Prognosticator's Advice: Counter Risk With Innovation

BY HOWARD GLECKMAN

Catholic health systems — indeed all health delivery systems — are at a crossroads. Demographics, new consumer demands, severe and growing government budget constraints, restrictions on credit, a major economic slump and rapid technological change are placing immense pressure on hospitals, nursing homes, assisted living facilities and other providers of both medical and long-term care services. Perhaps most challenging of all, Catholic health systems must adjust to these changing markets in an environment of massive regulatory uncertainty, created in large part by the Patient Protection and Affordable Care Act of 2010.

There is no doubt that this environment creates huge risks for providers. However, it also opens the door to new opportunities — a chance to break free from the secure, but limiting, shackles of an increasingly obsolete payment system. Some new health systems will thrive in this new world and better serve their mission of providing the best possible care to patients and residents. Others will fail both themselves and those they serve. Those who succeed will adopt a culture of constant innovation that is very different from the way most health systems operate today.

The nation's deficit crisis is the predicate for a debate over health reform which by no means ended with passage of the Patient Protection and Affordable Care Act. The Congressional Budget Office estimates that, by mid-century, federal spending on health (primarily Medicare and Medicaid) will exceed more than 20 percent of gross domestic product — and absorb all projected tax revenues.[1] The inevitable outcome: major tax increases, or substantial reductions in government health spending, or both. States, facing severe long-term budget shortfalls of their own, must make the same calculation regarding their share of Medicaid.

The Affordable Care Act is expected to cover 32 million currently uninsured, a reform that should significantly reduce uncompensated care currently provided by hospitals even as it increases demands on primary care physicians. Yet it will also cut payments to many of these providers. About $500 billion in projected cost savings from Medicare alone will come from providers. By covering 16 million new acute care patients through Medicaid, the law will increase financial pressures on those nursing facilities and home health agencies that must compete with acute care for increasingly scarce Medicaid dollars.

Integration of care for chronically ill seniors


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is just one example of the crosscurrents health systems will face in coming years. It will require nothing less than breaking down long-standing — but artificial — barriers between medical care on one hand and personal, social and spiritual care on the other.

The new health law includes both carrots and sticks, many aimed at the twin goals of lowering costs and coordinating care. The carrots include funding for a wide range of demonstrations explicitly designed to better coordinate care for chronically ill patients, as well as higher payments for providers that exceed certain performance benchmarks.

The biggest stick: Starting in 2012, Medicare will begin reducing payments to hospitals with high readmission rates. It is hard to overestimate the importance of this change. Not only does it have the potential to dramatically affect financial results for hospitals that already struggle with narrow margins, it is already driving managers to qualitatively rethink the cost-benefit calculations of programs aimed at reducing readmissions.

In the current payment environment, readmissions benefit some hospitals and hurt others. Hospitals that can fill beds with high-margin patients already have some incentives to reduce admissions of chronically ill, low-margin seniors. However, for hospitals with empty beds, programs aimed at reducing these "round trips" not only cost money up front, they reduce revenues. Those calculations are likely to change once Medicare begins cutting payments for excessive readmissions.

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The overall impact of health reform on providers will be dramatic. Hospitals will have as much as 6 percent of their base Medicare payments at risk by 2017. These financial incentives will not only affect hospitals, but other providers as well. For instance, the Centers for Disease Control estimates that in 2004, 123,000 nursing home residents made an emergency department visit in a 90-day period, and that 40 percent of those visits were preventable.[2] Inevitably, skilled nursing facilities will find themselves under pressure to reduce the causes of these visits (including falls, pneumonias and urinary and skin infections).

Finally, the law will require greater consumer-oriented transparency for hospitals and nursing homes, a step likely to reward high performers and punish those unable to adjust to the new environment.

To add to this uncertainty, it is impossible to predict exactly how these models will be designed until regulations are written — a process that is likely to take at least three to five years and perhaps much longer.

