Beyond Reform: Better Healthcare For Less
The *Frameworks For the Future* series

A Strategic Survival Kit For Hospitals and Health Systems

by Joe Flower
Imagine What If
The Change Project, Inc.
Beyond Reform

We want health care to be abundant, effective, easy, and cheap; for too many of us too much of the time it is scarce, ineffective, maddeningly difficult, and far too expensive. The real revolution in health care is emergent, it’s happening now. It’s not simple, it’s complex. It’s hard to explain, it’s sometimes hard even to notice, even if you’re doing a piece of it. It’s not political. It’s not about rationing. It’s not about abating symptoms, it’s about healing the system, because the dysfunction in health care is deeply systemic.

A range of powerful vectors are coming together right now to make this period we are in right now the period of the most rapid and far-reaching change in the history of the sector. These vectors will shift the market-place of healthcare, changing every structure and every relationship to render the system far more lean and effective than it is today. It’s not recognized yet as a movement, a revolution, a wave, but the new structures and relationships are already emerging. Do you feel it?

There has never been a time like this in healthcare, never a time with so much fluidity, so much uncertainty, so many challenges, not in our lifetimes, not in the last hundred years, probably never in the history of this singular industry.

People who run the vast, complex institutions of healthcare can assume nothing about the future, even the relatively short-term future of the next three, five, seven, 10 years. An unprecedented concatenation of shifts and changes mean that anything we are used to—any revenue stream, any org chart, any program, any initiative, any job, any relationship—may turn to vapor.

In times like these, same-old same-old is no option. Just getting by will not get by. Business as usual is done. It was patched together with bailing wire and spit for years, sucking fumes, and now it’s out with the recycling. Any resemblance to a living, working business model is a conflation of memory and mass hypnosis. Forget it. Leave it by the curb. Build something new.
Build something new, build a lot of new things, and build them now, while the whole thing is still going full bore. That’s a tall order, but that’s exactly the extraordinary demand of the times.

How?

How do we do that? How do we know what to try, what direction to move? How do we know when we are succeeding?

Luckily, new models are emerging all across healthcare, just when we need them. The crisis is producing its opportunities everywhere. A shape is growing in the fog ahead. If we pay attention, we can pick out its parameters and prerequisites and interrelationships from here, and build accordingly.

How do you feel about the future?

I have been an independent healthcare futurist and analyst for 30 years. I’m on the faculty of (and write for) the American Hospital Association and the American College of Physician Executives. I speak all over the industry. I’ve worked with everyone from the World Health Organization and the Department of Defense to free clinics, major health systems and small rural hospitals, state hospital associations and national coalitions, the list goes on. In the late 1980s, my co-author Ken Dychtwald and I predicted, based on demographics, that healthcare would be a major campaign issue in the 1992 election. People said. “Healthcare?” They thought we were nuts, but we were right. In the 1990s, when managed care was the big coming thing that was going to sweep healthcare, I predicted that it would not—because it delivered everything both doctors and patients hated. That tsunami petered out. After the 2004 election I began saying, again based on demographics and the kind of deep trends featured in this ebook, that healthcare would be a big issue in the 2008 election, and we would have a bill by Christmas of 2009. I was off by three months. I’ve been doing this a long time, and I don’t look at the froth of the moment. I look at the deep trends, the unstoppable, the systemic, and we how they will play out in what we do every day, how we get paid, how we shape our institutions and our careers, and how we care for people.
I’ll tell you what I feel about hospitals’ futures.

Here’s what I think: If somebody doesn’t pull a rabbit out of a hat some time real soon now, hospitals—and all of us who depend on them—are in serious trouble.

The good news is that there is a hat, and it has a rabbit in it. Handfuls of rabbits.

Here at Imagine What If, we do a constant scan of healthcare, through the published literature, online blogs and email, and through constant contact with a network of physicians, people who run healthcare institutions, people who run health plans, startup entrepreneurs, and policy wonks. We are seeing things that are so encouraging that they warrant a special report. A new shape for healthcare is emerging in a wide variety of new forms and models. What they have in common is that they drive healthcare to become both better and far less expensive than it is today. Yes, cheaper: Not just “bending the cost curve” to a lower level of medical inflation, but driving the cost downward.

This is not about rationing, or some Soviet-style commissions dictating what we can do and for how much. Nor is it about further waves of reform. It is about opportunities for hospitals and health systems that are emerging out of the private market, inside the healthcare industry, and only partially in response to the reform. The demographic, economic, and technological pressures of the time have been building for years and will continue to create these opportunities. But we have to learn to see them.

You’ve seen stage magicians. You know that when a stage magician pulls a rabbit out of his hat, there is no magic involved. It’s a real rabbit, and an ordinary hat. There’s a trick to it, it’s a trick you might not pick out no matter how many times you watch—but it’s a trick he could teach you to do, if you really wanted to learn. That’s what we are doing right here. There’s some homework first, then the rabbits. In these pages I will lay out:

• First, the **groundwork and background**—the big factors re-shaping healthcare right now, so that you can see exactly where we are, how we got in this mess, and what kind of rolling maximum disaster the future will become for all of us involved in healthcare if we don’t do something fast.
Then I will work through some “Healthcare Economics 101” concepts, so that we are all on the same page about the mechanisms driving the market for healthcare services—and you will begin to see why I believe there are opportunities everywhere around healthcare, but not necessarily in the places you would expect.

Now for the rabbits: The opportunities that arise from five key strategic imperatives for healthcare providers. This is the “trick:” Take care of these five factors (and only these five), and you and your organization will survive and thrive in the new healthcare. You will find opportunities out of which you can fashion a better future for your organization and better healthcare for the people you care for at the same time.

Finally, I will give you some resources for further study, and talk about next steps.

Along the way, I will note “Hats” (places where we might find rabbits) and “Rabbits” (real opportunities). Just for fun, and to make them as easy to find as possible, I will give them little icons, to invite you to “Think about this—there might be an opportunity here,” or “Take a look at this. Here is a place where some organizations have found real opportunities to serve their patients better, and to create a better future.”

I am optimistic. In almost every healthcare gathering I am the most optimistic person in the room, because I can see a path out of the wilderness, a path shown by explorers all across healthcare. Each piece has been tested and shown to work by entrepreneurs and bold leaders just like you. The pieces work in today’s system, and I believe will only work better under the coming system changes. When we come out the other side of this inflection point in history, two groups especially will be seen to be clearly better off: Patients, and the clinicians and healthcare organizations who serve them.

- Joe Flower
Where We Are Now

Cost and the crisis of capacity

The reform drive was aimed at three things: cost, access, and quality. The reform act does a pretty good job at providing access to healthcare for all Americans, but it does little that is forceful and directive to drive down costs. Adding new people (and new covered needs) to the system will combine with other factors—demographics, the shifting insured base, the internal constraints of the industry—to drive up healthcare premiums and the actual costs of providing healthcare with surprising speed, over the next few years especially. This great rise in costs, and its shocking speed, will mean that cost will jump to the fore as the single most pressing concern of patients, employers, health plans, health systems, and government.

At the same time, we are adding tens of millions of new people and new covered needs to the system, while doing nothing special to increase the capacity of the system to deal with them.

So the question of cost becomes very much a question of cost-effectiveness: How do we use the resources available as effectively and inexpensively as possible. This is the dominant question of the healthcare sector for the foreseeable future.

Trends

These two major crises are complicated by a range of other trends:

**The Economy**

We can expect the economy to improve, but jerkily, spasmodically and with wide regional variations. We can expect second and third dips over the coming few years. We cannot expect steady growth or anything like full
employment throughout this decade. These bumps and twists will effect different regions and sectors of the economy differently, but the job market will be especially hard on the age cohort that is just pre-retirement.

**Digitization**

The sector will computerize and automate rapidly over this period, but the process will be more expensive and difficult than expected. The gap between the efficiencies that digitization could drive, and the understanding of how to drive it, both by healthcare providers and by vendors, remains wide and deep.

**Chronic disease, prevention, maintenance**

Chronic disease, which is estimated to be the root of some 75 percent of the costs of U.S. healthcare, is on a long upward trend. One marker of this future might be seen in the growth of obesity, with nearly a third of all Americans registering a body mass index higher than 30. In this first map, the red states are those with more than 25 percent of the population with a BMI over 30. The dark red states have more than 30 percent.

This problem skews strongly against African-Americans. The second picture shows the African-American obesity profile. In the brown states, more than 35 percent of African-Americans have a body mass index over 30.

Finally, the problems posed by obesity and diabetes skew strongly against the Southeastern quadrant of our country. The third map shows what I mean: See all those dark counties to the south and east? They are the counties that count in the top two quintiles for both obesity and 

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1 Centers for Disease Control and Prevention: Population Health Studies
diabetes. The scattered dark patches in other parts of the country are mostly counties that have a heavy Native American population.²

Our healthcare system is not set up to deal with chronic, maintenance, and preventive problems; both the payment system and the expectations of practice are set up to deal with acute episodes. We deal with chronic disease so poorly that it could almost be said that we do not deal with it at all. We need to direct far more attention and money into, for instance, programs to effectively manage such conditions as diabetes, congestive heart failure, asthma, COPD, alcoholism, and clinical depression. Cutting the cost and suffering associated with chronic disease by any significant fraction would make an enormous difference.

² Centers for Disease Control and Prevention: Division of Diabetes Translation, National Diabetes Surveillance System. Available at: http://www.cdc.gov/diabetes/statistics
Boomers

The leading edge of the Baby Boom generation turns 65 this year. This massive cohort is beginning its long transition from the years of racquetball and kung fu through its years of Viagra and pacemakers, on the way to its years of walkers, hearing aids, and Depends. Their needs would swamp the system even without the rise in chronic disease.

Aging workforce

But Boomers make up as big a chunk of the clinical workforce as they do of the healthcare market. Just when tens of millions of Boomers will be entering their peak years of needing diabetes care and cardiovascular care, many of the endocrinologists, cardiac surgeons, and other clinicians that they need will be ready to retire. Already, surveys show that more than half of all physicians plan to cut back on patients, cut back on hours, or get out of the field altogether within the next few years. A quarter of the RNs in the U.S. are already out of the field, while another quarter are planning career moves in the short term that will take them away from direct patient care.

Aging patients, aging workforce, rising chronic disease, steeply rising cost: All of these point to a vast and increasing need for some kind of new efficiency and effectiveness in the way we provide healthcare. And that crying need is sharpened by the increasing awareness that we could do healthcare for less—much less.

Hat

Any business model that can offer show efficient results from managing diabetes, metabolic syndrome, Alzheimers, COPD, or other major chronic diseases will expand rapidly in the coming years.

Hat

Boomers do not like getting older one bit. They are far less accepting of aging than previous generations. Business models that promise to slow aging and manage its problems have special potential.

Hat

Again: Clinical efficiency will act as a force multiplier.

Changes in the insurance market

The reform act is bringing tens of millions of new people into the healthcare system, widening the covered conditions, and mandating that all preventive and maintenance care be covered from the first dollar.

At the same time, the pace at which consumers are switching to high-deductible “consumer-directed health plans” is accelerating, and can be expected to continue to accelerate until such plans dominate the market. Based on current experience, such insurance customers, with more “skin in the game,” can be expected to act much more like “consumers,” seeking out value and comparing costs, and being much more active in deciding what medical care to access, where, when, by whom, and how paid for.

