

Executive Dialogue

High-Value Health Care

Achieving Success and Demonstrating Results



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High-Value Health Care

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As the transformation of the nation's health system begins to take shape, hospitals and health systems will find themselves more accountable for patient outcomes, patient experience, the cost of care and population health. To be successful, organizations will need to demonstrate their value to their patients and the communities they serve. Hospitals and health systems across the country continue the challenging work of improving quality of care while also reducing costs. Transformational initiatives are yielding results — better outcomes, greater patient engagement and satisfaction and significant cost savings. Health Forum convened a panel of hospital executives and industry experts Oct. 2 in Chicago to discuss the delivery of high-value health care, particularly the changes in infrastructure and care delivery necessary to do that. Health Forum would like to thank all of the participants for the open and candid discussion, as well as VHA Inc. for sponsoring this event.



MODERATOR (Bob Kehoe, Health Forum): Our discussion today is about demonstrating high-value health care. How do you define it within your organizations?

TODD LINDEN (Grinnell [Iowa] Regional Medical Center): In a community the size of Grinnell, it quite simply comes down to running into the patients we serve in the grocery store, at the



ballpark and at church. High value is being able to look people in the eyes and know that we met their needs and improved their quality of life. It's very personal when you're in a town of 10,000. That's what we're about. We provide competent care in a way that's personal and safe and affordable.

JULIE MANAS (Sacred Heart Hospital): We define it as perfect care, which means we did the right thing for the patient at every encounter. We view statistics at the individual patient level to see if we met every one of their needs. Did they have an infection? Did they have a fall? Did we meet all of the core measures for that patient at that particular time? Was the length of stay average or less than average? Unfortunately, it's not always

perfect. But looking at the data this closely will help us get there. It leads to greater transparency. It's not about what we did wrong, it's learning how to do things right and not making the same mistakes again.

VIC BUZACHERO (Scripps Health): At Scripps, we've gone through multiple iterations of trying to define what this means. To us, it means that we spend more time talking about the patients and their expectations. It's humbling when you begin to base every decision around patient expectations. It still boils down to the basic perspective of cost related to outcomes. People do look at the cost perspective today. It's a challenge for us as an industry as we try to meet that. We are moving toward a zero defect system because that's what patients expect and deserve. The health care system has too much variation in care and outcomes and we're concentrating on eliminating that variation.

PEGGY NAAS, M.D. (VHA Inc.): As Vic stated, it's about achieving great outcomes at a lower cost. It's providing the level of care that we would hope to receive. It's providing top-quality care with excellent service without waste and inefficiency.

DAVID FOX (Advocate Good Samaritan Hospital): At Advocate Health Care, we like to say that we are first and foremost a safe enterprise. When we talk about value, we talk about delivering safe care that follows evidence-based, best practices. It's about delivering care in a compassionate and caring way for the patient and family members. And, of course, it's increasingly about delivering care that's affordable. Historically, we've looked at the value equation as doing the best job we can in the provider organization, the hospital or the medical clinic. But, of course, we're moving to a world of value where we will judge our success by being able to improve outcomes at more affordable cost for care across the continuum.

MODERATOR: How do you maintain a focus on high-value health care while at the same time trying to cut 20 to 30 percent in costs within your organizations?

MANAS: From a value-based perspective, we need to do what is right for the patient but reimbursement hasn't quite caught up with that. We're trying to be more patient-focused and make

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decisions that are in the best interest of the patient and not necessarily in the best interest financially. It will take some time for the reimbursement system to catch up and, until then, it will be difficult to run a hospital or health system.

FOX: Advocate Health Care is focused on accountable care and value. In 2011, for example, we formed an accountable care organization with Blue Cross Blue Shield of Illinois. Our challenge is that we are still largely reimbursed in a fee-for-service world. As Julie said, we're moving to a world of value and the reimbursement systems haven't caught up with us yet. We still make money the old-fashioned way, which is providing appropriate volumes of services. We're right in the middle there, and it's a very challenging transition.

