Enhanced Recovery After Surgery: Acceleration of Positive Outcomes

View from the “C”-suite

Robert Probe MD
Chief Medical Officer
Baylor Scott and White Health

Republican Repeal?

National landscape

- Growth related to ACA expansion is gone
- Continued shift to outpatient services
- Continued rises in bad debt in non-expansion states
- Rising expenses:
  - Pharmaceuticals
  - Employed Physicians
  - Personnel
- Revenues not keeping pace
  - 3% increase in commercial premiums
  - 0.5% for traditional Medicare
  - Looming MACRA implications
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Acceleration of Positive Outcomes

Employers are dropping out

A reminder of our patients’ financial burden

AFFORDABILITY

MRI – SPINE
Total Charges: $2,769
Adjustments/Discounts: $1,245
Insurance Payments: $978
Total Payment Due: $544

APPENDECTOMY
Total Charges: $17,228
Adjustments/Discounts: $7,485
Insurance Payments: $8,768
Total Payment Due: $974

There are multiple ways to look at price/costs; our approach triangulates our approach across a variety of benchmarks

BENCHMARKING APPROACH

<table>
<thead>
<tr>
<th>DATA SOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total premiums</td>
</tr>
<tr>
<td>Commercial premiums by state</td>
</tr>
<tr>
<td>Total cost per Medicare Beneficiary by state</td>
</tr>
<tr>
<td>Dartmouth Atlas</td>
</tr>
<tr>
<td>MSFB</td>
</tr>
<tr>
<td>Per-unit/Per-episode</td>
</tr>
<tr>
<td>National peer system comparison on high volume episodic care costs</td>
</tr>
<tr>
<td>Normalized unit cost basis comparison across BWH facilities and similar peer facilities</td>
</tr>
<tr>
<td>INHC</td>
</tr>
<tr>
<td>MSFB</td>
</tr>
<tr>
<td>Truven Action O/I</td>
</tr>
<tr>
<td>Total cost for BWH managed lives</td>
</tr>
<tr>
<td>Comparison of total cost of care for a given life under care, including cost savings from decreased utilization</td>
</tr>
</tbody>
</table>

While each benchmark has benefits and limitations, this approach will allow us to triangulate our cost position in the market
BSWH appears to be higher-cost relative to national benchmarks, but performs well

1. At a system level, BSWH appears higher cost than peers on a per-episode cost basis
2. When looking at a facility level, BSWH performance varies among facilities
3. However, when looking at managed lives, BSWH performance is much stronger relative to benchmarks

- BSWH is higher cost than U.S. median, and significantly higher than national peers (SWQA)
- Texas is a high-cost state relative to national benchmarks; BSWH appears in-line with the Texas market
- Cost varies widely among BSWH facilities on a per-unit basis, partially driven by acuity difference
- Cost varies widely between BSWH facilities and similar facility benchmarks
- When comparing managed lives, BSWHQA performs in the top 25th percentile nationally
- Among TX ACOs, BSWQA outperforms hospital ACOs, and is in-line with physician-led ACOs

Variance to benchmark
- ~10% higher cost than national median
- ~35% above median peers for CMS bundles
- ~20% higher cost than top quartile
- ~5% lower cost than national top quartile

However, TX ranks near the top in Medicare spend per enrollee; within TX, major metro areas are highest

Compared to national peers, BSWH’s total inpatient cost is ~5–35% higher across the highest volume bundles

Note: Customized CMS cost data from national peer group of 16 providers committed to improving healthcare value through data and collaboration; among these, Intermountain (ITMTN), Mayo Clinic, Providence Health & Services, and Virginia Mason (VMMC) are most comparable to BSWH.

Source: High Value Healthcare Collaborative
BSWH facilities vary widely in their cost position compared to each other and to benchmarks.

Comparing Medicare ACOs in TX and nationwide, BSWQA’s position is top quartile.

BSWH performance: While top-line revenue growth has been strong, costs have outpaced revenue on a per-unit basis, revenue is decreasing faster than costs.
We are not alone

Augusta University Health System blames lack of physicians for $8.8M loss
MD Anderson starts 2017 fiscal year with massive losses

Prior Year YTD Actual YTD Budget YTD
Total Operating Revenue $1,471,907 $1,529,289 $1,573,457

$0
$200,000
$400,000
$600,000
$800,000
$1,000,000
$1,200,000
$1,400,000
$1,600,000
$1,800,000

Key Financial Metrics
August 2017 – Year to Date

Income Statement ($ in 000's)

