MANAGING THE TRANSITION

Positioning for the Future

H&HN

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Dear Reader

Welcome to “Managing the Transition; Positioning for the Future,” a special supplement to Hospitals & Health Networks developed in conjunction with Citi and the Healthcare Financial Management Association. This is the 13th year of this partnership that seeks to promote the exchange of information between hospitals and health systems and the investment community. Together, we seek to facilitate access to capital that can enable a higher-performing health care system.

This year, the focus is on the present but with a forward-looking perspective — what are hospitals doing now to get ready for the future state of health care delivery and payment? Responding to their communities and the unprecedented changes in health care, each hospital and health system must develop their own path and indeed we see great evidence that they are developing innovative delivery models and partnerships to address evolving stakeholder expectations.

This supplement is being distributed at the 13th Non-Profit Health Care Investor Conference, designed as a continuing effort to enhance communication between health systems and investors. We thank Citi and HFMA for their continued support and hope that this supplement will be of value to your organization.

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Health care organizations are bracing for a maelstrom of change. The transition from a fee-for-service, volume-based model to one based on value requires them to reinvent what they do strategically, operationally and financially. Revenue from traditional sources will decline. Risks will rise. Financial sustainability may be threatened.

Yet, perhaps the toughest challenge of all is in not knowing how fast the transition to a new era will occur or what it will look like.

Hospitals and health systems are busy rethinking how they provide services and how they need to transform. But the uncertainty is weighing on their preparations. In sports parlance, they are under pressure to switch to a new playbook without abandoning the old one — and no one knows the new rules or when the next season starts.

Many are paralyzed by indecision or a perceived lack of resources. Such inaction may be the biggest misstep they could make, according to health care insiders. They say it’s time to follow the lead of organizations that are placing their bets — as industry expert and former hospital chief executive officer Jeff Selberg puts it — on improving value. Those that wait until the business model changes, he maintains, will not succeed.
“Over the long term, it’s absolutely clear that the organizations that provide higher value are going to win, competitively. Waiting is very short-term thinking.”

— Jeff Selberg
“Over the long term, it’s absolutely clear that the organizations that provide higher value are going to win, competitively,” says Selberg, executive vice president and chief operating officer of the Institute for Healthcare Improvement. “Waiting is very short-term thinking.”

First Movers
Ralph Lawson, chief financial officer of Baptist Health South Florida, travels a lot as national chairman-elect of the Healthcare Financial Management Association. Most of the organizations he visits are talking about change, improvement and the need to reform. “The really good thing about what’s going on in health care today is a genuine focus by most providers on quality and patient safety,” he says.

But few, he notes, are actually making tangible changes to help them navigate the transition to the future. Indeed, an HFMA survey last year found that while more than half of respondents had begun measuring the costs of adverse events and the margin impact of readmissions, only 20 percent were using the data to drive actions that reduce costs or improve margin.

The hesitancy is understandable, as even the most ardent proponents of change acknowledge. “If you move really aggressively toward the fee-for-value support system, it’s apparent you would leave a certain amount of revenue on the table,” says Ken Kaufman, CEO of health care consultancy Kaufman, Hall & Associates.

Revenue declines are drawing nearer even for those that stand pat, however, and more farsighted organizations are exploring alternative solutions now. Hospital revenues are in “critical condition” after growth dropped to 4 percent in 2010, according to Moody’s Investors Service—barely half the rate of a decade earlier and the lowest since at least 1990.

There are ways to mitigate the downsides of reduced hospital admissions, average length of stay and outpatient fees, Selberg emphasizes—starting with eliminating variation and lowering cost. “In refining your clinical model, your profitability will grow as the costs decrease,” he says. And health systems that are refining their operations to achieve improvements are seeing encouraging signs.

