Leading Transformational Changes

Report from the SHSMD 2016 Thought Leader Forum

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About the Society for Healthcare Strategy & Market Development

The Society for Healthcare Strategy & Market Development (SHSMD), a professional membership group of the American Hospital Association, is the largest and most prominent voice and resource for healthcare strategists, planners, marketers, and communications and public relations professionals nationwide. SHSMD is committed to helping its members meet the future with greater knowledge and opportunity as their organizations work to improve health status and quality of life in their communities. For more information, visit www.shsmd.org.

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Kaufman Hall provides management consulting services, benchmark data and analytics, and enterprise performance management software that help healthcare providers sustain success in a changing environment. Since 1985, Kaufman Hall has been a trusted advisor to boards and executive management teams, enabling them on a self-sufficient basis to incorporate proven methods into their strategic planning and financial management processes, and to quantify the financial impact of their plans to consistently achieve their goals. Learn more at www.kaufmanhall.com.
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Foreword

The Society for Healthcare Strategy & Market Development held the fifth Thought Leader Forum at its 2016 annual conference in Chicago on “Leading Transformational Change.” The following panel of professionals in healthcare strategy, planning, and business development were invited to share their perspectives: Christopher O’Connor, executive vice president and chief operating officer at Yale New Haven Health; Jeffrey Kraut, executive vice president of strategy and analytics at Northwell Health, and associate dean of strategy at Hofstra Northwell School of Medicine; and Lee B. Sacks, M.D., executive vice president and chief medical officer at Advocate Health Care, and chief executive officer at Advocate Physician Partners.

The forum, which featured a high degree of audience participation, covered a wide range of topics, including:

+ Establishing a strategic framework in a rapidly changing healthcare environment
+ Developing an internal innovation capability
+ The implications of the Medicare Access and CHIP Reauthorization Act (MACRA)
+ The use of partnerships to position organizations for success
+ Perspectives on healthcare’s future landscape

This report summarizes the panelists’ comments on pertinent strategic and financial considerations facing healthcare leaders nationwide, and their responses to specific inquiries during a question-and-answer session with attendees about what leaders are doing to prepare their organizations for healthcare’s uncertain future.

The forum was moderated by Ryan Gish, managing director of Kaufman, Hall & Associates, LLC.
HEALTH SYSTEMS NATIONWIDE ARE LOOKING TO BUILD SCALE AND ENHANCE CAPABILITIES FOR VALUE-BASED CARE AND POPULATION HEALTH MANAGEMENT.

Yale New Haven Health

Connecticut’s largest health system, Yale New Haven Health, has developed a strategic framework centered on: scale, cost, care delivery, and clinical redesign. The health system is investing in strategies to enhance clinical outcomes, and to reduce its acute care business through providing community-based care. The organization has launched multiple physician-led clinical redesign projects, including one that significantly lowered the average length of stay for patients with sickle cell disease through improvements in care standards.

The Medicare Access and CHIP Reauthorization Act (MACRA) is a game changer. Large physician groups are better equipped to meet the new requirements due to greater resources. Yale New Haven is investing in information technology and other infrastructure. The key to helping physicians meet the requirements of the new law is to reduce their administrative burdens through such investments, allowing them to focus on treating patients.

Northwell Health

Previously known as the North Shore-LIJ Health System, Northwell Health includes 21 hospitals, more than 450 patient facilities and physician practices, and the Hofstra Northwell School of Medicine. Northwell Health is redefining the hospital of the future through several initiatives, such as creating Manhattan’s first free-standing emergency department, restructuring its inpatient facilities, and creating a clinically integrated regional ambulatory care network.

The organization has a clear purpose in building scale. Northwell’s growth will continue through innovative, strategic alliances with regional providers. Examples include Northwell’s participation in the Cleveland Clinic Cardiovascular Specialty Network and commercial development of its innovations through Northwell Ventures.

Northwell’s leadership seeks to invest in and reward innovation through development of an equity investment fund, and prizes to encourage ideas from employees. The organization has been a pioneer in bioelectric medicine. One of its companies developed an implant to control inflammation associated with rheumatoid arthritis that has proven successful in initial clinical trials. Another product, the Healthflix app, provides patients with personalized discharge information to improve compliance with physician orders. Hofstra Medical School has implemented innovations in its curriculum. All first-year medical students, for example, become licensed EMTs to gain early hands-on patient experience in the community and patient homes.
Organizations that will succeed are those that build scale by evaluating what existing services may be better provided by outside strategic partners, and that are proactive in embracing innovation.

