Eliminating Defects in Value: Turnaround of an MSSP ACO

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ABSTRACT

Study findings estimate that defects in value—the practices or systems that worsen quality or patient experience and increase costs without benefit—account for one-third of health care expenditures (or $1.4 trillion) in the United States. Federal policy makers have implemented programs to address these defects. The Medicare Shared Savings Program (MSSP) rewards provider organizations with shared savings when they reduce the annual cost per Medicare beneficiary and improve overall quality. However, payment policies, such as MSSP, alone have had limited impact on improving value across the United States. To realize larger gains in value, health systems and providers must redesign their care models and implement strategies to achieve their value improvement goals. Our health system took this journey, aligning the health system around a common purpose to maximize value by designing and implementing a framework to eliminate its defects with 3 frames: believing, belonging, and building. Using purpose-driven, principle-led, and people-centered approaches, the health system was able to implement a management system that includes declaring goals, roles, and resources; creating an enabling infrastructure; creating peer learning communities; and reporting transparently and creating shared accountability systems. After employing these tactics, the health system saw a reduction in annual Medicare expenditures and improvements in quality between 2017 and 2020. We are early in this initiative and working on using data to offer estimates of the impact of this framework.

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Health care spending in the United States increased 2.7% in 2021, reaching $4.3 trillion in total (or $12,914 per person) and consuming 18.3% of the gross domestic product.[1] Despite this spending, health care quality is highly variable and many patients suffer preventable harm. Prior study findings estimate that defects in value—defined as practices or systems that worsen quality or patient experience and increase costs without an offsetting benefit—account for one-third of health care expenditures, or $1.4 trillion.[2]

To address this decline, federal policy makers have implemented programs that align payments to better value rather than to higher volume. One such program is the CMS Medicare Shared Savings Program (MSSP).[3,4] The MSSP rewards provider organizations with shared savings when they reduce the annual cost per Medicare beneficiary and improve overall quality.

However, payment policies such as MSSP have had limited impact on improving value on their own. To realize larger gains in value, health systems and providers must completely redesign their care models. Our health system undertook this journey, aligning the health system around a common purpose to maximize value by designing and implementing a framework to eliminate defects, which was associated with a 9% reduction per beneficiary in annual Medicare costs between 2018 and 2019.[2] Because the MSSP incentives had not changed over time, improvements in performance could be attributed to clinical redesign.

In this article, we explore barriers that prevent leaders from embracing true transformational change, lay out the transformational leadership framework and management system that we implemented in our approach, review the impetus for change within our health system, and describe the struggles and lessons we learned as our accountable care organization (ACO) worked to improve value. Although we have published subcomponents of this work,[2,5-7] we have not yet reported a full description of our framework for leading

change, which has matured through real-world implementation. We believe that this framework is generalizable to other health systems.

Overcoming the Fear of a New Business Model

Few people know that Kodak invented the technology for capturing digital images…in 1975, more than a decade before that technology hit the market! Nonetheless, Kodak declared bankruptcy in 2012, having failed to adapt to a digital market while competitors flew past them. How did this happen? Simple: Film was a comfortable, highly profitable business in 1975 and Kodak dominated the market. Why upend their core business model when times were good? Frustratingly, Kodak saw the digital world coming—and even made substantial investments to develop it—but ultimately could not reconcile centralizing digital technology and phasing out prints.[8]

Likewise, for 50 years, health systems have developed and honed a fee-for-service, hospital-centric infrastructure that continues to deliver their biggest margins. Like Kodak, health system leaders across the country recognize that they will have to transform substantially to thrive in risk-based payment models. Yet, despite invoking the word *transformation* often, precious few health care leaders have implemented true systemwide change to their core business model. So, with such a pressing need, why aren't we seeing this widespread innovation and transformation?

We believe 3 factors are to blame. First, health systems are disinclined to take risk from payers, whereas payers are disinclined to change the terms for how financial savings are distributed. Neither side ever feels ready and both think the other is trying to negotiate them into a raw deal. So, they continue to procrastinate on payment reform, allow the cost to pass on to consumers, and maintain the status quo. Second, upending their core business, after decades of success and now under extreme financial pressure, seems like madness to system leaders and their boards, just like it did to Kodak.

