

A quarterly publication providing topics of interest to the healthcare industry.

The New CJR Program: Everything You Need (But May Not Want) to Know

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A Mandated Program

On November 16, 2015, the Centers for Medicare and Medicaid Services (CMS) announced the final rule for the Bundled Payments for Care Improvement Initiative and the mandatory bundled payment test called Comprehensive Care for Joint Replacement known as CJR. Effective April 1, 2016, acute-care hospitals in 67 geographic regions (known as metropolitan statistical areas [MSAs]) around the country will automatically be part of this new program. The program goes for five years (although the first year is nine months long) with various terms and risks phased in over time. There is no application process and no “opt-out.”



The Basics

CJR applies to Medicare fee-for-service (FFS) beneficiaries who have lower joint replacement procedures (diagnosis-related groups [DRG] 469 and 470) at any facility in the program. The patient’s financial benefit is not affected by being in the bundle and the patient cannot opt-out other than by going to another facility that is not in the program.

Under CJR, hospitals are responsible for the total Medicare FFS spend for patients from the index admission through 90 days after discharge (the episode period). The hospital is responsible for the DRG, plus all additional related Part A and Part B spending during the episode period. There is a long list of included and excluded services available from the CMS web site (<https://innovation.cms.gov/initiatives/cjr>).

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Looking Forward to 2016—Challenges and Opportunities Abound

The healthcare industry continues to experience a profound transformation. Industry pundits expected big changes in 2015 and they were correct. The Affordable Care Act has been an expected driver for change during the past year, along with do-it-yourself healthcare where mobile medical devices are allowing providers to transfer some basic monitoring tasks to patients. We saw new entrants to the healthcare market such as Apple and Google, who are pushing technologies in the smartphone and wearables space and retailers like Target and pharmacy chains such as Walgreens and CVS Caremark are answering the demands for better healthcare access and affordability.

Delivering quality coordinated care, expanding population health initiatives and providing consumers with greater pricing transparency for medical services continued to evolve as our healthcare industry is slowly taking shape as a true consumer-driven market.

The healthcare industry is rapidly evolving and therefore, our healthcare journal, MiraMed's *The Focus*, must deliver content our readers will find valuable. I believe we have hit the mark with this quarter's edition of *The Focus*. I am hopeful you think so as well.

We are pleased to introduce several new contributors to *The Focus*. Sheldon Hamburger, a consultant with the Aristone Group, has addressed a hot topic in healthcare today with his article *The New CJR Program: Everything You Need (But May Not Want) to Know*. Phil C. Solomon, Vice President of Global Services at MiraMed, has taken an interesting tact by explaining how the healthcare industry needs to treat patients more like customers in his article *Will*



Thinking Like Apple Change the Healthcare Customer Service Paradigm? In his article *Patient Protection? Who is the Bogeyman in the Room?*, Dr. Alan M. Preston, a professor in the Healthcare Management MBA program at Texas Health and Science University, discusses how the industry needs to change the perspective about how patients are being protected in the era of healthcare reform.

Another contributor to *The Focus* is Erik Wahl. He is a best-selling entrepreneur, successful speaker, author and philanthropist who has contributed the article *5 Traits of Creative Leaders (And How to Become One)*. His experiences as a corporate keynote speaker have given him a unique perspective about how to develop strong leadership skills. He shares those insights in his article.

We are proud to welcome back three authors that have been featured in past editions. Nathaniel Lacktman, healthcare attorney at Foley & Lardner, has authored an article titled, *2016 Forecast: What to Expect from Telemedicine*. He outlines five key trends that will drive telemedicine's continued growth and transformation in

healthcare delivery for 2016. Bird Blitch, the CEO of Patientco, discusses how high deductible and consumer-driven health plans are negatively affecting point of service collections in his article, *A Roadmap for Revenue Success at the Point of Service*. And lastly, David Johnson, CEO of 4sight Health, has written an interesting article, *Value Rules: Playbook for Post-Reform Healthcare* which highlights how fee-for-service payments to hospitals, doctors and pharmaceutical companies are affecting how Americans pay for their healthcare services.

I hope this edition of *The Focus* provides you with insightful articles that address many of the challenges and opportunities facing today's healthcare leaders. As always, I welcome your feedback and suggestions about how we can improve our idea-driven healthcare journal.

I wish you and your family good health and happiness as we enter 2016 with hopeful expectations. Happy New Year!

With best wishes,

Tony Mira
President and CEO



2016 Forecast: What to Expect from Telemedicine

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Telemedicine continues to be an innovative alternative to traditional brick-and-mortar healthcare. The number of providers offering telemedicine-based services rapidly increased in 2015, and several states enacted laws last year requiring health plans to cover telemedicine services and telemedicine technology. It is expected that the global telemedicine market will expand at a compound annual growth rate of 14.3 percent through 2020, eventually reaching \$36.2 billion, as compared to \$14.3 billion in 2014. And while the growing demand for convenience, innovation and a personalized healthcare experience may be the greatest factor; other forces are at work as well.

Here are five key trends that will drive telemedicine's continued growth and transformation of healthcare delivery in 2016.

1. Greater Payment Opportunities

Both private and government payers will continue to expand telemedicine coverage as consumers gain experience with the technology and increasingly demand access to telemedicine-based services. Some health plans have already begun bolstering their coverage of telemedicine, which they view as a form of value-based care that can improve the patient experience and offer substantial cost savings. On the government side, 2016 will particularly see more coverage among Medicaid managed care organizations and Medicare Advantage plans.



Simultaneously changing is the misconception that telemedicine creates a financial strain or relies on grant funding. Smart health system leadership are creating sustainable telemedicine arrangements that generate revenue, not just cost savings, while improving patient care and satisfaction. Telemedicine saves money for patients, providers and payers compared to traditional healthcare practices, particularly by helping reduce the frequency and duration of hospital visits.

While Foley & Lardner's 2014 telemedicine survey¹ revealed that reimbursement was the primary obstacle to telemedicine implementation, new laws requiring coverage of telemedicine-based services have been implemented at the state level, and 2016 will be the year these laws drive implementation in those states. Providers are becoming increasingly receptive to exploring payment models beyond fee-for-service reim-

bursement and 2016 will continue the growth of these arrangements. Examples include institution-to-institution contracts and greater willingness by patients to pay out-of-pocket for these convenient, valuable services.

At the same time, consumers are increasingly willing to visit retail medical clinics and pay out-of-pocket for the convenience and multiple benefits of telemedicine services when telemedicine is not covered by their insurance plans. In 2015, both CVS Health² and Walgreens³ publicly announced plans to incorporate telemedicine-based service components in their brick-and-mortar locations. There will be continued expansion of these services throughout 2016.

2. More Telemedicine-Friendly State Laws

State governments across the U.S. are leading the way in telemedicine expansion. According to a study by the Center for Connected Health Policy,⁴ during the 2015 legislative session, more than 200 pieces of telemedicine-related legislation were introduced in 42 states. Currently, 29 states and the District of Columbia have enacted laws requiring that health plans cover telemedicine services. In 2016, we will see more bills supporting health insurance coverage for telemedicine-based services introduced in various state legislatures.

While state lawmakers are leading the way in incorporating telemedicine into the healthcare system, there is a burgeoning interest at the federal level. The Centers for Medicare and Medicaid Services (CMS) is considering expansion of Medicare coverage for telemedicine,

¹ While Foley & Lardner's 2014 telemedicine survey, <http://www.foley.com/2014-telemedicine-survey-executive-summary/>

² CVS, Direct to Consumer Services <https://www.cvshealth.com/content/cvs-health-partner-direct-consumer-telehealth-providers-increase-access-physician-care>

³ Walgreens press release announcing telehealth expansion, <http://news.walgreens.com/press-releases/general-news/walgreens-and-mdlive-expand-telehealth-platform-to-three-new-states-add-desktop-and-tablet-functionality.htm>

⁴ Reimbursement report CCHPCA, http://cchpca.org/sites/default/files/resources/STATE_TELEHEALTH_POLICIES_AND_REIMBURSEMENT

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Common Included Services in CJR

- Physicians' services
- Inpatient hospitalization (including readmissions)
- Inpatient psychiatric facility (IPF)
- Long-term care hospital (LTCH)
- Inpatient rehabilitation facility (IRF)
- Skilled nursing facility (SNF)
- Home health agency (HHA)
- Hospital outpatient services
- Independent outpatient therapy
- Clinical laboratory
- Durable medical equipment (DME)
- Medicare Part B drugs
- Hospice

Payment

The payment process is based on a “shared savings” model where the hospital and CMS share savings generated by driving the average case spend below a CMS-defined target price. To the extent CMS spends less than the target price, the hospital shares the vast majority of the savings. If the CMS spend exceeds the target price, the hospital will pay the overage back to CMS. This payback, or down-side risk, does not go into effect until the second year of the program. See Figure 1 for a simple, illustrative example of this.

Example Excluded Services from CJR

- ✓ Acute clinical conditions not arising from existing episode-related chronic clinical conditions or complications of the lower-extremity joint replacements (LEJR) surgery
- ✓ Chronic conditions that are generally not affected by the LEJR procedure or post-surgical care

FIGURE 1 Example of a Shared Savings Model

CMS Spend (Claims Paid)	Target Price*	Result
\$18,000	\$20,000	CMS pays hospital \$2,000
\$21,000	\$20,000	Hospital pays CMS \$1,000

*Adjusted twice per year throughout the life of the program

Throughout the program, all parties (the hospital and all post-acute providers) continue to bill CMS as usual. The claims processing revenue cycle continues uninterrupted as does cash flow. On an annual basis, a reconciliation process will occur where CMS provides the hospital with the results of the prior year's performance. CMS totals all relevant claims for each case. This total is compared with the target price and the difference determines whether CMS pays the hospital or visa-versa.

Target Price

It is important to note that CMS determines the target price based on the hospital's recent performance (DRG + 90 days post-discharge spend for a rolling three year period as shown in Figure 2) AND other hospitals in the region. These regions are much larger than the MSA geography designation used to determine which hospitals were initially placed in the CJR program. This is a very important point and means that a hospital's target price is based on how other institutions are performing. The formula for this calculation is phased in over the life of the program as shown in Figure 3.

The CJR program is largely based on CMS' previous voluntary demonstration project Bundled Payment for Care Improvement (BPCI) Model 2. Three of the key differences include a stratified target price for fractures, a change in the discount structure and the requirement that the hospital meet a minimum quality score in order to receive any savings it generates. Many BPCI Model 2 participants, as well as those providing public comment for CJR, have raised the fact that elective procedures and fractures bear substantially different risk profiles and that the target pricing model should reflect that. CMS has responded by agreeing to provide separate (i.e., stratified) pricing. Exactly how that will work won't be known until CMS releases the initial target prices, most likely in Q1 2016.