Advocate Health Care

Illinois’ largest health system, Advocate Health Care, encompasses more than 400 care sites. Its 2020 Strategic Framework—originally developed in 2008—is reviewed annually and focuses on: patient, physician, and employee experience; ensuring that the organization remains financially sound; and enhancing care delivery toward a value-based paradigm. Advocate has disrupted the business model in its market in two ways by establishing its own exchange product and employee health plan. Advocate Health Care Network is becoming the dominant choice for the health system’s employees due to lower premiums and co-pays, and reducing overall care costs.

In a partnership with Walgreens to improve patient access, Advocate owns and operates 56 retail clinics inside Walgreens stores across the Chicago area. Conversely, Walgreens operates retail pharmacies at Advocate’s hospital campuses.

Keys to Success

Hospitals and health systems face tremendous challenges. According to the Thought Leader Forum panelists, organizations that will succeed are those that build scale by evaluating what existing services may be better provided by outside strategic partners, and that are proactive in embracing innovation to improve access, reduce costs, and enhance overall quality in healthcare.
Introduction

MODERATOR: Ryan Gish, Managing Director, Kaufman, Hall & Associates, LLC

Healthcare is in the midst of a radical transformation, and the rate of change is accelerating. This year’s Thought Leader Forum was an opportunity to engage in executive dialogue around the topic of change leadership with a panel of top executives whose organizations have recently undergone significant changes, such as care model transformation, unconventional affiliations, large-scale acquisition, new service strategy, and infrastructure or organizational changes. We will discuss how they executed and managed change; key lessons learned; and how culture, engagement, brand, and systems factored into the changes.

The following are excerpts from the 2016 Thought Leader Forum at SHSMD’s annual conference in Chicago.

ESTABLISHING A STRATEGIC FRAMEWORK FOR THE FUTURE: Yale New Haven Health

Christopher O’Connor, Executive Vice President and Chief Operating Officer, Yale New Haven Health

*Yale New Haven Health is the largest and most comprehensive health system in Connecticut, consisting of Bridgeport, Greenwich, and Yale New Haven hospitals, and Northeast Medical Group, a foundation of 600 employed physicians. Affiliated with the Yale School of Medicine, the academic health system is the state’s third largest employer, with more than 20,000 employees. Yale New Haven Hospital is ranked among “America’s Best Hospitals” by U.S. News & World Report in 11 of 16 specialties.*

Yale New Haven Health’s strategic framework for transformational change has three categories:

1. **SCALE:** Encompasses not just size in terms of facilities, but also how we operate and who we collaborate with.

2. **COST AND CARE DELIVERY:** Includes our labor and non-labor expenses, and benefit structures. We launched our cost and value initiative about five years ago. Our costs are high as an academic medical center because the research and teaching components require significant investments.
3. CLINICAL REDESIGN: Focuses on our transformational journey to a high-reliability organization with a progressive approach to providing care, reducing clinical variation, and reducing cost.

Physician alignment is critical across these categories, as physicians will be the catalysts for change and ultimately responsible for our success under a value-based model.

Connecticut lags behind many markets in mergers and acquisitions and network formation, but there has been a flurry of activity in the past two years. State officials are concerned that mergers and acquisitions could lead to higher costs. We need to help correct misconceptions that these affiliations adversely affect patients, efficiencies, and costs.

Our expansion has been very selective, based on our performance and our commitment as an academic medical center. Yale New Haven signed an affiliation agreement in July 2015 with Lawrence + Memorial Healthcare, a two-hospital network in eastern Connecticut and a major source of referrals. An executive order by the governor that put a moratorium on hospital transactions delayed the affiliation. State officials approved the agreement on September 8, 2016, following negotiations with the governor and the Connecticut Office of Health Care Access.

Funding for academic medicine is dwindling. Our future depends upon our ability to create a viable financial structure. We can drive down costs by having our specialists provide community-based, high-end tertiary and quaternary care so that patients don’t have to travel to New Haven. This is a more sustainable model, and was core to our affiliation with Lawrence + Memorial Healthcare.

Ryan Gish: The healthcare industry doesn’t have a revenue solution; there really is only a cost-reduction solution. Where do you see the greatest opportunities to reduce costs?

