GALLAGHER INTEGRATED PRESENTS

OFF-SCRIPT THE NEW NORMAL

Transcript of the Podcast: Part 1 of 2

ANNOUNCER: Gallagher Integrated presents the second episode of the Off-Script content series, The New Normal. Featuring: Dr. David Bjork, Dr. Bill Jessee, Susan O'Hare, Dr. Jim Rice, and Steve Rice. This audio content was captured in March 2016.

STEVE RICE

Area President
Integrated Healthcare Strategies (Gallagher Integrated)

You know, I think from what we do in the physician services area and looking at the industry in total, I mean, what I'm going to focus in on is the new practitioner at two levels: 1) The physician 2) the advanced practice clinician which we have Susan in the room who is an advanced practice clinician and Dr. Bill Jessee, a physician. The new practitioner, one of the things that we've found that has been remarkable over the years, the past 5 years in particular, really with physicians, is the fact that the expectations in terms of what their practices life is going to be like is dramatically different than even 5 years ago, let alone 20 or 25 years ago. One of the things that concerns me a lot, right now, in full truthfulness, is are they getting the right amount of training at this point due to some of the restrictions on residency fellowship hour requirements. I talked to Dr. Phil Burns at University of Tennessee Chattanooga, he's chair of surgery there, to sort of short-cut that. One of the innovative things that he's done because of this concern is he's actually put in an additional year outside of the requirements for graduate medical education that they fund on their own so that these young surgeons going into practice are not afraid of that twilight hour where they're by themselves and not able to make the decision.

Secondarily, a lot of physicians at this point coming out are actively seeking employment, not wanting to hang out the shingle, not wanting to be independent, and want security and also want to focus on quality of life. On the advance practice side, actually what we're seeing is their status going up in the market. And, you know, that brings a whole different level of new things that occur, some good, some bad, some conflict. And I think 5 years from now what we're going to see is a delivery model that probably will be dramatically different than what we have today.

SUSAN O'HARE MSN, CPNP

Managing Director & Senior Advisor
Total Compensation & Rewards

Hope it will be more collaborative. I really think it will be more collaborative when you think about the conversations that we're having today that we weren't having 5 years ago. Every week, I'm having conversations with clients about how you pay advance practice clinicians. Should it align with nursing? Should it align with physicians? Should we add value and incentive compensation into it? What are those

practitioners doing? Everything they're doing today isn't necessarily, in our view model, billing by the hour. Some of it is navigating patient care, it's home visits, or just being used in ways that are different than what they were even 5 years ago. And don't you share the concern that the number of women, and I'll say this as the woman in the room, the number of women going into medicine and primary care right now has increased. And a lot of women aren't working full time. And so the numbers that are going through the medical schools today and then being produced as physicians are the same or even greater but when they get into the workforce, their work effort, because of their other commitments isn't as great. And so, I think we've got a problem.

BILL JESSEE MD, FACMPE

Managing Director & Senior Medical Advisor
Physician Services

Well you know, when defining the new normal, we kind-of divided it into 4 categories: new patient, new practitioner, new leader, new culture. But it's important to not just look at those in isolation because they all interact with one another. One of the reasons why we're having new practitioners emerge is because of new patients. People who are more responsible for out-of-pocket expense for their health care are really starting to look more for value and payers are starting to look more for population health management. On the practitioner's side, we traditionally have had a very physician-centric delivery system and there are some places where they're still trying to do that, but they're the places that are not being very successful. The cutting-edge leaders are the ones that are realizing it really does take a team. At the risk of stealing an old political phrase, it takes a village. I went to a conference just recently where they talked about the impact of the electronic health record on the physician and on patients. And they had some really telling videos of a physician sitting in an exam room staring at the screen with a patient over to the side and not making eye contact with the patient at all. And that's a source of dissatisfaction for patients, it's a source of dissatisfaction for doctors, they spend hours on the E.H.R. over and above their patient care time. One organization staffed their primary care clinics with 2 medical assistants per physician. So that the MA now sits in the room and they're the one that sits in front of the screen. The physician is interacting with the patient. They saw patient satisfaction scores go up. They saw physician satisfaction scores go up. The MAs love their expanded new role and, best of all, by having 2 MAs per doc, they increased the physician's productivity more than enough to pay the cost of the extra person. So they're actually generating more revenue as a consequence of their staffing model. And I think that's what we mean by the new practitioner. It's not just one person anymore. It's a team.

