Hospitals and health systems strive to deliver and demonstrate high-value care. As health care delivery becomes more complex, serving patients with complex needs while maintaining a system that is both affordable and accessible to the community will remain a challenge. This executive dialogue brings together hospital and health system leaders at the forefront of addressing these challenges to discuss their approaches.
LARRY KAISER, M.D. (Temple University Health System): The main concern for us is what’s going on in Washington right now. If the Medicaid program is cut back, as has been proposed, it would have a significant impact. We’re talking about huge numbers of people who currently have insurance who would no longer be insured. We’re very concerned about what’s going on. We’re focused on controlling our costs, but our costs keep going up. Year over year, we see an increase in our costs simply because of inflation, and we are doing our best to try and control those costs.

MODERATOR: Given these uncertainties and challenges in D.C., how do we still continue to do the important work that organizations are doing and need to continue doing? What kinds of partners do we look to for help?

SCOTT MALANEY (Blanchard Valley Health System): As a member of the AHA Task Force on Variation in Health Care Spending, it was hard to ignore the fact that about one-third of the care delivered in the U.S. is unexplained variation. And the other thing that is relevant to this is that the U.S. just surpassed $20 trillion in debt. The harsh reality is that we no longer can afford the promises we’ve made to Americans around health care. There are many venture capitalists poised to develop methods to take care of people in ways that doctors and hospitals aren’t nimble enough to do right now. Pretty soon our country will get used to the idea that we’re not going to favor access over cost and quality. At Blanchard...
Valley Health System, we’re working to reduce unnecessary variation. Our admission rates are pretty low. We’ve found some clever ways to take care of people outside the hospital walls. It’s a real challenge on the reimbursement side, but that’s what we are trying to do.

**JANICE NEVIN, M.D. (Christiana Care Health System):** I wake up every day uncertain about what will happen next. We are focused on driving quality, driving high reliability. That’s more important than ever.

In most states, employee health costs are a strain on the budget. In Delaware, the state insures about 120,000 people through the state employee insurance program and another 250,000 through the Medicaid program. We see a greater need to partner at the state level. In July, we entered into a partnership with Aetna and Nemours/Alfred I. duPont Hospital for Children as part of a consumer-directed plan for state employees, pensioners and their dependents. It’s an innovative care delivery model, essentially an HMO with Aetna that’s being managed by a population health management tool that we’ve developed called Carelink CareNow. And we are at risk — if we don’t manage the health care costs of this group of about 30,000 employees and their dependents, we will be writing a check to the state. For us, it’s our first foray into downside risk. We’re not putting the whole place at risk; we can identify the dollar amount at risk and be cautious about it. It gives us an opportunity to learn how to deliver care differently. And it gives the state an opportunity to say, ‘Hey, you can do some things differently and it will create value.’ What’s been interesting is the employees. Our tool allows us to get data in real time. We’re not waiting for claims data. At the end of the month, we know if anyone is using the emergency department too frequently. And our team has identified three women with high-risk pregnancies who we can’t find. They are literally going out and trying to track them down. It’s a drastically different way of delivering care.

Another thing that we’ve done is a partnership among four health systems called eBright Health. We’re looking at how to take cost out of the health care delivery system. For example, we now have one tissue plasminogen activator (tPA) provider, and a preferred primary benefits management provider for all of our employees and are saving about $35 million over three years. It’s really all about value, providing the high-quality, safe care. People are blown away that hospitals across the state are actually trying to figure out how to work together.
MODERATOR: Going back to the topic of variation, is everyone using Lean principles? Are there particular approaches to high reliability?

