THE 2014
CEO/INNOVATORS
ROUNDTABLE

Highlights from the Eighth CEO/Innovators Roundtable: June 12 and 13, 2014

In June of 2014 we gathered in Boston for our most recent CEO/Innovators Roundtable. One reason we chose the location is because the area is home to some of the finest hospitals and medical research facilities in the world, but also because it's a hub of innovation across biotech, pharmaceuticals, high-tech and, importantly, quality-driven payer-provider partnerships such as the well known Alternative Quality Contract program. Years before the Affordable Care Act, Massachusetts also introduced its own health-insurance exchange, the Connector, and 97 percent of its residents are now covered.

At our previous meeting in Chicago, the federal government had just opened its online healthcare exchange, only to see its gears seize due to high response and faulty technology. The problems with healthcare.gov were ultimately fixed, and by the time the March 31 deadline was reached, more than eight million people visited healthcare.gov to sign up for health insurance. Projections suggest that enrollments—including those in state-run exchanges—will double by next year. Despite the setbacks, this was a major milestone in government-driven healthcare reform.

9.9
Percentage increase in healthcare expenditures during the first quarter of 2014.

As we met in Boston, the debate and discussion had moved beyond the ACA and was focused on the challenges of moving from volume to value based care, pricing transparency, cost containment, better use of remote monitoring devices, changing patient behavior, increasing accountability, and aligning incentives for consumers, payers and providers. If anything, there was a call to action that the industry must now take the lead when it comes to healthcare reform. As one attendee put it, "the challenge for the future is federal solutions versus industry leadership." And the race is on.

Framing the discussion over our two days in Boston were some troubling signs. Healthcare spending between the weak economic years of 2009 to 2012 seemed under control, growing at an average of 3.6 to 3.8 percent. While that rate still exceeded the growth in the overall economy during that period—often by double—these were the lowest healthcare growth rates in the 53 years that the data has been tracked. Now it seems that much of that slower growth may have been a result of consumers simply cutting back amidst tough economic times.

A report by the U.S. Bureau of Economic Analysis reported that healthcare spending surged to a rate of 9.9 percent during the first quarter of 2014. During that same quarter the overall economy actually contracted by 2.9 percent, making for a 12.8 percent difference. Many took an optimistic look at the numbers, suggesting the healthcare spending surge was a result of the newly insured taking advantage of health care benefits for the first time. The White House took that same position, and on its blog argued that costs should stabilize:

> **"Furthermore, any upward pressure on health care spending growth from expanding insurance coverage will cease once coverage stabilizes at its new, higher level, so it does not affect the longer-term outlook for spending growth"**

The White House Blog, Advance Estimate of GDP for the First Quarter of 2014.
http://m.whitehouse.gov/blog/2014/04/30/advance-estimate-gdp-first-quarter-2014.

Participants took a decidedly more wary view. Simple demographic facts about an aging U.S population are likely to put extreme pressure on healthcare costs. In July, The Congressional Budget Office (CBO) also weighed in with its own long-term analysis of healthcare spending, predicting that federal spending on healthcare will increase from approximately five percent of Gross Domestic Product (GDP) today to eight percent of GDP within 25 years. Driving the increase will be increases in Medicare, Medicaid, and the Children's Health Insurance Program.

$500 Billion
Cost per year to treat the estimated 9 million Americans who will have dementia in 2040.

According to a recent study published in the New England Journal of Medicine, just the costs of treating the nine million Americans with who will develop Alzheimer's and dementia by 2040 could surpass $500 billion a year—up from approximately $200 billion annually today. As Dr. Ronald C. Petersen, chairman of federal government's National Alzheimer's Plan, put it to the New York Times: "It's going to swamp the system."

Enter the Consumer: The Healthcare Business Model On the Verge of Radical Upheaval and Innovation

As we discussed at our event, while there is danger on the horizon, there are equally profound and positive transformations taking place in healthcare. For years many of our attendees decried the need for consumers to get more involved in their own healthcare, both in leading healthy lives, but also in being good stewards in managing the costs of their care. Today, this is happening, catalyzed in part by high-deductible insurance plans which are putting consumers directly at risk to healthcare costs, but also by the entry of the technology enabled tools as well as the entry of high-tech and retail industries into the marketplace.

