ATLANTA BUSINESS CHRONICLE

Table of Experts

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Health Care:

Examining the Transition of Value in the Atlanta Market

VAL AKOPOV
WellStar Health Network

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KEVIN BROWN
Piedmont Healthcare

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PATRICK HAMMOND
Emory Healthcare

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JOHN M. HAUPERT
Grady Health System

"The insurance companies' versions of care coordination are very different than what you would hear the four of us lay out as the best way to coordinate care for our patients."

The goal for any business is to provide the best product or service at the most competitive price. It is no different for Atlanta's leading health-care institutions, whose "holy grail" is the intersection of the best quality of care for its patients at a price that the patients, insurers and government subsidizers can afford. In hospital language, the topic is called "value-based care." Hospital systems throughout metro Atlanta have devoted countless resources to determine what works best for their organizations. How do they create a cohesive process along the continuum from virtual, primary, urgent, specialty, tertiary and long-term care, as well as skilled nursing? Four Atlanta health-care leaders discuss the building blocks needed to bring more value to the market and how to deliver an entire integrated experience for the patient, while at the same time meeting community needs. They also look at the future of the city's health-care market, especially in the light of regulations and the recent presidential election.

MEETING THE EXPERTS

ROSS ARMSTRONG: There are three areas I'd like to hit on during today's discussion, and the topic is centered around the transition to value. I'd like to begin by discussing overall organizational strategy. I'd also like to talk about the Atlanta market, including where it is; forces that might be pushing your organizations toward value compared with organizations in large metro areas of a similar size; and programs and initiatives that are transitioning your organizations to value. We also will talk a little about the election. You all have strategic plans for your organizations, and I just want to see where the move to value ranks as you prioritize those strategies. As you think about your overall strategy in the direction of the organization, where does value fall on that list?

So, Kevin, if you want to kick off things.

KEVIN BROWN: Sure. We, obviously, are on the journey to value-based care. It's interwoven into everything we're doing with regard to where we're headed. We're making sure we have the building blocks in place, so if our payment mechanism changes we're able to be successful in that arena, and if payment mechanisms don't change, we're still able to manage care in a different way using a value-based approach.

On the front end, we're investing heavily in the underserved primary-care market. We're also developing virtual-care options, urgent care, specialty care, as well as strategies for post-acute care services. We're putting the pieces together so we can manage care successfully across the continuum. Our best asset at Piedmont is the Piedmont Clinic, our Clinically Integrated Network (CIN) of 1,700 physicians who are doing a great job managing care across the continuum. We have some risk-based contracts, and at the same time, we're building and making sure we have the analytics – the business tools – to be successful in a value-based model.

So, we don't call the strategy a value-based strategy. We call it a patient-centered care model.

JOHN HAUPERT: We just put the finishing touches on a new strategic plan for next year. One of the four key strategies is around value, but in a much broader sense than just payer value. How does a very large safety-net institution bring value to the market? Historically, institutions such as Grady have been the lower-cost provider in the market. That is usually attractive to insurers and positions you for risk. At the same time, if you're not delivering the patient experience, the outcomes and the entire integrated experience for the patient – from outpatient to inpatient and post-acute care – you will wind up being the lowest volume. So, within that strategy are all of those elements.

As an academic medical center, too, most of the benchmarks we've established for ourselves are among other academic medical centers and large safety-net institutions nationwide. Our goal is to be in the top one or two nationwide among that group of institutions. We are a closed medical staff made up of physicians from Emory and Morehouse Schools of Medicine.

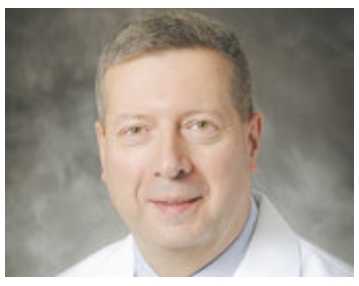
We do have an employee physician group populating our primary-care centers, which is part of this value-based proposition. It's the same as Kevin, with a bit of a different focus: There is not enough primary care for the patients we serve, truly not enough. So, we now are expanding that network of neighborhood health centers, community-oriented primary-care centers, to be much more comprehensive and to deliver care where people live rather than them having to come downtown and maneuver a big, massive institution. To deliver primary care based on the demographics of the neighborhoods, we're designing the care based on a specific neighborhood or area based on what is needed there. For example, we have a large center in West Atlanta that is serving a large senior population, so the subspecialties we're placing there are very different than the ones we're placing in East DeKalb County, which serves more young professionals.

PATRICK HAMMOND: Similar to the other organizations, while we don't necessarily call it value-based reimbursement strategy, it definitely is one of the top priorities we have in our organizations – to be a leader in transforming this market into more of a value-based system or taking on the responsibility of population management. For the most part, the U.S. health-care system has been set up to manage acute isolated episodes of care, and it's been more reactive.

We're trying to put many of the building blocks in place to be more proactive and to manage populations, because again, our physicians and others feel that is a better model of care and will produce more sustainable cost and consistent quality outcomes. It will also provide more value in experience for the physicians. They want to provide the best care possible, and the current world sometimes doesn't allow them to do that. This is one of our top priorities, and not only in the actual delivery of care but as an academic medical center it is also a part of our mission of research and teaching. We're looking at this as a

PARTICIPANTS

The discussion on value-based health care took place November 16 at Atlanta Business Chronicle.



Val Akopov, M.D.
Senior Vice President and Co-President, WellStar Medical Group, Chair WellStar Health Network

In his role as senior vice president and co-president of WellStar Medical Group, Val Akopov helps oversee one of the nation's largest multispecialty medical groups. He also serves as chair of the board of managers of WellStar Health Network and as a board member of WellStar Clinical Partners. Before joining WellStar, Akopov held positions at the Emory School of Medicine Department of Medicine at Grady Memorial hospital and Emory Crawford Long Hospital.

