

Healthcare Strategy **alert!**

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on transformational innovation

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forum FOR HEALTHCARE STRATEGISTS

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Ready, Set ... Innovate

The U.S. healthcare system is ailing. Cost growth is unsustainable; access to care is a problem for the tens of thousands of uninsured Americans as well as many who have insurance, services are not coordinated, and a genuine emphasis on health as opposed to healthcare tends to be lacking.

The challenge for healthcare leaders is to find solutions that transform delivery and financing in a way that improves access, quality, and outcomes while also producing savings.

Innovation will lead the way toward these new solutions. And whether the innovation is driven by disruption or a focus on enabling customers, the ultimate goal is the same: to make the system work better for patients.

Let this issue serve as a guide to get your innovative juices flowing. Read on for expert insights on what drives innovation; the potential for disruptive influences, including the role of employers as disrupters; and designing and implementing effective new models of care.



Judy Neiman, President
Forum for Healthcare
Strategists

Disruptive Innovation

It's Healthcare's Turn

By **Darcie Cross**

While the healthcare industry grapples with economic uncertainty, urgent pressure to reduce costs, burgeoning advances in technology, and lively debates on health policy and reform, the time is right for innovation—innovation that transforms the system, leading to more efficient, customer-focused ways of delivering care.

According to a 2009 book, *The Innovator's Prescription*, the healthcare industry is ripe for “disruptive innovation,” innovation that disrupts the status quo. The concept was coined in 1997 by Clayton Christensen, a Harvard professor and one of the authors of the book. Disruptive innovation happens when innovators, often from outside the industry, develop simplifying technologies and business models that offer more affordable and accessible alternatives to a broader customer base.

Countless industries have been transformed this way, either through high-value new products (the personal computer vs. mainframe computers), convenient processes (online banking), or new delivery channels (Netflix vs. Blockbuster). Basically, the innovators rewrite the rules of competition by bringing the product closer to the consumer.

Disrupting the Healthcare Business Model

“The same thing can happen in healthcare,” explains **Jason Hwang, MD**, Executive Director of Healthcare,

Innosight Institute, San Francisco, CA, and a co-author of the book. “The healthcare system right now is deeply centralized; services tend to be retained and housed within centralized, complex hospital facilities rather than decentralized to deliver care closer to the patients or in their homes. Yet extraordinary technology and new business models are being developed all the time that can bring high-quality solutions closer to patients, and at a lower cost. Adopting those changes and new delivery channels could lead to better levels of quality and patient satisfaction and help relieve the continuing crisis in the high cost of healthcare.”

The beginnings of these decentralizing transformations are already under way, with physicians performing increasingly complex “hospital” work in outpatient settings, nurse practitioners being deployed to do “doctor’s office” work in retail clinics, and patients becoming empowered to perform more self care and monitoring in their own homes using simplifying technology. And since these solutions often outperform conventional channels in terms of patient satisfaction and quality metrics, while also expanding



access at a lower cost, it seems likely that these and other innovative venues and delivery channels are poised for exponential growth. Continues Hwang, “As in other industries, the ultimate goal is to create more affordable solutions that increase access for people while delivering it to them when and where they want it.”

Toward Better Value

“We simply can’t afford to keep operating as we are today,” adds **Paul Keckley, PhD**, Executive Director, Deloitte Center for Health Solutions, Washington, DC. “And uncertainty about health reform and the economic recovery only serve to turbocharge the need for transformation.” So, he says, “conditions are favorable for disruptive innovation to play a prominent role in the U.S. healthcare system.”

Paul Keckley, PhD, will be a speaker for the **Forum’s December 2 Webinar, *Disruptive Innovation: Challenging the Status Quo***. Register online at www.healthcarestrategy.com.

Regardless of the details of any health reform legislation that ultimately passes, one thing is sure: the mechanism for funding any sort of reform will fall largely back on Medicare’s ability to cut costs, along with provider improvements in operating performance. “That drives innovation,” asserts Keckley. “It forces healthcare executives and policymakers to think about different ways of financing and delivering services—and that is often very difficult for people in traditional roles in the system to do.”

That means there is a substantial opportunity for new players to come in with approaches and processes that offer a much stronger value proposition. “For instance, I think we’ll see cross-state medical tourism accelerate at warp speed as providers in hub cities like Atlanta develop regional programs that really drill down into low-cost, high-value delivery,” says Keckley. “These destination programs will offer care for a particular service line, whether it’s sports medicine or CABG procedures, for up to 30 percent less than other providers in the region.”

Advances in technology enabling what Keckley terms Distance Medicine 3.0

also represent a huge opportunity to take costs out of the system. “The capacity is there to deliver seamless, synchronous, real-time care, ranging from simple applications like e-visits between patients and primary care physicians to highly sophisticated team-based care using robotics,” Keckley explains. “Conceivably, as robotic technology continues to improve and providers become more experienced, mid-levels may be able to perform simple procedures that previously could only be performed by physicians, and that dramatically changes the game.”