Christopher O’Connor: Connecticut remains largely fee-for-service, with few shared savings contracts and little interest in going full risk. Within that context, we’re investing in strategies that ultimately drive down our acute care business. Yale New Haven has embarked upon a Medicare Shared Savings Program within Northeast Medical Group, which is allowing us to:

+ Invest in patient-centered medical home structures
+ Put care coordinators in our large primary care offices
+ Frame the analytics and technology to support our clinicians
+ Prepare for the inevitable change to a value-based system

The organization does not own post-acute facilities, but is partnering with post-acute providers to reduce readmissions and decrease costs.
**Ryan Gish:** What is your approach for clinical redesign initiatives?

**Christopher O’Connor:** Our clinical redesign initiatives involve 90-day, physician-led projects. For example, a team of clinicians looked at our sickle cell patient outcomes, and pathways for disease management across two hospitals. They identified the desired metrics and which actions would be most effective. As a result, patient length of stay dropped from more than 12 days to 6–8 days.

In another example, materials management traditionally negotiated with hip and knee replacement suppliers on behalf of each hospital. We recruited a physician to lead our musculoskeletal program and take the supply discussion system-wide. Working with representatives from all of our hospitals, we selected two vendors. The effort established a framework for our supply partners, bringing significant cost reductions system-wide.

**Ryan Gish:** How is Yale New Haven preparing for MACRA?

**Christopher O’Connor:** MACRA is a game changer. Large physician groups will have the advantage as MACRA takes effect. Some smaller practices have approached us about partnering because they are concerned about having the necessary resources. Our scale puts us in a better position. We are investing in information technology and other infrastructure, and our physicians are confident we will have the resources to support the transition.

**DRIVING INNOVATION FOR CHANGE: Northwell Health**

**Jeffrey Kraut,** Executive Vice President of Strategy and Analytics, Northwell Health; and Associate Dean of Strategy, Hofstra Northwell School of Medicine

*Previously known as the North Shore-LIJ Health System, Northwell Health was founded in 1997 with the merger of North Shore Health System and LIJ Medical Center. The network includes 21 hospitals and more than 450 patient facilities and physician practices, including The Feinstein Institute for Medical Research. With more than 13,600 physicians and 61,000 employees, Northwell is the largest private employer in New York State. In 2011, Hofstra University and Northwell opened Hofstra Northwell School of Medicine, which has nearly 2,400 faculty members.*

Northwell Health’s differentiators are experience, reputation and brand, and overall organizational effectiveness to execute strategies. A description of each as components of our structural framework for transformation follows:

**+ EXPERIENCE:** We target key initiatives to enhance customer/patient experience. Price and quality metrics will be available and consistently measured. We aim to reduce our quality metrics from 100 to a few key indicators for greater clarity.
+ REPUTATION AND BRAND: Building the story of our brand is a major challenge. We changed our name to Northwell in January 2016 to stress wellness and our North Shore LIJ heritage. We want to move from a model that currently is focused on attracting illness to one that radiates health.

+ ORGANIZATIONAL EFFECTIVENESS: To look for value, cost pressures will be incessant. Enhancing our overall effectiveness includes removing fixed costs across the episode of care. We want to constantly assess how to eliminate costs while improving quality and patient safety.

We are transforming from hospital-centric to ambulatory-centric. We aim to have more beds at fewer hospitals, which will reduce costs. We are building centers of excellence, regionalizing services, and redefining the hospital of the future. In some areas, it may be a facility without beds, such as in Greenwich Village, where we’re opening a freestanding emergency room, ambulatory surgery center, and other services. In other areas, that entity may be a hospital with economic care delivery that is connected to regional care centers. Expanding ambulatory and post-acute care is absolutely critical, and allows us to diversify our revenue and enter new markets at less cost—but the competition is significant.

We are focused on building network scale through strategic alliances. Scale matters, but scale without “systemness” doesn’t work. Getting larger has to be done with a very productive purpose. Northwell will continue to grow through innovative, strategic alliances. Growth will not be just system-to-system, but product-to-product, such as our participation in the Cleveland Clinic Cardiovascular Specialty Network.

We also are looking at population health management and the ability to take on risk. In 2013, Northwell launched an insurance company, CareConnect. Although our market isn’t ready for value-based purchasing now, we anticipate that will change in the next 3–5 years.

