

HEALTHCARE  
BEYOND REFORM:  
**DOING IT RIGHT  
FOR HALF THE COST**

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**The X Questions**  
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**Healthcare is changing**

The changes will **deeper, broader, and more chaotic** than many expect.

Most changes will happen over the relatively short term — **in this decade.**

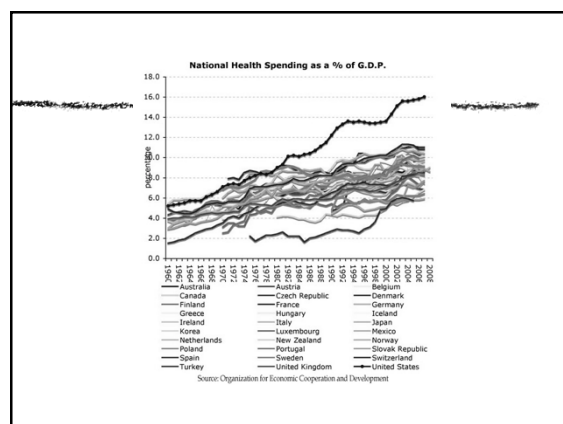
Elements of the changes are very promising. They could lead to healthcare which is **both less expensive and better.**

**We are at a tipping point**

**We are facing a steep and slippery slope into something unknown.**

Before the 1980s, the US was expensive, but its costs ran with the pack of most developed countries. As soon as “cost controls” kicked in, our costs took off.

They were **unit price controls, not system cost controls.**



Recently, we are seeing headlines such as:

“...healthcare spending in the U.S. in 2011 grew at **one of the slowest rates in 50 years...**”

and

“The growth of health spending has **slowed substantially** in the last few years.”

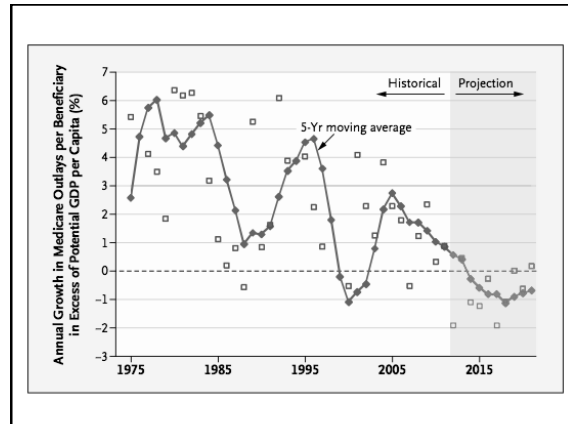
Some healthcare economists think this is the cyclical result of the recession.

Some measures show the trend moderating slightly in 2011.

But the trend is still there — healthcare inflation is definitely slowing.

Others economists, looking more carefully at the pattern of reductions in utilization, believe that we are seeing **“the new normal.”**

Their forecast is that soon and for the foreseeable future, growth in healthcare spending will be **slower than growth in GDP.**



### The Next Healthcare

Vastly **more complex ecology**

Shifts in **incentives** and **risk** across the industry

More **efficient**, more **effective**, more **“upstream”**

**Wild proliferation** of methods, modalities, physical environments, business models

**A tough fit** for everyone currently involved in healthcare. **Especially so for small and rural.**

### Factors forcing change

**Reform:** The ACA catalyzes the change. The ACA did not cause the change.

The ACA brings healthcare:

- New customers
- New payment models
- Focus on prevention
- Expansion of Medicaid — downmarket

### Market changes

**Strategic uncertainty:** large-scale discontinuous change. [Comments on the likely effect on strategic uncertainty of the recent elections]

### Market changes

- **“Fiscal Cliff”:**
  - Most likely: Re-elected Obama refuses any deal, holds very strong political hand to forge deal later —> some new taxes, more gradual deficit reduction.
  - Actual effect is gradual; perception is instantaneous.
  - Effect on markets if no deal: Maximum strategic uncertainty. Possible trigger of new US recession, tripwire to global recession, especially Euro, India, China, Japan.
  - Effect of likely Obama deal: Steep cuts in Medicare reimbursements stay, but healthcare markets stabilize with very strong cost-cutting incentives.

