Certainly, there are any number of written pieces and speeches expressing opinions and outlining observations about the ongoing transformation of the healthcare industry; it is, in fact, a very noisy time for our industry in many respects – and external commentary is understandably a part of that noise. We note as well that the trite “one foot on the dock and one foot on the boat” metaphor seems to be the driver of a significant amount of that commentary, which itself seems to drive a tactically oriented discussion that actively avoids (by some important definition) the larger macro trends that should encourage greater urgency and accelerating pace around our industry’s fundamental disruption and transformation.

We are hopeful that there remains room for distinctive commentary that isn’t simply an echo, and so our purpose in this piece is to step away from the day-to-day dialogue (“get above the trees,” so to speak) and explore five specific macro themes that our research indicates may be getting less-than-appropriate attention in the conversation. We believe that currently anticipating and responding with urgency and pace to the emergence of these matters may be foundational to future success for healthcare organizations, and we hope that these thoughts are accretive to the broader industry dialogue during this unprecedented transformational period.
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1. LEADERSHIP TRANSITION REDEFINES INSTITUTIONAL STRATEGIES

Many, and possibly most, healthcare organizations articulate a focus on succession planning and evidence formal succession plans of one kind or another. Having said that, the deep prevalence of external searches for key executive talent (including important C-class positions) seems to demonstrate that the internal succession board is less than optimal, and that the ‘succession plan’ at times is really just a wish list as opposed to deeply planned succession that is a routine in-process activity.

This issue is further complicated by our anecdotal observations that talent pipelines are generally weak across the country, and we seem to be at a unique time in the industry’s talent succession as more tenured, long-standing senior executives are reaching the end of their careers.

The combination of all of the factors above, along with a willingness and interest on the part of institutional leadership in some instances to explore non-traditional executive talent, presents an emerging landscape where new executive leaders from non-traditional venues and experiences are active succession candidates. While this is likely not the norm across the country today, solving the equation presented above supports the concept that we will increasingly see key executive leadership positions filled by this type of candidate.
1. LEADERSHIP TRANSITION REDEFINES INSTITUTIONAL STRATEGIES // CONTINUED

The strategic, operational and financial perspectives of these types of executives will of course have been shaped by individual experiences, and so they will be expected to incorporate and execute from those perspectives in the new institutional game plans that will form their executive charge and range. There has never been a pervasive dynamic of this type, and it is reasonable to expect that these non-traditional experiences (and accompanying playbooks) will serve as meaningful and, perhaps, material accelerators and disrupters in the shaping of the transformational landscape.

One proof point example of a leadership trend that is accelerating is the emergence of the physician CEO, reflective of the increasing recognition that clinical leadership is required throughout the C-suite, and not just in the more traditional Chief Medical Officer role. Another forward-looking example worthy of commentary is the selection several years ago of Carlos A. Migoya as CEO of Jackson Health System (Miami) – before his selection to lead Jackson, Mr. Migoya was a local banking executive with significant community and political relationship equity. Under Mr. Migoya’s leadership, Jackson has achieved a crucial level of financial sustainability and closed important public capital financings to fund the System’s critical infrastructure needs. It seems reasonable to associate an important level of the ‘turnaround’ of Jackson with the deep banking acumen and community equity associated with the financial services leadership experiences that Mr. Migoya brought to the CEO’s role at Jackson.
DHG Healthcare’s technical point of view associated with Risk Capability (see www.dhghealthcare.com) is a platform that reconciles the current dialogue with respect to cost and quality with a perspective emphasizing that markets (widely-defined) are effectively past the so-called “tipping point,” and therefore the core industry questions are now related to:

- Market-level transformational urgency and pace;
- Executing against critical themes (revenue transformation, clinical enterprise maturity, and enterprise intelligence) and tactically addressing related foundational catalysts; and
- Achieving a level of transformational agility to facilitate accelerated execution and a higher level of success assurance.

Fundamental to that Risk Capability point-of-view is the concept that the current transformational dynamic is not really being driven by “industry reform” as we typically see characterized; rather, the critical catalyst here is about fundamentally new purchaser expectations, with the “purchaser” defined as that critical economic pool of federal and state governments, employers, and (crucially) individuals. Those purchaser expectations are profound and creating a level of momentum towards a new U.S. healthcare industry paradigm that is unprecedented.
The focus and evidenced intent of the federal and state governments here is well-publicized; what is not receiving an adequate level of attention is the fact that institutional urgency and pace are not matching the urgent socialization of the intent of the governmental purchasers. Emerging Alternative Payment Model (“APM”) frameworks are putting important pressure on the provider community – not only in future strategic and tactical APM planning, but on current revenue streams as mandatory programs take hold. At DHG Healthcare, we are receiving literally daily calls from provider clients and friends trying to understand why their volumes are exceeding plan yet their per-unit revenues are dramatically down – clearly, the impacts of governmental APM frameworks are a crucial component of that equation.