To train future clinicians, Northwell started one of the newest medical schools in the U.S., and we have made innovative improvements to the traditional medical school curriculum. We also recently started a graduate school of nursing to train nurse practitioners and physician assistants. Northwell has invested heavily in its research enterprise, which is helping us optimize our assets, leading to new business ventures. We are commercializing our discoveries and creating revenue streams to support the health system.

“Expanding ambulatory and post-acute care is absolutely critical, and allows us to diversify our revenue and enter new markets at less cost–but the competition is significant.”
Chief Executive Officer Michael Dowling has been working hard to strategically focus our people on innovation. One of his first actions was to establish The Center for Learning and Innovation (CLI), which has grown to be the country’s largest corporate healthcare university. Through CLI, we conduct succession planning at all levels, including physician leadership, because we have to be clinically led and professionally managed.

Through the CLI, all of our managers receive training in Lean Six Sigma. These “improvement sciences” aim to enhance quality, and reduce waste, time, and total cost of care. The principles have been applied to supply chain management, excess inpatient days, ED wait times, and how we manage bed flow.

One initiative we are particularly proud of is reduction of sepsis mortalities. About 250,000 people die of sepsis every year in the U.S. Our team of representatives from the ED, ICU, and clinical research developed a uniform definition of sepsis, examined how we identify and diagnose patients who come into the ED with sepsis, and evaluated our treatment measures for those patients. As a result, we changed the triage criteria to ensure test results are flagged immediately. A sepsis diagnosis now triggers treatment standards that occur within the first three hours, including ensuring that we start fluids quickly. We reached our five-year goal of sepsis mortality reduction in just under two years; and The Joint Commission and the National Quality Forum awarded Northwell the 2014 John M. Eisenberg Award for Innovation in Patient Safety and Quality at the local level for reducing overall sepsis mortality by 50 percent across 10 acute-care hospitals.

Ryan Gish: How are you rewarding innovation and helping your people manage change?

Jeffrey Kraut: We need a culture of strategic thinking, not just a strategy. This requires having good data to inform clinical decision making, and ensuring that our people have the necessary skills. Systemness is critical. It encompasses the expectations of how we behave, and our cultural transformation. Any services that are not patient-touching or patient-facing are operated within our system-wide, shared service infrastructure. Innovation also is important to our cultural change. We want to invest in and reward innovation. At Northwell, there is no penalty for trying and failing. There's only a penalty if you fail to try. It all comes back to our people and our relationships with our physicians. We recognize individuals with leadership potential, and work to ensure they understand our goals.

Our most successful partnerships are ones with people who understand the benefits of joining a health system. They recognize the importance of having nimble governance to make decisions and respond quickly. This involves significant cultural change. In past years, the board grew as the system grew. At one point, we had 132 board members. Recently, 100 board members voluntarily moved to a Board of Overseers who remain engaged in community health at the regional level, and we now have about a 30-member fiduciary board.

“Systemness is critical. It encompasses the expectations of how we behave, and our cultural transformation.”
**Ryan Gish:** Tell us more about innovation within Northwell, including the structure and some initiatives in non-clinical areas.

**Jeffrey Kraut:** We want innovation to be part of our brand. Northwell Ventures is an equity investment fund for our organization and our partners. We seek innovation within the organization, nurture it, and invest in it. For example, we offered employees a $100,000 innovation challenge. The prize project involved using a 3-D printer to replicate patients’ existing tissue for replacement. Fostering innovation helps us expand our delivery system, defend our portfolio of services, and diversify our financial risk portfolio, which helps to strengthen our overall financial performance.

Another example is our research enterprise, The Feinstein Institute, where we are pioneering bioelectronic medicine, which uses implantable devices to help the body heal. SetPoint Medical, one company we invested in, developed a stimulator implant for the vagus nerve, which controls the anti-inflammatory response. Recently completed clinical trials using this device essentially cured individuals of rheumatoid arthritis. The innovation has been profiled in *Science* and in *Scientific American*. Microsoft and GlaxoSmithKline recently formed an alliance and are investing $700 million in bioelectronic medicine.

In another initiative, we teamed up with one of our neurosurgeons and hired an engineer with experience at Apple to form Healthflix. The company developed a mobile app, which provides patients with personalized discharge information, including a description of the treatment, medications prescribed, medical imaging, and a recording of the discharge discussion with the physician. The patient can share the information with caregivers. The Healthflix app has helped Northwell build patient loyalty, and we are looking to license this technology with other activities.

