

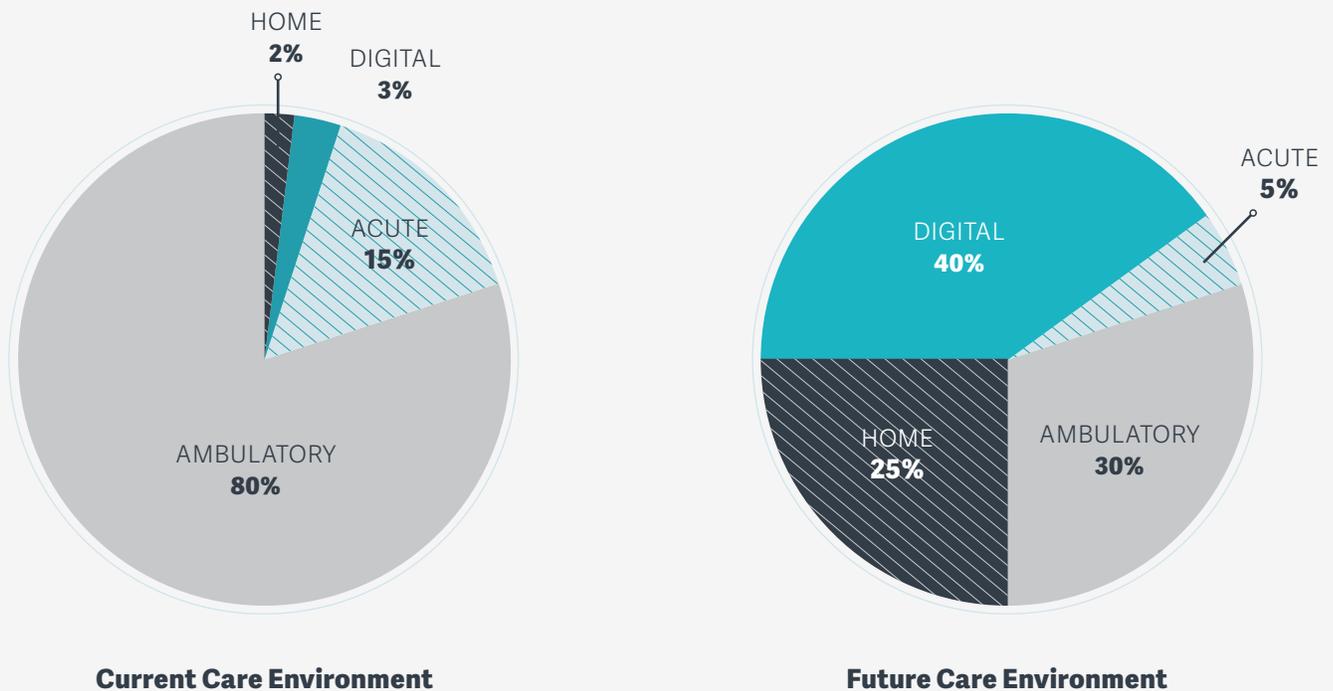


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Transformational Drivers in the Health System of the Future

While there are many perspectives and publications on the “Hospital of the Future,” few, if any, provide a system perspective. Too often, when imagining the “Health System of the Future,” a hospital-centric model emerges. The challenge in this hospital-centric view is that it ignores most of the factors that are already driving services, activity, and revenue to new and different care environments, and will do so increasingly over the next decade (see **figure 1**). Even today, the vast majority of patient care activity occurs outside the hospital, and hospital-based activity continues to be the most costly, given the infrastructure and payment models that have evolved.

Figure 1: The Shifting Care Environment



THE NEW RULES

The forces driving this shift are well known, but their downstream implications are seemingly not. It has always been clear that competition is one of the major factors shaping an individual health system, but the new challenge is that the nature of competition is changing. Where volume once ruled the day, the shift to competition based on value is changing the rules, and other forces that previously had little impact on how we structured care delivery, such as consumerism and cost transparency, are becoming central to the ability to compete.

Provider Cost Risk

The first and most compelling force driving the Health System of the Future is the degree of cost risk that the provider organization owns in caring for the populations for which it is responsible. We see a variety of factors driving the evolution of different risk-based payment models on a market-by-market basis. Not all markets are evolving at the same rate due to a combination of demographics, economic trajectories, competition, historical trends in employment patterns, and payor margins. The obvious exception to these local market drivers is the role that CMS plays in pushing increasing levels of risk to providers in Medicare. The influence of CMS decisions and policies becomes less relevant in younger-age-trending markets such as Denver, Atlanta, and Nashville.

Where volume once ruled the day, the shift to competition based on value is changing the rules, and other forces that previously had little impact on how we structured care delivery, such as consumerism and cost transparency, are becoming central to the ability to compete.

Markets that are more likely to shift sooner to a significant level of cost risk for providers include areas where:



**Demographics
Shift Toward
Medicare Age**



**Very Large Employers in
Lower-Margin Businesses
Do Not Face Intense
Workforce Competition**



**Medicare Advantage
Penetration Rates
are Higher**



**There are
One or Two
Dominant Payors**



Markets more resistant to the trend toward higher cost risk for providers appear to be those where there is rapid economic growth and competition for a skilled workforce.

As can be seen in **table 1**, it is the relative influence of these factors in a particular market that will ultimately determine its risk equation. What follows from a significant level of cost risk is the need for the system to deliver care in a more efficient manner through a combination of population health management and cost reduction. This required level of transformation will be extraordinarily challenging for most systems.