Total Operating Revenue | Variance | Net Patient Revenue Unfavorable | Variance | ED Visits Unfavorable | Variance | Surgeries Unfavorable | Variance | Premium Revenue Unfavorable | Variance | Other Operating Revenue Unfavorable | Variance |
--- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
$1,471,907 | | $29,0M | | -3.3% | | -11.5% | | -4.4M | | -7.6M |

Operating Income & Margin %

--- | --- | --- | --- |
5.4% | 6.1% | 5.1% | 2.3% |
6.1% | 5.1% | 2.3% | 3.2% |
5.4% | 6.1% | 5.1% | 2.3% |
5.4% | 6.1% | 5.1% | 2.3% |

Operating Cash Flow Margin

Prior Year YTD Actual YTD Budget YTD
EBITDA* |
--- | --- | --- |
$156,462 | | $221,160 |
$179,674 | | $200,000 |
$200,000 | | $250,000 |

Summary Statement of Operations
August 2017 – Year to Date

Total Operating Revenue | Variance | Net Patient Revenue Unfavorable | Variance | ED Visits Unfavorable | Variance | Surgeries Unfavorable | Variance | Premium Revenue Unfavorable | Variance | Other Operating Revenue Unfavorable | Variance |
--- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
$1,471,907 | | | | | | | | | | | |

Income (Loss) from Operations | Income (Loss) from Operations excl. Minority Interests |
--- | --- |
$93,640 | | $8,349 |
$80,490 | | $10,131 |
$13,150 | | $2,702 |
$14.3% | | 6.1% |

Net Income (excl. unreal) | Minority Interests in Operating Margin |
--- | --- |
$135,472 | | $53,509 |
$91,711 | | $48,708 |
$43,761 | | $4,801 |
47.7% | | 9.9% |

Minority Interests in Operating Margin | Income (Loss) from Operations |
--- | --- |
53,509 | | $8,349 |
48,708 | | $10,131 |
4,801 | | $2,702 |
9.9% | | 6.1% |

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Operating Income Excl Minority Interests | Income (Loss) from Operations |
--- | --- |
8,349 | | $8,349 |
10,131 | | $10,131 |
2,702 | | $2,702 |
6.1% | | 6.1% |

Income (Loss) from Operations (Moody’s 3.7%) | Income (Loss) from Operations excl. Minority Interests |
--- | --- |
6.1% | | 3.2% |
5.1% | | 2.4% |
5.4% | | 2.3% |
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The ISFP projects an ~2.5% operating income margin expansion from FY17 to FY23

![Graph showing ISFP operating margin expansion from FY17 to FY23](image)

**Note:** Margins are for combined operations and exclude JVNCI.
Source: BSWH ISFP 2017

Effects of MACRA

**Medicare Payments vs. Wage Inflation**

![Graph comparing Medicare payments to wage inflation](image)

**Note:** Reimbursement rates remain flat:
- 1.2% growth in the ISFP
**Payor mix shifts to government plans (~3%)**
- 2% shift in the ISFP
**Shift to outpatient care accelerates (2.5%)**
- Historical rate of ~1% p.a.

While the ISFP projects margin expansion, a market downside scenario would cause significant pressure

**Drivers of Market Downside**

- Reimbursement rates remain flat:
  - 1.2% growth in the ISFP
- Payor mix shifts to government plans (~3%)
  - 2% shift in the ISFP
- Shift to outpatient care accelerates (2.5%)
  - Historical rate of ~1% p.a.

**Graph showing actual vs. forecast operating income from FY17 to FY23**

**Note:** Margins exclude JVNCI; Only Care Delivery business units (e.g., all hospitals, clinics) are flexed, with other business units (e.g., BSWH) assumed to have ISFP growth rates.
Source: BSWH ISFP 2017; BSWH Budget Projections FY18; Bain Analysis
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Provider-based strategy: Austin is a highly attractive market and builds upon existing BSWH presence

HIGH GROWTH MARKET
ATTRACTIVE PAYOR MIX
BSWH FOOTPRINT
• BSWH has an existing footprint in Austin
  - 3 owned hospitals
  - 1 JV emergency hospital
  - 2 retail pharmacies
  - 8 other OP facilities
• and is building 3 new micro hospitals
  - Pflugerville (under construction), Austin, Buda
• BSWH has a reasonable network of clinics
  - 18 PCP clinics
  - 12 multi-specialty clinics

ATX NTX CTX
Inpatient Hospital
ASC Outpatient

BSWH FOOTPRINT
• BSWH has an existing footprint in Austin
  - 3 owned hospitals
  - 1 JV emergency hospital
  - 2 retail pharmacies
  - 8 other OP facilities

Note: Patient volumes excluded psychiatry.

