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A Burning Platform and Trust: Key Ingredients for Payment Reform

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In June 2013, Robert Wood Johnson Foundation (RWJF) grantees aiming to advance innovative methods of health care payment gathered in Baltimore to learn from experts and from one another. Over a day and a half, meeting participants shared experiences and lessons learned. While the initiatives varied widely, some factors that had helped generate progress seemed to come up over and over again and seemed to be missing for those who had experienced comparative difficulty.

The two repeated factors were a) a burning platform to motivate action through fear, and b) trust that allows people to work together in the face of uncertainty. This brief explores these concepts to understand how to facilitate movement toward fundamentally different payment and delivery models than those that have dominated American health care until now. It shares insights gathered from both the payment reform grantees and a separate RWJF-funded study of safety net accountable care organizations (ACOs).

A Burning Platform

The term "burning platform" has become widely used business jargon for a crisis demanding action.[1,2] The image is a compelling one, suggesting a need for change that is frightening but necessary. Its origins come from a horrific fire on the Alpha Piper oil platform in the North Sea in July 1988. A rig superintendent Andy Moylan famously said, "It was fry or jump, so I jumped."[3]

Fear is a powerful motivator. While some have argued that change inspired by fear is ill-suited to complex and ambiguous problems and generates less creative solutions,[4] others point to creative solutions that are fashioned at the precise moment when the status quo seems untenable. The classic story of David and Goliath is an example based on these experiences: David finds the creative solution to his seemingly insurmountable problem only when faced with certain death.

There are multiple examples of a burning platform leading provider organizations toward new payment and delivery models. Here are a couple of scenarios. First, there is an organizational threat emerging that seems highly likely to strengthen and spread (an "approaching fire"). When a provider organization notes such a general trend in its environment, it may decide it would be better off adopting a new behavior before it is compelled to do so. The second scenario arises when there is an immediate and real threat with near-certain negative consequences for failing to act—a true burning platform.

RWJF supports several grants testing health care payment reforms, which are managed by AcademyHealth.

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An Approaching Fire

Most organizations pay close attention to their environments to identify both opportunities and threats. Provider organizations that see a coming threat—be it market-driven or governmental—may choose to make pre-emptive modifications because of what they see as a highly likely, if not inevitable, change in their environment. An expectation that change is coming is a powerful motivator. Acting because of an "approaching fire" is certainly different than acting because of a present crisis, but both are actions motivated by fear.

The three case examples below illustrate anticipatory behavior by individual provider organizations.

- **Baystate Health**: Baystate Health (Baystate) is an integrated delivery system with a large employed physician practice, three community health centers, a provider-sponsored health plan, a home care agency, and three hospitals, including an academic medical center. Baystate saw the "approaching fire" and began to track the state government's direction towards payment reform.[5] The Massachusetts legislature created payment reform-related commissions in 2009 and 2011 that drew much attention and—with the respect to the former—called for large-scale change.[6] In addition, the state's largest commercial insurer was approaching the health system with a request that it enter into a risk-based contract. The president of Baystate's physician-hospital organization (PHO) and ACO described the organization as "trying to read the crystal ball." The PHO responded by creating medical homes in nine of its larger practices to develop clinical infrastructure, and then by entering into risk contracts with commercial insurers and Medicare through the Medicare Shared Savings program.[7] Noting that the state Medicaid program is now also legislatively required to pursue payment reform, the health system CFO stated that relative to movement towards population-based payment, "We don't think we have a choice."[8]

- **Palo Alto Medical Foundation**: The Palo Alto Medical Foundation (PAMF) is a large medical group located in the California counties of Alameda, San Mateo, Santa Clara, and Santa Cruz, and is part of the larger Sutter Health system. Hal Luft, who is a health services researcher at PAMF and participated in the RWJF meeting, indicated that the medical group moved toward payment reform because "it saw where things were going." Anticipating environmental changes, PAMF committed to transforming care delivery through changes such as adopting lean management principles, introducing discussion of "increasing value," and balancing month-to-month management of dashboard-tracked goals with a longer term perspective.[9]

- **Fletcher Allen Health Care**: Fletcher Allen Health Care (FAHC) is based in Burlington, Vt., and is the largest Vermont-based health care provider. Like Massachusetts, the Vermont state government was interested in advancing change in health care payment and delivery. The state had already taken definitive action in 2011, when its legislature passed Act 48 establishing a path to a state-level single-payer health care system and creating the Green Mountain Care Board (the Board). The legislature assigned the Board responsibility for hospital budgets, health insurance premiums, covered benefits, rates paid by commercial insurers and Medicaid, and policies governing the health care work force and medical technology. In this context, the Board planned a series of pilot payment reform projects in late 2011. The state acknowledges that the Board has the authority to mandate these voluntary initiatives at any time. In response, FAHC entered into collaborative discussions with the Board, Medicaid, commercial insurers, and other stakeholders to design a three-year commercial and Medicaid ACO pilot for Vermont, effective January 1, 2014. FAHC described the rationale for its decision to participate as follows: "To work on this ourselves rather than have it done by others to us was a big reason we embarked on this journey."[10] FAHC engaged in the pilot and partnered with its largest tertiary care competitor and Vermont's community hospitals, and also entered the Medicare Shared Savings program effective January 1, 2013.

