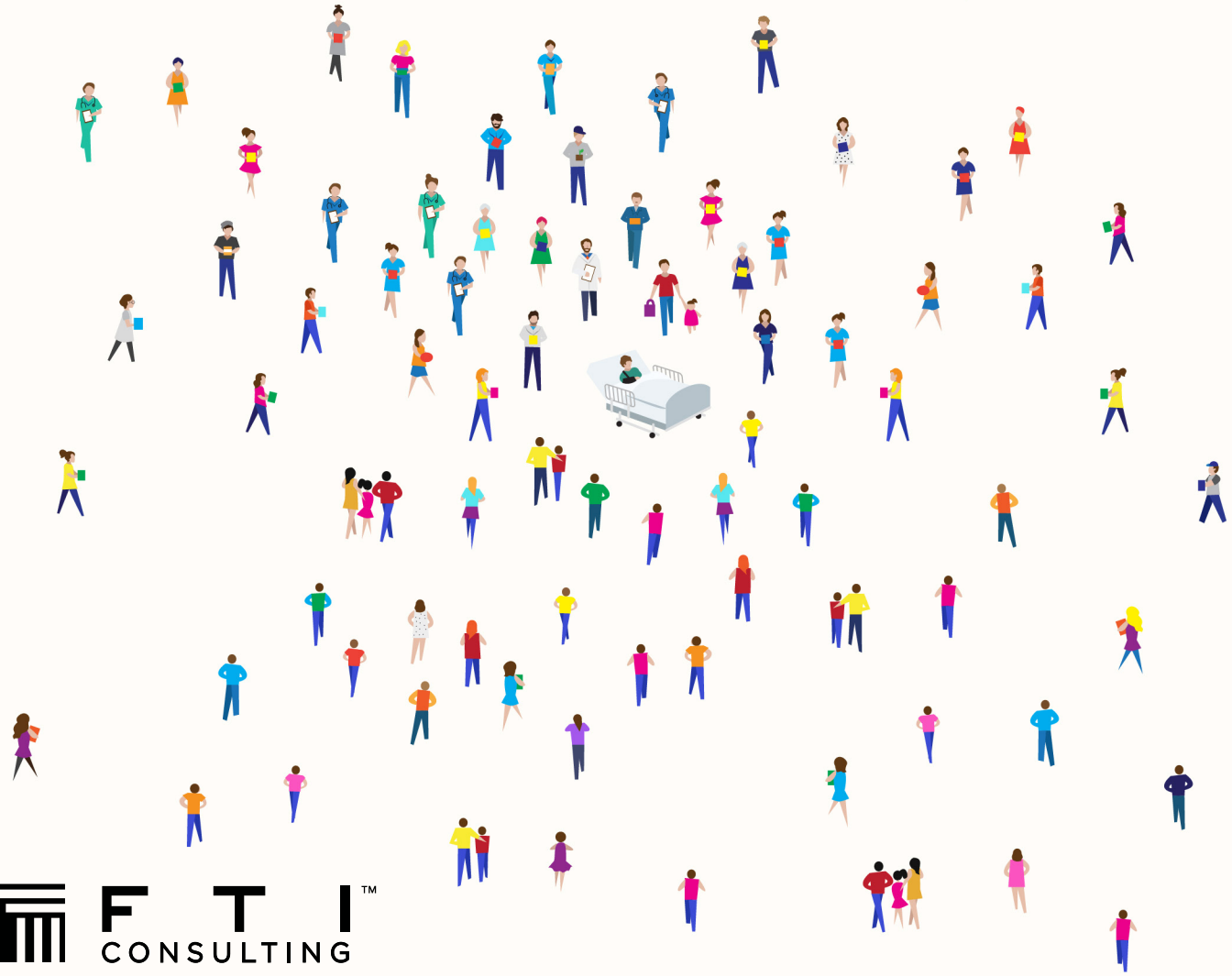
It Takes a Community to Improve Healthcare



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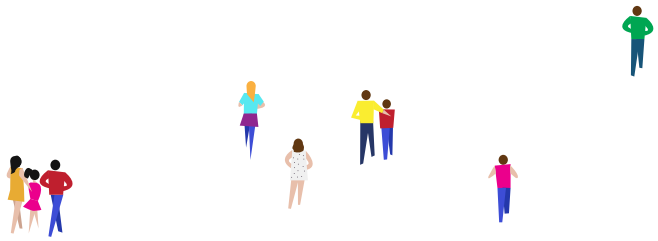
The Affordable Care Act was designed to lower the cost of healthcare while improving its quality. One requirement for achieving both goals is to have individuals make better decisions about their own health and for the health of their community. More communities are attempting to take on the challenge of spreading that message but have had mixed success to date. To find out why, FTI Consulting convened a roundtable of community-oriented healthcare experts. It was hosted and moderated by Margaret Guerin-Calvert, FTI Consulting Senior Managing Director and President of the Center for Healthcare Economics and Policy.