Like BPCI, CMS takes a percentage “off the top” of the program. This

FIGURE 3 Target Price Phase-In



FIGURE 2 CJR Target Baseline Pricing

2016	2017	2018	2019	2020
Jan 12-Dec 14	Jan 12-Dec 14	Jan 14-Dec 16	Jan 14-Dec 16	Jan 16-Dec 18

FIGURE 4 CCJR Reconciliation Payments Caps*
As A Percent of Target Price

	2016	2017	2018	2019	2020
Upside cap	20%	20%	20%	20%	20%
Downside**	None	10%	20%		20%
** Exceptions	None	3%	20%	5%	5%

*Spend greater than 2 std. deviations from the mean is excluded.

there is also a limit to the upside. This formula is phased in over the life of the program as shown in Figure 4.

As stated previously, the hospital has an opportunity to reduce the three percent discount (called the Quality Incentive Payment) based on a CMS defined quality performance scoring mechanism. This mechanism revolves around the reporting and/or results of three quality measures (two of which are already being reported). Each measure counts toward an ultimate composite score of up to 20 points. Based on this composite score, the discount can be reduced.

Figure 5 shows the quality measures and their relative value on the point scale. The first two measures, risk-standardized complication rate (RSCR) and hospital consumer assessment of healthcare providers and systems (HCAHPS), are already being reported. The hospital's results will be compared to national performance as shown in Figure 6. Based on this comparison, the hospital will be awarded points on a sliding scale. The third measure is patient reported outcomes and its reporting is, initially, voluntary. CMS indicates that this could be mandatory later in the program.

For each of the three quality measures, the hospital is awarded points. The sum total of those points is the composite quality score and is used to determine the quality incentive payment (i.e., the change in the discount percentage). Figure 7 shows how the composite quality score relates to the discount. For example, a composite score greater than 13.2 out of the maximum possible 20 will result in a discount of one and one-half percent. Also note that a score below 4.0 is considered so poor (CMS calls this "below acceptable" performance) that the hospital would not even be eligible to share in any savings at all.

FIGURE 5 CJR Composite Quality Scoring

Quality Category	Maximum Points	Score Allocation	Notes
RSCR for THA/TKA National Quality Forum (NQF #1550)	10	50%	Based on hospital's decile performance nationally
HCAHPS (NQF #0166)	8	40%	Based on hospital's decile performance nationally
THA/TKA outcomes	2	10%	Voluntary year 1-3, may be mandatory year 4-5

amount is called the discount and is currently pegged at three percent. This means that CMS takes three percent of the total program spend. CMS offers hospitals an opportunity to reduce this percentage to as low as one and one-half percent. Remember, a reduction in discount means more money for the hospital assuming there is savings to be shared. Note that the target price given to the hospital already includes a three percent discount.

Caveats

An important note: even if the hospital generates savings, CMS will not share those savings unless the hospital also achieves a minimum quality performance score as described later in this article. This requirement is designed to be sure that hospitals maintain quality while reducing overall

spend as opposed to simply cutting services to generate savings without regard to outcomes.

It's also important to know that CMS provides some protection against runaway spend caused by outlier cases. But this is a two-way street. In return for limiting the hospital's downside,

FIGURE 6

CJR Composite Scoring Scale		
Performance Decile Percentile (national)	THA/TKA Complications (points)	HCAHPS Survey (points)
> = 90th	10.00	8.00
80-90th	9.25	7.40
70-80th	8.50	6.80
60-70th	7.75	6.20
50-60th	7.00	5.60
40-50th	6.25	5.00
30-50th	5.50	4.40
< 30th	0.00	0.00

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FIGURE 7

CJR Discount Structure

Composite Quality Score	Quality Category	Eligible for Reconciliation Payment	Eligible for Quality Incentive Payment	Discount for Reconciliation Payment	Discount for Repayment Year 1	Discount for Repayment Years 2-3	Discount for Repayment Years 4-5
< 4.0	Below Acceptable	No	No	3.0%	N/A	2.0%	3.0%
4.0-6.0	Acceptable	Yes	No	3.0%	N/A	2.0%	3.0%
6.0-13.2	Good	Yes	Yes	2.0%	N/A	1.0%	2.0%
> 13.2	Excellent	Yes	Yes	1.5%	N/A	0.5%	1.5%

Note that the discount structure for sharing savings (Discount for Reconciliation Payment) remains constant over the life of the program. However, the discount structure for repayment to CMS (when the spend is above the target price) increases over the five year period. In the first year, there is no repayment to CMS since there is no downside risk. In year two, a discount begins as shown in Figure 7 and that discount increases in year four.

Gainsharing in CJR

The CJR program allows hospitals to share its savings, or gains, with other healthcare providers known as collaborators. A hospital may wish to share money with surgeons, for example, to create an incentive for them to achieve quality goals and improved outcomes which ultimately drives down spending generating more savings. Any such gainsharing must be based on quality improvements consistent with CJR.

The hospital might also want collaborators to share losses. This is allowable under CJR but certainly a topic for negotiation between the hospital and collaborator. A contract must be in place with the collaborator *before* any patient care is rendered in order for any gainsharing to be effective.

In addition to savings generated by the total episode spend compared to the target, hospitals can also share savings generated inside the hospital known as internal cost savings or ICS. Although this reduction is not reflected in the reconciliation process (since it is part of the DRG), reduction in ICS improves margin and this improvement can be shared with collaborators. This sharing of ICS is unique to BPCI and CJR and creates a special opportunity for organizations willing to spend the time and effort to work on this option.

CMS Offers Waivers

CMS provides a number of waivers under the CJR program to allow hospitals flexibility to experiment on methods to improve care and lower total spend. The three key waivers for care delivery are:

- **Skilled nursing facility (SNF) 3-day rule:** Beginning in year two of the program, SNFs may bill CMS for CJR patients with a hospital stay of less than three days.
- **Home health:** Beneficiaries who do not satisfy requirements for home health services (the “incident to” rule) may receive up to nine post-discharge home visits during an episode.

- **Telehealth:** The geographic site requirement for telehealth services as well as the requirement that the eligible telehealth individual be in one of eight eligible types of sites is waived.

In addition, CMS and the Office of the Inspector General (OIG) have issued a joint statement (available on the CMS website) that waives the federal anti-kickback statute and the physician self-referral law in CJR for gainsharing arrangements. Legal counsel will, of course, need to review this statement and associated contracts to be sure arrangements are in line with these guidelines.



Beneficiaries' Incentive and Protections

CJR allows the hospital to provide beneficiaries with certain incentives that would assist patients in getting care. But there are limits and requirements.

- Incentives to beneficiaries in excess of \$25 must be documented. Work with legal counsel to be sure these don't constitute inducement.
- Technology provided to beneficiaries such as remote monitors must be valued at less than \$1,000.
- Any items given to beneficiaries must be returned to the hospital at the conclusion of the episode.
- Beneficiaries must be provided with a complete list of post-acute provider options. Hospitals are not prevented from establishing preferred networks.

Data Is Still Key

Like all valued-based programs, CJR success is heavily dependent on the availability and use of data. Your organization has plenty of data that will be helpful and should be used. CMS will provide data sets that will be essential for you to have, analyze and leverage to design and monitor your program.

CMS intends to make several data sets available but hospitals MUST request that data:

- Baseline claims history (inpatient and post-acute). – This will give you insight into historical patterns.
- Ongoing data (at least quarterly, possibly monthly). – This will give you some insight into your program's performance along the way but it's still retroactive as opposed to real time.
- Aggregated data showing average episode spending by DRG for the



hospital and the region. – This will give you insight into where you stand compared to other hospitals in your region whose performance affect your target price.

The process of getting this data has not yet been defined by CMS.

Hospitals may have capabilities to handle these data sets or may choose to use external, commercially available consultants and/or solutions. Either way, the ability to quickly and thoroughly analyze and interpret this data will be a key success factor in your program.

CJR Implications for Your Organization

Clearly, CJR is a game changer. With responsibilities now extending beyond discharge, hospitals need to become immediate experts in the post-acute care process. Using that newly acquired knowledge, the challenge will be to reengineer care delivery to optimize outcomes resulting in reduced spend.

The implications of CJR also extend beyond the initial program. Hospitals should align CJR with their corporate strategy and their plans for other value-

based programs. The issues in CJR regarding risk management, post-acute care networks and gainsharing (to name a few) are the same as those in accountable care organizations (ACOs), for example. Recognizing those synergies enable you to leverage your model across the new care continuum.

You will find, as other industries learned quite some time ago, that your competitors will sometimes need to be your collaborators. Working with other hospitals' emergency departments to identify readmission patients is an example where sharing this data could benefit both institutions as everyone is moving into the value-based world.

The April 1, 2016 start date puts pressure on hospitals to quickly ramp up. On the other hand, the fact that the first year (through December 31, 2016) has no downside risk may cause some to take a somewhat slower pace in adoption. This is a big mistake. Your target price is based on regional performance and the faster you get ahead, the better your chance for maximizing gains. Conversely, those who wait could very well find themselves spending the next five years playing from behind, always trying to catch up with

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everyone else in the region only to find themselves continuously outpaced and losing money.

The post-acute world is often a black hole for hospitals and CJR will provide an opportunity to see what happens there. These providers (such as SNF and HHA) have limited capabilities and resources and hospitals could very well find themselves providing support services to help make these post-acute partners successful. Some hospitals have found that placing their own in a SNF, for example, can be tremendously helpful in reducing length of stay and readmission and well worth the expense.

Numerous challenges lie ahead as you attempt to reduce post-acute spend. SNFs will be reluctant to reduce length of stay (this is top line revenue), patients will push back at being asked to use your “preferred” post-acute provider network and your internal staff may reject various strategies since they don’t understand the value-based world. Do not despair—this is all normal for hospitals implementing these new value-based programs. Consider bringing in some experienced help from people who have lived this before.

You will also find yourself needing skill sets in the areas of risk management,

analytics and care coordination. The role of care navigator, a kind of traffic cop, will help monitor your CJR patients to be sure they stay on track in your new care pathway. Technology tools are available to support what is often a new role for the hospital.

What Should I Do Now?

Two words: GET STARTED. Waiting will only make things more difficult, costly and frustrating. Here are some simple things you can do right now if you haven’t already done so.

- Appoint, hire or contract a dedicated full-time project manager. This is not a part-time responsibility given to someone who’s already busy with other hospital responsibilities.
- Establish a project leadership team. It doesn’t have to be your final governance team, but it should consist of champions who can drive action now. Consider using an orthopedic surgeon leader (essential) and someone from finance, IT and operations.
- Get data from your internal systems. You should be able to determine how many cases (DRG 469 and 470) you’ve had over that past several years. Look at who’s doing the surgeries, internal costs, readmissions, discharge dispositions and anything else you can find about your patients, surgeons and post-acute world.
- Create a list of key post-acute providers in your area. Do some research to get an understanding of that post-acute world where you and your patients live.

- Get outside help. There are experienced consultants who can provide invaluable education, advice, guidance and solutions so you don’t waste precious time and resources.

The Bottom Line

CJR is a great opportunity for those willing to embrace it and make it part of their overall strategy in moving toward the world of value-based care. Other such programs are coming. Indeed, your other payers may already have value-based models available. You should be contacting them now to see how you can leverage your CJR investment into those opportunities.

