expert Perspectives
Systemlessness

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Note to Readers

Many health systems are only scratching the surface of the potential that their scale offers. It can feel difficult enough to maximise the operations of one facility—let alone a group of providers.

But we also know that to deliver the kind of care our patients want and need, very few of us can do it alone. So this year, the Global Forum set itself the task of looking across the globe to find what a true system of care looks like and how others have achieved it.

We found several leading organisations that have built systems of care purposefully and with an eye for sequential and reinforcing benefits. We refer to these cumulative benefits as ‘systemness,’ and they follow an order of tackling back office consolidation, standardising clinical delivery, paring down the fixed cost base, and finally driving new collective objectives.

As part of our commitment to help members understand the path towards systemness and the critical areas of focus, we’ve compiled some of our most popular posts from our blog, The Forum, on this topic. Since not every organisation has the same ambition for system assembly, we’ve chosen blog posts that outline insights and strategies that will be helpful regardless of where you are on your systemness journey. Here are some systemness topics you will find in this resource:

• System access strategies
• Diagnostic questions for accountable care readiness
• Clinical standardisation methodologies
• Cross-continuum system planning

We hope that these insights are helpful. As always, please do not hesitate to contact our team with any questions or comments at gfhi@advisory.com.

Best regards,

Vidal Seegobin
Practice Manager
Global Forum for Health Care Innovators
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## SYSTEMNESS AS AN ASSET | 20
Our research shows that properly organised systems can excel in providing predictable, consistent care. Here are seven characteristics that set these organisations apart.

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Pursuing integration can mean different things for different organisations. Our survey of 150+ members revealed the four most critical and challenging integration goals.

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3 reasons health systems are stuck in neutral
Over the past few years, I’ve held many informal strategy sessions with executive teams of both large and small provider systems.

After participating in dozens of these sessions, it is becoming clear to me that while each markets is unique, these executives and the systems they lead are virtually clones of one another. They are wrestling with the same problems, and plagued by the same shortcomings, as they attempt to transform fee-for-service mindsets and organisations into entities aligned to where health care is headed.

Specifically, provider systems around the world, with very few exceptions, are alike in three important ways.
A complex and sometimes irrational portfolio of assets

First, practically every health system I encounter is an aggregation of disparate assets: acute care hospitals, employed doctors, urgent care centres, ambulatory surgical centres, ambulatory clinics, nursing facilities, and so on.

Rather than select assets according to a master plan, health systems accrue them over time at the direction of successive chief executives for any number of reasons—some principled and others expedient, oftentimes to counter competitors. This being the case, there is little logic to the system’s geographic footprint.

Worse still, within the inventory of assets, there is redundancy, excessive capacity, an undesirable weighting of doctor types, and a tangle of supplier relationships. As things now stand, some of the assets benefit the system, while others are an iron ball around its neck.

Strategic uncertainty about how to leverage those assets

Second, sitting atop these assets, executive teams have little idea what to do with them. To be sure, some progress has been made in taking advantage of scale, mostly in back-office functions.

And the executives agree that under health care reform they must mobilise against care quality. But having these objectives in sight, they have no sense of how to take what they have—a mixed bag of assets—and reconfigure it into the provider entity they know they’ll need.

Reluctance to upset the status quo

Third, even when there is a clear strategic direction, executive teams are reluctant to move far enough or fast enough.

Their timidity is understandable: to transform disparate assets into integrated health systems capable of delivering value-based care, health system executives will need to overturn the status quo—comprehensively and decisively—and shoulder the resulting fallout.
For starters, duplicative facilities—hospitals included—will have to be shut down or converted to a new activity. Clinical services will have to be consolidated. Hospital management will have to be streamlined, or disbanded entirely in favour of centralised control.

On the medical-staff side, health systems will need to impose order on autonomous clinical practice by adopting and enforcing guidelines, closely monitoring doctor performance, and ‘coaching’ outliers. All this will require some doctors telling other doctors what to do, and expecting compliance.

In many markets, solo doctors and small independent practices will cease to exist.

**Radical change, after all, cannot occur without an equivalent amount of disruption to the existing order.** The transition can’t bring everything and everyone with it; old-world behaviours can’t be preserved; and many, many people will have their interests crossed and feelings hurt.

Health care systems cannot be true ‘systems’ by asking employees to make the right calls on a voluntary basis. Nor will they survive by propping up pervasive inefficiencies.

**The single active ingredient: Leadership**

Considering how challenging the road ahead will be, I’m convinced the health systems that succeed will do so because of the quality of their leadership. Successful health system leaders will need to be able to form a compelling vision of where health care is headed and what will be required of providers. They will need conviction—the fortitude to steer the organisation where it must go, despite the expected turbulence. And they will need to communicate that vision and that conviction with the entirety of the organisation.