The transformational potential in distance medicine is huge not only in terms of costs, but also as a means of engaging people more directly in their health. Take, for example, in-home management and monitoring of chronic conditions and post-acute care. “When used in conjunction with evidence-based care management programs, in-home monitoring not only increases medication compliance and reduces avoidable post-acute complications, it could also save up to 20 percent of the costs of that care,” says Keckley.

Health, Not Healthcare

A third major area that offers cost savings as well as market potential lies in prevention, wellness, and healthy living. Americans have demonstrated a willingness to spend money out of their own pockets on nontraditional health services—to the tune of \$35 billion in 2008—and employers are increasingly showing interest in wellness programs. But traditional players in the healthcare industry have not found the health and

Continued on next page

“**U**ncertainty about health reform and the economic recovery only serve to turbocharge the need for transformation.”

wellness market particularly interesting. “We’ve built healthcare around episodes of acute and specialty care, but we’ve missed the simple things that can improve population health, like investments in preventive health and in improving care coordination,” notes Keckley.

Bradley Perkins, MD, Executive Vice President of Strategy and Innovation and Chief Transformation Officer, Vanguard Health System, Nashville, TN, concurs, emphasizing that today’s healthcare system needs to fundamentally shift models from a focus on sickness to one of wellness and prevention. “If hospitals and health systems intend to compete in health and healthcare delivery in the future, they will have to think bigger and distinguish themselves as authentic, trusted key players in changing delivery,” says Perkins.

“Too many Americans seem to have the idea that healthcare is about hospitals or doctors or insurance companies, but it’s not. It’s about the individuals whose health and healthcare we are trying to improve,” Perkins adds. “So, providers need to take a larger and more holistic responsibility for health at the community level, which may mean moving beyond just taking excellent care of sick people as they arrive at the door.”

There’s no doubt that this shift is likely to be driven by the transition from “fee for service” to “fee for health.” “Today this is characterized by bundled payments, but the assumption of risk by hospitals will continue to transition to a much broader population health perspective,” Perkins notes.

Recognizing that change begins at home, Vanguard Health is applying that emphasis on health to its own workforce. A new initiative called Tenzing Health, named for Tenzing Norgay, the sherpa mountaineer who accompanied Sir Edmund Hillary to the summit of Mount Everest, guides Vanguard employees in navigating the healthcare system. “The healthcare industry has been eclipsed by other industries in terms of innovations in workforce health, and employees of healthcare delivery companies, including our own, are not as healthy as they should be,” says Perkins. And when employees of a healthcare system are frustrated with the difficulty of navigating the system’s own facilities, as Vanguard’s were, it’s obvious that solutions are needed.

Tenzing Health includes concierge, clinical, and financial resources and other tools to help Vanguard employees coordinate care and manage their health. The program also provides each employee with a personally controlled health record, which Vanguard will help populate and maintain.

“We view Tenzing Health as a basic and fundamental start to reorienting the system to improve the health delivery experience and to more actively engage people in their health and healthcare,” says Perkins. “By establishing a force that is scalable and replicable, yet also high-touch, high-tech, and hyper-local, we hope that this will be a program that can eventually be used not just by Vanguard but by others as well to help transform the experience that people have with the current healthcare system.”

Vanguard Health is also the first major hospital system to sign on as a founding member of the Dossia Consortium, a

group of large employers who have come together to create a lifelong, personally controlled health record that is not tethered to any particular health system, payer, or company. Other members of the consortium include Intel, Wal-Mart, AT&T, Pitney Bowes, and Cardinal Health.

The goal is to facilitate a logical tool that integrates people’s health and healthcare data, says Perkins, and the group is moving rapidly to advance the notion of auto-population of data beyond the tipping point. Vanguard will be one of the first health systems to stream clinical data directly into the personal health record without having to work through insurance or claims data sources. “We are committed to providing all Vanguard employees and their dependents with these records and to making it as easy as possible for them to maintain the records,” Perkins adds.

Encouraging Innovation

It’s clear that innovations that fundamentally disrupt and transform health and healthcare are an unstoppable force, and physicians and healthcare executives willing to accept the changes will best position their organizations for sustainability and relevance in the future.

“The most successful organizations are those that start recognizing change and talking about what is happening,” suggests Perkins. “They are collaborating and innovating in fundamentally different ways and expanding innovation strategies beyond just departmental silos. They know how to rapidly identify innovation outside the organization, bring it in, and diffuse it quickly. This takes strategic decision-making support and a nimble culture.”

Although change may be uncomfortable, “Healthcare executives need to recognize that fighting new market entrants or

Today’s healthcare system needs to fundamentally shift models from a focus on sickness to one of wellness and prevention.

innovations using lobbying, licensing or other regulatory hurdles, and payment changes to block disruption is a short-lived strategy," adds Hwang. "Solving healthcare's cost challenges while simultaneously improving access, quality, and safety demands a 'letting go' of today's highly centralized systems and a focus on getting closer to the patient. It may mean giving up some revenue in the short term, but in the long term it will be better for all."