Wal-Mart, which has returned to the number one spot on the global Fortune 500 list, has recently opened seven Care Clinics across Texas, South Carolina and Georgia, where consumers pay a flat $40 fee for a drop-in visit. For the company's 1.1 million employees who are covered by Wal-Mart's insurance plan, their cost is just $4 a visit.

The clinics, which are staffed by certified nurse practitioners, take patients seven days a week, and as late as 8:00pm. Lab tests ranging from Quick Strep to Urine Protein Tests and HIV tests, cost an additional $3 to $15 with results delivered on site during the office visit.

Wal-Mart describes their Care Clinic as:

> **A primary care clinic, which encompasses diagnosis and treatment of chronic and acute illnesses, as well as preventative services, such as immunizations, physicals and additional health screening. Our expanded scope of services enables us to be your primary medical provider.**

The company's pitch is that "Quality care doesn't have to cost a fortune," and by the end of the year there are plans to extend the pilot program to 15 locations. Today, Wal-Mart operates more than 4,000 stores across the U.S. and their entry into the healthcare field is worth paying close attention to. Target, Walgreens, and CVS have also opened clinics around the U.S. Taken together, these businesses, which are driven by a consumer-focused mindset, will have a dramatic impact on how healthcare is delivered in the U.S.

$40
Cost for a visit to a Wal-Mart Care Clinic. The 4,000-store retailer plans to open 15 clinics by the end of the year.

The high-tech world is also aggressively entering the healthcare market by appealing directly to consumers. Apple's new HealthKit, Google's Google Fit, and Samsung's Gear Fit are all seeking to put personal health data—from blood pressure to exercise and glucose levels—right in a consumer's back pocket. These hubs will ultimately integrate with products and services from a wide range of healthcare operators. Apple, for its part, has partnered with the Mayo Clinic, as well as with Epic in rolling out facets of HealthKit.

How quickly consumers, and physicians, adapt to sharing and providing care based on real-time health information is an open question, but if nothing else it signals a profound transformation in consumer-driven healthcare.

We would be remiss if we did not directly address the consumers' role in the future of healthcare. Hardly a month goes by without a new story about how consumers are trying to tackle the often-Byzantine healthcare system. While far from a full-scale movement, many patients are negotiating with providers and payers over costs, and trying to figure out their financial and health exposure to different procedures. One of the company's at the forefront of this movement is Castlight Health. The six-year-old venture works with self-insured employers to optimize their healthcare spending by analyzing pricing information and pairing it with quality and patient-experience metrics. By revealing the cost of care between providers—based on claims data—and overlaying with quality metrics, the company is helping employees pick excellent doctors at the lowest cost. This is becoming increasingly relevant to employees as more companies shift to high-deductible insurance plans.

Adopting and Learning From Innovation

As difficult as this evolutionary period is, there are incredibly positive signs in the industry. These include partnerships between for-profit and non-profit sectors, between payers and providers, and partnerships across industries. While the underlying economic and quality statistics are troubling, they reveal an enormous opportunity for innovation and success that draws Roundtable participants together each year.

With that in mind, on our first day, we asked our panelists to focus on cost mitigation and sustainability. Specifically, we asked our first panel and the participants in the audience to examine how we can continue to "bend the cost curve," and also explore which high-leverage interventions will help reduce the total cost of care in the U.S. We asked our second panel to examine the successes and challenges that are arising as not-for-profit health systems partner with for-profit companies to deliver both value and innovation.

On our second day, we tackled a broad spectrum of population health-management issues including workforce planning, and IT infrastructure for care management. At the end of each day, we also held a series of rapid-fire discussions on everything from bundled payment initiatives to the healthcare exchanges, from home care innovations to the role of mental health in healthcare costs.