A number of forward-thinking systems are being lauded for pursuing the transformation intensively but wisely, despite the short-term risks. Aside from those addressed at length in this article, industry experts single out pioneers such as Intermountain Healthcare of Salt Lake City, a model for Medicare’s accountable care organization program, and Geisinger Health System of Danville, Pa., the physician-led system that has cut costs with its bundled-payment system and set up an advanced medical home for chronic disease. Among others, Advocate Health Care of Oak Brook, Ill., signed a landmark accountable care agreement with an insurer; AtlantiCare of Egg Harbor Township, N.J., created its own successful medical home, a special care clinic for casino workers; Fairview Health Services of Minneapolis has switched much of its revenue to fee-for-value; and the Cleveland Clinic created institutes focused on the full cycle of care.

These “first movers” are pushing ahead with physician alignment, cost control and care reorganization. They all have what Selberg describes as “an absolutely maniacal focus on improvement.” And they share the willingness to experiment, confident that the long-term payoff justifies the near-term revenue risks.

“The transition from volume to value is challenging, especially when utilization and performance risks are being shifted to providers. Because of this, many organizations begin by shifting the care and payment models for their own employees, where they own the risk already,” says Richard Clarke, president and CEO of HFMA. Others look for opportunities to experiment.

Baptist Health South Florida is experimenting with its insurers, its doctors and its payment model. It’s working with commercial payers on different payment methodologies, trying new risk-based contracts focused on wellness with Caribbean island nations, and preparing a bundled-payment model for urgent care.

The Miami-based organization is fully aware that some trials may not work, Lawson says. But value to the customer will be increased, developing technology to handle bundled payments will help in the future, costs will be reduced and the organization should be better positioned for the years ahead.

“We’ll probably lose money in the short term on many of these initiatives, but we’ll get valuable experience,” he says. “We’re not betting the farm, we’re experimenting. If it does lower our revenues, so be it.”

Getting physicians on board is a key focus for transitioning organizations. The new era requires an entirely different level

**Percentage of hospitals reporting some percentage of their revenue is paid on a capitated or shared risk basis, 2003-2010**

<table>
<thead>
<tr>
<th>Year</th>
<th>Capitated</th>
<th>Shared risk</th>
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</thead>
<tbody>
<tr>
<td>2003</td>
<td>10.2%</td>
<td>6.4%</td>
</tr>
<tr>
<td>2004</td>
<td>11.9%</td>
<td>6.6%</td>
</tr>
<tr>
<td>2005</td>
<td>11.0%</td>
<td>6.8%</td>
</tr>
<tr>
<td>2006</td>
<td>9.9%</td>
<td>7.1%</td>
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<tr>
<td>2007</td>
<td>7.1%</td>
<td>8.5%</td>
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<tr>
<td>2008</td>
<td>9.3%</td>
<td>7.1%</td>
</tr>
<tr>
<td>2009</td>
<td>7.8%</td>
<td>6.6%</td>
</tr>
<tr>
<td>2010</td>
<td>7.6%</td>
<td>6.4%</td>
</tr>
</tbody>
</table>

Source: Analysis of AHA Annual Survey data for community hospitals 2003-2010. Capitation is defined as an at-risk payment arrangement in which an organization receives a fixed prearranged payment and, in turn, guarantees to deliver or arrange all medically necessary care required by enrollees in the capitated plan.
of cooperation between doctors and hospitals, Kaufman says. The two sides must be in sync on their goals before signing new risk contracts based on the fee-for-value model.

The best hospitals and care systems also are changing their cultures to become more transparent and collaborative. An AHA report last September stressed that before any specific strategies are implemented, organizations must develop a culture that enables performance improvement, high reliability and accountability. That’s what is happening at those that are not just waiting for the future and hoping for the best.

“Health care is moving hard from that concept of individual accountability to one of team accountability — appreciation for a system,” says Selberg. “That’s the culture we need to build in every organization, whether they’re concerned with reducing ventilator-associated pneumonia or they are in an environment where they’re trying to develop a full cycle of care for a diabetic over a two-year period of time.”

The model organizations are moving forward on multiple fronts. A look at four of them follows.

