patients.

**KEARNEY:** That's a good point. Getting agreement on how to standardize practices does create some challenges, however. As a vendor, we work with the organization to gain agreement on standardization and to make sure the protocols that we say we're going to standardize are, in fact, followed. Once organizations take on risk for outcomes, we all need to make sure

everyone is aligned and supportive.

**HOWES:** It has to be physician-led. That's the only way we'll be able to get the standardization we need to improve the cost and quality of care.

**CURRY:** The element of risk will be a huge game changer for us and for physicians. When physicians realize they have to work collaboratively among themselves and with the hospital, that alignment will force better utilization. Once we build alignment across all stakeholders, it will be easy to standardize care and we'll begin to see better outcomes.

**EESLEY:** One of the changes we've made deals with admissions. Our hospitalists manage all admissions that come through our emergency department. Their outcomes are significantly higher. It changed all of our metrics dramatically.

**HOWES:** But did the payment system change?

**EESLEY:** No, the payment system hasn't changed. But both our readmission rates and our infection rates have dropped, in addition to a significant improvement in outcomes. Variability had been minimized. When people saw these results, it made it easier to make other changes, such as consolidating orthopedics.

**WATSON:** We've had the same experience with our use of hospitalists and the impact on our quality measures. Our next goal is to get surgeons involved to co-manage the patients with our hospitalists, so we can begin to improve some of our surgical outcomes as well.

**MODERATOR:** That's the big challenge for the hospital field, balancing between fee-for-service and value-based payment. You have to build the capabilities to be successful in the future. What are the leadership competencies your organizations will need to develop to get to that point?

**EESLEY:** One of the challenges I see has to do with C-suite turnover. At Centegra, we've been fortunate to have some tenure in key leadership roles. I'm not talking 20 to 30 years, but we have leaders who've been in their roles for 10 to 15 years. It shows some consistency. We

can't make significant progress if we're constantly changing the executive team around. In my view, organizations that have consistency in leadership have pretty good outcomes.

**CURRY:** We've had success with the dyad model. Pairing an administrator with a physician leader is effective — one person knows the business side, and the other is a patient advocate, a passionate leader. It's a balanced approach and we're doing that in most service lines. It's a model that works, and one that will be successful in the future.

**ESTES:** I agree that it's a successful model. But it raises the issue of the need for formal management training for physicians. The competencies and mindset required to effectively partner in a dyad are not part of formal medical training. However, physicians are well-positioned to learn. We just need to figure out the best way to do that.

**HOWES:** Mental agility and the desire for lifelong learning are important leadership characteristics. As we navigate the transformation from volume to value, we need people who are agile and open to change. It's hard to change your mindset, particularly when it deals with a practice that has been successful for a long time.

**WATSON:** Two of the characteristics I look for are the ability to make decisions quickly and not being afraid of failure. If we sit around and overanalyze things, the world will take off and leave us behind. We've got to be able to make quick decisions. Sometimes it's going to work and sometimes it won't, but we have to be willing to take risks.

**KEARNEY:** A big challenge in health care is that incentives are misaligned. Is it difficult to align across departments?

**EESLEY:** We're on the same incentive plan throughout the system. Unfortunately, that plan is built off of margin. When you start dabbling in that margin, everyone's affected. It's hard to stress the need for change and standardization when the department's making a reasonably good margin. Of course, no one really wants them to stop that, but that doesn't mean changes shouldn't be made.

One of the challenges we face is how to make

our incentives meaningful to our 4,000 employees, including about 160 managers. We need to find meaningful measures that everyone can get behind. We haven't quite figured it out yet.

**ESTES:** We have a well-developed incentive plan, too, around such traditional measures as cost and call-in measures, among other things. We take it seriously, and it permeates through the management structure. But we know the world is changing, and we need to change along with it. We are contemplating developing a long-term incentive plan beginning next year. We're working to identify the different metrics that would be incorporated into that plan.

**KEARNEY:** Siemens is looking at long-term measures, as well. And we're also tying incentives to the performance of our clients — how hospitals and health systems fare with their key performance indicators. It builds loyalty. We're not 100 percent there yet, but it's where we are going.

**CURRY:** We've taken a hard look at our incentives and are really focusing a great deal on outcomes measures. We've worked with our risk manager, legal counsel and chief medical officer to measure the reduction of harm to the organization, the results of liability and settlements, etc. It's worked. I don't know if anybody else is doing that, but it's resulted in a great deal of teamwork, which is a competency that's going to be so imperative in the future. It's a twist on incentives, and it's generated better results.

**MODERATOR:** How is the rise in health care consumerism impacting your organization? What effect do you anticipate in the future?

**HOWES:** Well, the shift to high-deductible plans is a big disrupter. We are going to have tremendous pressure to lower our costs, not just to compare ourselves with other hospital costs, but what is available through other marketplaces.

**EESLEY:** We need to find the right access point for consumers and then engage in that access point. How do we get more people to use primary care physicians? How do we steer patients toward immediate care and away from the ED? One way will be to show them the most



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cost-effective point of care. If they use the ED, there's no margin for the health system and it will be more costly for them. We want them to make the right choices, and having a primary care physician who serves as a gatekeeper is ideal.

**HOWES:** The question becomes whether there is enough access to primary care in the community?

**EESLEY:** There is in our marketplace. We used local federally qualified health centers to provide primary care services to the Medicaid population. Many of the independent physicians in our market do not accept Medicaid patients, so the centers provide a point of access for that population.

**WATSON:** We are located in a rural community and are looking to telemedicine to ensure access to services. It's an effective way to reach out and stop patients from having to drive 50 to 100 miles to receive care. We're starting with primary care, and we're testing it with some of our specialists as well.

