Recap of the Center's 5th Forum: Learning from each other – scaling ideas up to the next level.

By Katharina Janus

While the topic of this year's Forum was entitled "Learning from each other – Scaling ideas up to the next level" the underlying concern and impetus of the participants was how to use that knowledge to design the delivery system of the future.

A delivery system encompasses at least three elements: payers, providers and patients. All of those perspectives were represented at the 5th Forum in Berlin and connected through an ever changing value chain that was compared to and challenged by other industries with respect to data management, communication, contracting, product innovation and collaboration in general. Here are a few snippets of what we learned during the two days we put our heads together.

Please note that our style of "reverse conferencing" meant that participants did not prepare presentations in advance, but rather compiled new knowledge and insights once they were back home after the Forum. You may access detailed results under virtual broadcasting of the 2016 Forum.

Discussions started with a clean slate and an open mind. First, participants discussed that despite common sense that healthcare is special, different and alike, healthcare systems are not uniquely inept, given size, organizational form and competitive landscape (Sherry Glied), but their stage of development might vary. While New York City's local healthcare market has responded to the needs of an on-demand society also in healthcare, the "UBER-fication" that has hit many other industries is not yet served by providers in most other healthcare markets. However, attention was paid to the setting in which healthcare is provided as session discussions moved from a system to an organizational level. In a complex and predominantly matrix organizational form, communication was often based on interpersonal relationships within the healthcare firm, largely leveraging social capital. Therefore, an organization's context is key to understand the spread of new models of care delivery before diving deeper into the implications for individual stakeholders.

Patients first: is consumerism the new wave of empowerment?

In order to put patients and their concerns first we started the Forum with a pre-conference on retail healthcare and heard from New York City's market leader in urgent care – CityMD – how this innovative model of care delivery pursues consumer-centric care rigorously. Nedal Shami provided insights into how he thinks about how to provide value and define quality care. Together with Brent Stackhouse he shared his philosophy on access, service and value.

A growing expectation of care-on-demand is that patients should not have to wait. Hence the rise of urgent care centers, retail care, convenience care centers, and the like operates on that premise. Have a patient see a provider as quickly as possible (average wait time at CityMD is eight minutes) is their motto. When patients do interface with the healthcare system, it is important to engage them, understand them, build trust and leverage that trust to impact actual outcomes. This also implies recognizing and addressing the difference between a patient's perception of quality and that of a physician. Further, it requires collaboration with other providers to ensure that patients are guided back home to their providers through aftercare. A challenge is the sharing of information with those collaborators, but participants expressed their hope that patients will be in charge of their own data someday.

Participants of the Center's 5th Forum stressed in other sessions and presentations that patients need to be involved – not only in decision-making, but in particular in the development of innovative yet simple technologies early on in the development cycle (David Roye). While diagnostic developments such as 23&me were rather considered to be "genetic entertainment", attendees agreed that an underlying constituent of consumerism is patient inclusion in planning and decision-making of diagnostics and treatment.

Users demand good services, but what this means has to be defined and adjusted continuously during the process. This will also be relevant for best agers who will turn from silver surfers to become a silver tsunami in society. Jack Rowe provided insights into the potential of an elderly workforce, but also their sophisticated demands. "Old sick people are sick because they are sick and not because they are old." They will have equal access to information and question established paradigms and, thus, shape consumerism.

In this respect Larry Brown's roundtable on consumerism elaborated on the major determinants that will drive change in the current and future development of consumerism:

- The accumulation and easy availability of information and data, especially on the internet, is empowering or intended to be so.
- The pervasive importance of choice.
- Paternalism – the notion that doctor knows it best – is in retreat.

Provider roles, assessment, and…manners

Providers have various roles, such as being the gatekeeper or the connector. The former has been propagated in many primary care models over the past decades, but is becoming less of a topic as retail care and consumerism (see above) gain prevalence and other entities might take on that role. The latter is more complex, requiring the provider to connect patients with other providers and services organizations that are required to implement the patient's care plan, share information, and coordinate the care provided across the continuum of care.

Referrals and integration of care should be based on the quality of care provided. However, there exist challenges of reciprocity between providers, particularly with respect to the lack of quality indicators available to truly judge one another. While the current age of medicine has attempted to drive quality, these indicators are still largely lagging behind the industry's needs and will remain so until sufficient investment is made to enhance it. In her speech Sherry Glied demanded that information about peers should be made readily available to provide the basis for better judgment. She also provided insights into the hospital side where hospitals that attract more patients have better survival outcomes, but not necessarily better cost outcomes. So size really helps, but can be considered a necessary, albeit insufficient condition.