Beyond hospitals

The Henry Ford Health System has earned recognition for successfully navigating industry changes in recent years, winning a Malcolm Baldrige National Quality Award in 2011 and posting nine consecutive years of financial growth. The Detroit-based organization has managed to increase hospital admissions steadily at a time when the area it serves has been devastated by the automakers’ slump. Yet, Robert Riney, president and chief operating officer, says health systems can make a mistake by focusing on hospitals at the expense of other areas.

“Most organizations are hospital-dependent — they depend on them as a revenue source and a source of growth,” he says. “While hospitals will continue to be an important part of the industry, the continued move toward doing more in an ambulatory and home-based environment will accelerate.”

Focusing on that diversification is at the heart of the Henry Ford strategy. That means “working the intersections” between hospitals, ambulatory and home-based services, Riney says, and ensuring smooth, well-communicated handoffs from one to the other to create a seamless experience for the patient and family. The organization seeks to play an active role in every part of the total health experience, from wellness education to products and retail services related to its core competencies — pharmaceutical and wellness products, durable medical equipment, retail eye care and more.

The five-hospital system last October opened a new think tank on its Detroit campus for creating medical products. The Innovation Institute at Henry Ford unites medical and biotechnology researchers with engineers and design experts from the universities and elsewhere to look for commercially viable products and push for medical advances. Among the early items on the drawing board: a miniature wireless pump to help a failing heart and a bra with ultrasound that can detect breast cancer.

“It’s a way to not only advance the industry but create a nontraditional revenue source,” Riney says of the think tank.

The system also is looking at different ways of using technology to provide better alternatives to facility visits, satisfying demand from patients who crave such services and broadening the care experience while also saving money. The goal is electronic visits to the patient with all the capabilities of home monitoring.

It established five leadership and development academies for its employees, reducing turnover and improving performance.

Greater collaboration with physicians is another priority. Henry Ford’s physician network brings together its 1,200-strong medical group with private doctors into a clinically integrated network of more than 1,800 physicians.

The initiatives testify to why the organization is considered a model for overcoming the fragmentation in health care systems — by using clinical integration to improve collaboration and care coordination and foster innovation.

Financial futurism

Novant Health isn’t waiting to see what a world of no cost shifting will do to its bottom line. The 13-hospital system, based in Charlotte and Winston-Salem, N.C., projected itself forward into that financial reality by transferring to a payer-neutral revenue system.

The system considers all payers as if they were Medicare, with its substantially smaller payments than private health, by evaluating claims submitted to other health plans through a payment algorithm based on Medicare reimbursement rules and rates.

It’s much more than a financial fire drill. Novant is using the resulting data at the core of efforts to reduce cost and unnecessary health care utilization. Pro forma financial statements prepared with the data show which service lines would be profitable if all health plans paid as Medicare does. Physician councils established at 14 clinical sites help analyze the data to figure out how to root out varia-

U.S. nonprofit health care outlook remains

**Negative for 2012**

> Increased need for capital relating to plant modernization and IT systems
> Greater limitations on access to capital due to wider credit spreads for lower rated credits
> Cost of compliance with changing regulatory environment and new requirements under health care reform
> Increased reimbursement pressures across all payers
> Large unfunded pension liabilities
> Possibility that benefits of tax-exemption will further diminish
> Benefits of economies of scale, including increased bargaining power with suppliers, payers and labor

Source: Moody’s Investors Service
tion and establish new best practices. The clinical staff has made improvements in care that Novant says also have cut costs, improved operating margins and saved millions of dollars systemwide.

“We’ve had lots of success with this, but what it did was fully integrate Novant as an organization,” CEO Carl Armato says. “We’re looking at it not in one market, but across our four-state system.”

In the first round of analysis alone, Novant identified 12 opportunities to trim more than $24 million in variations — everything from differences in labor costs at imaging facilities to a 25 percent cost differential between joint replacement surgeries. After using the tool for two years to identify and address variation, the organization is going all in this year. By June, 44 of Novant’s hospital patient units will have transformed their model of care.

The transformation touches on most elements of Novant’s six-point strategic plan, says Armato: safety, quality, affordability, accessibility, patient choice and personalized relationships.