JIM RICE PhD, FACHE

Managing Director & Senior Advisor
Governance and Leadership

One of the things that is a difficulty, however, with the new practitioner and it's the point that both Steve and Susan were making in terms of not just the training they get and not just the roles and responsibilities—how much time will they have for, what we're referred to in the past as patient care activities. Many of the new graduates, both in medical school and even schools of nursing, advanced practitioners, they're recognizing, to have an impact they have to influence the system. So they want some leadership development and many of the curriculums are just now starting to try and hardwire a little bit of management stuff into just before they go out into their residencies—regardless of what the

clinical background is. So we're becoming quite busy now looking at how to support physician leadership development and nurse management training and many of the large systems are developing their own internal universities or academies. And we're looking at how to network and link those organizations so they can share with each other, learn from each other. But that is a piece of time that is going to be consumed by the clinical background folks in leadership. Whether it's leading teams or leading organizational units. Even once they get prepared for that, they're going to have less time available for care. And so there's going to be some dynamic tensions over the next 3-5 years as we sort this out. We almost need a new measure of health manpower availability. It probably gets down to hours rather than F.T.E.s because they're using their time so much more eclectically and differently now. And the new normal is—it will be a moving target of what we mean by normal.

BILL: Jim, your comments about the need for trying to integrate this into education kind-of reminded me of an antidote. About 5 years ago the dean of the medical school where I went to school asked me if I would come out and do an education session for their residents and fellows that were finishing up their training on the business issues of medicine. What they needed to know before they were unleashed on the world. And I said, sure, I'd be happy to do that. How much time do I have? And he said, how about 4 hours? And I said so let me make sure I understand this. You've had them for 7, 8, 10 years on the clinical side and I get 4 hours to teach them what they need to know about the business issues. And it was Yeah, that's what we've got available. So I did it. Fast forward to where we are now. The same school of medicine is now doing a joint venture with the business school to try to better integrate business issues into their training program. So I think the new normal is that there is a growing recognition on the part of medical education that it's not just enough to train clinical experts. You need to have them understand how the system works, how to influence the system, how to be leaders, and how to create that kind of culture.

STEVE: But you know what? Jim talked about the tension that's going to be there in the system. The system, the tension, and Susan raised it a little bit, between the new collaborative, hopefully the new collaborative model, that's going to have to force it's way into our delivery system. There's going to be tension on the patient side of things too. Which is—we're used to having open access and now, at some point, somewhere, somebody is going to say potentially no, or, you will not see the physician, you will see an advance practice clinician and you really don't have a choice. So we're going to have the tension . . . there is going to be tension, not just on the delivery model, within the practitioners, but also on the patient side of what do you mean I can't have what I'm so used to having.

JIM: Well, it's not even that they won't see a physician; they may not even see an advanced practitioner. They're going to be looking at a screen themselves. We're seeing an exploding increase in e-consults and the Mayo, the Cleveland, others, they're innovating on that. And some of the studies are coming back that it's not so bad. Some interaction is very acceptable to patients. But if it's the only one, that probably is going to be an issue. So how to balance human contact with the digital links as well.

DAVID BJORK PhD

Managing Director & Senior Advisor
Total Compensation & Rewards

Another thing that's changing what practice is itself and affecting any kind of practitioner is the responsibility for managing continuity of care that comes with population health management. Where a doctor used to focus on seeing a patient when they came to the office or when they were in the

hospital, now there is this responsibility that's emerging for seeing that the patient is cared for wherever they are, which might be at home, might be in the workplace, but making sure that they are getting the attention they need so they don't end up either in the physician's office or the hospital. It's all a matter of controlling the cost of hospitalization more than anything else. But it's monitoring patients much more aggressively and assertively than has been done in the past. That can be done by a doctor, but more than likely it's going to be done by another member of the team, whether an advanced practitioner or an RN or a pharmacist or even someone less clinically trained who can monitor what's going on at home and intervene with the patient to make sure they're doing a better job taking care of themselves.

