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A CONVERSATION WITH DR. JAMES V RAWSON
*ARCHITECTING THE UNITED STATES' FIRST LONG-TERM
VENDOR-PROVIDER MEDICAL IMAGING ALLIANCE*

January 2016

"We Accelerate Growth"



A Conversation with Dr. James V Rawson, MD, FACR, chair of Department of Radiology and Imaging at the Medical College of Georgia at Augusta University

Interview by Nadim Daher, Principal Analyst and Tanvir Jaikishen, Senior Industry Analyst, Frost & Sullivan

Architecting the United States' First Long-term Vendor-provider Medical Imaging Alliance

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Dr. James V. Rawson, MD, FACR, chair of Department of Radiology and Imaging at the Medical College of Georgia at Augusta University, and its Health system, speaks with Nadim Daher, principal analyst, and Tanvir Jaikishen, senior research analyst, both with the Transformational Health group at Frost & Sullivan. They cover the 15-year alliance that AU Health, then known as Georgia Regents Health System (GRHealth), signed with Philips Healthcare in June 2013.

Interview at a Glance

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“Imagine an MRI scanner designed by the patient. I think that’s the future, and that’s the direction that, together, we are heading here.”

“The challenge is really to have found two organizations ready for that type of collaboration. The successful vendor-customer relationships or collaborations are going to require some transparency and honesty at levels that not everyone is going to be comfortable with.”

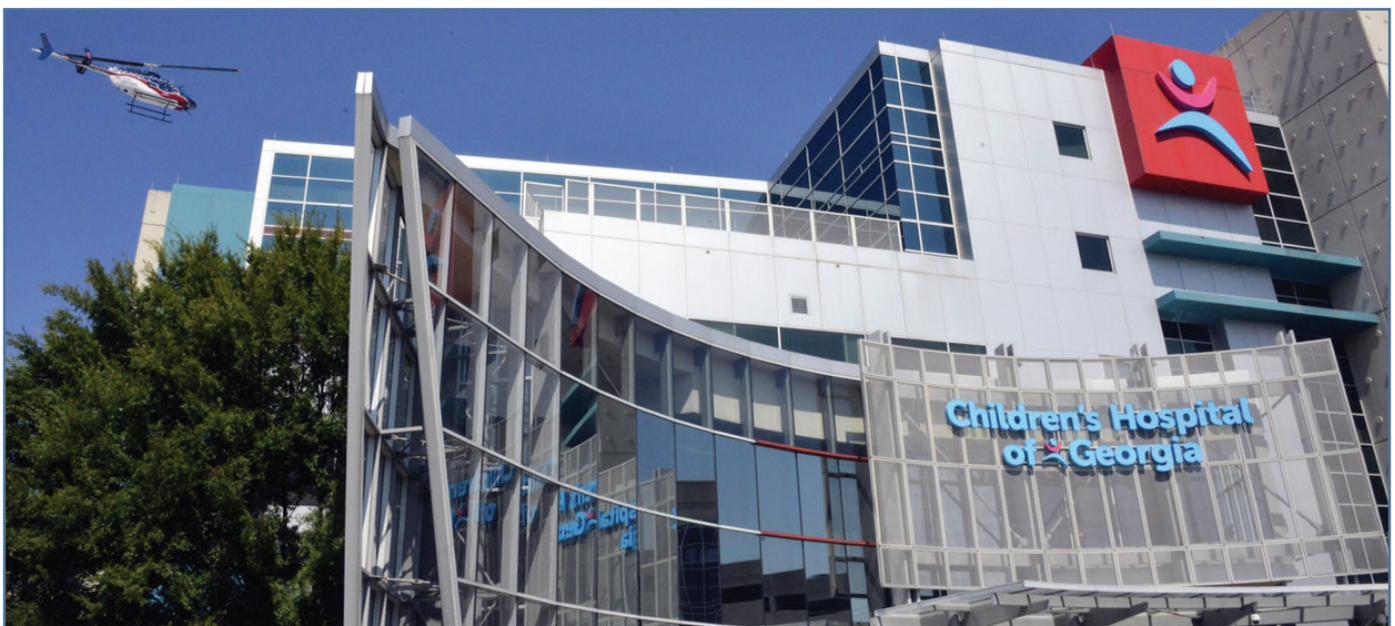
“If you want to shift from a transactional to a really transformational model, you have to be in this for the long term.”