MODERATOR: David, how is Advocate dealing with the cost issue right now and getting the cost out of the system?

FOX: There are many different ways to get cost out of the system. One is to improve the performance of the current delivery model, managing productivity more effectively. We are also beginning to take cost out of the system by reducing what we refer to as "avoidable care," including 30-day readmission rates. Thirty-day readmission rates have come down substantially in the last two years. We're reducing avoidable emergency department visits by getting our physicians to improve accessibility to their offices, for instance.

We've seen a reduction in our average daily census in my hospital by about 15 percent in the last two years, largely caused by our focus on providing better outpatient care. We've had to shrink our inpatient workforce as we build a larger outpatient workforce because that is where we want to be able to take care of patients.

NAAS: Organizations are coming up with creative ways to deliver care and lower costs. Prevention efforts are keeping people out of the hospital. And we're seeing more procedures move out of the inpatient setting into ambulatory care.

BUZACHERO: We're not sure that reimbursement will ever catch up with the shift toward population health. Most organizations, regardless of what type of system they are in, still operate in silos. To address this, we flipped the organization on its side a few years ago. We created a

horizontal co-management model to identify and eliminate variation. Over the last 36 months, we've identified more than \$200 million in duplicate or excess costs in such areas as physician preference items, supplies and equipment. We've combined our education and orientation efforts across our hospitals to streamline processes and reduce costs. We've set a goal to reduce expenses by another \$100 million over the next 12 months. We've achieved greater productivity and we've done that without layoffs. We have a philosophy of no layoffs; we use a series of processes to redeploy people within the organization. It's interesting because our employee base is actually increasing while our inpatient base is decreasing dramatically. We're doing such things as deploying patient navigators or case managers to help manage patient care in the appropriate setting. Another area of focus for us is clinical variation. We are focusing on Lean principles. It's something we've done before, but it never really took hold in our culture. Our success so far has been significant and it has allowed us to price differently in the marketplace. We're only a fraction of the way there, however. There's still a lot more for us to do.

MODERATOR: As you continue to progress, Vic, do you feel as though you'll truly reduce cost or just bend the curve a little bit?

BUZACHERO: We're not trying to bend the curve. We look at a cost-reduction from the prior year, and take inflation into account. When we look at labor costs per adjusted discharge, we're looking at year-over-year improvement and reduction. We think that's the only way we can go, unfortunately. But we're not seeing inflation built into either Medicare reimbursement or commercial reimbursement.

LINDEN: As an industry, our biggest challenge is that health care is not affordable. Individuals can't afford it, states can't afford it and the federal government can't afford it. We've got to change the way we deliver care. For us, our challenge has been that we're too big to be a critical access hospital, but we're not big enough to be a rural referral center. We have some of the worst Medicare reimbursement in the country. For our survival, we've had to dramatically reduce costs.

We look for ways to partner with physicians and other providers in our community. We have a committee that we refer to as our \$500,000



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Todd Linden

committee, that includes nine physicians and advanced practice clinicians, and their goal is to identify things within their purview that could save the institution a half-million dollars. Another thing we're doing — and it's been mentioned here already — is focusing on keeping people well. We opened a fitness center about 15 years ago. It doesn't make a lot of money, but it is a positive for the organization. A banker once advised that we close it since it isn't a great moneymaker,

saying it was counterintuitive to keep people well and out of the hospital. I explained the value to our employees by promoting wellness and the benefits of a healthy community. We also embrace integrative therapies. We have a massage therapist who performs chair massages to pre-op patients. It reduces anxiety. Our anesthesiologists say they use less anesthetic. Our surgeons say their patients experience less pain. It makes sense to look at how we're delivering

Panelists

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Transparency is key. We have to be willing to share and admit that we haven't lived up to expectations.

Julie Manas

care to reduce costs and improve outcomes. It's doing what's best for our patients.

MODERATOR: What quality benchmarks are most important to your organizations today?