On the commercial side of this discussion, contrary to what many industry commentators assumed, the Affordable Care Act did not drive employers to forego offering traditional health plan coverage to their employees – in fact, the number of employers offering health plan coverage in 2015 is similar to the number in 2005. What IS different, however, are the emerging new expectations of employers regarding “value,” which itself has multi-faceted definitions and can vary by employer. In the commercial space, we are seeing both increasingly sophisticated HR leadership and the complex cost dynamic moving to the CFO’s desk – both of these factors are driving an emerging new corporate financial understanding (and questioning) of the traditional insurance marketplace, new levels of collaboration with local leaders in healthcare benefit program initiatives, and an increasingly vigorous and knowledgeable dialogue that is insistent with respect to value development and delivery. DHG Healthcare and Health Choice, through our joint venture iluminus, are working with a Fortune 400 commercial company that is actively bringing related perspectives to life in one of their key employee geographies covering approximately 15,000 employees. This work is in process and confidential, but what can be disclosed is the important disruption to traditional commercial insurance “backbone” relationships that is emerging as this major employer’s vision is brought to life.
2. MARKETS ARE DRIVEN BY DRAMATICALLY NEW PURCHASER EXPECTATIONS // CONTINUED

Both the governmental and commercial purchasers will increasingly incorporate a mandatory retail experience into their definitions of value. Regardless of the retailing metaphor describing what access to healthcare should be “like,” it seems clear that the typical retail experience for most Americans in accessing the healthcare system is deeply flawed. Two key factors – cost-shifting to individuals and technological adaptability – will drive not just a desire for a dramatically enhanced retail experience, but a swelling demand that will emerge with pace that is currently not being anticipated by the industry in general. Emerging strategies (which, in the context of our overall healthcare economy, are in their infancy) related to urgent care and retail pharmacy are informative here. For example, the ability of retail pharmacists to be one of the prominent faces of a new retail experience is profound – the average American lives within five miles or less of the nearest community pharmacy, and yet:

- Approximately $300 billion is wasted each year by patients not taking their medications (13% of total healthcare costs);
- Chronically ill patients who take their medications save the health system up to $7,800 annually per patient, yet roughly 50% of all chronically ill patients stop taking their medications within the first year of starting such therapy;
- Up to 70% of hospital readmissions are related to poor medication adherence, estimated to cost $100 billion a year outside of hospital readmission penalties; and
- Approximately 50% of all adult patients experience a medical error post-discharge and up to 23% experience an adverse event related to prescribed medication.
The observations called out on the previous page are generally well-socialized statistics; however, the current levels of market-specific urgency and pace are not consistent with the opportunities related to a pervasive transformation of the retail pharmacy as a crucial access point in delivering population health and a new retail paradigm. This is one example where it seems likely that the pace will increase with respect to disruptive strategies to harvest almost 15% of “bad spend” in our healthcare economy and create a transformed retail experience.

Finally, the traditional commercial payer will increasingly find it challenging to deliver value in the context of the transformational landscape described above. Large and undifferentiated networks, disruption of the traditional broker framework, niche and segmented product/service challenges, and a need for a “Google-like” innovation response are driving the commercial payers to re-evaluate and re-construct their business models in real time and experiment market-to-market with “live ammo.” These challenges are profound in an environment where the traditional payer relationship is distinctly subject to disintermediation because of the challenge to deliver value as articulated above. This isn’t to say the payers will go away – there is certainly a “too big to fail” component here that can’t be ignored. Rather, the disruption emerging here represents significant opportunities for the direct provider-to-purchaser relationship to emerge without the involvement of the traditional payer in a new value paradigm.
3. ACUTE CARE CAPACITY BECOMES COMMODITIZED

The commoditization of acute care capacity has important disruptive implications for healthcare systems and provision of care in every market. The concept here is not necessarily one of “over-bedded” markets (although that conclusion might be an outcome of the transformation) – rather, while not actively discussed currently, this is directly related to declining inpatient utilization emerging from a wide variety of population health, APM and “right-time right-place right-care” implications.