### Market changes

#### Consolidation:

- Systems consolidate across the industry. Taking advantage of cost strategies that are more difficult for or unavailable to small and rural.
- For-profit systems grow rapidly.
- FP and NFP mega-chains grow fastest of all.

### Market changes

#### Proliferation:

- No consistent strategic pattern across country or sectors.
- Wild proliferation of tactics and strategies.
- No one really knows how to make it work.

### major factor: chronic disease

**Chronic disease:** A growing epidemic of chronic disease is sweeping the country

**Chronic disease:** Diabetes, Alzheimer's, cancer, heart disease, pulmonary conditions

Chronic disease accounts for **75% of all healthcare costs.**

### major factor: chronic disease

A great deal of chronic disease arises from obesity and other lifestyle factors.

Most chronic disease is **preventable,** and most is **manageable.**

Most chronic disease is **managed poorly, if at all.** There is little serious prevention.

So serious prevention and management of chronic disease is **the great gold mine in the heart of healthcare.**

### The 5 Shifts

They are already happening.

They model the shape of the Next Healthcare

1. Explode the business model
2. Build on smart primary care
3. Put a crew on it
4. Swarm the customer
5. Rebuild all processes

### Explode the business model

Traditional business model is:

**commodified** (price no indicator of quality)  
**insurance-supported** (chooser and payer separated, cutting the economic feedback loop)  
**fee-for-service** (paying for items off of a menu, not for outcomes)

### Explode the business model

Providers today are slipping out of the traditional business model in a number of ways, including:

- bundling** (total hip, for instance, all one price)
- capitation** (whole life all one price)
- mini-caps** (diabetes care, e.g., all one price)
- ACOs and ACO-like organizations**
- other risk-based arrangements**
- shared savings**
- prospective payments** (such as for medical homes)

### X Question: Business model

In what ways are you shifting your business model?

In what ways are you putting yourself at risk (and so at profit) for:

- **Quality**
- **Outcomes**
- **The health of populations**

### Explode the business model

Consumers today are also taking on risk:

- health savings accounts**
  - high deductible health plans**
  - incentives for **wellness activities**
  - incentives for **smart shopping**
- E.g. BC/BS of MA's "Blue Options" and "Hospital Choice Cost Sharing" offer no-copay if patients picks high quality/low cost options defined by BCBS

### Explode the business model

When risk shifts, everything shifts:

- revenue sources**
- work flows**
- relationships** within and between organizations
- business structures**
- data flows**
- physical environments**

### Explode the business model

Mantras of the new environment:

- **"Move fiercely upstream"**
- **Measure, improve, try, measure again**

### Explode the business model

Everyone in healthcare is concerned that they will be **cut out of the market.**

So everyone is seeking **new allies and partners,** and creating **new structures**

### X Question: Allies

**Who is going to work with you?** Who will share the risk and the benefit? Are there competitors—such as physician groups, specialty clinics, urgent care clinics or retail clinic chains—that are now potential allies?

Are there **employers** in your area **with whom you can work directly**, either to be at risk for some aspect of their employees' care (behavioral health, for instance, or spine care), or all primary care in a workspace clinic?

### X Question: Setting

In what new **settings** will you be providing healthcare? Where will such care have to be delivered?

Through what kind of channels, and in what kind of environments?

If your survival depends on managing the health of populations, how do you bring them care?

### X Question: Setting

How do you snuggle up to your customer?

What are the **technologies** that could put your relationship to your customer in her purse, on her desk, in her house?

### X Question: Setting

How will your **physical plant** and built environment have to change?

How conversant are you and your executive team with the principles of **evidence-based design**? Are your architect and interior designer certified?