JIM: David, you've reminded me of another tension point and that is as we try to manage continuity of care in population health management, the tension point and the disconnect is hospitals where still a large amount of the money is going for, because we're still in that volume stage, struggling to make the journey toward value, they're starting to realize that there's millions of dollars at risk for their re-admission rates. If they don't have a way to monitor them, engage with that patient after the discharge in the different kinds of care settings, that re-admission rate could come back to haunt them and cost them lots of penalties. They didn't care that much, but in the most recent publications that are out, readmission rates are a big issue. And this means that the people that have traditionally be involved in managing clinical governance and management and the boards themselves have to worry about some new relationships. Managing continuity of care across organizations that they don't own or they don't control. And so population health management moves us into community health gain not just community health care and so there's going to be tension that bubbles from the patient and the interaction with the clinician up into the boardroom. So we used to joke about from the bedside to the boardroom we need to all align our thinking. Now it's going to be much more challenging because we're going to look at into the community for social determinants of health. And that's a big tension point in the future as we look at systems trying to manage all of these different delivery points when they don't control them, they don't own them.

BILL: It's interesting that New York Health and Hospitals Corporation is actually managing facilities for underserved individuals housing because they recognize that a lot of their utilization is coming from the poor, people who have inadequate housing. So the health system is actually…they're converting some old buildings but they're also building some new buildings to provide housing and that's probably the most aggressive model I've seen. But it really is quite remarkable that they've reached out beyond the traditional medical care system to recognize the importance of the social determinants of health.

STEVE: But you know what Bill? I've just run into this last week in Chillicothe, Ohio, with the dean of health system, they just built a village to house 5 medical school resident programs of about, I think it's 12-15 residents, I'm not exactly sure, so that they can bring those residents into their community and train them, which they set up through ACGME as a feeder system to rural health care and they made the investment. And they're really excited about it. And they've got medical schools from not just Ohio, from Tennessee, from other places and, you know, they're very, and they are going to open up an advanced practice clinician program too. So there's a small community hospital saying let's take…independent…40 miles from Columbus…taking charge of seeing what the new normal is going to be and taking charge of their future frankly.

BILL: I think what we're all seeing hospitals and health systems embracing the new normal and trying innovative approaches. It's important to recognize that every innovative approach you try is not necessarily going to work. And people are learning some valuable lessons from their failures. It's very popular right now for hospitals and health systems to say, well, we want to learn how to do population health management by managing our employee health. And that's a nice place to start. I heard one person say, if you make a mistake, it's not fatal. (Laughter) You don't want to make too many mistakes with your workforce. But just to give an example, one organization identified who their high utilizers

were and they tended to be diabetics, people with congestive heart failure, people with COPD, as you might expect. They then hired a disease management firm to help manage those individuals and reduce their hospitalization, their use of services. The first wave of contacts with somebody from the disease management company calling the patient and saying, “I’m calling on behalf of your employer.” The backlash they got from their employees was, “Why is my employer giving out my confidential health information to these people? They didn’t ask my permission to do that. And I have a primary care physician. I want him or her to be involved in the process. They also got backlash from the physicians because they hadn’t told the physicians that their patients were going to be contacted by the disease management firm. So they had to retrench. And the 2nd year, that they had this pilot program in place, they had the disease management firm contact people, but it was done with the full knowledge of their primary care physician. And there was a letter that came out in advance on the letterhead of the primary care practice saying, “You will be contacted by a disease management firm that I am working with to help me better manage your care.” Little things like that make a total difference in how patients react to it and in many cases the difference between success and failure with population health management. So I think people are really learning some important lessons as they go through this new normal.

SUSAN: You know, all of this represents a serious disruption to the way that health care has traditionally taken place. It’s outside the 4 walls of the hospital. And we tend to think of that as the traditional health care system. It’s completely disruptive. It’s fraught with a new need for risk tolerance that we haven’t had in the past. Think about the mistake that you just talked about, Bill. And traditional hospital health system leaders haven’t always had a tolerance for risk. It’s not there in health care, the way that maybe it is in business or other innovative industries. And so the need for innovation, the need for risk tolerance, the needed add for value…Governing outside the 4 walls of the hospital into organizations you don’t own, really does require a new characteristic of leaders that we haven’t always seen. And that is someone that can lead through influence and not coming into control. (Music swells)

ANNOUNCER: This is the end of Part 1. The discussion continues in Part 2.