Will your executive team rise to the challenge?
As discerning governments and commissioners challenge hospitals and health systems to prove their value in an increasingly strained marketplace, integration has risen on many executives’ priority lists. That may be because integration promises strategic nimbleness; or because it can create a more unified and recognisable external brand; or even because it can bring tangible improvements in cost, quality, and patient experience. But whatever their reason for pursuing integration, hospital and health system executives are telling us that acting cohesively and addressing breakdowns in ‘systemness’ are top concerns.
Survey reveals four most critical—and challenging—integration goals

Even with this widespread focus on systemness, pursuing integration can mean different things for different organisations.

To better understand which elements of systemness are keeping providers up at night, we surveyed more than 150 of our members. We asked them to rank a list of 18 integration initiatives by level of difficulty and importance to the future success of their organisations.

Four distinct initiatives rose to the top, with more than a quarter of survey respondents selecting those initiatives as one of their top three picks against both vectors.

### Percentage Reporting Initiative as Most Challenging and Most Important for Organisational Success

*n=160 C-suite executives

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<tr>
<th>Percentage Rating Initiative as Most Challenging</th>
<th>Percentage Rating Initiative as Most Important for Success</th>
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<tr>
<td>Rightsize the service portfolio</td>
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<td>Develop system culture</td>
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<td>Improve system-wide patient navigation</td>
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<tr>
<td>Improve supply chain</td>
<td>Create system-wide brand</td>
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<tr>
<td>Optimise capital allocation</td>
<td>Centralise back-end functions</td>
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<td>Rationalise physical footprint</td>
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* Of the initiatives selected as ‘underway,’ which of the following are most challenging? Of the initiatives selected as ‘underway,’ which of the following are most important to your organisation’s success?
Doctor alignment has been a perennial issue for hospitals and health systems, especially efforts to optimise referral streams. But today’s doctor alignment aspirations extend far beyond that: hospitals and health systems view engagement with and leadership from doctors as a crucial linchpin to success on a wide range of cost, quality, and experience initiatives.

When it comes to driving clinical standardisation, for example, best-in-class organisations put significant time and energy into building clinical governance structures that empower doctors to lead the charge on creating and deploying care standards. Doctor alignment is similarly crucial for many cost-improvement initiatives (e.g., rightsizing service portfolios/rationalising assets, centralising purchasing of doctor preference items) and patient experience initiatives (e.g., improving care transitions, creating a unified patient experience).

Driving clinical standardisation
Reducing clinical variation was the single most popular selection by both measures. This isn’t surprising; in markets where payment is increasingly tied to value rather than volume, providers are looking to improve quality across their entire enterprise.

And as systems double down on margin improvement, they see a significant opportunity to reduce cost through improved and consistent care processes. For systems that have already targeted obvious cost saving opportunities such as reducing staff, controlling supply costs, and centralising back-office functions, clinical standardisation represents the next frontier of potential cost savings.

Clinical standardisation’s high difficulty rating among survey respondents, meanwhile, is almost certainly linked to the second most widely selected initiative along both vectors: creating system-wide doctor alignment.
Increasing IT interoperability

Much like improvements in doctor alignment, the third most common selection—increasing IT interoperability—can significantly affect success across a wide range of system goals. In our conversations with provider executives, they often cite breakdowns in communication and the exchange of meaningful information as key barriers to achieving system goals.

Furthermore, IT interoperability is crucial not only for sharing information but also for enabling internal benchmarking and allowing organisations to identify strengths and improvement opportunities.

Integrating assets post-M&A

Finally, survey respondents identified post-merger integration as a pressing and challenging issue. Although for most organisations this aspect of integration tends to be more sporadic than others, its appearance near the top of the list in both vectors suggests that it’s likely to become a lasting priority.

As long as health systems continue to grow through consolidation, the path toward systemness will be an ongoing challenge, and in many cases hospitals and health systems will need to repeat processes and integration initiatives time and time again.

At times, organisations anticipating future consolidation have used that as a reason to table integration initiatives in the near term. But rather than putting off integration indefinitely, top performers recognise the need to continually evolve and modify processes and structures to account for growth and integrate new assets into the organisation.

For more on this topic, visit: advisory.com/globalforum
Make no mistake about it, operating in anything resembling an accountable care model is incredibly difficult work. It makes providers more responsible for outcomes. It requires us to think about nonclinical factors. It forces us to rely on others. The gains are hard won and may not even be visible in the near term.

And yet most will argue that it’s the right thing to do.

Given the inherent challenges of accountable care, it’s worth evaluating whether your organisation is ready to make the changes that are needed to succeed under this model.

