The accountable healthcare leader: Can a supply chain mindset lead the way to value-based healthcare?

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Abstract: Healthcare is undergoing unprecedented change as it transitions to a system that rewards the value, rather than the volume, of care delivered. The rules are changing, with new payment methodologies that levy stiff financial penalties on healthcare providers that fail to deliver quality care, along with incentives to improve efficiencies, care coordination and patient satisfaction. As the system changes, so, too, must the strategies and skill sets of those charged with leading their organisations through this disruptive conversion. The newly released final rule on Comprehensive Care for Joint Replacement Model provides insight into the changing nature of healthcare reform under bundled payment programmes and can be used to assess the kinds of leadership strategies and skills that will be needed to succeed in a value-based healthcare market. Hospital leaders will be measured on their ability to improve collaboration and coordination across internal functions and with outside partners whose financial and clinical performance will have a real impact on hospital reimbursement. This level of coordination will require investments in underlying technology and care coordination to link financial expenditures and process improvements with outcomes data. To achieve these fundamental objectives, healthcare executives can learn from essential traits of leaders in iconic firms outside of healthcare, from Tesla to Netflix, the application of design thinking and open innovation, and a supply chain mindset that organises care around the demand — the patient — in contrast to a more traditional supply-driven system that is focused primarily on hospitals and physicians.

KEYWORDS: leadership, innovation, collaboration, care coordination, bundled payments, comprehensive care for joint replacement, value-based healthcare, alternative payment methods

INTRODUCTION

The harsh reality for many leaders is that the strategies and skills sets that have served them well in the past will not necessarily do so in the future. This paper explores the changing nature of the healthcare leader, and the role a supply chain mindset can play in improving cost, quality and outcomes in the form of better reimbursements.[1]

The transition to value-based care is not limited to the US, with countries from Canada to China seeking to understand what drives better quality at a lower cost. For example, the German Government is studying the costs and benefits of different types of therapies to determine which deliver the best outcomes while introducing a series of discounts and surcharges to reward good care, not unlike the approach taken in the US. Also, similar to the response in the US, the changes being made are not always welcome. For example, some pharmaceutical manufacturers have chosen to exit the market in protest of new laws that limit their ability to set the long-term price of their products.[2] Healthcare leaders around the world face similar leadership challenges as they help their organisations navigate this sea change and overcome what have been rational individual behaviours based on policies of the past but now threaten system-wide improvement.[3]

WHAT IS DIFFERENT?

The most significant change in US healthcare is the movement away from fee-for-service revenue models towards those that will pay providers based on the their ability to provide better quality care in a more coordinated and less-expensive manner for the patients for whom they are accountable. Rather than making money by keeping hospital beds full, ordering more tests and/or performing more procedures, hospital executives in accountable care organisations (ACOs) could lose money by doing more. This is not substantially different from the managed care programmes that saw significant uptake in the 1980s and early 1990s as a way to curtail rising healthcare costs. The argument in favour of managed care, then and now, is that paying providers a fixed amount per patient creates an incentive to keep patients healthy and out of the hospital. The arguments against, which contributed to the American Medical Association proclaiming 'the death of managed care' in 2001,[4] stemmed from patients who were fearful they would be denied necessary care and physicians who were protective of their autonomy and opposed to spending more time on paperwork and less with patients. Right or wrong, many of those arguments persist today, despite evidence that managed care can lower healthcare spending without a corresponding decline in quality.[5]

If we revisit the fundamentals of managed care, they ring true for many of the objectives of healthcare reform, with a focus on more coordinated care, aligned incentives and a revenue model tied to the patient, not to what is or is not done to him or her. It stands to reason, if you can keep patients healthy such that they require less-expensive services, the providers and payers involved will make money, and arguably, the patient will be more satisfied.

Another critical component of the managed care approach is the need to match the patient with the right type of care (therapy, test, drug or device), in the right setting (inpatient, outpatient, home) and by the right level of clinician (specialist, primary care, nurse practitioner, etc.). This is contrary to today's 'supply-driven healthcare system', which is focused more on the volume of services provided by hospitals and physicians and the corresponding profitability than on what patients need and the outcomes achieved.[6] Optimising the care profile for the patient — what, where, when, who — is not unlike the process that supply chain leaders go through when

seeking to get the right product to the right place at the right time for the right patient in the hands of the right clinician and all at the right price. In other words, can a supply chain mindset help us redesign healthcare to achieve this level of accuracy and appropriateness?