Welcome to CJR. May the forces of change be with you! 🌀

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and a bill working its way through the U.S. House of Representatives would pay physicians for delivering telemedicine services to Medicare beneficiaries in any location. We may see these policy changes debated further (or possibly implemented) in 2016.

3. Medicare Accountable Care Organizations (ACOs) will Use Telemedicine to Improve Care and Cut Costs

Telemedicine is establishing itself as a key component in the healthcare industry's shift to value-based care. It can generate additional revenue, cut costs and enhance patient satisfaction. In 2015, telemedicine saw rapid growth and deployment across a variety of applications. This adoption is fueled by powerful economic, social and political forces—most notably, the growing consumer demand for more affordable and accessible care.

2016 will be the year of telemedicine and ACOs. Since the advent of ACOs, the number of Medicare beneficiaries served has consistently grown from year to year and early indications suggest the number of beneficiaries served by ACOs is likely to continue to increase in 2016. These organizations present an ideal avenue for the growth of telemedicine.

While CMS offered heavy cost-reduction incentives in the form of shared-savings payments, only 27 percent of ACOs achieved enough savings to qualify for those incentives last year.⁵ Meanwhile only 20 percent of ACOs use telemedicine services, according to a [2015 study](#).⁶ The widespread need to hit the incentive payment metrics, coupled with the low adoption rate will lead to significantly greater telemedicine use among ACOs in 2016.

4. Cross-Border Licensure and the Interstate Medical Licensure Compact

2015 saw notable efforts to streamline and simplify physician licensing across state lines. Perhaps the most important example gaining traction is the Federation of State Medical Boards' Physician Licensure Compact. Under the Compact, participating state medical boards would retain their licensing and disciplinary authority, but would agree to share information and processes essential to the licensing and regulation of physicians who practice across state borders. The Physician Licensure Compact has received significant support and at least 10 states have completed the process necessary to bring it to adoption once it becomes effective. More participation is anticipated in 2016.

A 2015 [Towers Watson study](#)⁷ found that more than 35 percent of employers with onsite health facilities offer telemedicine services and another 12 percent plan to add these services in the next two years. Other studies suggest that nearly 70 percent of employers will offer telemedicine services as an employee benefit by 2017. The growth of nation-spanning telemedicine companies such as MDLIVE and the now publicly-traded Teladoc, which offer health services tailored to the specific needs of employers and other groups, is a reflection of the demand for these services.

5. International Arrangements

In 2016, more U.S. hospitals and healthcare providers will forge ties with overseas medical institutions, spreading U.S. healthcare expertise abroad. They are exploring both institutional arrangements and direct-to-patient service

offerings such as internet-based medical consultations and online second opinions.

These cross-border partnerships will provide access to more patients, create additional revenue and help bolster international brands. Many programs that were in pilot phase in 2015 will see a maturation and commercialization in 2016, as they are a win-win for participants in both countries.

The growing purchasing power of middle-class populations in countries like China is giving more patients the means and opportunity to pursue treatment from Western medical providers. We have seen both for-profit and non-profit models for international telemedicine and hospitals partnering with organizations in the developing world to expand healthcare availability or offering commercial care to customers in nations with areas of concentrated wealth but lacking the capabilities and access of Western healthcare. ☎

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including hospitals, clinics, physicians and entrepreneurs, on the opportunities, business models and regulatory issues presented by innovative healthcare delivery approaches and disruptive technologies. A true believer in healthcare innovation, he advises clients on telehealth issues nationwide and internationally with a particular focus on U.S. to China telemedicine arrangements. He earned his law degree from the University of Southern California School of Law and his undergraduate degree from the University of Florida. He may be reached at nlacktman@foley.com or www.foley.com/telemedicine.

⁵ CMS Shared Savings Program, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-08-25.html>

⁶ ACO use of telemedicine services savings, EHIDC, <https://www.ehdc.org/articles/418-2015-aco-survey-results-webinar>

⁷ 2015 Towers Watson study, <https://www.towerswatson.com/en/Press/2015/05/employers-plan-to-expand-use-of-onsite-health-centers>

Will Thinking Like Apple Change the Healthcare Customer Service Paradigm?

Phil C. Solomon

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With increased competition and declining margins, every healthcare provider must continue to find ways to stay fiscally viable. Providers must begin to un-think¹ their concept of healthcare delivery—beyond how well they improve patient outcomes and cut costs—if they want to prosper in an industry undergoing a transformation.

A Shift of How Customer Service is Delivered in Healthcare

Healthcare providers are being forced to embrace the market reality that consumerism and pricing transparency are redefining healthcare delivery. Organizations that are succeeding are taking a radical approach to serving their patients as a means to foster loyalty. This stratagem has resulted in improved patient satisfaction and financial stability. Unthinking the way organizations approach the delivery of health services begins with treating a consumer more like a customer than a patient.

The importance of providing outstanding customer service has long been a focal point of business. Companies like Apple and Ritz Carlton Hotels have succeeded in highly competitive markets by delivering excellent customer service.

The former President of Ritz Carlton Hotels, Horst Schulze, built a successful



six-star luxury hotel chain by following a simple premise: provide service that goes above and beyond the call of duty. He believes great customer service begins at the highest level with the leaders of his company. When asked about this he said, “Great leaders truly care. They care about people, and they care about excellence.”³

The late Steve Jobs, founder of Apple, understood customer service and how to provide it. He said, “Be a yardstick of quality. Some people aren’t used to an environment where excellence is expected.”⁴ Today, these philosophies are considered critical to every businesses’ success.

Unfortunately, the healthcare industry has been slower to adopt similar customer service strategies. James Merlino, MD, Chief Experience Officer at Cleveland Clinic and President and Founder of the Association for Patient Experience, believes that “It is especially unfortunate because hospital ‘customers’ are very different than those in any other industry for one important reason—they don’t want to be there. The experience is scary, confusing, and they often feel as though no one understands them. Yet often these same patients are made to feel that because healthcare is a necessity rather than a luxury; they aren’t entitled to a superior patient experience. And this is probably the biggest mistake our industry makes.”⁵

Dr. Merlino believes creating a great patient experience is not about making patients happy over quality. It’s about safe care first, high-quality care and then patient satisfaction.

Some healthcare organizations have taken the first step towards providing customer service that improves the entire patient experience. Walnut Hill Medical Centre (WHMC) in Dallas, Texas has created their own customer service model, W-E-C-A-R-E = Warm welcome, Empathize, Communicate and connect, Address concerns, Resolve and reassure, End with a fond farewell, to improve relations between patients and staff.⁷ WHMC believes that taking a few extra minutes to find something in common with a patient, to explain what is happening or to make sure the patient is comfortable goes a long way in creating a better patient experience.

The University of Toledo Medical Center (UTMC) recently launched an en-

¹ Definition of un-think, <http://www.merriam-webster.com/dictionary/unthink>

² Definition of consumerism and pricing transparency in healthcare, <http://www.healthcarefinancenews.com/news/consumers-driving-price-transparency>

³ CEO Perspective: Time with Horst Schulze, Jeremie Kubicek, <http://jeremiekubicek.com/ceo-perspective-time-with-horst-schulze-2/>

⁴ Steve Jobs, the CEO of Apple’s most memorable quotes on business and customer service, <http://www.cheatsheet.com/technology/20-most-memorable-quotes-from-steve-jobs.html/?a=viewall>

⁵ James Merlino, MD, Chief Experience Officer at Cleveland Clinic and President and Founder of the Association for Patient Experience, <http://finance.yahoo.com/blogs/the-exchange/why-customer-matters-healthcare-industry-214727535.html>

⁶ James Merlino, MD, President and Founder of the Association for Patient Experience, <http://www.patient-experience.org/Home.aspx>

⁷ Walnut Hill Medical Centre, Dallas, Texas, Created a customer service model called (W-E-C-A-R-E), <http://walnuthillmc.com/>

tire program based on patient satisfaction, iCARE University, which mandated patient satisfaction course work and training for every university student and employee. UTMC's Service Excellence Officer, Ms. Ioan Duca, said, "I am really focused on creating a church-like environment here. We want a total cultural transformation. I want that Disney-like experience, the Ritz Carlton experience."

The Patient Protection and Affordable Care Act (PPACA) and its Effect on Customer Service

Why is it now so important to treat a patient more like a customer? The health industry is preparing for the changing healthcare ecosystem driven by the Patient Protection and Affordable Care Act (PPACA), commonly called the Affordable Care Act (ACA) or Obamacare, signed into law by President Barack Obama on March 23, 2010.⁸

As a byproduct of the PPACA, Medicare is now requiring providers to perform a Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey asking patients about such things as:

- Communication with doctors and nurses;
- Responsiveness of hospital staff;
- Cleanliness of the hospital environment;
- Quietness of the hospital environment;
- Pain management and communication about medicines;
- Discharge information; and
- Overall rating and recommendation of the hospital.

The results of that survey have financial repercussions that are substantial: beginning in 2013, nearly \$1 billion of Medicare reimbursements are at stake based upon the results of the survey, as well as other data sources on the quality of care available online.⁹

The HCAHPS reimbursements are not the only remuneration at stake for health providers. Unsatisfied patients can have a damaging effect on provider organization's reputation and its financial sustainability.

Consumers making day-to-day purchases have experienced an improvement of customer service because they control who they buy from and are allowed to "vote" with their wallet. Sam Walton, founder of Walmart, once said, "There is only one boss, the customer. And he can fire everybody in the company from the chairman on down, simply by spending his money somewhere else." However, purchasing healthcare services is different.

As the focus of consumerism and pricing transparency gain acceptance and healthcare becomes increasingly more competitive, the healthcare patient will be empowered to make similar purchasing decisions as a typical consumer and those decisions will affect a health provider's bottom line. The "news of bad customer service reaches more than twice as many ears as praise for a good service experience" regardless of the industry.¹⁰ Since it takes 12 positive customer experiences to make up for one negative experience,¹¹ health providers have a lot at stake and must change their culture to focus on improving customer service and the patient experience.



What is Good Customer Service and How Does it Improve the Patient Experience?

Customer service is the act of taking care of the customer's needs by providing and delivering professional, helpful, high quality service and assistance before, during and after the customer's requirements are met.¹² In healthcare, it is defined as providing the best clinical care, safety and physical comfort, as well as meeting the patient's educational, emotional and spiritual needs.

The tenants of delivering good customer service for healthcare begins with understanding what patients think is great service, recognizing what they want and knowing how to create loyalty. The following are examples of fundamental actions toward providing excellent customer service.

- Establishing rapport with the patient and their family;
- Creating personal relationships and being friendly;
- Being kind and empathic;
- Proactively providing information;
- Keeping the patient and their family informed of their treatment; and
- Listening to patients to determine their wants, needs and desires.