Population health, while still to some degree defined differently by different stakeholders, is becoming not only a central part of the healthcare lexicon but representative of multiple paths to a crucial goal of healthy communities. That goal has been both relatively undefined and largely aspirational until recently; now, we are seeing the emergence of population health baseline goals as central to the goals of many different constituencies. These are certainly important societal matters at their core, as the much more effective management of chronic conditions, medication compliance, access to services, and personal responsibility for health will clearly have a positive impact on quality of life for community members and the overall sustainability of our healthcare economy. The research indicates that:

- The U.S. spends up to one-third of its healthcare dollars on medical services that do nothing to improve health and can even be harmful;
- Only 20% of health is determined by clinical care while 80% is determined by health behaviors and other non-clinical-care factors, so related other determinants need to be addressed in order to improve health; and
- Shifts to APMs require that health systems consider the relevance of their value proposition and create new capabilities to deliver value against new purchaser expectations.
As well, technology and the rapidly increasing leverage of both “big” and “little” data to shape wellness and care paths (in a wide variety of ways) is disproportionately impacting the need for traditional inpatient bed capacity. This is not to any degree strictly an EMR dialogue, although the ability to access and mine warehoused patient data in properly connected and populated EMRs is obviously important; through the wider lens, this is a discussion about both speed and confidence in evidence-based medicine that defines tighter paths and dramatically reduces clinical variability (and, therefore, cost). For example, the emerging transition of IBM Watson Health as not just a concept but a practical population health and clinical management platform is facilitating the described transition. These new technologies, leveraged against exabytes of relevant data, will provide speed and confidence to clinical decision making and, in certain future circumstances, will not only supplement but may supplant direct clinical care in the traditional sense. The implications for traditional inpatient utilization are clear.

Finally, in some quarters there remains a frantic focus on retaining a fee-for-service mentality and continuing to plan provider economics around a core FFS focus. The supply and demand implications of this misplaced and possibly irresponsible direction are obvious, especially taken in context considering the discussion above. The need to demonstrate ROI on significant facilities capital investments will necessarily drive market pricing down for these heavy, volume-dependent economic commitments.

The above discussion indicates the greater (and to some degree, expected) emphasis on the broader continuum of care that should result in a focus on coordinating both wellness and care activities, helps to reduce unnecessary medical care, reduces costs and improves quality. More innovative health systems are actively working to develop models specifically designed to make traditional bricks and mortar inpatient capacity much less relevant to delivery models (for example, the “virtual” inpatient multi-modal facilities being designed and constructed by Cleveland's MetroHealth system). More advanced pharmaceuticals are rendering traditional inpatient stays less necessary and more advanced outpatient facilities and modalities are limiting the need for inpatient admissions. These are not, as in the dialogue of the 1990’s, “managed care” impacts on inpatient utilization. This is a focus on doing the right thing that deemphasizes the need for inpatient capacity and will create a supply and demand scenario that will necessarily commoditize inpatient capacity to an important degree. The concept that inpatient capacity will be subject to EBay-like auction is not wild-eyed; in Kaiser Permanente markets where KP doesn’t have inpatient capacity, there is already a bidding process for defined “buckets” of inpatient capacity that KP contracts for, and anecdotal observation proves that pricing at the margin for that capacity is already the rule versus the exception.
4. THE TRADITIONAL ECOSYSTEM IS REMARKABLY AND PROFOUNDLY DISRUPTED

Interest in the transformation of U.S. healthcare has never been higher. There are many reasons for this level of interest – some of them altruistic, some of them deeply personal, and all of them important. However, there is one interest that should be acknowledged and requires deeper system-wide consideration – that which is driven by entrepreneurial and economic considerations and will deeply disrupt traditional infrastructure and other operational platforms and modes.

Consider that we have a $3 trillion current healthcare economy that is now widely acknowledged as wholly unsustainable and evidences incredible opportunities for improvement. Additionally, the transformational environment has never been more encouraging and accepting of new solutions to help achieve sustainability and solve the Triple Aim equation. In this defined state, there is material economic opportunity to be harvested by creating and driving these solutions – as an example, every 25 basis points of “savings” on our $3 trillion healthcare spend is approximately $7.5 billion, which stated in revenue terms would place a disrupter who could harvest that level of opportunity squarely within the Fortune 400. This simple example demonstrates the dramatic levels of potential return that are available to invested disruptive innovators.