FOX: We use several large databases and benchmarks at Advocate Health Care. For example, we look closely at risk-adjusted mortality rates and complication rates. We then look within the data for areas where the mortality rate or complication rate may be higher than expected. We also participate in databases like the National Surgical Quality Improvement Program that allows us to compare against about 300 health systems around the country on a procedure-by-procedure basis. Our overall surgical mortality is good. However, we have identified areas in which we have significant opportunities for improvement.

LINDEN: It's really a healthy balance with other benchmarking organizations between competition and collaboration. We are all here to make a difference in peoples' lives. As a rural organization, we believe that people deserve to access as good of care in our community as they would elsewhere. There are clearly some services that we don't provide. But for the things that we do, we want to do it as well or better than the largest health systems in the country.

MANAS: Transparency is key. We have to be willing to share and admit that we haven't lived up to expectations. Ten years ago, if I were to announce that we could go three months without a ventilator-associated pneumonia, no one would have believed me. But once you go a month to two months and beyond without an incident, that's when you realize you can make the type of improvements that patients deserve.

BUZACHERO: Transparency is a high-leverage point for us, particularly with our board. Every board meeting starts with a look at our quality indicators and a patient's story. The quality committee meets as frequently as our finance committee. That was not the case 10 years ago. We are looking at ways to concentrate on the most important, useful benchmarks because, frankly, the sheer volume of benchmarks creates a great deal of administrative burden. As an industry, we haven't identified the vital few metrics that we're confident in, so we have a tendency to collect way more than may be necessary. Our infrastructure

needs to be more about improvement and about the patient and not about reporting. And we've been building the reporting capability more than we've been building the patient capability.

NAAS: There's so much more that we can do today because of the metrics. When we work with our members on cost-reduction opportunities, we look for opportunities where there's excessive spending that doesn't add value. We're able to do that today because of the wealth of data. We didn't have that capacity five years ago.

LINDEN: There's no perfect system. I think we've at least gotten over the hump now where we're not constantly shooting down the data. There's a paradigm shift where people start to recognize they may not be perfect and that the data are necessary for improvement.

BUZACHERO: We've recently been looking at one of our provider groups and when you look at the data as a whole, the group is performing very well. But when you begin to drill down to individual providers, it creates a unique situation. The data show that most of the providers are performing at a high level while one provider is off the charts in the other direction. So it really is to the point of how we use that data for that physician. We can show him the cost per month on emergency department visits, for example. David, if I recall, Advocate has been doing this for some time.

FOX: Advocate began the process in 2004 with a clinical integration pay-for-performance program. We provide physician-specific information on the cost and quality of care and on adherence to evidence-based practice. Physicians are scientists. If you give them data that show their performance relative to their peers, they will make improvements.

MODERATOR: Let's switch gears a little bit. We've talked about the focus on quality and data but are we missing opportunities along the way?

MANAS: What we're missing — and I don't know if it's universal — is really looking at the entire care continuum. A person may only be a patient in our health system for a few days out of a given year. The rest of the time, he or she is out in the community or in a nursing home or other care setting. We need greater care coordination and

the ability to look at patients' needs from a longitudinal perspective.

FOX: When I look at the cost equation, I actually look at it on several different levels. There's managing down the cost per unit of care. For example, cost per adjusted discharge at my hospital has been coming down over the last several years. To make a breakthrough improvement in the cost of delivering care, we have to move into the realm of clinical transformation. We have to design more effective ways of treating patients in the hospital. We not only need to bend the cost curve, we need to break it. To do this, we have to focus our attention on the patients who consume the greatest amount of health care. We know that about 10 percent of the population consumes about 60 percent of health care. These people have multiple chronic conditions. One of the things we need to do to make health care more affordable is to bring new resources and new structures to this 10 percent.

NAAS: That's true. But another missed opportunity is the use of predictive analytics to identify the segment of the population before it becomes part of the 10 percent. If we can identify them and keep them well, then we are providing high-value care and cutting costs.