⁸ Patient Protection and Affordable Care Act, Wikipedia, the free encyclopedia https://en.wikipedia.org/wiki/Patient_Protection_and_Affordable_Care_Act

⁹ Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey http://www.hcapsonline.org/executive_insight/default.aspx

¹⁰ Customer service statistics in business, White House Office of Consumer Affairs, <https://www.whitehouse.gov/>

¹¹ 2012 Global Consumer Pulse research on customer service, Accenture, <https://www.accenture.com/us-en/insight-accenture-global-consumer-pulse-research-study-2012-summary.aspx>

¹² The definition of customer service, Study.com <http://study.com/academy/lesson/what-is-customer-service-definition-types-role-in-marketing.html>

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The organizations that survive and thrive in today's evolving healthcare climate must provide excellent customer service to remain competitive. Providing good customer service just isn't good enough anymore. It must be excellent.

Lessons Learned About Improving Customer Service From Steve Jobs and Apple

Healthcare leaders need to start thinking like business people, like Steve Jobs. When he returned to Apple, he decided to re-imagine the computer experience and he ended up re-inventing it. He blew up Apple's old model of customer satisfaction and started all over again from scratch. His efforts resulted in Apple being rated as one of the "Top Companies with the Best Reputations" as reported by [24/7 Wall Street](http://247wallst.com/special-report/2015/05/06/companies-with-the-best-and-worst-reputations-3/2/).¹³

There are eight important lessons health providers can learn from Steve Jobs and Apple to improve patient interactions and satisfaction, increase performance, productivity and loyalty. They are:

1. **Stop doing just your job.** Take a lesson from Steve Jobs. When he first started Apple, instead of figuring out how to grow the company, he focused on improving his customers' lives. Compare this philosophy to your organization's vision and your own personal beliefs. Just doing your job isn't enough to improve the patient experience. Don't just do your job; enrich the lives of your patients, co-workers, clients and partners.
2. **Enrich lives.** When you begin to think about enriching lives, magical things start to happen. For

example, enriching lives led to the creation of Apple's "Genius Bar," where trained experts are focused on "rebuilding relationships" as much as fixing problems.

3. **Hire for smiles.** The soul of any organization is its people. Consider when you hire, train and motivate your new employees and retrain existing employees, you teach them to create magical and memorable moments for the patients they serve. When a patient calls your facility, instill values in your employees to exude a magnetic personality as well as perform the tasks of their job.
4. **Celebrate diversity.** Apple hires people who reflect the diversity of their customers, and healthcare providers should follow that premise. Providers must hire people based on how passionate they are instead of just focusing on previous experience.
5. **Unleash the inner genius.** Employees need to be empowered to try things they never knew they could do before. They will make a patient's experience delightful, instead of just good. Staff members need to think creatively and be rewarded for it.
6. **Empower employees.** Empower your people to do what they believe is the right thing to do for your patients.
7. **Sell the benefit.** Interactions with healthcare providers are typically not planned events. Always keep in mind a patient's encounter could improve their life and the lives of their loved ones. The level of customer service given will stand out

as a part of the overall benefit they gained from their treatment.

8. **Follow the steps of service.** Leverage Apple's five steps of service as they relate to healthcare:
 1. Approach your patient with a warm greeting;
 2. Probe politely to understand the patient's needs;
 3. Provide an explanation or solution the patient can understand;
 4. Listen for and address all unresolved questions; and
 5. End with a farewell that leaves a lasting positive impression.

There are many ways a healthcare provider can deliver excellent customer service that supports a positive patient experience. Micah Solomon, a patient experience consultant, customer service consultant, speaker and bestselling author outlined seven ways "To Improve Patient Satisfaction, Experience, and Customer Service."¹⁴ They are:

1. Strive to deliver service on the schedule of your patient, not just a schedule that happens to be convenient for your institution.
2. To improve HCAHPS scores, take a relatively broad approach. Being too selectively focused on the individual HCAHPS questions can actually backfire. Create an organization-wide halo effect that raises your scores as well as your actual rate of referral—not just the hypothetical "willingness to recommend."
3. Excellent customer service means systems as well as smiles. When

¹³ "Top Companies With the Best Reputations" reported by 24/7 Wall Street, <http://247wallst.com/special-report/2015/05/06/companies-with-the-best-and-worst-reputations-3/2/>



Mayo Clinic overhauled their scheduling system, they employed industrial engineers using stopwatches to time wheelchairs between appointment locations in order to ensure that correct scheduling algorithms were created.

4. Not-for-profit hospitals and institutions in healthcare can benefit by recognizing and embracing their inherent organizational advantage over for-profit institutions: It is easier for the employees to identify with the aims of an organization that doesn't have profit at the center. If you're not-for-profit, be aware of this advantage and make the most of it.
5. Eliminate bullying and disrespect of employees by superiors. Working in an environment characterized by bullying increases turnover intentions of nurses and employees. They report high turnover intentions whether

directly bullied or simply in a work unit with bullying.

6. Every single employee needs to know how to handle customer complaints and concerns. Even if handling the concern means responding similar to "I'm finding you someone right now who can address this." That response is far better than "I can't help you, I'm the wrong person."
7. Much of what's wrong in patient satisfaction and customer service is related to poor use of language, and to nonverbal language cues (such as hospital employees avoiding eye contact with civilians in the hospital, and acting like they are "other" from them).
8. Creating a blame-free environment leads to improved transparency, improved systems and, ultimately, better results. Horst Schulze, founder of the Ritz-Carlton brand, frequently says, "If a mistake happens once it may be fault of employee. If it happens twice, it is most likely the fault of the system."¹⁵ So get to work fixing the system."

One of the key factors driving positive changes in customer service and patient satisfaction in healthcare is the concept of patient-centered care.¹⁶ In this new approach, patients are involved at every level of care design and implementation. They are treated with dignity and their needs for privacy and individual expression respected. Also, patients are informed about their clinical status, progress and progno-

sis, and their test results and treatments are promptly and clearly explained.

Patients and their families are viewed as partners in decisions about treatment and care. They are offered options including access to complementary therapies and alternative healing practices.

Customer Service and Its Effect on The Eight Dimensions of Patient-Centered Care

The Picker Institute and Harvard Medical School created a structure or plan that providers can follow to improve the patient experience. The Eight Dimensions of Patient-Centered Care (EDPCC) was created through years of research by thousands of interviews and the experiences of caregivers and patients. Analysis of this research showed that there are certain things, certain behaviors that are instrumental to patients' healing, feeling cared for and having a positive patient experience. From that research, the medical community better understands what's most important to patients.¹⁷

Building on the legacy of Harvey Picker's EDPCC, National Research Corporation has been helping hospitals and health systems develop patient-centered care strategies for over 30 years. They recognize how important customer service initiatives are as they relate to the EDPCC efforts. Delivering quality customer service touches every dimension of patient centered care and ultimately drives patient satisfaction.¹⁸

Research and analysis shows there are certain actions a provider can employ that are instrumental to patients' healing, feeling cared for and having a positive patient experience. They are:

1. **Respect for patients' values, preferences and expressed needs** – Patients indicate a need to be recognized and treated as individuals by hospital staff. They

¹⁴ Micah Solomon <http://www.forbes.com/sites/micahsolomon/2013/11/02/quick-truths-for-improved-patient-satisfaction-and-customer-service-from-consulting-in-hospitals-and-healthcare/>

¹⁵ Horst Schulze, founder of the Ritz-Carlton brand quote about mistakes, <http://www.forbes.com/sites/micahsolomon/2015/01/11/8-ways-to-improve-patient-satisfaction-and-patient-experience-and-by-the-way-improve-hcahps-scores/>

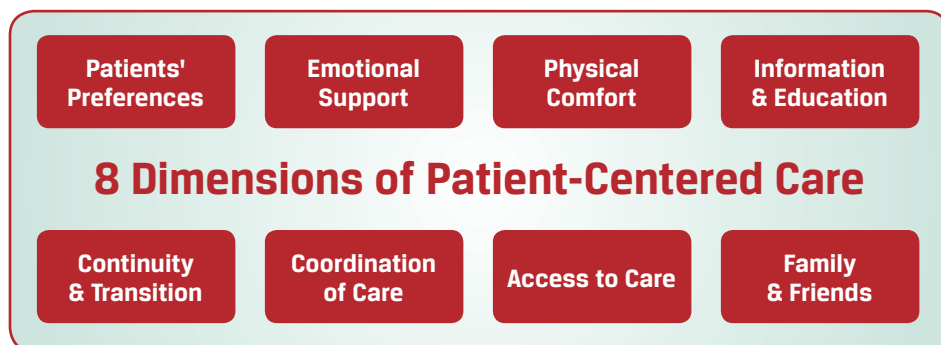
¹⁶ Patient Centered Care defined by Wikipedia https://en.wikipedia.org/wiki/Patient-centered_care

¹⁷ The Eight Dimensions of Patient-Centered, the Picker Institute and Harvard Medical School, <https://www.ncsb.org/PCC-PickerPrinciple.pdf>

¹⁸ National Research Corporation, policy of implementing Patient-Centered Care, <http://www.nationalresearch.com/products-and-solutions/patient-and-family-experience/eight-dimensions-of-patient-centered-care/>

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are concerned with their illnesses and conditions and want to be kept informed.

- An atmosphere respectful of the individual patient should focus on quality of life;
- Involve the patient in medical decisions; and
- Provide the patient with dignity and respect a patient's autonomy.

2. Coordination and integration of care

– Patients report feeling vulnerable and powerless in the face of illness. Proper coordination of care can ease those feelings. Patients identified three areas in which care coordination can reduce feelings of vulnerability:

- Coordination of clinical care;
- Coordination of ancillary and support services; and
- Coordination of front-line patient care.

3. Information and education

– Patients express fear that information is being withheld from them and staff is not being completely honest about their condition and prognosis. Based on patient interviews, healthcare organizations can focus on three

communication items to reduce these fears:

- Information on clinical status, progress and prognosis;
- Information on processes of care; and
- Information to facilitate autonomy, self-care and health promotion.

4. Physical comfort

– The level of physical comfort patients report has a tremendous impact on their experience. Three areas were reported as particularly important to patients:

- Pain management;
- Assistance with activities and daily living needs; and
- Hospital surroundings and environment.

5. Emotional support and alleviation of fear and anxiety

– Fear and anxiety associated with illness can be as debilitating as the physical effects. Caregivers should pay particular attention to:

- Anxiety over physical status, treatment and prognosis;
- Anxiety over the impact of the illness on themselves and family; and

- Anxiety over the financial impact of illness.

6. Involvement of family and friends

– Patients continually address the role of family and friends in the patient experience, and often express concern about the impact illness has on family and friends. Family dimensions of patient-centered care were identified as follows:

- Providing accommodations for family and friends;
- Involving family and close friends in decision making;
- Supporting family members as caregivers; and
- Recognizing the needs of family and friends.

7. Continuity and transition

– Patients often express considerable anxiety about their ability to care for themselves after discharge. Meeting patient needs in this area requires staff to:

- Provide understandable, detailed information regarding medications, physical limitations, dietary needs, etc.;
- Coordinate and plan ongoing treatment and services after discharge; and
- Provide information regarding access to clinical, social, physical and financial support on a continuing basis.