Third, health care leaders are blind to defects in value, despite swimming in them. For example, 34% of Medicare patients are readmitted within 90 days, but because fee-for-service metrics dominate strategic planning, readmissions are counted as wins.[9] Even more strikingly, defects are often viewed as inevitable rather than preventable. System leaders perceive that many of the customers they serve cannot realize better outcomes because they fail in the system *as it has been built*. So, they invest little to nothing in new ways of doing business that adapt to consumer needs, and when they do, they maintain it at arm's length from their core business, labeling it as charity or funding it with grants.

But the story of entrapment is just that: a story. Successful businesses can and do reinvent themselves (think: Disney in the late 1990s or Apple multiple times throughout the 2000s). Yet, leaders across the health system lack the right balance of frameworks and capabilities both to create an environment that leads to successful innovation and to drive transformation at scale. Successful, transformational leadership in health care requires just 3 things:

- Believing: communicating a compelling and inspiring vision of the future that people can believe in
- Belonging: creating a structure and culture that internalizes for everyone the notion that change begins and ends with them and also connects people so that promising practices and diverse ideas can spread widely
- Building: building the infrastructure to allow frontline workers and clinicians to successfully drive and implement change

Believing

Truly transformational leaders must first and foremost communicate a clear, inspiring vision of how future health care delivery will look and feel. But beyond lofty rhetoric, leaders themselves must believe in and live their own vision. Leaders who espouse lofty goals and invoke language suggestive of transformation, but who do not live and support it in their daily interactions, will ultimately fail to inspire others.

Too many leaders believe that great performance can be driven purely through extrinsic motivation: Set up a series of positive and negative incentives, enforce them, and good results will follow. They fail to engage staff in the change process, choosing instead to concentrate decision-making among a small group of individuals, opaque to everyone outside this inner circle. This philosophy runs counter to a fundamental belief that their employees are good, capable, and self-motivated (which, in fact, most are). Such a transactional approach is usually sufficient to get predictable results in predictable times, but it will utterly fail when the environment is tumultuous and the path is less clear.

Truly transformational leaders seek to inspire individuals to pursue those values and aspirations that drove them to enter health care in the first place: their intrinsic motivators. They relentlessly communicate their trust in the worth and potential of others. They ensure that their employees believe that defects are preventable (rather than inevitable) and that eliminating defects is their job rather than someone else's. To instill these beliefs, they must create forums where individuals hear stories of change, both successes and failures, framed with empathy and hope. In short, they must become evangelists for the process of transformation, repeating their message over

and over so that individuals, teams, and entire organizations embrace transformation as a way of doing business, rather than something that happens "over there."

Belonging

Innovation occurs when diverse ideas collide to produce something new that performs better—yet most organizations erect structural and cultural silos that prevent diverse ideas from meeting and germinating. Meanwhile, for virtually every problem, someone, somewhere is hitting it out of the park. To facilitate the alchemy produced from ideas bumping into each other and the escalation of great ideas, leaders need to build scaffolding to organize work around goals rather than around departments or functions. They must connect people and promote a culture that makes it safe to speak up, one that is focused on learning and improving rather than judging. Then they must get involved locally to ensure the horizontal and vertical flow of ideas.

The metaphor we use to ensure we have the right structure and culture is a fractal. Fractals— ubiquitous in nature, notably exemplified by a stalk of broccoli—are structures that can be broken apart into pieces that are smaller copies of the whole. Applied to organizations, they are units and processes that are duplicated at increasingly lower levels and operate with a small set of consistent, simple rules, but with considerably less structural rigidity than hierarchical (top-down) organizations. Hierarchical organizations operate with complex and rigid rules that result in siloed work and reduce the sharing of information, both of which ultimately impair creativity and create a feeling of isolation from peers and from the larger organization. Such organizations see individuals as interchangeable, devaluing workers' identities, values, and aspirations—and the workers feel it. Fractal organizations, in contrast, operate with[10]:

- Shared purpose and values at all levels of the organization
- Universal participation in ideas and solutions for continuous improvement
- Decision-making related to goals rather than hierarchy
- Democratic, universal distribution of leadership
- A positive emphasis on relationship development that enables the effective flow of information between individuals and among teams

At all levels of a fractal organization, members share information iteratively and make decisions collectively in response to constantly changing conditions. Our simple rules are that, first, every higher level of the organization needs to create a structure where every lower level has a seat at the table and that anyone who touches the process is involved, cascading from board to bedside. Second, each leader at each fractal level is responsible for creating both the structure relevant to the problem they are solving and a culture of humility, curiosity, and compassion that allows people to speak up, thereby accelerating learning.

This approach doesn't guarantee a frictionless process; in fact, it all but guarantees an increase in friction as individuals sort out how to work across silos, learn to leverage inspiration rather than power, and incorporate disparate cultures. But the message to people is clear: Transformation is everyone's work and your energy and ideas are welcome; you belong.

Building

Believing and belonging are essential ingredients to success in transformation. However, absent the right infrastructure, capabilities, and accountability systems, even well-intentioned leaders will fail and create disillusionment. Many organizations are good at monitoring expected outcomes (eg, budgets, staffing goals) when every level of the organization is focusing on the same exact goal year after year. Health system leaders, however, struggle to implement an infrastructure that supports innovation and transformation. To the contrary, their structures usually inhibit innovation and discourage transformation.

We have published before on the fractal management and accountability system, which we have implemented to great success for transformation. It has 4 components[11]:

- Declare and communicate goals, roles, resources, and expectations
- Create an enabling infrastructure to help ensure success
- Create a peer learning community
- Report transparently and create shared accountability

Shared accountability means that leaders hold themselves accountable to ensure the success of the team prior to holding the team accountable. Leadership should espouse a "We're all in this together" mindset rather than a "Gotcha!" mindset. Doing so requires leaders to ensure that the components of the management system are in place and that teams have what they need to succeed. Rather than waiting for problems to surface, leaders should meet with teams to review performance, learn, and improve. Sadly, shared accountability systems are largely absent in health care.

Description of University Hospitals Health System

University Hospitals Health System (UHHS) is a 156-year-old nonprofit academic health system serving northeast Ohio. It has $5.4 billion in annual revenues, 23 hospitals, and in excess of 55 ambulatory sites, 30,000 employees, and 600 employed

primary care physicians. In addition, UHHS trains 1185 residents in 105 residency or fellowship programs and conducts more than 3000 clinical trials annually. The health system cares for 1.4 million individuals annually, and more than 600,000 now receive care through our ACO.

Our ACO serves patients across 16 value-based contracts with CMS Medicare, Medicare Advantage, Medicaid, and commercial insurance companies. The goal is to deliver high-quality, coordinated care that improves outcomes and reduces costs for the patients served. However, our fee-for-service model with provider reimbursements based on relative value units (RVUs) has made it challenging to transition to a value-based model. The fee-for-service model promotes volume and revenue over quality of care and value-based spending.

Impetus for Change

When UHHS joined the MSSP back in July 2012, the fee-for-service model was firmly rooted and, mainly, the reason why program performance failed to improve. For the 2017 MSSP performance year, the Medicare ACO, named Coordinated Care Organization, earned zero savings, quality performance was at 73%, and cost performance showed expenses $27 million above the benchmark. To succeed in a value-based world, UHHS had to completely renovate the ACO. That renovation involved 2 distinct phases. First, in 2016, UHHS brought in experienced leadership to change all aspects of the core accountable care infrastructure, then mindfully added resources necessary to succeed in the MSSP. This started by developing deep connections with our Primary Care Institute—creating formalized leadership linkages as well as inviting primary care providers into meaningful roles in change. Once those connections were established, the system expanded its data science infrastructure, refocused its care management functions away from transactional work and toward a focus on longitudinal care of complex patients, expanded its quality team to support the primary care providers in meeting quality standards, and purchased and installed a range of electronic tools to facilitate the work of everyone involved.