He received a doctorate degree in medicine from the Tbilisi State Medical University in the Soviet Union, served an internal medicine residency at Emory Affiliated Hospitals, and earned master's degrees in business and health administration from the Robinson College of Business at Georgia State University.

Kevin Brown
President and CEO
Piedmont Healthcare

Since joining Piedmont Healthcare as president and CEO in 2013, Kevin Brown has spearheaded the organization's growth from five to seven hospitals –– including Piedmont Athens Regional, a 360-bed regional referral center that has become the second-largest hospital in the Piedmont system. The Piedmont Clinic's clinically integrated network also has grown from 900 to 1,700 physicians, and Piedmont has generated about $200 million in improvements aimed at reducing health-care costs.

Before joining Piedmont, Brown served as CEO of Swedish Health Services, a five-hospital health-care system based in Seattle.

He is active in the Buckhead Coalition, Metro Atlanta Chamber, Georgia Hospital Association, Georgia Alliance of Community Hospitals and Holy Innocents' Episcopal School.

Patrick Hammond, M.D.
CEO, Emory Healthcare Network
Chief Market Services Officer
Emory Healthcare Inc.

As CEO of the Emory Healthcare Network and chief market services officer of Emory Healthcare, Patrick Hammond's responsibilities include Emory's clinically integrated network; managed care; market development, marketing and outreach strategies; credentialing, enrollment and medical staff support; and data analytics and market research.

Emory Healthcare is a $3 billion enterprise encompassing seven hospitals, 16,000 employees, more than 2,000 physicians, and 200-plus delivery sites in and around Georgia; it is the only system in Georgia with three Magnet-designated hospitals.

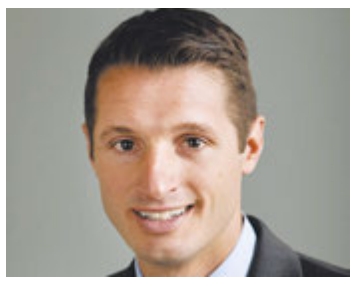
Hammond received a bachelor's degree from Emory University and a master's in health administration from Duke University.

John M. Haupert
President and CEO
Grady Health System

John Haupert is president and CEO of Grady Health System, home to the metro area's primary Level I trauma and burn center and nationally recognized clinical services including the Marcus Neuroscience and Stroke Center and Georgia Cancer Center.

Before joining Grady, Haupert held leadership roles with Methodist Health System and Parkland Health and Hospital System, both in Dallas. A native of Fort Smith, Ark., he received a bachelor's degree in business administration and a master's in health-care administration from Trinity University in San Antonio, Texas.

He serves as a fellow of the American College of Healthcare Executives, and is active in the Rotary Club of Atlanta, Central Atlanta Progress, American Heart Association, Atlanta Women's Foundation and Atlanta Committee for Progress.



Ross Armstrong
Senior Vice President and Head of Market
Lumeris

As Head of the Market for the South, Ross Amstrong leads a team that helps health-care systems and managed-care organizations transition to value-based care. He is responsible for business development and account management. Previously, Armstrong was a partner in Kurt Salmon's Healthcare Strategy practice, where he developed skills including strategic planning, financial analysis, value-based transformation, payor strategy, and physician group practice development and integration. Armstrong also speaks and authors content on the topic of health-care. He received his bachelor's degree from Rhodes College, and master's degrees in health-services administration and business from the University of Alabama, Birmingham.

PHOTOS / BYRON E. SMALL

From left, Val Akopov, Patrick Hammond, John Haupert and Kevin Brown met to discuss value-based health-care in the Atlanta market.

research opportunity of what are the most effective methods. As you look around the country, there are a multitude of different ways to go about this, but there's not a lot of science around what the best results and outcomes are with each method. With our new CEO, Dr. Jonathan Lewin, that is a big part of our overall strategy.

VAL AKOPOV: WellStar has always been about value. As all four of us represent not-for-profit health-care organizations as well, we understand the core mission of such organizations. You can express the mission and vision in many different ways, but the core of what a not-for-profit health-care organization does is provide high-quality, cost-effective care that improves the health of the people in the communities we serve. When we look at value-based care, it is just the natural way of what we do within the framework of what we refer to as the "triple-aim." As a matter of fact, we coined the term "quadruple-aim." The conventional triple-aim means high-quality care, patient satisfaction and lower cost. We began realizing that the well-being of providers is as important as any of those other aims – the value-based care is just a natural expression of what we view as our core mission. It is not tactics. It is not strategy. It is our core business based on this quadruple-aim. We live in a chaotic health-care world – we know that we are moving toward the value-based purchasing of health-care services, but the pace varies from region to region, and in many regions, the value-based purchasing has not become part of the common landscape yet. So, regardless of the pace of change toward "value-based payment" for care, we will continue to invest in the strategies that improve the value of care to our patients ... those that support our quadruple-aim goals, because patients shouldn't have to wait for this important change to occur. Simultaneously, we have to pursue traditional tactics, such as increasing market share and improving margins. These conventional venues are important to embrace, because we simply don't know when we will end up in a world that is irreversibly tilted toward value-based purchasing (and away from the volume-based care).

HAUPERT: That's an incredibly important point, that many of the elements you would want to have in place for a pure risk model would include having care coordination across the entire continuum. There's a cost to that. We're not in that role yet, so the hesitancy may be making that investment and instituting a care-coordination model. Value-based care is where we should be, but the market hasn't moved there. Many

of the elements of a true value-based system are not funded, so to speak, and if you step out and do that and absorb that additional cost, will there ultimately be funding for those elements?

BROWN: I agree with that, but the only exception is that I think some of it is funded, it's just funded in a different silo. Health plans are trying to do care coordination, when the providers are in the best position to manage the care of a population.

