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Scott & White Healthcare of Temple is Texas's only example of an "Accountable Care Organization" (ACO), as described in the national health reform of March 2010. This case study seeks to identify *how* Scott & White is able to contain costs while maintaining patient health and satisfaction and *why* they were able to create their unique system. Conclusions were drawn from personal interviews with Scott & White administrators, physicians, and staff, whose responses were analyzed for recurring themes addressing the research questions. This case study concludes that Scott & White promotes accountability by achieving an alignment of incentives: namely, a physician led governance structure and electronic health record, integration with their health plan, and being open to other payers.

ACCOUNTABLE CARE IN TEXAS: A CASE STUDY
OF SCOTT & WHITE HEALTHCARE

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ACCOUNTABLE CARE IN TEXAS: A CASE STUDY
OF SCOTT & WHITE HEALTHCARE

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CHAPTER 1

INTRODUCTION

In 2008, Barack Obama ran for the presidency of the United States of America on the platform of change, which included national health reform. He vowed to make health care more accessible and more affordable for all Americans. After about a year into his presidency, both houses of Congress had passed bills addressing comprehensive health care reform in the United States¹ (H.R. 3962, 2009; H.R. 3590, 2009). In March 2010, the House passed the Senate's Affordable Care Act, and on March 23, President Obama signed it into law. Throughout the legislative process, experts posited many models for health reform. One model, which made its way into the 2010 law, is that of "Accountable Care Organizations", or ACOs (H.R. 3590, 2009). According to the American Medical Association, or AMA, "The goal of ACOs is to encourage physicians and hospitals to integrate care by holding them jointly responsible for Medicare quality and costs" (Cys, 2009).

A few examples of health delivery systems that meet this criteria are well known for delivering high quality care at a below average cost. In the President's remarks to the joint session of Congress last fall, he referenced both, "the Intermountain Healthcare in Utah [and] the Geisinger Health System in rural Pennsylvania..." as evidence for, "reducing the waste and inefficiency in Medicare" (Obama, 2009). Another example is the Mayo Clinic in Scottsdale, AZ.

¹ On November 7, 2009, the U.S. House of Representatives passed the Affordable Health Care for America Act (H.R. 3962, 2009). The U.S. Senate passed the Patient Protection and Affordable Care Act on December 24, 2009 (H.R. 3590, 2009)

Dallas, TX, is one region where Medicare costs have soared. BlueCross BlueShield of Texas, North Texas' largest insurer, was quoted in a September 2009 Dallas Morning News article, saying, "prices in Dallas have gone up more than 10 percent a year for the last five years" (Landers, 2009). (Please see Appendix A). As of yet, this trend shows no sign of slowing down. While the cost of care continues to rise in Dallas, there may be a beacon of hope for cost containment only two hours south on I-35. Scott & White Healthcare is a physician-run organization in Temple, TX, that has managed costs for over one hundred years, "by managing all aspects of medical care, including health insurance, outpatient clinics, and hospice centers" (Garrett et al., 2009).

The Dartmouth Institute for Health Policy and Clinical Practice, in conjunction with the Robert Wood Johnson Foundation, recently analyzed Medicare expenditure data from 1992 to 2006 and compiled it into the Dartmouth Atlas of Health Care (Dartmouth, 2009). (Please see Appendix C). According to their reports:

- "Expenditure for Medicare enrollees in Temple was a third less than in Dallas – \$7,015 per enrollee in Temple and \$10,103 in Dallas – in 2006" (Please see Appendix A).
- "Of 93 teaching hospitals studied nationwide, Scott & White Memorial spent the least money on end-of-life care for Medicare patients between 2001 and 2005.
- During the last two years of life, Scott & White Memorial spent \$44,090 per Medicare enrollee, "about \$2,300 below the national average. In Dallas, the average at Medical City Dallas Hospital was \$66,248; Baylor University Medical Center at Dallas, \$58,079; and Texas Health Presbyterian of Dallas, \$55,734" (Garrett et al., 2009).

At Scott & White (S&W), healthcare coordination and payment incentives encourage cost efficiency. “Doctors are on salary and paid bonuses linked to patients being happy and healthy – not just how many office visits and procedures the patients generate” (Garrett et al., 2009). The success of this compensation approach—as measured by Scott & White's doctors’ earnings being comparable to the average compensation of their Dallas counterparts—relies on quality of care and patient satisfaction. According to their website, Scott & White was named one of the Thomson 100 Top Hospitals in the country in 2009, for the sixth straight year, “based upon clinical excellence, patient safety and satisfaction, operating efficiency and community responsiveness” (Scott & White Healthcare, 2010). “In addition, Scott & White Healthcare delivers care to members of the Scott & White Health Plan, which has consistently been recognized among the highest rated health plans in the nation for member satisfaction” (Scott & White Healthcare, 2010).

This thesis seeks to answer two main questions. How is Scott & White Healthcare able to contain costs while maintaining patient health and satisfaction? And why was Scott & White able to create such a unique system?

CHAPTER 2

LITERATURE REVIEW

Failures of the Current System: The Need for Change

Currently, Medicare is funded with a fee-for-service schedule. This method gives medical providers an incentive to treat as many patients as they can, while providing as many services as they can (tests, lab work, imaging). Often physicians may also have a stake in the hospital or their preferred imaging center. As a result, the last decade has seen a plethora of new physician-owned medical centers enter the market, creating more and more competition. Classic economics dictates that healthy competition will benefit the consumer by driving down prices. This concept does not hold true for healthcare, however. Greater competition in a supply market that grows much faster than the demand must create a *false* demand to succeed. In the Medicare market, this phenomenon leads to overutilization of services, resulting in higher average expenditures, and eventually, responsive increases in insurance premiums. Evidence of this spending growth has been identified and measured in markets, such as Dallas and McAllen, TX. (Please see Appendices A and C).

Unfortunately, greater expenditures for Medicare beneficiaries have not clearly shown evidence of improved quality of care or better health outcomes (Guterman et al., 2009), and the seemingly limitless spending trend has already become unsustainable for consumers and the government. Hence, finding solutions to curb such expenses have become the focus of our nation's recent health reform efforts.

Accountable Care Organizations

In 2009, the Medicare Payment Advisory Commission devoted a chapter of its June report to Congress to the concept of Accountable Care Organizations (ACOs) (MedPAC, 2008). Consequently, the health reform bill that is now law (H.R. 3590, 2009), includes a provision for the establishment of a “shared savings program” that promotes accountability for a patient population and coordinates items and services, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery.” Under such a program, groups of providers may work together to manage and coordinate care for Medicare fee-for-service beneficiaries through an accountable care organization (ACO); and ACOs that meet quality performance standards established by the Secretary are eligible to receive payments for shared savings (H.R. 3590, 2009).

Medicare has already been acknowledged as one of the best places to start such a pilot, due to the Centers for Medicare and Medicaid Service’s (CMS), “experience with payment innovation and ideas for delivery system reform” (Crosson, 2009).

Many details of the proposed pilot are not yet explicit; instead, the bill’s language simply leaves ACO criteria to be, “as the Secretary [of the Social Security Administration] determines to be appropriate” (H.R. 3962, 2009). An article in American Medical News, published by the American Medical Association (AMA), suggests that a, “typical Medicare ACO would include a hospital, primary care physicians, specialists and potentially other medical professionals” (Cys, 2009). The idea is that the entities in the ACO would, “coordinate care for their shared Medicare patients with the goal of meeting

and improving on quality benchmarks.” This way, medical services could still be billed under fee-for-service, “but...because ACO members are held jointly accountable for this care, they would share in any cost savings that stem from the quality gains” (Cys, 2009).

The Dartmouth Institute for Health Policy and Clinical Practice is one of the leaders promoting the ACO concept. With or without Medicare, they are moving forward with their own pilot project designed to test an ACO in the private sector. The Dartmouth Institute's director of population health and policy, Elliott Fisher, MD, MPH, was quoted in the AMA publication, “this is the most likely way my colleagues and I have been able to figure out to help address variations in spending. It's much better than simply cutting prices in high-cost regions.” In the midst of dwindling Medicare reimbursement rates, Dr. Fisher continued to describe one of the main reasons why health providers are paying close attention to the outcomes of such a pilot: “The ACOs are really intended to help physicians get back in the driver's seat” (Cys, 2009).

While the specifics of a Medicare ACO model have yet to be determined, the basic theme often includes: better coordination and communication between providers, shared accountability coupled with shared cost savings, fee-for-service payments, and preservation of patient choice of physician. In order for a Medicare ACO to become successful and highly adaptable to various local circumstances, existing examples of successfully coordinated care need to be closely examined. Case studies of other well-known examples, like Geisinger Health System of Danville, PA, have already been published (Breslin et al., 2009). Given the dramatic difference between Medicare

expenditures in geographically close regions in Texas; however, more attention should be given to Scott & White Healthcare and others like it.

The Case of Scott & White

Scott & White Healthcare describes itself as a fully integrated, physician-managed health system, “the largest multi-specialty practice in Texas, and the sixth largest group practice in the nation” (Scott & White Healthcare, 2010). Scott & White’s patients span 25,000 square miles across Central Texas and are cared for by over 800 physicians and research scientists. (Please see Appendix B). Scott & White is also the clinical education site for Texas A&M Health Science Center College of Medicine, so all employed physicians at Scott & White’s Memorial Hospital in Temple TX, are also faculty members at Texas A&M. Temple is now the site of a four year medical campus with 261 medical students and 375 residents and fellows across 32 programs (Knight et al., 2010).

In 1982, the Scott & White Clinic and Hospital founded a non-profit community-based Health Plan. Today, the Scott & White Health Plan (“SWHP” or “the plan”) provides medical, pharmacy, and insurance products to 220,000 members, including individuals, employer-based groups, and Medicare beneficiaries in 51 counties across Central Texas. Plan members can seek care from Scott & White and external providers. SWHP is the highest rated health plan in Texas (Knight et al., 2010). Every year, its 500 employees process 2.3 million claims valued at over \$1 billion. Annually, SWHP earns revenues in excess of \$600 million (Knight et al., 2010).