BUZACHERO: That's an excellent point. When we talk about benchmarking, we are talking about what our current practices are doing and how we can make them better. Our current practice largely was designed for us and our physicians and is largely a sick-care system. We have to develop a system that is more patient-focused. That system will allow us to identify individuals before they become part of the 10 percent.

LINDEN: Ultimately, that's the plan. We've got to engage folks. If there's a disappointment for me in the Affordable Care Act, it's that it has no personal responsibility built into it at all. It's one thing to know who that 10 percent is, it's another thing to engage them in a way that they want to improve their health or take advantage of opportunities that we provide. We're at a point where we can start to individualize care and engage folks in a way that they've never wanted to be engaged. We'll see. If we're going to make huge improvements in reducing cost and improving the outcomes of quality, it's going to be through greater patient engagement.

We often hear stories from patients who may not care about their health, but a father cares about walking his daughter down the aisle. As providers, we need to embrace their goals and know how those goals impact their health. We are essentially in the quality-of-life business. We have to make the transition of helping people recognize that our institutions are beacons of health, and not just a place for them when they're sick or injured.

MODERATOR: How do physicians fit into this whole equation and are you partnering with them to make some of these things happen?

MANAS: Again, it's about information-sharing. We've talked already about the importance of transparency. We're also forming co-management agreements so that they are really at the table with us. Employing physicians has been a model for some of the hospitals within our system, but not all. Employment doesn't necessarily equal alignment. The focus on how to take care of patients does create alignment.

BUZACHERO: Years ago, our CEO formed the physician leadership cabinet. It does not have formal authority, but its informal authority is probably far greater than some of our formal committees. Every decision of the organization is laid on the table with those physicians and we've taken 100 percent of their recommendations. It has built a great deal of trust among our physicians and we've made a great deal of progress.

LINDEN: We're doing an experiment right now with a self-funded health plan. We have partnered directly with physicians who have employment relationships with us, and we have plenty of private practice in our community as well. All of those providers take care of our employees and their dependents. And, yet, legally, we can't come together and sit down and identify the 5 or 10 percent of patients that may be at risk for health care complications. We've created a simple, clinically integrated network so that we can legally sit down and begin to work around how we improve care and reduce cost. We're going to learn a great deal from this process. I've had the good fortune to be at my institution for almost 20 years and it's largely because I work with a fantastic board and a fantastic medical staff. I just can't leave.

FOX: We're all in the relationship business. We're



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Peggy Naas, M.D.

building lifelong relationships with our patients, certainly. And we're all trying to attract a highly competent workforce. One of the most important relationships is with our doctors. My personal belief is that a hospital or health system cannot be successful if the physicians are not professionally successful, even economically successful. At Advocate, we've created a company half-owned by doctors and the hospitals, through which we run all of our managed care contracts and our clinical integration incentives. We've got doctors and executives sitting around the table deciding how we're going to advance health among our insured populations. It's been an incredibly powerful tool for moving the ball forward.

NAAS: The relationship certainly has evolved and is continuing to evolve. Hospitals have worked, and will continue to work, on physician relations. It's no longer just about physicians on staff. Now organizations have to partner with the physicians who never come to the hospital.

MODERATOR: What are some of the remaining barriers to attaining clinical integration? What are some of the challenges with which organizations are dealing?

MANAS: For us, it's lack of clinically integrated information. There are many different systems out there and they don't talk to one another so there's no singular place to access patient information. In our health system, we have two different clinically integrated networks and many of our independent physicians don't have electronic health records. There is no true continuum of care record yet.

LINDEN: Incentives still aren't fully aligned. Financially there are a lot of challenges. We're clearly headed toward better alignment, but such challenges as clinical integration will continue for some time.

MODERATOR: Let's talk some more about IT. How are you leveraging IT and data in your efforts to improve quality and demonstrate high-value health care?