I don't think it requires new dollars, and I know John isn't saying that.

"We do care coordination for 60,000 at-risk lives in our population health unit, and our readmission rate is half of what it is for our general Medicare population."
— Kevin Brown

HAUPERT: Right.

BROWN: It's just a redistribution, maybe, of where the money is being spent. We do care coordination for 60,000 at-risk lives in our population health unit, and our readmission rate is half of what it is for our general Medicare population. We're able to do it more effectively, rather than having someone from an insurance company call from somewhere like Minnesota to say, 'I'm your care coordinator, who are you?' versus 'I'm with Piedmont. I'm your nurse care coordinator, and I'm here to help make sure you're getting what you need while you're at home.' Building that personal relationship is very different than having a third party do it. The insurers have been reluctant to give up some of that for obvious reasons, because it affects their business model. But the dollars are there; they're just not getting used very effectively.

HAUPERT: I totally agree with Kevin on that. The insurance companies' versions of care coordination are very different than what you would hear the four of us lay out as the best way to coordinate care for our patients.

Being a little unique on the safety-net side, our patients have numerous socioeconomic issues with which they are dealing that require us to have care coordination in place to assist the patient to receive care in the most appropriate location and to reduce inappropriate use of the ER. We all have this problem, but with this population, it's quite evident. Our definitions are very different than the insurance companies.

HAMMOND: I definitely agree that you have an extra challenge in serving the socioeconomic groups that you're treating. However, we have found that the coordination around the social needs, even if it's someone who has good economic resources, actually can be a big determinant in health. Similar to the other organizations, when you hear stories of how our care coordinators who manage those complex patients are intervening and reducing unnecessary emergency room visits or readmissions, a lot of that is centered around the social aspects and how you better integrate the coordination of today's fragmented ambulatory delivery system. We're sort of in this chicken-or-egg issue. Everybody wants to move in this new direction, but it requires new investments, again from an acute episode management that you didn't invest in that before and now you have to. It also requires lead times.

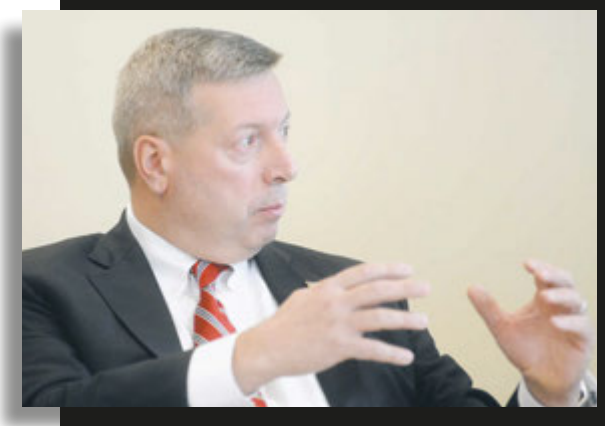
If you wait until it changes, you may be way behind the curve. You almost have to make some initial investments, but it does create doing it incrementally as opposed to changing your entire system, and that is one of the challenges, to have multiple models.

THE GREAT UNKNOWN

ARMSTRONG: What are your organizations doing about the social determinants that impact health care? It's kind of the great unknown right now; there are no real best practices out there. It's a little bit like feeling your way around in the dark. But we all know it's hugely impactful. Have you started down that path at all?

HAUPERT: That's a major part of the role Grady plays in this health-care market. Grady has a greater obligation to address social determinants given the role we serve as the safety-net health provider. But none of us, none of these health systems, can afford to own all of those issues when it comes to housing and education. There are so many determinants that go into the health status of an individual.

Grady clearly doesn't have the funding, nor do probably the four of us collectively have the funding, to fix the housing, education, day-care and preventive-health issues. Some of that we can enter into and heavily partner on with other organizations. All four institutions participated in an entity called the Atlanta Regional Commission for Health Improvement (ARCHI), which was created by a group of local foundations to begin holistically addressing these issues. We're fortunate that those foundations, along with Georgia State's health research group, are funding studies to examine what those determinants are and where to make that investment. That has helped, but most of what we're dealing with in our care-coordination model is around disease-specific processes. We think of it as a disease-specific approach, and within each of these specific disease processes reside unique social determinants that influence how care should be provided. The ARCHI initiative is helping to address some of these disease-specific social issues.



"It's one thing to manage 40,000 lives and different to manage half a million."
— Val Akopov

AKOPOV: At WellStar, 10 percent of the patients we provide care to are uninsured. This translates into roughly $400 million a year of uncompensated care. That's one interesting fact, and the second is that WellStar is the largest Medicaid provider in Georgia; we see the most number of Medicaid patients in the state. Put these together, and it becomes clear that without addressing and solving the social determinants of health, we cannot design clinical services that meet the needs of our communities. In everything that we do, we have to keep that in mind that a significant portion of our population we are responsible for is either uninsured or underinsured. Therefore, the way we design care models has to be payer-source agnostic. We have to take this into account because it is our reality. The general concept of population health management is the foundation upon which all of these efforts are built, because the hallmark of the new reality is the heightened accountability of health-care systems. We're not only being held accountable financially and otherwise for episodes of care, but for the entire continuum. We're not only responsible for patients' health outcomes when they come see us at our care sites, but we're held accountable for the well-being of the patients when we don't see them in-between the episodes of care, and they're outside of our sphere of influence. This the new paradigm and we just have to learn how to adapt to it.

HAUPERT: What I find interesting is that there are a lot of entities holding health-care institutions accountable, but each entity has a different set of success measures, and the industry still is in flux around what the true definition is and what you are measuring. One of the federally mandated quality reporting systems that was in place for several years ended up deleting half of their measures because they realized they were process measures and not quality-of-care measures and now they have issued an entirely new set of required quality measures.