And making things better is really what it's all about. "There's a moral imperative to bring the best possible healthcare to the community that you serve," says Keckley. "Start by acknowledging that what gets measured gets improved. Be honest about what the organization does well in terms of quality and effectiveness and don't just dismiss measures that people don't like. Then recognize that the organization's survival may well depend on embracing

the services it does best and innovating where there are better ways to deliver care." ○

○ Sources

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Driving Organizational Innovation

Healthcare executives thinking about sponsoring innovation programs within their organizations can learn from the experiences of early adopters. Consider these seven key success factors:

- 1 Support.** Executive level support, dedicated staff resources, and adequate funding are necessary or programs will wither quickly. Funding sources typically include the health system itself, endowments, and charitable contributions.
- 2 Independence.** The best programs are granted enough autonomy from the sponsoring organization to protect them from innovation-stifling organizational politics. Many have the freedom to choose which concepts and focus areas they will study to benefit the health system.
- 3 Insight.** Seek out feedback from clinicians, front-line staff, and patients regarding problems or processes in need of improvement. Collaborate with other innovators, even from other industries. Be inspired to find new uses of existing technologies to solve problems—solutions don't always have to start from scratch.
- 4 Structure.** Employ a rigorous, well-designed methodology to advance concepts from model to field testing to implementation. Bring in physicians and staff to reality-check solutions for real-world relevance and applicability.
- 5 Measure.** Define the tools and necessary skills, measures, and metrics to evaluate how an innovation transforms or adds value to process cost, quality, or access.
- 6 Retool.** Fine-tune and evolve pilots and prototypes as needed, and be open to changing directions or abandoning a project if it doesn't produce results. Expect disappointments and failures before hitting a "home run" solution.
- 7 Implement.** Transform healthcare delivery systems, in ways both large and small, by implementing practical, real-world solutions into operations across the organization.

Source: California Healthcare Foundation. "Reinventing Healthcare Delivery: Innovation and Improvement Behind the Scenes." September 2009 Issue Brief.



An Interview With
Jeff Goldsmith, PhD
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Innovation— Don't Disrupt, Enable

By **Debbie Reczynski**

With all the attention to healthcare reform and “bending the cost curve” from government policymakers, industry groups, academics, and independent policy analysts, it certainly is the right time for those within healthcare to step in with new, innovative ideas. *Healthcare Strategy Alert!* talked with **Jeff Goldsmith, PhD**, President, Health Futures, Inc., and Associate Professor of Public Health Sciences, University of Virginia, Charlottesville, VA, about his views on stimulating innovation.

Q There seems to be a “buzz” right now about disruptive innovation and how it can drive changes in healthcare ... is disruption really necessary in order to innovate?

In my view, you make fundamental changes to a business not by setting out to disrupt others, but by enabling the values of customers. As Peter Drucker argues in his 1985 book, *Innovation and Entrepreneurship*, innovation is about enabling the customer to get something quicker and/or more cheaply than ever before. Rather than ‘disrupting’ something, the entrepreneur aims to streamline processes that don’t work, eliminate

steps, and make the path to fulfillment shorter. Even though that book was written 25 years ago, the principles still apply.

Q What was happening in the 1980s that made this book meaningful to healthcare executives, and why do the same lessons apply now?

When Drucker’s book was written, healthcare was in the midst of an outburst of entrepreneurial energy. Huge chunks of the hospital business were disappearing into physician practices and new ambulatory facilities as a result of technological advances that allowed more care to be provided on an

outpatient basis. Hospitals responded to the competitive pressures and the threat of disruption by expanding their own outpatient capabilities.

Physicians responded as well. In response to new competitors like urgent care clinics, the forerunners of today’s retail clinics, they began altering their schedules for patients to walk in or come in at more convenient times. Some practices reconfigured themselves as urgent care hybrid practice models. Physicians also created independent practice associations that have succeeded in some of the toughest markets in the United States, like metro Los Angeles.

For the past decade, though, healthcare has been in a prolonged dry spell of innovation from both a technological and care delivery standpoint. Pharmaceutical research and development has seemingly collapsed and the industry is experiencing a catastrophic net outflow of patented product. We're also in a flat spot in the device industry where we aren't seeing anything approaching such advances as MR scanning, coronary artery stenting, or flex scopes.

That flat period may be ending, though, as Internet-based companies are beginning to have a major influence on changing how healthcare is delivered and supported.

Q Where do the opportunities for innovation lie?

As mentioned earlier, innovation is about enabling ... enabling patients by making services more accessible and easier to use, and enabling the values and goals of practitioners by making it easier to practice medicine. So, those interested in changing the system might ask, how can we get patients connected to physicians sooner? Can we end what Don Berwick calls "the tyranny of the visit" through Internet technology?

New innovative companies are surfacing to do just that. For instance, Hello Health is a powerful example of a social networking platform to connect doctors and patients. If young clinicians and young patients are already online all the time, why not create ways for them to interact through instant messaging or video connection tools like iChat or Skype? These are not patient portals, but powerful tools that allow real-time access and communication

between patients and doctors. Of course, access can't be unlimited—it has to be controlled so that physicians aren't slaves to their inboxes—but it is something worth pursuing.

Administrative processes can be shifted to real-time as well. Insurance claim adjudication is one example. Companies like athenahealth and Availity have shown that Internet technology can reduce the delays and inefficiencies associated with the currently partially automated claims payment system where we've got hundreds of people in swivel chairs talking on the phone and waiting for callbacks. The question is, How long will it take for this technology to diffuse? This is disruption with a purpose: eliminating the huge clerical overburden that is strangling hospitals and physician practices.