There is a range of pathways/options available to pursue our ambition

Degree of integration (network and payment model)

High
- High-specialist driven model
- Largely FFS

Premium integrated network
- IF and OP; specialist oriented plus primary care
- Largely FFS but some FFV investments

Value-based care network
- Primary care driven, designed around lowering utilization
- Heavy FFV emphasis

Fully integrated, closed network
- Primary care driven, designed around lowering utilization
- Heavy FFV emphasis, with focus on full-risk
**Enhanced Recovery After Surgery:**
**Acceleration of Positive Outcomes**

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**STRATEGIC IMPERATIVES**

- **Value**
  - Transform BSHW into an integrated network that ambitiously refines and consistently provides value-based care

- **Experience**
  - Leverage our people and our brand to intentionally design and deliver a world-class customer experience

- **Affordability**
  - Aggressively and continuously reduce costs to meet customer needs and support investments

- **Alignment**
  - Implement a leadership approach and operating model to ensure engagement and alignment on actions and results

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**Supply Chain Successes**

<table>
<thead>
<tr>
<th>Category</th>
<th>Addressable Spend</th>
<th>Anticipated Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood</td>
<td>19.8</td>
<td>1</td>
</tr>
<tr>
<td>IV Pumps</td>
<td>15.0</td>
<td>3.1</td>
</tr>
<tr>
<td>Hips and Knees</td>
<td>25.3</td>
<td>7.0</td>
</tr>
<tr>
<td>Cardiac Rhythm Devices</td>
<td>31.0</td>
<td>5.8</td>
</tr>
<tr>
<td>Cardiac Stents</td>
<td>10.7</td>
<td>2.3</td>
</tr>
<tr>
<td>Cardiac Valves</td>
<td>19.0</td>
<td>1.7</td>
</tr>
<tr>
<td>Advanced Energy</td>
<td>12.5</td>
<td>2.5</td>
</tr>
<tr>
<td>Endo-Sutures-Trochars</td>
<td>26.9</td>
<td>7.3</td>
</tr>
<tr>
<td>Spinal Cord Stimulators</td>
<td>6.3</td>
<td>1.7</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>11.6</td>
<td>1.6</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>178.1</strong></td>
<td><strong>34.0</strong></td>
</tr>
</tbody>
</table>

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**BSWQA**

**Growth in Covered Lives**

<Diagram showing growth in covered lives from 2013 to 2018>

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Acceleration of Positive Outcomes

2017 Contract Financial Performance  
Data through May 2017

Clinical Leadership Council  
Value Creation Projects  
FY17 Progress

Clinical Value Initiative  
Summary Dashboard
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Value Creation

Alignment  Discovery  Diffusion  Measurement


Today’s Focus

• System Stroke Care
• Antibiotic Stewardship
• Total Joint Replacement
• Congestive Heart Failure

Treatment of Stroke 2017

• National Burden of Stroke:
  – Every Year approximately 795,000 people in the U.S. have a stroke
  – Stroke is the 5th leading cause of death in the U.S. with more than 144,000 deaths annually
  – Stroke is the leading cause of long-term disability: 40% with moderate disability; 10-30% severe disability

• Number of Strokes within the BSWH System
  – North Division: Estimated of 2400 stroke pts/yr
  – Central Division: Estimated 2300 stroke pts/yr
  – At an estimate of ± 4700 stroke patients per year; BSWH has one of the largest stroke volumes in U.S.

• Evolution of Endovascular Thrombectomy: Neurothrombectomy (NT)
  – Treatment for Select Group of Stroke Patients
  – Since 1/1/15 there are 7 randomized controlled trials showing benefit in select patients
  – 2015: Neurothrombectomy (NT) updated to class 1 for patients meeting the specific criteria
  – Very specific criteria define those stroke patients eligible for endovascular thrombectomy
  – Very specific criteria define those hospitals qualified to perform neurothrombectomy

• Capabilities of Comprehensive Stroke Centers
  – Recognition for 24/7/365 care of the most complex stroke cases utilizing highly specialized technology
  – Advanced Neuro-imaging, multidisciplinary performance measures, dedicated for stroke outcomes
  – Comprehensive Neurosurgical 24/7/365 coverage for Neurovascular procedures as aneurysms, hemorrhages
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Treatment of Stroke 2017

- Members of the Neuroscience High Risk Low Volume IR Task Force
  - Executive Sponsor: Irving Prengler
  - Administrative Chair: Gerri Garrison
  - Medical Chairs: Stuart Black and Jason Huang
  - Members: Dr. Dina Goyfman, Osman Mir, Jeff Kerr, Robert Risch, Jeff Clark, Jennifer Rasmussen