An important difference in the approach to managed care under healthcare reform is the introduction of payment policies and methodologies designed to increase care coordination through more aligned incentives such as bundled payments. Managed care in the 1990s attempted this with capitated pricing, but capitation in most instances was limited to the services provided by the individual physician or provider. In other words, there were no real financial incentives for the various players, especially those who are not part of the same owned organisation, to work together to achieve care objectives at a lower overall cost. That is beginning to change.

COMPREHENSIVE CARE FOR JOINT REPLACEMENT: SETTING THE DIRECTION FOR EVOLVING LEADERS

The newly released final rule on Comprehensive Care for Joint Replacement Model (CJR) provides insight into the changing nature of healthcare reform under bundled payment programmes, which in turn can be used to assess the kinds of leadership strategies and skills that will be needed to succeed in a healthcare market increasingly subject to these kinds of initiatives.

Under the CJR rule, participating hospitals (nearly 800 in 67 geographic areas) will be financially accountable for the overall cost and quality of a growing percentage of hip and knee replacements, rather than just for the portion of services that occur inside their facilities. In developing the rule, the Centers for Medicare and Medicaid Services (CMS) noted that there is significant variation in the total cost and quality of these procedures. The episode of care covered under CJR begins with the patient's admission to the hospital and lasts for 90 days post-discharge. This includes not only what happens in the hospital but also post-acute care provided by skilled nursing facilities (SNFs), home care agencies and some outpatient care, as well as any related readmissions.

The message to hospital leaders is clear: Your organisations will be financially impacted (good or bad) by the care delivered beyond your four walls and by parties that are not under your administrative control. The key to thriving in this environment is structuring the right kinds of agreements with the right partners, along with good systems to monitor performance for the purpose of continual improvement. Hospitals can enter into risk-sharing agreements with associated care providers and suppliers, including SNFs and home healthcare agencies, as well as inpatient rehabilitation facilities, long-term care hospitals, physicians and group practices, and outpatient therapists. Such risk-sharing agreements can only involve those parties that are part of an overall care redesign effort. Ideally, the care redesign includes quality improvement systems that enable the parties involved to learn together to improve their collective services. Creating the right kinds of agreements and working collaboratively to optimise results takes more than just a good lawyer. It requires constructive collaboration, the first of five essential traits required of today's evolving healthcare leader.

THE ESSENTIAL TRAITS[7]

Constructive collaboration

One of the criticisms of the traditional healthcare system model is its tendency to operate in silos — organisational, clinical, functional, even technological and informational. It starts with medical education, with few schools allowing for different types of clinical students, for

example, physicians, nurses, etc. to train together.[8] How then are they supposed to know how to work as members of a clinical care team in the real world? Further, in the provider environment, it can be difficult to get those responsible for clinical care and supply chain operations, as an example, to collectively decide on which products provide the most value. Finally, making such decisions is hard when technology does not enable data on costs and quality to be shared, let alone in a manner that fosters effective analysis.

Traditional reimbursement structures that reward volume over value have provided few, if any, incentives for care coordination. New programmes, such as CJR, seek to change that dynamic. Federal and state regulations also make it difficult to be innovative in what kind of care is delivered, where and by whom, to best match patients' needs. Regulations often limit reimbursement based on who is delivering the service or where that service is delivered, although we are seeing some positive movement on this front. For example, CMS recently changed regulations expanding coverage for non-traditional asthma providers working under the supervision of a physician and delivering care in the home; one programme had a 500–1,400 per cent return on investments in home-based asthma interventions.[9]

A potentially more formidable barrier to constructive collaboration is the culture of medicine, one that has fostered a hierarchical structure yielding ultimate responsibility for patient care to the individual physician. The increasing volume of medical knowledge, as well as the numbers of patients who suffer from multiple complex and chronic conditions, makes this approach not only difficult but potentially dangerous.[10]