However, simply putting together the right infrastructure was not enough. Along with structural changes, the system had to undertake a journey of cultural change that involved centralizing value-based care as a core part of the UHHS mission and creating a platform for designing and executing transformational change in all corners of the enterprise. Thus, in autumn 2018, the UHHS CEO hired a chief clinical transformation officer (P.J.P.), who reported directly to the CEO, communicating to the system that the work of transformation was to be a central focus of all work at UHHS.

Box. Tips for Leading Adaptive Change[15-17]

Inspire with stories of hope
Respect and seek out the wisdom of those closest to the work
Use words and actions that demonstrate power with rather than over others
Build trust by doing things with rather than to others
Involve all who touch a process in designing solutions
Communicate why we are changing and what the goals are, and engage those closest to the work to figure out how to reach the goals within their local context and culture
Recognize that people fear loss, not change, and seek to identify and minimize their loss
Assume positive intent from value resisters to identify why they resist
Set teams up to succeed (tied to the 4-part management system described in the text)

Early work focused on galvanizing the health system board of trustees, leaders, and clinicians around the concept of *value*—why it is important, how to measure it, and what to do to improve it. Stories were central to that work because they are among the most effective and efficient ways to communicate complex ideas. Early stories focused on highlighting existing defects in value, such as a patient who was admitted 15 times, each one of them preventable. Those stories, though, did not denigrate the great work that clinicians were doing, which would have demotivated leaders and clinicians alike. Indeed, for almost all preventable readmissions, all stakeholders needed to hear that the system had worked exactly as it had been designed—because readmissions had not been identified as a defect in the first place. As in so many health systems around the country, admissions, broadly speaking, were seen as successes, a sign of providing services to individuals in need. So, the Office of Clinical Transformation redefined success as *keeping people*

Table. Key Actions to Eliminate Defects in Value

Pillar	Action
Eliminate	Create management and accountability systems to eliminate defects in value
Anchor	Organize care around the patient's needs, anchored in primary care
Transform	Reduce mindless variation and augment mindful variation
Innovate	Use data and technology to continuously innovate
Connect	Hardwire the connections upstream and downstream in the patient journey
Engage	Engage all staff in improving value

healthy at home rather than healing in hospitals, then created a framework for making defects in value visible to everyone throughout the organization. All employees were charged with changing the narrative from "Harm is inevitable" to "Harm is preventable," and accepting that "Value is my job rather than someone else's responsibility."

As change happened, the stories changed. Stories still highlighted defects in value, but now, they also described how our clinical teams identified defects, changed our model of care to address them, and got transformative results. We share these stories relentlessly—they fuel further, iterative change and recruit people to "the cause." They are proof that when value is your job rather than someone else's, and you are empowered to make change, you can indeed make a huge impact on the life of someone you serve, which is why we all got into this field in the first place.

UHHS' Journey of Change

We used a previously published quality improvement framework for managing large complex projects.[12,13] This framework provided a foundation to "communicate priorities and progress, create conditions for success, and actively seek continuous stakeholder engagement."[14] To prepare the health system for change, we used purpose-driven, principles-led, people-centered, and performance-focused approaches. The **Box**[15-17] describes the people-centered concepts we used to lead adaptive (ie, culture and buy-in) change. This enabled us to implement a management system that included declaring goals, roles, and resources; creating an enabling infrastructure; creating peer learning communities; and reporting transparently and creating shared accountability systems.

Purpose driven: aligning around a common purpose. In 2018, UHHS aligned around the purpose of maximizing value. We defined health care value as the quality and experience of care divided by the total annual cost of care. This purpose was broadly communicated throughout UHHS as an organization-wide goal to keep people healthy at home, rather than healing in the hospital. To make this concrete, we communicated that we sought to eliminate defects in value. This meant zero physical harm such as from complications or delays in access to care, zero suffering from receiving disrespectful care, zero inequities, and zero waste.

Principles led: creating a culture to drive change. Along this journey, health system leaders recognized the need to lead with key principles that would increase awareness of the realigned purpose and define our culture. These principles include:

- I am humble, curious, and compassionate.
- I respect, appreciate, and help others.
- I am accountable to continuously improve myself, my organization, and my community.