Waste

A good rule of thumb in systems thinking says that the solutions inevitably lie in the problems themselves. In the face of all this extraordinary chaos and uncertainty, one factor shows special promise. It is a problem so large that its solution could solve all other problems. That is the problem of waste. Healthcare in the United States is done with such astonishing inefficiency, maldistribution, and waste that it turns out to be an extremely useful question to ask whether we could actually do it better, for everyone, for less money than we now spend—and to ask whether any mechanisms exist (or could be imagined) that would get us there.

We could, in fact, do healthcare for less. How much less? Ten percent less? Twenty percent? Thirty percent? How about 50 percent?

We could do healthcare for half of what it costs today.
We could do healthcare, at markedly higher quality, for everyone in this country, without rationing or denying anybody the care that they need, without having the government dictate how doctors practice or whether hospitals could expand, at half the cost we do it now.

This is not so much a prediction, or even a goal. Exactly what “half as much” would mean 10 or more years from now is not clear, since in that time both the population and the economy as a whole will grow, there will be inflation, and other factors that render such a prediction mushy to the point of meaninglessness. It is, instead, an expression of the enormous size of the opportunity. It wasn’t that long ago that we spent half as much on healthcare as we do today.\(^4\) There is nothing inevitable or absolute about the idea that we have to spend as much as we do, or that every year we have to spend more and more. Other basic sectors of the economy supporting basic human needs, such as food, shelter, and clothing, have steadily shrunk the percentage of GDP and of the average person’s budget, over the decades.

The remarkable thing about this assertion is that most of the economists, statisticians, and policy experts who most deeply study healthcare in the United States would not find it remarkable at all. They would argue how we got here and how we could get out of it, but the idea that theoretically we could do healthcare for half as much would not be that controversial.

Why would I make such an assertion? Where is the evidence to back it up?

The most obvious evidence is the experience of other countries: All other advanced economies render healthcare to all their citizens for half (at most two thirds) of what we do, whether measured per capita or as a percentage of the national output, and they have better health outcomes. In other words, they get more for less than we do.

In the public conversation, on talk shows and at parties and in online forums, people immediately ask the obvious question: “What are we spending so much more on?” They all

have their favorite answers: Malpractice, the profits and overhead of insurance companies and drug companies, greedy doctors, wasteful government bureaucrats, lazy and unhealthy patients, answers that spring from their particular political worldview or their experience. It’s like a Rorschach inkblot test.

But there is a real answer to the question, “What are we spending so much more on?” The real answer is: Everything. A number of careful, thoughtful analyses that compare U.S. healthcare spending to that of other wealthy countries come to the same conclusion: We pay more across the board. We pay more for each drug—and we buy more expensive kinds of drugs, and more of them. We pay our doctors and nurses more, and each of us on average uses them more. We also use our clinicians far less efficiently, with many doctors spending inordinate amount of time on non-productive tasks such as arguing with insurance companies and filling out forms to comply with HIPAA and other measurement regimes. We pay more for inpatient care, and for outpatient care. Administrative expenses for insurance are higher than other countries with private insurance because of our highly fractured system, but even our public program expenses are higher than theirs. We spend far more on public health and prevention (public health departments, community health centers, the FDA and the CDC), research, and medical facilities. Compared to the size of our economy, we spend substantially more on every category of healthcare except long-term care, home care, and durable medical equipment than every other OECD country.5

But “paying more” does not necessarily mean “waste.” Perhaps it is reasonable that we spend more for some things. We certainly want to be preeminent in medical research, and maybe we insist on more access, and more choice, than say citizens of the U.K. have. But what is more telling, more instructive, what might actually lead us to some thoughts about how to spend

5 U Reinhardt, P Hussey, Anderson, “U.S. Health Care Spending In An International Context: Why is U.S. spending so high, and can we afford it?” Health Affairs, May/June 2004
less, is a different set of statistics: The variation in costs within our own borders, variation that is not matched by sicker people in one place than another, or richer people, or different state regulations, or any other obvious factor—or by better outcomes. In some parts of the country we pay much more for healthcare per person than in other parts, and get no more health in return. As any quality engineer will tell you, when you see variation for no reason within a system, you’ve got a problem—and an opportunity for improvement.

The variation in costs within our own borders is huge: It typically costs Medicare 60% more (per patient per year) for patients treated in places like Miami, Los Angeles, New York, Boston, or McAllen, Texas, than if you are treated in places like the San Francisco Bay Area, Seattle, Minnesota, or northeastern Pennsylvania. The growth rate of Medicare spending over the last two decades has been wildly different in different hospital referral regions. Between 1992 and 2006, Medicare spending per person grew twice as fast in some places than others. This variation does not correlate with socioeconomic status, education, or race. The San Francisco Bay Area and Seattle, for instance, are among the better off parts of the country, while McAllen, Texas is one of the poorer spots. In fact, every year Medicare pays more on average per recipient in McAllen area than the average working person there earns. The variation correlates only with how many medical resources there are in an area—how many specialists, ICU beds, and scanners there are per capita—and in the readiness of

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6 A Gawande, “The Cost Conundrum: What a Texas town can teach us about healthcare,” The New Yorker, June 1, 2009


physicians to use those resources. One Dartmouth Group study found that, in cases where the supporting evidence was strong, doctors in the high- and low-cost areas were equally likely to recommend specific, standard interventions. But in the grey areas, they acted differently. They were much more likely, for instance, to send someone with typical gastroesophageal reflux or stable angina to a subspecialist. For an 85-year-old with an exacerbation of end-stage congestive heart failure, they were much more likely to admit the patient to the hospital, three times more likely to admit directly to the ICU, and 30 percent less likely to discuss palliative care with the patient or the family.  

The people in the more costly areas are no better off. As Atul Gawande, the Harvard surgeon and New Yorker writer has noted, “To make matters worse, high-cost communities appear to do the low-cost, low-profit stuff—like providing preventive care measures, hospice for the dying, and ready access to a primary care doctor—less consistently for their patients. The patients get more stuff, but not necessarily more of what they need.” In fact, the only visible variations in outcomes is negative: every procedure has a risk, and when you do more of them, more people die, an estimated 30,000 per year.

In our own country, some people get a lot better care for a lot less money.

A striking example arose from a 2008 Dartmouth Healthcare Group study that compared what it cost to be treated in the last two years of life at different medical centers. The high-end examples were not surprising—Cedars-Sinai and UCLA in Southern California, and New York University Medical Center, all premier institutions offering the best healthcare money can buy. What was surprising was the low end. Among major medical institutions, the least


expensive were the Mayo Clinic and the Cleveland Clinic—also premier institutions offering the best healthcare money can buy. How can the best healthcare money can buy cost half as much as the best healthcare money can buy? When, in aggregate, you get the same high-quality product for half the price, the difference in cost can reasonably be characterized as waste.\(^{12}\)

This is actually the good news. This means that there are models right in our own country, in the existing system, that show how to do it better for less. And those models show that it is possible to ignite a “virtuous spiral” which will progressively drive down costs and give better care at the same time.

A wide range of studies identify huge amounts of waste in U.S. healthcare—most of it leading to worse care, not better. Thomson Reuters released a large meta-analysis of a number of these studies in the fall of 2009. The aggregate of the studies identifies $600-$850 billion in waste per year—\(\frac{1}{4}\) to \(\frac{1}{3}\) of the entire amount that we spend on healthcare.\(^{13}\)

Asked in confidential surveys, nearly all U.S. physicians admit that they practice “defensive medicine” and “assurance medicine.” Collectively, they estimate that roughly 30 percent of the tests, images, and other care they render is unnecessary and inappropriate, rendered either out of fear of malpractice suits, or out of a desire not to lose the patient to another doctor who would, for instance, prescribe an antibiotic for a

\(^{12}\) R Pear, “Researchers Find Huge Variations In End-Of-Life Treatment,” *New York Times*, April 7, 2008

cold, or order an MRI for a hard-tissue knee problem.\textsuperscript{14}

If somehow the whole country emulated the way medicine is performed in the less expensive areas, the cost of U.S. healthcare would drop by approximately 30 percent.

Finally, these differences—between the U.S. and other countries, and between different parts of the U.S.—only measure the way we do healthcare now. They do not take into account any of the myriad ways in which healthcare could be made more efficient and effective. Taking all this into account, it easy to imagine that we could drop the cost of healthcare not just by 30 percent, but by 50 percent or more, while giving better care to all Americans.

So the waste, inefficiency, and maldistribution are definitely there, at massive levels. But how could we become more efficient? What mechanisms are there that would drive healthcare to do its job better, for more people, for substantially less money?

To get to that, we have to examine some fundamental economic ideas.

\textsuperscript{14} “Waste and inefficiency in the U.S. healthcare system, Clinical Care: A comprehensive analysis in support of system-wide improvements”
New England Healthcare Institute, February 2008

Economics 101 (and Healthcare Economics 101)

How did we get in this mess? How do we end up paying so much for health care and not getting what we want?

It’s a big question, and it’s at the core of the mess we are in. The convoluted way we pay for health care in the United States gives too many patients treatments that they don’t need, or treats them for conditions that could have been prevented with much cheaper care, or denies patients services that they actually need. How does this happen?

To answer this question, we have to dig into the actual structures of health care, and some of the basics of economics. And in that answer we can begin to see how we need to rebuild those very structures in order to survive and thrive beyond reform.

Why Doesn’t Competition Seem to Work in Health Care?

There certainly seems to be plenty of competition. For example, there are:

• thousands of hospitals of all different types (for-profit and nonprofit, free-standing and chain, general and specialty, teaching, children’s, public and private, military and veterans);
• hundreds of thousands of doctors in scores of specialties organized every way you could imagine (solo practice, small practice, large multispecialty practice, working for hospitals and health systems, running their own centers, or in cooperatives like Group Health of Puget Sound and staff-model HMOs like Kaiser);
• hundreds of health insurers;
• scores of pharmaceutical companies, device manufacturers and other health care vendors supplying bed pans, gurneys and ambulances; and
• thousands of pharmacy benefit managers, vendor certification companies, disease management agencies, consultants and other companies providing bits of outsourced management expertise.
Though there is plenty of regulation, on most levels of the system there is no central Soviet-style commission allocating resources and deciding who gets which customers. All these organizations are free to compete for the customers’ dollars.

Why, with all that competition, can’t most of us seem to get the care we need when we need it, where we need it, at a reasonable price? For most Americans, though we can see that modern medicine offers a nearly miraculous plethora of cures and therapies, our access to it through the care industry is often arbitrary, often so arbitrary as to be cruel. For those under 65, the price is often so high that even insured people can be one serious disease or traffic accident away from permanent poverty. And even when it works, it can be mind-blowingly inconvenient.

How can that be? How can a “free market” system so blatantly fail to serve its customers? Until we find the answer to that question, we will never be able to find our way out of this mess.

Let’s do a little basic analysis, a little Economics 101.

The Value Test

Every time you buy a shirt, a latte, or a stock, you ask a series of questions: “How good is this thing? How do I know? How much will it cost? To be specific, how much will it cost me? How much will it cost me, really? How much will the whole thing cost me? What are my alternatives?” Under our usual business models and payment structures, and without any way to get real information, most of those questions are unanswerable in healthcare. We have few real measures of value, few real prices, and little opportunity to even find out what “the whole thing” we are buying is. And the most common “alternative” is doing nothing.
As healthcare costs rise, more and more of healthcare’s customers (from individual consumers to employers, insurance companies, and government payers) are seeking ways to ask and answer these fundamental questions: How good is this? What does it cost? What are the alternatives? They will be increasingly basing their “buy decisions” on finding satisfactory answers to those questions. So organizations in healthcare that can answer those questions clearly and satisfactorily will survive and thrive; those who cannot will fail.