5 questions to determine your accountable care readiness

BY VIDAL SEEGOBIN
These are the five critical questions you need to ask yourself and your organisation before you move forward on accountable care:

1. **Are you ready to destroy downstream demand?**

Accountable care systems or organisations assume financial or clinical responsibility for a defined population, usually through some form of risk-based or capitated contract. They’re rewarded for keeping key clinical indicators high and keeping cost and use low.

We think of this as a risk-management challenge. On the one hand, you and your partners need to effectively manage clinical conditions (performance risk). On the other, you need to determine ways to shift demand to lower and clinically appropriate sites of care (utilisation risk).

In practice, we find that accountable care organisations or systems that are able manage these kinds of risk effectively destroy inappropriate or avoidable demand. The largest measured savings come from reduced hospital and pharmaceutical use. For health systems operating at or above capacity, this is a welcome and worthy goal. But for others, particularly those with excess capacity, this reduction can have negative financial implications.
2 Are you ready to work with primary care in new and meaningful ways?

A major reason why many health systems are considering accountable care arrangements is that more patients are struggling to manage one or more long-term conditions. Acknowledging that one of our major goals under an accountable care model is to reduce inappropriate and avoidable hospital demand, we need primary care to transform into a new and more interconnected web of pre- and post-hospital services. That transformation will likely include a role for the hospital—perhaps extending clinical decision support to primary care partners, or co-locating with new care team members, or even investing in new delivery models depending on how progressive your goals are. Accountable care cannot succeed unless primary care services are robust and an attractive first point of contact for the majority of your patient population.

3 Are you willing to stick to this for longer than two years?

By this point you should have a sense that accountable care is going to be a challenging and complicated road to navigate. The adage goes that Rome wasn’t built in a day. Yet I’ve been involved in numerous discussions where the assumption is that savings can be achieved early (i.e., in the first 2 years). To be fair, we have seen this happen, but it’s more the exception than the rule. In fact, the world’s best accountable care organisations have been at this work for over 10 years, with many not seeing significant savings for the first five years.

The good news is that managing a population is a lot like learning an instrument: the more you practice, the better you get. But leaders thinking about this work should set realistic timelines and be prepared for steps backward before steps forward—particularly in the early days as you start to surface unmet population demand.
Are you ready to think more like an insurer?

Accountable care organisations or systems succeed when they effectively manage the health of a population. That means understanding the needs of individuals who have more than one concurrent condition, plus psychosocial risk factors that make it difficult for them to self-manage. It also means turning that understanding into methods and protocols to predict risk of escalation into heavy health care use. You have to think more like an insurance provider—predicting risk.

The good news is that while your inclination might be to think of this problem as one requiring reams of data and a huge investment in information technology, many high-performing accountable care organisations started with modest means. What they are able to do—either through information sharing or staffing—is to build approaches with patients that surface both clinical and nonclinical challenges, and develop meaningful plans to support patients across these challenges.

Are you prepared to balance delivery and incentive changes simultaneously?

The last question you have to ask yourself before moving on accountable care is whether you are willing and able to balance two interconnected but potentially competing changes.

The first change is how we connect and deliver care. This includes the ways address the need to connect the clinical and nonclinical, the ways we shift towards multidisciplinary teams, and the new roles we develop to cover gaps. In short, everything we’ll have to do to reduce demand.

The second is how we reward outcomes instead of paying for inputs. This involves payment change, which often falls outside the remit of any one provider. But hospitals in particular have to ensure that they’re not moving too aggressively on demand reduction strategies without being compensated for the lost demand. No hospital can afford to forget about finances. Incentives to destroy demand need to exist or be created.

For more on this topic, visit: advisory.com/globalforum
Helping patients access health care is an age-old problem, but it’s also an ever-changing one. This summer, we held our first-ever Patient Access Executive Summit in the US, where access was rated the #1 issue of interest by attending CEOs. At the summit, we spent a full day unpacking what it actually means to focus on patient access to care.

Progressive US health care leaders led the discussions, and it was inspiring to hear different perspectives on why this issue is so important to our members. One participant put it best: “We’re not selling widgets. Patients and people are involved at the end of the day.”
Across the 14 organisations present, different constituencies owned patient access operations at almost every one—spanning from chief marketing officers, to individual hospital presidents, to chief medical officers. And it’s understandable, since access operations cross functions and facilities. In many ways, this focused competency is still emerging, and dedicated patient access teams (unicorns, in our view) are still rare. We were excited to have a few directors of patient access in the room for the summit, but the group was mostly CEOs, COOs and VPs of operations, medical directors, and other network leaders who are very much focused on improving access to care at their organisations.

To ensure success, leaders must clearly define and consistently communicate a purpose and vision across the system. Our co-host shared that Lehigh Valley Physician Group, a doctor practice in Pennsylvania, US, defines access as ‘every touch point between the patient and our health network, bi-directional and relentless in nature, in the pursuit of true and meaningful patient partnerships in their health, care, and experience.’ This mission statement ensures that when it comes to access, everyone at Lehigh Valley is speaking the same language.