What I like about what you just said is, if we do the right thing – call it population health or coordinated care on a continuum – and satisfy the indicators and move toward a true value-based model, I believe that's where we need to be. Then the rest falls into place.

ALIGNING PAYMENT

ARMSTRONG: You all deal with so many different payers that all have different ways of measuring you and looking at outcomes differently. How do you start to align some of those things?

HAMMOND: There are hundreds of different things that we're being measured on by different organizations, and depending on how they measure, one measure says you look great and the other can say you look terrible for the exact same service.

Most provider organizations have to make the decision to say, 'We cannot focus on all these measures, so what are the measures we need to focus on that will provide the most value to our patients? Then, how are we doing on those, realizing there will be others that we may not look great in simply because of the way they're measured?' It's about trying not to be distracted by all of those different measures and trying to stay on a path that keeps you focused on the true measures that improve care and outcomes for the patients you're serving. Right now that is one of the other challenges in health care – you have way too many measures that supposedly are measuring the same thing, and it really gets confusing for the consumer and patient. One of the challenges that exists across the entire industry is simplifying value-based reimbursement measures – helping patients judge where to go for the best care.

BROWN: The outcomes are just one piece. There also is unit price, utilization and the total cost of caring for the population. When you talk to a

lot of insurance companies, they're worried about the unit price, and they don't talk much about utilization or the patient-centered care model.

We lined up every outcome we're measured against – about 400 metrics – and then we got our clinicians together and said, 'Of these, which do you think are the most important for delivering high-quality patient care?' We narrowed it down, and we just stay focused on those metrics. The public can visit our website to see what our clinicians said are the most important, as well as our performance. I expect you would find similar quality scorecards at the other local health systems. Our board also is focused on these outcomes, as to what we think are important. We're going to try and avoid the noise that's happening out there, because every time you turn around there is a new pay-to-play hospital-rating scheme. Our focus is on improving care – not chasing the last entrant into this market. There's one coming out every day. Also, a lot of the things that have been measured in the past have turned out not to be the things that are important to delivering value-based care.

AKOPOV: One way to maintain the sanity in this environment is to stay focused on certain things, something that you believe is representing true value, and also to start small.

I'll give you one case study from WellStar. We've been in the Medicare Shared Saving Program (MSSP) Accountable Care Organization (ACO) since 2012. When we enrolled in 2012, we knew very little about population health management, but it proved to be an excellent opportunity to experiment in this space. The 40,000 Medicare beneficiaries enrolled in our ACO represented a very distinct, well-defined population for which we were held accountable for clinical and financial outcomes, and patient satisfaction. It was a great opportunity to develop the population-management skills – some day in the future, we will find ourselves caring for a half-million patients in a similar manner as we took care of 40,000 Medicare beneficiaries. Fast-forward, and we've been in the top 25 MSSP ACOs in the nation for three consecutive reporting periods. We achieved an 88-percent higher quality score and 87 percent in patient satisfaction within our ACO. By the way, we also saved Medicare $41 million during that time. So, this is your triple-aim in action. We took the "triple-aim" concept and operationalized it, and along the way, we learned a great deal, too. We have a long way to go, of course. It's one thing to manage 40,000 lives and different to manage half a million. Nonetheless, the experience we gained from this relatively small-scale experiment is indispensable – all of those skills with population health management, care coordination and looking after patients throughout the continuum. So, this is just one way to cope with the avalanche of changes coming down at us – to take something small and make sure it works. There is also a great opportunity to get physicians' buy-in, when for three consecutive years we can reward them for what they have done in the area of population health management. This wins physicians over and makes the conversations with them much easier.

"... the coordination around the social needs, even if it's someone who has good economic resources, actually can be a big determinate in health."
— Patrick Hammond

HAUPERT: We were using the unicorn analogy with the ACO, too – no one's seen one, but here's what it's supposed to look like. But there's been more proof of concept as they evolve. The WellStar ACO is probably the largest in the market, and there is an ACO between Grady, Morehouse, Emory and the Federally Qualified Health Centers. We've had the same experience. Once you figure out how to manage utilization and how to provide appropriate care coordination, then you can better manage the care of the patients you are charged with serving across the entire continuum of care. As you focus on better managing the care for the patients and remain focused on improved outcomes, you also create standardized care processes based on evidence-based care models. So, many of these ACO pilots have proven that it can be done.

At the same time, it's interesting that in some markets, the tier-one and tier-two providers walk away from it because they couldn't generate the savings because they didn't put in place the infrastructure to review utilization; they didn't have the infrastructure for solid care coordination.

AKOPOV: Not all ACOs are unicorns. The innovative ACOs – like Cleveland Clinic, Memorial Hermann and WellStar – have all proven that higher-quality, better care can be achieved, all at a lower cost. To some, these goals may sound like an "iron triangle" that cannot be broken, but to WellStar, we know the "triple aim" can be achieved.

THE ATLANTA MARKET

ARMSTRONG: Let's switch gears a little bit and talk about the Atlanta market. You all have various backgrounds and experiences, and you all talk to your counterparts across the country.

Kevin, you came from Seattle, which is very different from here. Where do you see Atlanta as a major metro area on the value-based care spectrum compared with some of the other metro areas across the country? Are we right in the middle? Are we behind? What's the rationale that justifies what the current position is?

BROWN: I don't think the Atlanta market is that far behind. There are markets that are really behind and several that are ahead of us. I don't know if we're right in the middle, but we're somewhere in that range. If you've ever been to Alaska, they're a long way from where we are. Even some of the markets in Texas still are very fee-for-service markets.