Technology, too, can exacerbate the problem, with a proliferation of systems that may work great in silos but do not perform well together. You only need to do an internet search on interoperability (or the lack thereof) to get a sense of the magnitude of the problem and how it is keeping healthcare from realising the full value of health information technology. Others would argue that even if technology allows data to be shared, there are still many in healthcare who are reluctant to give away what they may consider to be their competitive advantage.[11]

That kind of thinking is in stark contrast to a growing recognition by business leaders primarily outside of healthcare who understand that the success of their corporations is dependent upon the health of the larger ecosystem in which they operate.[12] A recent example of constructive collaboration comes from Tesla chief executive officer Elon Musk who chose to release all of his company's electric car patents to his competitors. The official rationale from Tesla: It will help stem climate change by bringing more electric cars to market faster. Analysts also think it's a good business move on Tesla's part. If there are more electric cars, more companies will start building charging stations and other critical infrastructure needed to support a market for electric cars.[13] Tesla would then have a better environment in which to grow and compete.

Think about this concept as it relates to alternative payment models (APMs), including ACOs and bundled payments. As a result, hospital leaders can find themselves dependent upon the quality of care delivered outside of their direct control. Not only are patients negatively impacted when care is not delivered in a well-coordinated manner, but so are the providers who are ultimately responsible for the cost and quality of that care. Most APMs have strived to protect patient choice, albeit with some restrictions, for example, under CJR patients can choose their SNFs as long as those facilities have met certain quality ratings.[14] That means patients could choose a SNF that is part of an organisation that has historically been viewed as a competitor to the primary CJR hospital. Suddenly, success is dependent upon the quality of care provided by others and the ability of competitors to work together to coordinate care.

From a technology perspective, the growing appreciation for open source development reflects the value of constructive collaboration. Jim Whitehurst, chief executive officer of Red Hat, says the value of his company's essential product relies on the willingness of software developers around the world to continually improve it, even though it means giving access to his biggest competitors. By increasing access to the source code, he can increase the 'brain trust' working on his product, while also building a community of supporters.[15]

A highly publicised example of the emerging interest in open platforms in healthcare is the 2013 formation of the Common Well Health Alliance, an independent not-for-profit organisation dedicated to interoperability in healthcare information technology founded by seven competing IT vendors: Allscripts, athenahealth, Cerner, Evident (then known as CPSI), Greenway Health, McKesson and Sunquest. As Allscripts president and CEO Paul Black stated during the news conference announcing the alliance, 'We believe open platforms are required to . . . make the improvements our health care delivery system needs to dramatically improve outcomes while reducing cost'.[16] Beyond the value of competitors working together, open platforms also offer the flexibility needed to meet the demands of a changing healthcare delivery and payment system. Today's smartphone technology provides platforms on which independent software developers can create applications from which consumers can pick and choose. In the same way, open platforms in healthcare can support care coordination among providers by enabling them to choose and even switch out applications to meet their changing needs, as long as data can be shared among the various parties in a secure manner that protects patient privacy.[17]

Now consider the possibilities of unleashing a broader collective intelligence to solve the problems of healthcare. A good example comes from the use of the online game FoldIt to unlock the code to an enzyme that could lead to a cure for AIDS. In less than ten days, gamers from around the world solved a problem that university researchers had not been able to, despite ten years of trying.[18]

Change agent (the soul of leadership)

Many of the world's most successful leaders are not only driven by a desire to make the world better, but also have an uncanny ability to do well by doing good. Tesla's Musk stated desire to tackle climate change certainly exhibits this, as have entrepreneurs like Anita Riddick, who founded The Body Shop on a pledge not to sell any products tested on animals and went on to make £130m when she sold her business to L'Oreal in 2006.[19]

In healthcare, perverse incentives have undermined efforts to improve the system as a whole because of the negative impact change would have on individual players. Former CMS Administrator Donald M. Berwick, MD, says historic payment methodologies have made it completely rational for hospital administrators to try to increase volume, fill beds, and focus only on care within their walls. Being more efficient and effective — even seeking to prevent disease — could be a threat to profits.[20]

The new payment incentives seek to change the market dynamics, making it easier for healthcare leaders to enhance value for their own institutions and for others at the same time. Healthcare supply chain leaders have been among the first to grasp this concept, moving away from adversarial relationships with suppliers that are focused primarily on price to collaborative relationships aimed at taking waste out of the process for the benefit of all. Rather than push costs on one another, they seek to take costs out of the system by eliminating operational inefficiencies.