At our medical school, we reconceptualized the curriculum. Our first-year students become licensed EMTs in New York State in the first six weeks of school to help them gain early hands-on patient experience. Throughout medical school, they work as paid EMTs, staffing Northwell’s large ambulance and EMS service. This gives them valuable experience in the community, and helps them better understand what they’re learning in the classroom.

In summary, innovation is “baked into” everything we do. When something is broken we don’t fix it, we try to rethink it, renew it, reinvigorate it, and reinvent it—that’s very much part of our philosophy.
Lee B. Sacks, M.D., Executive Vice President and Chief Medical Officer, Advocate Health Care; and Chief Executive Officer, Advocate Physician Partners

Advocate Health Care is a faith-based, not-for-profit health system based in the Chicago area, with more than 35,000 associates, including 6,300 affiliated physicians. The state’s largest health system, Advocate encompasses more than 400 care sites and 12 acute-care hospitals, including the state’s largest integrated children’s health network.

Advocate Health Care’s 2020 Strategic Framework is reviewed annually with improvements focused in three areas:

1. THE ADVOCATE EXPERIENCE: Involves safety, quality, and service. We’re moving from physician-centric to patient-centric. We want to be the best place for patients to get their care, the best place for our associates to work, and the best place for physicians to practice.

2. FUNDING OUR FUTURE: Focuses on the system’s strategic growth, ensuring that it is financially sound, and that we maintain an adequate operating margin to reinvest in Advocate’s capital needs and future so that we can continue to serve our community.

3. ADVOCATE CARE: Focuses on achieving the Triple Aim and moving to a value-based paradigm through coordinated care across the continuum.

We began the 2020 effort in 2008 with the goal of taking small steps, but our efforts accelerated with the advent of the Affordable Care Act two years later. Our market’s characteristics drive our execution and focus. BlueCross BlueShield of Illinois is the dominant payer in the Chicago area, with 70–75 percent of the commercial market share. This helped to propel us toward a value-based model where we can better control insurance premiums for our employees.

In the ambulatory space, Advocate’s medical group has more than doubled the number of employed physicians in the past five years, and the health system has nearly 500 advanced practice clinicians. Additionally, 3,500 aligned physicians are part of our clinically integrated network. In the post-acute space, we have a robust home health company and are assessing our post-acute network, including possible partnerships. We have disrupted the traditional business model. To be successful going forward, we need to move patients away from the ED and the inpatient setting to ambulatory and post-acute care.
**Ryan Gish:** Tell us about Advocate’s employee health plan and why you opted to offer a product on the health insurance exchange.

**Dr. Lee Sacks:** Capitation has existed in the market since the early 1980s, and Advocate had 400,000 capitated lives at one point, so we have significant experience in that area.

When care is coordinated within our network, we get better outcomes at a lower cost. For about five years, we have had a benefit plan design that offers our employees options in a predominantly PPO model. The Advocate Health Care Network plan has the lowest payroll deduction, and care within our network requires only a 10 percent co-pay compared to a 50 percent co-pay for non-Advocate care.

The plan is becoming the dominant choice for associates, contributing to cost-of-care growth of only 1.6 percent from 2014 to 2015. We refer to it as a “high-performing network,” with high quality, great access, and a great experience at a lower total cost.

We have shown that we can bend the cost curve. We need to do that for every employer in this market.

Advocate’s exchange product was our first foray beyond our employee base into a high-performing network. We introduced a product that was 10 percent less expensive than the lowest BlueCross offering on the health insurance exchange. We’re not asking our physicians to take a 10 percent fee cut; we’re asking them to be good care coordinators and to reduce waste. If things go well, they will receive a bonus and ultimately do better than under fee-for-service arrangements.

**Ryan Gish:** Why did the organization move into Walgreens retail clinics?

**Dr. Lee Sacks:** To provide new access points, Advocate owns and operates 56 retail clinics inside Walgreens stores across the Chicago area. The clinics offer low-acuity care as an alternative to higher-cost ED care. These Advocate Clinics are part of Advocate Medical Group, using the same electronic health record and advanced practice nurses. In the first four months, more than 70 percent of patients had no prior relationship with Advocate, so that is a “win” for us.