In stark contrast to the classic economic mantra of “competition drives down cost”, Scott & White dominates the Central Texas market, but manages to control costs better than its competition-laden neighbors. Contrary to initial assumptions about regional cost of living differences, price-adjustment analysis studies have shown that the cost of goods and services in certain areas resulted in less variation in what Medicare pays regionally (Gottlieb et al., 2010). According to Scott & White’s president and CEO, Alfred Knight, “What we did with the competition was that we merged with it...It is collaboration and cooperation – not so much competition – that allows us to be successful” (Garrett et al., 2009). In places like Dallas and McAllen, specialists are typically paid when they see patients or order services from other businesses, like imaging centers, in which they may own a stake. At Scott & White, the doctors don’t have the same incentive to see as many patients as they can or order more tests or MRIs. Their incentive is based on treating patients and keeping them well. Rushing through patient visits at the detriment of quality may actually decrease their earnings, instead of the opposite. Jeff Hall, a family doctor and director of one of Scott & White’s outpatient clinics, admits, “We’re not going to get rich doing this...If we are seeing our patients getting good health care, it’s very rewarding to us. That’s what we want to do. That’s true of the specialists, too” (Garrett et al., 2009). The truth is that most of Scott & White’s doctors make only about 80% of the national average, but doctors with a genuine interest in practicing medicine are willing to take the “pay cut”, because, as Dr. William Walton, a primary care physician, wrote in a letter announcing to his patients his decision to leave his private practice in Dallas for a position at Scott & White in Temple, “This opportunity

will free me to practice good medicine without the pressures of the ‘business’ of medicine” (Tarrant, 2009).

Doctors at Scott & White appreciate the ease and efficiency of collaboration offered by the large group practice. “If I don't know something, I can call somebody up in the system and they will talk to me – anybody. They will collaborate. We have that advantage,” Hall said” (Garrett et al., 2009). As a result, patients can get faster diagnoses with fewer complications and lower costs. Scott & White also has a high-tech electronic medical records system that fosters collaborations and communication, while reducing medical errors. The electronic records can permit any doctor in the system to see a patient’s prescriptions prescribed by another doctor and even send x-rays to a specialist for consultation and receive a reply the same day. The records store allergy, medication, and treatment information in a patient’s profile, so they don’t have to remember their entire patient history every time they want to visit a new doctor, which also speeds up admissions.

From a policy standpoint, these attributes beg many questions. How did the Scott & White system arise? Is there anything unique about Scott & White or Temple, TX that makes them conducive to such a system? Why haven’t other systems embraced the EHR? Can other providers seeking to form ACO’s learn anything from Scott & White’s experience? This case study will ask these and other questions from the people who know Scott & White best, its administrators and clinicians.

CHAPTER 3

METHODOLOGY

According to Robert Yin's *Case Study Research: Design & Methods*, case studies have a unique and distinctive purpose as a research strategy. Performing a case study is most appropriate when "a 'how' or 'why' question is being asked about a contemporary set of events over which the investigator has little or no control" (Yin, 1994).

Purpose

This single-case, embedded case study seeks to answer two main questions. How is Scott & White Healthcare able to contain costs while maintaining patient health and satisfaction? And why was Scott & White able to create such a unique system?

Procedures

After collecting data from documents and literature, the primary source of data for this case study is responses gathered from personal interviews with Scott & White administrators, physicians, and staff. Any contact with human subjects for research requires approval from the University of North Texas Health Science Center's institutional review board (IRB). This research qualified for exempt status and was approved before initiating contact with interview subjects.

Selection of interview subjects

To achieve an accurate portrayal of Scott & White operations, potential interview subjects were selected based on subject roles in the Scott & White system and the diverse perceptions the researcher hoped to include. Administratively, the researcher sought the perspective of one or more executive officers, operational officers, medical officers,

financial officers, nursing officers, quality and safety officers, policy directors, and board members. Clinically, the perspective of primary care physicians, specialists, and clinic managers were sought.

Recruiting interview subjects

To prepare for recruitment, the researcher studied the Scott & White website, relevant academic literature, and Scott & White's 2009 Annual Report to obtain the names and contact information for specific Administrators and Board members at Scott & White. Existing contacts were also used to get referrals. IRB approved materials for recruitment included the initial recruitment email text, an informed consent document, an information sheet for participants, and the interview guide (Figure 1).

Initial recruitment contact was made via email followed by both phone and email confirmation. Interviews were scheduled according to the subjects' availability.

Gathering and recording data

The data for this research is in the form of interview question responses. These responses were gathered during a personal 30-45 minute interview, according to the IRB-approved interview guide (Figure 1), consisting of five question families containing three to four related questions each. Interviews were conducted from March 29, 2010 through April 13, 2010. Two interviews were conducted in person in Temple, TX, while five were conducted via phone. Interview subjects' responses were recorded by hand-written notes.

INTERVIEW GUIDE	
1. Personal Background	<ul style="list-style-type: none"> •When did you come to Scott & White? •Why? •What do you think of your employment experience at Scott & White? •How does it compare to previous employment experience?
2. Forming Scott & White Healthcare	<ul style="list-style-type: none"> •When did Scott & White “merge” with its competitors? •Why? •What was the driving force behind Scott & White’s continued pursuit of coordination and collaboration, i.e. the electronic medical record, etc.? •Can you give examples of important lessons the organization learned during this transition?
3. Scott & White Operations	<ul style="list-style-type: none"> •What unique attributes of Scott & White contribute to the success of its coordinated care? •Please describe the peer review process for monitoring physician practices and preventing overutilization. •How does Scott & White continue to prioritize the patient’s interest? •Can you give examples?
4. The Patient Perspective	<ul style="list-style-type: none"> •What do you think the patients appreciate most about your organizational approach? •Can you give examples? •What are you developing to improve consumer access to price information?
5. An Adaptable Model	<ul style="list-style-type: none"> •If your system is so successful, why hasn’t it already been adopted in other regions in Texas? •How can other systems of separate, but cooperative, hospital systems achieve the same level of coordination and efficiency? •How can the private sector adapt a similar ACO model?

Figure 1 Interview Guide

Obtaining consent

For the face-to-face interviews, voluntary participation consent was obtained in person immediately prior to initiating the interview. Prior to the long-distance phone interviews, participants were asked to sign and return the consent form by mail or email.

Participants were given the opportunity to ask questions regarding their participation in the study both before and after the interview. Participants are permitted to rescind consent at any time. During key parts of the interview, participants were asked if illustrative quotes might be attributed to them by name for this thesis. In all cases, participants gave consent for quotation, except for specific “off the record” remarks, which were not recorded in the researcher’s notes nor stated here.

Respondents

The respondents interviewed for this thesis research (listed alphabetically below) hold different positions at Scott & White and represent a wide range of perspectives and experiences. Collectively, they have 84 years of experience at Scott & White Healthcare, ranging from 6 months to 28 years, with a median length of 10 years. Some of the respondents have spent their entire careers at Scott & White, while others came from private practice or administrative positions at for profit and not for profit hospitals and health plans.

- Patricia Currie, FACHE, *Chief of Hospital Services*
- Allen Einboden, MBA, *CEO of Scott & White Health Plan*
- Dr. William P. Hamilton, MD, *Orthopedic Surgeon at Temple Clinic, Scott & White Board of Directors, and Scott & White Board of Trustees*
- Will Rogers, MA, *Clinic Manager at Northside Family Medicine Clinic, Temple,*

TX

- Dr. J. James Rohack, MD², *Cardiologist at Temple Clinic, Temple, TX, Director of the Scott & White Center for Healthcare Policy, Medical Director for System Improvement of Scott & White Health Plan*
- Deborah Saunders, RN, BSN, *Associate Executive Director, Chief Nursing Officer, and Chief Operating Officer of Scott & White Memorial Hospital, Temple, TX*
- Dr. William Walton, MD, *Primary Care Physician at Northside Family Medicine Clinic, Temple, TX*

Analysis

This case study is based upon multiple sources of evidence. The resulting documents and narratives were transcribed from hand-written notes into a digital format and compiled into a case study database, while maintaining a clear chain of evidence to the original source. The subsequent analytic strategy relies on the hypotheses that served as the basis of the research questions, namely, that Scott & White Healthcare provides care for Medicare beneficiaries at a markedly lower cost than other Texan counterparts, while maintaining equal or better health outcomes—evidence of savings is clearly depicted in Appendix C. Using Yin’s text as a guide, the study’s dominant mode of analysis is pattern matching, which, strengthened the case study’s internal validity (Yin, 1994). By gathering several different perspectives by means of different subjects’ responses to the same questions, the study achieves a convergence of evidence, which

² Dr. Rohack was also acting President of the American Medical Association at the time of his interview.

provides for the triangulation of fact. This method is figuratively illustrated in Figure 2, adapted from Robert Yin's *Case Study Research*, Figure 4.2.

Interviews were conducted in a conversational manner, using the questions detailed in Figure 1 as a *guide*, not as a strict script. Questions were not always asked in the same order and not all respondents could answer every question. Therefore, responses were reviewed for recurring themes. The specific responses in each case were compiled and grouped by theme to determine how many respondents gave similar responses and determine the validity of the perceptions. The results of this study are detailed below.