“Both Philips and AU Health had to be willing to acknowledge that we had to buy the best product to meet our clinical needs in each unique setting we put a device in. Sometimes it would be a Philips product and sometimes it would not be a Philips product.”

“The only other way to install this much equipment in such a short timeframe would have been to build a new hospital.”

“The alignment of leadership and culture centered on taking care of the patient will be the ingredients that are necessary. If those aren't there, you can't make the best business model. At the end of the day, this is about people taking care of people. If that's not what they are focused on, then their eyes are on the wrong target.”

“Our MRI volume is up more than 30 percent, but we didn't add any new MRI scanners. We've increased significantly our interventional radiology volume, but we didn't add any interventional suites.”



Dr. Rawson, thank you very much for taking the time to speak with us today.

You are chair of the Department of Radiology and Imaging at Augusta University's Medical College of Georgia, and one of the architects of the alliance that your health system signed with imaging vendor Philips Healthcare back in June 2013.

This major contract spans your entire AU Health system, including Augusta University Medical Center, Children's Hospital of Georgia, Augusta University Cancer Center and numerous outpatient clinics, which collectively have a catchment of around 5 million across Georgia and South Carolina.

Given its scale, its length and its scope, this contract is touted as the first-of-its-kind, large-scale, high-profile partnership between a medical imaging provider and medical imaging vendors in the US. It also reflects many important trends taking place in the medical imaging and healthcare industries.

Like many others in the imaging community, we at Frost & Sullivan are very eager to better understand how this large-scale contract came to be, and hear you reflect on it as it approaches the conclusion of its third year.

Nadim Daher (ND): *Dr. Rawson, thanks again for your time today, we really appreciate it! It'd be great for us to start off this conversation by filling us in on your role and the kind of work that you do as the radiology chair at the Medical College of Georgia.*

Dr. James Rawson (JR): Well, as chair of radiology, I work in a matrix environment. Imaging is performed in many different locations and many different departments, so we view imaging as a service line. As chair of radiology, I sit on the Medical Executive Committee of the hospital. I also sit on our Practice Plan Board of Trustees, and hence I have a balanced enterprise and department perspective. I have also served previously as our medical staff president for three years, so that also gives me a nice enterprise vantage point.

ND: *Dr. Rawson, please tell us a bit more about the genesis of this important contract between Augusta University Health System and*

Philips. How long was it in the works before it came to fruition in mid-2013, and what were the top two or three initial objectives that prompted the early discussions?

JR: It took us almost two years to plan the alliance. As resources in healthcare continue to shrink, and the need to do more with less continues, we recognize that as a system, we would need a different model. We would need to be less transactional, more collaborative and more transformational in our thinking.

You really cannot build this type of complex alliance without alignment. Our approach was to start with organizational values and direction and strategic plans. So when we compared our values and strategic interests with Philips, we saw areas of overlap. So, we started with the alignment at organizational levels and we built that out into department and individual alignments.

What we found was that as long as we stayed focused on the patient, we could work through any of the complexities and

any of the barriers. We are all very committed to improving patient care, and we were not afraid to take on the challenges involved in creating a new model.

ND: We know you were an internal champion on the AU Health side in getting this major deal off the ground. To what degree did this require an effort of aligning around common objectives and multiple stakeholders in your organization, as well as within the vendor organization over at Philips?

JR: It definitely involved different stakeholders at the table. Both organizations are complex organizations, and we found that we both have our own internal silos and processes; and we had to work across all of the silos and all of the business units to be able to bring together a vision for a new model. That really was a very different mind-set.

We were not trying to buy a single piece of equipment; we were trying to build a relationship that would transcend individual transactions.

ND: Was it about finding a common denominator between everybody's wish list, or was it about adding everybody's wish list to a master proposal?

JR: That's a great question. It was not about combining everybody's wish list. It was about the common denominator, which is that we all have a passion for improving patient care. The alignment was around the patient and as we expanded the team to build this, we brought on more people from different areas in our organization who share that same passion.