We're inching in the right direction here, but part of it has to do with the fragmentation of Georgia's delivery systems. It's a market that didn't consolidate in the 1990s when everyone else consolidated, especially on the physician front. Therefore, you don't have these integrated platforms that have enough breadth to cover a population. It's a big marketplace that still is pretty fragmented. As I said before, there's a particularly massive shortage of primary-care physicians, which creates significant access issues in all of our communities. If you're turning Medicare-eligible and you're looking for a primary-care physician in Georgia, good luck. People are accessing the emergency room for treatment that they should be getting in primary or urgent care or retail. In my experience, the utilization of emergency rooms is three or four times what it was on the West Coast. I attribute a lot of that to the access to primary care, and then there are some socioeconomic factors driving it here as well. But we have to figure out how to get the right services to the right people in the right location. And I think that is keeping us from moving quicker along the value continuum.

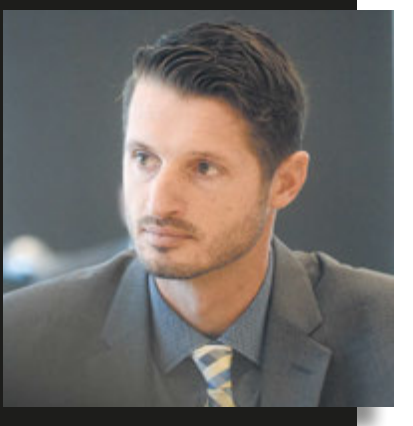
ARMSTRONG: Any other thoughts?

HAMMOND: I agree with Kevin, and I think you also have to look along that continuum of value-based reimbursement models. There are a lot of different value-based type of reimbursement structures. If you look at the West Coast, it is very much a percentage premium capitation. However, there are other value-based reimbursement models from bundled payments, shared savings, etc. On the commercial side, it also depends on what different employers and payers are willing to do in that market and what they're ready to do in this market.

It's fascinating that you have potentially national payer companies that are used to managing capitation with providers in other parts of the country, and then in this market, it's almost like they have never dealt with it. You'd think they're the same company that should be able to do those things. There definitely are markets that are farther ahead than Atlanta – along that continuum and all the way to capitation – but I also think there are markets where employers are starting to do some unique things. Delta recently did an Orthopedic Centers of Excellence with us that included bundled package pricing. Some of the employers in this market, especially the big employers, are also challenged by the fragmentation in the market. It's a huge geographic market that none of us can completely cover. There is also a misunderstanding that providers manage populations today, as opposed to managing acute episodes of care. So, employers are taking a sort of wait-and-see approach, saying, 'OK, show me the value for it.' But then you get into the chicken-or-egg issue, 'If employers and payers are not collectively moving in that direction, provider organizations can't put the necessary investments and other resources into this transformation to show employers the value.' That's the other quandary as far as the Atlanta market – how we collectively move this transformation forward together.

BROWN: It's also about appropriate utilization. You can't manage populations and produce value without addressing quality, cost and utilization. Our unit cost is competitive, but the real opportunity for our industry is in utilization, the over-utilization of services.

"Across the country, there are different philosophies about how you manage the continuum."
— Ross Armstrong



Whether you call it population health or continuum of care, it can't be one sliver. It has to be the whole thing.

Employers here are ready to have a broader conversation about that, and there is a lot more conversation with the employers on the West Coast for sure than there is here. But the employers I've talked to recently have come to the conclusion that they've gone to the high-deductible plans, which was their first step in managing cost, and the savings out of that have been achieved. Now it's what is the next step? The next step has to be a different model, and for that different model, you have to have a product underneath that that can manage care across the continuum and change the fundamentals of this transaction-based system we have.

"One of the challenges that exists across the entire industry is simplifying value-based reimbursement metrics – helping patients judge where to go for the best care."
— Patrick Hammond

A SENSE OF URGENCY

ARMSTRONG: Do you think any of that is we haven't seen a burning platform here like you do in some markets – like the Rust Belt – where physicians felt a sense of urgency to change because the fee-for-service model was breaking and they didn't have the growth to kind of push them through like we've seen here?

HAUPERT: I think it's one of those chicken-and-the-egg things. How quickly can a market move from fee-for-service toward fee-for-value. Payers are working with providers to do so in some isolated pilots, but this market is not advancing as quickly as others toward a pure fee-for-value model. Most negotiations with payers are totally centered around prices. You have to move past that to get to a fee-for-value model.

Is it because the insurance companies still are focused on unit price, which equals kind of a fee-for-service model, or is it that the providers should be pushing for that movement? I don't see the providers pushing for that movement, and I don't see the payers moving that aggressively out of the current model.

BROWN: Part of it is that the economy is so strong here, the population is growing and the physician supply is less than it should be. So, we have all of those factors that are working against the needed change. There also is a general labor shortage in health care and other industries in Georgia. As an employer, we have at any given time 500 openings, and nurses in town can work anyplace today or tomorrow and get a bonus to change their employer.

So, the employers also are worried about competitive benefits to retain their employee base. However, new models are being considered because the cost of our current product is unsustainable. We have to figure out how to get health-care costs under control for the employers so that the economy continues strong. And the answer to it isn't lower unit costs, it's a different model of care that better manages the utilization of services and takes care of the entire continuum of care. Just trying to beat on unit price may have been a strategy that worked 20 years ago, but it isn't going to work today.

HAMMOND: Let me give you an example that we've had several conversations about. Sometimes you have a payer focused solely on the unit price, and ultimately, the employer is focused on the total cost, but they have representatives who are only focusing on the unit price. They may drive someone to very low-priced imaging and the quality is not there and the image is not good, and then it has to be repeated. I think there are provider organizations like Emory that want to engage the employers and say, 'How can we talk about total cost? How can we talk about bending your cost on that total cost and not focus just on the unit price?' Again, for example, 40 percent to 50 percent of the back surgeries in this country are not necessary, and just because you have a less-expensive price on a back surgery, there is a possibility that the surgery should not have been done at all. As we have taken that on, we have been pushing the payer community into moving more toward a value-based reimbursement.