What does the customer want?

Health care is a business. Health care is the biggest business in the U.S., which is to say it is the biggest single business sector in the history of our species. Every business has customers. Some people object to calling health care a “business.” They want to think of it as a “service.” Many parts of healthcare are not-for-profit. But to really thrive, every business, for-profit or not, must think of itself as a service; and every service must think of itself as a business. It must think: Who are our customers? What do they want?

What do you want, as a customer of healthcare? I want four things:

1. When I am sick, fix me.
2. If you can’t fix me, help me manage it.
3. When I am not sick, help me stay well.
4. Be there when I really need you.

In general, healthcare is really good at the last of these. It’s there when we need it. That’s why our Emergency Departments are overflowing. The other three have far more spotty results.

If I am not getting what I want, chances are it’s because I am not the true customer. Those providing the services don’t really see me as the customer. Who is the customer?
What’s a customer? Customers decide that they want something, choose it and pay for it. You decide that a new TV would be nice. You look online, maybe, or go to a big-box store, maybe check out some local independent store. You find what seems a reasonable value for your money, and you plunk down the credit card. You’re a customer.

The customer is the key regulating part of any market economy. The customer is the reason you never see either a plate of scrambled eggs or a new car advertised for $1,000. It’s the customer that enforces all sense of value.

So what’s different between classic economics and health care economics? Classic economics pictures a buyer and a seller. There is a constant, dynamic feedback loop between the many buyers and the many sellers in a market that establishes not only what things cost, but even what’s offered for sale, and on what kind of terms.

Economics starts with this image of a marketplace: There are buyers and sellers, and some flow of information between them. They haggle, and a “market price” arises out of that continuing dynamic.

The core driver of all health care economics is the utilization decision, that is, people deciding to make use of some health care service. They get a new hip, take a new drug, get an exam, go in for a mammogram. The great majority of health care is insurance-supported, whether through government insurance such as Medicare, or through employers’ private insurance. And the great majority of health care is provided fee-for-service, that is, the health care provider (the doctor or hospital) bills the insurance payer for each separate test, procedure or prescription.

So what happens to that feedback loop in insurance-supported, fee-for-service healthcare? First of all, the buyer is split in two, into a chooser and a payer. The organization that pays the bill does not make the decision to use that particular service. So the feedback loop between buyer and seller is obscured. And the chooser and the payer have quite different agendas. If the payer is just there to pay, it can have only one goal: to pay as
little as it can get away with. It might set rules and payment schedules, but can never quite get it right, since it is really not there in the transaction, making the choice.

It gets even less clear: Who is the chooser? Who is deciding to use the service? Again there’s a split. The chooser is not the patient alone, but the patient (or the patient’s family) in consultation with the provider (usually the doctor). So again, and in a different way, the buyer is split. And the patient and the provider have very different stances. The patients have enormous “skin in the game”—great incentive to use whatever services might seem to help, since it’s the patients’ body, their pain, indeed often their life or death, that is on the line. The provider, on the other hand, has almost all the resources: the knowledge, expertise, equipment and access to drugs and therapies. And in any given transaction, the provider has far less skin in the game: this patient is one of hundreds or thousands. So the feedback loop gets even more obscured and tortuous.

It grows yet more murky: Who is the “seller?” Who is providing the service that is being sold? In most instances, it is the provider. The doctor who is advising the patient on buying the service is often either providing the service or working for the organization that will provide the service—or even owns it. You need a new knee. But you’re in luck, you’ve come to the right place, because I am an expert knee-installer. And the seller, of course, has a completely different agenda from the buyer. Any seller’s agenda is simply to sell as much as possible. So the feedback loop between buyer and seller becomes so tortuous and knotted as to be useless, and the system skews, as a normal part of doing business, toward selling the services that make the most money, and that get the seller in the least trouble.

Out of this we get markets in which, for instance, it can be very hard for a Medicaid recipient with diabetes to get (or even hear about) the nutritional counseling that might help her save her feet, but quite easy to get a surgeon to amputate her feet when her diabetes destroys them.
What Are Health Care Providers Paid To Do?

This may sound overly cynical. Many doctors would protest that they never offer a service just because it would make them more money. But, as one neurologist put it to me: “The more I care about my work, the less money I make. The way for me to make more money is to serve my patients less: Give them less time and attention, and cut them loose as soon as possible.” That’s a terrible bind to put our best medical minds in. Many doctors doubtless choose the path this doctor does: Do better work and make less money. But many doctors feel forced to make the other choice: Do poorer work and make more money. This is scandalous. Any improved system of healthcare has to find a way to compensate doctors well and fairly for doing the best work they know how to do.

It is important to remember the two core rules of economics:

1. People do what they are paid to do.
2. People do exactly what they are paid to do.

People notice in exquisite detail what makes them money and brings them success. They will not as a normal practice do things that cost them money, or put them at risk of getting in trouble. In health care, what brings a provider money and success is doing more of the procedures and tests that are well-compensated by payers, and doing less or none of the ones that are not well-compensated—and certainly never failing to do some test or procedure that might keep them out of a malpractice suit, whether the patient really needs it or not. And those well-compensated and malpractice-safe procedures and tests are only indirectly related to the four things we really want when we think we are the customer. **Almost no one in health care is directly paid to give us what we actually want.**

This is the core reason why the economics of non-integrated, fee-for-service medicine run counter to the expectations of classic economics in one crucial respect: Supply pushes
demand. Patients in the high-spending areas are not getting charged more per service; they are getting more services—more visits to specialists, more time in the ICU, more tests, more images—with no better results.

**The core driver**

The core driver of this revolutionary change emerging in healthcare is that the sector is getting clearer about who its customers are, and what they need and want and demand—largely because the customers are getting clearer and more demanding. They did not use to see themselves as “customers.” Now increasingly they do, with all that implies, and that will make all the difference. Individual consumers, because of high-deductible plans that give them more “skin in the game,” are much more inclined to question the value of any given expense. Employers are increasingly seeing that they can drive down costs by getting deeply involved in the health of their employees. And health plans, deprived of many of the “risk management” techniques that were core to their business models, are increasingly seeking other ways to differentiate themselves in the marketplace by bringing real value to their customers.

Who, finally, is the “customer” of health care? That’s still complex. Obviously the ultimate customer of health care is the individual with a human body—the employee, the patient, the rate payer, the citizen. But there are many proximate customers representing the individual—employers, health insurers, state and federal governments. And for many parts of health care, the proximate customer is some other part of health care. What is driving the revolution is that the major customers of health care—individuals, employers, insurers, and governments—are coalescing on the same set of desires: They want health care that works, that costs less, and that is accountable. And they are willing to pick and choose to get it, even willing to set up whole new business structures and payment systems to get it.

**What the customer wants, the customer will get, one way or another.** Though these emerging forces may take years to work their way through the healthcare marketplace, in the
end, they will prevail, and reshape the entire sector. Any healthcare organization that wishes to survive must figure out how to provide:

1. Healthcare that works, that provides the outcomes that the customers want
2. Healthcare that costs less, not just less per item, but less overall—a lot less
3. Healthcare that is accountable, that is truly measurable by the yardsticks that customers choose, and truly transparent

How do hospitals and health systems do that? In this new climate, they must excel at five interdependent imperatives.
The 5: A Framework

There are five imperatives for healthcare organizations in the new environment.

1: Explode the business model

Most of healthcare uses one business model, and always has: fee-for-service. Most other industries use variations on a strikingly different model: fee-for-outcome. When you go to a restaurant, you don’t pay the cook to turn on the burner or slice the pie. You pay for the outcome: a meal. When you travel, you don’t pay the pilot to go to 32,000 feet and lock onto the Chicago approach vector. You pay the airline for an outcome: to take you to Chicago. You leave the details up to the airline.

If the outcome is uncertain, and the path to the outcome is uncertain, then “fee-for-service” is the only way to pay for something. You go to a lawyer with a complex legal situation. She can’t guarantee any particular result. How much work, and what kind of work, it will take to get to any result at all is unknowable. So you pay the lawyer by the hour to do particular tasks, such as researching the case law and representing you in hearings: fee-for-service.

This is the model that healthcare has always worked in: Every case is different, every doctor is an individual, using their own judgment to arrive at a highly individual diagnosis and treatment plan. There is no way of knowing ahead of time what sort of tests or procedures might work, so you just have to do what the doctor says and pay for each test, procedure, drug, or consultation along the way.

But this image is simply false for much, if not most, of healthcare. For a fracture, a myocardial infarction, for multi-drug-resistant tuberculosis and a host of other presenting situations, there is a clear path to diagnosis and a standard, recognized treatment plan.

In the face of these marketplace pressures, we will see a proliferation of ways of working in healthcare. What we need, and what we can bet will arise, are disruptive ideas, disruptive
technologies, disruptive business models, and entire disruptive value chains—“disruptive” in that, to the extent that they provide solutions to the disjunctures and fissures of the current healthcare marketplace, they will shoulder aside our current business models.

In *The Innovator’s Prescription*, Clayton Christensen and his co-authors make a compelling argument that what is holding health care back from true innovation is a confusion of different business models within single institutions.\(^\text{15}\)

Porter and Teisberg,\(^\text{16}\) and Herzlinger,\(^\text{17}\) make similar arguments: Competition does not work in health care because of a confusion of business models. Put two health care systems in direct competition, and what they do is add services that are reimbursed well enough to make money, add specialists, jack up utilization as much as possible, and avoid as much uncompensated service as possible.


\(^\text{17}\) Herzlinger R, *Consumer-Driven Health Care: Implications for Providers, Payers, and Policy-Makers*, John Wiley and Sons 2004
possible. Done this way, competition between general hospitals and comprehensive medical systems helps drive the cost of health care up, not down.

Medicine comes in different flavors, Christensen et al. argue. Some diagnoses and some therapies have no settled pathway, and truly call for the intuition, experience and judgment of the best clinicians, ideally working in teams that bring different skill sets to bear on the same problem. Think migraines, depression, multiple sclerosis and most types of cancer. Call this “intuitive medicine.” On the other hand, there are broken bones, strep throat, type 1 diabetes, cataracts, and hip and knee replacements: conditions for which the diagnosis is certain and the clinical pathway quite clear. Call this “precision medicine.”

These two types of medicine have completely different pathways to value, so we will never be able to find that value until we separate them, each with their own business model. Intuitive medicine calls for a “solution shop” model, in which the right resources are gathered to look at your particular problem. Examples are M.D. Andersen for cancer; National Jewish in Denver for pulmonary disease, particularly asthma; the Texas Heart Institute; or the heart and vascular institute and the neurological institute of the Cleveland Clinic. Intuitive medicine must always be billed as “fee for service,” since both the level of resources needed and the outcome are unpredictable.

Precision medicine, on the other hand, calls for a “value-added process” model, much like a factory. You do one thing over and over and get really good at it. The project is well-defined, the outcomes highly expectable, the variations well managed. Such processes can be bundled into products, from diagnosis through rehab, including imaging, pharmaceuticals and counseling; and given a price tag and warranty. They can be billed on a “fee for outcome” basis, as the outcome is fairly certain. On such a targeted basis, you can get rapid improvement and lower costs.

Christensen et al. cite Ontario’s Shouldice Hospital, which does only hernia repair, as a four-day in-patient process on a country-club-style campus—and still charges 30 percent less than...
the U.S. CPT 49560 outpatient hernia repair reimbursement. And U.S. hernia repairs average 10 to 20 times the Shouldice’s 0.5 percent complication rate.