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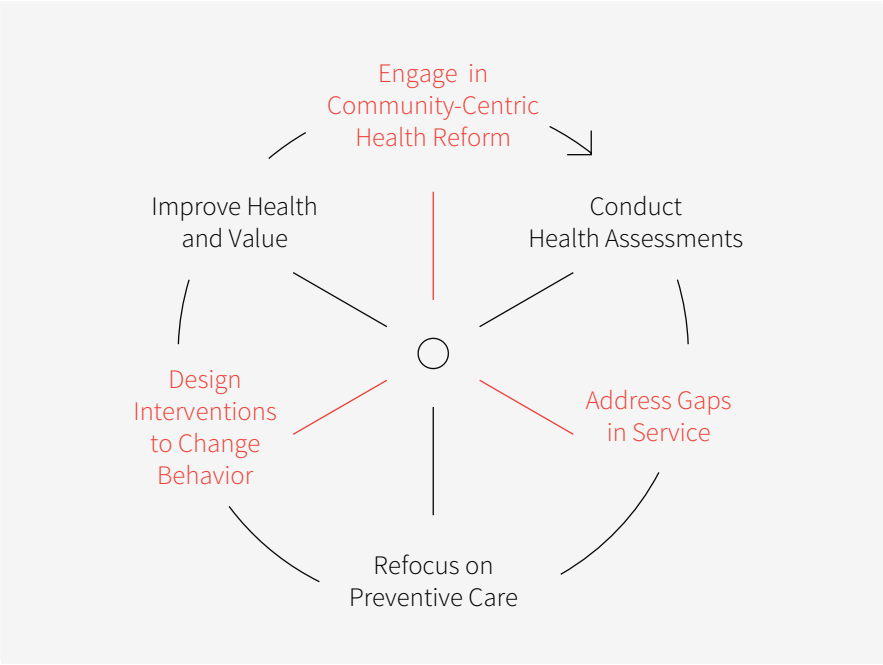
Ideally, the implementation of certain provisions of the Affordable Care Act should have encouraged community-centric healthcare reform that would provide incentives for stakeholders and individuals to act and produce meaningful improvements in individual-level health. 501(c)(3) hospitals now are obligated to conduct health assessments to gather data necessary to align resources with the needs of their respective populations, and $11 billion in funding was earmarked for the operation, expansion and construction of community health centers. Federal and state funding along with private sector grants are opening opportunities for local providers, insurers and other leaders to engage in community outreach; working to assess and address gaps in services; refocusing their constituencies on preventive care; and spearheading interventions that would reduce national healthcare costs in the long term. The goal: a healthier community whose members spend less time in hospitals and emergency rooms. And given the increasing prevalence of high-deductible plans, consumers should need minimal convincing to change their behaviors, at least theoretically.

To better understand these issues and explore the transformation that communities still need to make to promote accountability, stimulate savings in healthcare, and, most important, improve health and value, FTI Consulting convened a roundtable of experts with experience in community healthcare.

MEG GUERIN-CALVERT: Let's start here: What are some of the key factors driving healthcare costs today?

DR. MICHAEL CROPP: While the Affordable Care Act certainly has made some great strides toward improving access to care for more Americans,



affecting quality and affordability requires us to go back to the local level: to the communities. There's a tremendous sense of urgency about our ability to manage healthcare costs and to do it in such a way that we maintain — or actually improve — quality at the same time.

DR. MELINDA BUNTIN: There's been a lot of economic literature about the drivers of rising healthcare costs, and when I was at the Congressional Budget Office, I spent a lot of time thinking about how to project future healthcare costs and the implications of trends that we were seeing in the market. It can be broken down into three components, particularly on a federal level. One is the aging of the population; a second is changes in insurance coverage, which will increase federal responsibility for healthcare costs; and a third is the extent to which healthcare costs are rising faster than gross domestic product ("GDP"), meaning our productivity, and that's the component people like to label as unsustainable.