When it comes to affordability, the switch to payer-neutral revenue clearly benefits the organization as well as patients and payers. “It makes us better able to navigate the changes as health care reforms are implemented and state budgets are cut,” says Sallye Liner, R.N., chief clinical officer.

Quality and value
Amir Dan Rubin, president and CEO of Stanford Hospital & Clinics, is as worried about the coming reimbursement decline and related financial pressures as any other chief executive. But he is determined that the Palo Alto, Calif.-based academic medical center not stray from its overall vision and strategies to improve the bottom line. A relentless focus on improving patient care, he says, will be the biggest difference-maker not only for the patient, but also the organization.

“Every organization has to have some viewpoint or strategy about where it wants to fit in in the health care world, as opposed to changing particular concepts,” Rubin says. “If we’re focused too much on reimbursements or structures or systems, there’s a risk in getting lost in the charts rather than [putting] the patient [first].”

Indeed, he says, Stanford is finding that when it improves quality, it improves the cost side of the equation. It went a year and a half without a central-line infection, for example, saving considerable money. Likewise, coordinating care better by having teams of diagnosticians has paid off for patients and the organization alike.

The academic center is making other moves with a close eye on the financial benefits. It is working to standardize its supply chain. It’s using more Lean techniques adopted from Toyota, streamlining processes by eliminating steps that add no

tronic medical records system from the HIMSS Analytics Database. Patients are logging into their charts and emailing with their physicians.

It’s an approach that works for an IT and medical research powerhouse, although Rubin emphasizes that it may not be the best model for every organization to transform to the future. “I don’t think one answer fits all,” he says. “And that’s good. We’ll serve our communities better by having a variety of approaches.”

Collaboration and cooperation
Small, rural organizations can follow many of the same strategies as those with the resources to fund multimillion-dollar technology initiatives. For Glendive (Mont.) Medical Center, transformation means an intensified effort on patient-centered care, with wellness as the focus.

“Working to not have anybody in the hospital — now, there’s value,” says CEO Scott A. Duke, an AHA board member.

Leadership, strengthened collaboration with medical providers and closer cooperation with patients all are being used to lay the groundwork for change at the 25-bed acute care hospital.

Glendive has:
• Launched a new customer service initiative focused on exhaustive communication, sharing information before patients come to the hospital, and helping them navigate the health system.
• Established a leadership institute under the auspices of its board of directors. Duke says he often hears from peers at small hospitals who claim to be too busy just keeping their organizations running to get their boards talking about better collaboration, to which he responds: “That’s where it takes leadership and vision. The quintessential difference is leadership.”
• Made working with physicians and other medical providers a top priority.
• Created patient-family advisory councils, involving people in the community to share insights that can help its 475 employees improve the overall patient experience.

Notwithstanding the urgency for hospitals to change their business models, it’s still about the patient, Duke stresses. “The emphasis on patient-centered care cannot be overstated,” he says.

“We’ll probably lose money in the short term on many of these initiatives, but we’ll get valuable experience. We’re not betting the farm, we’re experimenting.” — Ralph Lawson
Managing the Transition

>>The Role of Governance

By Richard L. Clarke

In health care, we strive toward short, seamless transitions — whether it’s a care handoff between providers or a behind-the-scenes switch to a new health IT system. Hospital and health system board members recognize the value of streamlining these transitions, and support their management teams in an effort to reduce transition times and improve efficiency.

On a larger scale, the health care system is in the midst of the most significant transition it has experienced in decades — a transformational shift from volume-to value-based payment. Although the nature of the transformation is clear, the duration of the transition period is hard to predict and probably will be defined only in retrospect. At the macro level, there is little that board members can do to expedite or streamline it.

But there is a great deal boards can do to help their organizations prepare for value-based health care as the transition unfolds. In their book, Governance as Leadership: Reframing the Work of Nonprofit Boards, Richard P. Chait, William P. Ryan and Barbara E. Taylor identify three roles or functions of governance. The first is a strategic role — helping the organization chart a course for the future. The second is stewardship — helping to sustain the organization’s viability through oversight of its management and resources. The third function is generative — grappling with the issues an organization confronts, and generating ideas that potentially reframe or refocus the organization’s priorities and goals.