Q What will it take to really get some of this new thinking going?

To put it bluntly, our field is in a kind of boomer menopause right now. Today's healthcare leaders would do well to surround themselves with younger executives who understand and use social networking technology and listen to their ideas. Younger executives understand that rather than spending so much time in meetings singing "Kumbaya" and getting people comfortable with change, executives must spend more time solving problems and communicating more instantaneously and effectively. We need to end the "tyranny of the meeting" as well as the "tyranny of the visit."

Q Given the current uncertainty about reform and the economy, and the potential for disruptive influences, what advice do you have for healthcare executives?

The point is not so much being able to predict what's going to happen, but engaging in an analysis of potential significant changes in the economic environment to understand the effect they could have on your business.

At the larger health system level, I would argue that if we really want to bend the cost curve, it's depressing that the models and payment reforms everyone talks about are not only not new, many are resurrections of failed ideas from a decade or two ago. The Accountable Care Organization, for example, is a retreaded version of the at-risk Physician-Hospital Organization. The medical home, which I think is much more promising, is not a new concept. Bundling was actually proposed and quashed in the 1980s. The failure to invest at CMS in more research and demonstrations on innovative payment methods is really hurting us now that we need proven tools.

On the positive side, I love the fanaticism that I see in some of the places that have adopted the Toyota "Lean" processes, like Virginia Mason in Seattle; they have a real passion to eliminate wasted time and motion. We need more health systems to learn to get 40 miles a gallon on regular gas. It isn't rocket science. It isn't disruption that really matters, but better execution, and a clearer path for the patients and families we serve to get what they need from us. ☐

You make fundamental changes to a business not by disrupting but by enabling ... enabling patients by making services more accessible and easier to use, and enabling practitioners by making it easier to practice medicine.

Patient-Centered Medical Homes

Better Care, Better Value

By **Debbie Reczynski** and **Katie Carow**

Innovative healthcare systems aren't waiting for national action on health reform to address issues of quality, costs, and access in their communities. Many have been developing promising new solutions for years. Geisinger Health System, Danville, PA, is one system that has caught the attention of policymakers—and its medical home model offers lessons for any healthcare executive interested in delivering a better care experience while controlling costs.

Geisinger introduced its patient-centered medical home model, called the “personal health navigator,” in 2006, as one way of meeting the system’s lofty goal of becoming “a high-value delivery system.” “We defined value in line with the Institute for Healthcare Improvement’s ‘Triple Aim’ goals for healthcare transformation and laid out three objectives: improving the patient experience, improving quality of care and outcomes, and improving the cost trend,” says **Richard M. Gilfillan, MD**, Consultant to Geisinger Health System and former chief executive officer of Geisinger Health Plan.

Those objectives guided the development of the medical home model. For instance, to improve quality and outcomes, Geisinger looked at how primary care practices and the health plan could work together to better coordinate and manage care. And it helped that Geisinger physicians were already in the process of transforming their practices to be more patient-centric.

Hardwiring Quality

The electronic health record (EHR) already in use at Geisinger’s 35 primary care practice sites emerged as a key tool. Practices had started using EHRs to deliver more evidence-based preventive care and chronic disease management in 2005. With the medical home approach, capabilities were added to enable the EHR to generate time-of-service reminders for nursing staff to help

patients manage chronic conditions. For example, in the case of a patient with diabetes, the system automatically issues a prompt when it is time for a blood sugar check, an eye exam, or a foot exam. “When a patient comes in for care, the EHR pops up on the nurse’s Electronic Rooming tool, listing all of the things the nurse needs to do on that visit,” explains Gilfillan.



“Having a system like this for tracking and monitoring care is the top operating necessity for ensuring quality outcomes,” says Gilfillan. “But to be successful in changing the cost trend, you need to help physicians manage the experience of the sickest patients.”

So, the Geisinger Health Plan placed case managers in all of the practices to work with patients—especially those with conditions like heart failure, diabetes, and lung disease—to help them be healthier, manage their chronic problems, and avoid emergency room visits, hospitalizations, and readmissions. Case managers also coordinate care across the system, including any services needed at home or at such facilities as hospitals, rehabilitation centers, or nursing homes—although the goal is to keep patients out of these facilities as much as possible.

The fact that the case managers are based in the physician’s office makes a big difference in their ability to connect with patients. “We’ve found that more than 80 percent of patients in our medical home practices have engaged with their case managers,” notes Gilfillan. “That’s much higher than what you find with disease management programs typically offered by health plans, which typically see 20 percent of the patients who would benefit from case management.”

The right incentives also need to be in place to get physicians thinking along the lines of managing health for a population of patients. To that end, Geisinger adjusted the way it pays its primary care physicians. Practices that achieve savings (by reducing hospital admissions, unnecessary tests, or other utilization) and also meet a checklist of quality goals receive a share of

the savings generated. The payment incentives encourage efficiency, but not at the expense of quality. The remainder of the savings go to the health plan, which funds the services required to support the medical home model.