The really, really fascinating phenomenon is that for the past couple of years, there has been a slowdown in the growth of healthcare costs. That slowing rate of growth is continuing even as economic growth is coming back. We're seeing this slowdown across all sectors; it's very pronounced in the inpatient sector. And, largely, its causes are not well understood. My personal opinion is that the increasing pressure that these rising costs have brought to bear in the system have caused healthcare leaders at all levels to believe that in the future they will be rewarded more on the basis of value. So, it would be very ironic if the slowdown in rising costs led to an easing up of that pressure. I worry about that.

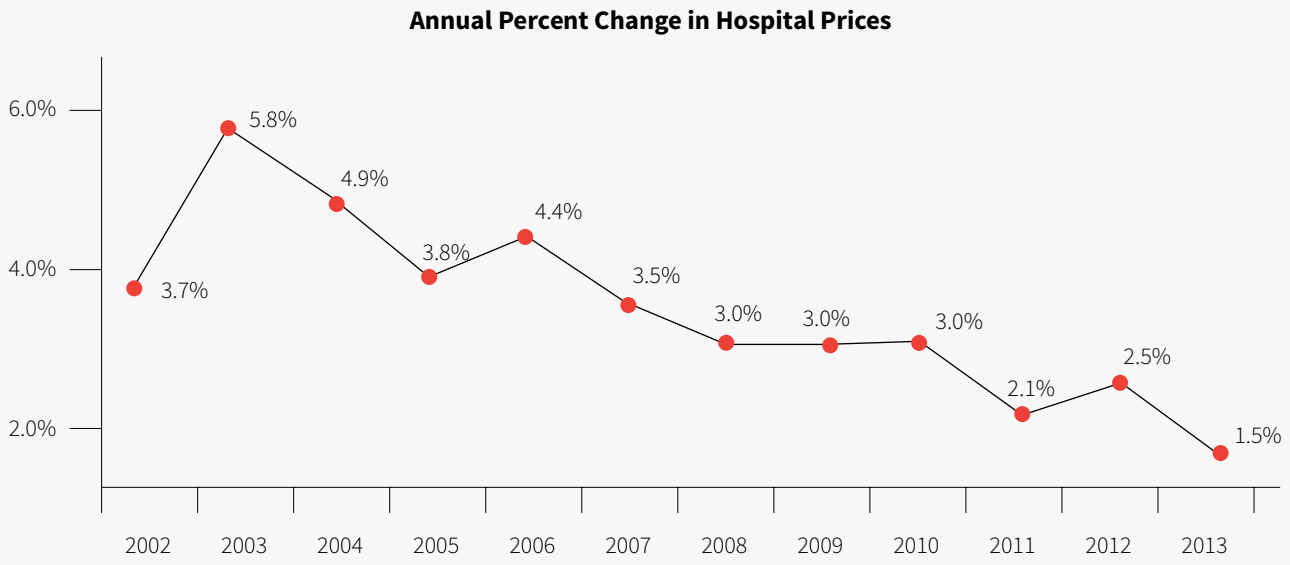
MEG GUERIN-CALVERT: Is it possible that what we are seeing reflects a fundamental change in the behavior of both the consumers and the providers of healthcare, who now are fully conscious of the need to economize? Does the slowdown in rising costs give us a reason to believe that the situation might not be as bad as we had thought?

BILL PURCELL: That kind of change may draw the attention of political leaders and, hopefully, researchers, but it does not give me much comfort for the immediate future. For the near term, we continue to have high expenses borne by individual payers, employers and governments — payments that, in many cases, are causing governments to make hard decisions about other services that must be foregone in order to meet those costs.

We are still overwhelmed in America by the number of personal and family bankruptcies, a large number of them driven by healthcare bills. That is not a condemnation of anyone or anything; it's a recognition that the costs of healthcare continue to impact all of us, and some of the reasons for that now are clearly understood. I work with the Institute of Medicine as Chairman of the Roundtable on Obesity Solutions, and while estimates vary, 10 percent to 20 percent of all healthcare costs in America are related to obesity. And we know that the costs related to obesity will be with us for generations unless we do something now. So this is a time when we need not just more research but also the ability to act.