Hospital and health system boards will need to draw upon all three functions to help their organizations prepare for a value-based future, including: defining the strategic vision for the organization focused on providing value for the purchasers of care; assessing the organization’s strengths and weaknesses to position it for success in a value-based environment; and holding management accountable for making a successful transition.

Boards also will need all three functions to support the development of four key value-driving capabilities among board members and throughout the organization. Organizations must focus on: people and culture to instill a culture of collaboration, creativity and accountability; business intelligence, including collecting, analyzing and linking accurate quality and financial data to support organizational decision-making; performance improvement — using data and evidence-based medicine to reduce variability in clinical processes and improve the delivery, cost-effectiveness and outcomes of care; and contract and risk management — developing and managing effective care networks and predicting and managing different forms of patient-related risk.

At the board level, preparation for a value-based world should include an assessment of the composition of the board itself and of the senior leadership team, along with development of educational programs designed to help board members gain the forward-looking, value-focused perspective they will need.

In its January 2012 outlook for U.S. nonprofit health care, Moody’s Investors Service cited strong management and governance as key assets to providers, with opportunities for those with strong governance and management teams to “outshine” others. In that same report, Moody’s also predicted that credit trends for nonprofit hospitals will remain negative “until the next wave of regulatory and business model changes are more established in coming years.” One thing is certain: Considering the scope and magnitude of the work to be done, time is short. Organizations that don’t use this transition period to prepare for the next wave of change risk being washed away by it.

Richard L. Clarke is president and CEO of the Healthcare Financial Management Association in Westchester, Ill.
What will the hospital of the future look like? That question was posed to American Hospital Association members recently to stimulate future thinking and to develop a clearer vision of where health care is headed and how hospitals can prepare and adapt. Size, configuration, workforce, reimbursement, and even the name “hospital” itself were considered in the feedback from members.

What emerged was a surprising consensus on key strategies and metrics that members consider essential as transformation moves forward. The “Hospitals and Health Care Systems of the Future” report, developed by the AHA’s Performance Improvement Committee, includes 10 must-do strategies coupled with metrics of change that are seen as essential in the future state. The report is not a prescription for hospital health nor does it set a timetable for change. Rather, it is a broad look at the strategic planning, measurement and metrics as well as organizational competencies that will be needed to succeed as transformation proceeds.

The first four strategies are considered top priorities for hospitals:

• Physician alignment — getting in sync with doctors whose current incentives and view of the world may be very different from that of hospitals — is considered essential. A spectrum of alignment strategies may range from simply engaging greater physician leadership all the way to sharing financial risk in an accountable care organization or capitated contract. Engaging physicians as partners in the journey ahead is a top priority.

• Information systems that are intuitive, adaptable, and connect doctors to patients, colleagues and hospitals are viewed as fundamental to the hospital’s future. Systems that facilitate excellent and efficient care but do not add to health care’s complexity will form the e-network required to succeed.

• Quality and safety programs that grow in depth and strength to benefit the patient as well as the bottom line are a fundamental strategic priority. Saving patients from harm also brings savings in health care spending essential under global payments.

• Improving efficiency through productivity and financial management will require greater creativity than ever before as reimbursement shifts from a fee-based to a value-based system. The aging workforce, the demands of new technology and pressures on costs will create challenges that must be met to succeed.

Going from the current state to a future state requires new thinking and change, but how do you know when you have arrived? Performance metrics were developed to assist in measuring progress. The move from counting admissions to tracking the number of covered lives in risk contracts is an example of a changing metric. Examining expense per episode of care rather than expense per discharge is another example.

When an athlete shifts from one sport to another, different muscles are needed. Training and hard work develop new strengths to compete and win. Similarly, new competencies are required for leaders and staff to succeed in the future. Organizational core competencies of accountable governance and leadership, strategic planning in an unstable environment, and both internal and external collaboration are examples of those that must be mastered.