Besides laying medicine out on axes of “intuitive” to “precise,” we can imagine many separate types of medicine, such as:

- urgent care
- primary care
- mothers and children
- chronic disease management
- major acute management
- major body refurbishment
- managing aging
- late-life multiple system failure.

Here is the core argument that Christensen et al. make: In fee-for-service medicine, we treat all these different types of medicine as if they fell in the lower left corner of the diagram, in which the diagnosis, the work flow, and the path to treatment are all unknown, variable, intuitive, subject to judgment and trial. In fact, many cases and encounters are not like that at all: The diagnosis is easily and definitively established (“broken femur”), and the path to treatment is standardized (“set bone, install cast”). Such cases and encounters could be and, they argue, should be, billed and paid for under other business models. When all processes are lumped together under the wrong business model, it is impossible for the market to find the value in any one process, because there is no actual price for anything, nor any set measurement of value. When you can say, “Mrs. Smith, here’s the price if you have your baby here in an uncomplicated birth, and here are our patient satisfaction scores, and our medical quality scores,” then every process can compete to get better, faster and cheaper.
Emerging Business Models

Because the traditional fee-for-service model does not fit much of the actual need for health-care, many other models for health care delivery are already emerging, including guided patient networks (for patients with chronic conditions), the medical home, and clinical well-care. On the simple end, we are seeing an enormous growth in urgent care clinics (largely small, doctor-owned operations), which are essentially primary care operations that have extended hours and take walk-in traffic. Even in the midst of the current recession, the number of urgent care clinics has grown seven percent since 2007, and the first franchise chain of locally-owned clinics has popped up—Doctor’s Express, based in Towson, Maryland.\textsuperscript{18}

Retail clinics, mostly large chains associated with Wal-Mart or chain drug-stores such as CVS/Caremark or Walgreen’s, have slowed their growth in recent years, but are projected to resume rapid growth in the coming years.\textsuperscript{19} Retail clinics do a strictly limited menu of primary care items, such as coughs and colds and cut fingers, for set prices, and often take no insurance. We are beginning to see them help people manage their chronic disease, as well. For instance, CVS/Caremark’s Minute Clinics are launching an aggressive program of supporting customers with diabetes by doing A1C tests on demand, as well as showing them how to test their own blood glucose levels and administer insulin.\textsuperscript{20}

Another example of a strikingly new business model in health care is MDLiveCare.com. You want to talk to a board-certified doctor, or a licensed

\textsuperscript{18} W Price, “Urgent care clinics carve out a key health care niche,” \textit{USA Today}, October 10, 2010

\textsuperscript{19} “Retail Clinics: Update and Implications,” Deloitte Center for Health Solutions, November 2009

\textsuperscript{20} Interviews with CVS/Caremark executives, January 2010
mental health professional, right now, by phone, email, chat, or web-cam videochat? That will be $59.95. Sign up, and you get the better deal—$9.95 per month, $99.95 per year, each call is $39.95 and the first one’s free. For $129.95 per year you can include your whole family in the deal, and the first two calls are free—and they can do lab work, fill prescriptions, and keep your medical records, too.

All three of these business models not only save the customer costs on each encounter, they save system costs, as well, since many of the encounters are substitutes not for ordinary primary care visits, but for ER visits. A RAND Corporation study published in *Health Affairs* in September 2010 showed that some 17 percent of all ER visits in the U.S. are for conditions that could be treated in retail or urgent care settings. If they were, that one shift would save the system $4.4 billion.\(^{21}\)

**Employer-based business models**

Employers are realizing that they can save money by improving the health of their employees, and are getting aggressive in finding ways to do that.

Take, for instance, Boeing’s experience. In the spring of 2010, Boeing announced the results of a 30-month trial of an “Outpatient Intensive Care Program” in which 750 employees with multiple chronic conditions were given intensive personal attention from multi-disciplinary clinician teams to help them manage their disease. Boeing has a lot of high-value employees, especially hard-to-replace aircraft engineers. The company is concerned not only with medical costs, but with turnover, disability, productivity, and absenteeism. Boeing is self-insured (with the plan managed by Regence Blue Cross Blue Shield), so any improvements in cost drop straight to the bottom line.

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\(^{21}\) W Price, “Urgent care clinics carve out a key health care niche,” *USA Today*, October 10, 2010
The experiment was a collaboration between Boeing, Regence, and several major healthcare providers in the Seattle area, mostly multi-specialty practices that Boeing had worked with before. Over the course of the test, in comparison with a control group of 750 with similar health profile and the usual access to healthcare, and counting the cost of the clinician teams, the intensive effort saved 20 percent of their healthcare costs.

Twenty percent cost reduction on “frequent fliers” with multiple conditions is a big result. This is not just another “insurance program.” It is a business model, in which Boeing is paying the healthcare providers in a different, packaged way, with performance guarantees built in.

Such a success does not go unnoticed. As experiences and results like Boeing’s become better known among large employers, we will see many more examples like this.

**Onsite clinics**

Some employers are turning to onsite clinics which are, as the website of WeCare TLC clinics puts it, “Not your grandfather’s company doctor.” The number of companies with onsite primary care clinics has been growing, with nearly a third of the Fortune 500 companies having one by 2009. But their growth stalled with the recession, except for one segment of that market.

Clinics built on an advanced model designed to drive patient health continued to grow. The WeCare TLC clinics, for instance, use onsite nurse health coaches, evidence-based medicine, full digitization, registries, and an array of other tools to become “fully-realized medical homes and integrated full-continuum medical management machines located in the front end of the care delivery system,” according to Brian Klepper, WeCare TLC’s Chief Development Officer. The chain will have expanded to 13 onsite clinics in five states by the beginning of 2011. Klepper claims that, depending on the local situation, clients who install a WeCare TLC clinic can expect a rapid 25-35 percent reduction in healthcare costs.
The business model is simple: The client pays the up-front costs to install the clinic. One client, for instance, is the union for the civilian laborers at a submarine base in Georgia. The capital cost of installing the clinic was less than one month’s healthcare costs for the union. Once it’s up and running, WeCare TLC bills the client for the actual itemized cost of running the clinic, from salaries to drugs, plus a management fee. There is no insurance involved, but for a self-funded employer, much of the employees’ regular utilization of outside doctors goes away, because the clinic is so much more convenient.

The model offers something for everyone. The employee still has their usual array of choices. They can use their insurance to go to whatever doctor they want. But if they go to the onsite clinic, not only is it far more convenient, but there is no co-pay, and no payment for pharmaceuticals. Experience shows that employees with such a clinic are much more likely to stay on track with their chronic syndromes. The employer gets not only a lower and better-controlled healthcare bill, employees take less time off for doctor visits, and are less likely to be absent for problems that were not adequately taken care of up front. The doctors involved typically make more money at the clinic than in a regular practice, especially since they waste no time arguing with insurance companies or filling out forms. All they do is treat patients. This is the combination we are looking for across healthcare: Better health for less money.

The rule of thumb in the past has been that an onsite clinic only makes sense when the employer has a minimum of 750-1000 employees at a single site. With aggressive medical management and scalable hours, WeCare TLC has made it work economically at sites with as few as 62 employees.22

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22 B Klepper, WeCare TLC; W Montoya, Montoya Benefits; Presentation at Health 2.0, San Francisco, October 7, 2010
B Klepper, private communication, October 15, 2010
Could this model, a clinic, fully paid for by the client entity, structured as a “integrated full-continuum medical management machine,” work for Medicare patients, Medicaid patients, people in convalescent homes, or as a different type of Federally Qualified Health Center? There is no reason why it could not work for any population, as long as the population is relatively concentrated, and some entity is at risk for their healthcare costs. Even insurance companies are likely to warm to it as part of their offering, as it is a way that they can offer better healthcare for less money to employers and employees.

A pharmacy-based business model

HealthMapsRx is also a partnership with employers to improve the health of employees. But the partners are networks of community pharmacists trained to be “health coaches” for employees of local businesses with chronic health problems. The pharmacist gives the employee’s physician a report after every visit, and refers any problems that need attention to the appropriate clinician. A year-long test, the “Diabetes Ten-City Challenge,” concluded a year ago, showed that even simple coaching could save an average of seven percent of total healthcare costs (counting the costs of the program). The pharmacists helped the employees track their A1c, blood pressure, and cholesterol, and manage their disease through exercise, nutrition, and changes in lifestyle. And it seems to work: The employees improved on every metric from A1c scores to body mass index and eye exams.

That’s a lot of success on the cheap. Pharmacists are well-deployed throughout the community, and feel a lot more available than doctors and nurses—and the cost is zero to the employee and minimal to the employer.
The HealthMapsRx diabetes program is now expanding nationwide, supported by Glaxo Smith Kline and the American Pharmacists Association, which is running similar programs for asthma, cardiovascular disease, high cholesterol, and osteoporosis.23

**Insurer-based business models**

CIGNA Choice Fund: Every year-end for several years now CIGNA has released the results of participation in their “Choice Fund” consumer-directed health plan (CDHP). In January of 2010, for instance, CIGNA reported that employees enrolled in the CIGNA Choice Fund, compared with those enrolled in their more traditional plans, incurred 14 percent lower medical costs. People with specific chronic conditions did even better—15 percent lower for diabetes patients, 21 percent lower for people with joint and back pain, and 27 percent lower for people with high blood pressure. And this is key: The employees did not save money by skipping medical care. People on both types of plans were equally compliant with treatment regimens. The difference in cost seems to spring from better management of the chronic conditions, and more careful use of preference-sensitive services.

The business press regularly reports their results as proof that CDHPs lower healthcare costs and improve employees’ health — but that’s getting the story wrong. The CDHP alone is not what works. What works is using the employees’ “skin in the game” as the basis for a comprehensive program of incentives and massive clinical and information support aimed at behavior change, education, preventive measures, and control of chronic syndromes. The programs vary from market to market, even from one employer to another, and often involve contracts with specific healthcare providers to deal with specific types of problems. Employers pay a small amount extra per year for the extra support, expecting that they will be able to recoup the extra payment in lower costs over time.

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23 HealthMapsRx.com
CIGNA’s star example is Safeway, a large employer with a very different employee profile from Boeing. But the rough shape of the CIGNA program is not all that different from the Boeing experiment: A malleable, intensive, ad-hoc partnership between providers, employers, and a health plan, aimed at driving down the costs of health care for specific employee populations. Again, this is a different business model, in which healthcare providers get paid for different packages of services than in a simple fee-for-service model.

**Medicaid-based business models**

One more example. If you were to look around, as an entrepreneur, for a way to make money by helping some population be healthier, what populations would seem like the “low-hanging fruit”? Would you think, “Ah, yes! Frail, elderly people on Medicaid in state-supported convalescent homes! And kids on Medicaid with disabilities!” Probably not. And yet that is exactly what happened in Illinois. McKesson’s disease management subsidiary contracted with the state to provide its Your Healthcare Plus services to just such populations. Teams of doctors, nurses and case managers, many of them on-site across the state, working with the patients’ existing providers, measurably improved the health of these patients. Counting the costs and fees for running the program, **McKesson saved the state of Illinois $307 million in the first three years of the program**—by giving people more services of the right kind of care and attention, not less. 24

**Change the scoreboard**

Competition has generally not worked in healthcare to bring the customer better

24 McKesson Corporation case study, “Illinois: McKesson Program Generates $300+ Million Net Savings in Three Years,” 2010
healthcare for less. But in some places it has. When the Dartmouth Group on Health-care and the Institute for Healthcare Improvement collaborated to find the hospital referral regions with the best cost/quality combinations, or the best improvements, some of their top examples had fierce competition between health systems. In Lacrosse, Wisconsin, for example, two health systems battle for patients and revenues; Richmond, Virginia, has three; Sacramento, California, has four.²⁵

What was the difference? The systems, of course, competed to maintain their financial viability. But importantly, they did not keep score by such top line measures as gross revenues or sheer size. They incorporated serious measures of how well they served their customers, and how well their bottom line could do by serving those customers really well.