BRIAN DONLEY, M.D. (Cleveland Clinic): Going back to Scott’s comment about balancing outcomes vs. variation, I don’t see these as competing priorities. The better the quality of care we deliver, the more our cost goes down. We’ve worked hard to drive out variation in multiple ways in our organization. The partners who have helped us the most are actually our caregivers. We’ve worked with our caregivers and our patients to help design how care should look. We can get rid of all of the unnecessary aspects. We have about 130 care paths for different diseases. And we have about 3,500 employed physicians and another 1,500 aligned physicians. Our aligned physicians are critical to our success, so they have to be part of the design. We have seen quality improvement with all of our different care paths. Take stroke, for example. When we started the care path, we had a mortality rate of 21 percent, which is about the national average. Our mortality rate is now 12 percent and the cost was reduced 24 percent. Our care paths have improved quality and decreased cost. We have to take more ownership, responsibility and accountability.

STEVE CORWIN, M.D. (New York-Presbyterian): This may sound heretical, but I don’t believe we can get enough cost out by virtue of all these things we’re doing in terms of outcome and quality. If you look at all the accountable care organization experiments, they took out relatively small amounts of money from the system. We should continue to do it, but I don’t see that kind of money coming out in terms of quality. The biggest impact on cost will come from reducing utilization and taking a hard look at the cost of care. At my organization, 60 percent of the cost of care is in labor. With the ACO experiences you’re talking about, even the best of them, you’re talking about relatively small amounts of money.

KAISER: Let’s not forget the issue of diversity. We live in a diverse country. If you want to find where costs are the highest for care, look toward the poorest communities. You can deliver the highest-quality care in these communities, but you will still have the highest costs. It’s been shown time and again. We can certainly decrease costs with improved quality, but the question is whether we can decrease costs enough. And the fact is, if you want to reduce health care costs in the U.S., you have to reduce poverty.

We are focused on driving quality, driving high reliability. That’s more important than ever.

Janice Nevin, M.D.
Getting back to Steve’s comments, we are never going to be able to get enough cost out of the system through quality alone. I think of the steam engine. Prior to the steam engine, the focus was about how to get more work out of one individual. How can they become stronger and work more hours? I think we’re in the steam engine and our steam engine is going to be machine learning and artificial intelligence. It’s going to completely redefine care and that’s where we’re going to take tremendous costs out of the system. It’s going to be a care model that none of us can even imagine.

KAISER: We’re going to get disrupted, there’s no question about it. But, we’re already seeing that. Take Smart Choice MRI, for example. Anyone can walk in and get an MRI for $600. You don’t need an appointment and you can walk out with your disk and the films are read by Cleveland Clinic radiologists. Think about that. Depending on the deductible, and many are extremely high, why would anyone not make that choice?

NEVIN: One issue is, of course, is whether the patient needs an MRI in the first place. There was a piece in Health Affairs that looked at Virginia’s All Payer Claims Database that found that low-cost, low-value tests are driving unnecessary health care spending. Patients can get a cheaper MRI, but many didn’t need it in the first place. To me, that’s one of our biggest challenges. How do we engage clinicians in not doing some things that they have done as a matter of course for decades.

KAISER: That’s a tough problem.

DONLEY: In all honesty, the providers have played a part in this, too.

PENNY WHEELER, M.D. (Allina Health): We have to recognize when things don’t need to be done, when things are not going to improve patient outcomes. How do we tackle utilization? The fastest payer segment in the country right now is the individual payer. We are going to face disruption and more companies trying to enter into the health care revenue stream. I think there will be a disruptive force that plays a role in this.

KAISER: I wish I could tell you that we are educating the next generation of physicians to be able to make better decisions but, as dean of a medical school, I can tell you we’re not. They’re a different group entering medical school these days and they have different priorities. But I don’t think that we are targeting education in a way that they’ll be able to make these kinds of decisions. That’s a pessimistic view, and we are certainly looking at how we can do that better.

CORWIN: We are taking some cost out of the equation by using telemedicine, and we are venturing into artificial intelligence and machine learning. We’ve invested in a company that uses a machine learning...
we provide urgent care via telemedicine and we can increase the productivity of our ED physicians. Our physicians really like telemedicine. They love separating themselves from the ED to do it. And the next generation of physicians will be open to practicing differently.

A great deal of end-of-life care can occur virtually, and can be conducted in a personal, meaningful way. We’ve seen an increase in patient and family satisfaction through this program. Length of inpatient stay has decreased and ED visits have declined.