Still, to truly transition access to care from a project orientation to a system orientation, creating a structure of ownership is crucial—whether that’s setting up a new and dedicated team or a structure wherein existing teams work together in a new way.

But there’s no playbook to follow, and designing an access-optimised system infrastructure is a complex puzzle that keeps changing form. Here are a few key takeaways from the summit that I came away with:

1. **Access starts with a clear vision and sponsorship**

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2 You can’t get anywhere without your doctors on board

We all know doctors are burning out at rates higher than we used to see. And advancing access to care is like any important initiative—it won’t happen unless the doctors are on board. So how do you engage them while recognising the burden of change?

First, give doctors the reins to lead the change. One presenter walked us through how his organisation put together a guiding coalition of doctors to lead the operational redesign—with the expectation that they should challenge the status quo and ensure that doctors’ needs are being met so they can provide high-quality care to their patients. Next, support those doctors with the tools and insights they need to rally champions. For example, one of our attendees brought data to his providers who struggled getting patients in for appointments—he showed them that patients will actually go to another doctor or health system (or avoid care altogether) if they aren’t able to get on the schedule for more than a week or two, which created an evidence base for other doctors to latch onto.

3 Metrics are easy to get—insights are much harder

In a live poll of the attendees, Advisory Board’s Duane Reynolds asked the group: “What is the most challenging aspect of access reporting and analytics?” The top answer—capturing 45% of the group—was that there are just too many metrics and data sources to track; after that, 33% said the biggest challenge is in making data actionable. While most of us may have access to relevant data, it’s incredibly hard to think holistically about those data points, balance real-time and lagging metrics, and know which levers to pull for the greatest impact.

Additionally, the attendees acknowledged that we don’t have adequate industry benchmarks when it comes to measuring patient access to care. For example, if it takes an average patient 45 days to get an appointment, that’s not the target to strive for—so organisations need to set goals that better honour and reflect their mission to patients.
4. You don’t have to tackle everything at once

It takes an investment in organisational development to move from pockets of access to a network-wide strategy and solution. However, it’s impractical to focus on every practice, doctor, or initiative right off the bat.

For example, Lehigh Valley deployed a strategic plan that broke practices into three tiers:

1. **Pilot practices**, where they implemented identified solution bundles and went through systemic transformation

2. **A broader group of practices**, where the team focused on piloting targeted elements

3. **The remainder of the practices**, where they included patient experience teams, workshops, and shared learning opportunities

While the entire effort required an investment from the organisational development team, with 12 people dedicated to the initiative, this layered approach allowed the organisation to deploy resources efficiently and place more emphasis on the practices most in need of transformation.
Health care is an industry that seeks answers in familiar places, and we’ve repeatedly seen hospitals and health systems respond to financial pressures and regulatory changes by turning to consolidation. In some respects, this has been a sound and successful strategy.

But some advantages are harder to come by. Few systems have pursued operational efficiencies as aggressively as they might have, and major changes to service and facility portfolios are rarely at the top of integration agendas. In many cases, it seems that the larger a system gets, the less effective it becomes, as conflicting incentives, redundant structures, fragmented information, and a range of other troubles impede concerted effort. In short, too many systems lack ‘systemness.’

Clinical standardisation is especially prone to these pitfalls...

Efforts to improve the quality and consistency of care through clinical standardisation—a crucial task in any organisation today—are particularly vulnerable to failures of systemness.

It is naive to expect adherence to agreed-upon, evidence-based standards if doctors and hospital leaders operate independently, rely on siloed data, and are never held to account for system-wide performance. What’s more, as a system’s size increases, so does the potential for unwarranted variation in both practice and outcomes.
...but also poised to benefit from the power of scale

On the other hand, systems can bring unique strengths to bear. Systems’ ability to collect and assess large amounts of evidence from within their organisation enables them to address common concerns about external, ‘cookbook’ standards.

In addition, a successful system that delivers value not only to its patients but also to its internal stakeholders can make a stronger case for teamwork and engagement. And of course, systems draw on larger financial, technological, and intellectual resources, which can prove exceptionally valuable in overcoming many operational barriers to effective clinical standardisation.

Seven characteristics of systems using scale to their advantage

Our research shows that systems, properly organised, can excel when it comes to generating a true product advantage through predictable, consistent care. Note that the elements of ‘proper organisation’ are not structural; in fact, our research shows that top performers vary widely in core structural features such as size, location, and density.

Rather, we have observed a set of seven common core principles that are foundational to best-in-class systems’ success. These characteristics enable organisations to overcome the unique challenges they face as multi-regional organisations striving to set consistent care standards across large and often dispersed footprints:

1. The system’s top quality champions are the board and CEO—not just clinical leadership. Top performers lead from the very top, with the system CEO and board propelling the organisation toward greater standardisation.