### Explode the business model

In institutions, this increasingly means the **end of cost shifting**.

All need to **upgrade their cost analysis**.

Institutions no longer able to charge **the big institutional premium**.

### Explode the business model

Deeper: Must take cost analysis to the **individual patient/case level**

Then: How much does it cost for **this integrated practice team** to replace a hip?

Then: How much does it cost for **this entire integrated practice unit** to do each of the things it does?

To track costs this way, **you have to have integrated practice units, dedicated teams** working together all the time on the same things. Most don't.

### Explode the business model

Traditional fee-for-service revenue cycle: simple in concept — do more well-reimbursed items, make more money. **Incentives all line up.**

New hybrid revenue model (especially for the large systems) **layers in** at-risk revenue streams on top of fee-for-service.

**Incentives in conflict:** Maximizing at-risk revenue drives down fee-for-service revenue.

+ **Delay** in cash flow of at-risk revenue

+ Need to **spread costs, revenue across network.**

### X Question: Cost

How do you upgrade your cost analysis to bring you the information you need?

### X Question: Revenue

How do you upgrade your **revenue cycle management** so that you know if you are making money?

### Explode the business model

Uncertainty about costs and revenue cycle management leads to **deep strategic uncertainty.**

### Build on smart primary care

**“Move fiercely upstream.”**

Emphasis on **“smart”** because **not enough** primary care docs: need **efficiency, effectiveness.**

### Build on smart primary care

Example: **“Vermont Blueprint”** Build on full medical home practices. Add a 5-person care team with nurse, community health specialist, behavioral health specialist, etc., to reach out to patient.

Cost: \$350,000 to cover 20,000 people = **\$17 per person per year.**

Results: **ED costs down 36%, overall down 12%**

### Build on smart primary care

Example: BC/BS of MA's "alternative quality contracts" Go to primary care providers, offer everything their patients have spent at all venues as their budget. At end of year, back out whatever patients have spent elsewhere. Docs make more money if they provide great care to patients so that they do not need surgery or emergency care.

### Build on smart primary care

Example: **Home Health Laptop/kit**

Cost? Few hundred dollars per unit.

**Who pays?** Under fee for service, customer — keeping her out of the facility is a cost.

If at risk, institution would pay — keeping her out of the facility is a benefit to the bottom line.

### X Question: smart primary care

What would it take to derive the **majority of your income and profit** from primary care in three to five years?

What would that look like?

What **capacity** would you have to buy or build or ally with to do that?

### X Question: smart primary care

What structure would make primary care a **profit center** instead of just a source of patient flow for the real profit centers?

Do you recognize the elements that make a primary care practice "**smart, lean, effective and a true "medical home"**"?

### Put a crew on it

**Build teams at all levels** from the organization to the clinical teams.

**It's the scoreboard that makes a team.**

### Put a crew on it

**Example: Alaska Natives.** Since taking over, ED, urgent care down 60%, hospital admits down 40%, 60% drop in specialist use, 70% drop in ped asthma admits, 20% drop in primary care visits, quality scores > 90%, patient/staff satisfaction > 90%

Key: Compensation, bonuses tied not to volume but to **improvement in health scores** of patient panel for each integrated practice team.

### X Question: Teams

What sort of clinical teams **will you need to build** to take on this kind of risk?

What will **make those clinical groups into teams**, and not mere collections of clinicians with their own agendas?

### X Question: Teams

In what ways can **the way you pay those clinicians** tie them directly into the organization's goals for each group of patients?

How will the **business structure, patient flow and workflow** have to be different from what you have now?

### Swarm the customer

With **help, information, attention**  
**"Move fiercely upstream"**

### X Question: Definable populations

Are there definable populations in your market **whose health costs could be driven down by improving their health status?**

### X Question: Definable populations

Defined by:

- Payer (Blues members in your area, for instance).
- Disease process (all the diabetics)
- Living situation (a particular retirement home),
- Income level (lower-income people)
- Life stage (all the mothers of young children)
- Occupation (dock workers with the bad backs)

### X Question: Definable populations

How could you put your organization at risk—therefore at profit—for those particular health costs?