Results Generate Returns

Geisinger system and health plan executives sit down each month to monitor how well the model is working and where improvements might be needed. “We evaluate how we’re doing in terms of quality and outcome metrics. We look at how many people went to the emergency room and whether anyone was admitted, or readmitted, to a hospital. If so, we look at what we could have done differently to avoid the need for these more costly, higher-level services,” Gilfillan explains.

So far, results are positive. “We’ve seen improvements across all three dimensions—quality, experience, and costs. And, because the savings generated have exceeded the investment required, we have had a significant positive return on investment,” says Gilfillan.

Making It Work

Geisinger has had a distinct advantage in transitioning to a medical home model in that the health system, physician practices, and insurance arm share common governance. “It helps that we can sit down with just three people, representing the Geisinger Health System, Geisinger’s physician group, and Geisinger Health Plan, to set strategic goals, decide on an initiative, and have control of the whole process,” says Gilfillan.

But that level of integration is not an absolute necessity for pursuing a medical home model. A healthcare or physician organization interested in the

model doesn’t need to own a health plan to make it work, but it does need insurers as partners. The insurer brings a population perspective that primary care practices typically do not have, and can provide data, population management tools, nurses, patient care managers, and funding to support the model.

Similarly, the model works just as well with employed or non-employed physician practices, as long as the right tools, resources, and support are provided. In fact, Geisinger’s model is in place and working quite well at five practices that are not owned by the system.

“The foundation of a good medical home model is the agreed-upon strategic intent to do it,” advises Gilfillan. “Healthcare organizations, physicians, and payers that recognize the benefits of the model should seek each other out and try to develop community approaches that make sense and improve value.”

“Frankly, there isn’t anything terribly unique about our model other than that we were willing to make a leap of faith,” Gilfillan continues. “We were willing to believe that this would work, and we made the investment. Now that we are seeing positive returns and benefits to patients, we hope that leap of faith is no longer necessary. Other organizations can see from our results that the model results in better care, better outcomes, and lower costs, and it is indeed worth the investment.” ○

Source

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The right incentives need to be in place to get physicians thinking along the lines of managing health for a population of patients.

Disrupting Provider Value Networks



BY **Mary Hassett**

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How Employers Are Changing the Game

Employers are fiercely concerned about the impact of healthcare costs that have left them flatfooted in competitive markets that have never been more challenging. And they're acting on those concerns by disrupting the current healthcare value network—and changing the game for providers in the process.

The Existing Healthcare Value Network

A value network is the dominant competitive architecture that shapes the roles and relationships across healthcare players. It is a nested system of interactions with self-reinforcing loops. In healthcare, a key reinforcing loop relates to reimbursement—where employers, who contract with health plans that in turn contract with provider networks, pay a hefty portion of the tab.

As the tab continues to increase and providers remain slow to address employers' greatest cost concern—chronic disease prevention management—some employers are becoming their own integrators and providers of healthcare delivery. Specifically, they are making calculated “buy value or make it yourself” decisions in the areas of primary care, chronic disease management, and high dollar surgical procedures that could have a significant impact on current provider networks.

Global Medical Travel: Employers' Newest Tool

A growing number of employers are direct contracting with global medical travel companies to offer health benefits to their employees. The companies arrange for services with foreign healthcare providers that offer comparable quality at up to 90 percent less than U.S. providers (see figure 1 on page 11).

Estimates of the number of Americans traveling outside of the country for care vary widely, but sources all seem to agree that the numbers will increase. Deloitte, for instance, reports that in 2007, 750,000 U.S. patients left the country for care, and projects that 1.6 million will do so in 2012.¹

The motivation for medical travel is economic. In Deloitte's 2009 study, only 1 percent of Americans had traveled outside of the country for treatment in the past year, but 9 percent said they would likely do so if they could save 50 percent or more on a surgical procedure. Other research indicates that the willingness of consumers, whether uninsured or insured, to travel abroad increases as the financial incentives become more compelling; a study from Arnold Milstein and Mark Smith reports a market potential of 20-40 percent for incentives of \$10,000 or more.²

When employers offer a medical travel benefit, the savings to employees typically include no out-of-pocket costs for co-pays or deductibles, plus a share of the employer's cost savings in the form of pocketed cash. Employers also cover the costs of air travel and amenities for the patient and a companion. All logistics, including coordination of pre- and post-care arrangements at home, facilitation of direct communications with the overseas surgeon, and assignment of a nurse navigator for hand-holding and problem-solving, are

A growing number of employers are contracting with global medical travel companies to offer health benefits to their employees.

handled in concierge style by the medical travel company. Amenities before, during, and after care are 5-star, with 1:1 nursing care. Tours and other options to make enjoyable use of recovery time might also be included.

Now, Enter Domestic Medical Travel

Some employers are ramping up arrangements with domestic medical travel companies as well. Patterned after the global medical travel companies, companies like BridgeHealth, HealthPlace America, Olympus, and others contract with networks of high-quality, low-cost domestic providers, which they market to employers. The mechanics and amenities work as outlined above, and although the cost savings are less—30-60 percent—the domestic option has broader patient appeal and less liability concern.