- Annual Intracranial Thrombectomy (Neurothrombectomy) volumes for BUMC/Memorial
  - BUMC: Average over 2 years = 46/47 per year. Projected from 6/17 going forward 72/84 per year
  - Memorial: Average over 2 years = 15 per year. Projected from 6/17 going forward 24/36 per year

- Low Volume High Risk Stroke Task Force on IR Procedures: Recommendations
  - 15 Neurothrombectomy (NT) cases/yr. minimum. Desired goal would be 30 patients treated per/yr.
  - Center must eventually achieve Comprehensive Stroke Center Certification
  - Center must treat 25 stroke patients per year with intravenous tPA (more than ±2 cases per month)
  - Center must have Endovascular Surgical Neuroradiology Fellowship trained Interventionists 24/7/365
  - 24/7/365 availability of Neurohospitalists (and/or Telestroke coverage) with expertise in Stroke
  - Hospital volume to include 30 Endovascular Aneurysmal Coiling Procedures per year
  - Hospital: 25 non-traumatic SAH/yr. and perform 10 microsurgical aneurysm clippings/yr.

- Considerations for future BSW Stroke Comprehensive Programs
  - Applications: Submitted to Neuroscience Governance Council for review and recommendations
  - Applications then sent to CLC for further review and recommendations/approval

Today’s Focus

- System Stroke Care
- Antibiotic Stewardship
- Total Joint Replacement
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Regulatory and National Standards

FY18 Goal

- Antimicrobial Stewardship will achieve a ≥2% reduction in days of therapy, a ≥2% reduction in days of antibiotic-stopped per patient per year compared to FY17, and a ≥5% reduction in antimicrobial antibiotic use in adult acute bronchitis by May 31, 2018.

- Literature
  - 40% of outpatient antimicrobial prescribing is unnecessary or inappropriate. Reducing unnecessary antimicrobial use can decrease antimicrobial resistance.
  - 20%-50% of all antibiotics prescribed in U.S. acute care hospitals are either unnecessary or inappropriate (Centers for Disease Control and Prevention). This can lead to serious adverse effects such as Clostridium difficile infections.

- Trends
  - Carolinas Health System which is comparable to Baylor Scott & White Health had an average days of antimicrobial therapy of 500 days in calendar year 2015.
  - National average for days of antibiotic therapy per day using MedMined clinical decision software tool is 670 for teaching hospitals and 641 for non-teaching hospitals for Calendar year 2017.
  - A 2016 study showed that Intermountain Healthcare System had a median DOT of 646 and 509 for small and large community hospitals, respectively.
  - Baylor Scott & White Health’s average days of therapy upon implementation of tracking in FY17 was 603. As of Q4 FY18, BSW’s average days of therapy is 509.

- As of Q4 FY18 BSW’s average days of therapy is 509.

- Literature & Trends

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- As of Q4 FY18 BSW’s average days of therapy is 509.

- Literature & Trends

10/7/2017
Interventions and Results

**Interventions**
- NTX & CTX physician representatives
- Pharmacists
- Information technology representatives
- Laboratory & infection control representatives

**Results**
- Inpatient Stewardship - May 2015
- Carbapenem & Daptomycin restriction guideline - December 2015
- Automatic Renal Dosing and IV to PO Policy - June 2016
- Fluoroquinolone Guideline and MedMined Implementation - August 2016

Successes
- BSH Inpatient Stewardship - May 2015
- Carbapenem & Daptomycin restriction guideline - December 2015
- Automatic Renal Dosing and IV to PO Policy - June 2016
- Fluoroquinolone Guideline and MedMined Implementation - August 2016

- Antioxidant & Dextrose IV to PO Policy - August 2016
- BSH Orthopedics Opportunity - 7 million joints per year at a cost of $7 billion nationally

Today's Focus

- System Stroke Care
- Antibiotic Stewardship
- Total Joint Replacement
- Congestive Heart Failure

BSWH Orthopedics Opportunity

- Large Joint Population
- Cost Variation and Post Acute Care Use
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CJR Bundle Performance

- Goal: Improve Coordination and Reduce Cost of Care with 90-day episode for Joints

Participating BSWH Facilities on Track to
- Receive Incentive Payments in Year 2
- Maintain Excellent Quality Ratings

BSWH System Initiatives

- Avant-Garde Time-driven Activity-Based Costing for Joints and Spine
- Pending OGC approval
- BSWH Joint Replacement Patient Selection Criteria
  patient pre-optimization, education, BMI thresholds, etc.