MEG GUERIN-CALVERT: Mike, as the CEO of a health insurance company, is there action that your organization can take to address the issue of rising healthcare costs?

DR. MICHAEL CROPP: Looking within the healthcare system, there's still a tremendous opportunity to root out inefficiencies. Studies show that 30 percent of all healthcare dollars are going



Source: "Hospital Realignment: Mergers Offer Significant Patient and Community Benefits," Guerin-Calvert, M. and Maki, J.A., FTI Consulting, Inc., January 2014. **Available,** here

to administrative costs and aren't adding value to an individual's care. To change that, the providers and consumers of healthcare require better information. And there needs to be a payment model that doesn't just reward providers for the *volume* of services delivered but for the *quality* of those services. That's an important step that must be taken. It is taking place at a macro level, with Medicare making some changes in its reimbursement policy, but it has to spread to the local level with local payers bringing about those changes.

Aging of the Population

Changes in Insurance Coverage

Healthcare Costs Rising Faster than GDP

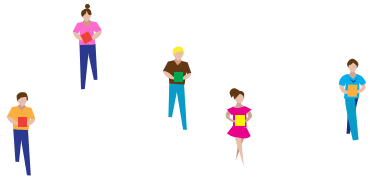
Seeking Greater Efficiency and Value in Healthcare Delivery

MEG GUERIN-CALVERT: Melinda's findings that the rise of healthcare costs is slowing suggest we are seeing a change, perhaps due to the recession — changes made by participants in healthcare delivery or as a result of some of the healthcare reforms that have been put in place. To keep making progress on that front, do communities need to get involved? Where should they be looking to ensure that, in the future, they have a healthcare delivery system that delivers even greater value while being, hopefully, more affordable?

DR. MICHAEL CROPP: I think that in many communities, healthcare has become an arms race, and everybody has to have the latest technology to try to attract the volume of patients needed to maintain a certain revenue stream. As we go forward, communities will have to understand that. Rather than taking a top-down view, they need a bottom-up perspective in determining the illness burden in a community and what resources the community is going to need to deal with that burden.

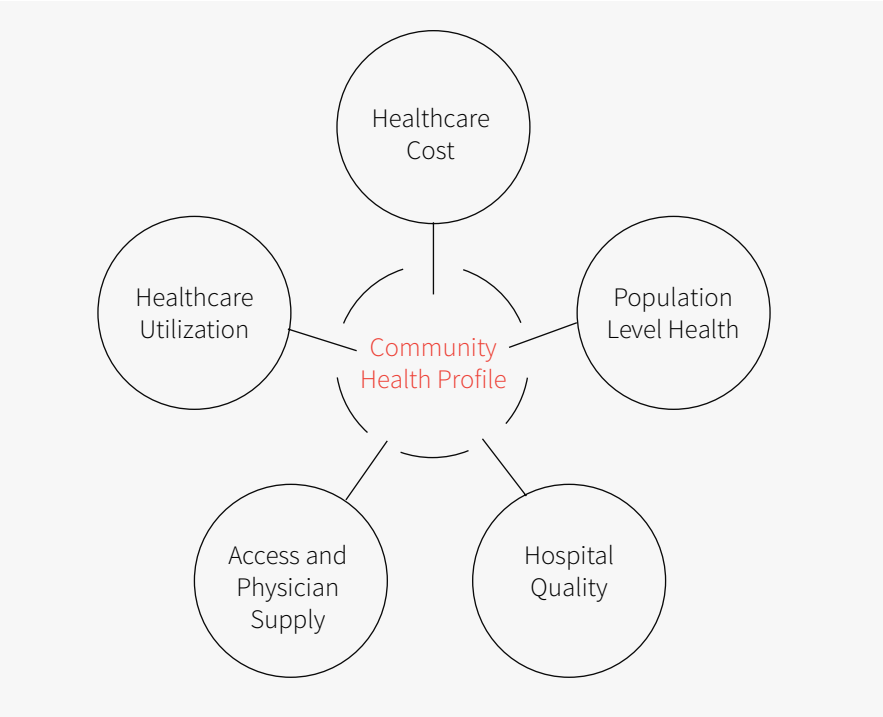
Because of the arms race, I think many communities are over capacity, and historically, healthcare has been a sector of the economy where supply drives demand. That's changing a little bit now but some high-end capacity has been overbuilt into our communities and into our system, and at what cost?