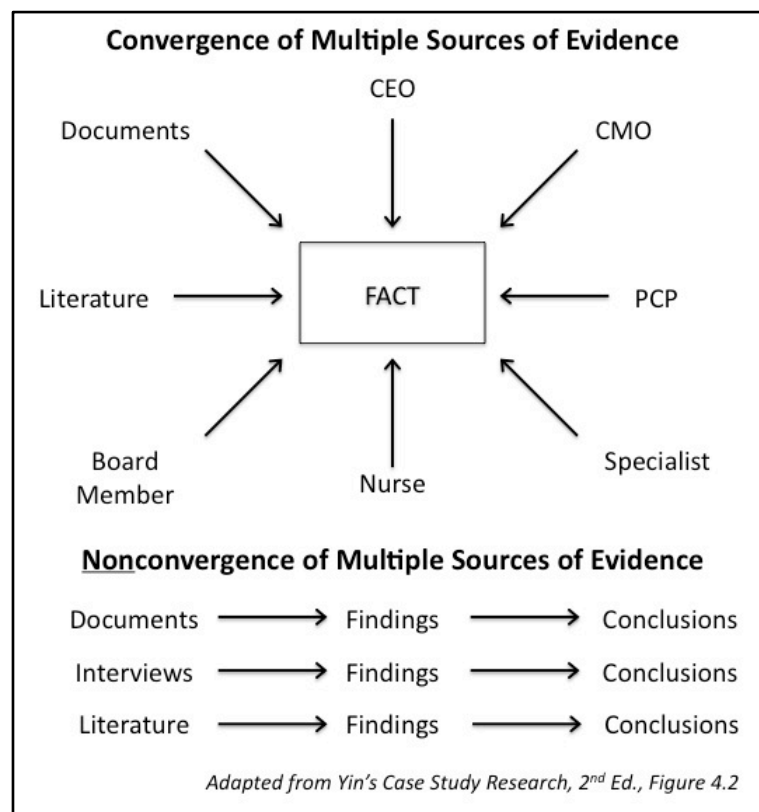


Figure 2 Convergence and Nonconvergence of Multiple Sources of Evidence

CHAPTER 4

RESULTS & ANALYSIS

Development of Analytic Themes

Interview responses did not fall neatly into a question-by-question categorization. For instance, the results pertaining to the “Evolution of Scott and White” came from responses to questions regarding the respondent’s personal background, the formation of Scott & White, Scott & White Operations, and the adaptability of the Scott & White system (Question families 1, 2, 3, and 5, respectively). This concept is visually mapped in Figure 3. To further illustrate, discussion of the Scott & White mission and culture was introduced, in some cases, as early in the interview process as the respondent’s reply to why they came to Scott & White as compared with their previous employment (Question family 1). Additionally, the mission was described as a driving force behind Scott & White’s continued pursuit of coordination and collaboration (Question family 2). Scott & White’s group mentality, which contributes to Scott & White culture, was cited as a

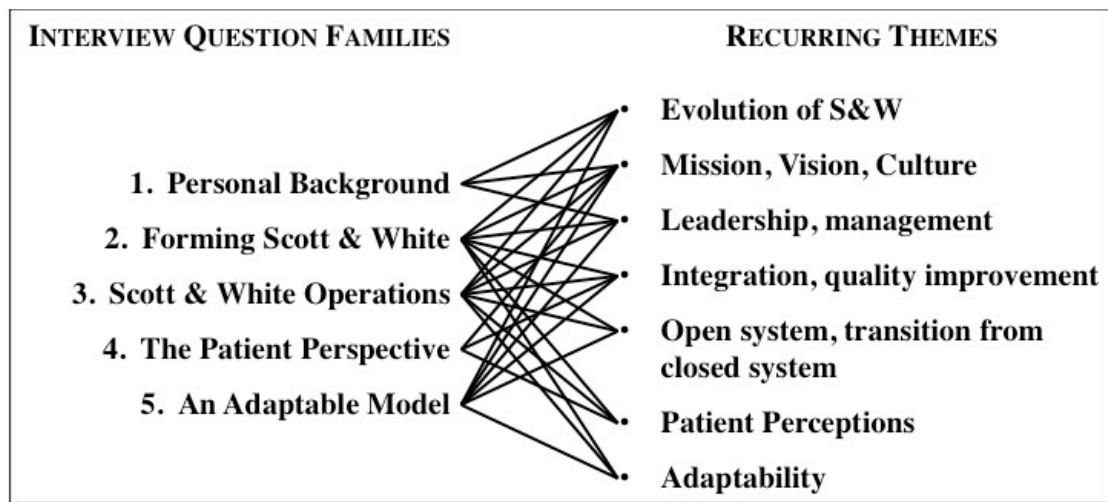


Figure 3 Theme Analysis Map

major factor in the Scott & White peer review process (Question family 3). The culture of patient care was also discussed in response to the patient perspective family of questions (Question family 4). Finally, the values central to the mission were referenced several times when discussing the adaptability of the Scott & White model (Question family 5). Further, respondents often volunteered additional views and insights that were not in direct response to questions from the interview guide. Consequently, the responses were categorized according to a set of recurring themes addressing the research questions, namely how and why Scott & White is able to maintain and improve quality and efficiency. The recurring themes fell into seven categories, containing inter-related subthemes: (1) Evolution of Scott & White; (2) Mission, Vision, and Culture; three themes within Scott & White operations: (3) Leadership and management, (4) Integration of the system, and (5) Opening the system to other payers; (6) Patient perceptions; and (7) the Adaptability of the Scott & White model and its policy implications. Some details and sub-themes within the recurring themes are outlined in Figure 4.

For the most part, the results presented in the remainder of this chapter are organized according to this outline. However, because the themes outlined in Figure 4 are inter-related, many of the results overlap. As a result, not all results can be neatly categorized and presented in a single section. For example, the benefits associated with the electronic health record are described in all six of the following theme-associated sections. Some of the subthemes of “Adaptability” are described in the *Challenges and lessons* subsection of the “Opening Scott and White...” section. The remaining insights regarding adaptability and policy implications are presented in Chapter 5 Discussion &

Conclusions. Due to the large volume of material obtained from the interviews, the responses have been summarized according to each of the recurring themes. Additionally, the responses that have been quoted or paraphrased were selected as either a good representation of several respondents' viewpoints or because it provided a unique insight.

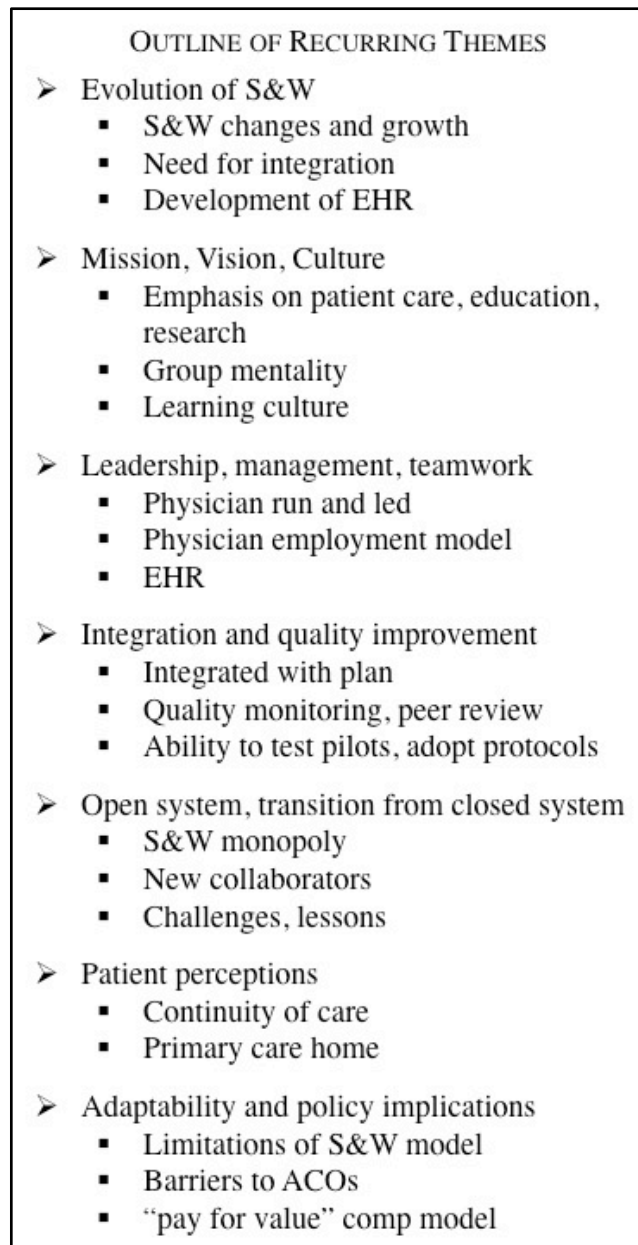


Figure 4 Outline of Recurring Themes

Evolution of Scott & White

Temple, TX, is located in north central Texas along Interstate 35, about 130 miles south of Dallas and 70 miles north of Austin. In 2005, Temple was home to 58,240 residents, and the population was projected to reach 61,965 by 2010 (Irving, 2010). What began as a railroad town in 1881 with the creation of the Temple Junction for the Gulf, Colorado and Santa Fe Railway pushing north from Galveston, is now one of the leading medical centers in the Southwest, due in large part to the hospital and clinic founded by two railroad doctors, Dr. Scott and Dr. White in 1897 (Irving, 2010).

Today, Scott & White Healthcare of Temple, TX, represents the largest non-profit multi-specialty group practice and integrated health system in Texas, with over 9000 employed staff and over 800 physicians and researchers (Knight et al., 2010). The 501(a) hospital-physician organization uses a capitation-based employment model to pay its physicians a base salary with an opportunity to earn performance-based bonuses for achieving certain caseloads, while maintaining high quality, and patient satisfaction.

As of February 2010, Scott & White Healthcare (S&W) comprised nine owned, partnered, or managed hospitals, 50 regional primary care and multispecialty clinics, the foundation, and the Scott & White Health Plan (SWHP). The system includes 1485 beds, and conducts 1.8 million outpatient visits, 57,000 hospital discharges, and 51,000 surgical procedures every year (Knight et al., 2010). Financially, Scott & White operates with \$1.3 billion in operating revenue and \$1.7 in assets.