2. Final authority to approve and endorse care standards is delegated to a system-level entity. A corporate-level structure with cross-system oversight has the broad view necessary to identify variation and prioritise among areas of opportunity.

3. The makeup of care standard working groups is as diverse as the system’s clinical network. Systems are likely to have a range of clinical relationships—groups tasked with developing standards should include representation across all alignment models.

4. The role of local medical executive committees is to provide input and encourage adherence, not to develop care standards. Facility-based medical executive committees should no longer be the sole platform for quality improvement; however, systems must solicit their input along the way.

5. A centralised pool of experts supports implementation in lieu of facility-led quality departments. Centralising quality improvement staff at the system level allows the system to deploy assets where and when they’re most needed, extending the reach and efficiency of the system’s staff.

6. Multiple types of incentives are necessary to account for inevitable variability in doctor alignment models. Creative use of individual and collective incentives allows systems to encourage adherence within a diverse doctor network.

7. Rigorous scorekeeping not only assesses protocol efficacy but also enables organisations to overcome trust barriers. Scorekeeping gives the corporate office the proof of concept necessary to build trust among dispersed leadership teams and frontline staff members.

For more on this topic, visit: advisory.com/globalforum
Health system M&A doesn’t always deliver on its promises, sometimes causing a rise in costs instead of the intended economies of scale. In fact, Booz and Company recently reported that 20% of acquired hospitals in the United States experience negative margins that continue two years after a deal.

To avoid the baggage of M&A, we’re seeing many systems favour a ‘merger-lite’ alignment approach. They’re coming together through clinical integration, accountable care organisations, or other regional affiliation models to form a multi-member network that offers the benefits of scale as well as continued independence.
I recently spent a few enlightening days with some of the largest regional multi-member networks in the US that are taking this approach. Based on the success stories and struggles of participants and my work with multi-provider ‘networks of networks,’ I’ve learned the following lessons.

FOCUS ON YOUR CORE

Of course, there are major strategic benefits of building an alliance of multiple networks—all without integrating ownership. The big ones include:

- **Financial and clinical value** for the aligned health systems and their patients
- **Efficiency of shared functions** and infrastructure
- **Consistency in care delivery** through effective employment and clinical integration
- **Competitive positioning** for contract negotiation

But simply putting your resources together doesn’t necessarily create value or market strength, nor is it practical to run after all of the benefits I’ve mentioned. In fact, the bigger you get, the farther afield you might drift from what the market actually wants to pay for, spending more to develop a product that doesn’t have a market.

The most successful network alliances are built around a shared focus, whether that is to design a technology and data sharing infrastructure at scale, to generate supply chain efficiencies through purchasing power, or to coordinate as a market-responsive, regional population health manager. Ideally, these business aims and outcomes are identified in the early stages of network development.

PLAN THE EXIT STRATEGY

Members of an aligned network are not married to each other like in M&A. This means that it is critically important to include specific provisions in the original agreement about the consequences of walking away. Some examples I’ve seen include:

- Members have to make a significant financial contribution in order to leave
- The acquiring entity has to continue to fund the network for the remaining partners over a specified period of time
- There are significant geographic and time restrictions to starting a competitive network

Here’s an example of why this is such a big deal. Recently, five hospitals in the US formed a federation in a competitive, urban market in the Northeast to work collectively on cost and quality initiatives. But circumstances changed for some of the participants, and a number of them were acquired by regional competitors. After this the federation fell apart quickly, and suddenly there were bigger competitors to contend with in the market.

Interestingly, one of the major benefits to participants in network alliances—indpendence in system ownership—can also be one of the most risky elements for the network as a whole. This certainly doesn’t mean these partnerships are any riskier than M&A, but whatever strategy you pursue to build a regional network comes with a unique set of challenges to consider.

For more on this topic, visit: advisory.com/globalforum
Policymakers and health care leaders point to primary care doctor shortages, patient complexity, ineffective payment models, and care fragmentation as reasons for a decrease in care quality. By now, innovative solutions to overcome these struggles have been piloted widely.

One organisation that has worked to solve these challenges is Buurtzorg, a Dutch home care organisation that has attracted international attention for its innovative use of independent nurse teams in delivering high-quality, relatively low-cost health and preventive care. ‘Neighbourhood Care’ translates to ‘Buurtzorg’ in Dutch. Its value proposition is to swap a traditional care team for tenured nurses to provide comprehensive care management, reduce fragmentation, and keep patients independent and at home for as long as possible.

We spoke with Jos de Blok, CEO of Buurtzorg, about the organisation’s history and goals, as well as their keys to success. What follows is an edited transcript of the highlights of our conversation.
Q: Why did you start the Buurtzorg model?