We know there is a critical shortage of primary care providers in the country, largely because the payment system has rewarded the high-end specialties and the high-technology institutions. We need to understand ways that we can put more capacity in the communities at the front end and design the high end more effectively to fit the community's needs.



MEG GUERIN-CALVERT: If the market on its own is not necessarily moving us to the place we need to be, where can communities get the leadership when it comes to taking collective action? Do they need to include players who are not involved now?

BILL PURCELL: I think we all know intuitively that an individual citizen is not going to change the healthcare system. As a former mayor, I'm willing to concede that any single official, acting alone, is not going to change the healthcare system in the country or even in a city. But every political leader should and does care about their health and the health of the community. Business leaders feel this way; academic leaders feel this way; and individual citizens feel this way.



But people can't make educated decisions because so much of the information we receive is contradictory and incomplete. Even when we think we have a sense of our own personal health, we truly do not know about the health of our neighborhood, our city, our region or our state. We don't have a sense of how it compares with the rest of the country or the rest of the world. We hear lots of things said, most of them rhetorical and political, but little of it with any factual basis that we can internalize and analyze on our own.

The Need for Data

MEG GUERIN-CALVERT: Let's suppose you — as a political leader or head of a major provider, insurer or business — had the ability to engage leaders in a community. What would be on your short-list of the data or information that you would most want to have to help you start trying to move the community toward taking meaningful action about reducing healthcare costs?

DR. MICHAEL CROPP: Information that's available right now primarily surrounds disease prevalence: diabetes, heart disease and other chronic conditions. You'd want to know where you stand: You'd like to know what the costs would be for caring for the defined population in a community, regardless of the payer. You'd like to know the percentage of people participating in activities that are good such as engaging in regular physical activity or those that are harmful such as smoking or drinking alcohol to excess. It also would be helpful to know what the health status of the community is pertaining to metrics that already may have been collected and are readily available. That information would be very powerful and motivating.

There's a nonprofit group, The League of American Bicyclists, that ranks American cities in terms of how bicycle friendly each one is, on a scale from bronze to platinum. Only four cities have reached the platinum level, but I can't tell you how many metro areas are on the path to attaining that designation. Making that kind of information publicly available motivates people to make changes.

MEG GUERIN-CALVERT: Melinda, as an economist, how do we take this data and information and make use of it in a form that could help a Buffalo, a Nashville or a Memphis to improve?

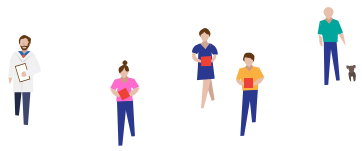
DR. MELINDA BUNTIN: If you appeal to me as an economist, then I have to invoke the concept of marginal cost and benefit. We may know where the

information gaps are, but we may not know where we have the opportunity to achieve the best marginal benefit at the least marginal cost. I think the sweet spot is where you can demonstrate that you invested your resources wisely and made headway against a problem. Once we get to that point, then decision makers and policymakers — whether they are employers, chamber of commerce leaders or public officials — can say, "Here's the list of things we might try; here are the biggest problems in our community; and here is where we can marshal the community resources to get the biggest bang for the buck." That's how a community can make a start.

MEG GUERIN-CALVERT: Is there some way of talking about the quality, access and affordability of healthcare that can better engage the communities?

DR. MICHAEL CROPP: Yes. Even though the rate of growth of healthcare spending has slowed, when you look at it as a percentage of GDP, even at its current growth rate, it's still pretty alarming in terms of how much it costs. When you can chart that out, it becomes pretty graphic and compelling that we need to take action, and nobody can sit on the sidelines.

But it's easy to feel paralyzed when it comes to figuring out what to do. You take a step back and you look at all the factors, and it's daunting. To some extent, it might not matter where you start. There's enough literature out there to suggest that there are some interventions that can make a difference. What's really important is that a community rallies around some actions to take, so that they're doing it collectively and they're in it together to make a difference.



About the Center for Healthcare Economics and Policy

The Center for Healthcare Economics and Policy applies cutting-edge economics and quantitative methods to assist clients in developing and implementing market-based solutions across the spectrum of healthcare activity. We are at the leading edge of "Triple Aim" economics.