Part 2 of 2

ANNOUNCER: This is part 2 of the second episode of the Off-Script content series presented by Gallagher Integrated. We join the discussion already in progress.

JIM: I'd like to spend just a few minutes, if we could, on risk. Let's do a little bit deeper dive into some of the risks associated with the new normal because Bill cited one risk which is somewhat related to sharing information and access to information. This is a huge risk for physician leaders, administrative leaders, the board, and so compliance is also a challenging issue. And one of the things that is certainly not going to change in the new normal is regulatory oversight. The need to comply with agents of the government working ostensibly on behalf of the public and how does that ripple through. How are we seeing that in our clients? Dealing with compliance, compliance with accreditation, with quality standards, with compensation that's reasonable. I think it's a thorny area that needs to have its own subset of attention and discussion when we talk about journeying into this new arena, this new normal. And compliance and risk and those issues are going to be, I think, troublesome for board members, for physician leaders, for managers, into the workforce as well.

DAVID: You know, you talk about moving outside the hospital as being one of the exceptions that comes with the new normal, I want to take it even further and say that part of what healthcare organizations are being asked to do seems to be outside the mission, the old mission, of healthcare organizations. Healthcare organizations and their mission statements and their value statements have always talked about the importance of meeting community needs. But they've never thought about it as community health. They've never thought about it as tackling problems outside the clinic or the hospital as part of their responsibility. I recall a situation I was in maybe 8 or 10 years ago with a very prominent, big health system that had 4 focuses in its strategy and one of them happened to be transforming the way health care is delivered. The others were operational. They were access and cost effectiveness and quality and things that were really closely related to running a hospital well. The last one was thinking about how to deliver care better. When I press them on what they meant by transforming health care, they really couldn't give me a good answer. So I suggested that they might want to think about tackling a public health issue—whether it's obesity or early delivery of premature babies and the answer was, "That's not part of our mission. That's not what we do." Talk about the change from that attitude to where we are today where certainly any open minded and aggressive health system recognizes that public health in a way has become part of their mission and the mission has got to focus on tackling problems because they're going to be at risk for the health of people that they never were at risk for before.

STEVE: But I think Susan and Jim both raise a really good issue which is everybody romanticizes the new normal and how great it's going to be and good and all of those things, but a lot of organizations are reluctant to be the first one into the pool. Because what they're worried about is: What happens when I get to the end of Q1 and my board looks at me and says it's all great, but what happened to the bottom line? So the big, you know, sort of question out there is are you willing to make that investment into this hoping that there's a long term payoff for it and do you have the financial, not just the financial, but also the intellectual buy-in to it at a bunch of different levels. Well, there's board, physician, community, do you have that kind of support. Because, and I think Susan brings up a really…we're talking about the new normal. Let's remember, right underneath that is the old normal which everybody was very, including myself, was very comfortable with the old normal and we know what the old normal is because it's comfortable.

BILL: Susan talked about the importance of risk power and learning to take risk all at the same time being prudent about the risk that you take. In all candor, I think in many cases the old leadership model was the CEO ran the place and let the board know what he or she felt the board needed to know. Not

really embracing the board as part of the decision-making. That's changing in part because of the compliance issues. Board members increasingly realize that when I agree to serve on the board of a not-for-profit organization I am personally taking on some risk for making sure our organization is compliant. So we're starting to see the dynamic change between boards and leadership and we're getting more positions in those leadership roles, which are changing the equation as well. And the new culture, I think, is really one where people are realizing that we're going to have to take risk. We can't just do this year what we did last year and expect the results to be different. That's Einstein's old line. But you've got to be very careful about what risk you take and make sure you get as much information as you can on the front end about what the down sides are for any risk so that you're not taking imprudent risk. That's part of the new culture.

JIM: One of the risks of journeying into this population health and community health that David was talking about is that we have to work with some new people that we've not been able to or incentivized to or encouraged to work with before. So the hospitals need to work with housing organizations. They need to work with the schools. They need to work with job development. They need to work with long-term care organizations. They need to work with all kinds of new practitioners that are coming in to the field to engage with patients. And governing and managing these kinds of new inter-organizational relationships to have an impact on the social determinants of health is easy to talk about, easy to design nice charts and graphs for, it's very difficult to do because any of the senior executives and the boards and the physicians have enough challenge coordinating and working with themselves. But when you talk about bringing into the mix new organizations across the region or across the market or in that community it adds a new complexity. So we're going to be looking at not just the old normal that we all have been fairly comfortable with but we're going to quickly race through the new normal into some really uncharted waters in the future.

