

The Footbridge from Today to Sustainability

A Roadmap for Health Systems on their way from their Current High Fixed Cost Models to a Markedly-Altered Future

A Medically Home White Paper

MARKET FORCES PLACING SUSTAINABILITY PRESSURE ON HEALTH SYSTEMS AND THEIR FIXED COSTS

The inconvenient truth is that the current U.S. healthcare delivery system is unsustainable and all enlightened stakeholders know it. Large and growing pressures on reimbursement sources are colliding with the increasing costs of medical care delivery, while regulation and compliance activities continue to grow and constrain innovation.

Cannibalization of traditional hospital-based services by more-nimble providers with superior cost and service models (e.g. ambulatory surgery centers and free-standing radiology and diagnostic centers) have eaten-away at hospital volumes. As hospitals inevitably see their volumes decline, they struggle with how they will spread their large fixed cost burden across a reduced revenue reality.

After many years of paying for hospital-based care through a fee-for-service model, Medicare, the largest payer in the health system, is driving new initiatives to improve cost and quality. These initiatives include: penalties for short-term hospital readmissions, value-based pricing initiatives and bundled payments. These initiatives create concurrent demands to reduce costs while improving quality. This clinical + financial improvement objective is a tough assignment for health system management, especially with hospital volumes continuing to decline, while fixed costs are growing with the addition of new programs designed to meet the future (e.g. Epic, population health, physician practice acquisitions, etc.)

In a small and declining percentage of systems, hospital volumes are increasing, as they take on additional public payer patients and find their inputs are getting clogged. For those systems, management faces a tough decision about investing \$1M-\$2M per bed to grow capacity, while soberly-recognizing that the future is not friendly to a bed-rich/high fixed-cost ecosystem.

Growing forces of consumerism are finding their way into healthcare as well. Fueled by a mobile device app-laden consumer ecosystem, patients put on their consumer hat and increasingly seek care transparency, on-demand service, ease of decision making and mobility from their providers of medical care. These are not characteristics that are part of the current health system delivery platform, which leave hospitals out-of-step with patient expectations. Those that are slow to adapt to these trends, will potentially face additional volume declines and yet higher burdens from underutilized fixed assets.

Historically, growing health system fixed assets has been an effective strategy to ensure market competitiveness and sustainability. Evolving market forces have altered the effectiveness of that time-tested strategy. Today, the high embedded fixed costs of health systems are experiencing a head-on collision with the above-cited market forces that will unavoidably result in a more *asset-light* approach.

Taken together, many health systems are experiencing a valley of depressed earnings and hope that all of their initiatives and investments will take them out of that valley sometime in the next [three] years. While some of these initiatives will yield fruit, there is no evidence they will keep pace with ongoing downward pressures. Said simply,

without a fundamental transformation in the delivery of medical care, the current asset-heavy model cannot provide reliable financial sustainability anymore.

LARGE, UNWIELDY FIXED COSTS HAVE BECOME A MEDICAL CONDITION THAT NEEDS GREATER ATTENTION

As health system volumes decline, out of sheer necessity, fixed cost-intensive institutional sites of care will be forced to symmetrically right-size their assets to avoid unsustainable deficits. As market forces gain steam, some health systems that operate with deficits, crumbling infrastructure and/or challenging labor contracts, wonder how they will keep their doors open. In many markets, health systems have had no choice but to consolidate, shrink or shutter assets for survival. In other cases, systems now operate with razor-thin margins as they shift from sustainability to vulnerability.

AN UNINTENDED CONSEQUENCE OF HIGH FIXED COSTS - STRAINS TO THE QUALITY OF PATIENT-CENTRIC CARE

An unintended consequence of the growing fixed-cost burden in brick and mortar-intensive health care delivery is strains on the quality of patient care. Faced with reduced volumes, hospitals cut expenses to balance budgets. The playbook for this reality places risks on the quality and experience of patient care in predictable ways: clinician touch points and total time with patients are reduced as labor costs are placed under the microscope. Increasingly, hospitals turn to software programs that improve workflow to off-set reduced staffing requirements. Many clinical leaders report that those programs often result in requiring more (not less) time from hospital staff. Frequently care processes (*tasks*) become the de-facto substitute for a patient-centric relationship and mission. Above and beyond the satisfaction issues that patients and clinicians face in hospitals, is the stark shadow of +400,000 patient deaths per annum from preventable medical errors¹.