Yet, for all that, we are entering a period of great opportunity. The Affordable Care Act holds at least the promise of innovation and creativity in delivery of both medical and long-term care. It recognizes that chronic, not acute, care is the fundamental challenge of the health delivery system in 21st century America. It acknowledges the need to restructure the Medicare and Medicaid payment systems to reflect these changing realities. It takes steps — albeit small ones — in the direction of provider flexibility. At the same time, technology is making possible new systems of care that were unimaginable even a decade ago.

The sides of the fee-for-service box that in many ways curbed innovation are crumbling. Accountable care organizations, bundled payments, medical homes and other explicit coordinated care demonstrations will all create opportunities for better integrating care.

The result may be a system in which buildings — hospitals, nursing homes and large assisted-living facilities — give way to hybrid designs where care, sometimes provided at quite intense levels, moves to the community. Health systems will still provide that care, but not in the familiar edifices they are comfortable with. For example, hospitals and traditional senior-living providers already are finding new ways to reach into their communities to help those with chronic disease manage their illnesses. In New Brighton, Minn., the Benedictine Health System is partnering with the parish of St. John the Baptist to provide health clinics, care management, information and referral services and volunteer programs to help aging parishioners remain at home.

In Memphis, Tenn., Methodist Le Bonheur Health Care, the city's largest hospital system, is partnering with more than 250 churches of many denominations in a program aimed at breaking down the barriers between medical, personal and spiritual care. Called the Congregational Health Network, the project uses both volunteer

church-based liaisons and paid hospital-based patient navigators to both improve inpatient care and help participants better manage their health after they have been discharged. Early evidence suggests the project is reducing both admissions and readmissions and trimming lengths of stay for participants.

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Why would an operator of nursing homes and assisted-living facilities such as Benedictine Health want to help parishioners stay at home rather than move into its facilities? Why would Methodist Le Bonheur want to keep patients out of its hospitals? It seems counterintuitive, but in fact, these are cutting-edge responses to rapid changes in payment systems. They are creative ways for institutions to forge new relationships with members of their communities and help serve the mission of providing the best possible care. Just as we are entering an era of highly customized medications, so too may we be stepping into a time of highly customized health and personal care.

During this transition, health systems must survive in the current payment environment even as they adapt to future designs. Says James Higgins, CEO of Bon Secours New York Health System, "We are driving the car and repairing it at the same time."

To take advantage of this challenging — and no doubt threatening — environment, Catholic health systems will have to turn to uncomfortable and unfamiliar territory: massive, disruptive innovation. This process can't simply be a one-time adjustment to the new health law.

Think about how profound changes in the way we read books, listen to music or watch television have disrupted the entertainment industry, or consider how technology has remade the financial services business.

Firms such as Google, Apple and IBM have thrived by embracing this process of never-ending innovation. Those that can't adjust will die. Even companies that dominate industries or product lines must never stop innovating. Consider Apple's iPad. The product was synonymous with tablet computers, but 12 months later, in the face of intense competition, the iPad's market share was expected to shrink to 60 percent by 2012.[3] To flourish, the firm will have to once again out-innovate its competition.

Students of business practice define eight models of innovation. The most difficult to implement may be strategic innovation, defined as "the creation of new product categories, services or business models that change the game. It generates new values for customers and the organization."[4]

Yet, this may be exactly what will be required of successful health care systems as they face an extremely challenging future.

Until now, Medicare and Medicaid have functioned as golden handcuffs that, in many ways, insulated the health care industry. After all, the payment systems assure a steady revenue stream (though perhaps not always a sufficient one), and providers have learned to live within their limitations. But this legacy payment system seems to defy the rules of economics, thus discourages creativity and innovation.

Adjusting delivery to changes in Medicare and Medicaid is nothing new for Catholic health systems. But, until now, providers have survived with modest course corrections. Health reform and the federal government's severe long-term fiscal pressures will turn this trickle of change into a flood. For all of its risks and uncertainties, the Affordable Care Act opens the door for health systems to seek creative solutions to the challenges of delivering care to the chronically ill. The best systems will see the opportunity and thrive.

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NOTES

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