ND: Were there some ongoing changes in the way AU Health partners with its radiologists, for example through full-time employment or

joint ventures, which may have been part of the rationale to look for new ways of working with your imaging vendors?

JR: We had made some governance changes in our organization so that the CEO of the hospital also served as the CEO of the practice plan and also had a leadership appointment in our school of medicine and our university as well. So we had a degree of organizational alignment within our own house, which was rather unique at the time.

At the same time, the way that the hospital and the radiology department worked together was unique. We had a long history of radiology leaders being at the decision-making table with the hospital leadership for many years. As radiologists, we were partners with our hospital, focused on taking care of the patients together. We weren't adversaries with conflicting agendas.

ND: Do you think it makes a difference, for the ability to build an alliance such as this one, whether radiologists are employed by the hospitals or under other types of working agreements like joint ventures?

JR: Certainly one of our strengths in being able to build the alliance was our strong internal organizational alignment among our physicians, our hospital and our school. I don't think you need to have a single organization that employs all the physicians or owns all the equipment or owns all the imaging centers.

I think these can be partnerships and collaborations, provided they can work together and be at the table with a focus on a common goal. I don't think the secret sauce to this type of relationship is purely corporate structure. The secret sauce really is individuals with a passion to improve healthcare, working with people, organizations and enterprises to do that.

Tanvir Jaikishen: The advent of value-based healthcare is bringing significant changes to the structure of provider reimbursement. Are there initiatives at AU Health around quality-based or outcomes-based reimbursement that may have been contributing factors to the deal?

JR: As providers of care, we needed to find ways to increase the value that we would bring to our patients. IHI (Institute for Healthcare Improvement) talks about a triple aim where we have improved clinical outcomes, improved patient experience and lower cost per capita. I think we realized

that no one provider and no one organization could have accomplished this in isolation. What we really needed to do to improve and increase the value that we were bringing to the patients, we had to build teams, and we had to work together. So we were looking for partnerships. We are looking to build and expand relationships.

TJ: So it was not so much about the financials or the revenue stream and reimbursement values, but more toward the value end of things?

JR: Yes, that is correct.



ND: The alliance between AU Health and Philips seems promising for your organization to move further ahead its patient-centered care paradigms. Can you tell us a little more on how you are seeing this promise materialize in practice?

JR: Our hospitals have a legacy of patient- and family-centric care that goes back over two decades. We had designed and built a children's hospital, which brought children and families to the design table. Since 2000 all the renovations, equipment replacement and upgrades in

radiology have had patient advisors on the design team. There are no areas left in our radiology department that weren't designed by patients. By bringing Philips in to this environment, what we now have is patients at the design table along with the vendor that makes medical equipment. Patients are providing feedback on how various changes to the equipment could make for a better patient experience.

Imagine an MRI scanner designed by the patient. I think that's the future and that's the direction we are heading in together here. We just finished re-designing our

Children's Hospital of Georgia radiology department, and the experience is completely different to the patient. When they come to register, they actually come into a lounge that has an interactive video screen. When patients come back for their X-ray or any other procedure, we ask them what their favorite color is, and we use a color wheel to change the lighting in the room to become their favorite color. We have given back some of the controls to the child, for the procedure that they are having. This translates into the child having more control over their experience; being better able to cooperate ... procedures are shorter and have less radiation.

ND: And some of these new technologies would have been developed by AU Health advising Philips or is it a co-designing relationship at this point?

JR: This is a co-design relationship between AU Health, Philips and patients.

TJ: Over the past two to three years we have seen a few more of this type of large-scale, vendor-customer partnerships being signed in the US. Do you think we are indeed witnessing an accelerating trend, or would you still qualify them as isolated cases?

JR: There certainly is a trend in health care for consolidations and collaborations. We are seeing this with hospital mergers. In terms of vendor partnerships with hospitals, I think it is part of that trend, but the challenge is really to have found two organizations ready for that type of collaboration. The successful vendor-customer relationships or collaborations are going to require some transparency and honesty at levels that not everyone is going to be comfortable with.