If you were not able to make it to Boston in June, we hope this report will help bring you up to speed on some of the new solutions emerging from industry innovators. We also hope you will be able to join us at the next CEO/Innovators Roundtable later in 2015. As we lock down the details, we will keep you posted.

Finally, a brief note about the write ups that follow: Each session during the event was moderated by experts in the field—those listed at the top of each summary—but the discussions included lively debate, input and dialogue from the entire group of attendees.

Cost Mitigation and Sustainability. How can we keep "bending the cost curve"? What high-leverage interventions will help reduce our total cost of care?

- Joanne Conroy, Former Chief Health Care Officer, Association of American Medical Colleges
- Wendy Everett, Chief Executive Officer, Network for Excellence in Health Innovation
- Dr. Joseph Smith, Chief Medical Officer, West Health
- Dr. Jed Weissberg, former Senior Vice President, Quality and Care Delivery Excellence, Kaiser Permanente

How can we reduce the total cost of care while increasing the quality of care? This is the foundational question driving innovation and the transformation of healthcare today.

The root causes behind America's singularly expensive healthcare system are complex and manifold. It's now taken as a given that roughly a third of all treatments and related healthcare spending—approximately $750 billion a year—is either wasted or unnecessary.

One example cited at the CEO/Innovators Roundtable was the 700,000 operations conducted each year in the U.S to repair torn meniscus in patients' knees. This operation, which is the single most common orthopedic procedure, costs $4 billion a year. However, a recent study published in the New England Journal of Medicine found the actual procedure was no more effective than a fake procedure. Earlier studies had already shown physical therapy to be just as effective for meniscal tears as the expensive arthroscopic surgery. This is a powerful example of misaligned incentives: orthopedic surgeons are paid to perform procedures, not convince their patients of a procedure's viability.

Another hard-to-control form of waste is poor medical adherence, particularly with chronic disease patients. Much has been written about this phenomenon, but it's worth putting it into a cost perspective. Some estimates suggest that nearly 50 percent of insured Americans take at least one medication for a chronic condition, and that nearly half of this population doesn't take their medication as prescribed. One estimate by the Network for Excellence in Health Innovation put the cost of this lack of adherence—in the form of hospital treatments and patient visits—at $290 billion a year.

Further compounding the problem is that the business model for training future doctors at academic medical centers, AMCs, is most likely unsustainable. It's estimated that AMC's currently incur costs of approximately $1.30 for every $1 worth of research they conduct, and ultimately requiring a shifting of those costs to the AMCs' clinical payers. Meanwhile, medical students pay an average of $180,000 for their degree, but if physician pay drops substantially then that tuition will be increasingly harder to justify. Tracking the costs at academic medical centers has also proved challenging, and as one participant put it: money moves through AMCs like ghosts through a haunted house.

Despite these challenges, leading medical centers are tackling the issue of costs directly. Most have adopted the Healthcare Financial Management Association's guidelines on price transparency, and hospital cultures are also starting to change. At the UCSF Medical Center, medical students and physicians are now making their daily rounds and asking the question: What did we do that was unnecessary? Not only is this a first at medical centers like UCSF, but a strong argument was made at our event that only when that type of question becomes part of the larger medical culture will we see a drop in unnecessary and excessive procedures and treatments.

Other solutions include shifting patients from high-cost AMCs to lower-cost community hospitals, and using technology to monitor patients remotely so that red flags are raised before conditions require hospital care. In addition, aligning incentives is essential so that providers are paid to keep patients healthy and not for performing procedures. Likewise, consumer incentives need to be aligned so they have a stake in their own care and how their financial resources are spent.

State Governments and Cost Containment—the Massachusetts Example

Beyond what AMCs, community hospitals, other providers, and payers are doing to contain costs, a few state governments have entered the cost-containment fray. To date, this is limited to Vermont, Maryland, Oregon and Massachusetts—the state with the highest per capita health care costs in the country.