**Structure matters**

These solutions are structural. The ordinary structures of health care, with doctors, clinics and hospitals in strict fee-for-service relationships with payers, have great difficulty acting as if the patient is a customer.

If we are to get out of this mess, we need to tweak those old structures and build new ones. That’s why we are seeing fascinating, weird experimental structures arising across health care—“extended medical home” PHOs, and “virtual accountable care organizations.” And that is why almost all of these are new forms of partnerships, ad-hoc contractual relationships that cut across the traditional structural lines to deal with the health of particular populations. The contracts set up incentive relationships that guarantee that someone makes a profit specifically by tending to the real needs of the patient, not just by providing services to the patient. And they are all over the place, taking different shapes to fill niches in the vast ecology of health care.

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²⁵ Institute for Health Improvement, “How Did They Do That?” conference, July 21, 2009
Hospitals can form these OWAs (“other weird arrangements”) in all kinds of shapes, from at-risk contracts with insurers or CMS, to shared-risk medical-home arrangements with PHOs, to disease-management contracts with government agencies. And increasingly they are, across the country, because in the new environment the overburden of high cost and low capacity is killing us. We simply must find more efficient and effective ways of serving our customers.

What all these structures have in common: They pay healthcare providers directly to work in teams to save healthcare dollars by improving the health of specific target populations.

Structure matters. The old attitude toward business models was that there was only one: Fee-for-service. “I do a service, I get a fee. I do two services, I get two fees.” The emerging attitude is that there are many business models, both simple and complex, working with different customers who have different objectives. With the right structure, you make money by saving money. Help the customers meet their objectives, and you get paid for it.

The acronym

Now of course nothing can happen in healthcare unless it has a proper name and, especially, an acronym. My name for the class of all these emerging structures is “Ad-Hoc Hybrid Semi-Mayo Not-Exactly-HMO Kinda-Sorta Accountable Care Organization Business Model,” or “AHHSMNEHMOKSACOBM.”

That’s a bit of a mouthful, though. So for the moment let’s just call them VACOs: Virtual Accountable Care Organizations.

The future trajectory of VACOs

We’re going to see a lot of this. VACOs will start out as an option for large, self-funded employers (as in the Boeing experiment), then will be replicated and mass-marketed by aggressive health plans to medium and small employers and government employers. The shift will likely be quicker than we are used to in health care because VACOs now offer a tested
model that leads directly to higher profits for private employers over a relatively short term.

VACOs will likely be built into the health plan exchanges as they are deployed in 2014 and after, soon becoming a standard option in all health plans and a major way of competing among health plans. As VACOs show good results in the private market, health plans will find ways of offering them under Medicare. The success and cost differences eventually will be so large that employers will stop offering other alternatives, and Medicare will offer sharp incentives for participating in a VACO—using every resource at our command to help people be healthy will have become the standard model of health coverage.
2. Integrate

If you’re thoughtful, if you’re thinking about how health care in the United States actually works; if you’ve been following the bouncing ball here about why it costs so much for such mediocre results; if you’ve been thinking about all the partnerships in the examples in the previous section, you’re thinking: Integrate. Get the docs and the hospitals playing on the same team. Align the incentives.

If you’ve ever tried any version of this patchwork, Rube-Goldberg-style, bee-corralling exercise, you’re thinking, “Good luck with that.”

Acres of print in *Health Affairs*; the entire suite of studies from Dartmouth’s Institute for Health Policy and Clinical Practice; the books just mentioned by Porter and Teisberg, and Christensen, Grossman and Hwang; “The Cost Conundrum,” Atul Gawande’s justly famous article in the June 1, 2009 *New Yorker*; the writings of Regina Herzlinger, Elliot Fisher, Don Berwick, John Wennberg, Karen Davis and a host of other thoughtful analysts—all have somewhat differing prescriptions for fixing the mess we are in.

But all these sources, and my examination of systems across the country, and countless discussions with health care executives and economists, make it abundantly clear that the answer (or answers) lie in the direction of some kind of integration. The organizations in U.S. health care that seem to work best, that provide the highest quality health care at the most reasonable cost—the organizations that continually pop up as examples of healthcare done better, such as Pennsylvania’s Geisinger, with its warranties; Intermountain Health; Kaiser Permanente; the Bozeman Clinic; the Mayo Clinic; and the Cleveland Clinic—all work from some form of integration.

In many markets across the country, health care institutions are hiring physicians by the boatload, because many physicians are desperate to find a way to make a living, and many
health care institutions are desperate to rationalize their patient flow. But a hired physician is not an integrated physician.

And a hired physician is often not a productive physician. More than one health care CEO I have talked to has used the phrase “dead men walking” to describe hired physicians, usually older physicians with long-established work habits, suddenly released from decades of having to grind patients through the mill in order to make a living, now “retired on the job.” Truly integrated care runs much deeper than a paycheck. It’s a philosophy and a way of life, and not every physician is ready for it.

At the same time, physicians who have sold their practices often end up regretting it. The litany of complaints is long and brutal, and most of them speak to how tone-deaf hospital managers can be. Doctors complain that they are not paid fairly. They often are surprised to see that they no longer get income from in-house imaging, and they may discover that the fine print says that they are on the hook for all their old receivables. They are surprised to be told that their practice is a money-LOSER in need of subsidy, though it was profit-able when they owned it—it’s the burden of the hospital’s overhead that is causing all the red ink. Doctors find their practice shifted across town, away from their patient base—then find them-selves blamed for not bringing in enough patients. They may find their hours shifted, the patient burden randomly increased, or their longtime assistants taken away, all without consulting them. And once they regret it, they may find that they can’t get out of the agreement without moving out of town, because they signed a “non-compete” agreement as part of the sale.

But it is no news that if you do something badly it doesn’t work—and there are a thousand ways to integrate with physicians.
Many faces of integration

How should you integrate with physicians? Every which way. That's the real, pragmatic answer: Every way that works with the organization you have, the resources at your command, the payers in your market, the physicians in your area, and the physicians you could likely attract to your area.

True clinical integration can make an enormous difference in outcomes. To take just one example, Kaisern of Northern California set out 10 years ago to lower the rate of heart attacks among its members. They put a crew on it: A set of clinical teams who worked toward that single goal. Over the last decade, they were able to lower the rate of AMIs by 24 percent, and serious AMIs requiring hospitalization and surgery by 68 percent. That’s good work.

Geisinger in northeastern Pennsylvania is integrated, working mostly with its own physicians. But its insurance company, Geisinger Choice, insures many patients of independent doctors in the area. Geisinger went to these independent primary care physicians with a deal: We will place and pay for an extra nurse to work in your office. Her sole job will be to track your chronic patients. We believe we will save money by doing this. We will share the savings with you 50/50, if you promise to spread that rebate out across your whole staff. The result? An 18 percent reduction in hospital admissions for those tracked patients—and a seven percent reduction in their overall healthcare costs.26

North Shore/Long Island Jewish has been offering a deal to independent doctors in its area: You want to digitize your office? We'll pay half. But if you do it in a way that allows us to share your data, so that we can track what works and what doesn’t in dealing with chronic disease, we'll pay 85 percent.

The old image of partnering with physicians was that there was only one model. It was simple, loose, and voluntary. The emerging image of partner-

ships is that there are many models, simple and complex, and they are contractual, and built to the purpose of an over-arching business model with specific goals and incentives.

**Lessons from Those Who’ve Tried**

There is no clear roadmap to integration. GPS doesn’t work on this frequency. But we can make useful observations, drawn from the experience of CEOs who are attempting it.

**Public obstacles.** Integration is a legal minefield. A broad movement to integration may require changes in the Stark Laws and in HIPAA, as well as clarifying leadership from the anti-trust division of the Department of Justice. Christina Varney, Assistant Attorney General for Antitrust, has said, “Antitrust is not an impediment to legitimate clinical integration and should not be a concern to those contemplating such efforts.” In some states, integration will need reform of Certificate of Need laws, as well as laws against the “corporate practice of medicine,” and the “emolument” of physicians by providers. Such laws tend to cast in stone traditional assumptions about the proper business model of healthcare institutions—assumptions that often work against the best interests of patients and citizens by limiting what institutions can do to meet their needs.

**Structure and ownership.** Partly for these legal reasons, the structure of integrated systems is often quite complex. Kaiser of Northern California is actually three self-owned entities with interlinked exclusive contracts: the financing arm (Kaiser Foundation Health Plan), the doctors (Permanente Medical Group) and the facilities and staffing arm (Kaiser Permanente). Group Health Cooperative (an affiliate of Kaiser) is owned by its members, with an exclusive contract with its doctors, in their own Permanente Medical Group—but it includes a complex nest of other institutes, health plans and other relationships. Intermountain is similarly complex—and complexly inter-related.

27 quoted by Mark McClellan, MD, PhD, in “Potential Federal Support for Community Initiatives,” a presentation for the “How Will We Do That?” conference, Institute for Health Improvement, May 27, 2010
For large-scale, serious change, don’t assume that the default business model, in which the health system owns everything, is the right model. You may need some over-arching entity, or a series of inter-related entities, or joint ventures with limited scope. Even on a local or regional scale, health care is not a simple problem, and it is unlikely to yield to one big solution.

**Big tent.** Market dominance helps. Even substantial breadth in your market helps. Trying to regionally integrate physicians and services in a highly fractured market is a more difficult proposition. In whichever area you choose to work—an ortho JV, a micro-capped chronic care service—you need to have enough of the physicians with you to make it work. A fractured market allows the physicians more possibilities to play the market against you.

**Financing.** Having your own health plan helps clinical integration. A key thing to notice about Geisinger’s bundled, warrantied procedures is that they are available only through the Geisinger Choice Health Plan. Other payers won’t go there yet. Capturing some part of the local health plan market allows you to offer bundled products, “micro-cap” products for chronic conditions and even full, Kaiser-style capitation.

**Be aggressive.** If your goal is true clinical integration, do not open your health plan to other providers in the area unless they work with you toward that goal. Having control of a financing mechanism that competes well regionally gives you a tool to entice other organizations into clinical integration that reaches beyond institutional walls.

One small example: In one region where I consulted recently, the number of MR and CT scans equaled eight percent of the population per year—a huge number, it would seem. How many of these were redundant, did not need to be done? Who knows? There is no way for clinicians to share images regionally, or even between their own clinics and the hospitals where they also work.
**Speed and crisis.** It’s hard for anyone to change when they seem to be succeeding. And no matter what we say, no one is really “open to change.” Change makes everybody a beginner, and who wants to be a beginner again?

The current sense of crisis—the current financial crisis for everyone, and the sense of crisis in health care and the looming implementation of reform—makes everyone’s sense of the future more fluid, and lowers confidence in present arrangements. That sense of crisis is likely to continue for some years, as the financial crisis works itself out, as the *sequelae* of reform work themselves out, and as physicians find themselves in increasingly untenable positions. This fluidity will not last. The time to move is now.