While we have a healthy price for total price per unit, when you look after risk adjustment, we actually manage the total cost better than the majority of the providers in the Atlanta area. But you have to get into that conversation, and I think that's where we're making that transition. There are so many infrastructure limitations that come into play right now. As one example, visit-based attribution models that are used to determine which provider system is accountable for a particular individual. There is no one good visit-based attribution model. They all have flaws. You almost need to look back and question whether the insurance products and the others really go back to having a selection of a primary-care physician while still maintaining the ability of self-referral to specialty care. With this change, you could eliminate the use of visit-based attribution models, which is a major infrastructure problem in managing populations today.

AKOPOV: Also, as to the original question of where we are on the spectrum compared with other metro areas, many comparable metro areas are way ahead of Atlanta in terms of penetration of the advanced-payment models. One of the best options, in my opinion, is relatively slow consolidation of the health-care delivery systems. The pace of movement toward the value-based health-care services, as Kevin pointed out, is clearly linked to the consolidation of the health-care delivery systems in the market. In that regard, the metro Atlanta market still is very fractioned, and I think that is one of the reasons that the third-party payers have not kept up with this transition. The consolidation has started to accelerate, though.

"There is not enough primary care for the patients we serve, truly not enough."
— John Haupert

MANAGING CARE

ARMSTRONG: You've talked about the continuum of care and coordination. Across the country, there are different philosophies about how you manage the continuum. Can any of you talk about what your philosophy is?

HAUPERT: One of the biggest issues in the Atlanta health-care market is that a huge infrastructure has been created over time to support the acute episode of care, but primary care has been needing – and continues to need – to be strengthened to provide proactive care for our patients. We have adopted a make-or-buy model to address the post-acute needs of our patients. We have outlined strategies for every single component of post-acute care, one of which is we own and operate the largest nursing home in Georgia. We've now built within that facility a rehabilitation center. We purchase post-acute services for our patients that we don't currently own, such as hospice care, home health care, long-term acute care and other post-acute services. Our contracts with those providers include very specific performance measures because we want the best care for our patients. Patients get their entire continuum of care through us. We look at that entire thing as constituting the cost or the episode of care for that patient.

So, that part has been very productive for us. Five years ago at Grady, the inpatient hospital was full of patients that couldn't be placed. Everything came to a grinding halt, and we wanted to save some room because we're taking care of patients who needed to be in other environments. We had to figure out the post-acute portion of that, which has proven to be very successful.

BROWN: So, we have a similar strategy – some make, some buy, some contract – based on the competencies we have. For post-acute, we use a lot of vendors, and now we're assessing and picking a few strategic partners. That means not having to have ownership in something we don't know how to operate effectively, but to integrate it so our patients who need to can get out of the hospital efficiently. Then when they get into another environment, we're connected clinically so that the care can be coordinated much more effectively than it has in the past, but not feeling that we have to own everything, like primary care, for instance. On the front end, we're doing more employment and less contracting. The key is getting all of the silos stitched together, whether we own and operate it or contract for it from a care perspective. We're trying to break down those silos by redefining how the process of care is taking place.

HAUPERT: One way it looks very different than even a few years ago is that if it's not a known situation and it's a contracted situation, we have care managers in the other facility overseeing our patients and helping coordinate care from our perspective.

Years ago, it would have been OK to check out of the hospital and into a post-acute environment; we were off the hook. But we need to make sure that we're following that patient and know what's going on with them in someone else's environment and how we then loop the patient back into continued care with their primary-care

provider.

AKOPOV: That is an excellent point. I don't think we're doing anything different from what you have been doing in the space to accomplish that "stickiness." The interesting thing is the post-acute care sites – nursing homes, in particular – are coming under the same scrutiny from CMS and commercial payers as the acute-care hospitals. The same rules of engagement are being applied to them as have been applied to acute-care hospitals for years.

For example, in the near future, nursing homes will begin getting penalized for unplanned patients' return to the hospital (an equivalent of hospital 30-day readmission). All of the sudden, post-acute care sites are trying to figure out how to accomplish these goals. And who has the best expertise in this? The large health-care systems. Let me give you one concrete example: total joints. The patient comes in and gets a joint replaced. As you so eloquently pointed out, we push the patient out of the hospital, wash our hands and we have no idea what happens next. If the patient went to the nursing home for sub-acute rehab, we had no idea what happened to the patient in the skilled nursing facility, and no control over spending or quality. And that patient may not reemerge until he or she comes to the emergency room with some complications or returns to their primary-care physician. Fast-forward to a totally different scenario, and today we have nursing homes in our primary service area with whom we have service agreements to deploy our physicians and advanced practitioners to provide care to patients in those nursing homes. What's happening with total joints patients is that we maximized as much utilization as we could in the hospital. A stay for a hip-replacement patient normally is less than two days, and cost per case is very low, so there's not much opportunity there. The greatest opportunity is in the post-acute setting. If you look at the length of stay of these patients traditionally in nursing homes, they all stay there for 25 days.

"On the front end, we're investing heavily in the underserved primary-care market."
— Kevin Brown

BROWN: The magic number.

AKOPOV: The magic number, because Medicare reimburses rehab care for up to 25 days. Bringing that length of stay appropriately down to 10-15 days can optimize the utilization. Also, increasing the number of patients who go home with physical therapy rather than to skilled nursing facilities is another opportunity.

So, assuming oversight of care delivery in the post-acute care facilities is the key to success.

HAMMOND: There are two unique things that we have done that we believe will improve our ability to provide value to the market. Every provider that is part of our health-care network must be connected to our Emory Health Information Exchange by a certain date. This connection allows providers with the different medical record systems to share key clinical information on patients they are jointly managing. As an example, if someone leaves our hospital and goes to their primary-care physician who is in the Emory Healthcare Network, then the key clinical information is shared electronically back to the primary-care physician office to, hopefully, create a better continuity of care for the patient. It also allows you to begin pulling certain across-the-board quality measures applied in different settings. That's one thing we've invested in, and it was a big initial investment, and then the ongoing cost of the maintenance of this component.