As the Scott & White system grew, its leadership recognized the need for facilitated communication within the system and for a way to link the care being provided throughout Scott & White. As a result, Scott & White invested in creating its own electronic health record (EHR) twenty years ago. It allows patients being seen anywhere in the system to have a complete medical record available to whomever is treating them. As the system continues to grow, Scott & White continues to optimize its EHR (J. Rohack, personal communication, April 7, 2010).

Scott & White has been led and operated by physicians since its foundation in 1897. While the Scott & White hospital, clinics, and health plan worked very closely together, they evolved as three separate legal entities with three separate CEOs, due to limitations in Texas law that prohibit corporations from directly hiring physicians.

According to Scott & White administrators, several operational and regulatory issues occurred from 1995-1997 that caused the Board of Trustees to conclude that Scott & White would benefit from having a single president for the entire enterprise. In 2000, Scott & White legally merged the not-for-profit hospital and for-profit clinic into what is known as a 501(a)³. A 501(a) is required by Texas law to have a physician-only board of directors, which deals with all decisions regarding the clinical practice. Integrating the system under one umbrella, sharing both revenues and expenses, “helped streamline the

³ Texas law prohibits the corporate practice of medicine, barring non-physicians from owning physician groups. In response, a 501(a) nonprofit medical corporation allows physician groups to assume risk and act as one physician as long as it is owned by a not-for-profit entity.

decision-making nexus and didn't have the system fighting against itself, but rather optimizing across itself" (A. Einboden, personal communication, April 12, 2010).

Until that point, Scott & White had operated as a "closed" system, in which the hospital only treated SWHP members and SWHP members could only seek medical care at the Scott & White hospital and clinics. In an effort to better meet the needs of their patients and the community, the health plan pursued a strategy of broadening their network, which led to the health system contracting with all other major payers. The plan was open to other providers and Scott & White was open to other payers, which helped both to grow significantly. The hospital and clinic subsequently increased their business by double digits since that time. If the system had remained closed, Scott & White would have remained a regional Temple hospital. Opening up allowed continued expansion in central Texas. "This was huge and has been very successful no matter how you look at it" (P. Currie, personal communication, April 8, 2010).

Mission & Vision: A Culture of Patient Care

Scott & White's stated mission is, "To provide the most personalized, comprehensive, and highest quality health care, enhanced by medical education and research" (Scott & White Healthcare, 2010). As several respondents stated, this begins with caring for the patient. "The mission statement says to put the patient first...you can't [generate revenue] at the expense of patient care, you have to put patient care first." Dr. William Walton is a primary care physician, who came to Scott & White in the fall of 2009 from a 25-year private practice career in Dallas. In his experience with medical school graduates, "the main reason people become doctors is to help people...this

organization cultures that attitude and keeps it going.” (W. Walton, personal communication, March 30, 2010).

Scott & White’s culture of patient care echoed in its mission was a recurrent theme in interview responses. Some of the most important aspects of the Scott & White culture are being a team player and having a commitment to continuous quality improvement, including accepting and adopting new evidence-based protocols when they are issued. In other words, the culture involves buying into a group mentality that acknowledges that what is best for the hospital is best for everyone. According to Dr. James Rohack, a cardiologist and director of the Scott & White Center for Healthcare Policy, “It’s an important distinction, because it shows that in a multispecialty group, you are focused on how best to care for patients. To do that, you sometimes have to give up your autonomy” (personal communication, April 7, 2010).

Being part of a learning culture that is committed to continuous improvement involves continuous education. “Continuing education is highly valued here. [Scott & White] is always pushing us to learn stuff. We have meetings with the family practice staff and discuss quality measures. Every department in our organization does that,” said Dr. Walton (personal communication, March 30, 2010). They may make sweeping changes in policy, or just disseminate tips such as this, “the patient perceives that the doctor spends 30% less time with the patient, if she stands up during the evaluation, whereas the patient perceives that they spend 10% more time, if the physician sits down.” Bringing all of the staff together for educational departmental meetings also strengthens the culture and fosters social interaction between physicians, who may regularly practice

hundreds of miles apart. Dr. Rohack pointed out that, “you also don’t want to have the clinicians feeling isolated, or that they’re out there by themselves...these events help to establish a consistency within the Scott & White system” (personal communication, April 7, 2010).

Evidence of Scott & White’s patient focus, as pointed out by family medicine clinic manager Will Rogers, is illustrated by the fact that the system has numerous clinics that are strategically located to be geographically convenient at reasonable access points to meet the needs of Scott & White’s vast service area. Furthermore, after being seen at the clinic, every discharged patient gets a follow-up phone call by a physician (personal communication, March 29, 2010). Traditional physicians in private practice might find this kind of service financially difficult to justify; it is just one of the benefits of Scott & White’s salary structure.

Simply accepting Scott & White’s comparatively below average salary in exchange for some loss of autonomy and for benefits the physician values equally (if not more) than compensation affirms an alignment of common values. According to Dr. Rohack, “Like many systems, when you start something brand new, you want to make sure that the people you are hiring understand the culture” (personal communication, April 7, 2010). When physicians are hired by Scott & White, they don’t have a contract; instead, they sign a legally binding document agreeing to believe in and abide by the mission of quality patient care, education, and research. If a doctor ultimately does not fit the group culture or finds the mission agreement difficult to uphold, Scott & White would rather not have that person bound by contract to stay.

The issue of culture and the absence of contracts may be even more important, because, as described later, the Scott & White culture is still actively shifting as a result of the changes and continued growth that Scott & White is experiencing. As Scott & White continues to expand and acquire new hospitals and clinics, they face the challenge of maintaining patient care quality that is consistent throughout the system. Scott & White has spent over a century establishing a the Scott & White name, and they want that name to represent a consistency in high quality no matter what building, white coat, or name tag that it is on.

Scott & White Operations

Leadership and management

Another obvious trend in interview responses was how much the staff appreciated its leadership and the benefits of working for a physician led organization. When asked how Scott & White was able to maintain a patient-centered focus, multiple respondents replied that it was, “as simple as the CEO setting the goal.” Will Rogers referred to Scott & White’s well-circulated vision milestones to be “the most recognized and valued name in healthcare,” and an emphasis in his clinic to achieve a “high likelihood to recommend” status by the patients (personal communication, March 29, 2010). Dr. Walton, who is still new to Scott & White, said, “they have some very good leadership. The people at the top really know how to lead an organization like this” (personal communication, March 30, 2010). Not surprisingly, this view was reiterated at the top, as well. Deborah Saunders, the Chief Operating Officer of Scott & White’s original Memorial Hospital, said, “We

have a good management team together. We're all very tight and we have each other's backs" (personal communication, April 13, 2010).

Even the non-physician administrators lauded the Scott & White bylaws for dictating that the CEO must also be a physician. Allen Einboden, CEO of the Scott & White Health Plan, attributes much of their success to the fact that, "at the heart of Scott & White, it's a physician organization, and we have physicians in leadership positions across the enterprise...It's not just a business, it's actually a medical organization, as well. The decisions aren't made unilaterally in the interest of business, but in the confines of both the medical and business ramifications" (personal communication, April 12, 2010). The Chief of Hospital Services, Patricia Currie, echoed Mr. Einboden's sentiment, "When a doctor comes into this model, they feel that it's a group practice that is run and led by doctors. It's not run and led by an administrator, like me. That does make a difference to the cultural mindset" (personal communication, April 8, 2010). The physician leadership doesn't stop at the top, though. Respondents noted that the Board of Directors that runs the clinic side of the organization is elected by all of the doctors. The Board of Directors also makes up almost half of the system's Board of Trustees. Community lay people make up the remaining majority of Trustees.

The employment model

Being a "physician organization" is due in large part to Scott & White's large group practice and their employment model. Scott & White has been successful by attracting highly qualified physicians and keeping them. Staff physicians enjoy many benefits in exchange for some autonomy. "Everything is organized and they have ways of

doing everything here. On the one hand, I don't have any control over how the system works, but on the other hand, I don't have to worry about how it works, either" (W. Walton, personal communication, March 30, 2010). For the most part, the clinicians enjoy being able to do their job, which is treating patients. Physicians at Scott & White also have opportunities to teach and do research.

Freedom from the hassles of running a business includes a better understanding of what they bring home at the end of the day, instead of worrying about having a 20% "no show" rate that week. For some respondents and their peers, this stability in schedule and compensation carries over into their home lives, especially when the group can cover for an absent physician. The large group practice offers other benefits, too, such as technological support like infrastructure and the electronic health record, as well as more typical employment benefits like great health insurance, paid leave, a pension, etc..

Respondents identify the compensation model as another unique component of Scott & White, but one that remains a work in progress. Unlike the typical fee-for-service (FFS) reimbursement model, Scott & White physicians have no incentive to do more services or treat more patients—probably a major factor in the systems' cost savings. The physicians are focused on running tests when it is best for the patient. The Scott & White Health Plan, an HMO, has always paid physicians by capitation. A traditional capitation model, however, can have the opposite effect, since it does not always motivate physicians to see patients in a timely manner. Access to care had become a problem for patients in the closed system. The health plan uses what is considered to be a modified capitation arrangement with an underlying FFS, so the capitation payments get adjusted

over time based on what is happening with the FFS. To motivate physicians to pull their weight, Scott & White developed a bonus system linked to volume, quality, and patient satisfaction. According to Dr. Walton, “If I see x number of patients, I can get a little bit extra, but it’s a tiny part of my salary; not really enough to change my behavior very much, except to make sure I keep working.” Currie noted that, “We’re still trying to optimize the compensation model to get more quality and patient satisfaction indicators represented.” There is some patient satisfaction compensation included, now, based on feedback from randomized patient surveys (personal communication, April 8, 2010).