Today's Focus

- System Stroke Care
- Antibiotic Stewardship
- Total Joint Replacement
- Congestive Heart Failure
Heart Failure Burden

- Number of people diagnosed with heart failure is on the rise – 5.7 million (2009-2012) to about 6.5 million (2011-2014)
- Projected to rise by 46 percent by 2030, resulting in more than 8 million people adults with heart failure

- BSWH Calculated HF readmission rate
  - FY16 = 21.3% (N=5595)
  - FY17 = 18.3% (N=5592)

- Hospital Readmission Reduction Program
- Heart Transplant Programs

Executive Team
- Dr. Cliff Fullerton
- Nancy Vih, PhD
- Mae Camero, DNP
- Dr. Mike Massey
- Dr. Robert Scott
- Dr. John Erwin III
- Dr. Shelley Hall
- Dr. Brett Stauffer

Workgroup Leaders
- Sonya Flanders, Patient and Family Learning
- Dr. Shelley Hall, Inpatient and Advanced HF
- Dr. Mike Massey, Outpatient Primary Care
- Dr. Robert Scott, Outpatient Cardiology
- Miranda Schueng, Post-Acute Care
- Melissa Carranza, Jennifer Day, Paul Noblitt, Outpatient HF clinics
- Dr. Robert Fine, Dr. Laurel Kilpatrick, Martha Phlaster, Palliative Care

BSWH Heart Failure Integration

BSWH Standard Heart Failure Care Protocol

<table>
<thead>
<tr>
<th>BSWH Standardized Care Guidelines</th>
<th>Implementation Date</th>
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<tbody>
<tr>
<td>Heart Failure Action Plan</td>
<td>March 15, 2017</td>
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<tr>
<td>Heart Failure Referral Guideline</td>
<td>May 30, 2016</td>
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<tr>
<td>Heart Failure Discharge Instructions</td>
<td>May 2, 2017</td>
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<tr>
<td>Heart Failure Treatment Algorithm</td>
<td>October 2016</td>
</tr>
<tr>
<td>Systolic Heart Failure Medication Titration Algorithm</td>
<td>November 30, 2016</td>
</tr>
</tbody>
</table>

| BSWH Standardized Order Sets                        |                      |
| Inpatient Order Set                                 | June 2017            |
| Systolic Heart Failure Smart Set (Ambulatory)       | April 2017           |
| Systolic Heart Failure Smart Set for Cardiology     | December 31, 2017    |
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**Diffusion Model**

- **Leadership Culture**
- **Sponsoring Body**
- **Value Creation Team**
- **Best Practice**
- **Standardized Care Practice Model**

**Operational Work Unit Implementation**

- Order sets
- Rules/Alerts
- Best Practice Systems
- Patient education
- Best Practice Repository
- Workflow changes
- Outcome measures
- Medical Informatics Support

Best Practice Owner

---

**R.E.A.C.H.**

- **Executive Sponsor**
  - John McWhorter
- **Project Management Office (PMO)**
  - Bethany Ferguson (BSWH)
  - Gregg Lambert (Huron)
  - Jason Ahlberg (Huron)
- **Enterprise Operations Team**
  - Dan May
  - Leslie Grimmer
  - Erin Bartley
- **Huron Leadership Team**
  - Dr. Bob Probe
- **Executive Support Team**
  - Human Resources (John Lacy)
  - Jackie Tischler
- **Workforce (Dr. Bob Probe)**
  - John McWhorter
  - Pat Currie
  - Bethany Ferguson (BSWH)
- **Purchased Services (Non-SCS) (John McWhorter)**
  - Tony Johnson
- **Physician Enterprise (Dr. Bob Probe)**
  - Matt Chambers
  - Nick Reddy
- **IT (Dr. Bob Probe)**
  - Tammy Cohen
- **Clinical Doc. Improvement (Dr. Bob Probe)**
  - Sunita Varghees
- **Revenue Cycle (Fred Savelsbergh)**
  - Sarah Knodel
- **Pharmacy (Dr. Bob Probe)**
  - Jeff Ingrum
- **Clinical Care Variation & LOS (Dr. Bob Probe)**
  - Dr. Ernest Franklin
- **Care Access (Dr. Bob Probe)**
  - Contact Center Leader

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**Kotter’s 8 Steps**

- Step 1: Establish a Sense of Urgency
- Step 2: Create the Guiding Coalition
- Step 3: Develop A Change Vision
- Step 4: Communicate The Vision for Buy-In
- Step 5: Empower Broad Based Action
- Step 6: Generate Short-Term Wins
- Step 7: Never Let Up
- Step 8: Institutional Change Into The Culture

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