The outputs of these principles are a culture based on a profound respect for honoring and supporting the wisdom of frontline staff and a clinical practice that aggressively reduces mindless variation while augmenting mindful variation. Mindless variation occurs because we have not anticipated the potential for harm and, thus, have not designed interventions to mitigate harm. We recognize that patients and conditions are often unique, and we need to personalize care by *mindfully* increasing variation. Yet mindful variation imparts an obligation to learn from and improve care. To guide the work, we created a checklist of key actions to help eliminate defects in value (**Table**).

Performance focused: human resources and financial investments. Although this work was largely cultural, we did change incentives and make investments. When we started this effort in 2018, our physicians were largely paid by RVUs without quality incentives and were rewarded for productivity. In 2019, we introduced a quality incentive to our primary care physicians to meet specific quality goals for their patients, including annual wellness visits, control of hypertension and diabetes, and cancer screenings. The office staff also received a financial incentive based on the same metrics.

We also invested heavily in our information technology systems and analytics. To visualize and eliminate defects in value, we needed to add new technologies to our electronic medical record and invest in data science capabilities to build the data architecture linking electronic health record data and claims data from our ACO.

Struggles

Although we present this as a clear, detailed framework, we have had many struggles. First, the framework details emerged and evolved over time. We were clear on our purpose from the beginning and on the mission of keeping people healthy at home. Yet we added more principles and concepts over time, struggling to find the right balance between principles to guide behavior and defining behaviors. At times, staff would say, "I am lost," and we would go back to our purpose and work to revise the principles.

Second, not all the leaders understood our approach. Although the entire organization stood behind maximizing value and eliminating defects, the actions of some leaders were not always aligned. Moreover, some were still leading in the command-and-control style, which at times confused and demotivated staff. When this occurred, the chief clinical transformation officer or designee would provide private feedback to the leader and communicate to staff that although we are a large organization with many microcultures, we are all aligned around maximizing value for those we serve.

Third, our data and analytical systems lagged behind our vision. Staff were inspired by the vision, and we had many early wins. Nonetheless, often we were building the data and analytical systems after the vision was communicated. Staff would, at times, lose momentum when the program they designed to eliminate a defect in value could not be implemented or measured until the analytic capabilities could be built.

Lessons Learned

We learned multiple lessons on our journey. First, aligning all employees around the goal of maximizing value is challenging, often because the message is complex. We learned that we could make the concept real and relatable through simple messages (such as keeping people healthy at home) and patient stories and by defining defects in value and making them visible. Second, this approach requires a robust analytics infrastructure, which we are still trying to mature. Third, the use of a robust management and accountability system allowed us to integrate quality improvement with management operations by embedding the work in clinical operations. Fourth, although progress in this journey has been hopeful, it has also been humbling. We, and others, previously estimated that 33% of health care is waste.[2] The current initiative was associated with further reductions in annual costs of care, suggesting that health care waste is higher. Thus, defects in value persist and, therefore, we hypothesize that waste is greater than 33%. For example, we recently published on defects in behavioral health, diabetes, and surgical care, and these were not included in our original 33% estimate of waste.[5,18,19] The new framework to eliminate these by designing care around patient needs,[20] and by creating centers of excellence for surgical care,[21] offers hope for making further progress.

Conclusions

Most health system leaders genuinely want to steer their organizations toward a brighter future. Our proposed framework for implementing transformational leadership that focuses on the individuals in the organization, rather than the leadership itself, is a simple and easily digestible template for effectively guiding any system through a rigorous transformation process. Indeed, we observed improvements in quality associated with a reduction in costs relative to our benchmark.

Despite this success, significant opportunity to further eliminate defects in value remains. We have been at this for 4 years and feel as though we are just getting started. Still, we see miraculous results every day, which has reinforced that we, as leaders, are not the ones who will discover and implement the most important innovations. Rather than command and control, we seek to engage and empower, always curious about the potential of those we lead.

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