MODERATOR: Yes, the intersection of the generational shift and technology. The next generation will be more open to different types of practice.

MALANEY: We all know the story. The cost of advanced serious illness and dying in this country can be unbelievably high and for what value? We see families being torn apart and patients with 14 tubes in them and they are completely unaware. I’ve talked to our senators and representatives in Ohio and no one will broach the issue. It’s too polarizing.

BHATT: How do we make it easier?

MALANEY: La Crosse, Wis., has one of the best models for end-of-life care in the country. The efforts to improve end-of-life planning and decision-making have cut costs and ensured that individual wishes are followed. We can all learn from that model.

WHEELER: I think Scott has a key point regarding advanced serious illness and end-of-life care. We have a program now that we’ve done after rigorous research that actually has nonclinically trained people going into homes and deciding what matters most. It can also happen virtually.
MODERATOR: The hospital-at-home model, too, can enhance for advanced illness. And there is a payment structure around this model. Patients can have conversations about their goals for care and spend their last days of life at home instead of in the hospital.

NEVIN: That’s frustrating, because there are so many great ideas that people have tested and that have demonstrated to create value — and they end because there’s no payment mechanism. We keep having the wrong conversations because it’s about insurance premiums and politics. The conversation should be about how we take solutions like that and spread them and find a way for them to be sustainable.

CORWIN: We’ve decided to pay for virtual care and just take a hit on the margin. If we wait for the reimbursement mechanism, we’re not going to catch up. So, whether it’s virtual care, palliative care, chronic care visits, we’ve made the physicians whole on it so that it’s revenue neutral to them. It’s the only way to really get costs down.

Another challenge in health care is that we’re the only industry in which the cost of technology keeps going up. The only area in which the cost of technology is going down is sequencing the genome. Everybody else is better, cheaper, faster. And we’re getting better, faster and more expensive. That’s a problem for us.

TOM KEARNEY (Siemens Healthineers): It’s not just the life cycle of the machines, right? It is managing your investment in the technology to make sure you get the return on investment.

DONLEY: Getting back to Steve’s comment, that’s an important decision, deciding to go forward without the reimbursement mechanism in place. We need more of that, looking at the long-term gain. History will tell you in every industry that the organizations that make the long-term gain or the long-term plan will always win. We talk frequently about the retail industry and retail provides great examples of this. Best Buy Co. and J.C. Penney Co. are struggling. Neither digitized and then Amazon.com Inc. comes along. Amazon stock is up 2000 percent over the past 10 years. I love that decision that it makes no sense right now to do it, but we’re going to do it.

NEVIN: The problem is that it’s not possible for all hospitals and health systems to take that stand. Small, rural hospitals will not be able to shoulder the lack of revenue. What is the small, rural hospital to do?

DONLEY: You have to have scale.

NEVIN: Exactly.

MALANEY: It can be a challenge for large, urban hospitals as well.

NEVIN: Agreed. Not everyone is positioned to do that.
MODERATOR: We’ve talked some about the challenges, and some of you actually had solutions on the table and decisions that you might make to address cost, but what would you say are resources that would be helpful? Some were saying standardization is innovation, to reduce variability, to innovate care, to move toward standardized care pathways as well. But in terms of resources and support, what would be helpful?

DONLEY: Before we get to all of the great resources and come up with all of these great ideas, we have to drive culture. If the culture isn’t in place, whatever we try will fail. We can come up with the greatest ideas and innovations, but if we’re not, as leaders, driving the culture within the organization, we won’t accomplish anything.

MODERATOR: Culture eats strategy, which is then eaten by infrastructure, if you don’t have the right infrastructure to support it.

CORWIN: I couldn’t agree with you more. And it goes beyond what is happening within our organizations. About 60 percent of our employees are minorities, and they are impacted by what they are hearing recently on the news. It’s corrosive to the culture of our society. We need to reiterate that we’re multicultural, tolerant and able to work with each other to help build culture. We have populations within our organization who are very concerned about what’s going on and we have to make them feel supported.

