Phase 4 Case Study: Redesign

Organizations Exhibiting Characteristics of the Phase

On the Pathway for Transforming Regional Health, stewardship groups find that the tenor of the work changes significantly between the Align and Redesign Phases (Phases 3 and 4). At this crucial transition point, the many different stakeholder organizations that are participating in regional health transformation efforts must adopt new business models, change core practices and cultures, and create incentives for new behaviors. These changes can be precipitated by an internal or external crisis, or by a compelling “man on the moon” vision for the future that spells the end of business as usual.

Phase 4 stewardship groups must promote addressing controversial matters that strike at the heart of old organizational practice. Most critically, they must address the needed changes in organizational independence and the reduced power to act autonomously that results from new partnerships and increasing integration. In Phase 4, multi-stakeholder stewardship groups increase in complexity as they negotiate new working relationships among the players who recognize the “commons” they share. Examples include developing new community health plans to collectively maintain more local control of incentives and reinvestment; creating common health records and databases to manage population health; integrating processes and budgets across an array of services for those most at risk for poor health due to social determinants.

Currently, even the most advanced regional efforts in the U.S. known to ReThink Health inhabit Phase 3 on the Pathway, and organizations moving into Phase 4 encounter significant barriers. We believe that the Redesign Phase only becomes possible when key stakeholders embark on significant internal strategic realignment that catalyzes change elsewhere in the community. Cambridge Health Alliance in Cambridge, Massachusetts, and the Dartmouth Hitchcock Health System in New Hampshire are examples of stakeholder organizations where this type of realignment has happened. Other stewardship groups that illustrate some key characteristics of Phase 4 include The Community Technology Assessment Advisory Board in Rochester, New York; and The Health Collaborative in Cincinnati, Ohio. These groups collectively steward issues of capacity control and information exchange that would serve a regional stewardship group well in efforts to advance beyond Phase 3.

While no single structural arrangement can address the stewardship needs of every regional context, certain common features of the stewardship structure are needed to address critical Phase 4 challenges. Multiple groups may serve different stewardship functions that together promote transformative change. We offer these illustrations not as models to be copied but as examples of some key stewardship functions that are necessary in Phase 4.
Advancing Stewardship

Phase 4 activities require discontinuous change in organizational strategies, and a redeployment of their core competencies.

Discontinuous change processes require (1) organizational leadership within the stakeholder collaborative that leads the way in promoting transformative change (2) stewardship structures that stimulate, guide, and promote genuinely transformative change.

Leadership through discontinuous change and shifting financial resources

The Cambridge Health Alliance and the Dartmouth-Hitchcock Health System represent examples of organizations pursuing some of the discontinuous-change characteristics of an entity participating in a Phase 4 effort. They are changing their business practices based on regional conditions, anticipating that business-as-usual will no longer be possible in the future. Rather than resisting change or making only token incremental changes, these organizations are embracing discontinuous changes in their business models and in how they deploy their resources. They are pivoting in new, uncharted directions and investing money and other resources in new priorities informed by a novel vision for taking on a significant role in promoting regional health and what their organizations can contribute to that end.

The Cambridge Health Alliance

In 2008, the Cambridge Health Alliance (CHA), a local safety net health system and insurer, experienced a significant change in state funding that threatened to put it out of business. In response, the organization’s leaders engaged in a broadly inclusive, collective process within the organization and beyond, to identify meaningful ways to restructure and focus more intently on providing needed services to its community.

They started by recognizing that their main value came from being a true community partner in promoting health, and that a new business model would require patient-centered health system redesign. They began by downsizing their footprint, closing one hospital and consolidating from 20 small community health centers to 15 mid-sized, robust ambulatory practices. CHA became a learning organization that is continually experimenting, assessing, and acting on results to improve quality of care and the health of community. Its innovations include: testing new global payment and incentive models; redesigning primary care to be team-based, accountable, and proactive in population management; integrating new IT systems across the healthcare delivery system; reducing hospitalizations and improving care transitions and access to primary care, and reinvesting savings more broadly into primary care, behavioral health, and social services that impact health.

When asked what advice she would give to other organizations facing similar challenges, Soma Stout, then vice president of patient-centered medical home development, said: “Start thinking about what creates health and what reduces costs, look at the numbers, and change and build from the person and population up. Include those people in the conversation as you’re redesigning. And then really think about how you can structure your organization around high-functioning teams that can reliably, proactively meet the needs of a population along with community and public health partners.”
Dartmouth-Hitchcock Medical Center

At Dartmouth-Hitchcock Health System (D-H)—a key stakeholder in the Phase 2 ReThink Health-Upper Connecticut River Valley regional stewardship group—a visionary CEO and innovative board of trustees are creating new business and financing models focused around high-value health care. Several years ago, CEO Dr. James Weinstein recognized that DHMC was struggling to compete financially because of a major disruption in Medicaid payments to the hospital. DHMC responded in part by creating its own health plan, and by focusing more intently on improving the health of its community. Because health-improvement services were not always reimbursable through standard agreements, Weinstein began investigating novel financing structures and strategies that would allow the health system to expand its focus on population health.