A Burning Platform

There are circumstances when provider organizations act not because of anticipated approaching threats, but due to immediate threats. Organizations see that they have no choice but to act if they wish to continue to operate. Two case study examples depict this scenario:

- **Hennepin Health**: Hennepin Health is a Minnesota-based ACO formed by Hennepin County Medical Center, NorthPoint Health and Wellness Center (a federally-qualified health center), a county-owned Metropolitan Health Plan, and the county's Human Services and Public Health Department. Hennepin Health was created in the midst of fire. The state cut 66 percent of the funding to the General Assistance Medical Care (GAMC) program for childless adults whose income fell below 70 percent of the Federal Poverty Limit and converted it to a block grant. The GAMC had been a significant funder of indigent care for the county. Making matters worse, a severe economic downturn resulted in an increased demand for safety-net services at a time when the County's tax base and state revenue were decreasing due to lower employment rates. This crisis spurred the need to innovate. The county decided to focus on the heaviest utilizers of health care and reduce avoidable hospitalizations to mitigate the impact of the funding cut. Initially focusing on the former GAMC population patients with three or more admissions a year, in June 2010 it set up a complex care clinic and began to integrate physical health and behavioral health, followed by county-operated health services and human services. When new Governor Dayton subsequently signed a bill to expand Medicaid coverage to the former GAMC population, Hennepin County Medical Center proposed an ACO pilot with Metropolitan Health Plan.[11] Initial results have been positive.[12]

Implications for those wishing to advance payment reform and delivery system change

Purchasers, payers, providers, and community conveners often struggle with how to create an impetus for change. While burning platforms may move organizations toward payment and delivery system change, how can they be created or manufactured to spur action?

1. **Create momentum for change**: When individuals and organizations sense that a significant trend is underway, they don't want to be left behind. Continued discussion of and attention to an emerging trend can contribute to that trend's emergence—prophecy can become self-fulfilling. This strategy may take time, but few large-scale changes occur rapidly. Once organizational leaders become convinced that the rules by which they have operated have changed, so too will their behavior change. This recognition of and response to changed rules is reflected in the following observation by a physician executive: "In the old days, no one paid attention to cost, but now that's changed. It's not altruistic. It's good business sense. You've got to be efficient to succeed."[13]

2. **Emphasize that it is better to shape your destiny than to have it shaped for you**: If there is conviction that change is coming, it can be effective to convey that an active stance will be more effective than a passive one. This may allow individuals and organizations to shape their path and feel more in control of the change. Pat Montoya, leader of the RWJF Aligning Forces for Quality alliance in New Mexico has stated that this message contributed to the alliance's success.[14] Conversely, if change is not viewed as imminent, providers may opt to wait.[15]

> *"As we have traveled the payment reform road in our Alliance we have worked hard to communicate that this time health care is changing and we need to work on redesigning the delivery system at the same time that we change the payment system…We keep messaging that our stakeholders can be part of the solution and inform the future or be on the receiving end of decisions made."*
>
> *– Pat Montoya*[16]

3. **Light the match if it is appropriate and feasible to do so**. Some entities, especially state government, can light a match to create a burning platform. Some states, including Massachusetts and Oregon, have compelled payment reform through statutory and/or contractual requirements. Oregon's Governor Kitzhaber described Oregon's approach and his optimism about future results when he recited a poem by Christopher Logue:[17]

> *"Come to the edge,' he said*
> *'But we're afraid,' they said*
> *'Come to the edge,' he said*
> *'But we'll fall!' they said*
> *'Come to the edge," he said*
> *And they came*
> *And he pushed them*
> *And they flew*

Trust

Change is a perilous process, about which many have fear (especially chief financial officers). Conversations among those attempting to forge payment and delivery system change are replete with references to trust. This is not surprising, as trust is the necessary companion for those undertaking change—trust in the path to change, but at least equally importantly, trust in those working to make the change successful.