8. Access to care

– Patients need to know they can access care when it is needed. Focusing mainly on ambulatory care, the following areas were of importance to the patient:

- Access to the location of hospitals, clinics and physician offices;
- Availability of transportation;
- Ease of scheduling appointments;
- Availability of appointments when needed;
- Accessibility to specialists or specialty services when a referral is made; and
- Clear instructions provided on when and how to get referrals.

The Risk For Not Providing Excellent Customer Care and a Positive Patient Experience

Geisinger Health System has made a commitment to their patients that they will deliver great customer service and a positive patient experience every time a patient interacts with the health system, and they guarantee it. They believe so strongly that they are going to do everything right every time, that they have put their money where their mouth is.

Once a medical treatment is completed, patients have access to an application on their smart phone that allows them to evaluate the treatment and customer service they received during their medical encounter. If they are unsatisfied with their experience, they can request a refund based on a sliding scale of the total cost of their care.

Geisinger Health System President and CEO Dr. David Feinberg calls the new application “Geisinger Proven Experience™.”¹⁹ Dr. Feinberg said, “We’re going to do everything right. That’s our job, that’s our promise to you.”

Something has to be done to change the healthcare system, Feinberg added. He compared the refund idea to getting a

coffee at Starbucks. “If the barista makes it for you and you sip it and you don’t like it, Starbucks says we will make you a new coffee or give you your money back. I’ve never seen a Starbucks barista sip the coffee and say no, we made it right, you have to drink it.”

Feinberg envisions other big changes in the field as healthcare becomes more focused on the patient experience:

- Same day appointments upon request;
- Easy to understand bills;
- Automatic delivery and installation of supplies you may need upon returning home from surgery; and
- Office visits where you go directly to the exam room and the doctor is already there waiting for you, rather than you waiting for the doctor.

Offering a program like this has its risks, however “I don’t know if a money-back guarantee or warranty is the right way to do it,” Feinberg said, “but I do know if we don’t figure out how to do it, somebody else is going to do it.”

Summary

Today, every healthcare organization should have a customer service and patient satisfaction policy in place to show every employee what their organization expects of them and what is required by their patients.

The current healthcare consumer is better educated and informed than ever before. Healthcare organizations must address those aspects of service that consumers most readily appreciate: access to care; relationships between physicians, meaningful and understandable infor-

mation; and participation in their own healthcare and treatment decision making processes.²⁰

Providing excellent customer service in the healthcare industry needs to be a top priority for every provider. Improving patient satisfaction, customer service and the customer experience is critical to the long term stability and viability of a healthcare provider. Increased competition and the changes brought on by the Affordable Care Act have elevated the importance of delivering a consistent positive patient experience. Healthcare organizations that understand the implications of consumerism, pricing transparency, customer service and providing positive patient experiences will have a clear advantage over the competition in the future. ☺

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which drive new business development and client engagement for the company’s business process outsourcing and revenue cycle service lines. Mr. Solomon has over 25 years of experience consulting on a wide spectrum of healthcare initiatives for clinical and revenue cycle performance improvement. He has worked with many of the industry’s largest health systems developing executable strategies for revenue enhancement, expense reduction and clinical transformation. Mr. Solomon is a published author and featured speaker for the Healthcare Financial Management Association (HFMA), the American Health Information Management Association (AHIMA), National Association of Healthcare Access Management (NAHAM) and the Healthcare Information and Management Systems Society (HIMSS). He can be reached at phil.solomon@miramedgs.com.

¹⁹ Geisinger ProvenExperience™ money back guarantee program, <http://www.geisinger.org/pages/newsroom/articles/ProvenExperience.html>

²⁰ Customer Satisfaction and Health Care Delivery Systems: Commentary with Australian Bias, Internet Scientific Publications, <http://ispub.com/IJH/3/1/4173>

Patient Protection? Who is the Bogeyman in the Room?

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When the Patient Protection and Affordable Care Act (PPACA), affectionately called Obamacare, was introduced, there were a number of claims that were made in order to gain support for the legislation. Of course, this could be said about any introduction of legislation. Whether the Democrats or Republicans introduce legislation, the theme is almost the same: to protect the American public. The question we should ask ourselves; who are we protecting the American public from? Who is the bogeyman in the room that requires a 2,410 page law to “protect” the patient from such a bogeyman?

The Patient Protection and Affordable Care Act has in the title, *patient protection*. Before the legislation was passed, Nancy Pelosi, the then Speaker of the House, said, “*We have to pass the Bill so that you can find out what is in it... away from the fog of controversy.*” When people read the title of the Bill, many felt pretty good about it. Forget about reading the 2,410 pages of the legislation when you can quickly come to a conclusion based on the title alone. And there are two very important concepts in the title. One is protecting the patient; that sounds good. After all, everyone wants to be protected. And then there is the concept of “affordable.” Who would be against something affordable? More on the concept of affordability later.

So if we are going to protect the patient, who are we protecting the patient from? Is it the government? No, the government is the entity that wants to protect you, the patient. Though, many have suggested that the govern-



ment can often play the role of the bogeyman quite well when they decide to overreach through the many administrative rules and regulations. Is it the doctors? No, the doctors are here to help you get well. Is it the hospitals? No, because they too are here to help you. Is it the patient; are they the bogeyman? Not exactly, because even if they live an inactive lifestyle and eat poorly, we have learned that we should blame someone else. And there are many to blame. And the patient can then feel like a victim. So it is not the patient. Who, then, is the bogeyman? The insurance company!

Since the insurance companies are indeed the bogeyman, we should explore why they are before we indict the insurance industry altogether. They are an easy target to gain consensus about who we should blame. However, is the blame warranted? To answer that ques-

tion, I am going to try to understand the dynamics of the healthcare system in the U.S. and I am going to use analogies to try to make a point.

The question we are trying to understand about the bogeyman is why the insurance industry came to be labeled as the enemy. And why did we need to pass 2,410 pages of a law in order to “protect” patients from the insurance industry? And if we can answer that question, we can then understand better why the patient needs protection. If the insurance company is the bogeyman according to the Obama administration, what makes them deserve such a label? One of the talking points we heard from the Democratic Party was that the U.S. spends more money on healthcare on a per capita basis, than any other of the 190 countries in the world. The other talking point was that even though we spend so

much money on healthcare, we don't get the bang for the buck, evidenced by the rankings in infant mortality rates (IMR) when compared to other countries, the U.S. ranks near Cuba, around 29th in the world.

On the first talking point, it is true that the U.S. does spend a tremendous amount of money on healthcare services. In fact, the U.S. spends approximately \$2.2 trillion dollars every year on healthcare services. That comes to nearly 20 percent of our gross domestic product that is spent on healthcare services. This is where the insurance companies come in. Many believe that the insurance companies are the drivers of healthcare cost. Many believe if the insurance companies are driving up the cost of healthcare, then they get the label of the bogeyman and the government must step in to protect the patient.

On the second talking point, though an emotionally charged claim, one must understand how IMR are calculated to determine whether or not this is a good metric of quality of care of our hospitals. First, a baby must be born. Then, the baby must die. If these two events occur, then an IMR has developed. However, the length from birth to death in order to be labeled as an infant mortality is 12 months. Once the baby is discharged with the mother, if the baby dies months later in the care of the parents, is that an appropriate measure as to how the hospital is doing providing quality of care? NO, it is not. And most of the infant deaths occur after the hospital discharge. So IMR is not a good metric to tap quality of healthcare of the hospital. In the 1930s, IMR may have been an appropriate measure in that the rate was close to 50 percent. Today the rate is 5.87 percent which is a significant improvement which most of that improvement is due the high quality of care mothers and babies receive in our healthcare system. Of course mothers need to access care



during their nine months of pregnancy and they should adhere to the advice of the healthcare professionals. All too often, mothers are not nearly as careful as they should be in prenatal care.

Implicating the healthcare system as a poor performer in quality as a result of IMR is intellectually dishonest at best. Passing a law to reform the entire healthcare system based on IMR rates would be no better than suggesting that I should use a thermometer to measure how tall you were. The thermometer is not a good metric to tap the measurement of height. IMR is not a good metric to tap quality of care in our hospital system. In fact, the quality our healthcare providers, delivering services to our citizens here in the USA, is second to none.

Let's look at another industry to analyze the cost drivers of the oil and gas industry. In particular, why is it when I go to get my car filled up with gas at my local gas station, it seems to cost a lot? When President Obama took office, I paid about \$1.76 per gallon for gas. Some years later, I paid over \$4.00 per gallon. Is the local gas station the "bogeyman?" To answer that question we need to find out what the cost drivers are for the gas at the gas pump. If I gave

you three choices and asked you to select one, which choice would you select as to the biggest cost driver to gas at the local gas station? Is it:

1. The cost of transporting the gas from the refinery to the local gas stations that have driven up the price of a gallon of gas to \$4.00 from \$1.76.
2. The huge profits of the local gas stations which was achieved by driving up the price of a gallon of gas to \$4.00 from \$1.76.
3. The cost of the barrel of oil in the open market based on, in a large part, supply and demand.

The right answer as to the biggest cost driver as to what a gallon of gas at the pump is primarily due to the price of a barrel of oil. When the price of a barrel of oil goes up, the gas at the pump goes up. When the price of a barrel of oil goes down, the price of gas at the pump goes down once the inventory of the higher price gas is exhausted. Would it make sense to label the local gas station as the bogeyman and create legislation to

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protect the commuter? We could call it the *Driver Protection and Affordable Gas Act*. And we would blame the high cost of gas on the local gas station. Then solve the problem through a 2,000-page regulation keeping the focus on the local gas station in the hope that they would lower the gas prices at that pump. Would that work? Of course not! As it turns out, they are not the bogeyman.

What does that have to do with healthcare you may ask? Who is the bogeyman in healthcare? I am going to look at three possible culprits as to cost drivers of healthcare. Which one would you select?

1. The increase of cost of prescription drugs and in one case, the drug was increased to over 5,000 percent;
2. The huge profits of the insurance companies which was achieved by driving up the premiums of insurance policies; and
3. The increased cost of the hospitals and doctors charges as well as

the utilization of the consumer of healthcare services.

The selection of these three can be tough for many people. As it turns out, prescription drugs account for less than 10 percent of what we pay in healthcare services and many of the drugs help the patient avoid other costly services so the first one is not the right choice.

Insurance companies that are publicly traded file their financials with the U.S. Securities and Exchange Commission (SEC) and this allows us to evaluate the net profit of these insurance companies. As it turns out, over the last 20 years, the insurance companies have had a rather consistent net profit. When I would ask people to guess what they thought the net profit was of an insurance company, I would get more answers that were north of 35 percent of net profit. Some individuals suggested insurance profits of 95 percent. The answers were nothing more than impressions or speculations as to what the insurance company's net profit were. All were

wrong! Over the last 20 years, the publicly traded insurance companies made on average three to five percent profit. For most people, that is a shocking revelation. If the huge increases in healthcare costs were due to the "huge" profits of the insurance company, well the facts do not bear this out. The administrative costs range from 10 percent to 25 percent, depending upon the size of the company based on membership. Those who claim that CEOs make too much money sounds plausible, unfortunately, with administrative cost so low, that argument has no credibility. So we can eliminate the insurance companies as to the culprit of the big cost driver.