At Scott & White, having ready access to one’s peers in the group practice often results in greater collaboration and coordination of the patient’s care, leading to better quality and lower cost for the system and the patient. Dr. Walton attested that, “we are supported so much by our fellow physicians that we don’t feel insecure. If I’m not doing a test because I don’t think it’s in the best interest of the patient, I can consult with colleagues to make sure I’m not going off base with that. Whereas, if I’m isolated somewhere, I might do a CT scan, just because I’m not sure” (personal communication, March 30, 2010). All of the physicians interviewed enjoyed having informal peer interactions when they practice.

The electronic health record (EHR)

Another important tool that respondents said aids efficiency and reduces cost is the electronic health record (EHR). The EHR has many benefits to every part of the system. Most obvious may be the elimination of redundancy and improved communication and collaboration, since all of a patient’s medical records, including tests,

and scans are stored on the record. If a patient gets an MRI, for example, “not only is the MRI on file for a second provider, but they can trust that the people that did the MRI are the people they would have used,” said Einboden (personal communication, April 12, 2010). What’s more, is that collaboration can take place across long distances and on the same day. Dr. William Hamilton, an orthopedic surgeon, often consults with primary care providers at remote clinics in the Scott & White system. For example, if a child breaks his arm in Belton and visits his local urgent care clinic, the PCP on duty may not know if the child’s case requires surgery. Instead of having the patient travel to Temple, Dr. Hamilton can look at the film in the record, and inform the PCP that the arm merely needs to be cast. The EHR saves the patients’ time and money and Dr. Hamilton can spend more time on his own orthopedic caseload in Temple (W. Hamilton, personal communication, April 6, 2010).

Having a complete medical record on file is often more accurate than a patient’s memory, and it speeds up admissions. Because the record contains all allergy, medication, and treatment information, it could very well save a life by reducing errors. The paperless EHR eliminates waste and abuse. Providers can send e-prescriptions directly to the pharmacy, and avoid potential abuse by a patient falsifying a controlled medication prescription to read, “count 10” instead of “1”. At the clinic, the EHR system will automatically graph the trends of vitals as soon as they are entered. In the ICU, the vitals monitors will interface directly with the computer, so the nurses don’t have to double document. Deborah Saunders, the COO of Scott & White Memorial is also the Chief Nursing Officer, “one of my pet peeves is having to write something a hundred

times, and if a system will do it for the nurse, then the nurse can focus on caring for the patient” (personal communication, April 13, 2010).

Currently, the EHR is being challenged in the face of expansion and the acquisition of other hospitals and clinics. Tying the entire system together with records and communications tools that are compatible with one another is becoming cumbersome for Scott & White. Currie acknowledged that this will be an expensive issue to address, but it is so essential to how Scott & White operates that it cannot be ignored.

Integration and quality improvement

Integration and collaboration at the physician-level was understood to promote efficiency. Integration at the departmental and system level also offers avenues for achieving quality improvement—particularly the system’s integration with the Health Plan (SWHP). According to Dr. Rohack, the not-for-profit community based plan has helped with developing innovations within Scott & White to find better ways to deliver and pay for medical care, from the ability of Scott & White to test their own pilot programs to establishing new standardized evidence-based protocols. SWHP is also integral to tracking utilization and physician practice patterns, which is then used to provide meaningful constructive feedback to the physician.

Allen Einboden, SWHP CEO, touted several ways the hospital benefits from its integration with the plan, “we have a lot of data that show where the better outcomes are being created, what processes seem to support better quality and outcomes, in addition to being able to direct business to the hospital or clinic”. He continued, “we also coordinate on all of our medical policies, so they buy-in to how we administer authorizations, etc..”

Because all of the interactions between the organizations are electronic, it is also much more administratively efficient compared to other insurance plans (A. Einboden, personal communication, April 12, 2010).

Scott & White's integration and its unique ability to control all aspects of healthcare delivery, make it especially poised to be able to assume the risk involved with designing and testing new pilots in the interest of establishing more effective and efficient protocols. For example, interview subjects described an instance when Scott and White wanted to proactively address the issue of hospital-acquired MRSA (a particularly virulent Staph infection that is highly resistant to common antibiotics), so S&W developed their own pilot program. In order to determine the prevalence of MRSA in the admitted patient population and prevent the contagion of hospital-acquired MRSA, Scott & White swabbed every admitted patient during intake and tested for MRSA. Patients positive for MRSA were immediately given an effective antibiotic to both improve the patient's outcome and reduce the likelihood of transmission. Because Scott & White monitors quality, it can dictate, "this is quality and this is appropriate care, and this is not." According to interview responses, once the system defines the appropriate standard of care based on evidence, then everyone can agree and then deliver that standard.

While staff physicians may not have an incentive to overutilize services, the Scott & White employment model runs the risk of not giving physicians an incentive to control their utilization, either. The accountability that comes with a group practice can help. "The physicians are all working together to define what quality care is and holding each other accountable. No particular physician can behave in a way that is only to her

advantage without being called on the carpet by her colleagues,” said Einboden (personal communication, April 12, 2010). If and when inefficient practice patterns are not identified by the physician’s peers, having integration with the SWHP can help to identify outliers for the purpose of constructively addressing a physician’s practice patterns in a collegial way rather than a punitive one. When variations arise, rather than punishing the physician, Scott & White tries to identify some of the causes and what can be done to help that clinician understand why their clinical practice might be different than others. Dr Rohack: “if there’s a deficiency of education, let’s help educate the physician about a new or different way to provide that patient care.”

“For example, we had a surgeon who showed he was three standard deviations above his peers with managing people that were having simple surgeries. When we looked at the detail, we discovered he was referring every patient, regardless of age, to get cleared before the operation. As a result, patients that didn’t need to have EKGs, chest x-rays, or lab work, were having that done because of the way that that referral pattern occurred. And once we brought that to the clinician’s attention, and showed him the current guidelines on when additional testing ought to be ordered—who’s high risk, who’s not—he changed his practice and improved the care that was provided” (J. Rohack, personal communication, April 7, 2010).

To address quality, physicians at Scott & White noted that they are also given a “report card” regularly based on metrics such as mortality and morbidity. Sometimes, physicians can control those factors, but not always. Scott & White is continuously working on developing quality metrics to measure medically controllable factors so that quality data can be incorporated into the compensation model. Currie said that the system they use is great at monitoring quality at the system level, the departmental level, and the division level, but they are still struggling at the independent doctor level. “All hospitals

are struggling with this, because it's very difficult to determine who should get credit for a single patient when they are treated by the team" (personal communication, April 8, 2010).

Of course, physicians are not always willing to blindly accept new protocols and standards, because they like their autonomy. Dr. Hamilton described a situation when Scott & White surgeons adopted a new practice they called, "mark your site". The new standard operating procedure required all surgeons to meet with their surgical patient before receiving anesthesia to verify the correct operating site with both the patient and the patient's chart. At that point, the surgeon is required to sign their initials directly on the patient's right knee, for example, to avoid unnecessary surgery on the patient's good left knee. Many surgeons initially resisted the change they considered to be remedial and time-consuming. The fact remains, however, that operating on the wrong site is a very common medical error that is dangerous for the patient, wastes time and resources, and is comparatively easy to avoid with the "mark your site" initiative. In this case, the resisters eventually accepted that preventing potentially catastrophic ends more than justified the simple and benign means (W. Hamilton, personal communication, April 6, 2010).

Currie explained that doctors may rightly disagree with changes they don't perceive necessary, but "if the doctor is interested in helping the patient, and the evidence shows that the protocol is what is best, that makes it difficult to protest." This is why it is so important for the protocols to be tied to evidence of positive outcomes. Currie continued, "in our case, we also have a physician and department chair that work hand in hand with us, and *they* are working with the doctors, not an administrator trying to

convince the doctors that they should change their practice patterns” (personal communication, April 8, 2010).

When it comes to reducing some of the costs associated with the variety and non-standardization of practice patterns in healthcare, evidence-based medicine is the key to developing standardized protocols. The integrated model can also reduce costs by keeping doctors and hospitals on the same wavelength, since “what’s good for the hospital is good for the doctors”. Currie explained that it is easier to change behaviors in an employed model, “if the system as a whole feels one way is the way to go, then they can say, ‘OK, you’re employed here, this is what you have to do’, versus trying to get hundreds of doctors to change their behavior [for an unjustified reason]” (personal communication, April 8, 2010).

“It was clear that the integration of the institution—and the sharing of information— enhanced our ability to determine what is best for patient care.” Dr. Rohack maintained, “that integration was a key difference of Scott & White compared to many other institutions that were mainly a hospital or a hospital and clinic and didn’t have the insurance arm as part of that structure.” The end result is a fully integrated system capable of comprehensive quality monitoring for optimizing system-wide standard protocols.

Opening Scott & White in more ways than one

The past decade has brought dramatic changes to Scott & White, setting in motion achievements that facilitated unprecedented growth in a very short period. Currie described her somewhat brief experience at Scott & White, “when I came here five and a half years ago, Scott & White had about 30 clinics (mostly primary clinics in surrounding areas, with the specialists here in Temple). They had Scott & White Memorial Hospital (with 200 fewer beds) and a second hospital under a management agreement in Gainesville. Today, we have over 50 clinics, with the outlying clinics having multispecialties and only sub-specialists in Temple, and nine owned, partnered, or managed hospitals with two in the pipeline that we are expected to close on in the next few months” (personal communication, April 8, 2010).