**Piecemeal works.** Integration does not have to happen all at once. In fact, it probably can’t. The logical place to start is with a primary care network. The logical pool of customers to reach out for is, first, your own employees, then the employees of large employers in the area.

**Partners.** It would be normal in most markets to realize that there are some things that you should offer (and maybe are already offering), but that you don’t do all that well. And your customers deserve, and need, nothing less than world-class medicine. One answer to this conundrum is partnerships—affiliations, on the one hand, with world-class specialty institutions that can help you staff and run a cancer center, for instance; and on the other hand, partnerships with specialty providers in such well-defined areas as behavioral medicine, long-term care and rehab.

**Story.** Every Moses needs a promised land, and it’s got to have milk and honey. If you are attempting to shift your health care system to a more integrated model, you must be able to consistently create a story, to articulate a vision (a sense of where you want to go) and how it benefits everyone—the customers, the medical community, the local employers, the payers, the regulators. You must do this even if you are not sure exactly how you’re going to get there, or what all the pieces look like, or even who’s going to be in charge. Leaders are not necessarily about answers; they are at least as much about questions and challenges.
There are only a few compelling things that any business must do to survive: Get the product right. Get the price right. Get the costs down. Get the branding right. In the usual "general hospital" business model, we don’t have products, we just have menus of services. We don’t control the pricing. We can’t control the costs, because we have confused cost-accounting. And the “We do everything for everyone wonderfully” branding doesn’t help, because it doesn’t attach to anything real, any particular product, outcome or price. People don’t believe it because they can’t—there is no real meaning there for them to believe.

**Explode the business model and integrate**

Take a look at the alternative business models we talked about in the last section: They all require a different, more integrated relationship with doctors. We will see as we move forward that none of these five imperatives is independent. Each one needs the other four to make sense.
3. Share risk

The right balance of risk—accountability—is the life or death of any economic system. Every business transaction involves risk—what if the product is not as good as advertised, what if it breaks, what if the project over-runs its projected cost? Risk can be seen as friction in the system. Allocating risk within a system is as important as allocating payments, because every actor in a system will do whatever they can to minimize their risk.

Most products and services come with warranties or guarantees of one kind or another. If the product breaks or fails as soon as you use it, it will be replaced: The manufacturer takes the risk that the product works as advertised. This takes a great deal of friction out of the market (people are much more likely to buy the product) and pushes the manufacturer to make a product that will work, and won’t break.

In traditional, insurance-supported, fee-for-service healthcare, the personal risk is all on the patient—if the system fails the patient, there is little the patient can do. Even the malpractice system fails to help the vast majority of patients who are hurt. But the financial risk is all taken by the payers—employers, insurance companies, and government. Whether doctors and hospitals could make a good living had little to do with whether they did a good job, served their patients well, or came up with new and innovative ways to serve them even better. If a treatment went wrong and the patient got an infection or had to have the surgery done over, in fact, that was just more income for the hospital and the physicians involved.

This imbalance of risk is a cancer at the core of the healthcare system. Where there is no real risk, there is no accountability, and there is no accounting for value, so there is no real price.
A brief history of risk in healthcare

Thirty years ago, insurance paid the full price demanded by doctors and hospitals, and Medicare rates were based on whatever was “usual and customary” in a given market. There was no attempt at all to cap prices, much less to measure the quality of what was delivered.

In the absence of any market pressure prices, of course, rose rapidly. In the early 1980s, to combat this, the government instituted DRGs—diagnostic-related groupings—to establish set prices for a cardiac artery bypass graft, setting a broken bone, or prescribing an antibiotic for an ear infection. Private insurers soon came up with their own lists of payments, based on the government’s DRG payments. This transferred some risk to the providers. But it was a small risk. If they could keep their overall costs below their overall reimbursements, with a lot of shifting of costs from one payer to another, they were good to go. And there was no rating of quality, or outcomes, or appropriateness. As long as the provider had a medical justification for a procedure, and the right code, they could charge for it.

In the 1990s, as the Clinton healthcare initiative failed, a new fad arose in the battle to control costs. Insurers looked at Kaiser and other staff-model HMOs (health maintenance organizations with salaried doctors on staff) which combined the insurance function with the clinical delivery. The organization took in one premium payment from the individual (or the individual’s employer) and provided whatever the individual needed, from a flu shot to brain surgery. In this “captivated” model, the HMO took on financial risk of delivering the promised healthcare for the price of the premium. “Ah!” said insurance companies, “Perfect! HMOs! That’s what we’ll do! We’ll call it ‘managed care’ and do it a little differently. Since we have all the risk anyway, we’ll be like Kaiser and control the clinical side as well, and drive down costs. Bingo!”

This was actually a good idea—but it is not what they did. ‘Managed care’ turned out to be a quite a different animal. The “HMOs” that the insurance companies built in the 1980s were not
real, staff-model HMOs. The doctors did not actually work for the HMO. There was no clinical integration, there were no teams, there was no tracking of quality or outcomes. What there was, instead, was cost control by contract, with primary care physicians installed as gatekeepers to specialists and all services beyond the primary care office, and all physicians working at discount rates. Physicians were paid bonuses to deny treatment by other physicians. It was called “managed care,” but there was no real care management, only cost management. It was just a variation on the same business model insurance companies had always had: Avoiding risk by avoiding treatment whenever possible. Patients hated it, doctors hated it. It was, in fact, exactly the kind of interference with clinical medicine by Soviet-style functionaries that the insurance companies had told the public that healthcare reform would bring. We had a Soviet-style system, it was just outsourced to the private sector. Once consumers and employers experienced this form of discount healthcare, the rush to “managed care” slowed, and the hunt continued for a true, systemic way to find value in healthcare.

Only in the last 10 years have we seen the slow growth of more subtle and flexible ways of truly spreading risk appropriately among patients, providers, and payers.

**Bundling and pricing**

Hospitals have already seen the first level of taking on risk: DRGs and other mechanisms that set a fixed price for each procedure and test: So much for each office encounter, so much for an MRI, so much for a complex back-fusion surgery.

The next level is bundling: Take all the tests and procedures that go into a whole episode of care (an uncomplicated birth, a knee repair, a cholecystectomy)—from anesthesia to imaging, from diagnosis to rehab, from bed nights to pharmaceuticals—put it in one package, call it a “product,” put a price on it, and publish the price. “We charge so many dollars for
cardiovascular stenting, so many dollars for a hip replacement.” A single price, a single bill, just like any other business.

Obviously, no hospital could bundle and price everything they do. But most of the work done in a hospital is routine processes with set boundaries. We know what it takes to do a mitral valve replacement or a bariatric surgery. We know what the pieces are, and what they should cost.

**Warranties**

The next level of accepting ordinary business risk is to warranty your work.

A warranty is not a guaranty. A guaranty promises a good outcome: “If you don’t get the outcome we promised, we will refund your money.” That’s why they are rare. A beer commercial may show handsome young men drinking beer with beautiful young women, but the beer company won’t refund your money is you drink their beer and still can’t get a date. A warranty simply says, “We stand by our workmanship. If you have any problems with our product, we will make it right.” If the steak arrives burnt, the restaurant replaces it. If the patient develops an infection after an operation, or if the replacement valve develops a problem, the hospital will repair the problem at no extra charge.

Express or implied warranties are the norm in business. In fact, this is why you can go to CostCo or your local car dealer, buy something and expect that at minimum it will work. Plug the toaster in, it turns on and doesn’t blow up.

Until now, healthcare has been the one exception. Doing sloppy work and causing the patient a further problem typically just meant more business, another operation, more time in the hospital bed, more medications, all of it paid for.

Now Medicare and private payers are becoming more demanding. Increasingly they are refusing to pay at least for re-admits of the same patient for a related problem within 30 days of
discharge. But hospitals have to turn the tables on this, establish express warranties as a matter of policy, and use that fact not only as a marketing tool, but as a lever to drive quality through the organization – because you can’t warranty a product if you can’t control the quality of your output.

**Caps**

The ultimate acceptance of risk in healthcare is capitation. Like Kaiser, capitated organizations take in a set premium for each patient, and in turn provide all their healthcare needs. This seems like a good idea: Put the provider at risk for the patient’s health, and the provider will bend every effort to figuring out how to keep the patient as healthy as possible, as efficiently as possible. That’s why Kaiser-like organizations are called “health maintenance organizations.” In staff-model HMOs, doctors are paid to work in teams, and to be both efficient and effective.

As an example of the difference this makes, let me tell you one tiny story. I am a longtime Kaiser patient. Recently I discovered an odd bump on my hand. I suspected it was no big deal, but I wanted to be sure. I called Kaiser and got an appointment with my own doc for the next afternoon. It turned out that I was right: The bump was no big deal. But before I left the exam room, she had pulled up my entire patient record, inquired into every single condition I had from my asthma to my bum knee to my blood pressure medication, scheduled me for a yearly lab test I had been forgetting about, discussed my diet and exercise regimens with me, and given me two vaccinations—all in about 25 minutes.

In a strictly fee-for-service world, in which the doctor is paid per visit, few doctors would have tried to cram that much action into one visit, nor would they typically have had the resources for it (such as having the vaccines, lab records, and full patient record ready to hand). And I probably would have not bothered to come in for most of them, so my health would be worse off, and in the end the doctor would not have made the money for those extra visits, and I would cost the system more money with my worse health.

Still, capitation is not a total solution. The big problem at the core of capitation is simple: The provider can never really take on all the risk for the patient’s health.
provider can never actually take on all the risk for the patient’s health. Much of a patient’s health is determined by the patient, by their habits and lifestyle, what they eat and drink, how much they exercise, whether they see the doctor, whether they take their appropriate meds. An active and determined provider can influence some of that behavior, but they certainly cannot guarantee it. So putting all the financial risk on the provider puts the provider at risk for things they cannot fully control.

A capitated system is constantly seeking the right balance of incentives to get patients to lower their risk. In recent years Kaiser has instituted co-pays for most services: If you overuse the system, it’s going to cost you. At the same time, Kaiser has gotten extremely active in tracking patients, getting them to come in for maintenance and preventive care, and making preventive care as convenient as possible (often through mail-in home lab tests).

The second major problem with capitation is that it is really hard to get it right. Most fully-capitated systems are generations old. Kaiser and Group Health of Puget Sound go back to the 1940s, the Geisinger system a generation earlier. They require from doctors, as well, a different kind of commitment and a different mindset from the usual fee-for-service work. Morphing into a fully-capitated system is not a realistic possibility for most hospitals and health systems.

**Partial capitation**

What is realistically possible for a hospital system is to take on some capitated contracts, so that some percentage of your patients are capitated. This exposes the system to being at risk for the health of patients, and drives into the system the kind of systemic thinking, the kind of focus on efficiencies and effectiveness, that you need when you are at risk—while mitigating the actual amount of risk, and the difficulties of getting it right. The key thing to notice here is that healthcare processes are a system: If you have to redesign the systems to be more efficient for the capitated patients, you don’t
pull out the old, inefficient system to use for the non-capitated ones. The efficiencies driven by capitated risk apply to everyone across the system, not just to the capitated population.

**Mini-caps**

The other way to take on a modulated amount of risk is to take capitated contracts for certain chronic conditions: A diabetes-care subscription, for instance. For a set annual fee, we will give you all the diabetes-related care you need. The amount and types of care needed for a particular chronic condition is fairly well known and quantifiable. And since such care usually actually reduces the patient’s overall healthcare costs, an annual subscription is usually attractive to a payer at risk for that patient’s care.

