CASE STUDY

The Center Must Hold

Governance, leadership, and the road to value-based healthcare

Featuring Scott Barlow, MBA, and Anil Keswani, MD

Last autumn, AMGA hosted the second installment of its ongoing Value Pathways Webinar Series, in which AMGA member leaders share insights and lessons learned from their own move to value-based care. Moderated by AMGA's Senior Advisor on Value Kevin McCune, MD, the presentation, "Governance, Leadership, and the Road to Value-Based Healthcare," featured panelists Scott Barlow, MBA, chief executive officer, Revere Health, and Anil Keswani, MD, chief medical and operations officer, Ambulatory, Scripps Health, chief executive, Scripps Medical Foundation.

Just as the arc of the moral universe is long but bends toward justice, the arc of American healthcare's fee-for-service (FFS) payment system bends toward value-based care (VBC). McCune acknowledged as much in his welcoming introduction. "There's no turning away from this trend. The question becomes: Where are you struggling in value? It's a challenge to take a fee-for-service chassis and build a value system off of that."

What's Standing in the Way?

Beginning with a basic but necessary question, McCune inquired about the challenges and barriers Barlow's and Keswani's respective organizations have dealt with in transitioning from FFS to value. For Barlow and the medical professionals of Revere Health, one of the biggest hurdles is simply embracing the reality

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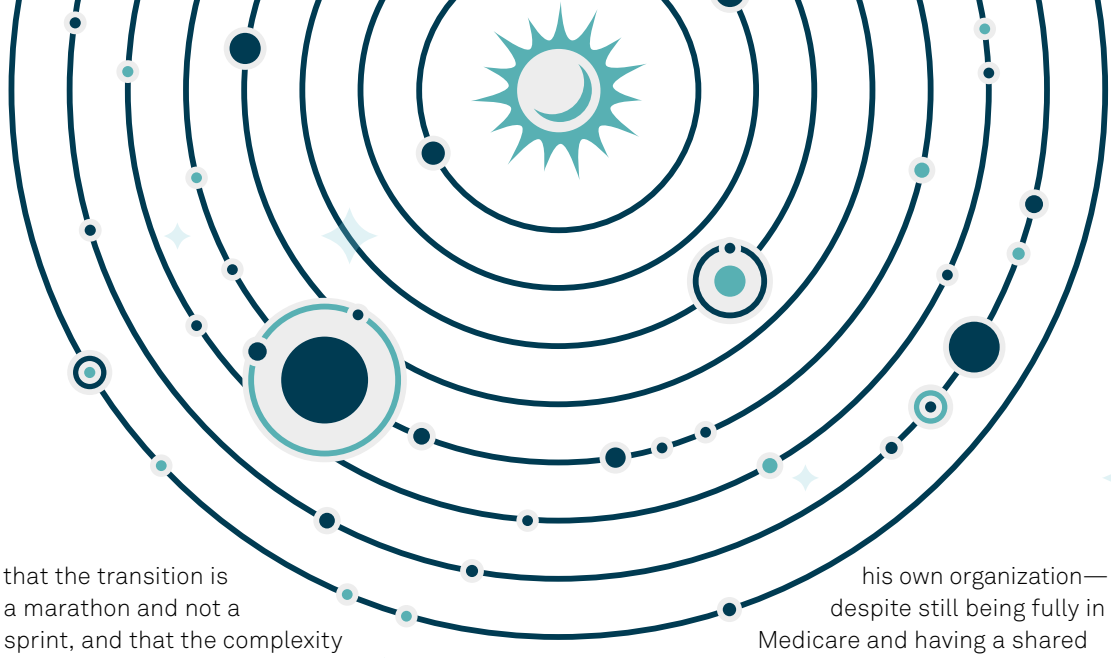

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—Scott Barlow, MBA

that the transition is a marathon and not a sprint, and that the complexity of it will always introduce new stumbling blocks along the path. "It absolutely requires a commitment to the principle of it, and you're going to experience some failures," he said. "We got on this train, and there wasn't really a clear path of how it could result in the successes that would even recover our costs. The challenge that we face continually is getting good program alignment. We have our traditional Medicare, we have our Medicare Advantage [MA] value-based contracts, and we have 13 commercial contracts. There's variety there, and you can only focus on so many things. How do you take what are multiple initiatives and design workflows and educate staff on what can be done to get better outcomes and not make it so burdensome? We've definitely hit that wall several times."

Barlow expressed that another challenge of value transition is the tremendous amount of system change it requires. "This isn't repackaging your market share or repackaging your service delivery. It really is looking at new care models and how you work together as a team, how you collaborate, and how you allow others to be involved in the care." Again, from Barlow's point of view, it comes down to maintaining that perspective of walking a marginal journey of improvement. "This is not an overnight turn. There is no pixie dust here. There are no silver bullets here. This is the hard work of really thinking about how we can find a way to just make the care a little bit better, day in, day out, month over month, year over year. And because it's that kind of a journey, sometimes it's very hard to see your progress as you're going."