MANAS: I've been through many different EHR iterations in the various organizations that I've worked for and there's no perfect system. Right now, our health system is implementing an integrated computerized provider order entry

system. However, we have a different product on the outpatient side and I'm not certain that the systems will talk to each other well enough. That's the next evolution: for all of us to have better integration of the information across the entire continuum. Forget the nursing homes and home care. That's a whole different animal that needs to be pulled into it as well.

FOX: By the end of the year, all of the physicians in our physician-hospital organization will have to have an office-based EHR, and it has to be an improved platform. We have two platforms within Advocate. We're now building the connections and we're also building some of the decision-support capabilities. Physicians no longer can practice at Advocate Good Samaritan without CPOE, without electronic physician progress notes. This initiative actually was led by our physician colleagues who thought it was a great idea. And, yet, we have so far to go. Soon we'll have connected all the pieces in the system, but then it's implementing the analytics and figuring out how to use the data and information to actually inform our timely engagement with patients.

MODERATOR: Do you believe you'll meet that goal of getting them on board by the end of this year?

FOX: Actually, if a physician practice makes a decision not to acquire the EHR, it will be resigning from the PHO. Very few doctors have said they don't want to embrace the EHR. What's happening, though, because of this requirement for doctors to purchase an EHR, is that we're seeing more interest from our doctors to be employed by the hospital. If we're going to make them buy an EHR that costs \$50,000 to \$60,000 per doctor, maybe it's time for them to join our employed physician group and let us pay for it, which we're happy to do.

BUZACHERO: We also have a combination of EHRs for our inpatient and outpatient settings and pretty much have that nailed. But as we move through CPOE and ICD-10, along with various stages of meaningful use, it is having a significant impact on workflow.

We are spending a great deal of time understanding the type of system that will be necessary for population health. We've looked at what some organizations are doing across the country. And, of course, many of the payers are beginning to emerge with their own solutions.

Key Findings



The delivery of high-value health care depends upon strong physician alignment. More than ever, organizations will have to forge relationships with physicians across the continuum of care.



Hospitals and health systems must partner with payers and employers to truly transform the care delivery system.



Consumers are demanding, and will continue to demand, high-quality care at reasonable cost.

On the third level is this whole wireless aspect of personal devices. We're fortunate to have Eric Topol, M.D., in our organization, who is a pioneer in this area. We also happen to be in the same cul-de-sac as Qualcomm and are working with them on a project with our self-insured employee health plan. We are piloting a program that gives free personal digital assistants to patients with certain chronic conditions. We are monitoring such things as diabetic compliance and congestive heart failure. We are exploring whether we should be using these devices for self-management. How should these devices work? What will patients actually value if given such a device? We think that's going to have a significant impact on eventual care design and the data that are available.

MODERATOR: Todd, you are in a rural setting. Are the challenges particularly unique there?

LINDEN: We're an independent hospital, but we joined the Mercy Health Network four years ago. IT was one of the primary reasons for this move. When we looked at the cost of data mining that will be necessary for value-based care, it made sense to join the network. It's much more affordable for us to tap into their network compared with doing it on our own. Many rural organizations are looking to system relationships, especially for IT support.

MODERATOR: What about dealing with physicians? Is there a way to leverage IT and gain compliance among physicians?

NAAS: I'll tell what I understand from the physician perspective. There are shared opportunities and revenue coming back from the PHO because of the capacity to deliver high-value care. Clearly, for organizations to deliver the economic rewards, there has to be data integration. It can't be done without it.

FOX: As we move into the era of population health management, we believe that EHRs between physician offices and hospitals are a critical success factor. That being said, making these systems work more intuitively is a challenge.

NAAS: We should talk about the price per physician, whether they're employed or aligned with you, for ICD-10. I've seen figures as high as \$60,000 to convert from ICD-9 to ICD-10 for a simple pediatric practice. Are you seeing a wave

of physicians approaching you about helping them with that?

MANAS: In our community, physicians are not as aware of the ramifications of ICD-10 as we'd like for them to be. When we first approached them about it, there was a reaction of surprise. We have to explain that the transition to ICD-10 not only impacts the hospital, it's going to impact them as well in their private practices. We're developing shared educational modules so physicians who practice within our 13 hospitals will have the same kind of information customized to their practice — whether they're pediatricians or orthopedic surgeons.