Mini-caps have the same systemic effects as partial capitation: They tend to drive into the system the necessary learning about how to be efficient and effective.

**Why?**

Risk and rewards drive behavior. If any player in a system is not doing what you think they should be doing to make the system work well, chances are they are not getting rewarded, or put at risk, in a way that matches their effect on the system. Or they are not noticing what their risks and rewards really are.

A patient that over-uses the system has no financial risk. Their costs don’t change whether they use it or not. A patient that under-uses the system does not see how they are hurting themselves. A healthcare system that does its best to drive maximum use of the system, getting the most bodies into scanners and beds and surgical suites, is not at risk for the health of those patients, and is only given incentives for doing stuff to them. **Balancing risk appropriately across the system allows the system to drive itself toward value.**
New business models, integration, shared risk

Once again, notice that these three parts of the framework link closely. You can’t warranty a product or service unless you have some control over its production. Warrantying a healthcare product means that you have to be working closely with the physicians, integrated in some way with them, probably in some new business model. Bundling, pricing, capitation, mini-caps, all depend on tight coordination between different parts of the production system.

Sharing risk depends upon integration of some kind. Integration and shared risk, together, form the basis of many new business models.
4. Build from primary care upward

Every healthcare system worldwide that delivers healthcare better and cheaper than the U.S. system has a stronger primary care sector. This is by design. Specifics in the policies of other governments support the primary physician.

Our primary physicians have been left to languish. The difference in income between primary care physicians (PCPs) and specialists is huge: The average PCP earns 55 percent of what the average specialist earns, and a mere 30 percent of what (for instance) an orthopedic surgeon does. Only 27 percent of PCPs describe their practice as “robust” and satisfactory. PCPs are flocking to sign on with hospitals; hospital employment is rapidly becoming the norm, with an estimated 40 percent of active PCPs to be on hospital payrolls by 2012.

Every year the medical schools produce fewer doctors who elect to go into primary care, at the very time when demographic shifts and the reform act mean we are facing a massive shortage of primary care docs. But the money is not actually the main thing burning docs out of primary care. It’s the burden of the work.

Medicine is becoming increasingly complex. The average Medicare beneficiary sees seven physicians across four practices in a year; which means the average PCP is

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28 Data on these two pages from “Blueprint for the Medical Home: Transforming Primary Care to Improve Practice Economics, Care Coordination, and Patient Engagement,” Innovations Center, Advisory Board, 2010

29 Data includes Family Practice (without OB), Internal Medicine, Pediatrics/Adolescent Medicine. “Physician Compensation and Production Survey 2008,” based on 2007 data, Medical Group Management Association


31 Health Care Advisory Board 2008 Survey on Physician Employment Trends
trying to coordinate care with 229 other physicians across 117 practices.\textsuperscript{32}

As health planner Andrea McKillop recently put it to me, “The primary care physicians I know are seriously bent out of shape, but it’s less about the money than about the burden of work. Scheduling patients in ten minute increments does not allow them to give the kind of care they want to. They’re upset that some specialists don’t appear to give a whit whether they ever get back to them about their patients; they’re upset that they don’t have good places to refer people for things like inpatient rehab; they’re upset that they have to fight insurers to get their patients appropriate, timely, and reasonable medications, treatment, and secondary and tertiary care.”\textsuperscript{33} And on and on. These are, indeed, the complaints I hear across health-care, all over the country. The job of primary care physician has become not only not very remunera-tive, it has become nearly impossible to perform. All of the changes that would make health-care work better, faster, and cheaper begin with making the job of the primary care physician easier, more streamlined, and better connected both to the patient and to the rest of the healthcare world.

\textbf{The Medical Home}

The “medical home” rubric does the job—if it is done right. The experience of different systems across the country show that it can seriously improve clinical quality, improve the economics of primary care, and make both physicians and their patients happier.

The phrase means far more than just “be a good doc.” The goals of the medical home are pretty clear: Give each patient a real, personal relationship with a physician who leads a team responsible for that patient’s care—all their care, whether acute, chronic, preventive, or even end-of-life. Coordinate their care with specialists, hospitals, long-term care centers, however

\textsuperscript{32} Pham, H. et al., “Primary Care Physicians’ Links to Other Physicians Through Medicare Patients: The Scope of Care Coordination,” \textit{Annals of Internal Medicine}, 2009, 150:236-242

\textsuperscript{33} Private communication, the Well (www.Well.com), 10/12/10
they get care. Track their care (especially their chronic problems) using disease registries and comprehensive medical records. Use information technology to support evidence-based medicine. Involve the patients and their families in decision making. Have open scheduling and expanded hours and other ways of making it more convenient for the patient to get care. And pay for all this by a combination of enhanced fees for visits, special per-person per-month payments, pay-for-performance incentives, and gain-sharing payments from payers who save money.³⁴

To compare the ideals of the “medical home” model to what is too often the regular experience of primary care doctors and their patients:

<table>
<thead>
<tr>
<th>Medical Home</th>
<th>Common traditional experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-centered</td>
<td>Not sharply focused on what the patient wants and needs</td>
</tr>
<tr>
<td>Team-based, using other team members “at the top of their license.”</td>
<td>Doctor generally does all the care</td>
</tr>
<tr>
<td>Tracked</td>
<td>Chronic patients often lost in the shuffle</td>
</tr>
<tr>
<td>Coordinated</td>
<td>Communication with other parts of the system difficult, slow, incomplete, and sometimes non-existent</td>
</tr>
<tr>
<td>Information-dense</td>
<td>Information-sparse. Patient often feels uncertain what test results or diagnoses mean. Physician often lacks information from test results, specialists, or hospital encounters.</td>
</tr>
</tbody>
</table>

³⁴ [Link](http://www.medicalhomeinfo.org/about/medical_home/index.aspx)
Evidence-based | Based on physician’s previous training, habits, and memory
Transparent | Opaque to the patient and family
Convenient | Convenient only for the physician

It seems like a tall order. Yet various pilot programs have shown that it can be done: All this can be given to the patient, while the physician makes a better income. It takes organizing it, and understanding it. A great deal of information about how to build a medical home, the economics of medical homes, and the requirements for rating medical homes is now easily available.35

Medical homes have been built in many different parts of healthcare, structured in many different ways. Hospitals can help establish them with physicians in their employ, physicians in physician-hospital organizations (PHOs) the hospital starts, or by assisting independent physicians understand and implement the necessary changes in their practices. Medicaid programs have sponsored medical-home projects in some states; employers have sponsored them. Some have been designed for specific medical populations, such as people with diabetes, or “frequent fliers” in Emergency Departments.

**No set price**

The experience of practices that have implemented “medical home” models show that the size of the investment can vary enormously. For example, the Capital District Health Plan in Albany,

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The Advisory Board has put out a thoughtful, comprehensive guide: “Blueprint for the Medical Home: Transforming Primary Care to Improve Practice Economics, Care Coordination, and Patient Engagement,” Innovations Center, Advisory Board, 2010.

New York, founded and run by physicians, decided to pilot the medical home idea in three practices, based on a risk-adjusted capitated payment model. To make the transition, the physicians invested in an EMR system, and hired an extra nurse practitioner, another RN, a data manager for the EMR and registries, a half-time nutritionist and a half-time social worker. Integrated Health partners of Battle Creek Michigan, took the opposite tack. A 180-physician PHO jointly owned by the Calhoun County Physicians and Battle Creek Health System, it moved to a medical home model (specifically the Wagner’s Chronic Care Model) by leveraging existing staff and using an open source disease registry.36

The Health Care Advisory Board has estimated the added annual costs of converting a practice to a full “medical home” model at $10,500-$52,100 for a sole practitioner leveraging existing staff, and $126,00-$346,500 for a five-physician practice hiring two RN health coaches.37

You can convert a practice to a medical home model on the cheap. On the other hand, in the experience of most practices trying it, investing in it up front is faster, and gets you more quickly to the increased revenue that it will bring in.

**Revenue opportunities**

In a well-structured medical home, the costs are more than offset by additional revenue. Consider Mercy Clinics, a 150-physician group (70 percent primary), employed by Mercy Medical Center in Des Moines, Iowa. They estimated a four-to-one return on investment from hiring RN health coaches. The coaches got chronic care patients more compliant on treatment,
which meant more office visits and tests, upcoding of office visits to greater complexity, and better documentation. The Health Care Advisory Board’s example analysis of one of the Mercy Clinics (a 10-physician practice) showed increased annual revenue of $122,000 from increased diabetes care and testing, $114,000 from pay-for-performance bonuses, and $15,000 from saved nurse and physician time, against costs of $73,000 for health coach staffing, $10,000 for a more expensive microalbumin test, and $5,000 for a more expensive HbA1c test, for a total bottom-line contribution of $163,000. The basic “business case” for the medical home includes increased office visit revenue, increased lab revenue, increased clinician productivity (by having all clinicians operating “at the top of their license”), shared medical appointments, and capturing pay-for-performance incentive fees.38

New business models, integration, shared risk, primary care

Once again, it is important to notice how the support of primary care through the “medical home” rubric ties into the other parts of the framework. The medical home can be seen as a method of appropriately sharing risk with primary care physicians, paying them appropriately for taking on that risk, and rewarding them for actions that result in better outcomes. Supporting and standardizing a “medical home” model among primary care physicians in your area is definitely a strong method of integrating them clinically and economically with your system, even if they remain independent. The whole idea of the “medical home” proposes a number of new business models, new contractual business arrangements that will support the medical home to make healthcare better and cheaper at the same time.

“Blueprint for the Medical Home: Transforming Primary Care to Improve Practice Economics, Care Coordination, and Patient Engagement,” Innovations Center, Advisory Board, 2010
5. Rebuild the production system constantly

Healthcare is a production system, a massive one with very high demands and expectations, huge and exacting transfers of information and material, meticulous manufacturing and processing needs—and until recently almost no introspection about processes. In most of health-care even now we do things the way we do them because that’s the way we’ve always done them, or that’s the way it’s convenient for this or that doctor, or for thousands of other reasons that have little or nothing to do with “that’s the most efficient, effective way to get this done. We know because we have tried other ways and measured the result—and we’re still looking for better ways.” Healthcare, in its core processes, is enormously wasteful, simply because its processes have never been studied and improved.

The new management toolkit

Lean management, the theory of constraints, benchmarking, six-sigma process quality, checklists, continuous performance improvement—a whole array of tools have been tested and refined in other industries, and are beginning to gain a foothold in healthcare. Their successes, when applied diligently and enthusiastically over time, have been remarkable and measurable.

To take just two examples:

- Seattle’s Virginia Mason, for instance, famously devised its own version of the “Toyota Production System,” dubbed the “Virginia Mason Production System.” Over just a few years it drove inventory down by half, lead time by 53 percent, while driving productivity
up 44 percent (the equivalent of hiring 77 new full-time employees), and saving some $12-15 million per year in capital costs.\textsuperscript{39}

- Seattle Children’s in-patient psych ward cut length of stay in half (from 20 days to 10), and increased the number of kids it could help from 400 to 650 per year, without adding new beds, all while patient satisfaction rose. The hospital as a whole cut per-patient costs by 3.7%. It estimated its savings in 2009 at $23 million — while serving 38,000 patients, a 41% increase just since 2004, with no new beds.\textsuperscript{40}

**Digitization and automation**

We are only in the first stage of digitization and automation in healthcare. And much of the work that has gone into it so far has only slowed down healthcare. If you simply run your current processes through a computerization machine, without using the new communications and computing environment to design new processes, you’ll actually make medicine and healthcare harder, slower, and more opaque.