Change is rarely easy but often necessary for good health and a better future. America’s hospitals are well on their way to creating an even stronger value-driven health care system for patients and payers alike.

Jeanette G. Clough is president and CEO of Mount Auburn Hospital in Cambridge, Mass.
Creating new sources of capital will be both a challenge and an opportunity for health systems as they manage the transition from today’s health care delivery models to the health systems of the future. Nonprofit health systems’ traditional sources of capital, including balance sheet reserves, cash flow from operations, philanthropy and debt, may not be sufficient for what is required for the future state. Ultimately, health systems of the future will achieve success by managing the health and wellness of a population — very different from managing the care and treatment of sickness and disease. As the health care industry evolves from a place where revenues are based on the volume of admissions, visits and procedures to one of bundled payments, performance sharing and, ultimately, capitated payments for the health of a population, the characteristics of those health systems that are successful will change from what we know today.

These characteristics or “success factors” of health systems of the future will include organizations with sufficient size to achieve economies of scale in all their operations. These organizations will be fully integrated with all care providers and health providers overseeing a community or population so that comprehensive and coordinated oversight can be managed effectively by deploying the right resources in the appropriate setting. Their culture will be one in which leading quality and service outcomes is the primary focus. Sophisticated information technology capabilities with high adoption rates throughout the organization and beyond to the community and health populations will enable these systems to operate efficiently and effectively. These system operations will be restructured to improve processes and allocate resources in a highly efficient way, resulting in an efficient cost structure. These health systems will need progressive governance and management oversight.

Managing the transition to achieve these “success factors” will require careful utilization and deployment of capital resources. As the health care delivery industry continues to undergo significant change, one major concern in deploying capital is making certain that expenditures do not result in “captured capital.” One example is building a new hospital when the industry trend is to provide care in homes and non-hospital settings. The more significant challenge for many, and perhaps all, health systems today is that there may not be sufficient capital resources within health systems themselves to achieve these new “success factors.” The capital resource challenge is particularly true for nonprofit health systems. Conversely, there is significant capital available and being deployed by for-profit health care companies, both publicly traded and privately owned, principally funded by private-equity firms.

As nonprofit health systems pursue developing and implementing those critical success factors, they increasingly will turn to partnering and joint venturing with for-profit companies as a source for capital and, yes, perhaps even operating competencies. There are numerous examples of progressive health systems having already partnered with for-profit companies to grow businesses to achieve greater scale and market essentiality. This has and is being done in the hospital business sector and the ambulatory surgical sector. There are likely opportunities in many other business sectors that nonprofit health systems currently operate. The challenge is to evaluate each of these businesses critically to identify those opportunities.

As health systems manage the transition to position themselves for the future, boards and management teams will need even more out-of-the-box thinking to creatively enhance their capital resources and operating competencies.

Frederick A. Hessler is managing director, Citigroup Global Markets Inc., in New York City.
The necessity of transformational change within the health care sector is now a matter of general consensus, regardless of whether elements of the 2010 reform legislation are repealed. While our nation continues to be the world’s gold standard for health care quality, the health status of our population continues to be unacceptably low compared with peer nations. We have unacceptable disparities in coverage, and our costs per capita continue to rise, stifling our struggling economy and resulting in 17 percent of our gross national product and climbing.

Norton Healthcare has committed to a change agenda and believes putting the patient first is the best way to prepare our organization for financial success and stability and to serve our community. In 2009, Norton Healthcare and Humana began working with the Brookings-Dartmouth Accountable Care Organization pilot. The intent of initial participants was to explore new payment methodologies to bend the cost curve for health care. This journey was built on the strengths of our organization and tied strongly to our historical transparency with clinical quality and safety metrics, a focus on performance measurement, physician alignment, expanding health information technology infrastructure and advancing new models for the continuum of care.

Our initial focus included the employees of Norton Healthcare and Humana. The goal was not to transform our organization into an ACO, but to enable greater accountability for care. Norton Healthcare and Humana spent many months working through the legal and data requirements to establish benchmarks for improvement and identify areas for success. Norton and Humana signed a letter of intent in August 2010 and began benchmark measurements.