Hospitals are drawn to these domestic contracts because they see this as a viable counterstrategy to pre-empt outmigration

of profitable revenues. There is no cost to participate, but providers must meet qualifications set by the travel company for quality, costs, volumes, outcomes, patient satisfaction, internal capabilities (including a good cost accounting system), location, amenities, integration of physicians, and the capacity to add volumes from outside their geographic market.

Hospitals in these networks are willing to accept the reduced pricing, which takes the form of a case rate or bundled pricing for the entire episode of care, because it is offset by additional volume that covers direct expenses while contributing to fixed overhead. The real kicker: hospitals are paid up front before the patient arrives for care. Most also experience an uptick in quality, as the hospital reviews patients prior to treating them, and has full prerogative to accept or reject the patient. All patients are non-urgent, healthy enough to travel, and can be screened for any attributes that may make them poor quality risks.

This (geographically) Unrestricted Value-Based Competition (UVBC)—with its cash up front incentive to providers—is dramatically disrupting the existing value network. Along with it comes an eye-popping new strategic assumption: healthcare is no longer local. Success in the future mandates strategic redesign to compete in a national and global marketplace. Indeed, Uwe Reinhardt, Princeton University Healthcare Economist, said it strikingly, “Medical tourism has the potential of doing to the U.S. healthcare system what the Japanese auto industry did to American carmakers.”

Employers in the Business of Care

Employers are disrupting the value chain in other areas as well. Some are getting into the delivery of primary care (see sidebar on page 12) and some are building their own networks to prevent and manage chronic disease.

Continued on next page

Figure 1.

BridgeHealth Medical—Representative Global Case Rates

| Procedure | Typical Case | BridgeHealth National | BridgeHealth International | | |
|----------------------------------|--------------------|-----------------------|----------------------------|------------------|------------------|
| | US | US | Taiwan | Costa Rica | India |
| Heart/Vascular | | | | | |
| CABG w/o cath | \$60,000-\$100,000 | \$32,000-\$36,000 | \$18,900 | \$25,000 | \$8,500 |
| CABG w/cath w/comp | \$70,000-\$110,000 | \$47,000-\$53,000 | \$18,900 | \$25,000 | \$8,500 |
| Orthopedic | | | | | |
| Hip Arthroplasty | \$45,000-\$50,000 | \$20,000-\$25,000 | \$7,500 | \$13,350 | \$8,000 |
| Knee Arthroplasty | \$43,000-\$50,000 | \$19,000-\$23,000 | \$8,000 | \$12,350 | \$7,000 |
| Bilateral Knee Arthroplasty | \$65,000-\$80,000 | \$32,000-\$35,000 | \$9,000 | \$21,175 | \$14,000 |
| Shoulder Arthroplasty | \$40,000-\$50,000 | \$20,000-\$24,000 | Price N/A | \$10,145 | \$8,500 |
| ACL Repair | \$20,000-\$25,000 | \$10,000-\$14,000 | Price N/A | \$4,795 | \$6,500 |
| Spine | | | | | |
| Cervical Spinal Fusion | \$65,000-\$90,000 | \$25,000-\$33,000 | \$13,860 | Price N/A | \$7,000 |
| Lumbar Spinal Fusion | \$90,000-\$120,000 | \$44,000-\$52,000 | \$15,000 | Price N/A | \$9,000 |
| Bariatrics | | | | | |
| Gastric Sleeve or Gastric Bypass | \$35,000-\$50,000 | \$20,000-\$25,000 | \$12,900-\$14,300 | \$9,775-\$12,895 | \$9,800 (sleeve) |
| Gastric Banding | \$25,000-\$40,000 | \$13,000-\$18,000 | \$10,800 | \$9,770-\$10,270 | \$7,500 |

Source: BridgeHealth Medical, used with permission.

Employer investments, methodologies, and early successes in disease management far exceed the commitment of traditional healthcare providers in this area. In addition to using their data competencies to pinpoint high yield opportunities, employers also use their systems-thinking skills to create collaborative care linkages (with peers and outside partners) to seize the advantages of shared resources, co-investment, and economies of scale. These cross-industry collaborative efforts and pooled resources are creating “best practice” protocols.

For example, employers have created bifurcated approaches to disease management. The dual approach uses “Solution Shops,” or multidisciplinary teams of providers, to diagnose and prescribe treatment methodologies, and then turns the patient over to “Compliance and Support Shops”—companies like Healthways and

OptumHealth that specialize in managing, monitoring, and motivating medical and behavioral compliance. Employers co-invest to share program costs, and collectively outsource to these contractors.

For employers, getting value for the healthcare dollar is all about reducing the total cost of expenditures over a longer horizon of time. While providers (except for fully integrated fixed-fee providers) are not paid to keep people healthy, employers can't survive unless they do. So, they are proactively putting their money where their mouths are—on improving value, cost, outcomes, and long-term health.

Disruption Will Grow ... Are You Ready?

As they build momentum on success, employers will likely become even more assertive in creating alternative networks and using their inherent advantages to create further disruption. Employers have a huge financial stake, large numbers of

covered lives, the leverage of employee relationships, critical data and the will to act on it, broad geographic scope, capacity to offer convenient care, and the clout and means to implement change in a decisive way.