The "Triple Aim"

1. Improving the patient experience of care (including quality and satisfaction)
2. Improving the health of populations
3. Reducing the per capita cost of healthcare

The Center and New York's DSRIP Program

In the summer of 2014, the Center began working with the Niagara-Orleans Emerging Performing Provider System (PPS) and its constituents in western New York to help coordinate stakeholders, provide direction, and support the analytical work that will be required for the project. New York's Delivery System Reform Incentive Payment (DSRIP) program relies heavily on established performance metrics which aligns well with the Center's goals and capabilities. We are involved in preliminary stakeholder meetings and supporting participants with our knowledge, experience, data and empirical analyses capabilities, and project management. We have provided bespoke data analytics to assist in determining issues and areas most suitable for intervention and to inform possible, effective interventions for consideration.

The Center and the NHS

In August 2013, FTI Consulting qualified as a supplier of consulting services for the UK National Health Service (NHS) to provide high quality advice and analytics on solutions to address the clinical and financial unsustainability of hospitals. The Center collaborates with other FTI Consulting segments to develop solutions that ensure continued access to care in these challenged localities. For more isolated areas, our solutions generally involve more cooperation and collaboration between the different elements of the healthcare economy.

How to Realign Resources

MEG GUERIN-CALVERT: In many communities, the existing healthcare delivery system is held in a number of different hands, including physicians, outpatient facilities, hospitals and others. What's your thinking in terms of how a community could move forward and make an assessment of its unmet needs? What are some of the approaches a community could take to work toward a realignment of resources?

DR. MELINDA BUNTIN: I'm not so sure that we actually have a great track record of communities doing very well in terms of planning. There are a lot of things for which we can rely on the market to get prices in the ballpark. If there's demand, then supply usually rushes in to fill it. The expansion of hospice care we've seen over the past decade has been stunning. The expansion of post-acute care we've seen over the past decade has been stunning. We can argue about gaps remaining, but that is the system we have, for better or worse.

Why is it that there aren't enough primary-care providers? Well, that's a question of reimbursement rates, in part, but I also think the states that have particularly low numbers of primary care physicians serving their populations are starting to address that by changing their laws. They're expanding nurse practitioner scope of practice, and some of the research might suggest that nurse practitioners are better at certain things than primary care physicians. If all clinicians practiced to the full extent of their education and training, we'd actually have a more effective system overall.

MEG GUERIN-CALVERT: Literature indicates we have misaligned capacity. For instance, a lot of areas have far more hospital beds than are needed, given the decline in in-patient admissions. What's the best way to go about making a change?

DR. MICHAEL CROPP: There are some positive examples of that. One that comes to mind is Rochester, N.Y., a community that has high quality and relatively low costs for healthcare. Rochester now is a two-hospital town. On the other hand, Buffalo, N.Y., which has about the same population, has 12 hospitals.

Rochester's case exists because its hospitals, along with insurers and government representatives, have worked cooperatively on health planning for a long time. It's a voluntary program that came into being largely thanks to the will of business leaders who wanted to analyze the needs of the community and to rationalize the healthcare system according to those needs. That led to hospital consolidation, as well as tightly managed capacity of fairly expensive diagnostic modalities, like high-end imaging systems. The program has produced better results, as measured by quality and affordability.

It all happened because leadership — including players like Bosch, Kodak and Xerox — stepped up and did some really good things. Not every community is blessed with leaders that have foresight and vision. However, we all have a sense of urgency and the information that should be able to drive us into having a dialogue and reaching some conclusions.

It Takes a Community

MEG GUERIN-CALVERT: That should happen, but will it?

DR. MELINDA BUNTIN: Maybe we've come full circle. A century ago, the debate was about improving public health and hygiene in an attempt to lower the death rate. We had to promote sewers, and we had to educate the people, among other things. Those were community efforts that resulted in positive results. Then we had the development of antibiotic agents, and that had a further tremendous impact on mortality reduction.

After that, we moved to more of a medical and pharmaceutical model and created Medicare and Medicaid. We've made great progress in bringing down the rate of deaths due to heart disease and other common medical conditions. And, now, we're coming to the point where we recognize we need to attack the lifestyle diseases. To do that, we must return to a community focus.

People care about their health. They are searching for information about a healthy lifestyle on the Internet. They're watching programs about how to prepare healthy food. They're joining weight loss groups. They're exercising. That gives me hope. When communities are given better access to higher quality information that can motivate, we may see the beginning of a crusade to improve health in general and contain healthcare costs.

MEG GUERIN-CALVERT: Let's hope we do. Thank you all very much.