Thriving through the Transformation of American Healthcare

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The next five years will be very challenging times for healthcare administrators as they must work
to maintain a clear vision and an inspirational voice amid the turbulent currents and complex
dynamics of change. The bad news: almost no aspect of healthcare will remain in its current state.
Historical trend analysis will be of little value in this new age; a realization that is discomforting at
best. The good news: if each component of care or delivery attribute is evaluated independently,
the direction is fairly clear. The real challenge is to remain objectively honest in the face of great
emotional stress, the turbulent politics of change, and a constant barrage of new information.

Future market evolution scenario work sessions can help facilitate such honesty and work
particularly well in the current environment. Such exercises are not an attempt to predict the
future, but rather, the creation of highly probable futures in the present. The goal is to turn
evolving and conflicting data into insightful discussions and, ultimately, to intellect actionable
information. You know a scenario work session is going well when a participant openly states “Yes I
can see how that could occur... and therefore what we must be prepared for in response”.

These work sessions have allowed our planning team to define high probability futures at the
micro-level, predicting hospital mergers, practice acquisitions, and Chapter 11 federal bankruptcy
filings. At the macro-level, we have been able to define the mildly probable Chief Justice John
Roberts ruling on the ACA’s insurance mandate, the highly probable re-election of President Obama
by a wide margin, and the inability of Congress and the President to come to agreement by January
1st to avoid sequestration.

Future market planning sessions should begin with a list of general assumptions about the direction
of healthcare. Do not focus on the time frame to a particular transition or the date of a milestone
event during the initial philosophical discussion. Instead, keep the discussion at a high level with
general statements that easily establish a consensus. These undeniable truths may include:
• The federal budget deficit is untenable; tax rates will be going up for a large number of citizens and the growth in annual Medicare expenditures will be reduced.
• Acute care delivery will evolve from the traditional hospital-centric model offered today to a distributed model based on levels of acuity.
• The majority of healthcare services will be provided in a range of ambulatory settings; however, inpatient services will remain a crucial cornerstone in the continuum of care.
• The financial pressures and incentives to reduce inpatient utilization, procedure volumes, and diagnostic testing will grow exponentially.
• The ultimate direction of inpatient volumes at any given hospital will be determined by the size and socioeconomics of your senior population.
• Information interconnectivity across all components of care will empower the medical home model; connecting patients, physicians, clinics, hospitals, pharmacies, and therapists.
• Profitable growth will be increasingly challenging to achieve. There may be some services or entire service lines that are no longer viable, or some components of care that need to be outsourced.

The next level of discussion should clarify the implications of the Affordable Care Act, both generally, at the state level, and within a specific service area. Some really big changes are scheduled for the next four years. List these initiatives on the board, discuss them around the table, and begin to talk about implications. Beginning in 2014:

• Insurance companies can no longer charge the sick more than the healthy; and there will be no more pre-existing condition exclusions.
• Individuals who do not get insurance will have to pay a tax penalty, but it’s minor. Initially the penalty is the larger of $95 or 1% of your income, but grows to $695 or 2.5% of your income by 2016.
• Insurance will be required to cover a standard set of services, with no annual or lifetime limits. A larger percentage of hospital charges will be covered for patients covered by traditional non-group policies.
• The federal government will soon offer two health insurance plans nationwide in all states, through exchanges. One of these plans will be offered by a non-profit entity.
• An expanded Medicaid program will cover those individuals with incomes below $14,400 and families with incomes below $29,300. The federal government will finance 100 percent of the program initially, and 90 percent in the longer term.
• Except for those states that refuse the expansion of Medicaid (an option due to the Supreme Court ruling), well over 90% of all citizens will eventually have health insurance coverage.
• Thirty-two million newly insured Americans assure a dramatic reduction in the self-pay percentage at most hospitals.