Philips's staff actually sits on our committees and they see the same data that I see, both good and bad. We then work together to improve the patient experience and patient outcomes. If you want to have this type of

model work, you can't hide anything. I think you will see more types of these partnerships, but I think they will only be in environments where you have the ability to build very transparent collaborations. Trust is essential.

ND: The few other similar contracts that have been signed recently all stipulate fairly long, but different contract durations. Could you help us understand what makes the 15-year duration that was decided for the AU Health contract the "right" duration, i.e., why that is a timeframe that's neither too short nor too long?

JR: Well, if you want to shift from a transactional to a really transformational model, you have to be in this for the long term. So you cannot have just a relationship that is going to be there for a couple of years. We needed to be able to discuss strategies and make investments that had long-term return on investments several years from now. If we didn't do that then the vendor-customer alliance would just stay transactional. We would be looking at short-term decisions.

ND: We know from talking with the major imaging OEMs that they have been working hard to better support new ways of working with large customers. In the case of AU Health, did you have different vendors bid over your request for proposal, or was it more a natural evolution of your prior relationship with Philips?

JR: Well, we tried to build these types of complex relationships in the past with vendors and were unsuccessful. When we began these discussions with Philips, we saw a potential partner that was actually committed to making a new model of care. When we dug deeper and found an alignment of values and strategic goals, we realized we could really build this together. So we built a first-of-its-kind model of how a vendor, a hospital and patients could all work together to improve patient care.

TJ: As health payers shift more risk on providers and their patients, it seems logical that providers will seek ways to mitigate or share part of this risk, so why not with their vendors? How would you qualify the importance and magnitude of the risk-sharing component in this long-term agreement with Philips?

JR: I think that risk is just part of the alignment. If you look at a vendor-hospital relationship, they are focused on the same objectives—whether they are risk objectives or whether they are metrics of performance. If you are both aligned with improving those metrics, then you bring the resources of both organizations to improve health care.

ND: We are under the impression that this type of alliance essentially revolves around a few, carefully selected outcomes metrics that the provider would like to see evolve in the right direction—for example, lowering hospital readmission rates. Is that the case for the AU Health/Philips contract?

JR: The success of the alliance really does not revolve around a few metrics. We certainly have metrics in the alliance, but really what the alliance has done has put the patient in the center of the health care discussion, so the alliance is revolving around the patient and not metrics. How we improve patient care is really what we have focused on. That includes the discussions on how do you minimize readmissions, have an appropriate length of stay, manage your costs and improve your outcomes. All of those are literally part of the daily discussion.

ND: Obviously, if the focus is on outcomes metrics, this will require mutually agreed upon ways of measuring and tracking these outcomes on an ongoing basis—likely through analytics. Is analytics indeed a cornerstone for tracking the health of the AU Health/Philips alliance?

JR: Well that's another great question. We have been working with Philips to study what we measure and how it reflects what's important to us. Analytics has to be part of any complex alliance so you can measure objectively the progress toward your goals. So analytics is a critical piece. You may not have all the analytics built out in advance, but it is probably something you build together and you have that evolve over time.

ND: So is it an analytics software tool from Philips that is deployed, or is it more of a collaborative effort between AU and Philips?

JR: I would characterize it as just an evolving process. We have not reached the endpoint yet.

ND: We realize that the deal with Philips goes well beyond just diagnostic imaging equipment. Philips's enterprise-wide value proposition in Patient Monitoring and Connected Health may have been a key differentiator for this vendor. Can you shed a little more light on the scope of this partnership?

JR: Traditionally, vendor-hospital relationships were radiology-based and focused on radiology equipment and services, so the scope was rather narrow. As system thinkers, we wanted to do this on an unprecedented scale, so this was never about imaging or radiology. It was always about looking at the patient and the entire enterprise.

Philips brought more than just the imaging equipment and service contracts to the table. They had clinical monitoring and management consulting. They had education and applications, and they also had a host of other products and services that could help us on a journey to really improve patient care. Our scope was really everything that Philips was making in the health care field and all of the services they were providing. Our scope was “all in.”

ND: Is this the largest partnership that AU Health has with an external vendor? Or are there other partnerships in different areas equally large or possibly even larger?