Another thing we have done is a unique exclusive collaboration with CareMore, which has had great success in managing populations by introducing a model that includes the use of Extensivisits. One of the most significant areas that creates fragmentation in the current delivery system is the hand-off points from the physician's office to the hospital to the post-acute facility or home. With the concept of Extensivisits, they follow some of the most complex patients through those hand-off points as a physician and can tell them if they're ready to go home or to a skilled nursing facility where they will continue their care in those settings as well. Patients are much more comfortable because they're not switching care teams. Those are two things we're trying to do as we're dealing with managing populations, because similar to everyone else, we don't anticipate owning every part of the continuum. There are other people who can do different parts, and we want to partner with those organizations. As a recent example, we just established a relationship with two urgent-care organizations in Atlanta to become part of the Emory Healthcare Network. As a part of them joining the network, the urgent cares must have a bidirectional connection to the Emory Health Information Exchange. So, now when we have a patient needing after-hour care who traditionally may have gone to the emergency room, if they're appropriate, we can say, 'We have a partnership with this urgent care.' The doctors now feel more comfortable sending the patient to our urgent-care providers because their patient is going to get what they need because that urgent care now can pull up what's been happening with that patient and contribute to any follow up.

BROWN: So, the alignment is being helpful because the skilled nursing facilities now are getting alignment with the same game plan. And now the physicians are as well with the roll-out of MACRA, which is a value-based program that also holds them accountable for a patient across the continuum of services. It's better lining up the incentives across what once were disparate sections of the industry, and you can't manage the total cost unless all of the pieces come together. That's been helpful regarding the journey of trying to create a different product.

CHANGING PHYSICIAN BEHAVIOR

ARMSTRONG: Let's talk about the physician piece of this, because in bending the cost curve, it's not going to be done inside the four walls of your hospital, right? It's really around changing physician behavior to help reduce that unnecessary utilization that is in all of our systems.

How do you engage the physician differently so they change their paradigm and start to really think about population management rather than caring for acute episodes and being on the hamster wheel?

AKOPOV: I think we all agree that, without having physician buy-in, none of this will be possible.

BROWN: Not just buy-in, but ownership.

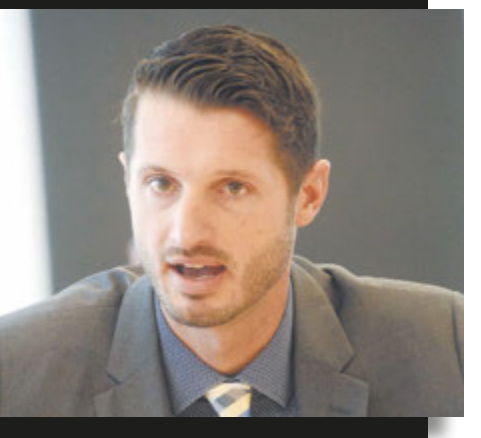
AKOPOV: Yes, you have to have physicians or board to embark on all that. So, how do you engage them? It depends. Most health-care systems are working with two distinct communities of physicians – employed by the health system and affiliated physicians.

In the Kotter model of change management, the first step is to create sense of urgency. If you look at it from the physician standpoint, that urgency has been created by the environment in which physicians are practicing. It started with PQRS, went on with the meaningful use of requirements and then with MACRA/MIPS. So, physicians are ready to engage in this new environment. WellStar's overarching strategy of the same is to gain alignment with physicians regardless of whether they're employed or affiliated. We call it parity. With employee physicians, WellStar has been quite successful at aligning physicians' value metrics, with those of the Healthcare System – in acute care, ambulatory and customer service. Then we created a system that rewards physicians for accomplishing those common goals. It's a win-win situation. The physicians accomplish these common goals and that moves the needle on those metrics for the health-care system at large. With affiliated physicians, it's a little different due to constraints in the legal and regulatory environments, but a Clinically Integrated Network seems to be the tool that aligns this group of physicians. Within CIN (we call it WellStar Clinical Partners – WCP), we developed metrics that are valuable and important to the health-care system at-large; the ability to share savings with physician-partners serves as an additional incentive. Affiliated physicians see the benefit of partnering with the health-care system.

HAUPERT: I agree, but at the same time, when you look at the final read on MACRA, CMS backed way down on its initial requirements and is putting in place a gradual but progressive process for reporting individual physician performance. The initial requirements do appear fairly basic, but MACRA will bring all providers, hospitals and physicians together to collaborate to provide quality outcomes for their patients.

AKOPOV: I believe 9 percent of the Medicare earnings at risk

"Let's talk about the physician piece of this, because in bending the cost curve, it's not going to be done inside the four walls of your hospital ..."
— Ross Armstrong



for the practice by 2022 will be a big enough club.

HAMMOND: I completely agree with Val that a lot of the physicians, and our physician leaders, want to see change. They're not happy with the health-care delivery, so the vision is there to say, 'We want change.'