The Massachusetts effort was signed into law in the summer of 2012 and, in large part, relies on "moral suasion" to contain healthcare costs. The law calls for costs to rise no more than the growth in the state's economy in any given year. If successful, Massachusetts predicts it will save more than $200 billion in health care costs by the year 2027.

The law also provided for $60 million in grants to be distributed to community hospitals to implement technology solutions. It also created wellness tax credits to employers, and established the creation of cost-transparency tools for consumers.

It is the law's Health Policy Commission (HPC), however, which may have the biggest impact on cost containment. Described as a velvet fist in an iron glove, the commission is challenged with monitoring healthcare costs in the state, and it has two primary means for exerting its influence. The first are legal hearings in which payers and providers are required to testify under oath about their efforts to control costs. The second tool is that the HPC is charged with analyzing and assessing any healthcare related affiliation, merger or acquisition in the commonwealth. The lens for approval is based on what impact the transaction will have on Massachusetts citizens and healthcare costs. While the Attorney General has the final say on any approval, the commission's analysis seeks to make cost controls a primary item in analyzing any merger.

Indeed, what makes the HPC, and its goals so audacious is that historically healthcare costs in Massachusetts have run 8 percent above the state's overall growth rate. Reining in those healthcare cost to the level of the state GDP, or just below, would prove to be extremely disruptive to the business of healthcare in Massachusetts.

Focusing on Health and Morbidity Compression to Decrease Costs

Some hospitals and healthcare providers are adapting. We noted in the introduction that many retailers are entering the primary care arena, and today some hospitals are quoting patients a guaranteed cost for their procedure. As costs come down, many executives believe that there will be an inevitable and painful restructuring as hospitals become smaller. Some hospitals will undoubtedly fail altogether.

One cost-control solution that has been proven to be effective in San Diego is directly related "managing healthcare costs by managing health." The Naval Medical Center San Diego recently implemented an Integrated Health Community (IHC) that focused on promoting and encouraging positive and healthy behaviors in combination with leveraging data analytics to determine high risk and high cost patients. Once identified, this high-risk patient group was subject to intensive "person-focused" medical care and prevention strategies. This was overseen by a care team that included physicians, nurses and other providers, plus dedicated case managers and "care navigators" who helped patients achieve their health goals.

Before the IHC program, these 200 high-risk patients accounted for $22 million a year in medical care. Following the IHC initiative, the at-risk population registered 719 fewer ER visits, 199 fewer hospital admissions, and 2,281 fewer specialty visits. This, in turn, has led to a cost savings of more than $8.5 million per year, not to mention dramatically increased health for their patient population.

The underpinning philosophy with the Naval Medical Centers' approach is to push back the point at which these patients become critically ill. This is known as "compression of morbidity," and was first hypothesized by Stanford School of Medicine Professor, James Fries. The idea is that by pushing back the age when patients develop chronic conditions, costs are saved. Take, for example, someone who is 60 and lives for 10 years with a chronic condition, as opposed to a person who is healthy until they are 80 and only live with a critical or chronic condition for two years.

What rang clear during the discussion is that by testing novel ideas, and leveraging opportunities, healthcare costs are on the decline in certain settings. The challenge will be in scaling the solutions and applying them on a regional and national level.

Novel Partnerships – How can not-for-profit health systems work with for-profit partners to deliver greater value and drive innovation?

- Gayle Capozzalo, Executive Vice President and Chief Strategy Officer, Yale New Haven Health
- Dr. Terry Carroll, Chief Innovation Officer, Dartmouth-Hitchcock
- Mark Pacala, Senior Adviser at Oak Hill Capital Partners, a private equity firm
- Jon Weiner, President & Chief Executive Officer, OR International
- Jeff Seraphine, Eastern Group President, LifePoint Hospitals and President, Duke LifePoint, LLC

Several the CEO/Innovators Roundtable sessions have debated partnerships between for-profit and not-for-profit health systems. Today, these partnerships have become a reality as organizations are collaborating on creating scalable and sustainable health care systems. There are still many questions including:

What is considered a fair return on for-profit investment?

When is a reasonable time to monetize a return on investment?