Who might pay you to care for them?

In what way might they pay?



### Swarm the customer

**Stem the ED tide:** Hospitals and health systems that do not want to simply abandon their communities will be forced to become extremely creative and aggressive at paring back the burden of the populations that surge into the ED. This will include:

**Triage:** vigorously, quickly, and accurately triaging non-emergency cases to clinics.

### Swarm the customer

**Behavioral triage:** Make psychological triage a normal part of the ED intake process. Mental health plays an astonishingly large role in addictive, traumatic and chronic disease processes — and an astonishingly large number of people find ways to need emergency services simply because that's the only place where someone will really pay attention to them.

### Swarm the customer

Identify and track **problem users**, especially those just seeking narcotics.

Use biometrics if necessary.

Establish regional patient identification registries to deal with "ER shopping."

Give your emergency nurses and physicians the legal and technical backup they need to not waste time and resources playing "What's My Line" with addicts.

### Swarm the customer

Identify and track "**frequent fliers**" with untreated chronic disease.

Establish pro-active Camden-style clinician groups to seek out such frequent users and help them.

If someone is showing up in your ED every three weeks with multiple chronic problems, you will spend far less money if someone goes to their house and helps them vigorously and intensively before they show up again.

### Swarm the customer

**Targeting:**

20% of the people generate 80% of the costs.

5% of the people generate 50% of the costs.

1% of the people generate 20% of the costs.

**So:**

Find the 1%, find the 5%, help them.

Be at risk for their costs, put a crew on it.

Lower their costs dramatically.

### X Question: Targeting

Do you know who **that top 1 percent or top 5 percent** of resource spenders are?

Do you know how to **find out?**

Do you have a clear idea how you could **lower their costs by serving them better?**

### Swarm the customer

**Targeting example:**

Boeing's Intensive Outpatient Care program targets people with multiple chronic problems (top 5%) with special care, **saves 20%** on them.

[20% on the top 5% who spend 50% = 10% drop in healthcare costs for the whole population]

### Swarm the customer

**Targeting example:**

Special care center in Atlantic City for top 5% of resource users in one union.

Hands-on, pro-active, team-driven clinic.

Results: **ED, hospital costs down 40%, overall costs down 25%** (=12.5% for whole population)

### X Question: Healthy Communities

What could you be doing to help members of your populations be healthier?

Do you know what the **key leverage points** are in the community you are at risk for?

Have you asked **them**?

Have you done the **community health risk assessment** that the ACA mandates?

### Rebuild all processes

**All processes top to bottom, such as:**  
**lean manufacturing processes**  
**workflow design**  
**evidence-based design**  
**benchmarking**

### X Question: Benchmarking

Are there organizations of your size and level of complexity, in markets like yours, that have done something like what you are navigating, that you could benchmark?

How could you best find them?

How could you best work with them?

### Rebuild all processes

**All processes top to bottom, such as:**  
**revenue cycle management**  
**clinical data flow**  
**strategic "big data"**

### X Question: Data

How satisfied are you that the **strategy** and the **company** you are choosing to lead your digitization drive are the best for you?

Or are you and your CIO simply buying the security of the imprimatur of a major company?

How aware are you of the new technological capacities arising and being showcased in the **Health 2.0** environment, in the **open source** movement or, in primary care, in the **Ideal Medical Practice** movement?

### Rebuild all processes

What to measure? **Everything.**

- Patient medical outcomes
  - Outcome measures
  - Complications, errors, failures
  - Diagnostic accuracy
  - Patient registries
  - Patient feedback

### Rebuild all processes

What to measure? **Everything.**

- Cost
  - By activity
  - Over entire care cycle
- Experience (volume)
- Methods used
- Patient attributes