The tough part is getting through those changes and assisting with those changes to get to a better outcome. And that's challenging. Some of the things that we've done in developing our Clinically Integrated Network was we realized health care is very local. Even within the metro Atlanta area, how a group of physicians in the Johns Creek area takes care of patients is different than how they may take care of patients in Midtown. So, we developed the network starting with local health groups of physicians and leaders in those communities to say, 'OK, I want to see change and I will help lead and take the ownership that you were talking about.' Then our board of managers is 100 percent physicians. The system itself has empowered those physicians to take full ownership to really guide the change. That really puts the physicians and caregivers in charge of the change. You also have to provide some enabling infrastructure. I don't think there's one provider who walks in the door and says, 'Well, I don't want to do a good job today for my patients.' It's how do you enable those things? That's where we're coming alongside as they identify their needs. For example, a big foundational part is converting a lot of our primary-care sites to patient-centered medical homes. We have a network of more than 2,000 physicians and more than 250 primary-care physicians, and half are private and half are employed, and we're working to convert as many of them to patient-centered medical homes as possible. There are different skill sets effectively manage proactively. We've created primary-care patient medical center training, and we bring in cohorts of different practices. We just completed our first cohort of practices and the physicians and other caregivers in their practices spent a lot of time, including some weekends, going through that training. A famous study done by the Brand Corp. a few years ago says that only 55 percent of what providers wanted to happen for their patients actually occurred. You want to fill those gaps with tools like disease registries that allow them to see what gaps are occurring and then provide training on how to do proactive outreach to patients to close these gaps in care. Just handing them the report and saying, 'Do better,' is not a long-term sustainable solution. You have to come with mechanisms to help them, but then they again want to take the ownership.

> *"... none of us, none of these health systems, can afford to own all of those issues when it comes to housing and education."*
> ***— John Haupert***

BROWN: The only thing I want to add is that we've gone upstream and said we have to give physicians leadership training. We have an internal MBA course for our physician leadership. We've had 200 physicians go through the course, and it's in partnership with a couple of universities. We've invested a lot in physician leadership on the front end, because there's no way we can get to where we need to go without physicians helping and leading the effort. We have this enormous talent that is clinically trained, but not necessarily leadership trained.

So, we have 200 physician leaders who are sitting there looking for opportunities to help lead a project, become a CEO or run a department, and it's been an enormous success for us on that front-end investment.

THE ELECTION

ARMSTRONG: We just had an election that surprised a lot of people. Obviously, there's now some risk to the groundbreaking ACA legislation that passed seven years ago. Are you thinking differently about your future because of the election that just occurred?

> *"WellStar is a strong believer in value-based care models, and is a recognized national leader for its success in achieving the healthcare triple-aim goal of higher quality, outstanding patient satisfaction, at a lower cost."*
> ***— Val Akopov***

HAMMOND: There are some underlying factors, regardless of who won the election, that are realities that either side really has to deal with: unsustainable health-care costs and inconsistent quality in outcomes.

If you look at the MACRA legislation on the Medicare side, that was one of the few things that was overwhelmingly passed bipartisan, because ultimately, Medicare runs out of money at a certain point. It has to deal with the issue. You may see some tweaks on the tactics of how it goes, but it's still the fundamental issue. We have to find a more sustainable model of producing better quality outcomes at a lower cost. In terms of the ACA, it has been struggling in this market. If you look at the insurance options available to individuals, at least here in Georgia, in 2017 a lot of the different insurance companies have fallen out and individuals don't have a lot of choices. I think it will be interesting. On the commercial side, health-care cost is one of the major factors of us being competitive in the world. So, employers and others are going to be looking to us as provider organizations to say, 'How can you do this more efficiently?' Again, there may be different ways of getting there, but I don't think it changes the underlying issues that still exist.

HAUPERT: Georgia is currently a non-expansion state. Several options for utilizing waivers and for expanding Medicaid have been presented to state officials. Hopefully, those options will still be considered in an ACA replacement model that will mostly likely be introduced by Congress in 2017. At the end of the day, uninsured individuals are better able to manage their health when they have access to health-care services via some sort of insurance. Hopefully, the state of Georgia will utilize whatever model comes out of Congress to improve access to health-care services for those who don't currently enjoy that access today.

ARMSTRONG: You're already at risk for the uninsured.

HAUPERT: Right. Part of the reason we've been doing population health work for as long as we have is that we own providing the entire continuum of care services for the patients we serve. Part of what we're hearing coming out of the Trump administration already, or the transition team, is the elements of the ACA that have been incredibly popular, including preexisting conditions and sustaining insurance for adult children. Even the replace part of it is really more around what's being discussed as the funding piece, whereas expansion has been very prescriptive from CMS to the states about what expansion can and cannot be. What they're looking at is block grants, primarily, which would leave that decision-making up to the state.

Then the big question is, 'What does Georgia do? If the state gets the block grant, what is it going to do?' The experience we've had with Medicaid has been that the state decided to move the management of many Medicaid patients to CMOs because that reduces some of the upside risk to the state. The CMOs are managing the care for the state, but very little "care management" has been occurring for the Medicaid population. Payment is still on a capped fee-for-service model that, in most cases, doesn't cover the cost of the care being provided. The two largest providers of adult hospital-based Medicaid services in Georgia are Grady and WellStar, and Grady is by far the largest provider of care to the uninsured. Should Congress go the way of providing block grants to states, then our hope will be that the funds are used to strengthen and improve the Medicaid program in Georgia and that those currently without access will gain access.

AKOPOV: I don't think we'll substantively change what we're doing. Remember my earlier comments about uninsured and underinsured patients we are caring for? We're not going to deviate from our core mission – to meet the needs of our communities. Let's refer back to the quadruple-aim, which serves as a framework for everything we do. The fiscal reality of 20 percent of the GDP spent on health care (and growing) is political-party agnostic; it has to be dealt with. As Patrick pointed out, SGR was repealed with bipartisan support, which is an extremely rare occurrence. This says a lot, doesn't it? The ACA in Georgia has been marginalized already, since most commercial insurers pulled out of the federal exchange market, and there has been no state Medicaid expansion. So, even significant changes to the ACA will not have a devastating impact on the health-care industry in Georgia. Regardless, as I stated earlier, as the largest not-for-profit health-care system in the state, we will stay the course of meeting the needs of our many communities we serve.

BROWN: The impact to the ACA here is less than other places, and if anything, it pushes us to accelerate our vision regarding a coordinated patient-centered care model and to make sure that the pieces and the parts are stitched together so that the consumer has a better experience, better quality and lower cost. Placing patients first wins in any scenario.