The current economics of the healthcare system are spurring a wide range of organizations to consider these novel partnerships. At Dartmouth-Hitchcock they are re-envisioning how they operate, and whom they will partner with, to create a sustainable health system. The singular goal of this health system is to "improve the lives of the people and communities it serves for generations to come." Partners will have to embrace that ethos to join forces with Dartmouth-Hitchcock.

This initiative is unfolding at a time when the New Hampshire over-65 population has increased annually, on average, by 11,000 people in the last five years, and is anticipated to continue to grow annually, on average, by 13,000 people over the next five years. The result is a sizable portion of Dartmouth- Hitchcock's population shifting out of commercial insurance and into Medicare. Reimbursements for this expanding Medicare population average just 28 cents compared to the $1 reimbursement when covered by commercial insurance.

Further compounding the problem is that the hoped-for benefits from expanding the pool of insured citizens through the Affordable Care Act's exchange-purchased insurance has not yet been fully realized. Initial reports at Dartmouth Hitchcock suggest that while consumers were able to afford their new health insurance premiums they are struggling to pay their high deductibles. The result has led to a surge in uncompensated costs, including charity care.

Yale New Haven Health System

Yale New Haven Health System is an Academic Medical Center based in southern Connecticut. In 2011, the three-hospital system was looking to scale across its own state, and also into the neighboring states of Massachusetts and Rhode Island. The expansion would provide needed scale in a competitive market, but also require substantial capital investment. This meant seeking out partners who not only had capital, but who also shared similar values. While debating the value of joining with a venture-capital partner, Yale New Haven determined that the potential pressure for a quick return on investment proved too risky for their non-profit culture. Finally, while Yale New Haven was extremely competent in operating large hospitals, it needed a partner that was skilled at running smaller community hospitals.

In March 2014, after two years of deliberation, Yale New Haven signed a letter of intent with Tenet Healthcare. The partnership brings with it—subject to regulatory approval—an additional four hospitals across Connecticut, as well as access to capital and a commitment to invest in the newly acquired hospitals. Yale New Haven, for its part, will lend its clinical expertise and reputation across a much wider area. As Yale New Haven's Vice President for Public Affairs recently stated: "The scale of Yale New Haven Health System is self-sustaining, but there is a need for us to be part of something bigger. We have to be prepared for growth."

Duke LifePoint

Like the Yale New Haven Health System partnership with Tenet Health, the partnership between Duke University Health System and LifePoint Hospitals began with a local focus. The initial collaboration started in 2005 when LifePoint sought out Duke to improve their cardiac care unit at a rural hospital in Virginia.

In Duke's home territory of North Carolina—and the wider southeast region—they are widely considered to be the premier healthcare provider. Besides Duke, there were 30 independent health systems across the state of North Carolina, and some consolidation seemed inevitable. LifePoint, an operator of "non-urban" hospitals in the southeast, was looking to partner with organizations that would enable it to integrate and create regional systems of care. With those factors in mind, the two organizations formed Duke LifePoint in 2011 with the purchase of a medical center in Henderson, North Carolina. The partnership yielded a shared vision and mission statement built around quality and excellence, commitment to expand services in the communities they serve, and a pledge to support charity care. The partnership brings together long-term financial strength and operational experience in non-urban areas from LifePoint and matches it with world-class clinical resources and reputation from Duke.

Foundational to the partnership was the creation of a Quality Program: a common way in which the two organizations would improve quality across their shared network. In the Duke LifePoint hospitals, this has led to a 14 percent improvement in optimal care scores, positioning the organization to be leaders in quality care. The organization's success has led to a national strategy. Since the first acquisition in 2011, Duke LifePoint has acquired—or signed letters of intent with—10 providers, including 12 hospitals and more than 500 employed physicians. By way of comparison, in 2011 the company reported approximately $8 million in revenue, while 2015 is on track for approximately $1.5 billion in revenue.