A: In Holland during the 1990s, we developed a new payment system that caused fragmentation in the elderly and health care systems. Before then, the Netherlands had a primary care system focused on community care and prevention; after, primary care became task-oriented and prevention became secondary. Providers were paid for activities rather than holistic care.

Many organisations restructured. They shifted their attention from identifying health care problems and solutions to performing the activities they were paid for.

As a result, health care service provision deteriorated. Patients started to receive much longer and more care than they should have, had doctors intervened earlier. Quality went down.

The change in payment structure also brought about administrative burdens and complexity around choosing the right care approach due to multiple payment layers and transaction costs. This was highly frustrating to nurses, who couldn’t provide the care they wanted and needed, but were pressured to make care decisions based on funding.

With a focus on cost and activity, rather than quality, many nurses felt less fulfilled in their jobs. It actually got worse as time went on because patients increasingly complained about the quality of care they received. Nurses became the target.

Then in 2006, I realised that things had to change. This was the starting point for Buurtzorg.

Q: What type of change did you envision?

A: I decided to launch an organisation to improve care provision and staff satisfaction, based on the principles of community-based care. The new organisation was built on integrated budgets, horizontal organisational structures, and a solid IT system.

The solution I envisioned was one that would not only improve care quality and stakeholder satisfaction, but also allow for cost savings. The goal was to pay little for overhead cost by streamlining administrative tasks through IT capabilities and reducing care team participants to one point of contact.

We switched from care provision by a team comprised of lower-skilled medical support staff and doctors to care managed by tenured nurses who could provide comprehensive care and keep patients independent and at home for as long as possible.

It took more than six months to move from vision to operation. We were careful not to launch another home care organisation similar to those that already existed, but to create a system change instead.

There were already too many home care organisations in Holland, and they all shared the same problems—high cost and low-quality care provision. Their overhead costs were around 30%. Our goal was to decrease these costs to around 5% to 10%. And we did. Over time, our overhead costs became significantly lower than the average of home care organisations within the Netherlands, allowing us to reinvest money into highly skilled labour. The experience and skill level of our nurses allows them to work at top of license, replacing the need for a primary care doctor and a bigger care team.

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The Esther Model

How one patient redefined an entire system vision in Sweden
In 1997, an elderly Swedish patient known as ‘Esther’ arrived at her general practitioner (GP) experiencing shortness of breath. The GP decided she needed emergency care and called an ambulance. During her five-and-a-half-hour journey through the system, Esther retold her story to 36 clinicians before she was admitted to the hospital and received treatment.

This journey highlighted a more pressing problem than just the glaring inefficiencies present across the continuum. Esther found herself lost in a system built around the provider, not the patient. With Esther’s experience in mind, Jönköping County Council sought to fix their system’s elderly, complex patient care—and thus the Esther Model was born.

‘WHAT’S BEST FOR ESTHER?’

Over the next two years, a GP-led team conducted interviews and workshops with providers to pinpoint care gaps and inefficiencies. They found that patients felt health care staff were too busy to listen to them, and that too many providers were involved in their care. The analysis also uncovered how uncoordinated the system was—it was full of redundancies, inefficiencies, and variation.

To address these challenges, they developed new care processes and the mantra, ‘What’s best for Esther?’ The new model elevated individual patients to the centre of care decisions and coordinated providers by aligning them around giving ‘Esther’ the best care possible.
UNITING PROVIDERS UNDER ONE VISION

To reduce fragmentation and increase coordination, Jönköping developed multiple avenues to bring providers together to co-design a system vision while ensuring individual Esthers remained central to their work. They focused on four streams of work:

- **Quarterly Esther cafés**: Cross-sector patient experience meetings held to share stories from recently hospitalised patients.

- **Yearly steering group**: Committee of community care chiefs of municipalities, hospitals, and primary care who discuss challenges seen across organisations.

- **Annual ‘strategy day’**: Nurses, doctors, coaches, managers, and Esthers come together for team-building exercises and to create a vision for the network.

- **Ongoing training**: Inter-organisational education sessions on palliative care, nutrition, fall prevention, and other topics to facilitate collaboration and understanding.

This model and meeting format emphasise that this is truly a network of providers who are equals in care provision. Most importantly, each meeting involves at least one Esther to guarantee that the patient’s experience is always included.

ESTHER COACHES DRIVE FRONTLINE CHANGE

In 2006, the network began training Esther Coaches to spread the initiative across the continuum and ensure continuous quality improvement. Coaches, usually nurses or allied health workers, are not
paid for this commitment—rather, this work is seen as part of their jobs. To become a coach, they receive eight days of training in problem identification, quality improvement, and client focus.