In 2009, Scott & White finally acquired the last non-S&W hospital in Temple, Kings Daughters Hospital (KDH), which had operated in Temple for almost as long as Scott & White. In the case of KDH, the physicians finally pulled out of the community hospital and it could no longer survive. Some members of the community were less than enthusiastic about Scott & White’s complete monopoly in the region. Dr. Rohack described the acquisition, “that hospital came to Scott & White and asked if Scott & White could absorb it. This was not a hostile takeover...In each situation, Scott & White has been approached by other systems. [KDH] recognized that the model that Scott & White has set up, is good for patients” (personal communication, April 7, 2010). Scott & White has already begun construction to convert the former KDH into a Children’s hospital to better meet the needs of the community.

Scott & White's monopoly has proved to benefit the community with the savings it produces for Scott & White, which are passed down to the consumer. When asked how Scott & White was different from its counterparts in Dallas, Dr. Walton explained, "Frankly, Scott & White is a monopoly here. We don't have to compete with anybody else to make big flashy institutions with mahogany desks. Its pretty plain around here—[pointing to the corner] those are plywood cabinets. They don't spend a lot of money on frivolous things here" (personal communication, March 30, 2010).

Patricia Currie is the Chief of Hospital Services at Scott & White, but she also has years of administrative experience in a for-profit hospital network. She offered that the savings reflected in the Dartmouth Atlas Map (See Appendix C) are because of the efficiencies that Scott & White's integrated system warrants (Dartmouth, 2009). The other reason, she was quick to add, "is that we haven't had to spend resources ridiculously due to the competition." At Scott & White, new technology is pursued based upon the needs of the patient and not because the hospital down the street has it, which respondents maintained was true even when there still was a hospital down the street. Currie explained that, "competing hospitals not only compete for patients but for the doctors, and they spend more money getting the doctors. Scott & White's integrated model takes that out" (personal communication, April 8, 2010).

Merging with the competition has other benefits, as well. Scott & White is able to offer services to an ever-expanding geographic area. Of course, newly acquired systems benefit from the electronic communications systems and learn about the Scott & White culture. According to Deborah Saunders, "we get referrals from all over, so for a patient

to come from Round Rock and have the same continuity of care, that's a big benefit" (personal communication, April 13, 2010).

Scott & White has also learned that, while they do many things very well, their way is not the only way. Scott & White is learning that the benefits of collaboration at the physician level can also apply to the hospital level. Saunders described an instance when Scott & White Memorial Hospital was trying to curb catheter associated urinary track infections (CAUTI), "when Hillcrest⁴ in Waco came on board, we were having trouble with CAUTI. We were working on how to improve, and one of the Hillcrest people was here from Quality. She said, 'Let me tell you what we did.' And we thought it was a great idea and adopted it." Saunders admitted that, "even though it wasn't the 'Memorial Way' we could learn from it." Saunders also has previous administrative experience at a for-profit hospital network, "I'm used to collaborating with a bunch of different hospitals, and not having to re-invent the wheel. Scott & White had never done that here, and that's a huge shift that we're having to work at" (personal communication, April 13, 2010).

Challenges and lessons

Growing and expanding at the rate that Scott & White has does not occur seamlessly. The entire system has faced and continues to face challenges. The transition from a closed to an open system illuminated how outdated the infrastructure was, especially with regard to the health plan. The plan's CEO, Allen Einboden, surmised,

⁴ Hillcrest Baptist Medical Center in Waco, TX, is jointly operated by Scott & White Healthcare and Hillcrest Health System. Its doctor mix is about 50% private independent, 20% Hillcrest employed, and 30% S&W staff (P. Currie, personal communication, April 8, 2010).

“we all learned that because we had been fairly closed as a model, that we all needed to bring our capabilities up to standard in the modern world.” He continued, “we all went through a big learning curve, in terms of managing claims in an open environment” (A. Einboden, personal communication, April 12, 2010). The same infrastructure was not necessary in the old capitation model when a claim was simply processed as a flat payment. Currie pointed out, “Adding the infrastructure may lead to additional costs, but it also allows you to track and measure yourself better” (personal communication, April 8, 2010).

When merging with new hospitals in which Scott & White only assumes a 20-30% stake, management had to learn how to work with independent doctor and foreign hospital management. “We experienced a lot of growing pains, but the model helped us work through it.” Only a few years ago, all of the physicians at Scott & White were on staff, subject to the employment model. Now, the outlying hospitals have both Scott & White employed and independent doctors, in varying ratios depending upon the hospital. According to Currie, the Round Rock hospital, now called Scott & White University Medical Hospital, is about 90% S&W employed, whereas Hillcrest in Waco is about 50% private independent, 20% Hillcrest employed, and 30% S&W staff. “The main lesson is to learn how to work with the hospitals and the independent docs, and still feel that we are able to assure that the quality is appropriate and consistent. We need to protect the integrity of the Scott & White brand.” In the end, Currie concluded, “[our success] always came down to being an integrated model” (personal communication, April 8, 2010).

The hospital and clinic also had to learn how to better manage utilization in the open environment. As a closed system Scott & White only treated S&W health plan members and those members could only seek treatment at Scott & White. Sometimes, it could take three months to see a doctor, but because the patients did not have a choice, the tradition remained. For example, when Deborah Saunders assumed her role as COO/CNO, “the unit clerk in a unit could refuse patients if their charge nurse said, ‘we can’t take any more patients because we’re too busy’—even if we had 15 patients in the emergency room, and they had 15 beds, they could refuse to take them. We don’t do that anymore.” Now, the unit must take the patients they have room for to keep the flow moving and prevent a blockage that results in a domino effect. Saunders continued, “because you’re backing up the ER at that point, and anybody else coming in isn’t getting treated” (personal communication, April 13, 2010). Currie attested, “we’ve had to work very hard to improve access and get the patients in, because we had a model that worked well at keeping the patients out, so that only the most urgent got in” (personal communication, April 8, 2010).

Responses described Scott & White as a very “set in its ways” place. Many people have been at Scott & White for a long time and only know the “Scott & White” way. “We did things just because they were always done that way, because I was trained by someone who always worked at Scott & White, and they were trained by someone who always worked at Scott & White, and so on.” To change that, Scott & White brought in some outside people to fill management and senior leadership roles, resulting in a new

kind of culture that is more focused on maintaining patient-centricity through teamwork and innovation.

The physicians now have to sign a code of conduct. Saunders described the change as basic. For example, physicians now answer their pages in a timely matter. “We used to have physicians that wouldn’t answer their page. If the nurse needs help, the physician needs to respond.” The new culture is not limited to the physicians, however, because the nurses were also used to working at a certain pace. Saunders explained, “they could be the best nurse in the world but have the worst attitude, and we let them stay.” As the current COO/CNO, Saunders considers attitude to be priority, “I encourage everyone to interview for attitude first. You can teach someone a skill set or how to do something, [but] you can’t really re-train someone’s attitude” (personal communication, April 13, 2010).

Currie admitted, “Our integrated model does not mean we have solved all of the problems with health care delivery; we still make the same mistakes as anybody else.” Scott & White has come a long way and they are still improving in their shift from a physician-run (and physician-centered) system to a physician led and patient-centered system. “Our model is better at putting the patient first, but it doesn’t always happen. Sometimes the doctors put themselves first.” Coming from a for-profit background where pleasing the consumer was always considered to be priority, Saunders was surprised by many of Scott & White’s old methods, “now, I’m watching all those things change to the way they should be done...It’s been fun for me to watch people grow and change and

move us into the position we are now: ready to take on anything that comes down the pipes. I think we're ready to do it" (personal communication, April 13, 2010).

Patient Perceptions

What do the patients think? While patients were not questioned for this case study, it is the providers' impression that the patients appreciate, "the comprehensive, personalized care, that's also high quality" (J. Rohack, personal communication, April 7, 2010). Several respondents reflected the same viewpoint. "The patient knows that when they walk into Scott & White, they'll have their medical record, they've got people who are coordinating for them, and if they need an x-ray, they don't have to go across town and then haul the x-rays back." All of the patients' care is dealt with in the same system and shared between doctors to decide how best to care for the patient. "We have a lot of patients that give us that feedback." The referral handoffs are more straightforward, and as a result, the care is less fragmented. "That we generate better outcomes stands for itself, so people trust us for wanting to do the right thing" (A. Einboden, personal communication, April 12, 2010).

Not all of the patients can feel so pleased all of the time. According to Dr. Walton, "unfortunately the indigenous people in this area don't appreciate how good we are...there are always disgruntled people and people with complaints, but they just don't realize how good it is here compared to other places" (personal communication, March 30, 2010).

Scott & White places a lot of emphasis on giving all of their patients a “primary care home”, where the patient can receive the entire continuum of care from birth through the end. Rohack said, “It begins with the plan, who makes sure that a patient has someone to coordinate their care when the patient enters the system, and that coordinator is a primary care physician, an internist, or pediatrician”. One of the benefits in having a primary care home is the subsequent physician-patient relationship that comes with it. It becomes easier to have the conversation regarding what the patient wants at the end of life, so that when a catastrophic episode occurs, “you don’t have to get every specialist to come render an opinion. You can deal with the situation as the patient wished with their family, and not have to exercise futility” (J. Rohack, personal communication, April 7, 2010). The unified EHR contributes to this, as well, so that if the patient discusses his or her end of life care with a specialist, the PCP is kept in the loop, too. This coordination at the end of life is likely to explain why Scott & White spends significantly less on Medicare enrollees during the last two years of life than the national and state average. Saunders said that from the patient’s perspective, “It’s about having the best options...It’s a ‘one stop shop’ for patient care. You come to Scott & White, and the care will come to you” (personal communication, April 13, 2010).

CHAPTER 5

DISCUSSION & CONCLUSIONS

The stated purpose of this case study is to answer two questions: **How** is Scott & White Healthcare able to contain costs while maintaining patient health and satisfaction? And **why** was Scott & White able to create such a unique system? Both of these questions can be answered by examining the alignment of incentives that Scott & White has achieved. These incentives can be organized into three main categories, each of which is discussed below: (1) its physician leadership and the compensation model, (2) having system-wide integration, and (3) having a system open to other payers.