Lessons Learned From Novel Partnerships

While Yale New Haven Health System and Duke LifePoint offer recent examples of the for-profit and not-for-profit worlds coming together, these combinations are not always successful. Some lessons learned from other experiences include: Discussions about reasonable returns on investments have to take place with investors. The expected percentage return on investment can vary, widely but in exchange for this return, investors are willing to deploy large amounts of capital.

Exit strategies will differ. It's important to outline acceptable exit strategies. When, for example, will an equity partner be able to leave a partnership, or sell a partnership stake?

Many hospital systems simply aren't ready to move quickly enough towards a population based health model. Establishing a new management organization may be necessary to move rapidly.

For-profit organizations may find it difficult to set the agenda with a large, powerful not-for-profit, and in many not-for-profit organizations there is a fundamental distrust of for-profit organizations.

Population Health Management—Workforce Needs for Care Management: Exploring the critical need and workforce planning challenges facing the workforce of the future

- Peter Ambrose, Chief Executive Officer, MindCare Solution
- Dean Hovey, Director, Senior Vice President, Marketing, Pensare
- Dr. Sachin Jain, Chief Innovation Officer, Merck
- Craig Jones, Director, Vermont Blueprint for Health
- Dr. Ted Wymyslo, Immediate Past Director, Ohio Department of Health

While the healthcare system moves towards population health in a myriad of different ways, what has become clear from these CEO/Innovator events is that there is still a disconnect between how healthcare should be delivered, and how it is delivered. Medical students, for example, are still largely taught to deal with patients on an episodic basis—not a comprehensive whole health basis. While hospitals can see a future where they will be paid based on the health of their patients, today hospitals are meeting their budgets on the basis of filling beds and performing procedures.

Furthermore, there is a disconnect between sound mental health and sound physical health. One estimate suggests that anywhere from 25 to 40 percent of primary healthcare visits have some form of behavioral health overlay. A strong argument was made that if providers don't address these behavioral issues, often by teaming up with behavioral specialists, they simply won't be addressing their patients complete care needs—and ultimately will be creating unnecessary future costs.

On the insurance side, it's estimated that 5 to 7 percent of the average insurance premium is attributed to behavioral health, but behavioral health accounts for to 8 to 11 percent of the costs. Compounding the problem further is that when patients can't access behavioral health experts, they end up seeking treatment for a wide range of linked ailments at gastroenterologists, neurologists, internists, and primary care doctors. In most cases, these physicians are not equipped or trained to address the root behavioral problems.

In Vermont, there is a test model for how an integrated whole-health system may work in the future. The state currently has 125 Patient Centered Medical Homes (PCMH). While these PCMHs originally had excellent primary care teams in place, they struggled with assembling the rest of a multidisciplinary team that needed to include social workers, behavioral counselors, and health-education experts. To address this, the state created Community Health Teams, paid for by all payers, and embedded these teams within the primary care settings. It was this change that was, arguably, the most important in setting up the PCMHs for success.

While the insurers covers the costs of the community health teams, the State of Vermont pays for "transformation infrastructure" including medical practice facilitators, program managers, and self-management leaders. While the program is still new, recent analysis by the state has shown lower year-to-year incremental growth in costs—compared to previous years—compared to traditional primary care settings.

The impact on the healthcare workforce, and its makeup, has been profound. Social workers, dieticians, and other counselors who previously used to work independently, are now working with Community Health Teams. And utilization of these professionals is up because there is no co-pay or other out-of-pocket expense for consumers. These behavioral professionals are also reporting that they are having more of an impact by being part of a multifaceted team.

Without an upfront investment in these teams, however, they simply wouldn't be able to exist. It's also important to note that while healthcare expenditures are lower than the comparison groups, expenditures on social services are up. However, total cost management is greatly enhanced.

The Impact of Consumer Technology on Workforce Planning

While much of the discussion centered on caring for consumers in clinical environments, an argument was made that only when organizations interact with consumers in their daily life can they have an optimal impact. Today there are a myriad of high-tech companies looking to do exactly that by engaging consumers and catalyzing them to live active, healthy lifestyles.