In their respective organisations, coaches are responsible for using this training to promote frontline improvement projects, lean thinking, and positive psychology in addition to their normal workload. And just like the cross-continuum meetings, every training session must have an Esther in the room.

RESULTS AND INTERNATIONAL ADOPTION

In Jönköping, the Esther project has been tied to a 30% decrease in ED admissions between 1998 and 2013, as well as a 9% decrease in 30-day readmissions for patients 65 and older between 2012 and 2014. Based on this success, the model has gained attention and traction around the world.

In Singapore, SingHealth Regional Health System began partnering with community organisations and GPs in 2016 to develop their own Esther network. They now have 60 ambassadors from hospitals, the community, and primary care practices leading the project.

We also saw Esther expand to two systems in the UK in 2016. In South Somerset, the same Esthers attend cafés every other quarter to report on progress they have seen. In Kent, they are expanding upon the model by offering cafés every two months and training care workers, social assistants, chefs, and maintenance workers to be a part of their vision.

By organising health care around individual patient needs, these regions are overcoming fragmentation and transforming care throughout their entire system. But more impressively, they are able to improve care for Esthers every step of the way. •
Banner Health’s approach to system-wide clinical standardisation
In September 2015, Banner Health in Arizona, US, announced six new system-wide clinical standards. They all went live on the same day at all 25 of Banner’s facilities. Now those standards are part of the ‘Banner way’ of practice. This process is now repeated every month at Banner, with its system-level care management structure overseeing the constant creation and implementation of care standards.

The rigour and resources Banner dedicates to clinical standardisation efforts are enviable—but it wasn’t always that way. Banner started as a fragmented system post-merger in 1999, with few doctor leaders and little cohesion across the medical staff. Now it is a US leader in taking a system approach to reducing care variation.

So how did Banner get there? The system’s doctor leaders told us about three strategies that turned the dial on this clinical, and cultural, transformation.
Secure doctor commitment to care reliability

If you analysed the mission statements of different health systems, you wouldn’t find many substantive differences. Every organisation dedicates itself to clinical quality, but often this is mostly lip service. Many organisations don’t invest the up-front will and resources to build a system-wide infrastructure that holds all facilities to a consistently high level of quality and safety.

Banner has established a clinical vision of providing reliable, high-quality care systemwide. Employed and independent doctors alike support this vision because it aligns with their values, including:

- Fixing the system, rather than blaming individual doctors for underperformance
- Putting doctors at the forefront of developing system-wide clinical strategy and care standards
- Implementing care standards based on evidence or clinical consensus, with rigorous outcomes monitoring
- Ensuring every patient in the system receives the best possible care

Notice—these efforts all focus on improving the quality of care. Banner does not incorporate cost reduction into its clinical vision, though cost savings is a positive externality from Banner’s standardisation efforts.

Build a clinician-centred infrastructure

Too often, systems create clinical guidelines and leave adoption to the local levels—leading to variation in implementation and outcomes. In contrast, Banner has built an extensive ‘machine’ to create and implement a ‘Banner way’ of practice.

Banner has a centralised (but inclusive) clinical leadership infrastructure that decides what standards clinicians should follow. And the system provides wraparound supports such as process engineers, data monitoring, and clinical workflow tools to ensure every frontline clinician can easily adopt those standards.

“It’s not just asking the doctors to come together to create something and hope that it gets cascaded through the system. It’s really a structure, and it’s very well-resourced.”

Dr Michael O’Connor, Chief Medical Officer
Banner Casa Grande Medical Center
For instance, Banner brought in an out-of-industry engineer with a background in helicopter manufacturing to walk its obstetricians and nurses through a meticulous process to outline every component of the labour and delivery process, from when a mother arrives at labour and delivery to when the baby and mother go home. The session enabled Banner providers to identify ‘failure locations’ and how the system could address those from an engineering perspective.

**Integrate independent doctors into organisational culture**

What’s perhaps most impressive about the Banner story is that, with an 85% independent medical staff, the system has created a culture in which all doctors participate in efforts to reduce care variation.

Banner encourages independent doctors to participate in Clinical Consensus Groups—and gives them the authority and support to truly transform clinical practice. Even though independent doctors are paid a per diem rate to participate, less than a third end up submitting their time sheets for compensation.

Of course, some doctors will be resistant to change. In those cases, Banner has embedded clear adherence expectations into ongoing professional practice evaluation (OPPE) and peer review, and will have escalating performance conversations with outlier doctors.
In the early part of this decade, the market was suffering from a cost, utilisation, and value problem. Consumers were using more and more, and yet their real-world outcomes weren’t improving—if anything, they were getting worse. But providers had no incentive to change.

Even though the value of their product was degrading (with consumer costs up but results not following suit), providers’ revenues were consistently rising. Therefore, the structure of the market, and the products offered to consumers, stayed virtually the same, year after year.