Given the economic stakes, it seems sensible that capital deployment will continue to align with a greater level of urgency against the innovation required to harvest the economic opportunity described above. This level of scaled capital deployment will increasingly accelerate the “innovation engine,” which itself will drive dramatic new pace in effecting many of the changes we describe here that shape the transformational landscape.
Additionally, the business model transitions associated with healthcare transformation are oftentimes messy at best and will require non-traditional stakeholders to intervene to bring order to these transitions. The increasingly dynamic M&A environment, which can involve physical mergers and more virtual partnerships and service consolidations, is itself ripe for order-making. The current “musical chairs” environment can result in less-than-thoughtful integration and deployment plans, and an innovator (with or without technology) can position itself as moderating transformational disruption and increasing the odds of success and, thus, anticipated return on investment. Both financing transformational activity and meeting/exceeding ROI expectations is risky business and likely requires incremental, non-traditional players to further assure success.

An example of capital deployment in this spirit, positioned against the business model challenges of the traditional payer that were previously described, is the Evolent Health story. Without endorsing or otherwise commenting on any specific business goals associated with Evolent, a review of the Evolent initial public offering (which was a capital raise of approximately $200 million) is a reflection of how a disruptive organization can capitalize based on vision and position itself in the healthcare marketplace as an innovation accelerator and an “option” to traditional business models in effecting healthcare transformation. There are other examples as well, including the recent creation of IBM Watson Health which has positioned IBM’s Watson technology at the center of the acquisitions of (among others) Explorys, Phytel, and Truven. These are significant capital raises and investments, all of which are bringing very sophisticated players into the fray and all of which are solidly pointed at solving the business issues that will help with the hard work of healthcare transformation and accelerate associated innovation.
5. THE NEED FOR SIGNIFICANTLY ENHANCED GOVERNANCE SOPHISTICATION REACHES A NEW LEVEL OF URGENCY

The implications of the perspectives described above mandate an urgent review of governance capability, framework, role and responsibility for most healthcare organizations. We are in the midst of the most provocative and complex period in the history of U.S. healthcare. There are few informative and actionable examples where roughly 18%, or $3 trillion, of an entire national economy is undergoing massive and fundamental operational and financial transformation. This level of deep institutional disruption calls for wholesale review of many healthcare organization governance models, to ensure that they are properly responsive to the transformational dynamic. This is a provocative and complicated topic, as governance of healthcare institutions has, generally, always been at its core a service of the heart delivered with the best of spirit by dedicated community stakeholders.

Unfortunately, wholesale transformation of business models in a step-change environment requires levels of acumen and responsibility on the part of governance that have traditionally been very much the exception across the country. The need for governance that can both intellectually engage and confidently act with transformational agility around enterprise risk, capital deployment, strategic affiliations, clinical enterprise optimization, and revenue portfolio design – just to name a handful – is a remarkably challenging topic.

As healthcare business models undergo transformation in this step-change environment, governance models need to not only match that transformation in urgency and pace, but should actually be well in front of the transformational dynamic to ensure the confident and responsible oversight of our healthcare institutions.
CONCLUSION

Much of what’s described in the discussion above may be, to some degree, unsettling and possibly provocative. The goal here is to provide DHG Healthcare insight that is honest, insightful and forward-looking; not to be a provocateur for sake of simply being provocative, but to inspire a dialogue about incredibly complex and important issues that is responsible, productive, and enabling. The overall implications of achieving Risk Capability as DHG Healthcare defines it mandate a level of institutional courage that is not easily achieved – but driving an intellectual stake in the ground around key perspectives and then forming a set of connected critical success factors is a tremendous first step in finding that courage and conveying it for all of the important constituents of this discussion.

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DHG Healthcare is ranked as a Modern Healthcare top 10 privately-held healthcare consulting firm and serves the industry with approximately 300 dedicated healthcare industry professionals across consulting, assurance, and tax. DHG Healthcare’s consulting business includes four distinctive service platforms (CFO Advisory, Enterprise Intelligence, Reimbursement, and Strategy) and is sharply focused on the critical business issues facing healthcare organizations in today’s transformative environment. We have aligned our practice organizational structure and delivery framework to support transformational themes related to the achievement of ‘risk capability’ as critical to the successful future of our healthcare clients. [www.dhgllp.com/healthcare](http://www.dhgllp.com/healthcare)