MODERATOR: How are you using data to align with physicians on this issue to eliminate or reduce unneeded care?

NAAS: The Choosing Wisely initiative of the ABIM Foundation provides assistance in this area. The initiative comprises numerous physician specialty groups and explores how physicians and patients can have conversations about the appropriate level of care.

BUZACHERO: We've reviewed Choosing Wisely and found some of it irrelevant to our population and some areas that are meaningful for our community. We have begun working with our physicians in those areas. Another thing we are doing is working to help our physicians determine which patients they really need to see. To some degree, this gets at their economic well-being. We are exploring opportunities of doing things differently, such as using a telemedicine type of approach where the patient does not go to the physician's office. Our hope is to avoid unnecessary ED visits and unnecessary physician office visits. It's a patient-focused approach that provides patients with reassurance because they have spoken with a physician and the physician gets a nominal fee — about \$5 — for the visit.

NAAS: One person's waste is another person's margin. So how does that ripple through the system? If we keep patients out of the ED, we have to repurpose ED nurses because there are fewer patients. If a patient visits a retail clinic, how will we make sure that information isn't lost? That's a big challenge.

MANAS: As hospitals turn toward the hospitalist



To make a breakthrough improvement in the cost of delivering care, we have to move into the realm of clinical transformation.

David Fox

model, the role of the primary care physician will change. The hospitalist can focus on managing the hospital stay, driving out variation and sharing information with the primary care physician. The primary care physician no longer needs to visit patients in the hospital and can focus more time on patient visits and providing same-day visits. It's an evolution for hospitals and physicians, but it is for the better.

FOX: This is a delicate matter because health care providers don't intentionally practice inefficient medicine. It is important to note that it's not just providers tackling this issue. Employers are directing their employees through the growth of defined contribution health plans. Employers offer a set amount and allow employees to shop for coverage from a menu of plans. In the future, perhaps, they'll select plans from the exchange. One of the effects of this is that more patients are questioning the costs of our services. There's also a big market for nontraditional health care companies. Walmart is now one of the largest providers of durable medical equipment in the United States. There are many things that are going to push us to be more price-sensitive. Consumers are going to get a better deal. Regardless of what happens with the Affordable Care Act, the employer community no longer will continue to pay what it's paying and will channel people to be more cost-effective with their care.

BUZACHERO: That's right. One of the things we are seeing is that many of the larger- and mid-sized employers are opening on-site clinics, and they're going past the point of just having a physician extender. They are adding imaging capability, for example. And there are organizations emerging to help large employers do that. I think this shift is going to be for the better, actually. Employers can help influence their employees to make better decisions.

But what does this mean for hospitals? Hospitals have so much more knowledge about how to care for the total population versus just a single incident of care. We are beginning to deploy care navigation teams to follow patients through an entire episode of care. It has reduced length of stay and improved quality.

MODERATOR: One of the big issues in regard to managing cost and improving value has been the move to bundled payments. How far along are your organizations with bundled payment? Are

you involved in any projects?

FOX: We are moving to full-risk capitation and are studying bundled payment. We are apprehensive about the formula for determining who gets what. We think there is a role for bundled payment and it probably will be easier to do with an employed physician workforce than with independent physicians. We have figured out how to share the savings with our accountable care strategy, but we haven't figured it out for bundled payments.

MANAS: We're in the infancy stages of bundled payment, too. It's about shared risk, but the challenge is getting the physicians to agree and figuring out a fair method of who gets what. Another challenge is determining the real driver of the cost or the efficiency. That's not easy.

NAAS: We're seeing a tremendous amount of activity, reluctance and fear among the orthopedic community around bundled payments. How do you divide between the delivery of services and the delivery of services saved? The folks that are eliminating costs think they should be rewarded for their efforts. Dividing the pie is a huge challenge. But the federal government and payers are moving in that direction.