DONLEY: For us, it’s been extremely important to engage all 53,000 employees. We try to listen to everyone — our physicians, nurses, the entire team. Every caregiver has the opportunity to share their thoughts. We try to listen to the voice of people, which helps to drive their readiness for change. We don’t always have to look externally for innovation. There are solutions we can find internally, and they drive that readiness for change.

Internal teams always will give us great incremental improvement, rarely breakthrough innovation. And we need break-through innovation...
Executive Insights: Delivery System Transformation

through innovation. We do listen and heed our employees’ recommendations. It does drive quality improvement. We do understand that, to your point, we’ll drive quality better. But we will also look externally for partnerships to help drive breakthrough innovation.

{ partnerships }

MODERATOR: There are many ways to partner to improve care. Take, for example, the use of dietitians. Many organizations staff them in the hospital or in the clinic. What if we moved them to the grocery store in your community? They could meet with patients there and then teach them how to shop and cook. That could provide a great benefit to patients and families.

WHEELER: If we don’t have the cultural alignment, then we don’t have the fertilized soil to even think about these novel approaches to care. Getting clinical and

We’ve found some clever ways to take care of people outside the hospital walls.

Scott Malaney

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operational alignment is essential, and then you need to look at the infrastructure needs. We’ve made big investments in integrated data technology and how to pull that together. We had 57 databases that had to be integrated so we would be able to show our providers what’s happening. What outcomes at what cost? We formed a creative partnership with an organization called Health Catalyst to get that information into the provider’s hands. And they find it incredibly liberating that, with a push of a button, they can get information to drive it. When you put the tools in the hands of the caregivers, the tools they need to improve care, there’s a lot of engagement that starts to occur.

KEARNEY: As vendors, we’re managing the cultural change, as well. We’re integrating our sales and services employees to ensure when representing the company, they are listening to the customer and providing the right solutions at the right time. Getting the team to start to appreciate and look at what the solution is, where and what it should be is driving us internally. To get people to be more thoughtful — not just selling any technology, but whatever is appropriate. Is it the right one? And do our customers really need it?

DONLEY: That’s great. It’s important to know that we’ll never come up with a solution and the resources to do this on our own. It’s going to take partnerships between providers and vendors to solve some of our challenges. We’ve talked some about machine learning today. We all know that’s the right answer. But we’re never, as an $8.5 billion organization with a $3 million to $4 million operating margin, going to be able to figure this out with the resources we have. It’s going to take partnerships across industries. In the past, there hasn’t been a lot of trust, but we need to focus on what’s best for the patient, what’s best for health care providers.

ADAM ARLAN (Siemens Healthineers): I second what Tom said about cultural change and what we’re trying to do within our organization. We’re looking at how we can assist provider organizations. What services and solutions do we provide? And what services and solutions should we be providing? We think companies like ours can help — whether it’s through machine learning or making sure that the services provided are necessary, getting back to Janice’s earlier reference to MRRs.

What kind of tools do we provide to help determine whether or not a test is needed? How do we get further upstream on the care pathways and how do we develop and measure the value that comes out of that? There’s a greater role that we can play. We can provide data and help with those decisions to become the trusted partner for our customers.

MALANEY: I’m curious what everyone feels about the role of artificial intelligence? From my perspective, it’s disquiet-
In light of regulatory uncertainty, hospitals and health systems are exploring a range of innovative solutions to ensure the delivery of the right care at the right place at the right time.

Hospitals and health systems are continuing their efforts to enhance efficiency and control costs, although they continue to face numerous external challenges, including rising labor and drug prices and administrative expenses for regulatory compliance.

Cultural alignment is an essential component of care transformation, providing all employees an opportunity to provide input, as well as to assess employee readiness.