Physician Leadership and Compensation Model

It is clear that all of the respondents felt that having physician leadership and input at every level was integral to Scott & White's success. One respondent suggested that physicians think and operate differently due to their unique perspective in providing medical care and because they have an ethical standard to uphold that accompanies their medical license. Business executives, on the other hand, come from a financial perspective, and the two schools of thought don't always meet when it comes to sensitive issues like quality and safety and the patient experience. Having access to the physician perspective, while integral, is not sufficient, however. Having the right business minds that can understand the physician issues and physicians who can understand the business issues are equally important. One administrator concluded that unless the two schools of thought can cross-pollinate, one or the other will suffer and lead to a lack of success. The rank of the physician leadership may also be equally important. At least one administrator

agreed that the governance structure of a newly created 501(a) would need to be absolutely run by doctors, where the physician-CEO also acts as CMO, or the two positions are equal in stature, in a joint-leadership structure. Another factor, stressed by administrators and clinicians alike, was in the importance of creating a group practice mentality. This can be addressed, at least partially, with the accountability that accompanies a compensation model that balances patient access with utilization.

Groups of providers who consider creating an accountable care organization (ACO) should learn from Scott & White by changing their entire business model from a mere hospital to that of a medical delivery system, in which physicians are fully integrated—not just hired—into the management apparatus. When all levels of the organization have physicians present in leadership positions, they will help to drive the organization forward and react to the issues that physicians deal with everyday.

System-Wide Integration

Integration is another essential part of Scott & White's successful equation. From integration between the clinical side and the health plan, to the effective and efficient EHR, and the informal collaborations between individual physicians, integration provides Scott & White with several advantages. Because of the relationship with the health plan, Scott & White clinicians and managers have access to a wealth of information about patient utilization and outcomes. This information can then be used to improve quality and efficiency on the supply side. This relationship with the plan, also makes the clinicians more sensitive to cost, so that if they engage in unnecessary testing, they understand that that can drive up the premiums for everyone.

Due in part to Scott & White's mission incorporating the values of education and research, Scott & White seeks to define standard protocols based on evidence. Scott & White's not-for-profit status, affiliation with Texas A&M Health Science Center College of Medicine, and integration with the health plan make the system uniquely poised to not only design protocols, but also pilot, optimize, and adopt them. Other financially driven institutions are not going to spend valuable resources on a program unless they know it will work. Scott & White is financially sound and fiscally accountable, so they can take on the risk of new ideas in a small system to test it, and adopt it system-wide if it works.

Open System

Scott & White has always had the ingredients for a truly accountable care organization. Until they opened up the system to other plans and patients, however, they did not have the incentive necessary to view the patient as a limited resource. One administrator revealed that when Scott & White opened up to other payers, and Scott & White patients gained the option to go elsewhere, Scott & White was forced to change their mindset to reflect the fact that if they did not want to lose patients, they would have to give their patients a good reason not to leave. Other competitive institutions are used to doing what is right by the consumer, but Scott & White had been used to doing what was best for the physician, first, which sometimes came at the expense of the consumer. It was not until the system opened to other payers that Scott & White began to realize that they might lose volume, if they did not figure out how to take better care of and get better access for the patient. Although Scott & White is a successful monopoly, having the open

system provides just the right amount of competitive drive for improved quality, efficiency, creativity, and innovation.

Conclusion

In summary, this case study concludes that Scott & White is able to contain costs while maintaining patient health and satisfaction by achieving an alignment of incentives. Those incentives most unique to Scott & White are its physician led governance structure, including its innovative EHR, its integration with the health plan, and offering a system open to other payers. Scott & White was able to secure a successful monopoly by listening to their physician leadership when it came to meeting the needs of patients and listening to its business leadership when it came to remaining economically viable. These relationships and processes are facilitated by collaborations and communications made possible by the EHR and strengthened by the Scott & White mission.

Scott & White can be accountable for its care, because it offers the entire continuum of care and all of the services that accompany it. When the patient enters the system, Scott & White can make sure they get the care they need. Like any human-run organization, they are not perfect, and they have room for improvement on many fronts. Given the current state of health care in America, Scott & White is delivering health care well ahead of the curve. It may not be possible for all systems to achieve the same organization as Scott & White, but they certainly have a model to emulate. This was the same conclusion reached by researchers at the Commonwealth Foundation, who selected Scott & White as one of fifteen model systems across the country. The Commonwealth study focused only on institutions, “that have achieved results indicating high

performance in a particular area of interest, have undertaken innovations designed to reach higher performance, or exemplify attributes that can foster high performance” (McCarthy et al., 2010). As one administrator put it, Scott & White is “positioned very well for the future.”

An Adaptable Model?

The most notable difference between Scott & White and other potential providers seeking to form ACOs is that Scott & White has been evolving for over a hundred years, which has helped greatly to create the cultural mindset they now have. Many hospitals are considering moving toward employment models, because it makes sense, but as Currie pointed out, about 90% of the practitioners are still in private practice and those physicians cannot be expected to change over night (P. Currie, personal communication, April 8, 2010).

The lessons that Scott & White has learned most recently in transitioning to an open system are pretty specific to Scott & White. Most other systems are already open to various payers, but they are attempting to achieve the same result as Scott & White without the same foundation. Scott & White began with a fairly solid foundation of physician leadership, an effective EHR, and system integration. The last puzzle piece was opening up to other payers. In this case, Scott & White had to back pedal to develop the infrastructure that other providers already had all along. With regard to adaptability, it may be easier to move in the direction that Scott & White did rather than in back-fitting an ACO formula onto a patchy foundation.

What's more is that Scott & White has already been practicing most of the advances coming out of the latest health reform. For years, they have been covering pre-existing conditions, chronic illnesses, and dependents through age 25. The financial impact of those changes is not going to affect Scott & White like they will other systems. One administrator noted that in some ways Scott & White is antiquated and backward, but in others ways, Scott & White is very proactive and comparatively advanced. Further, to replicate the Scott & White model, anti-trust regulations need to be addressed, because they will be a stumbling block for ambitious providers. Scott & White could only combine their hospital and clinic in 2000, after it became possible to form a 501(a) under Texas law. Dr. Rohack attested from personal experience that it takes a lot of energy to develop a culture when pulling together a group. Collaborative efforts can be tripped by the anti-trust prohibitions (J. Rohack, personal communication, April 7, 2010). Scott & White had been engaged in talks to form a relationship with Fort Worth's Cook Children's Hospital, but those efforts were quelled when the Federal Trade Commission (FTC) blocked the collaboration for encroaching upon certain trade prohibitions.

Policy Implications

Many administrators interviewed for this case study did not believe the corporate practice of medicine protections to be necessary. They suggested that changing the compensation model and governance structure could achieve the same ends. Ordering a test should be based on its appropriateness, and not who owns the service. What is ultimately important is that the services being rendered are of high quality. This depends on changing the traditional model from "pay for volume" to "pay for outcome" or "pay

for value”. The country as a whole needs to invest in finding a reimbursement model that can not only start aligning incentives, but can also be realistic in determining when a physician is responsible for the outcome. For example, when is a cardiologist at fault for a patient’s morbidity when the patient continues to smoke against the physician’s advice? When asked how such quality indicators should work, Dr. Rohack qualified that the infrastructure in the field of quality measurement is still in its infancy. He approved of the fact that the latest health reform legislation does contribute significant dollars to improve the infrastructure of quality measurement. He also warned, however, that until the nation has common platforms of EHR that can actually keep track of what the doctor does everyday and documents it, achieving the intended end will be very difficult (J. Rohack, personal communication, April 7, 2010).

What is evident is that the prohibition of corporate medicine effectively prohibits physicians from forming large group employment models. As a result, it is very difficult for other systems, especially in Texas, to mirror the physician-led governance model that is so integral to Scott & White. One administrator suggested comparing the organizations found in states that permit doctors to be employed by institutions to their equivalents in Texas, the 501(a), and postulated that there probably was not much difference in how the two interact with their staff physicians.

Health reform advocates should start looking at the entire system as a whole and how to start integrating providers across the board. Many policy analysts have noted that part of what’s wrong with health care in America is its fragmentation, due to the way it is paid for. Scott & White serves the entire continuum of care from birth to death, and more

providers should do the same, so that quality analysts can look at the patient's entire health continuum. Efforts to change to paying for episodes of care and outcomes make sense, but the best outlet the US has that can initiate the change is Medicare, which is far from ready. The ACO pilot program may be a good first step. While it is still anyone's guess as to what a resulting ACO will look like and how it will work, the idea is at least on the table, and both policy makers and health providers are entertaining the possibilities.

CHAPTER 6

LIMITATIONS OF THIS CASE STUDY

The results of this case study may be affected by certain limitations. The source of information was limited to seven Scott & White administrators and clinicians. While small in size, the sample was purposeful and directed in its selection, by involving the perceptions of key actors in the Scott & White system: a primary care provider and two specialists, including a board member and the policy director, the top hospital administrator, the CNO/COO for Scott & White Memorial, the CEO of the health plan, and a clinic manager. A valuable perspective that ultimately could not be attained was that of the CEO of the entire system.

Achieving validity of the results was addressed in the triangulation method of comparing multiple, and in this case, diverse viewpoints of the same issue. This is another value to the thematic approach used for analysis. Some responses were outliers, and those were noted when presented in the results.

A final limitation is that of the respondents, themselves, and the information and insights that they were willing to offer. It was obvious that some respondents were self-censoring their responses. Additionally, the potential exists for analyst bias in developing the themes and selecting representative quotes. Therefore, efforts were made to reexamine the responses to verify their accurate representation.