LINDEN: It's a big question and certainly a huge one for the critical access hospital community. There's a big disconnect between where most of health care is going and how the nation's smallest hospitals are paid. My colleagues running critical access hospitals are concerned about losing subsidized payments that are necessary for them to maintain access for their communities. At the same time, they're scratching their heads over how to fit in bundled payment.

We have to move toward a different payment structure for rural health care. If Americans value access in rural America, then there needs to be at least some kind of an access subsidy and it should be based on the need to maintain accessibility. And, of course, rural organizations will compete on cost and quality, along with everybody else. And then we can begin to be part of the unfolding delivery system. That's one of the biggest challenges for rural organizations today. How do we deal with the accessibility issue and the payment structure that right now doesn't incentivize any efficiency?

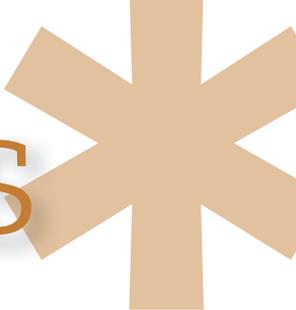
MODERATOR: What kind of partnering is going to



We are spending a great deal of time understanding the type of system that will be necessary for population health.

Vic Buzachero

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be needed with the payer community to get some of the data you need to reach the performance measures that payers want to see these days?

MANAS: Payers have a wealth of data. They know what their members are doing across the continuum. We have a snapshot of what's going on in our hospital and health system. The ability to partner with payers and share data is important.

BUZACHERO: Their approach in contracting heretofore has been to hold data close to the vest and use it to tier us as an industry and drive patients where they feel they can get the best value. That has to change to move to a different model.

NAAS: Some of our members have provider-owned health plans and it is interesting to see how they have been able to leverage that double vision. It provides clarity around the continuum of care, how they are controlling the flow of care and cost comparisons, as well as outcome comparisons per unit of payment and where care is being received. Some members now are leveraging that capability to provide those services to other provider organizations that do not have health plans.

FOX: Our partnership with Blue Cross for our ACO model is rather new, and it's an evolving model. We're now nearing the end of the third year. We've developed a close partnership but it's been difficult to get data translated into information. Blue Cross has struggled but made great strides, and we've struggled and made great strides. An advantage that we have at Advocate is having such good coverage in the Chicago market, so it makes sense for Blue Cross to work with us.

NAAS: In deference to the employers who are providing coverage, many would ask who's paying for this? Many health care organizations are following the premium dollar and working directly with employers.

FOX: Well, it's one of our benefit offerings in Advocate. We now have an Advocate-only health plan for our employees. It's a cheaper plan than our HMO and our PPO products. We've had such success with the Advocate-only plan that employers have come to us to ask if we could create something similar for them.

LINDEN: That's clearly our plan as well. That's why we're using our own health plan as a model;

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we then can share our experience with other self-insured employers in our community. We can highlight our partnerships with other organizations that provide services that we do not. It makes sense for employers and providers to work together, and it makes sense for payers to be at the table if they are willing to open their books and bring the value.

I am biased, but it doesn't make sense to me that in my small community, the prices of benefits go up for the employers every year, and the payment to us goes down every year. Where's that money going? As we work to improve the delivery system and bring down costs, it's the payers that will benefit. Hospitals and health systems need to either find people willing to partner with us to change the system in a way that benefits patients, or we need to do it ourselves.

MODERATOR: And you're comfortable with the risk side of this equation?

LINDEN: Absolutely not. But, again, that's not been our core competency in the past.

FOX: We view accountable care as a transition vehicle to full risk. And it does frighten us, because to take full risk, particularly for a Medicare population, is huge. We've spent the last three years working to build the infrastructure that gives us a chance to be successful in a full-risk environment. And we still have a ways to go.

BUZACHERO: There are relationships that have emerged in which some payers have worked with providers to help. That type of relationship can be advantageous to both parties. *

Thanks

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