For Keswani, transitioning to value requires a deft hand and malleability, because not every value-based maneuver is the right fit for every system. Keswani explained that in the case of his own organization—despite still being fully in Medicare and having a shared saving program Accountable Care Organization (ACO)—Scripps made the difficult decision to exit MA because it wasn't working under their unique circumstances. "What we've seen over the last year has been utilization going up at a significant pace," he shared. "Our admissions per thousand rate is rising. More people are seeking orthopedic care, and we are seeing an increase in cancer diagnoses from people who delayed screenings during the pandemic. When we looked at our revenue from the MA plans, we calculated our loss upwards of $75 million a year, and that's not sustainable." While he still embraces value-based care, Keswani made it clear that it is important to constantly reevaluate contracts.

In order to navigate the various twists and turns of this payment model transition, a supporting governance structure is vital—one that properly aligns with the health system's mission, vision, and values.

Aligning Governance

Barlow explained that Revere approached its own governance composition from the bottom up, placing the true driver of everything to support the point of care. He explained, "It's about having the system become less a director of the care and more of a facilitator of insight and perspective through tools, resources, benchmarking, market analysis, and identifying gaps in care. And then provisioning what we identified through our payer partners with those processes in a way that really makes it easy for point-of-care teams to know what they can truly do on a patient-by-patient, population-by-population basis to make an improvement. Our goals are set based on a philosophical model trying to find a 1% improvement year over year over year."

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Supplementing and strengthening this new standard is an anti-adversarial model among care teams. Barlow said, "If you look at managed care in the past—and even somewhat now—it is often built upon principles of the primary care folks as the good guys who will try to keep things from getting to the specialists and other systems of care, or the bad guys. That troubled us. We didn't want one group trying to control another group. We've approached this from the standpoint that everyone's involved in this work. We have our specialists actively working on goals to improve even primary care services where they have a chance to contribute."

"In our case," he continued, "we've chosen to share our success payments back with our work teams, including our specialists. Meaning our specialists get the same amount of reward payment for successes as our primary care teams do, and it's enabled us to try to leverage the system of care away from primary care as a specialty to primary care as a service obligation that we have to our patients, and how everyone can help contribute to that."

Bit by bit, Revere has embraced a more holistic, patient-centered approach, abandoning what were once siloed care departments in favor of a system in which departments refer and cross-consult with each other. "The governance has come about simply because we've really taken a patient-centric approach, which is easy for people to rally around," said Barlow. "Medicine professionals are healers. We like to take care of people. We want to help people. That value system can be leveraged into motivating and redesigning the work, as well as practices that are traditionally not done, all while figuring out a way to make it work in an efficient and safe manner."

Championing Value-Based Care

Pivoting to leadership and its importance for innovation, collaboration, and overcoming barriers, Keswani referred to a bit of advice he was given early in his clinical medicine career: "The further you get from the frontlines, the more you're obligated to support those frontlines."

Keswani believes real leaders are constantly listening to and understanding the needs of those on the frontline, and putting the necessary systems and resources in place to fulfill those needs. "When I round at my sites, I am not just there to shake hands and smile, but to really learn and ask, 'What can we do better as a system?'" he said.

The Basketball Theory

Keswani closed with a case study of Scripps' own leadership structure. Believing more in a "basketball theory" versus "golf theory," Keswani explained the importance of having the right people in the right positions on the court who can anticipate what they need to do.

He reiterated: "Our guiding principles always align with how we build a team-based approach on the frontline but also have the same team-based approach at all levels in the organization. Our goal in every decision we make is truly to keep that patient at the center."

To accomplish this mission, Scripps adheres to a tiered management system, with each tier overseen through an administrative and clinical dyad leadership structure. At the top tier is a corporate vice president and medical group president. Below, at the medical group level, is an assistant vice president of clinic operations and a chief medical officer or medical group division vice president. Below that, at the regional level, are senior directors and regional medical directors or division heads. Below that, at the facility level, are site managers, directors, and physician leads. And then finally, at the department level, are frontline staff and frontline providers.

One of the most important aspects of this arrangement is having humility—what Keswani calls the ability to step back and let the individual tiers drive and develop and change how they're operating. While a tier can certainly look upward to those above for guidance, the tier above should be careful not intrude into the tier below. In fact, they have created a humorous phrase: "Tier intrusion causes tier confusion." This is not to say that each tier is completely cut off from one another. Rather, it is about respecting how one communicates with another to understand goals and objectives, maintaining quality, and sharing actionable and useful data and analytics.

Returning to the sports analogy, Keswani said his leadership title could just as easily amount to "coach": "That's our job as a leader. Determining the things that need to happen, and then giving that high-level framework and the tools to the other tiers." GPJ

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