JR: We have a partnership with Cerner, which provides our electronic medical records. We built a partnership with Cerner called the Jaguar Collaborative, which is a 14-year partnership that allows working in a collaborative manner, again, focused to improve patient outcomes and care.

ND: The advertised value of the contract over its 15-year span is \$300 million. Could you shed some light for us on what this figure represents; is it an estimated net worth of planned purchases?

JR: When we looked at the 15-year cycle, we mapped out 15 years of capital equipment replacements and upgrades. We made some estimates on how markets would change and technologies would change, on how much training and education services for our staff we would put in, and on what type of process improvement and management consulting projects we would want to do.

We programmed all of that out over the 15 years. Obviously this is a draft of what our plan would be; it's a living, breathing document that gets edited on a regular basis. So what we have is a rolling plan that we continue to adjust based on changes in our environment, changes in technology, and changes in patient needs.

ND: One very interesting aspect of the partnership is that it does not bind AU Health into buying exclusively Philips equipment so that you always have the freedom to choose the technology that you deem best. Can you help us better understand this unique aspect of the relationship?

JR: Since we are focused on improving care, then both Philips and AU Health had to be willing to acknowledge that we had to buy the best product to meet our clinical needs in

each unique setting we put a device in. Sometimes it would be a Philips product and sometimes it would not be a Philips product. This was never about the equipment or the sales, it was about building a model that allowed us to work together to do the right thing for the patient.

We would never have agreed to a model where we agreed to buy all the equipment from one vendor. If the model was really committed to improving the health care of the patients, then they would never want to provide all of the equipment, because none of the vendors makes equipment for every single niche in any of these areas.

ND: In July 2016, the AU Health/Philips alliance will be entering its fourth year. Are there some early successes that you believe resulted directly from this alliance that you may already be able to highlight?

JR: We have already replaced most of our clinical monitoring equipment; we've standardized more practices in the past two years in the areas where we've placed this equipment. We've done all of that without actually stopping or discontinuing any clinical services. When we look at the scale of equipment we've installed, the only way to deploy this much equipment in such a short timeframe would have been to build a new hospital. We've done installations for equipment and standardization for processes that's on an unprecedented scale for us.

This also allows us to plan out projects across fiscal years—and be able to do it in a way that does not interrupt patient care.

Specifically in radiology, we've improved our patient flow, which means we improved our access to imaging to patients, and we improved their experience. And through this we were able to increase patient volumes without increasing the number of scanners. Our MRI volume is up more than 30 percent, but we didn't add any new MRI scanners. We've increased significantly our interventional radiology volume, but we didn't add any interventional suites.

ND: This means this was achieved through improvements in operational efficiency, workflow optimization—things that made it more efficient to work with what you already had?

JR: Exactly. If we had designed this relationship around the traditional transactional relationship where you get a better discount if you bought more equipment, we would never have gotten to the point where we can redesign workflow and take care of more patients with the existing equipment.

ND: To wrap up, are there any recommendations, best practices or lessons learned that you would like to share with your peers who might be considering getting on-board a formal alliance with their imaging vendor? Any caveat they should keep an eye out for?

JR: I think that potential partners need to really understand each other's values and motivations, and have a shared passion

for improving patient care. The rest of it is just hard work. If your passion is not the transformation of care, and you're not willing to share your mistakes with your partners so you're both able to learn and improve, this just won't work.

To me, this is about, "Who's in the center of health care?" It's going to be hard to put the patient in the center of health care if we're standing there ourselves. This has to be about the patient, and that takes leadership. You need the leadership and a culture of transparency in both organizations to be able to move this forward.

Not all of these partnerships are going to be successful, just like not all hospital mergers are going to be successful. When we look back at which ones were successful and what were the common factors, I think we will find an alignment of leadership and culture centered on taking care of the patient. These will be the necessary ingredients. If those aren't there, you can't make the best model. At the end of the day, is about people taking care of people. If that's not what they are focused on, then their eyes are on the wrong target.

Examples of outcomes achieved by AU Health in the first 2.5 years of the alliance

MRI Procedure Volume

38%



With no additional scanner install

Vascular and Interventional Radiology Procedure Volume

63%



By adding one C-arm in radiology but no additional angiography suite

Estimated Savings

Over
\$10 million



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