As with any change of this magnitude, the greatest challenges occur during the transition.

It takes time for organisational structures, process and policies to change; hospital leaders must take action now, even though many hospitals are still paid based on fee for volume, versus value. As a result, hospitals that make early progress towards quality improvement and preventive care could suffer financially in the short term, but they should be better prepared for the new value-based payment methodologies in the long run.

Change also requires innovation, which can be stifled by lagging restrictions from CMS on who can get paid for what. Presbyterian Healthcare Services in Albuquerque, New Mexico, has experienced this first hand with its Hospital at Home (HaH) programme. Originally developed in 2007 in response to a shortage of hospital beds, the programme has since positioned the healthcare system to move more of its care out of the expensive acute care setting and into the home. Under HaH, patients can be discharged sooner and treated in their home with a full complement of medical equipment and clinical visits (in person and via telehealth). The programme has shown to deliver better care at a lower cost, but despite these promising results, the HaH concept has not grown substantially due to a lack of payment schemes to encourage its growth, at least not yet.[21]

Empathy as a business imperative

The concept of doing well by doing good and the next essential trait, empathy as a business imperative, may seem like oxymorons, but they can yield impressive business results, especially when reinventing how healthcare is delivered. Empathy is the starting point for the process of design thinking, an innovation technique that is gaining in both popularity and application. A recent paper in *Harvard Business Review* on design thinking even mentions redesigning the healthcare delivery system as a possible project, while admitting it would be a much harder than designing a shoe or even getting software to integrate with hardware (and, I would add, other software).[22]

Tim Brown, CEO of IDEO, the firm credited with designing the first Apple mouse, describes design thinking as 'a discipline that uses a designer's sensibility (empathy, creativity, systems thinking, etc.) and methods to match people's needs with what is technologically feasible and what a viable business strategy can convert into customer value and market opportunity'.[23] In healthcare, there is real value in thinking about patients as consumers and paying attention to their pain points and needs.

Design thinking is not just about watching and coming up with ideas. It employs a disciplined approach to prototyping products or services, including observing how people interact with them. For example, IDEO founder David Kelly told 60 minutes that software design can be improved simply by watching a consumer interact with the product and asking questions if and when the person grimaces.[24]

The Center for Innovation at Mayo Clinic starts the design thinking process by asking what is its product (or service) and is it being delivered in a manner that creates a satisfying experience. The Center for Innovation lately redesigned its examination rooms to create an integrated but separate space for the actual examination and for consultation with patients and their families. The design team observed that as much time, if not more, is spent talking to patients compared to the actual examination, and that the examination room itself is not conducive to conversation.[25] Design thinking is also well suited to improving how someone experiences a service (very fitting for hospitals, where a portion of reimbursement is based on patient satisfaction).

Beyond empathy and prototyping, design thinkers also recognise that failure is part of any design process. You rarely get it right the first time. The question is, can you fail *fast*, which is the next essential trait.

Freedom to fail, fast

No one likes the idea of failing, especially in mission critical environments like healthcare. There are plenty of opportunities to test out ideas in a safe environment before deciding if the idea should be deployed, destroyed or further modified. The problem in healthcare, and frankly anywhere the human ego is involved, is that it is often hard to give up on an idea once you have invested time and money. But it is far more costly not to admit failure and move on. We have all heard of, if not experienced, failed technology implementations that should have been abandoned but are not, at least not right away, due to the protective instincts of the individual who made the original technology selection. Accountable leaders know how to move on in a manner that allows their organisations and teams to learn from the mistake and proceed to success sooner. Even some of the most well-respected innovators make mistakes. Remember New Coke or Apple's Lisa? Even Netflix tried opening a bricks-and-mortar store, only to close it in a month.[26]

Winston Churchill once described success as the ability to go from one failure to another with no loss of enthusiasm. A healthcare system leader must create the environment in which the freedom to fail facilitates learning, rather than regret, retribution or a threat to patient safety.