While medical quality is essential to build a convincing case for referral and coordination, we learned that innovative models of care delivery put a particular emphasis on manners and etiquette. They train their physicians to shake hands, sit down, look patients in the eyes and ask questions. One would think that this is evident, but considered an innovation in healthcare delivery. This is also reflected in one organization's net promoter score of 70% (compared to 17% on average for healthcare organizations).

At Tom Rundall's roundtable on "branding" it became clear how important patient experience is: it is used for local branding while international branding is mostly based on clinical reputation.

Payers' "creativity"

As fiscal pressures increase there is a temptation for governments to shift coverage incrementally from the public onto the complementary system, but systems face this temptation differently. While various pricing and packaging strategies were discussed, value-based insurance design (VBID) was in the spotlight at the 5th Forum.

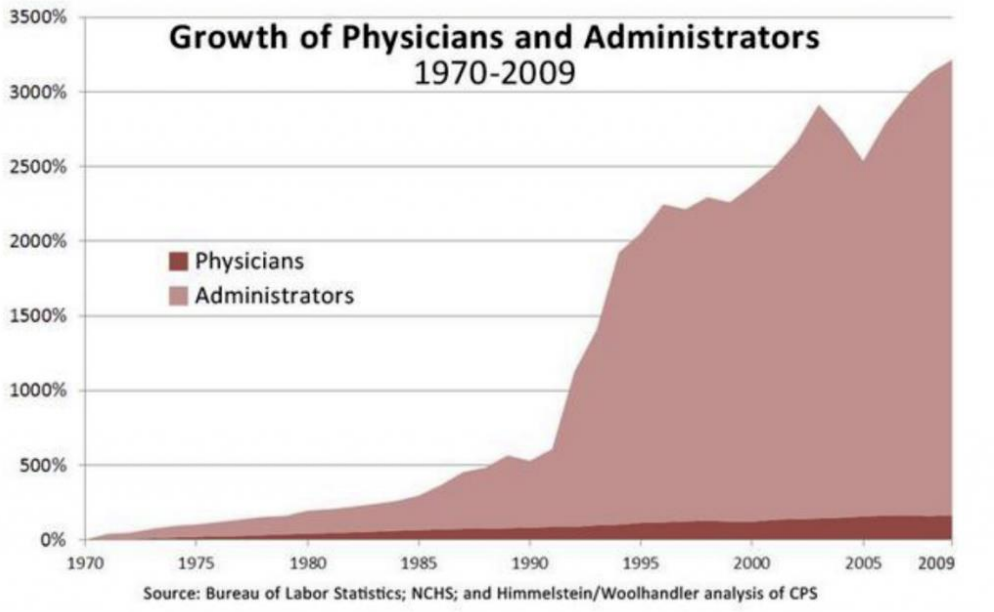
The rationale for VBID is to align financial incentives of patients who are seeking high value care, such that higher value systems of care or providers would be available at lower cost sharing and lower value care would cost patients more in terms of out-of-pocket payments. However, from the value perspective, improved outcomes at the same costs still yield improvement in delivering care. As a result, VBID will not be the "silver bullet", but remains an arrow in the quiver for improving the value of healthcare within systems that direly need solutions. The biggest issue with VBID, however, remains the complexity associated with various incentives and disincentives, a potential reason for its small impact. This complexity is reflected in the value chain of care delivery.

The value chain or "circle" or what does it actually look like?

Not only is the value chain as such defined vaguely it also changes constantly. We discussed resources needed to map and manage the value chain, the factors that impact change and potential role models for replication.

First, existing fee-for-service systems that are based on hoping that people will do the right thing will never achieve any meaningful outcomes (Ron Kuerbitz). However, deploying for example additional care managers or health navigators to supplement a physician and nursing dominated system to achieve the right care pathways at the right time would cost money up front to enable such infrastructure. The return-on-investment for such human resource interventions is frequently unclear.

If we consider these investments on the human side it becomes clear that the mapping and management of the healthcare value chain has changed considerably given the fact that the increase in administrators with respect to physicians has skyrocketed.



In addition to pure human factor innovation, changes in the delivery model of care have been more actively managed in the US than in European countries. Whereas traditionally new organizational forms of care delivery were imposed on participating actors and pushed into the system, at least in the US pull mechanisms are developing. Hospital or health systems create the in-house capability to identify, assess, and implement new technical and organizational innovations, and in some cases to create innovations to address problems identified in clinical or managerial processes. This move from push to pull approaches demands for a proactive design along the value chain.