The Walgreens initiative also has forced us to think more about being a retail-oriented care provider, thus helping the transition to a more patient-centric model. We aim to provide online connectivity with instant access and a seamless experience. As a health system, we are learning through the retail clinics how to use digital messaging to help individuals manage chronic disease.
Audience Questions and Answers

1. Could you comment on how you are helping physicians to manage the numerous demands on their practices and the associated change fatigue?

**Dr. Lee Sacks:** These are real issues. Our aligned physicians face compensation pressure, which threatens their ability to maintain small practices. We have helped them stay successful through our clinically integrated network.

MACRA is huge. If you’re not engaged in 2017, you will fall behind and the impact on your Medicare reimbursement may be significant. We have spent a lot of time and resources trying to understand the law and develop a plan to educate and support our physicians. The key is helping physicians to better serve patients with high-quality, safe care. We need to ensure that they are able to stay focused on doing what they went to medical school to do—taking care of patients. We can take off of their plates any responsibilities that don’t require an M.D.

**Christopher O’Connor:** Yale New Haven started a medical foundation of some 600 employed physicians about five years ago. The Yale School of Medicine has more than 1,000 faculty physicians. Building a cohesive group is challenging. Like many other large multi-specialty groups, we have grown through aggregation of smaller groups. Physicians have invested so much in creating their practices, and the regulatory changes are overwhelming. How we support doctors will be a differentiator. Ultimately, those systems that do it well will be the most successful.

**Jeffrey Kraut:** Change is pervasive and can cause fatigue at all levels. We have dedicated significant resources to “taking the hassle out of being a physician” for our 3,500-member employed physician group. Different doctors want different things. As we introduce new resources—such as a call center or infrastructure to support our MSO (management services organization)—we work with physician leaders because we want their buy-in. It can’t just come from the top down.

2. Where do you see post-acute care going?

**Jeffrey Kraut:** Post-acute care is foundational to our population health strategy. We have the state’s second largest home care company, and it is integrated into all of our value-based purchasing and population health efforts. We also are working with social service agencies to better address the challenges of high-cost patients. For example, Northwell has returned to offering physician house calls. We think the post-acute care opportunities for health systems will develop through many partnerships with community-based organizations.

New York has a Section 1115 Medicare waiver that incentivizes us to provide care in the nursing home or in the home under long-term managed care plans. This waiver is one of the factors that motivated us to invest in a graduate school of nursing to train nurse practitioners who—along with physician assistants and community health workers—are absolutely vital to moving care away from the hospital. In the future, we hope legislation will allow paramedics to provide care in the home or other settings.

3. Do you routinely reassess programs or service lines that you don’t have the bandwidth for, or that others might be able to do better?

**Jeffrey Kraut:** Historically in healthcare we’ve spent a lot of time building things and not as much time transferring or divesting things that don’t quite work, but we now have become more disciplined. For example, Northwell had two legacy early childhood intervention programs that we operated through our children’s hospital and some of our larger pediatric divisions. Approximately 200–300 personnel provided care to about 500 children, but the programs were losing money. With increasing Medicaid pressure, we approached the other large early childhood intervention program in our region about taking over our programs. We believed they could do a better job. We
gave them our contracts and leases, and supported their operating cash flow. We maintained everybody’s job and today have six schools providing services to more than 1,400 children, as well as operating community residences for autistic children and other developmentally impaired residents.

Dr. Lee Sacks: It is important to continually evaluate whether there are better options. In one initiative, we concluded that we weren’t effectively operating retail pharmacies on our hospital campuses. They provided convenience, but lost money. So we partnered with Walgreens, which now operates pharmacies on many of our campuses. We also have a long-standing partnership with Aurora Health Care for our laboratory services that has significantly reduced costs and improved service and quality.

Christopher O’Connor: We all need to look at any program or service that’s been commoditized and where our health systems add inherent costs. Urgent care, for example, involves significant cost. With a proliferation of urgent care facilities in our market, we are evaluating whether to run our centers as a stand-alone entity or find a partner that could be more competitive and operate them at lower costs. We need to constantly assess our paradigm, and whether partnerships or other models may make us more efficient.

4. With the transformative change in healthcare, what keeps you up at night with worry; and what do you think will offer providers tremendous opportunities?

Jeffrey Kraut: Could health systems ever see a day where they wouldn’t own a hospital? What would we do? Look at Uber. One of the country’s largest transportation companies doesn’t own a single car.