DAVID: You know, the old normal was very much tied to a place. And one of the consequences is that a lot of small and rural organizations that had been very secure economically because they controlled their market place and they had no competition are not going to be able to make the kind of transformations that are likely to be called for in the future because they can't afford the kind of investment that's really going to be required. We're going to see a lot of consolidation. We're going to see more of these collaboratives that are coming up that are in a way a virtual/regional system where they're integrated on certain things like contracting and purchasing and investing in the infrastructure needed to be able to identify and predict the risks of illness, better manage patient care because they're going to have a database that's adequate for that purpose. Certainly a small hospital can't afford that. An independent medical practice can't afford that unless they're linked in with a much bigger organization with that kind of capability. Even some of the big systems are discovering that they can't afford to do this on their own and need to form collaborative working relationships with payers. So you've got people that have been fighting each other for years over economics suddenly coming together, recognizing there's an advantage in having a partnership between a provider organization, a (pair? I can't tell what this word is) organization. Each one of them bringing certain strengths to it in order to be able to manage the economics of care a lot better than either one of them could do on their own.

JIM: There's a new art form actually that's come in to the arena now because of those pressures, David, and it's call collaborative governance. I was just working in Ontario, Canada. They have moved large amounts of money to be controlled and dispensed by an organization called LHIN. It's a Local Health Integration Network. And they moved the money out to deal with health not just health care. But it requires new styles of decision making and this set of decisions and the kind of information you need, it's not coming up out of the electronic health record or medical record. It's a new form of information that is not readily available for these people that are going to be making management decisions and governance decisions. And that's another tension point. That we not only have the challenge of collaborating and using some new styles of building consensus when we can't force it or can't control it, but we also need

some new information and there's a huge penetration in many of the markets where we're working with the epic health system. But that wasn't designed for population health management. So they're now having to retool quickly to come up with the information that you're talking about to make decisions about whole population groups. Not just the individual patients. That's another dynamic tension, the focus on the individual. We were recently at a conference where "The End of One" is a new book that's out. The individual patient. And yet, how do we manage the End of One for individualized, customized medical care and health care with populations. And the information for that and the decision-making processes for those kinds of activities are going to drive everybody crazy.

STEVE: Well, and I think, I mean, you know, again, the new normal, everybody wants to, no one wants to be left behind or viewed as being not innovative. And it kind-of reminds me of this, people clamored for Harper Lee to come out with a new book, and she finally did come out with a new book, and then people said, "I don't like the new book—The *To Kill a Mockingbird* is much more comfortable and I know where it's going." It's kind of like, we're in a Harper Lee syndrome here in health care in that we all want the new book, but we're still comfortable with the old book from 60 years ago, almost. And, God rest her soul, but I mean are we going to be able to get over the hump with all these different, with these 4 areas we've identified because you can't have half of it done right and the other half not done right. Because it will fail.

DAVID: I work with a couple of organizations now that are wrestling with the question of what to do when their CEO retires. They're in their mid to late 60's and the boards are wondering what kind of leader they need next. Now, one point of view often voiced by the retired leader is that there are only 10 people in the country who can do my job because there are very few of them who have the kind of experience needed to continue managing this organization or leading it into the future. The other point of view is that what we really need is a new kind of leader, a more entrepreneurial leader who is not just expert at running under the old normal, but somebody who is going to lead us into the new future. And, of course, what that all means depends entirely upon the way the organization has defined it's vision of where it wants to be. But it inevitably means somebody who is more willing to take on risk, who is willing to shake things up and look at the new normal as the past rather than the present and make hard decisions about how to create new structures, where to invest in order to position the organization for success in the future. A parallel to that is that any organization that is moving ahead toward clinical integration and population health management is creating half a dozen new types of jobs. Whether it's chief patient experience officer or head of population health, or somebody who is truly going to be the head of a health plan service division that is offering products on the exchanges. These are jobs that are being invented by the people who are placed in them because the role has not been done before. Often by people who have never done it before because the population talents or the pool of talent for people to do that is so small that it's often being given to somebody who hasn't done it before.