This experience toward accountable care has not been without challenges. Each of us provides patient care in unique environments with multiple financial and competitive pressures. Establishing alignment among physicians, hospitals and patients to improve care requires significant resources and relationships. As we approach the second year of our participation in the pilot, we have seen improvement in clinical quality indicators and slowed the progression of growth in health care costs for our attributed population.

The lessons learned are what makes the journey worthwhile. We found that the transformation to accountable care comes back to the basics:

**Information.** Each of our organizations is filled with data, but the true value comes from turning data into usable information for action.

**People.** The value of employees, patients and physicians to accept and manage change should not be underestimated.

**Partnerships.** Truly bending the cost curve will require modification to the current continuum of care. Future relationships require accountable and innovative partners to provide pre- and post-acute care.

The sum of these lessons will determine our future success. We believe a structure of accountability is an imperative for success, but also feel that changing methodologies to reimbursement structures will require an organization to be nimble and quickly adapt to change. It is a privilege to provide patient care and a responsibility to do so in a high-quality, cost-effective manner.

The health care field has never faced a more necessary or daunting requirement for transformational change. And we’ve never had such resources to facilitate those changes. Operating more efficiently under the current volume-based payment system while preparing for transition to a risk-based system will be our collective agenda for the remainder of this decade.

Steven Hester, M.D., is senior vice president and chief medical officer of Norton Healthcare in Louisville, Ky.
A new hospital is built. An ambulatory care facility is acquired. Your organization grows to include employed physicians and those in private practice in the community. Your health system or hospital network is growing, building new community relationships, and gaining patients. On the surface, it looks like a win-win situation.

In southeast Michigan, where the health care environment includes decreasing reimbursement from Medicare and Medicaid, increasing uninsured patients, complex compliance requirements and economic volatility, growth is both rewarding and challenging.

As Henry Ford Health System grew during the past decade, we were at times disjointed: new hospitals, employed and private physicians, competing interests and sometimes conflicting goals. And health care reform was knocking at our door.

To help stabilize and support the ongoing practice of value-based medicine, we needed to engage our 1,200-member Henry Ford Medical Group and our regional hospitals’ employed and private practice physicians in common goals and reward structures.

The result was the creation of the Henry Ford Physician Network, a coordinated system of care delivery that aligns HFMG physicians, regional hospital employed physicians, private practice physicians, hospitals and ancillary services around new initiatives for clinical integration and quality improvement efforts. Development of the HFPN lays the foundation for an accountable care organization that will enable us to enhance the quality of care throughout the community.

At the core of the HFPN is clinical integration, a model of collaboration among physicians in a defined network to improve quality and efficiency. Our first step in creating the HFPN was to engage physicians — both employed and private practice — in early program development discussions. From there, we launched private practice physician recruitment at three of our community hospitals, and then moved recruitment to other regional hospitals.

Other initial work included aligning the HFPN with business units and departments to develop quality measures and programs that will form the foundation of clinical integration. Similarly, the health system’s information technology team developed plans to deploy an electronic health record for use by HFPN and an ambulatory electronic medical record for private practice physicians.

To lead HFPN, we formed a board and work groups comprising predominantly HFMG physicians, regional hospital employed physicians and private practice physicians to direct the development of the network, services, quality measurements, referral management, accountability and incentive programs. The HFPN formally was incorporated as a new HFHS subsidiary in March 2010.

Thus far, we have nearly 1,900 members in the network, with more than 500 private physicians. The HFPN also allows HFMG physicians to collaborate with external physicians who want to enhance quality, efficiency and coordinated care delivery.

Through the new physician network, the HFMG is better aligned to create new clinical relationships, to engage in group contracting on a large geographic scale and scope, and to increase potential for greater reward and resources through earned incentives and value creation.

For us, this is the model of the future — true integration of all resources linked by physicians.