If you put four things together—Amazon’s digital experience, Walmart’s stores and supply chain network, Google’s integrated analytics, and the interaction and engagement of Facebook—you could radically transform healthcare. A day will soon arrive when somebody will figure out how to combine all of these capabilities and essentially come between legacy organizations and patients and physicians.

Christopher O’Connor: Tremendous challenges are ahead. Through incremental changes, we’re seeing a fundamental shift in our healthcare system. For example, we have been at the center of scrutiny around our payment structure. We are trying to explain the complexity of Medicare cost reports, why we use a charge master, and why we charge so much but get paid so little relative to the charge. The good news is that we are starting to question some of these things.

Our transparency initiative will significantly change how we operate. Academic medical centers are particularly vulnerable because Medicare is the only payer that actually funds teaching. The nation benefits tremendously from investments in academic medicine, yet such investment is very much under siege.

Dr. Lee Sacks: A recent Wall Street Journal article noted that, as of June 2016, healthcare consumed 18.3 percent of GDP. A chart showed that middle-class America has decreased spending in every segment of the economy since 2007, except healthcare, which went up 24 percent. The government already is paying for 50 percent of the care, and I bet everyone in the room would agree that the payment isn’t enough. At the same time, for every piece of our business that is profitable, someone is trying to take that away. It’s unsustainable. That is what keeps me up at night.
As healthcare changes, hospitals and health systems are caught in the parallel jaws of a vise, with one grip demanding that they build new capabilities for population health management, and the other grip exerting immense pressure to reduce costs and maximize efficiencies. Healthcare planners nationwide are struggling with how to ensure the viability of their organizations in an uncertain future, while continuing the critical work of serving their communities.

The results achieved to date are mixed. In a recent strategic planning survey conducted by SHSMD in collaboration with Kaufman Hall, planning executives from hospitals and health systems nationwide said they feel their plans are only moderately effective in addressing key drivers of change, such as payment pressures, advanced data analytics, consumerism, the shift to an ambulatory focus, regulatory challenges, hospital and health plan consolidation, non-traditional competition, and virtual care.

Many organizations are seeking more input and involvement from clinicians, middle management, consumers, and the community. In general, survey respondents said strategic plans remain heavily focused on financial performance and clinical quality. Other areas of strategic focus include physician alignment/network development, employee engagement, and building population health management capabilities. The survey suggests that capital resources are largely directed to information technology, new ambulatory facilities, and facility upgrades and maintenance. Some health systems are investing in acquisitions, joint ventures, partnerships, and network development, but the level of these investments is lower than in IT and facilities.

While planning executives broadly acknowledge the need for change and a desire to be more strategic, they remain uncertain about how and where to best direct those efforts. Increasingly focused on using enhanced scenario planning and setting more aggressive, broader goals, planners also are seeking better prioritization and alignment of tasks to ensure accountability and effective implementation.

Hospitals and health systems are threatened by innovative competitors that are changing how healthcare is delivered, yet a significant portion of resources continue to be devoted to building brick-and-mortar facilities. Current industry challenges are complex, with no clear, one-size-fits-all solution. Achieving the scale required to play a major role in delivering population health-focused services, for example, cannot be defined by a single number for revenue, aligned physicians, or covered lives. Local market dynamics, including hospital and physician consolidation, payer-provider collaboration, and new-entrant activity, have a significant impact, as does leadership’s ability to meet the Triple Aim goals.

Industry leaders—such as those included in this forum discussion—are rapidly working to build scale and drive innovation. Informed by in-depth assessment of organizational strengths and weaknesses, these leaders are pursuing strategies to optimize health system capabilities for success in the new healthcare era.
Considerations for Strategic Planners

Ensure physician engagement and alignment. Having the input and buy-in of physicians and other clinical leaders are critical, as they will be the catalysts for change and ultimately responsible for success under a value-based model.

Be proactive in addressing MACRA. Organizations that are not engaged in helping their physicians address the new requirements in 2017 will fall behind and may face significant decline in their Medicare reimbursement.

Pursue scale with “systemness.” Organizations should approach potential partnerships with a very productive purpose. Building scale is important, but growth for the sake of growth alone will not work.

Invest in and reward innovation. Numerous disruptive competitors threaten to siphon market share away from legacy providers. Hospitals and health systems must be nimble and enterprising in leading change.