In the face of these challenges, health systems have been hiring additional senior management resources to manage quality and the patient experience, which of course, further increases fixed costs. These additional investments have yet to translate in meaningful improvements.

The large loss-of-life while patients are in the care of health systems, should be an indicator that the fundamental model of care is broken and requires a transformative redesign. It is our view that this redesign cannot be limited to changes in work flow within the current framework of care delivery or bundling existing sub-optimal care delivery in currently high fixed cost sites of care. We believe that to achieve long-overdue quality improvements, a fundamental change is required in the care delivery model at the highest level of design (*where* care is delivered, *how* it is delivered, *how much* is delivered and *who* delivers it).

THE CHALLENGING ROAD TO AN ASSET-LIGHT FUTURE STATE

Most health system CEO's can describe some of the epic challenges they faced when they attempted to right-size their assets to align with their local market reality. The sources of these challenges include organized labor, patient advocates and regulators, all seeking to keep hospitals open and remain as the largest provider of jobs and care in the community. As the percentage of public payer patients enter the system, the two-pronged challenge for healthcare leaders grow more acute: (i) the growing mix of lower reimbursement patients further erode hospital margins and (ii) below break-even hospital capacity utilization forces the hospital to seek higher rates from commercial payers, which of course, places the burden on employers and their workers to fund an economically-flawed model.

¹: *Journal of patient safety, September, 2013 – Volume 9, Issue 3- p 122-128*

IMPERATIVE FOR THE RECONFIGURATION OF THE CURRENT CLINICAL DELIVERY MODEL AS THE BASIS FOR ACHIEVING SUSTAINABILITY

The only road to pivot from the constraints of the current delivery model is to fundamentally reengineer care in a holistically-systemic manner that reliably improves outcomes, satisfaction and costs and this can only be accomplished without the current burden of onerously-high fixed costs. This effort will require that *whole systems of care* need to be re-imagined, tested and delivered. For something to be a true *system*, all of its elements need to be seamlessly working together to achieve a well-understood common objective.

In our view, the ingredients for a systemic health system care redesign (above and beyond current initiatives like EMR's, risk contracts, clinical networks, etc.) include:

Strategies that will result in a dramatic reduction in fixed costs – e.g. shifting the site of care from hospitals and SNF's to safer/lower cost and more desired sites of care

Reliably improve quality by: (i) increasing the number of care touch points with patients, (ii) extending the period of time that patients are cared for when they experience a medical episode, (iii) avoiding care transitions and integrating care teams under a single episode of care, (iv) building relationships with patients so they invest more in their own care and health and (v) understanding and effectively-working with the psycho-social levers that more often than not drive preventable (costly) medical episodes.

Current efforts to improve the current system of care (e.g. increased PCP-patient engagement and value based payments) are a great step forward, but will likely fall short in creating the level of required improvement to align healthcare delivery design with short and long-term economic reality.

A FOOTBRIDGE STRATEGY TO SUSTAINABILITY

As part of a comprehensive strategy to bridge current health system challenges to achieve long term sustainability, two fundamental building blocks are required to build a footbridge to sustainability:

Building Block #1 – Acute Care Self-Substitution Products – a real world example: Medically Home