That leaves us with just one more choice. The doctors and hospitals account for over 70 percent of where the money is transferred from the insurance premium to those providers. Some of what the providers charge is due to two primary elements, the unit cost of the procedure and how many procedures are demanded by the patient. If patient demanded no utilization at all, the hospitals and doctors would receive nothing. So before we start blaming the provider community, we need to understand the demand side first before we complain about the supply side (physicians and hospitals). And here in the U.S., we want a lot of healthcare. We want all the healthcare services now and close to home and we want someone else to pay the bill. And as we get older, we demand even more services. And most healthcare providers have done a superb job supplying the demand. We also need to understand that physicians and hospitals have enormous expenses before they ever see a patient. Most of their expenses are fixed and a huge investment (besides their training) with the building, equipment, computer systems and most

employees who assist the physicians. The regulatory impact, requiring healthcare providers to comply with such, is also an enormous expense.

President Obama suggested that by passing Obamacare, we would see reductions in family premiums in the amount of \$2,500.00 per year. How did he arrive at such a claim? He was under the impression that if everyone was insured, that no longer would doctors and hospitals charge what they charge because the concept of bad debt would go away. How do they get everyone insured? Mandate everyone and increase the Medicaid rolls to the states that decide to expand Medicaid to 400 percent of FPL (Federal Poverty Limit). Yet, even if President Obama could achieve 100 percent insured, there are two natural problems with his theoretical academic hypothesis:

1. What is the probability that a hospital or physician group will lower their rates to the insurance company even if everyone was insured?
2. And to the extent there was a philanthropic physician or hospital, what is the likelihood that the

insurance will lower their rates based on the unit costs reductions by the hospital and doctors given there is a likely increase in the demand of healthcare services?

The answer to both questions is nil. Neither would happen. Neither did happen. And that is one reason why we did not see a decrease in insurance premiums.

Now the last few words of the PPACA are about “affordability.” That word is a meaningless word. What does it mean? If a word has 300 million definitions, then it has no universal meaning. So if the bogeyman was supposed to be the insurance company and, as it turns out, beating them up all day long will not drive down the costs of insurance no more than beating up the local gas station will drive down the price of a gallon of gas at the gas pump. And the concept of affordability is nothing more than a “feel good” word with no real meaning. What is affordable to Bill Gates is very different than what I find affordable. Now we can understand why Nancy Pelosi wanted the legislation to pass before anyone read it. Because had they simply read and analyzed the title, they would have had a lot of questions as to how this legislation would achieve their stated goals.

So did the PPACA “protect” the patient from rising cost of healthcare premiums? NO. The lessons to be learned are many. One important lesson is to ask yourself what words mean. How does proposed policy intend to solve a stated objective? If the framing of the problem is simply political and misses the real issues, then all the political solutions will never work because the problem was not framed correctly. And pointing the finger at a group because we feel that the group is the culprit does not make it so. A careful, cogent analysis is necessary and emotions can

often hide the facts. And some people live by the axiom that “my mind is made up, so don’t confuse me with the facts.” I think having a careful understanding of the words and industry overall is far more fruitful. And always remember: a government big enough to give you things, is also big enough to take things away. The United States was founded on two basic principles: freedom and liberty; and dependency on government assistance erodes the fabric of freedom and liberty. After all, it is hard to be free and enjoy liberty if you are held hostage by your dependency! ☹

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served as Chief Executive Officer for Oncologics, a company of eight radiation and oncology clinics, and GMG Management Group who operates primary care clinics, outpatient surgery center, physical therapy, occupational medicine, radiology and urgent care. He was CEO and Founder of Synergist Research, where he serviced co-owned research centers as well as contract research functions to various start-up pharmaceutical companies. From 2010 to 2012, Dr. Preston served as Vice President for Academics, Research and Assessment at Texas Health and Science University. He has served as Professor at University of the Incarnate Word in San Antonio and is currently Professor at Texas A&M University where he teaches graduate-level business and management students and conducts research in the areas of epidemiology, statistics, healthcare policy, health insurance systems and healthcare management. Dr. Preston has Sc.D. in Health Services Research and a MHA in Health Management from Tulane University, New Orleans, LA, and a BBA in Business Administration, from the University of Louisiana, Lafayette, LA. He resides in San Antonio, Texas. He can be reached at alan@preston101.com.



A Roadmap for Revenue Success at the Point of Service

Bird Blitch

CEO, Patientco, Atlanta, GA

Introduction

Beginning a few years ago, the healthcare industry began shifting the financial responsibility of care from the payer to the patient. By now you are probably familiar with high deductible or consumer-driven health plans and how they are increasing the amount of patient revenue you must collect. This trend will only continue over the next couple years.

Processing patient revenue is a task that involves multiple inputs and sometimes multiple vendors at different parts of the process. Besides the payment processing itself, which includes the physical terminals, virtual gateways, banks and credit card consortiums in some way or another, the healthcare provider must also consider payments made at different times and amounts during care process and in different payment methods. Uniquely to healthcare, providers are usually not able to require payment in full at the point of service so payment(s) must be arranged with the patient before, during and after care in cooperation with the patient's insurance.

This article will outline the different challenges associated with accepting payments at the point of service (POS) and will suggest areas you can evaluate for improvement.

Opportunity at the Point of Service

Much has been said about reorganizing the patient revenue cycle



process that takes place after insurance adjunction, specifically confusing bills, online payment options, offering payment plans and financing options to address the challenges of collecting patient revenue. Providers are right to evaluate and upgrade their revenue cycle technology and billing systems to meet these challenges.

One of the lesser-targeted areas for revenue improvement is processing and collecting dollars at the point of service. With the technology available to give patients accurate estimations and determine financial-aid eligibility upfront, more and more providers now have the ability to request an upfront payment at the time of service. However, a recent Transunion study shows that

70 percent of providers collect less than 30 percent of out-of-pocket costs at the point of service.¹

The challenges of requesting and accepting these payments mostly stem from a status quo that until recently was not problematic. But in this new model of payment for care, providers must address the staff, process and technology-related obstacles or risk losing valuable patient revenue in the future.

Staff Challenges

While your staff may be courteous and competent at the POS, revenue challenges can still occur if you don't implement the right culture to accompany improvements in process and technology. As the first and final human contact during an episode of care, your front-office staff has an opportunity to frame the encounter in terms of

¹ TransUnion Healthcare Report Finds Both Patients and Hospital Administrators Feeling the Squeeze of Increased Costs, <http://newsroom.transunion.com/transunion-healthcare-report-finds-both-patients-and-hospital-administrators-feeling-the-squeeze-of-increased-costs>

financial responsibility from scheduling to checkout.

Under the old system, a staffer's only financial-related task was to confirm insurance coverage and collect a copayment, if necessary. Because only a small percentage of revenue was at stake, little importance was placed on collecting payment upfront or upon discharge, especially at small practices.

Now, with close to 30 percent of revenue coming from out-of-pocket responsibility, determining coverage is just the first step in a list of must-dos at patient access. Staffers checking patients in can, and should, make every effort to determine a patient's out-of-pocket responsibility at check-in (as well as eligibility for financial aid) and make a reasonable attempt to collect that money at the time of service.

Collecting larger payments upfront requires additional staff time to handle issues related to processing these payments. One example is dealing with chargebacks, which are more likely to occur on payments of greater amounts. Chargebacks can cost money and require a staff member to work with the patient and/or vendor to resolve the issue.

Accepting upfront payments changes the patient check-in process and must be staffed accordingly.

Technology Challenges

Shifting your collections strategy to add emphasis to the POS presents more than just culture challenges. The technology required to process payments at the point of service may be inadequate for several reasons:

Interoperability: while you may be able to physically accept cash or check



payments from the patient at the POS, without the right software infrastructure you may find yourself succumbing to hours of paperwork involved in logging and posting transactions. Additionally, patients who make payments after the POS may become frustrated if their balance hasn't updated by the time they make the payment. Without integrated software, accepting payments upfront may not be worth the time required.

Hardware: having integrated hardware is a key step to accepting credit card payments. With the recent shift in liability for merchants who don't use updated EMV-enabled terminals,² now is the time to upgrade to hardware that connects to your payments platform and is EMV-enabled.

Payment Processing: providers who accept payments at the POS must find a way to efficiently accept multiple payment methods including health savings accounts/flexible spending accounts and cash and consolidate and deposit these payments into their bank account with proper attribution. For providers who previously collected only small amounts of money such as copays,

this can be an expected challenge. Finding a payment processor can be costly if not handled correctly, and sometimes require multiple vendors and contracts. Processing contracts tend to be complicated beneath the surface so review yours with extra scrutiny.

A Roadmap for Revenue Success at the Point of Service

An efficiently run provider business office weaves together people, process and technology in a way that removes obstacles to payment and delivers a superior customer experience. Below is a set of suggestions related to each category you can use to evaluate your current POS payments solution and make the appropriate changes, if necessary.

People

The most important part of your patient payment process is your people; both your staff and your patients. Therefore, your updated check-in/discharge process should embrace frequent and empathetic communication of your financial policies at every appropriate opportunity. Align all patient communications (online, posted in office, verbal and written communication, etc.) so that your patients understand their

² EMV is a technical standard for smart payment cards and for payment terminals and automated teller machines that can accept them, <https://en.wikipedia.org/wiki/EMV>

³ The Payment Card Industry Data Security Standard (PCI DSS) is a set of requirements designed to ensure that ALL companies that process, store or transmit credit card information maintain a secure environment. Essentially any merchant that has a Merchant ID (MID). <https://www.pcicomplianceguide.org/pci-faqs-2/#1>

A Roadmap for Revenue Success at the Point of Service

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financial obligations as well as their opportunities for financial aid and their options for payment.

Clear, consistent communication is the most important step to avoid patient confusion after the episode of care... when patients are less likely to fulfill their obligation.

Process

While your check-in/check-out process depends on your size and segment of healthcare, certain principles remain the same. The objective is to make the check-in/check-out process fast and convenient for both the patient and staff member assisting. Look at your reports and interview your administrators to staff the appropriate amount of people for a given time slot. Ask your staff where their pain points are and refer to patient feedback to determine which, if any, areas can improve.

Your financial policies should reflect the needs of your patients as well as your segment of healthcare and your classification as for-profit or non-profit. Make sure your business rules align with your technology, so that if a patient opts for a payment plan or financing, that you are able to implement this in a convenient manner.

Technology

To address the technology challenges mentioned earlier, the first step you should take is to evaluate your current business office technology solutions independently and in context. What this means is while one application may handle scheduling particularly well, it may be problematic if that application is used to process payments independent of your other payments solution(s). Ideally, you want to be able to tie any transactions to the patient automatically when that patient is going through the check-in process; this can only be done with properly integrated software.