DONLEY: I’ll give a quick answer. I think it’s actually comforting to think about it and see it being helpful. From a physician’s standpoint and a nurse’s standpoint, AI can take on some tasks and allow the caregivers to focus on direct patient care. It goes back to why they chose their professions. If we’re going to be relevant going forward, we have to continue to preserve time for the expression of empathy that occurs between a physician or nurse and a patient. I’m excited for us to get deeper into this and give that time back to our physicians.

DONLEY: We’re going to survive. We’re going to get through these challenging times. It’s going to be brutal. I always say, ‘We’re coming into the biggest storm we’ve ever seen but, boy, on the other side, there’s a really nice island over there.’ It’s going to take strong leadership to get us there.

CORWIN: We’ve tried to look at it from the standpoint of specific-use-cases, as opposed to artificial intelligence replacing the need for physicians tomorrow. We see it across the entire span of things we do. We’re using machine learning — artificial intelligence — as a tool to predict length of stay. We’re using AI around the echocardiogram solution that I mentioned earlier.
Q: Siemens Healthineers is often viewed as being primarily a diagnostic company or medical device company. How has Siemens transformed its portfolio over the past few years to support health care providers in the new market reality of consolidation and the move to value-based health care?

A: At Siemens Healthineers, we are partnering with health care provider organizations to deliver high-quality, affordable patient care. We hear from our partner organizations the challenges they are facing as they transition to value-based care. As they take on greater financial risks, we’re able to help harness the large quantities of patient data to help organizations look at the entire cost of care across the continuum. Big Data enables health care providers to assess their outcomes and operations to help identify where investments are best spent and to take unnecessary costs out of the system. On the imaging and diagnostic-side, we are working with our provider partners to help deliver fast, accurate results to improve patient outcomes, while also reducing costs. Our focus goes beyond the department or service-line level. We’re helping to standardize procedures to enhance efficiency and improve workflow so clinicians can focus on direct patient care.

Q: Information is the new currency of value in health care. How does Siemens support health care institutions in this new currency and enable them to utilize their data more effectively to ultimately make outcomes better and cost of care lower?

A: First and foremost, our diagnostic and medical devices create patient information to help assist in the diagnosis, monitoring and management of disease. We aggregate and analyze data from our customers to create benchmark data to help provide an understanding of their performance. But we also provide a more longitudinal look at clinical, financial and operational performance. Customers have turned to us for help to make better use of data. We are an information company, and can support organizations’ population health initiatives by helping identify and understand the health of populations and identify individuals in need of early interventions. By doing so, organizations are able to reduce the overall costs of care while also improving outcomes.

Q: Transitioning to a full risk-based model or population health model is a big undertaking for health care organizations. How can Siemens Healthineers support an organization through this transition and help tier this process? Where is the best place to start?

A: Risk-based arrangements focus on the long-term view, moving beyond episodes of care to overall health quality outcomes. It’s essential for health care organizations to understand their costs of delivering care and their performance. Through Big Data, organizations can evaluate their practices and benchmark within and against other organizations to determine what’s working and what areas need improvement. Through evidence-based practices, organizations can ensure the right care is provided to the right patient at the right time and in the right manner. This will ensure the best patient outcome and eliminate unnecessary treatment costs. You can deliver really great care and break the bank, but if you spend too much you won’t receive the right outcomes. We help organizations analyze data — putting it in greater clinical, financial and operational context — so organizations can make better decisions around value-based care.

Q: What are some of the new business models that Siemens is offering to work with institutions in the transition to value-based care?

A: In addition to data analytics, we are working with organizations to optimize their laboratory and imaging services. We offer laboratory and imaging management solutions to help streamline operations and enhance workflow. We can help maximize utilization to increase clinical capacity and drive better outcomes. It can also support enhanced patient engagement, and ultimately improve patient and provider satisfaction. This is a different business model for us, but it’s helping fill a need for our customer base.
**Siemens Healthineers** is committed to becoming the trusted partner of health care providers worldwide, enabling them to improve patient outcomes while reducing costs. Driven by our long legacy of engineering excellence and our pioneering approach to developing the latest advancements, we are a global leader in medical imaging, laboratory diagnostics, clinical information technology and services.