So, there is every reason to believe that employers will continue to self-solve their healthcare cost dilemma with disruptive moves. It's not personal. It's self-preservation. Healthcare providers will do well to stand back, reassess the new competitive landscape, re-think assumptions in light of the new value proposition, redesign strategies, and reinvent delivery systems to meet a rapidly unfolding future. ○

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Employer-Owned Primary Care: Case in Point

By **Mary Hassett**

Quad/Graphics, a Milwaukee-based self-insured printing company with \$2 billion in revenue and 11,000 employees, has become an iconic example and mentor to other self-insured employers on the benefits and mechanics of integrating their own primary care. Quad/Graphics already contracts directly with domestic providers for high-dollar procedures. In addition, the company now owns four medical centers offering family practice, internal medicine, and OB/GYN physicians, along with minor surgery, lab, and rehab services. Care is provided at a flat \$5 per visit. Over 80 percent of Quad/Graphics employees use the company centers, while the remainder choose to use other centers at higher out-of-pocket cost.

Quad/Graphics employs primary care physicians at a competitive \$130,000-\$160,000 per year, with large added incentives to improve health in measurable ways. Physicians are required to spend a minimum of 30 minutes with each patient to advise, anticipate, coordinate care, and focus on prevention. Employees and their families also receive financial incentives for behavior changes that improve health.

Quad/Graphics spends more than other companies on primary care (\$715 per person in 2003, compared with \$375 for other employers in its market) but results have exceeded national benchmarks, and cost savings have been significant. For instance, blood pressure medication compliance is 92 percent versus 40 percent nationally, and C-Section rates are 12 percent versus 26 percent nationwide. Yearly healthcare cost increases stayed at just under 5 percent for the company between 2000 and 2007, compared with average increases of 11 percent nationally. Quad/Graphics spent a total of \$6,500 per employee on health in 2007 while other Midwestern companies spent an average of \$9,800.

Quad/Graphics also invested early in electronic medical records (EMRs) and employee-controlled personal health records (PHRs). The company's success has spurred industry “buzz” and broad adoption. Others like IBM are moving rapidly in tandem to implement medical homes, remote delivery innovations, and new partnerships with global technology firms to increase the scope of primary care.



Navigating New Waters

By **Darcie Cross**

Innovation isn't always about the big things. Some hospitals and health systems are establishing in-house innovation programs to evolve and expand delivery strategies—and learning that even small changes can reap significant improvements in the healthcare experience.

Take the case of the Szollosi Healthcare Innovation Program (SHIP). Affiliated with Northwestern Memorial Hospital, Chicago, SHIP's mission is to use creative thinking and diverse technologies to produce a better healthcare experience for all involved, including patients, their families, physicians, and other caregivers. The program is funded with donations and staffed with just two people—one physician innovator and one project manager, whose combined time amounts to one-half of a full-time equivalent—along with outsourced IT help.

"Innovation can be done on a small scale, but it needs to be nourished," says **Lyle Berkowitz, MD**, SHIP Program Director and a practicing internist. "Hospitals and physician groups can benefit by formally or informally creating innovation centers within their own organizations, providing resources, funding, and executive support—and granting the program the freedom to say simply, 'How can we do this better?'"

Improving Workflow—and Care

Last year, SHIP launched two successful initiatives to create workflow efficiencies that incrementally improve care delivery processes. The first, a web-based tool called ExpectED, allows primary care physicians to electronically share clinical and contact information about incoming patients with emergency department

(ED) staff to help them triage and treat the patient and communicate back with the initiating physician. Physicians like the tool because it improves the transition of care, enables them to post a deeper level of content directly into patients' ED records, and effectively replaces a cumbersome telephone-based workflow.

A second initiative, the Inflection Navigator, helps patients at "inflection points," or times when patients have a sudden and intense increase in their healthcare needs as a result of a new medical issue, such as an initial diagnosis or new finding.

"We combined an EMR messaging system with a self-developed web-based program to empower care coordinators with a system that combines evidence-based protocols with schedule coordination. The resulting system helps patients get the right tests, appointments, and educational content quickly and in an organized fashion," explains Berkowitz. "Not only is this the right thing to do for patients during a difficult and confusing period, it also helps ensure that care is delivered in the appropriate order and kept within our enterprise health system."

What's more, innovations like these often don't require extensive investments or creation of complex new technology

but can be based on finding new uses for existing tools. The Inflection Navigator was developed by working with on-campus IT talent to modify an open-source software tool originally designed for tracking patients in clinical trials. "Innovators can take advantage of the many amazing technologies available today, adapt them to real-world situations, and create bigger and better solutions that apply to their organizations," Berkowitz adds.

Thinking Big

And though it's a small program, SHIP innovators think big. A current focus is on improving the usability of electronic health records. "Physicians aren't adopting them as quickly as we'd like, due in part to poorly designed user interfaces that simply mimic paper medical records, and inefficient architecture that often requires multiple clicks for simple tasks," Berkowitz notes. "We're putting together concepts for making the user interfaces more intuitive and visual, hoping that developers will run with the best ideas to help transform electronic records into tools that are more appealing and help boost adoption rates."