Your processing terminals should also integrate with your payments platform and be EMV-compliant. By integrating your terminal with your payments software, your swiped credit card payments and manually entered payments end up in the same place, saving administration from having to manually consolidate and reconcile payments. This enables a single bank deposit from a single source every day, which can prevent money from being misplaced.

For practice groups and health systems, consider your current credit card terminals. Do you pay a monthly fee to rent units? Are your terminals connected but also payment card industry (PCI) compliant?³ Are you required to make a separate deposit for each terminal? What about each credit card type? These are important questions to consider when choosing hardware to process credit cards and other payment types.

When selecting a processing partner, be wary of upfront reserves or contracts that reserve the right to adjust the interchange rates at any time. For processes upwards of a million dollars per year, a fluctuation in rates can affect revenue by tens of thousands of dollars.

You may consider a fixed rate solution for the sake of stability. As always, PCI-compliance is a must. Is your processing partner(s) experienced in healthcare and the additional risks of connecting patient financial data with healthcare data? In this case, HIPAA-compliant partners are important because most payment processors simply stick to PCI.

Conclusion

Once you have assessed your needs and implemented any changes, don't forget to compare your new process to your old one. Revisit any changes you make from the holistic perspective of the staff user or the patient. Is making a payment during check-in or check-out fast and convenient for the patient and the staff user? If so, then you have accomplished your mission. 🍷

Bird Blitch is CEO of Patientco. Mr. Blitch co-founded Patientco in late 2009 due to his own frustrating billing experience following the birth of his first child. Combined

with his expertise in the payments industry, he recognized an opportunity to create a faster, easier and more secure payment experience for both patients and providers. Prior to creating Patientco, Blitch co-founded and served as CEO for BroadSource, Inc. While transforming the venture-funded company into one of the leading Telecom Expense Management companies, BroadSource was twice listed by Inc. magazine as one of the fastest growing private companies in the United States. Mr. Blitch is a graduate of the Georgia Institute of Technology with a Bachelor of Science degree in Industrial Engineering. He can be reached at 888-747-2455 or bird.blitch@patientco.com.



5 Traits Of Creative Leaders (And How To Become One)

Erik Wahl

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Becoming a Leader Takes Courage as Well as Creativity. And Creativity Takes Practice.

Being a leader is difficult. That's why most of us end up taking direction from others in our professional lives. But *the ranks of the self-employed are swelling*, hinting that more people are getting comfortable taking the reins in their own hands. And, in fact, becoming a leader (even if it's just you) is something anyone who's committed to the task can master. There's no inborn quality that leaders possess. They're ordinary people who decide at one point or another to do extraordinary things.

That doesn't just take courage, it demands creativity—the kind you need to actively nurture and practice. I'm an artist, so I like to think about leadership as an art form. And I've found that in order to become a leader, you need to develop similar qualities to an artist—to tap into your creative intelligence in order to keep ahead of the crowd, stay nimble and inspire those around you to push themselves.

Here are five traits the most creative driven leaders, generally speaking, all possess:

1. They Rattle Cages

Change is a constant. In the natural world, in politics, in business, the only thing that stays the same is the fact that nothing stays the same. Some people wait until they're propelled into leadership positions by forces around them. But the best leaders—from Joan of Arc to



Martin Luther King, Jr. to Steve Jobs—first provoke themselves into action, then the people around them. They're constantly imagining new possibilities. They instigate change that they envision even when others don't.

Yet perhaps the only major difference between these great leaders and the average person is that they're willing to do something rather than let circumstances dictate life for them. That typically means rattling cages and shaking up long-standing beliefs and institutions—which is never easy or universally well-received. But that's precisely what makes them great. To rise to your true leadership potential, chances are you'll need to rattle a few cages as well, starting with your own.

2. They Listen to Intuition

There are things we *know* to be true and things we *feel* to be true. Thanks to our education, most of us tend to lean

on our existing knowledge base to solve problems and make decisions. But the best leaders are those who realize that the things they sense—those possibilities that lie just beyond the realm of the known—hold a special value, too. Listening to them is how real breakthroughs happen.

Most of us have problems balancing logic with intuition. But the truth is that those faculties aren't opposed to one another. In fact, you need to figure out how to get them working together if you're to become a truly creative leader. Intellect without intuition makes for a smart person without impact. Intuition without intellect makes a spontaneous person without direction.

3. They Move Fast

One of the biggest stumbling blocks for anyone trying to accomplish something is perfectionism—the need to get it exactly right before taking the next step. But the best leaders realize that perfection is impossible, and pursuing perfection often stands in the way of what's most important: progress. Leadership requires making consistent strides, no matter how big. The quicker the stride, the greater the progress one can make.

Don't buy into the notion that you can take a giant leap if you spend enough time carefully mapping it out. By the time you get done planning, others will have lapped you twice and already taken that leap you spent months mulling

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5 Traits Of Creative Leaders (And How To Become One)

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over. Opt instead to “just go” and let the sparks fly. You *will* make mistakes. But in the process, you’ll learn quickly and keep moving—refining your skills and igniting new levels of creativity you didn’t know you had.

4. They Have Convictions and Stick to Them

“Don’t ask what the world needs,” the great civil rights leader Howard Thurman once said. “Ask yourself what makes you come alive and then go do that. Because what the world needs are people who have come alive.” There’s something compelling about a person with conviction, whether or not you agree with everything he or she represents. But conviction is rare, because in our longing for stability and security, we often make the mistake of looking outside ourselves for direction when we should be looking inside. And over time we can lose sight of who we truly are and what’s really important to us.

Conviction can be cultivated, though—and it starts with you individually. While those who live with great conviction can always inspire you, they don’t know your passions and beliefs. Only you can ask, “What makes me come

alive?” From there, the gaps between who you are and who you can still be will become clear. You might find you need something dramatic like a career change, or the exercise of answering that question might help propel you down the path you’re already on. The key is to find something that you feel you’re meant to do and give yourself to it.

5. They Don't (Only) Do What's Expected of Them

The ability to come up with new ideas is a defining characteristic of great leaders. They’re able to step out of the common view and imagine new possibilities that set the course for others to follow. Each of us has a tremendous capacity for originality—we’re each unique, after all—but activating it can be difficult. Why? Because our lives are full of other demands—our jobs, our families—and we spend most of our precious time and energy just trying to keep up.

In order to free your own originality, you need to be willing to stop doing only what’s required and expected of you and start doing the things that only you can do—those ideas and projects you keep shelving until you’ve got time for them. But the truth is there’s never a convenient

moment to tackle them. There’s never going to come a time when you’ll be 100 percent certain you’ll succeed if you do. Get started on those things today and work on them every day thereafter.

Ultimately, the real difference between you and the creative leaders who inspire you is action. You have the innate capacity to develop all the qualities they possess. The key is to start. Start today. Start now. Don’t wait around until life demands something of you—it always will. That’s not what leaders do.

Enlightened leaders understand what it takes. Unlike traditional leaders, they don’t want a group or organization filled with efficient yes men and women or even the best and the brightest. Instead, they’re looking for people who care enough to be disruptive, to challenge the status quo, to take risks in order to find that elusive great idea. People with that mindset can change the world. ☸

Erik Wahl is the author of the best-selling book *Unthink: Rediscover Your Creative Genius*. He is an entrepreneur, graffiti artist, successful speaker, author and philanthropist who helps people unleash their creativity to achieve superior levels of performance. In the past 10 years, he has shared his message with the largest and most influential companies in the world. His list of clients includes AT&T, Disney, Microsoft, FedEx, ExxonMobil and many more and he has been featured as a TED TALK presenter. Erik challenges his client companies and their people to change their behavior and develop creative and breakthrough thinking. Erik can be reached at 858-715-1997 and on his website:

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Value Rules: Playbook for Post-Reform Healthcare

David W. Johnson

CEO and Founder, 4sight Health, Chicago, IL

Warren Buffett famously noted, “Price is what you pay and value is what you get.” In fee-for-service medicine, price and value never correlate. Payments to hospitals, doctors and pharmaceutical companies reflect complex reimbursement formularies, not straightforward supply-demand relationships. Value is ephemeral; or worse.

The United States achieves one of the world’s highest living standards despite a high-cost, inefficient and acute-centric delivery system, riddled with perverse incentives, sub-optimal resource utilization and uneven performance. Americans pay too much for healthcare and receive too little. Overall value is negative.

After fifty-plus years of activity-based payment and excessive medical inflation, American governments, businesses and people want more from healthcare providers. They want better outcomes at lower prices. They want greater access and more convenience. They want medical services tailored to individual needs and preferences. They want value.

The fee-for-service playbook still has life, but it cannot win in post-reform healthcare. Incumbents must develop value-based business models with new playbooks. This isn’t easy, but providers have no other choice if they want to maintain relevance. As Buffett notes, “Chains of habit are too light to be felt until they’re too heavy to be broken.”

Shifting Landscape: This Time is Different

Recent healthcare performance indicators suggest a return to normalcy after



turbulence created by the Affordable Care Act. More people are accessing the system. Demographic trends suggest accelerating demand for acute services.

Hospital employment, profitability and facility construction are on the rise. After years of quiescence, medical inflation is back and pushing the nation’s healthcare costs ever higher.

While health systems have never been stronger, they confront an uncertain future. Below the surface, the following forces are mobilizing to drive U.S. healthcare toward value-based delivery:

- **Shrinking Governmental Fee-for-Service Payment:** Medicare’s decision to employ “bundled payments” for joint replacement surgeries heralds the arrival of value-based payment for routine surgical procedures. Expect payment for routine cardiology, urology and oncology procedures

to shift to bundles. Beyond bundles, Congressional payment reform will dramatically reduce fee-for-service payment to physicians over time. Likewise, state governments are experimenting with expansive risk-based payment models. Meanwhile, Medicare Advantage and Medicaid managed care continue to grow membership and shift care responsibility to private insurers.

- **Enlightened Self-Insured Employers:** Historically passive, self-insured employers are becoming more discerning purchasers of healthcare services. Iconic corporations, such as Boeing, GE, Intel and Walmart are contracting directly with providers for outcomes-based care delivery with transparent pricing. Others are shifting employees into high-deductible health plans, private exchanges and public exchanges.
- **Engaged Consumers:** With more healthcare purchasing alternatives and expanding use of high-deductible health plans, individual consumers are becoming price-sensitive purchasers of healthcare services. Better information regarding prices, outcomes and service performance position consumers to reward value-based providers.
- **Smart Money Investment:** Increasing levels of private equity and venture investment

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Value Rules: Playbook for Post-Reform Healthcare

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are pouring into healthcare services and provider-based services. Inefficiencies in healthcare delivery present a target-rich marketplace for companies delivering or enabling better healthcare at lower prices in more convenient venues.

Value Rules

Enlightened health systems are embracing value-based service delivery to prosper in post-reform healthcare. It will take years of focused effort to overturn entrenched business models and “heads-in-the-beds” operating cultures.

The new post-reform playbook has the following five value rules:

Rule #1. Quality is “Job 1”: Trying to overcome a planned obsolescence managerial mindset and respond to voracious Japanese competition, Ford Motor Company launched its “Quality is Job 1” campaign in the early 1980s, transformed operations, started building great cars again and turned the company around.

