The Opportunities During Transformation: Moving To Health Care 2.0

by Greger Vigen

The health care industry is racing towards the long-awaited, but somewhat feared, industry transformation. Given the gigantic health care industry, the transformation will create significant change across the entire economy. This will change the support and services personally delivered to you. There will also be profound changes across all organizations.

Underlying this transformation is a wealth of new and powerful resources. The best minds in the country have been working to create powerful new solutions and prepare for this transformation. Early adopters are moving very rapidly toward Health Care 2.0—a new, powerful and productive health care system. Other players are settling for smaller, incremental improvement over their historic approaches, but increasingly they find themselves falling behind.

This paper will briefly outline the driving forces, and then primarily focus on the future of health care.

Forces Driving Transformation

This transformation is driven by the same powerful forces that create any transformation.

- Financial pressures overcome inertia to drive implementation of innovations.
- Major innovations in technology and new competitors create high potential for improved personal service and/or economies of scale.

Financial Pressures

Dire financial pressures are forcing the fast pace of this transformation. The latest forecast from CMS is that health care will rise to 17.6 percent of Gross Domestic Product (GDP) in 2009. This 1.0 percent increase over 2008 would be the largest single-year increase in history.

The employer-based health system—which historically provides a foundation for health care funding in the country—is being overwhelmed. Rising costs create higher member contributions. Enrollment drops. More people are uninsured. Providers raise prices to offset uncompensated care. This creates another round of rising costs and a rapidly accelerating downward spiral.

The current financial situation creates enormous energy. And, unlike previous years, there is unprecedented realism among the key players (government, hospitals, physicians, insurers and employers). These key players are working as we speak to define the positions and negotiate terms on the variety of major health care reform options, such as single vendor or mandatory individual insurance.

Solutions for financing and taxing health care are highly complex and require intense negotiations. The deteriorating financial situation creates a major impetus for change, but these options are not the focus of this paper.

Major Innovations

Industry expertise, systems resources and clinical support have never been stronger. New, powerful tools are available, such as electronic medical records, or modern techniques for member engagement and decision support. Leaders are using a much broader paradigm: from claims and disconnected services to a powerful concept focused on health and accountability.

At the same time, the financial situation has created a renewed energy to investigate long-standing fundamental questions about reimbursement systems and industry collaboration.

How will the future health care system work? What is different?

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LEADING EDGE PRACTICES

Evolving Concept	Historic	Future
Evidence-based management of hospital and acute care	**Slow** Results from clinical trials and innovations from disconnected pockets of excellence disseminated slowly. Occasional rapid distribution by collaborative medical societies, proprietary vendors, Veteran's Administration or accountable organizations. Major improvement in quality metrics from market leaders.	**Rapid and consistent** The wealth of innovation and leading-edge practices delivered rapidly to medical professionals. National and local disease registries. Comparative effectiveness analysis and professional guidance that indicates both underuse and overuse. Widespread use of major innovations, such as: – Major leaps in case management and chronic care – Hospitalists and intensivists – Predictive modeling – Leverage non-clinical staff
Payment reform (structure of reimbursement)	**Pay for basic production** Primarily fee-for-service reimbursement that rewards volume and discourages accountability and collaboration. Discourages powerful role and accountability for primary care physicians. Alternative reimbursement structures and pay-for-performance in parts of the industry (including various Medicare demonstration projects, Medicare Advantage, HMOs and a variety of Pay-for-Performance programs).	**Pay for value and results** Reimbursement aligns incentives and encourages results and appropriate care. Higher collaboration and accountability for cost, quality and resource use. New approach to primary care physicians—may include both reimbursement changes as well as systems support, training and/or implementation. Multiple reimbursement structures are targeted to each particular clinical need—including episode payments, bundled case rates across physicians and hospitals, capitation and limited reimbursement for preventable clinical complications.
Program management	**Uneven** Accountable provider organizations in 15 percent of the country manage their programs very differently from the rest of the country.	**Leading-edge practices and continuous improvement** Leading practices are reviewed, evaluated and customized, such as: – Leading-edge practice acute care management – Outpatient and pharmacy management – Lowest net cost rather than highest discount – Hospital/physicians/insurer collaboration – Appropriate mix of primary care and specialist – Selection of physician and clinical staff – Feedback, implementation and training – Discipline unproductive staff
Health Information Technology Single data record for personal and clinical use	**Disconnected** Multiple, disconnected sources for individual health information. A few key organizations have several years of experience with comprehensive electronic health records.	**Connected with customized feedback** Broad adoption of an integrated, comprehensive and secure data record for individuals, physicians and clinical staff through electronic health records. Reports customized to the audience: – Deep clinical results for physicians (lab, disease registries and evidence-based reminders). – The same information simplified for patients in a personal style. Done with appropriate security.