If you think I’m talking about health care, think again. This is the story of the laundry detergent market. But what happened next has direct implications for hospital and health system strategy.

The dirty truth about detergent
In case you aren’t a laundry expert, let me explain a bit further.

People tend to use too much detergent when they wash clothes. Over time, manufacturers have made their detergents more and more concentrated, but that has resulted in even greater overuse of detergent.

Clothes washers don’t work as well when people overuse detergent, but manufacturers haven’t had a compelling reason to address the ‘too much detergent’ problem; after all, more detergent used per load translates into more sales.

Innovation agitating the market
In early 2012, the US consumer goods leader Procter & Gamble launched Tide Pods, one of the first premeasured liquid laundry detergent products. In case you’re unfamiliar, here’s how they work: each pod is essentially a plastic capsule filled with a shot of detergent, so rather than a cupful of liquid or scoop of powder, consumers add one pod to each load—and that’s it.

What Tide Pods tell us about health system strategy

BY THOMAS CASSELS
P&G didn’t do this because they had to—sales of its detergents were strong and growing, though competitors had been gaining market share lately. Their motivation was to create a product that was easier to lift for the elderly and less messy for busy parents.

At any rate, introducing Tide Pods was by any measure a risky move; P&G jeopardised its own robust sales with a product that virtually ensured that consumers would use less detergent. Indeed, the overall consumption of laundry detergent fell in 2012 for the first time in many years, as consumers flocked to the new, convenient Tide Pods product.

But P&G’s gamble paid off for them. They captured a commanding portion of the new ‘unit-dose detergent category,’ taking market share from other manufacturers as well as their existing customer base. The losers in this scenario? The other detergent manufacturers, who stuck to their old approaches and were caught flat-footed when Tide Pods swept through the detergent aisle.

Tensions bubbling up for health systems

Based on what we have been seeing around the world lately, the acute care market is undergoing a shift similar to what detergent manufacturers experienced.

Certain health systems are investing in the equivalent of Tide Pods—what we call ‘care transformation’ or ‘value-based care delivery.’

Through care management, by supporting better patient decision-making and rewarding stakeholders who make financially responsible choices, these health systems are improving outcomes while reducing utilisation and costs.

The lesson of the Tide Pods introduction suggests that if there is a major transformation coming, it’s better to be a participant in the transformation rather than just a downstream recipient of the results. Of course, a sound first-mover innovation strategy requires a plan to accrue business value from transforming the market. Just as P&G realised success with the Tide Pods introduction by shifting market share as well as raising price, health systems need a mechanism for getting paid for their innovative activities.

Create an intentional, forward-looking strategy

From what we’ve seen, not all ‘first-mover’ health systems are aspiring to completely redefine themselves. Some have been building accountable care organisations, participating in shared savings models, or pursuing other novel risk-sharing arrangements.

But they are all thinking about their businesses differently than they did when their principal business was operating acute care hospitals—and they’re doing so not because they have to, but because they can. These innovators are creating an intentional strategy for the future, rather than waiting for their biggest utilisers or their biggest competitors to act.

The story of Tide Pods offers a cautionary tale about the risks of ‘wait-and-see’ choices. Health systems still focused on the status quo may find themselves at the mercy of innovators, whose efforts to transform care delivery have only just begun.

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Additional Resources

› The New Partnership Advantage
As providers struggle to cope with the unprecedented challenges of today’s health care landscape, hospitals and health systems are increasingly recognising the need to turn to partnerships for survival. This briefing discusses the two main obstacles that hinder successful partnerships in health care—and how your organisation can refine its partnership strategy. For more information, visit advisory.com/gfhi/newpartnership.

› The System Blueprint for Clinical Standardisation
Providers have responded to financial pressures and policy changes by turning to consolidation. Often, though, the result is a lack of ‘systemness’—too many get larger but less effective, diminishing quality and consistency of care in the process. This research briefing offers a blueprint for achieving a properly organised, successful system that delivers predictable, consistent care. Learn more at advisory.com/gfhi/standardisation.

› Accountable Care Readiness Diagnostic
Use this tool to assess your organisation’s readiness to become an accountable care system—an organisation that accepts financial risk for the total cost and quality of care delivered to a given population—within the context of your market’s relative demand for accountable care offerings. Learn more at advisory.com/gfhi/ACOreadiness.

› The System Approach to Service Line Management
While there is no one-size-fits-all organisational model for service line management, our research shows that some kind of system-level oversight is required to achieve true ‘systemness.’ This executive briefing includes an overview of more effective and cohesive service line approaches, analysis of eight organising principles common among top-performing institutions, interviews with service line experts, and detailed case studies. Learn more at advisory.com/gfhi/SLmanagement.

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