By definition, there can only be one “Job 1.” Health companies that don’t give quality primacy can never hit targeted quality, safety and outcomes metrics. Left unopposed, the energy generated from optimizing revenues (Job 1 at most health systems) overwhelms well-meaning quality initiatives. There is no wiggle room in pursuing quality.

Rule #2. Care Episodes, Not Treatment Codes: As more care becomes routine (episodic with high outcome certainty), customer assessment of quality shifts to price, convenience and customer experience. Most treatments, even surgical procedures, are

increasingly routine and potentially vulnerable to commodity pricing from retail competitors (see chart below).

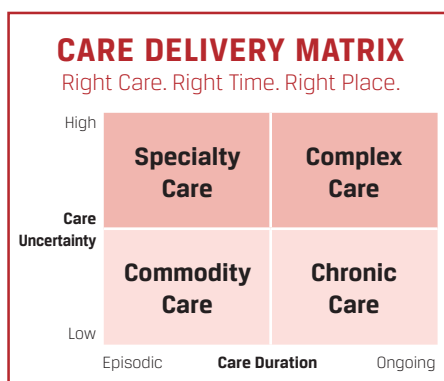
Piecemeal treatment activity is the principal revenue driver for hospitals and doctors. As delivery migrates toward value, entire care episodes will emerge as the logical units of outcome measurement and payment.

This will require providers to bundle all pre-acute, acute and post-acute activity into single cohesive treatment regimens that incorporate relevant clinical, operational and financial data.

Reducing performance and pricing variation, particularly in post-acute, care will differentiate high-performing health systems.

Rule #3. Price Matters: Third-party reimbursement for treatment activity has protected providers from traditional market forces governing supply and demand. Increasing transparency regarding treatment outcomes and prices is reshaping market dynamics.

When reimbursement payments are higher than market prices for routine treatments, it creates opportunities for independent entities to disintermediate tradition provider-patient relationships. Over time, market forces will drive payments for routine care to lower price points.



Expect value-driven behavior to shape pricing and service delivery for insurance products, diagnostic procedures and routine treatments. Using programs like [SmartShoppers](#), employers offer payment incentives to direct employees to lower-cost, high quality treatment centers.

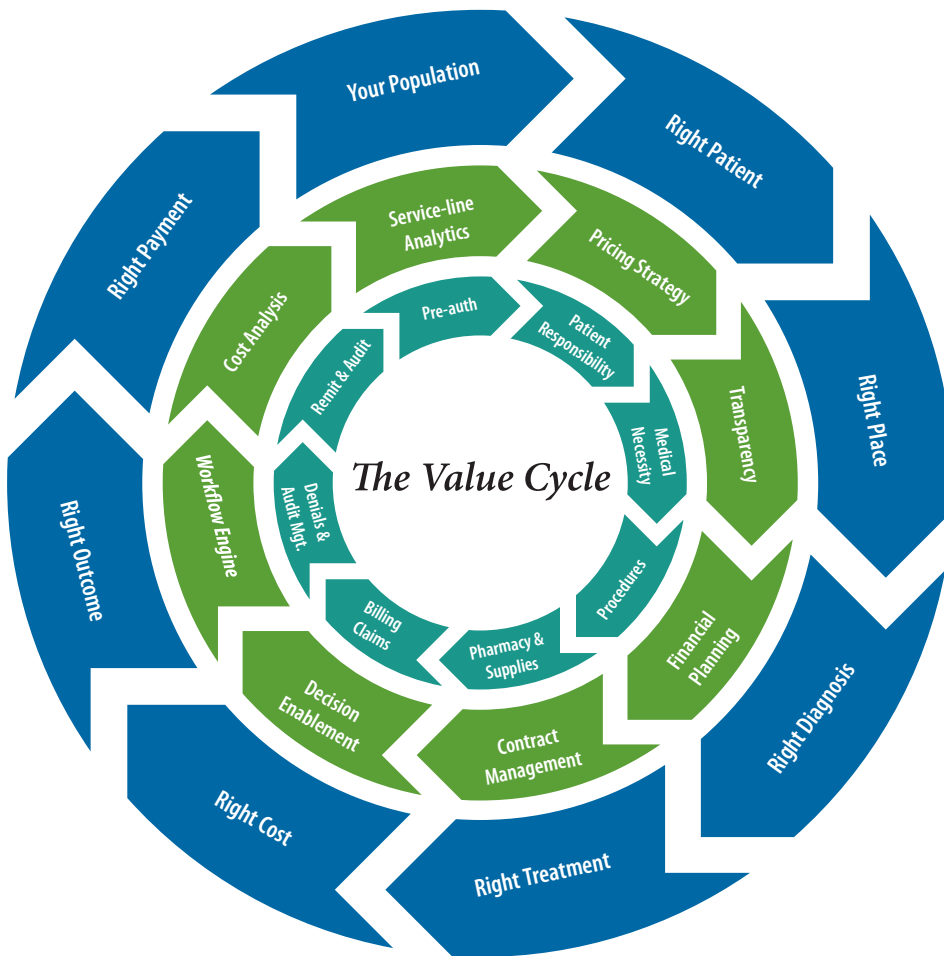
Rule #4. Data is as Data Does: Data informs decision-making when metrics and analytics support desired outcomes. Providers have excellent data for measuring treatment volume, payment flow and revenue optimization. Unfortunately, health systems have not developed effective metrics and analytics for optimizing care management and outcomes.

As big data evolves, precision searching of massive data sets informed by cutting-edge analytics will give external reviewers the ability to assess and rank health system performance. For better or worse, every provider and procedure will have a score.

The race is on. Data must support quality and cost-effective delivery. Health companies that advance value-based care delivery will develop enhanced data capabilities, earn external praise and gain market share. Paraphrasing Buffett, “*Time is the friend of value-driven companies and the enemy of revenue-driven ones.*”

Rule #5. It’s the Customer, Stupid! As the healthcare marketplace becomes more individualized, consumers will exercise more control over medical decision-making. Unleashed, consumers become value-seeking machines, rewarding companies that offer more selection, lower prices, greater convenience and better customer experience.

Businesses exist to serve customers in healthcare as well as every other



industry. Beyond providing appropriate care, health companies must engage customers through shared medical decision-making and offer meaningful second opinions. Health companies that help customers navigate healthcare's complex pathways will earn their loyalty.

Providers have executed transactions for decades with little customer involvement. As healthcare becomes more consumer-centric, health companies must connect with customers, listen to their concerns and tailor their services to individual needs. A good marketing campaign is not sufficient. Rhetoric and performance must align or valuable customers will seek care services elsewhere.

Launching The Value Cycle

Health systems are not the only companies scrambling to reinvent themselves

as healthcare moves toward value-based delivery. Companies that provide consulting, management and outsourcing services are reorienting their product lines to offer solutions that advance care design, effectiveness and efficiency.

During the last year, Craneware has reengineered its product mix to provide solutions for health systems that enhance value-based delivery.

The result is *"The Value Cycle."* Through *The Value Cycle*, Craneware has identified the essential clinical, operational and financial assets that health systems must employ to deliver quality patient outcomes and achieve optimal financial performance.

For Craneware to succeed, the company's solutions must become essential components within larger ecosystems that discover, convert and optimize

value potential. Craneware wins when health companies and their patients/customers win.

The Oracle Speaks

Warren Buffett is affectionately recognized as the "Oracle of Omaha." Buffett's common sense, value-focused approach toward investment has generated enormous wealth and returns for his shareholders.

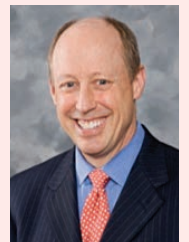
Buffett once observed, "Only when the tide goes out do you discover who's been swimming naked."

Real value in healthcare delivery is delivering the best outcomes at the lowest prices. As the fee-for-service tide recedes, America will discover which health companies are prepared for the value-driven demands of the post-reform marketplace.

Winning health companies will employ a new playbook that emphasizes quality, embraces transparency, optimizes performance, and, most importantly, embraces customers. Health companies that follow the value rules will rule their markets. 🌊

David W. Johnson

is the CEO and Founder of 4sight Health, a healthcare boutique specializing in thought capital, strategic advisory services and venture investing/capital raising. 4sight Health operates at the intersection of healthcare economics, strategy and capital formation. The company's four-stage analytic (Assess. Align. Adapt. Advance.) reflects the bottom-up, evolutionary character of market-driven reform. Mr. Johnson can be reached at 312-560-0870 or david.johnson@4sightthehealth.com.



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PROFESSIONAL EVENTS

Date	Event	Location	Contact Info
January 18-21, 2016	American College of Healthcare Executives St. Petersburg Cluster	Loews Don CeSar St. Petersburg, FL	http://www.ache.org/SEMINARS/cluster.cfm?MEET=STPETE2016
January 24-27, 2016	Healthcare Financial Management Association 18th Annual Region 11 Symposium	Manchester Grand Hyatt San Diego, CA	http://www.hfma.org/Content.aspx?id=42236
January 25-28, 2016	American College of Healthcare Executives Beaver Creek Cluster	The Westin Riverfront Resort and Spa Avon, CO	http://www.ache.org/SEMINARS/cluster.cfm?MEET=CREEK2016
February 10-12, 2016	Healthcare Financial Management Association National Payment Innovation Summit 2016	The Historic Peabody Hotel Memphis, TN	https://www.hfma.org/paymentsummit/
February 15-18, 2016	American College of Healthcare Executives Phoenix Cluster	The Wigwam Litchfield Park, AZ	http://www.ache.org/SEMINARS/cluster.cfm?MEET=SCOTT2016
February 22, 2016	American Health Information Management Association ICD-10 CM Workshop: Strengthening Your Coding Knowledge	Albuquerque, NM	http://www.ahima.org/events/2016febicd10cmworkshop-albuquerque
Feb. 28-March 1, 2016	Medical Group Management Association 2016 Financial Management and Payer Contracting Conference	Hyatt Regency Grand Cypress Orlando, FL	http://www.mgma.com/education-certification/education/conferences-and-programs/fmpc/mgma-financial-management-and-payer-contracting-conference
March 7-9, 2016	Ohio Health Information Management Association 36th Annual Meeting and Tradeshow	Hilton Columbus at Easton Columbus, OH	http://www.ohima.org/tradeshow/tradeshow10.html
March 14-17, 2016	American College of Healthcare Executives 2016 Congress on Healthcare Leadership	Hyatt Regency Chicago Chicago, IL	http://www.ache.org/congress/
March 20-23, 2016	Healthcare Financial Management Association Dixie 2016	Renaissance Nashville Hotel Nashville, TN	http://hfmadixie.org/2016/
April 10-13, 2016	National Cancer Registrars Association 42nd Annual Educational Conference	Westgate Las Vegas Resort Hotel Las Vegas, NV	http://www.ncra-usa.org/i4a/pages/index.cfm?pageid=3866

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