A midwest hospital provides an example of this concept in action. Its supply chain leadership collaborated with one of its major suppliers on an experiment designed to reduce the amount of expensive medical devices on consignment at the hospital. Team leaders respected clinician concern over the potential that a product might not be available for a patient when needed. To ease their concerns while testing out the new system, the hospital stored the regular amount of consignment inventory in a separate location that could be accessed *if necessary.* After a number of trial runs, clinical and supply chain leaders from both organisations agreed to put the programme into place and shared the resulting operational savings.

Freedom to fail, fast, stems from another essential trait: an experimental mind.

An experimental mind

Having an experimental mind means being willing to test a hypothesis and, more importantly, to learn when it works and when it does not. This mindset is fundamental to creating a learning environment, an objective of the 2012 IOM report, Better Care at Lower Cost. The report's objective is to build a body of evidence that can help guide clinical decisions on what delivers the best care at the most optimum price. The report contrasts healthcare with the automobile industry that produces cars that are 'standardised at their essential, while tailored at the margin'.[27] Certainly, making a car and treating a patient are different. While patients essentially have the same anatomy, there are variations in the body, not only structurally but also based on a patient's genetics and medical history. At the same time, there is growing recognition of the value of standardising those aspects of care where supporting evidence exists in order to allow physicians to vary where they deem necessary to meet the unique needs of the patient. Unfortunately studies have shown that much of the variation in how care is delivered (and the associated outcomes and costs) results from a lack of strong medical evidence, especially for chronic diseases that afflict nearly 50 per cent of Americans and account for the majority of healthcare spending. Lack of evidence results in uncoordinated, duplicative and at times unsafe care.[28]

Getting to better data on what works in actual practice from a supply perspective is the objective behind the US Food and Drug Administration (FDA) regulation mandating that manufacturers label their products with unique device identifiers (UDI) and additional rules from the Office of the National Coordinator for Health IT (ONC) and CMS requiring electronic

health records to hold and providers to exchange UDIs for patients' implantable devices. Unambiguous identification of these devices can help provide better visibility into adverse events. Just as importantly, it can provide data on what works best on which patients, which can inform better sourcing decisions.

CONCLUSION

Interestingly, while so many regulations and research efforts are designed to lessen ambiguity, many of the essential leadership skills for today's accountable healthcare leaders require leaders to be comfortable with two seemingly competing concepts at the same time. For many years, the debate in healthcare was quality versus cost. We now recognise that quality care is less-expensive care, especially with reimbursement policies that punish poor quality care by denying reimbursements for treating hospital-acquired conditions and unplanned readmissions.[29] In other words, it is not about quality or cost, it is about both. Healthcare needs leaders who can create the path to value for not only their own organisations but also the entire healthcare system and the patients it serves.

Some steps to get started

Successfully navigating your organisation through the demands of accountable and value-based healthcare is an ongoing journey, in which the steps you take going forwards are guided by what you have learned along the way. Here are a few suggestions to get started:

1. **Collaboration is an inside–outside job —** Successful collaboration with outside partners must be built on a foundation of strong internal collaboration among clinicians and financial and operational leaders. Make sure the respective leaders in your own organisation have a common view of success — focused on the patient's needs — before you try to extend collaboration to outside partners.
2. **Take the time to define and align what success looks like —** When working with new business and clinical partners, take the time to make sure you share a common view of what success looks like and how you will measure whether you have achieved it, individually and collectively.
3. **Measure success based on the needs of the patient —** We measure a lot of things in healthcare, but the only thing that really matters is what matters to the patient. When measuring performance — whether for a specific process, care team or organisation — make sure your metrics are tied to the overall objective of better quality care, lower cost and better patient experience.
4. **Match the data to the metrics —** If your objective is better quality care delivered at a lower cost, then make sure you understand what it truly costs to deliver care and how those costs relate to the outcomes achieved. For too long, healthcare systems have focused more on reimbursement than outcomes, and as a result, we have good data on charges but not on actual costs.
5. **Invest in technology that supports your ability to deliver better value —** To get to cost data, invest in good, old-fashioned activity-based costing across an episode of care, not just what happens in a particular department or facility. Make sure your technology (and technology partners) is flexible enough to meet the needs of varied and evolving care pathways, partnerships and payment structures.

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