Routinely assess the viability of existing services. Some services may be better provided at a lower cost by a partnering entity. Hospitals and health systems should examine any services that have become commoditized and where their operational structures add extra costs.
Jeffrey Kraut is the executive vice president for strategy and analytics at Northwell Health and associate dean for strategy for the Hofstra Northwell School of Medicine, one of the nation’s newest medical schools. He coordinates Northwell’s strategic planning and health policy activities, and development of its network of providers through mergers, acquisitions, or affiliated relationships. Mr. Kraut also is responsible for data governance, and organizing the next generation of business and clinical analytics throughout the health system.

Often recognized for his skills in health planning, policy, and analytics, Mr. Kraut serves as chair of the NYS Public Health and Health Planning Council (PHHPC). The PHHPC oversees public health, health planning, regulatory, and Certificate of Need activities in New York State. He focuses on enhancing the interoperability and sharing of health data through the development of regional health information organizations, and incubating innovation opportunities in pharma/biotech research and development environments. Mr. Kraut served as the founding chair of the Long Island Patient Information Exchange (LIPIX) and was instrumental in its merger with New York City counterpart, NYCLIX, to form Healthix—the largest regional health information organization in New York State.

Mr. Kraut is a board member of the American Hospital Association’s Society for Healthcare Strategy and Market Development, a fellow of the New York Academy of Medicine, and serves on the Standards Council of the Commission on Accreditation on Healthcare Management Education. He was the recipient of the 25th Anniversary Leadership Award of The New York State Society for Health Planning, an organization for which he is past president. Mr. Kraut also serves on various committees of the Healthcare Association of New York State, the Greater New York Hospital Association, and on the board of the Nassau-Suffolk Hospital Council.

Mr. Kraut is involved in regional economic development and community building activities as a board member of the Long Island Regional Planning Council, Sustainable Long Island, and The Brookville Center for Children’s Services. He is a health policy advisor to the Long Island Index and ERASE Racism.
Christopher O’Connor is the executive vice president and chief operating officer of the Yale New Haven Health System. His focus is on the continued development of shared system services and programs for the entire health system, including Northeast Medical Group, supply chain and corporate procurement, facilities and human resources, information technology, and shared clinical services.

Prior to this position, Mr. O’Connor was president and chief executive officer of the Saint Raphael Healthcare System and the Hospital of Saint Raphael, serving in that position until the successful affiliation with Yale New Haven Hospital in September 2012. Mr. O’Connor previously served as president of Caritas St. Elizabeth Medical Center, the 340-bed flagship of the six-hospital system affiliated with the Archdiocese of Boston and Tufts School of Medicine.

Mr. O’Connor served as vice president of clinical operations for the Ochsner Health System in New Orleans, which includes seven hospitals and more than 35 healthcare centers. He was the senior leader responsible for driving Ochsner’s response and operations during and after Hurricane Katrina—it was one of just three hospitals that remained functional.

Mr. O’Connor received both his master’s degree in health services administration and his bachelor’s degree in economics from George Washington University. He is a fellow of the American College of Healthcare Executives.

“Mr. O’Connor’s focus is on the continued development of shared system services and programs.”
Lee B. Sacks, M.D., assumed the role of executive vice president and chief medical officer at Advocate Health Care in 1997, with responsibilities for health outcomes, patient safety, information systems, managed care contracting, physician-hospital organization operations, research, medical education, risk management, and insurance. Since 1995, he has served as the founding chief executive officer of Advocate Health Partners (now d/b/a Advocate Physician Partners or APP), a clinically integrated network that includes more than 5,000 physicians. APP coordinates care for more than 850,000 attributable lives in commercial, Medicare, and Medicaid populations.

Dr. Sacks is a fellow of the Institute of Medicine in Chicago, and serves on the ACL Lab Operating Committee, a joint venture clinical laboratory between Advocate and Aurora Health Care. Prior to the merger that created Advocate in 1995, he served in a variety of executive roles at Lutheran General Health System. He practiced family medicine for 13 years in suburban Chicago. Dr. Sacks earned a bachelor’s degree in chemical engineering at the University of Pennsylvania. He received his medical degree from the University of Illinois College of Medicine, and completed a family practice residency at Lutheran General Hospital in Park Ridge, Illinois.

Dr. Sacks is responsible for health outcomes, patient safety, information systems, managed care contracting, physician–hospital organization operations, research, medical education, risk management, and insurance.