SHIP is a charitable endeavor, and replication of program innovations is welcomed and encouraged. Ideas and findings are shared with other organizations through the Innovation Learning Network, a consortium of non-profit innovation centers, as well as through articles, presentations, blog posts, and the program's website (www.theshiphome.org).

"Innovation takes hard work and a willingness to experiment," concludes Berkowitz. Those organizations that actively seek out innovations, both large and small, are the ones that are most likely to achieve the greatest long-term success." ◻

Source

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“Organizations that actively seek out innovations, both large and small, are the ones most likely to achieve the greatest long-term success.”



VIEWpoint

Accountable Care Organizations—A Provider-Driven

The Accountable Care Organization (ACO) is an emerging model for harnessing physician and hospital leadership to use the tenets of clinical integration to make the healthcare system work better. At a time when Medicare costs are growing at the rate of 8.9 percent per year, and with the forecast of insolvency by 2019, the ACO offers a provider-driven solution for containing costs and enhancing quality.

Over the past three decades, multiple attempts to contain healthcare costs have been introduced, including health maintenance organizations, with their emphasis on preventive care and physician accountability; capitation; and pay for performance (P4P). While preventive benefits, financial accountability, and rewards for results may be necessary components for improving healthcare delivery, they are not sufficient.

We are now much wiser regarding the complexities of containing cost and enhancing quality. The ACO offers a model that enables physicians and hospitals to address the problems of cost, quality, and access that threaten our nation's health using principles of clinical integration, including local accountability, shared savings among stakeholders, and performance measurement and improvement.

The ACO Model

The ACO would be responsible for providing a comprehensive array of healthcare services to Medicare beneficiaries who are not enrolled in a Medicare Advantage plan and for managing healthcare utilization as well as quality for the covered population. An appropriate legal structure and board governance would need to be in place for managing a network of primary care physicians, specialty care physicians, and at least one acute care hospital, all of which use the principle and practices of clinical integration.

Providers in the ACO would use advanced medical management systems to promote prevention and reduce the burden of illness and associated costs for patients with chronic health conditions. If successful, the ACO would receive surplus payment or dividends for its ability to deliver healthcare efficiently within a geographic region; those surpluses would be distributed to providers. The ACO would not have a downside risk, claims processing, or actuarial negotiations, just the opportunity to deliver healthcare faster, cheaper, and better under the Medicare payment system.

Understanding and Managing the Patient Population

So what will it take for an ACO to succeed? The first step is knowing the patient population and its health risks, so that care can best be managed.

The use of health risk assessments will help identify the most important opportunities for enhancing quality and reducing costs. Patient registries and disease management systems will help caregivers improve care and reduce unnecessary costs for those patients with the greatest burden of illness.

Practice guidelines would direct optimal care across the continuum of patient illness, from ambulatory to acute care settings. These guidelines would be used to monitor hospital utilization and ambulatory sensitive conditions to identify opportunities for reducing unnecessary admissions in favor of more appropriate, less costly alternatives. Admission diversion protocols would be developed, and appropriate discharge planning would be employed to prevent relapse and readmission. Most important, all physicians and their associated healthcare teams would be actively engaged in the coordination of care and committed to using best practices.

Coordinated Patient-Centered Care

That leads to the second criterion for success: the development of a strong collaborative primary care team that includes physicians, nurse practitioners (NPs) or physician assistants (PAs), nurses, medical assistants, pharmacists, nutritionists, therapists, social workers, and educators. These various team members may either be located within

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the office (as nurses would be) or be part of the virtual office (pharmacists, for example). Physician leadership in the team is vital for leveraging the expertise of each team member to their fullest abilities and licensure (where applicable).

The patient is at the center of the model; the practice now coordinates the care of the patient using the various services within the team. The physician has ultimate oversight, but the role of team members other than physicians in communicating information and managing care plans is increased; to that end, technology that facilitates information flow is essential.

Measuring Performance

Finally, to be successful, an ACO must also be focused on measuring objectively patient care outcomes and costs. The Institute for Healthcare Improvement Whole System Measures set forth an ideal set of key metrics for ACOs, including:

- ◆ Adverse events
- ◆ Functional outcome scores
- ◆ Hospital admission rates
- ◆ Ambulatory sensitive condition admission rate
- ◆ Core measure results
- ◆ Measures of effectiveness for treating chronic health conditions
- ◆ Preventive health screening rates

- ◆ Patient access measures
- ◆ Palliative care
- ◆ Patient satisfaction

A Model for Improvement

An effective ACO is in itself a model for healthcare reform that would enable Medicare to incent high-to-medium cost geographic areas to organize and bring performance in line with the average. Likewise, low-to-medium cost geographic areas would serve as models of how to succeed with leaner budget targets. If ACOs can demonstrate success, they will be positioned to work with private employers and health plans in creative ways to bring economies and efficiencies to the private sector.

In short, the ACO brings together traditional public health principles and best practice in managed care while aligning physicians and hospitals to make the healthcare system work better. Given current attention to healthcare reform, the timing could not be better. For those who are willing to integrate and find solutions to the everyday problems in healthcare that are bankrupting our country, the opportunity is now. ○



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