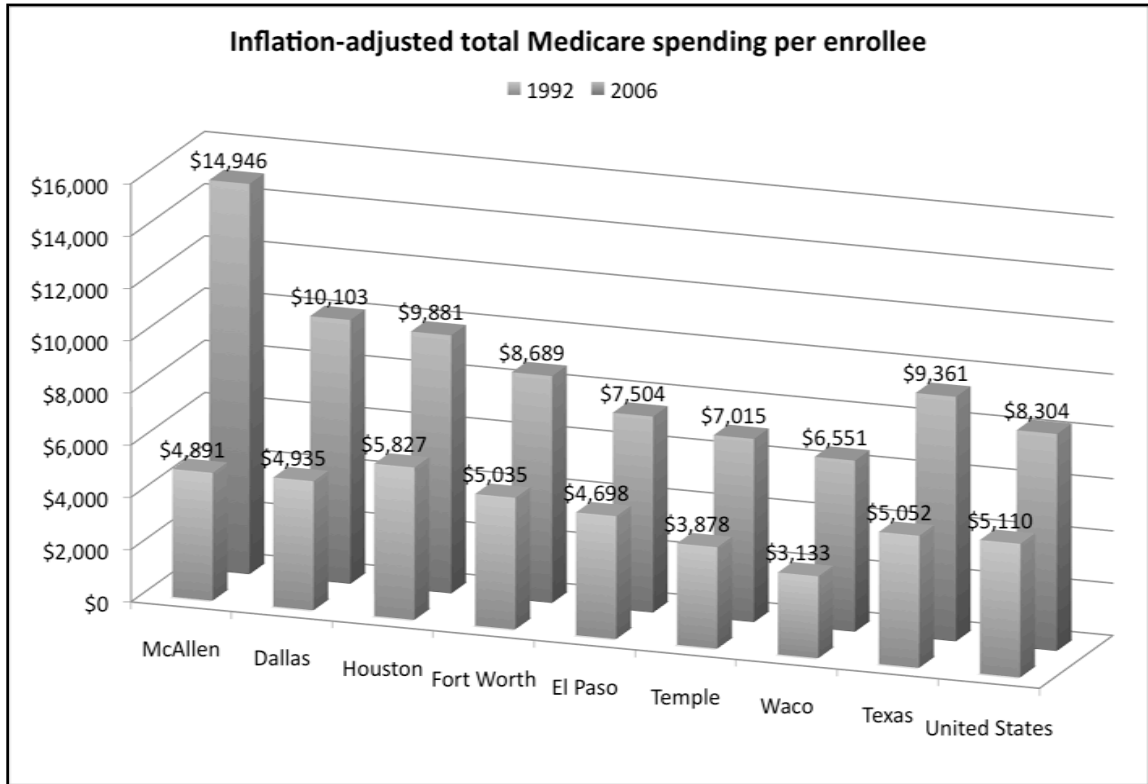
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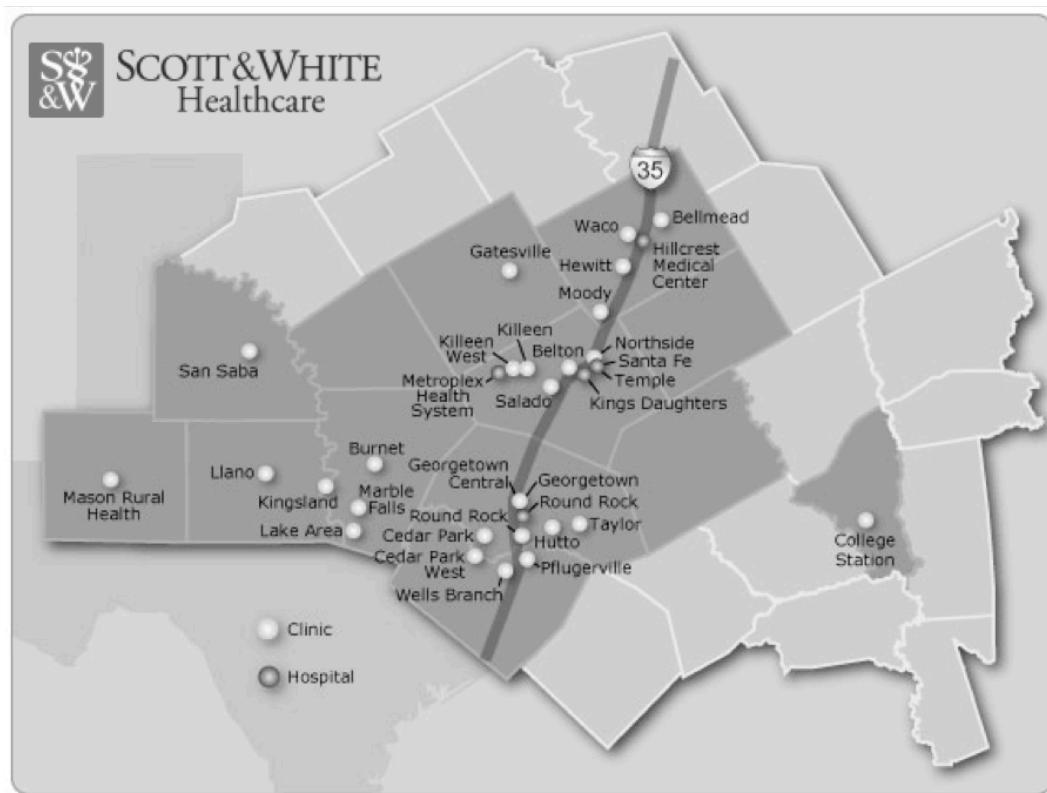
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APPENDIX A: Medicare Reimbursements Per Enrollee, 1992 & 2006



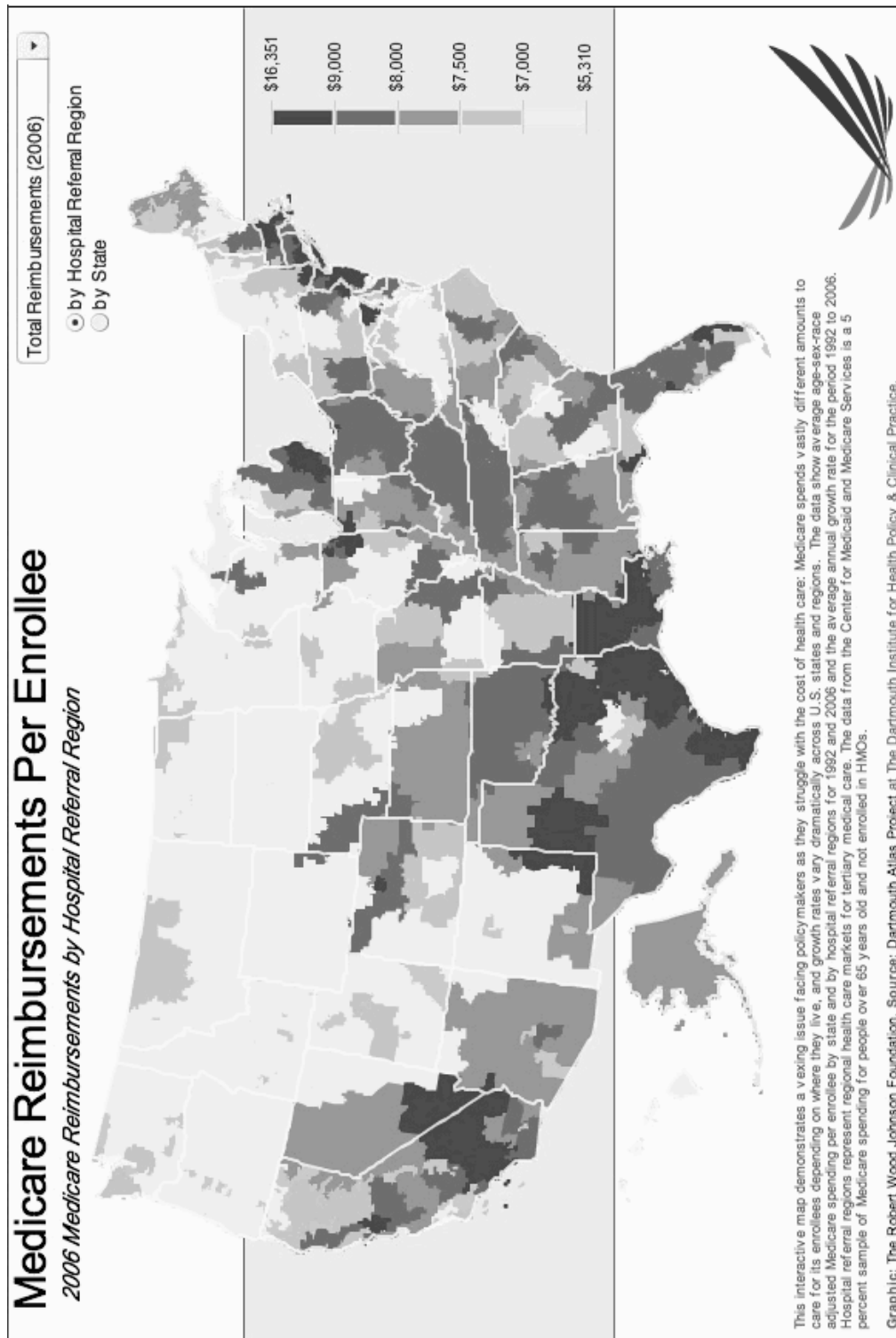
Source: Dartmouth Atlas Project at The Dartmouth Institute of Health Policy & Clinical Practice (Dartmouth, 2009).

APPENDIX B: Scott & White Healthcare Geographic Region



Source: www.sw.org (Scott & White Healthcare, 2010).

APPENDIX C: 2006 Medicare Reimbursements Per Enrollee



Source: Dartmouth Atlas Project at The Dartmouth Institute of Health Policy & Clinical Practice (Dartmouth, 2009).