**ESTES:** We are also using telemedicine to link with our rural communities. We are focusing on developing our mobile-health, telehealth strategy. Our hospitalists connect with smaller hospitals via the computer. There's not enough dermatology coverage in Chillicothe, Mo, so we deployed a dermatologist via telehealth.

Getting back to the new consumer, we are going to need someone in our organization with a background in consumer technology. We will be looking for that. We now have an executive in charge of our retail strategy and we're partnering with a local grocery store chain to enter into the retail side.

**UNGVARY:** Consumerism will impact the hospital field in several ways. We've discussed the economic impact, how higher deductibles will drive behavior. Patient expectations are high. They want ease of access and convenience. I'm curious what your organizations are doing along these lines.

**ESTES:** That's one of our reasons for expanding into the retail space. We're also trying to make our scheduling system more user-friendly.

**HOWES:** The bar is set high. Consumers are used to jumping on their smartphones and making dinner reservations, etc. They want that same level of access to health care.

**EESLEY:** Services will have to be distributed throughout the community, whether it's an urgent care center, a diagnostic center or a women's center. We're going to have to provide a broad distribution of ambulatory services that these consumers need to meet their expectations.

**HOWES:** This shift will have a significant impact on the way that physicians practice, especially specialists. They will need to provide faster access to their services. Consumers aren't willing to wait several months for an appointment.

**MODERATOR:** That's true. For millennials, one of the top deciding factors for health services is whether they can make an appointment online or on their phones. It's an entirely different entry point.

**KEARNEY:** CVS and other pharmacy retailers are stepping up their services, offering blood tests and even ultrasounds in some locations. What risks do you think that creates, and do you see potential partnerships in this area?

**HOWES:** CVS, in particular, is using Epic, so it will have the ability to connect with other providers. Epic is becoming widespread on the ambulatory side. At least we will have the opportunity to see what care has been delivered to our patients in other locations.

**WATSON:** That works if you can afford it. That's my concern. In a system like ours, there's no way we can afford it. So, how do we connect?

**ESTES:** The onus is on us, really, to think differently and be flexible. Through predictive analytics, we can potentially identify who will need our services before they need them. There may be an opportunity to partner with these providers in the retail space to support chronic care management. There's a great deal of potential. We need to be looking at all sorts of unique joint ventures. We'll need to rethink how we access capital. But, undoubtedly, there are new opportunities for growth.



We can do a better job managing the health of our communities. To get there, the most disruptive thing that we are doing is challenging every process that we have.  
Robert Curry

**HOWES:** Access to capital is a huge problem. Many health systems are doing quite well, but there are others that aren't. How can those systems get access to capital to make the changes they need to be successful in the future?

**MODERATOR:** I have a final, two-part question for all of you. What's a disruptor that you're working on today in your organization that you think has the greatest potential opportunity? And then, where do you want to be in five years?

**ESTES:** I'll start with where we want to be in five years. Saint Luke's has a 100-plus-year history in Kansas City and we want to continue to be a value-driven, accessible, thriving health system for Kansas City and our region. We are a mission-driven organization, and we're mindful of that mission going forward. Our plan, right now, isn't to build new hospitals, but we would like to find partners to expand our reach to a wider geographic area. We see ourselves as a regional resource. But our goal, really, is to not forget why we are all in this business, which is to provide the highest-quality, most accessible health care we can to our patients. It was the core of what we did 100-plus years ago, and is the core of where we want to be today and in five years.

In terms of a disruptor in our organization right now, it really revolves around this whole issue of mobile health and how we can bring health care into the living room, the car and the small, rural hospital. How can we deliver care wherever it needs to be, and not take our current paradigm and force it onto a small screen?

**CURRY:** In five years, I envision that we will be a completely different system, having a broad array of partners to improve population health. That's important. I believe we should be responsible for our diverse populations, be it disease, gender, ethnicity or age. We can do a better job managing the health of our communities. To get there, the most disruptive thing that we are doing is challenging every process that we have. One of the ways population health will evolve in the next five years is through our health information exchange, which is vendor-agnostic. It will gather all of the data from labs, pharmacies and other providers to enable us to make the best decisions for our patients. That will be a pretty compel-

ling change over the next five years.

**WATSON:** In five years, we want to prove that a small, stand-alone health system can change the population health of its community. We're approaching that in several ways, telehealth being one of them. And we're working to form a clinically integrated network without having to give up any ownership in our system. We want to make sure we can remain independent.

**EESLEY:** In five years, we want to be a thriving health system with geographic relevance, so people within our market use and value us. From a disruptive side, we continually need to change IT and the IT platform and how we meet the expectations of people in our community. How do we meet and exceed our patients' expectations? From a disruptive side, we have to shift gears a little bit and not be so traditional in our approach to care delivery.

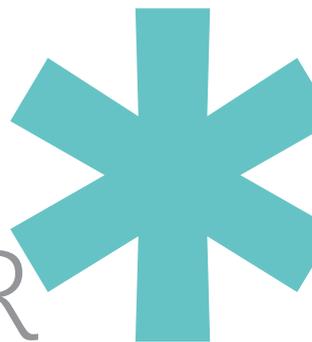
**HOWES:** Our most current disruption is that we formed an accountable care organization. It's forcing us out of our comfort zone. Our goal in five years is to address population health, and find the right partners in the community. We know we can't achieve it on our own.

**UNGVARY:** Our challenge is to get beyond the transactional sale of technology and into a more supportive partnership. How can we, over time, work with our hospital partners to help them achieve optimal outcomes? We don't want to end the relationship at the sale, and that's where we would like to be five years from now.



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Constance Howes

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