If a digitized process in healthcare takes longer than its pen-and-paper equivalent, it is badly designed. Ask yourself this: Does sending an email take longer and cost more than writing a paper letter and mailing it? Is bookkeeping slower, less productive, and more prone to error on QuickBooks than by hand? Nothing should take longer in a digital form. Any vendor that produces a system that, once the users get used to it, is more difficult or takes longer than what it replaced, should be run out of business by discriminating buyers – and hopefully soon will be.

Automation is similarly in its infancy in healthcare. All sorts of repetitive, exacting tasks in healthcare, from the pharmacy to the lab to image retrieval to security to mopping the floors, are beginning to be automated. Automation, applied appropriately, brings the same increase in

\textsuperscript{39} R Bohmer, E Ferlins, “Virginia Mason Medical Center,” Harvard Business School case study, October 3, 2008

\textsuperscript{40} J Weed, “Factory Efficiency Comes to the Hospital,” *New York Times*, July 9, 2010
quality and speed and drop in costs to healthcare that it has brought to every other industry.

**Ideal Medical Practice**

We need more doctors, and especially a stronger primary care sector. How can we quickly create more? By making better use of the ones we have. Some physicians have been experimenting to discover how inexpensively and efficiently they could run a primary care practice. The results were published in a series of articles in *Family Practice Management* in October, 2007, and February and April, 2008, under the rubric, “Ideal Medical Practice.” They found they could greatly reduce costs, see more patients, spend more time with each patient, spend less time at work, and take home more money each week.41

**Cheap software**

Physicians are used to being told that it will cost them multiple tens of thousands of dollars to digitize their offices with expensive, proprietary software. **This is a myth.** A range of cheap new software packages are changing that mind-set. For instance, Doctations is a complete physician practice package, from images to patient records to order entry to insurance qualification, billing, and appointment scheduling, designed by doctors for doctors, and beta-tested with both doctors and patients, all for a monthly subscription of $187.42

Practice Fusion is a similar package, complete with Chart Share and Patient

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41 Available at: [www.aafp.org/fpm](http://www.aafp.org/fpm)

42 Doctations.com
Fusion, interfaces allowing other doctors and the patients themselves to access the medical record on line – all for free, supported by advertising.  

While many programs have been given tablet and mobile faces (like Epic's Canto), the most interesting developments are cheap software suites designed from the ground up for the mobile environment, like ClearPractice’s Nimble, and DrChrono. These include a full EMR/EHR, images, e-prescribing, paperless billing, dictation, scheduling, lab results, in short a whole medical practice on a tablet. You can even re-design the interface if there is something about it that you want done differently. For security purposes, the program needs a login after any period of non-use, and all the data is stored behind a secure firewall in the cloud. If someone steals an iPad, they get an iPad, nothing else. One business option for DrChrono is unusual: Do your billing through them, for which they take three percent off the top, and the whole thing is free.

**Old and new**

Get really serious about driving your costs down and quality up by aggressively managing your production system. You may think that what you offer is done as lean and mean as possible. I guarantee you, you are nowhere close. If you don’t do it, in a consumer-driven healthcare world, someone down the road, or across the country, or in another country, will be perfectly happy to.

The old attitude toward process management schemes was dismissive: Don’t need ‘em, don’t want ‘em, get out of my face, it’s all just the management buzzword of the week. The theme song was Sinatra’s, “My way.” The new attitude: It’s what we do, it’s the way we do it. Every

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43 PracticeFusion.com

44 DrChrono.com ClearPractice.com
day, everywhere. It’s like a spiritual practice: computerized records, patient registries, follow-ups, handoffs, checklists, baked-in accountability, teamwork at the core.

**New business models, integration, shared risk, primary care, new processes**

Once again, notice that every other part of the framework depends upon having the administrative chops, the process management chops, and the technical chops to run your processes with precision, transparency, and total control. You can’t support primary care unless you can streamline its processes. You can’t appropriately share risk unless you can track outcomes and results. You can’t integrate if you can’t communicate. And you certainly can’t build flexible new business models unless you can fine-tune the processes in them and communicate in real time what is going on inside them. The five pieces of the framework are a unified package.

With these five strategic thrusts working together, hospitals and health networks will be able to transform themselves from lumbering, confused, often chaotic congeries of mis-matched pieces into lean, accountable, manageable, nimble organizations that will truly serve their customers – patients, employers, health plans, and government. When the customers respond by adapting themselves so that they can effectively be good shoppers and buy real value, we will see the virtues of market competition come to the fore. Healthcare will cease being the stubborn standout of industries, one that has magically suspended all economic laws, and begin to conform to that core economic belief that in the end you do get what you pay for. We will get healthcare that is better, faster, and far cheaper than the healthcare we have today.
Next Steps and Resources

Next steps

This document is the framework for what’s to come. It’s the place to develop your thinking and your planning for your organization’s place in the next healthcare. Where do you fit now? Where do you want to fit? Which roles are you prepared to embrace?

First, you have two fundamental choices.

1) You can wait to act while learning to track the trends and the business innovations so that you’ll be prepared to act later.
2) You can grab the bull by the horns; prepare to act sooner and use the leverage you have now.

Either way, you need the big picture and references to help you read the field and the opportunities. And you need a way to choose and develop your plan.

No matter what you do, you’re deciding. It’s either by default, or it’s with help and planning and the determination.

I’ve been in this fight now for many years. I’ve been sounding the alarm and providing guidance to the movers in healthcare. I’ve also been trying to awaken the sleeping. Now everyone’s waking up and more are joining the Next Healthcare every day.

So where do you go from here?


Re-setting your strategy

The Change Project, Inc. (http://www.TheChangeProject.com) and its project on building the next healthcare, Imagine What If (http://www.ImagineWhatIf.com), can help get your mind
around this stuff and where you fit in it, through consulting, board and executive retreats, speaking, and educational materials like this. To help you get your feet on the ground and to get your hands dirty with the application of these ideas, we are developing assessments, workbooks, and the other tools you’ll need to create your version, your model for yourself in the next healthcare. We also have resources and references we are constantly collecting, from years of interviews, networking, reporting, consulting, and speaking on healthcare. If there’s someone doing what you want to do, chances are we know who they are or how to find them.

We are learning all the time so you can get to the front of the line with your organization. It’s a new world. Let’s make it so we like it.

Background learning

Publications that can give a deeper understanding of the background thinking behind the Framework include:

**Papers by the “Dartmouth Group,”** researchers (mostly physicians and statisticians) centered on The Dartmouth Institute for Health Policy and Clinical Practice. The Dartmouth Group, whose best-known authors and analysts include John Wennberg, M.D., Ph.D. and Elliot Fisher, M.D. Wennberg is the pioneer and leading researcher of unwarranted variation in the healthcare industry. A collection of the Dartmouth Group’s seminal papers is available here: [http://content.healthaffairs.org/cgi/content/full/hlthaff.var.112/DC1](http://content.healthaffairs.org/cgi/content/full/hlthaff.var.112/DC1). There are various technical arguments about the details and conclusions of the work of Wennberg and the Dartmouth Group, but the cumulative weight of two decades of studies is, I believe, undeniable: There are large variations in the cost of healthcare in different areas that do not correspond to better outcomes, and that cannot be ascribed to differences in the health of the populations, socioeconomic status, state regulation, or any other relevant marker except for variations in the structure of the local medical marketplace.

Michael Porter and Elizabeth Olmstead Teisberg: *Redefining Health Care: Creating Value-Based Competition on Results*, Harvard Business Press 2006. Competition and competitive advantage guru Porter and healthcare analyst Teisberg attack the problem of why competition does not seem to work in healthcare to bring value to the customer. Their answer: There is competition in healthcare, but it is at the wrong level, over the wrong results, for the wrong customer. Business models that made their money by bringing measurable value (outcomes per dollar) to the end customer (the patient) would bring true competition to bear on healthcare.


Clayton Christensen, Jerome Grossman, M.D., Jason Hwang, M.D., *The Innovator’s Prescription: A Disruptive Solution for Health Care*, McGraw-Hill 2008. Christensen, yet another Harvard professor, is author of *The Innovator’s Dilemma*, which popularized the idea of the need for “disruptive innovation.” Here, with two physicians, he analyzes healthcare. The upshot, as detailed earlier in this book, is that the primary business model of healthcare (insurance-funded fee-for-service) does not match the needs of the healthcare market. Like Porter and Teisberg, they find that an array of business models that delivered value in various healthcare niches would greatly shift the marketplace of healthcare for the better.
Idea farms

Once you begin exploding the business model and trying new things, you’re constantly on the lookout for new ideas, from the nuts-and-bolts level to the strategic level. Here are a few places that I look to for ideas.

The Health Care Blog (http://www.thcb.com), founded by Matt Holt, has consistently focused on the leading edge of change in healthcare, with a fairly agnostic style, welcoming all comers. The blog has a number of guest bloggers in addition to Holt, from across the industry, and is known as a place where people trumpet new ideas, pilot projects, enlightening studies, and provocative points of view.

Health 2.0 conferences (http://www.health2con.com) As the web site says, “The Health 2.0 Conference is the leading showcase of web-based and mobile technologies transforming the healthcare system.” It is also a showcase for emerging ideas about the system as a whole, not just about its technology. Spawned by The Health Care Blog, and run by Holt and co-founder Indu Subaiya, Health 2.0 conferences typically happen in the fall in San Francisco, then in the spring somewhere else in the world. As the web site again puts it, “Health 2.0's original tag line of ‘user-generated healthcare’ contains the germ of a compelling idea—patients are using new tools to guide their own care. And now those tools are starting to integrate with the health care system.”

Institute for Healthcare Improvement (http://www.ihi.org/about) Founded by IHI was founded in the late 1980s by current CMS administrator Don Berwick, M.D., a pediatrician, and a group of visionary individuals committed to redesigning health care into a system no longer plagued by errors, waste, delay, and unsustainable social and economic costs. Especially in recent years, it has generated an extraordinary array of practical knowledge, results from the field, guidelines, and “bundles” of best practices that can be profoundly useful in the fifth part of this framework, “Rebuild the production system constantly.”
The Role of the Physical Environment in the Hospital of the 21st Century: A Once-in-a-Lifetime Opportunity (available at http://www.imaginewhatif.com/wp-content/uploads/2010/10/FutureHospitalPhysicalEnvironment.pdf) This extraordinary 2004 paper was written by Ulrich, Zimring et al. as a report to The Center for Health Design for the Designing the 21st Century Hospital Project and funded by the Robert Wood Johnson Foundation. This dense meta-study scanned several thousand studies of hospital safety design practices, reduced that to the 600 that met criteria of rigor and high impact, then correlated and compacted their results into 26 pages of very direct prose, 10 pages of references, and a 30-page bibliography for further study. Those 26 pages tell you exactly what is known as a result of rigorous study about the clinical impact of such design decisions as single vs. double rooms, placement of hand-washing stands, and positive- or negative-flow ventilation design. This paper is an important and serious companion to any attempts to rebuild the clinical production system.

Building the medical home


The American Academy of Family Physicians (http://www.aafp.org/online/en/home.html) has its own helpful, clear guides and toolkit.

The Advisory Board has put out a thoughtful, comprehensive guide: “Blueprint for the Medical Home: Transforming Primary Care to Improve Practice Economics, Care Coordination, and Patient Engagement,” Innovations Center, Advisory Board, 2010.

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