Continued on page 79

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LEADING EDGE PRACTICES *Continued from page 78*

Evolving Concept	Historic	Future
Measurement systems	Claims plus selected quality measures Measurement an expensive afterthought Historic techniques focus on selected quality measures or financial measurement of type-of-service. DRG measurement used for inpatient care. Growing use of episode measurement. Extensive measurement and provider feedback in certain locations.	Integrated database from claims, clinical results and disabilities to HRA responses Measurement creates improvement New integrated data bases provide foundation for complete measurement and improvement system. From tracking trends in illnesses to monitor cost drivers, predict illness, monitor results and provide feedback to improve quality and resource use. Broad use of powerful tools including episodes of care, gaps in evidence-based-medicine compliance, risk adjustment, severity and effectiveness of health engagement. Results are measured and communicated to end providers and individuals.
Industry Collaboration	Major turf battles Unclear roles and responsibilities across different industry sectors. Duplication of effort and ever-increasing complexity to gain financial advantage.	Clear roles and responsibilities Defined roles and responsibilities for each different sector. Authority and payments directly connected to responsibility. Stronger, collaborative working arrangements mimicking accountable care organizations. Administrative savings through reduced duplication and less unnecessary complexity.
Personal engagement (compliance, lifestyle changes and preference-sensitive conditions)	Uneven support Population health drops. Personal support for disease management and some lifestyle primarily through two options (boilerplate material or expensive direct contact). – Often only to people who can be easily reached. – Monitoring of results is uneven. – Compliance flat except for leaders. Obesity rising.	Personalized and systematic support Population health improves. Personalized support that is clear and powerful. These programs include member decision support, customized reminders and skill building. – Delivered immediately at the right moment in their life. – Builds upon health risk assessments, readiness-to-change and adult learning. – Multi-media communications pre-tested for effectiveness and customized to personal characteristics. Material "mass customized" to create economies of scale. – Results are monitored with personal feedback to member or provider if needed. – Higher compliance, lower obesity and smoking.
Personal responsibility	Limited Many individuals uninformed and isolated from personal responsibility. High expectations about power of medical care.	Targeted responsibility (as appropriate) Clear personal responsibility where individual behavior makes a difference. Transparency in areas where personal responsibility is needed. Higher engagement and compliance. More realistic expectations.

The leading-edge practices described above are not mythical vaporware. Many were developed and refined during the last three years and tested by a handful of early adopters. So, the early work has been done and the outlook is promising.

Implications

But, lots of work remains. On a personal basis, the first steps are simple. Get up to speed on what is happening and determine how you might get involved.

For successful organizations, given the large magnitude of this transformation, a more formal and focused plan is needed. Key steps include:

1. Monitor the external environment (essential during industry transformation).
2. Inventory, validate and prioritize leading-edge practices.
3. Approach potential allies.
4. Measure the current situation and inventory current capabilities.
5. Build analytic capabilities.
6. Integrate old and new programs into a comprehensive approach.
7. Evaluate obstacles and develop responses.
8. Develop a change management process.
    a. Vision and leadership
    b. Operations
    c. Transition management plan
9. Develop timeline.
10. Implement.
11. Ongoing feedback to providers, individuals and management.

Summary—The Future Is Near

Given the major forces in the environment, change is certain and the pace is accelerating. The challenges are daunting. However, for those willing to invest the time and energy, this presents an enormous opportunity that only comes once in a lifetime.

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