During the June 2013 meeting, RWJF payment reform grantees in Cincinnati and South Central Pennsylvania identified how the trust experienced among their multi-stakeholder participants was essential to their progress. Trust is more specifically evidenced in the case studies referenced below:

- **Hennepin Health** has succeeded because the health and social service providers were able to develop trust in the project lead and then in one another. Jennifer DeCubellis, assistant administrator for health of Hennepin County, said that trust was very low at the outset and was fostered by identifying and acting upon win/win opportunities, and identifying and addressing the pressure points that each participant brought with them. For example, she lessened hospital staff frustration by obtaining county human service department support to discharge patients to an appropriate setting after coverage had ended. DeCubellis also developed trust by ensuring all parties had a seat at the table and that all decisions were made by consensus, including reinvestment of some of the realized savings in development of a sobering center.[18]

- **Vermont's Green Mountain Care Board** has created trust through its efforts to develop a common set of parameters for commercial and Medicaid ACO pilots with three payers and three ACOs. The participants have demonstrated their trust in the Board as a fair and open convener and facilitator, in a consensus-based process that is respectful and responsive to the respective concerns of parties and values, and in the relationships that they maintain with one another.[19]

- **Wisconsin's Health Information Organization (WHIO)** spent years designing one of only a few voluntary all-payer claims databases (APCDs) in the country. It was successful in part because of the trust established among different stakeholders during the process of APCD development. With this strong foundation of trust, WHIO was then able to plan for and launch the Partnership for Healthcare Payment Reform, a multi-stakeholder group devoted to advancing payment reform in Wisconsin. The Partnership continued the momentum of trusting and positive relationships which have led to the implementation several bundled payment efforts through the Partnership.[20]

RWJF payment reform grantees frequently cited the importance of trust in a neutral convener in multi-party arrangements, but also noted how trust (or a lack thereof) was an essential influence on progress. Jeanne Ryer of the Citizens Health Initiative in New Hampshire shared that the Citizens Health Initiative had "…built up trust over nearly a decade by convening a common table and working on projects of compelling mutual interest. Leaders from all sectors come together for thoughtful discussions of shared goals and shared vision, even in the face of competing agendas and priorities...That trust has created a climate where transparency is becoming a shared value— not just on transparency of health care prices at the consumer level, but in cost and utilization and quality as well."[21]

Implications for those wishing to advance payment reform and delivery system change

Relationships among providers, payers, and other key players vary from state to state, and market to market. While certain states appear more culturally predisposed to the type of collaborative relationships that develop trust,[22] there are practical steps that may contribute to trust development:

1. **Manage a process that is conducive to the development of trust.**
    - Utilize a neutral convener if it is appropriate and feasible to do so.
    - Identify and agree upon objectives, process, and desired results at the start. Look for win/win opportunities that benefit all parties.
    - Let those with vested interests be a part of the process—be inclusive.
    - Be open and honest in communications among the participants—almost to a fault.
    - Be direct in communications. Opacity produces confusion and mistrust.
    - Listen. Identify the pressure points that cause fear and anxiety among participants and prioritize attention to at least partially resolving them.
    - Respond to voiced concerns and make compromise an expectation of all.
    - Be fair. This means give everyone their say and due respect.
    - Respect the process. Once decisions are made, they should be respected and those unhappy with them shouldn't be allowed to continually revisit them.
    - Deliver on promises and commitments. Trust is built on an understanding that parties will be true to their word.

2. **Facilitate the process with effective project management.**
    - Retain one or more skilled and trusted project leads or facilitators with sufficient project management skill and content knowledge.
    - Plan the process and document decisions clearly.
    - Be timely—processes that drag on lose commitment.
    - Assure linkages and continuity across multiple parallel-operating work teams.
    - Persist, persist, and persist.

Conclusion

Case studies of successful efforts to modify health care payment and delivery, as well as conversations with practitioners, repeatedly speak of the role that a burning platform plays in getting individuals and organizations to embrace change, and the role of trust in making sure that the change is successful in implementation. A crisis need not be engineered—there is overwhelming evidence that the American health care system must change. Still, articulating the imminence of change and the implications for individual organizations is not easy. Those standing on burning platform may not perceive the approaching danger of their situation. Once they recognize it, however, they will see the need to change. As author and journalist Christopher Hitchens wrote, "The moment of near despair is quite often the moment that precedes courage."[23]

Developing trust among internal and external parties whose interests may not be fully aligned and/or with whom there is no established historical foundation can also be challenging. As shown in the Wisconsin example, however, once trust is established it can serve as the facilitator for a series of changes over time.

Without either a burning platform or trust, payment and delivery system reform changes will be slow to occur. Those with a desire to effect change should consider how they might adopt the suggested actions within this brief to help propel their initiatives forward.

Endnotes

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