Robert G. Riney is president and COO of Henry Ford Health System in Detroit.
Our industry is now in its third year since the passage of the Affordable Care Act and, as leaders we are making choices — indeed, massive bets — that can create a renaissance, albeit through a period of painful transformation. Smart health systems are seeking the transformational edge vis-à-vis the competition in the evolving consumer-centric environment.

At Trinity Health, we are betting that we will be paid for value in a variety of methods from bundled payment to shared-risk contracting and global capitation. As such, we understand that we are moving toward large-scale, multistate engagement in the health insurance exchange marketplace, where consumers will demand transparency in price, quality and safety. We think clinical integration will be the foundation needed to meet those demands.

Trinity Health understands that the turbulence during this period of transformation requires clarity of direction and preparation for anticipated changes. Through careful and purposeful planning, we are able to create our destiny by leveraging 12 years of experience with a multistate, single-platform, HIT infrastructure. We predicted that our $1 billion comprehensive IT infrastructure would be a critical building block for any call for systemic change.

Today, it is a completely integrated, data rich system that undergirds our move to stem-to-stern clinical integration.

We view clinical integration as the construct that positions Trinity Health and its partners for success as accountable care organizations committed to population health management as a primary deliverable to promote value for consumers.

Our first step toward clinical integration was to create a strategic readiness assessment to determine the best way to align our national health system of 48 hospitals in 20 markets with more than 7,000 networked employed physician and patient care professionals, and thousands of caregivers in the traditional models of affiliation and employment. The assessment, which included an evaluation of barriers to clinical integration and took local factors into account, affirmed that while all markets need a core foundational structure, each is unique and will have different approaches and rates of adoption.

Trinity Health is in the process of clinically integrating our networks, covering the spectrum from physician employment to various economic affiliations. And we are now building market-specific networks that rely on continuums of care.

As with every tectonic shift, much is written about managing process, structure and culture. The most powerful and clearly articulated documentation of a work plan for this transformational era is the AHA’s, “Hospitals and Health Care Systems of the Future.” This playbook spares today’s leaders from having to invent a de novo planning model or repeat mistakes from the past.

Undoubtedly, this is a defining moment in which winners will engage in transformation strategies by 2014 and have a completely operational model in all markets by 2019, when the ACA is fully in place. At Trinity Health, we are choosing to navigate carefully the challenges of the “Seven Cs” — culture, consolidation, consistency, coordination, cost, collaboration and consumerism. We understand that clinical integration does not work without successfully managing these challenges. Our end goal is clear: to provide better and safer care at a price consistent with the demands of the marketplace, enabling us to fulfill our mission of service to our communities.

Joseph R. Swedish is president and CEO of Trinity Health in Novi, Mich.
We are excited to be hosting the 13th Annual Non-Profit Health Care Investor Conference this year. The conference brings leading health care service providers together with capital market participants to address major topics at the forefront of the health care industry. Given the market volatility over the past few years, changing investor needs, the ongoing implementation of health care reform and uncertainty surrounding its impact on health care delivery, this year’s conference comes at an important time for connecting health systems with the capital markets.

This year, our theme is “Managing the Transition; Positioning for the Future.” Our goal is to gain greater insight into the key strategies health systems are implementing to ensure success and sustainability in the evolving health care environment. We hope to learn how health systems are:

• Envisioning the operating model of the future
• Managing the transition from today’s structures to tomorrow’s model
• Preparing for the anticipated shift from volume- to value-based care
• Establishing operational and financial goals for the transition
• Aligning with payers, physicians, financial sponsors and others

The American Hospital Association, Healthcare Financial Management Association and Citi all are committed to providing a forum for health care systems and investors to exchange ideas and insights, and to fostering greater understanding of key issues. We look forward to continuing our collective dialogue.

We, along with Hospitals & Health Networks, hope that you find these materials beneficial.

Sincerely,

Frederick A. Hessler
Managing Director and Health Care Group Head
Citigroup Global Markets Inc.
Citi strives to be a leader and partner in assessing the ever-changing health care industry environment, addressing today’s challenges and developing solutions for the future.