BILL: And many organizations, in my experience, are starting to broaden where they look for new leaders. Outside of health care. They're starting to bring people in from other industries that may have some value as they create these new jobs.

SUSAN: And that works sometimes. I'm working with an organization right now that has had 2 CEOs who came from outside of healthcare. And the organization is not particularly well run. Because, again, there has to be some level of healthcare business savvy in some of these leaders. I would also say that not only are we going through this disruption in the way care is delivered but as you think about the generational differences of the employees in the workforce, it's really profound. So most of our board members are baby boomers, right Jim? Most of our most senior leaders are baby boomers. We have Gen X and Gen Y, who make up really the rest of maybe the director and the manager roles in the organization, and then the youngest generation in their 20s are really those who we fuss about texting on

the job and pulling out their cell phones and what are they doing? Are they looking up information about a patient diagnosis, are they texting their best friend? And so, the way that they communicate within the organization is really very different. And the expectations of communication are different. I'm working with an organization right now whose CEO is in his 60s, as you referred to, David. The upcoming CEO is in his late 30s. And the way that he manages communication is vastly different and the most senior executives don't think that he likes them—because he doesn't talk to them very much. Well no, he's multi-tasking. He's being efficient, he's texting them, he's emailing them quick quips. It's not about how you feel, it's about getting the job done in his mind. And so just the communication strategy among them is very different. And I think board members, Jim, I've seen them struggle with that communication style in the leaders that they're governing.

JIM: The new leader does need a new style. Most leaders are not particularly good at delegating or listening and so the idea of appreciative inquiry is going to become increasingly important. If we're moving as an industry into uncharted waters and no one has been there before to draw the charts or to know how to navigate those waters—you need people that are going to invite ideas from across the team, deep into the organization, horizontally as well as vertically. And that means they need to ask questions. We should probably say one of the road maps that you need for moving into the new normal is the Q factor. The art and science of asking good questions that can't be answered by yes or no. And the new leaders and the style that they need is to create opportunities where people can share their ideas. Not be threatened by raising new approaches and it's that new leader, whether they're a man or a woman, and almost regardless of age, older people can learn that style of listening and appreciative inquiry, but it's going to be probably more challenging for them.

DAVID: And everything you guys have said about the generational differences amongst the workforce and the leadership applies in spades to the physician workforce because we've seen huge changes. When I went to medical school it was a male dominated profession. Today the majority of new graduates were women. The Gen X-ers and Gen Y-ers are now forming more and more of the physician workforce and they have different communication styles. I've been to places where the physicians complain, "Nobody ever communicates with me." And administration says, "Well, we try. But you don't listen." And so I've asked administration have you asked your doctors individually how they would like to be communicated with and you may have to have, you may have to tailor your communication style to different people because different people learn differently, they communicate differently, and if we try to have these blanket approaches of, "Well, we have a bulletin board outside of the physician's lounge and we post everything there." That gets pretty low readership amongst the physicians. You may have to really spend some time and energy trying to communicate one by one with individual physicians according to the style that they like to be communicated with. And then when you don't hear back from them, keep after them. It's probably not because they don't care. It's because they don't have the time to communicate back to the leadership. That's a whole different style of managing.

JIM: One brief comment on the new normal that relates to the new culture because as we move into these new areas of population health rather than individualized health. And we need new kinds of collaboration across organizations. We need new styles of communication, new styles of listening. The culture that gets established by the senior management, by the board, by the physician leaders, the nurse managers, is very important in this mix as well. And we're going to need to explore a lot more creatively the kind of cultures that we need to allow teams to form for new ways to measure success to be identified. A culture that encourages new forms of recognition and reward, not just cash rewards, but new forms of appreciation and this is going to be part of the scary as well as the exciting future ahead. How leaders can establish and nurture new cultures.

ANNOUNCER: This concludes the second episode of the Off-Script series—The New Normal. For even more insights and discussions, visit our website: **IntegratedHealthcareStrategies.com**.

Integrated Healthcare Strategies
ARTHUR J. GALLAGHER & CO.

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