In addition to investing a portion of its hospital community benefit fund in population health, D-H’s board also created a “Population Health Innovation Fund” to help support new and creative approaches to improving the community’s health. This fund, which tops $11 million today, pulls from multiple streams, including savings that come from new payment models and a percentage of any windfall profits from the medical center’s investment portfolio.

System leadership through complex stewardship structures

In Phase 4, many different stakeholder organizations within a region are simultaneously working on redesign, internally and within and across sectors. The collaborative landscape becomes increasingly complex. In some regions, sector-specific organizations may take on comparatively narrow and defined stewardship functions, such as creating a safe space for sensitive, business-related conversations and for setting standards and norms for the sector.

In other regions, cross-sector organizations may step up to serve important stewardship functions, such as an overarching stewardship group that is composed of representatives from sector-specific councils. In both cases, a stewardship organization arises with more complex structures and shared leadership functions as appropriate. Two examples of this emergent multi-group structure are Rochester’s Community Technology Assessment Advisory Board and Cincinnati’s Health Collaborative.

Note that an advanced Phase 4 effort must have a forum that is viewed by organizations and residents as having the legitimate authority to set priorities and guide the investment of resources. It should have the capacity for joint decision-making that articulates shared goals, and that holds member organizations accountable to strongly shared norms across sectors. The examples presented here illustrate important Phase 4 stewardship structure characteristics, and they may eventually become the overarching stewardship structure for the health system.

Rochester’s Community Technology Assessment Advisory Board

In New York’s Rochester and Finger Lakes region, which spans nine counties, the Finger Lakes Health Systems Agency (FLHSA) has become the primary convener of healthcare stakeholders in the region. One of the convening organizations it staffs is the Community Technology Assessment Advisory Board (CTAAB). Established in 1993 to augment the healthcare planning process, CTAAB is a neutral table around which healthcare stakeholders can gather and consider if and how potential technology and capacity expansions align with the community’s healthcare needs. CTAAB reflects the diversity of the
Rochester community, with members representing the business and insurance communities, consumers, physician groups, health systems, and other community groups. CTAAB provides “an independent, evidence-based appraisal of community need for new or expanded medical services, technology, and major capital expenditures.”

Going beyond the widely known “certification of need” process for evaluating proposals for healthcare facilities, CTAAB’s recommendations focus on assessing the need for and efficacy of new medical services, staffing, and technologies, which are among the biggest drivers of healthcare costs around the country. CTAAB advises the payers, the providers, and other interested parties—all of whom come together voluntarily—on the need for, or efficacy of, certain healthcare services and technologies on a community-wide basis. The payers, in turn, may use CTAAB’s recommendations in the development of their reimbursement or network adequacy policies.

“The Rochester community has been involved in collaborative planning conversations around health for over half a century,” said Albert Blankley, CTAAB’s director of research and analytics. “CTAAB’s legitimacy as a neutral resource is well established. Our recommendations are heeded because everyone who has a stake in these decisions is together at the table. Everyone agrees that our methodologies are fair and that all applications are given equal weight and decisions are made in the best interests of everyone as a whole.”

As a result of its success with CTAAB and health planning, the FLHSA’s mission has expanded and it has become a trusted, neutral advisor and convener of several Rochester coalitions focused around multiple health-related topics, including disparities, mental health, Medicaid, and poverty. The FLHSA also is responsible for bringing the community together around a healthcare vision and strategy for the entire region. Further, CTAAB is tackling newer capacity issues, such as pulling together recommendations around whether or not to make available an expensive, new specialty medication for treating Hepatitis C.

Another result: CTAAB is credited with helping to reduce healthcare spending in the region. According to a 2013 news article in the Albany Times Union: “A new study finds that the Rochester area has the lowest overall Medicare spending rate in the nation, a feat health officials attribute to aggressive regional planning that keeps a lid on unneeded hospital expansions and technology upgrades that the community ultimately pays for.” While CTAAB’s recommendations are non-binding, the governor is encouraging replication of the program around the state.