Sherry Glied elaborated on the Starbucks model and how its learnings could be related to innovation along the value chain. Although Starbucks does not offer the best coffee, since its emergence in 1990, overall quality of coffee in the market has improved. However, the increase of quality in coffee in the market was not the result of a new innovation in coffee or better management, but rather because of the invention of a new organizational form that deployed resources differently. The question arises why we don't have Starbucks in healthcare?

1. *Focus*: Healthcare systems are focusing on selection (of risks) rather than optimizing processes.
2. *Politics*: It is more convenient to approach the person who controls the money and power than looking into organizational change.
3. *Inertia*: Medicine has been around much longer than coffee and the physician-patient relationship is perceived as sacred.

Essential to resolve these issues would be to get the focus of managers on the broader system instead of building policies around hospitals. Sherry considered three measures as important:

- Weaken incentives in healthcare systems
- Give patients access to their medical records (set up an opt-out instead of an opt-in system, making it mandatory to provide patients with their records instead of requiring them to ask for it)

- Provide more quality information to providers (such as performance indicators compared to their peers)

Besides these generic measures we discussed role models for replication at the Center's 5th Forum. One of those was the already described retail model of care that is emerging in big cities. Another more established model is Kaiser Permanente that has been founded and is running successfully in California. However, given the opportunities created by new technologies we asked whether the Kaiser model is outdated in a wired world. We agreed that in the future there will be greater opportunity to extract the essence of what Kaiser does well. This will also allow successful role models of care delivery to expand beyond geographic areas. However, especially this was seen critical by participants as the Kaiser model has been relatively unsuccessful because efforts to expand the model have failed. Even though Kaiser is a loadstar of what we want to be, it only worked in one setting in a magical place, but magic is not a way to build a healthcare delivery system.

In general, the question of make or buy is recurrent along the value chain. Information technology allows organizations to make more and buy more and creates ways to monitor within the firm that organizations could not accomplish before. Other countries, such as Italy, have made different experiences. When moving from a bureaucratic to a market-based system costs went up dramatically. This experience made stakeholders question retail strategies in healthcare. However, as organizations move their strategies from pure product offerings to solution packages rethinking the structure of the value chain is at the core of many multinational companies.

The glue or the sticky cake: data

We focused on the impact of data on the world of healthcare management and found that it will lead to a system which provides more precise and personalized services (precision medicine). During this process, data will drive consolidation of small providers as they cannot keep up with the challenges and changing demand from the user (Frank Maddux).

Data was also named a new "currency" that allows new forms of reciprocity and relationships (Sherry Glied). Similar to a currency converter we need a data converter that translates its value from one to another system. However, most exchange of patient data nowadays is still "r to r" – receptionist to receptionist. It will stick to interfaces as long as it is not managed jointly with other "currencies" that have an impact on the functioning of the care delivery system.

Other currencies in healthcare delivery

A currency is something that is used as a medium of exchange. Money is considered old-fashioned and leading scholars suggest to ratchet down monetary incentives (see above). Culture will replace money as it shapes health policy (Larry Brown). On the organizational level there needs to be a cultural meeting of the minds that requires a unique skill set for managers and leaders.

New (and well established) delivery models of care acknowledge the importance of trust as a currency, especially in a wired world and with respect to reciprocity. The wired world will challenge the understanding of what trust means and encourage higher transparency of information and exchange. Thus, fairness must be embedded in the contract and discourse that follows. Many healthcare systems are at a tipping point from moving from a collegial environment to a more competitive one and that can threaten this trust and fairness.

Change of the delivery system

Forcing change starts by selecting one person interested in the topic (Martine Bellanger). But in order to gain leverage, stakeholders have to be involved. There need to be discussions on redefining roles and incentives for participation as this is a sensitive process (Oriol Lacorte). It is important not to push change too fast too far, citing the managed care backlash during the 1990s in the United States.

In this respect the healthcare industry could play an important role in contributing to improving the value chain: the industry's manufacturing experience and capabilities in lean management, change management, project management, and culture-shaping is a critical component needed to align minds, mission and vision.

This opportunity has been present for decades, so why don't we emulate the best performers? Managers in healthcare are not uniquely inept, as the quality of managers is not the problem. But the focus has been primarily on selection and shifting risk. Entire networks have been developed around risk to generate referrals to drive volume and revenues. What we need, however, is a joint approach and a trustworthy distribution of risk. Parties need to share data and competencies to manage risk while focusing on outcomes for the patient and the delivery system.