Although aspects of the ACA will continue to be debated, there will be no repeal. These are the hard realities of a new business model; a solid foundation from which hospital administrators, designers and providers can challenge some traditional paradigms and pull people out of their comfort zone. The following statements are not meant to be contentious, but will typically raise some eyebrows and blood pressure levels.
We will eventually employ all of our physicians with a salary structure that does not incentivize additional tests and procedures.

A small independent community hospital will not survive without a big brother to provide the capital, clinical resources, and continuum connectivity.

Although expanded health insurance coverage will significantly reduce the self-pay percentage, it also reduces the possibility of meaningful revenue growth.

Financial survival is directly tied to the ability to reduce costs and establish a margin under Medicare payment.

We cannot provide profitable inpatient care under Medicaid payment; we must design a system of care to keep patients healthy and out of the hospital.

At this point, the discussion may appear all over the map on topics and issues. Where do we begin, how do we focus the team, and how do we make substantive progress? Returning to the service line level, selecting high volume procedures and defining specific market opportunities is a good starting point. Key statistics like service area population, utilization rates, market share, and Medicare margin, and some basic quantitative analysis can provide remarkable insight and determine the metrics for historical market dynamics and detailed future scenarios.

### Total Knee Replacement

<table>
<thead>
<tr>
<th>MSA Middle America</th>
<th>Historical Market Demand</th>
<th>Future Market Scenarios</th>
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<td></td>
<td>Cases Per 1,000 Population by Age Cohort</td>
<td>Quantify Multiple Forces of Change:</td>
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<td>Utilization Rates Significantly Below National</td>
<td>ACOs / Medical Homes / Aging Pop</td>
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<td></td>
<td>Economic Recession Slowed Surgical Growth</td>
<td>Aging Boomers Drive Rates Up Incrementally</td>
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<td><strong>Population Age 15 - 44</strong></td>
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<td>Use Rate / 1000 Pop</td>
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<td>Total 15-44 Cases</td>
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<td><strong>Population Age 45 - 64</strong></td>
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<td>Use Rate / 1000 Pop</td>
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<td>Total 45-64 Cases</td>
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<td><strong>Population Age 65 &amp; Older</strong></td>
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<td>Use Rate / 1000 Pop</td>
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<td>Total 65+ Cases</td>
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<td><strong>Total MSA Cases</strong></td>
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<td>Total Knee Market Share</td>
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<td>Regional Med. Ctr. Cases</td>
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<td>Patient Origin Percent</td>
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<td><strong>Total RMC Total Knees</strong></td>
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<td>Medicare Margin</td>
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The above template begins to frame the orthopedic market and provides significant insight into the total knee segment of the business. The boomer population (45-64 year olds) generates the same volume of business as the over 65 senior population. Surgical utilization rates are below national averages (a positive), and will continue to grow albeit at a slower rate. A population of half a million people generates 1,600 cases annually. Finally, the Regional Medical Center dominates the service area with over 87% market share. Future growth will only come from expanding the geographic service area.

For healthcare administrators, it’s time to stop pacing the halls and acknowledge physician alignment is the toughest job in America. Some have drawn similarities between managing a
medical staff and coaching a professional sports team. Both are attempting to develop a well-oiled machine with highly skilled and well paid professionals. We would argue coaching is a cake walk compared to physician alignment. There are no video tapes to watch after a performance, the season is twelve months long, and there are few multi-million dollar administrator salaries.

There are plenty of potential penalties, but no time outs. As soon as you schedule a kick-off and get the ball rolling the game is on. Select your team members carefully, a minimum of eight and no more than twelve. A combination of seasoned professionals and those new to your organization; several from the frontline balanced with a couple managers. At least one staff member from each component of the continuum must be included. Let’s hope it’s not the first time “the team” is together in the same room.

You are the coach. It’s time to ignite your planning process at the service line level. The questions are complicated, the answers are simple: shared sacrifice, compromise, and negotiation. Those three directives are an appropriate mantra for this transformational time; whether we are talking to our team in Washington, in the locker room, or in the medical staff lounge. Honest assessment, resourceful adaptability to change, and a clear eye to multiple futures will frame your ability to thrive in the next five years and beyond.