Cincinnati

Cincinnati is home to a number of multi-stakeholder stewardship efforts, including the StrivePartnership, a cradle-to-career collaboration that became an early example of collective impact to improve educational outcomes. A similar collective impact effort, The Health Collaborative, was formed in 1992—a time when the healthcare providers, employers, and health plans were experiencing great tension and conflict over issues related to cost. The organization began as a multi-stakeholder convener and successfully navigated the parties as they emerged from that initial storm. It went on to become one of the Aligning Forces for Quality communities, delivering cross-sector solutions and health improvement pilot projects to the region.
In 2014, The Health Collaborative launched “Collective Impact on Health,” which has convened about 75 local leaders to take accountability for achieving health goals articulated through other collective processes. The group currently is refining strategies and considering how these strategies can be funded sustainably.

And in 2015, The Health Collaborative merged with the Greater Cincinnati Health Council, which convenes 25+ hospitals and 100+ nursing home and primary care providers around sector-specific matters, and HealthBridge, the area’s health information exchange. With the merger, Cincinnati has brought together convening, information, and delivery capacity in a way that can more effectively improve population health.

In addition, the separate collective impact initiatives meet regularly, functioning as a learning collaborative, with the support and leadership of the Greater Cincinnati Foundation. The leadership picture in Cincinnati—that of many groups playing distinct roles, coming increasingly together over time—illustrates the kind of structural complexity that is the opportunity and challenge of Phase 4.

Tackling Pitfalls and Building Momentum

While ReThink Health currently is not aware of a region with a fully realized Phase 4 stewardship structure, we see many groups on the verge. And numerous regional structures—like those described here—are embodying important elements of a Phase 4 effort. To help these organizations and efforts feel confident about reaching their ambitious visions for transformed systems of health, we have hypothesized—based on examples of multi-stakeholder regional efforts to transform other systems—important pitfalls that may be encountered once Phase 4 has been reached. These include:

- **Political resistance.** Hard choices need to be made during the redesign phase, especially about competitive relationships, organizational priorities that are out of step with regional needs, capacity issues, and payment models. Resistance to making these choices escalates because all solutions are likely to create winners and losers.

- **Leaders mired in incremental change.** Veteran leaders take very few risks, making only small changes to the status quo. As a consequence, many may lack the vision or the change leadership skills to envision discontinuous change or to build commitment to whole new business models.

- **Successes don’t replicate.** Innovative models that have been launched and tested are successful within their context but prove difficult to replicate. At the same time, launching additional projects seems increasingly more exciting and motivating than creating conditions for spread and replication of models that have succeeded.

The consequences of these pitfalls may be that the sharp edges of regional purpose, focus, and strategy are sanded down and leaders return to “safe” topics under the strain of win-lose conditions.

To help overcome these pitfalls, efforts that reach the Redesign Phase may focus on a number of momentum builders to reach a fully transformed system of health in the Integrate Phase (Phase 5), including:
• **Take the long view.** Consider key scenarios beyond the tenure of current leaders. Key leaders, including hospital executives that are willing to say: “I can imagine that, in 25 years, there won’t be a hospital in our community” trigger a survival response in others that in turn leads to creative solutions that can only be achieved collaboratively.

• **Address institutional needs.** Recognize and respect the core needs of other organizations and shape the stewardship process to take these into account in collective decision-making. To do this, develop and use a high-quality practice of integrative negotiation, and sustain empathy for the threats to organizational identity and existence that are experienced by members of the stewardship groups.

• **Structure for stewardship.** Design a long-term stewardship structure, including strategies that will result in stewardship groups holding the legitimate authority to establish priorities and hold the effort’s feet to the fire about living up to those priorities.

• **Redefine success.** Define success as the uptake and spread of successful discoveries and redesigned models that have been shown to move the system toward the future state. And enhance the capacity for spread and scale of those redesigns that work.

These activities help to re-generate momentum as high-impact redesign innovations demonstrate that a new future is possible.

**Looking Ahead**

Stewarding the transformation of a regional health system is a complicated and challenging endeavor, regardless of what phase a stewardship group has reached on the Pathway. This is evident in Phases 1, 2, and 3, and becomes even more so during the transition to Phase 4. This is where the “rubber hits the road” in terms of implementing a regional, long-term vision. At this point, stakeholder organizations turn inward and begin the work of redesigning themselves to bring about a vision that spans outside of their organizational boundaries.

“We need an industrial revolution in health and health care in this country,” said Dartmouth-Hitchcock’s Jim Weinstein. “To have a population health strategy, you have to go beyond the normal business strategy of a healthcare system to be a health system. And until we change the incentives and align things around the patients and communities we serve, we’re not going to change the system.”