Digifit is one such company that creates mobile apps to enable consumers to assess their fitness level—including maximum heart rate during exercise. It also enables them to measure their physical activity on a day-to-day basis and then set and achieve goals. In business since just 2012, the company has more than two million consumers—including 250,000 who are actively engaged and exercising 35 minutes a day.

The company is just one example of how consumers are leveraging revolutionary technology and social media to not only monitor their health, but share their experience with friends by taking pictures of their feats, logging their paths and times, and challenging friends to do the same.

How Will the Workforce of the Future Be Trained?

Another way that technology is changing healthcare is by transforming how providers deliver care. Electronic medical records, for example, are starting to enable physicians to track patients through an entire hospital or clinical visit. In the past, a physician would have to physically track a patient down to follow the progress of their care—and also determine if their initial analysis and treatment were correct. Today, while limited in actual use, it's becoming possible for doctors to simply monitor the course of their patients as they navigate through a hospital.

Others speculated that as the sector shifts to population-based health, the workforce will increasingly be trained on-site—where consumers and patients are interacting with providers on a daily basis. There was also wide spread agreement that reforming training and education can only go so far without changes in the business model. Put another way, incentives need to be realigned so that physicians and other providers are paid based on population health metrics. Without that, workforce training will only yield limited results.

Population Health Management – IT Infrastructure for Care Management: Exploring best practices and solutions to the complex challenges facing industry leaders

- Dr. Brent Asplin, Chief Clinical Officer, Catholic Health Partners
- Dr. Kevin Fickenscher, Chief Medical Officer and President, Healthcare Division, AMC Health
- Dr. Sunny Ramchandani, Medical Director, Healthcare Business Directorate, Naval Medical Center San Diego
- Dr. David Lim, Director, Clinical Strategy & Design, Castlight Health

- Ian Steinberg, Health and Wellness Executive Lead, IBM
- Dr. Trenor Williams, Chief Executive Officer, Clinovations

How do we use IT as a tool for disintermediating traditional healthcare? And what are the impediments to optimal IT-catalyzed change? These were the questions that anchored this discussion. The problems are legion and well known. The healthcare sector is plagued by the lack of IT interoperability; its multiple systems and platforms aren't designed to communicate with each other. Furthermore, while 56 percent of physicians are now placing orders online, these physicians are plagued by multiple platforms and the time-consuming onus of inputting data. The insights gleaned from well planned data extraction are a paradigm-shifting tool when it comes to treating patients—but the burden of inputting and then extracting the needed data is costly.

Another impediment that emerged as a theme throughout the entire CEO/Innovators event is the prevailing fee-for-service model. Many hospitals are investing heavily in technology designed to optimize population health, but they are still being compensated on a procedure-by-procedure basis. Until this investment can be reconciled with their existing revenue model, hospital balance sheets will be under heavy stress.

A third challenge to the healthcare industry are consumers themselves. Not because many make poor health choices, but because consumers are beginning to demand that their healthcare providers operate as a service. The rise of outside technology companies and consumer-focused retail companies will also likely hasten the push towards a service model of healthcare. In a free market, most consumers will naturally go to the provider that gives them the greatest benefit for the best value. Healthcare businesses that position themselves for a consumer-focused service model will likely emerge as the winners.

There are some excellent examples of how existing organizations are leveraging technology to improve care and drive down costs. Castlight Health, for example, is helping self-insured organizations to drive up breast-cancer screening rates through targeted emails. The company also helps organizations educate employees who are over-utilizing the wrong kinds of care. One example includes employees who are regularly visiting ERs for minor ailments such as earaches and pink eye. By leveraging their claims data, Castlight can send the employees emails explaining that there are better, more cost-effective options for non-emergency treatment in their neighborhood.

Still, other organizations are using technology to change their workflow and drive revenue. One example comes from using social technology portals to drive patients to sign up for their annual checkup. This has, at once, led to a surge of new patients signing up for their annual checkup—and thereby increasing revenue—while also keeping costs down by having a trained, lower-cost workforce perform many of the key checkup functions.