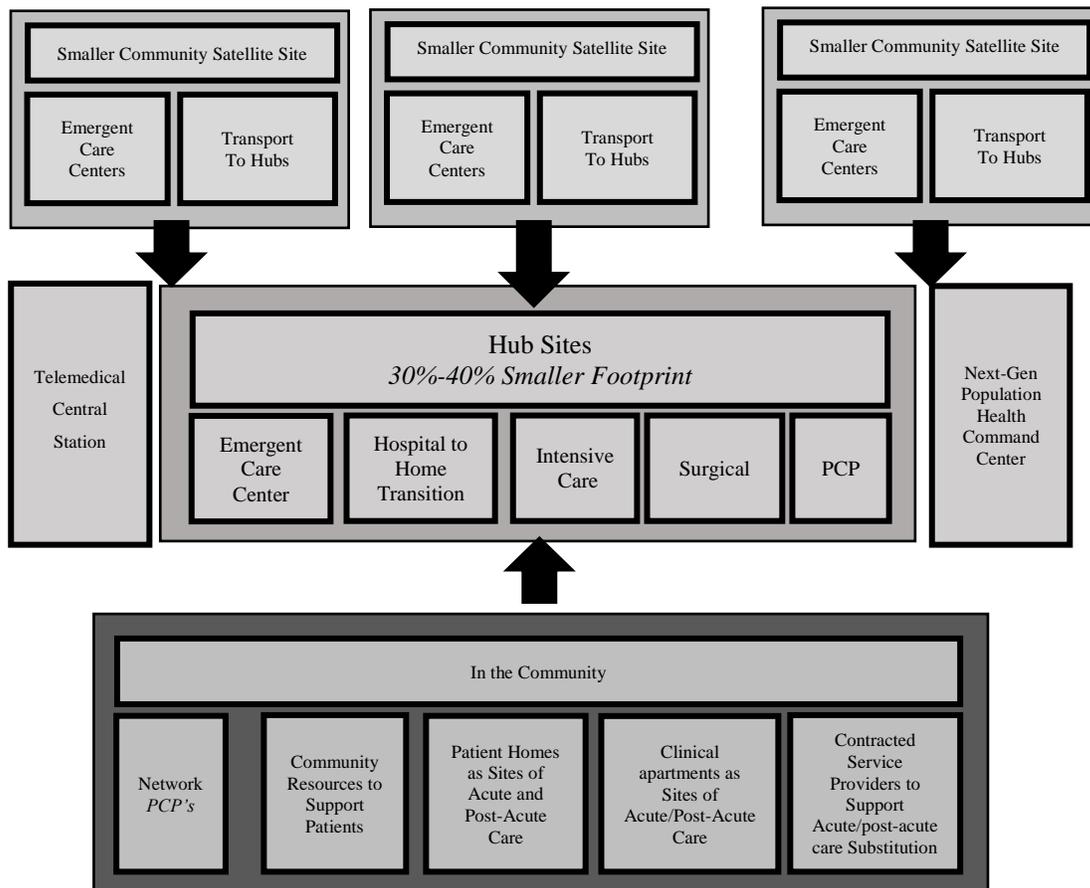
Medically Home - an acute care substitution product for ~30% of current hospital admissions - An asset-light/profitable acute care substitution product that combines acute care with post-acute care and episode prevention in a single episode of care with a single integrated care team. This product provides the platform for enhanced risk contracting and quality and cost based competitive differentiation. Importantly, it enables payer-supported acute care reimbursement at higher margins, while capturing meaningful post-acute and readmission reduction savings (for health system risk contracting). The merits of the model were validated in a recently published clinical trial².

The Medically Home model aligns the imperatives of financial, clinical, and service delivery transformation to achieve health system sustainability. The model provides an asset-light, new care delivery model that uses both the resources and infrastructure of the hospital and the patient's home, to substitute for the currently disconnected and costly: (i) inpatient hospital care, (ii) post-acute care (e.g. skilled nursing facilities) and (iii) readmission/episode prevention (e.g. population health) services.

2- *American Journal of Managed Care*. 2015;21(10):675-684

Medically Home improves the economics and quality measures for low margin/high utilization commercial patients and those commercial patients with high readmission rates. The result is a reduction in their total cost of care, reduced readmissions and a significant enhancement to existing population health programs.

Building Block #2 - A clear vision for the end state care delivery model – Our view of the end state model would consolidate markets to create hub and spoke health systems. Currently small, unprofitable hospitals would be transformed into small footprint/low fixed cost feeder spokes that do emergency care and facilitate acute and post-acute care at home, while transporting complex care patients to newly configured hubs. Hubs would be ~40% smaller and have both scale and profitable service lines. This vision is enabled by the acute care substitution product line.



A CALL TO ACTION

The logic and temptation for health systems and public payers to continue down their current path is great. The forces against full force transformation that are cited in this paper are compelling. No one would fault a health system CEO or CMS for waiting to see how current initiatives, volumes and reimbursement forces play out over the next three years before leaping to a future state deployment. On the other hand, for those who believe that their future depends on an orderly transition to the future state of healthcare in a sustainable fashion, there is a footbridge available today. We believe that as a result of the timing, momentum and magnitude of these market forces, health systems need to begin right now with a measured process that transitions their enterprise to a sustainable economic and clinical model.

We believe that regardless of any short-term action taken to launch self-substitution products, health systems and CMS need an acute care substitution capability as part of their core strategy to ensure sustainability. There is little doubt that a high fixed-cost business model will become a leading source of competitive disadvantage for the foreseeable future.