Additionally, there are two other major forces increasingly driving competitive advantage that will also shape the Health System of the Future, regardless of the degree of provider risk. While these two factors are often referred to as *consumerism* and *patient experience*, neither of these terms is adequate to understanding what's needed to compete, as both represent a substantial and distinct transformational challenge for current systems.

Table 1: Market Factors Affecting Progress to Cost Risk

Market Accelerators to Risk 	Market Inhibitors to Risk 
High Medicare population	Strong economic growth
Large employer dominance	Little or no provider competition
Provider-sponsored health plans	Intense workforce competition
Willing providers	High payor margins

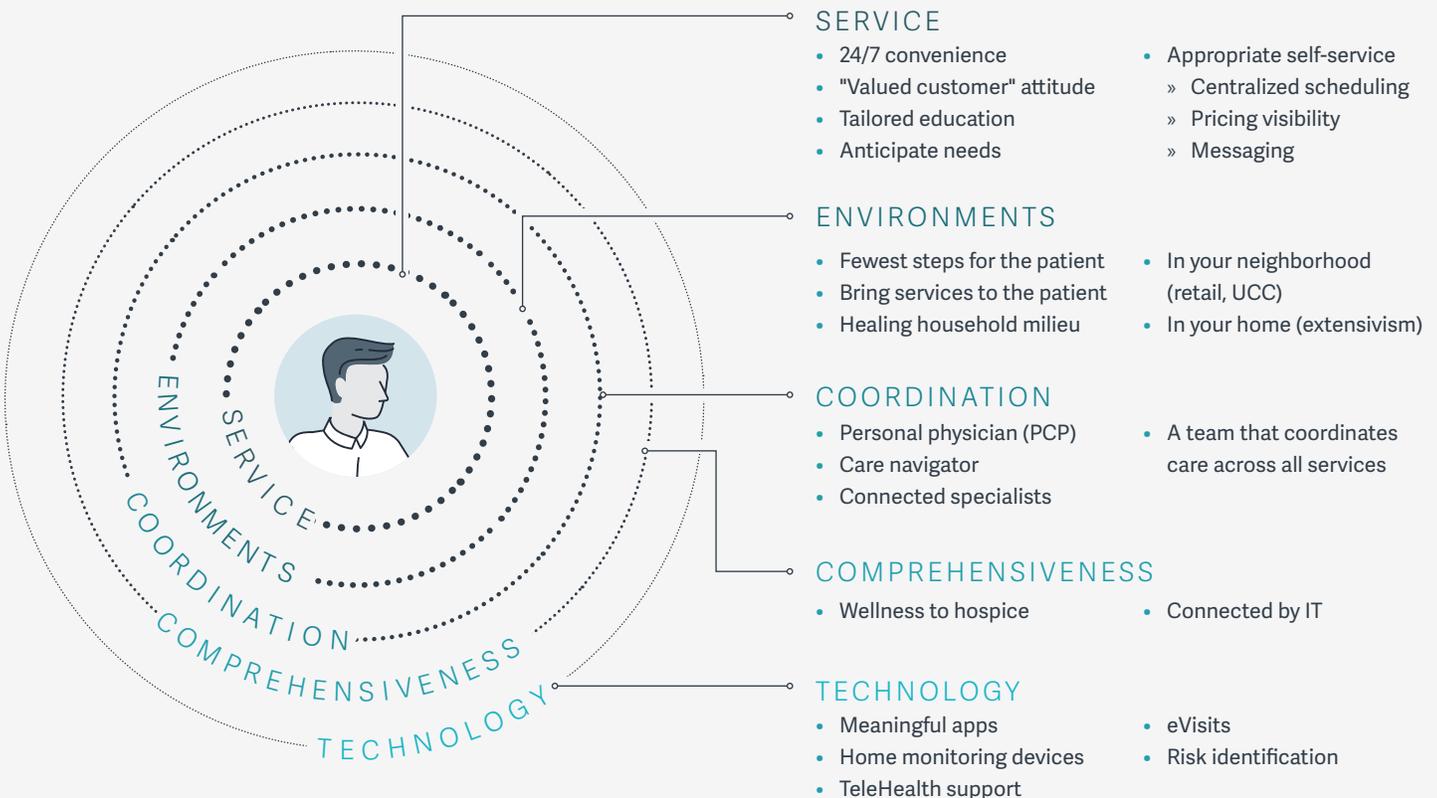
Patient Centricity

Most recent studies defy the long-held beliefs that providers know what matters to patients and that quality and outcomes are more important than factors that drive every other business on the planet—namely, cost and convenience. However, it is becoming clear that convenience trumps credentials, reputation, prestige, and the provider-patient relationship. In a consumer environment driven by the likes of Amazon, it is easy access to a prompt solution that draws patients, and a seamless, low-stress experience that keeps them coming back. The reality is that even the traditional, community-based primary care physician practice is designed around the provider in terms of schedule, location, and physical layout. The environment and operations of a hospital are patient “unfriendly” on another order of magnitude. There are many historical reasons for this, but regardless of history, those health systems in any market that get

nimble and pay attention to the needs of their customers will be the ones realizing significant advantage over their competitors. As disruptive innovators such as Amazon, ZocDoc, Turntable Health, and others enter the market, the need to improve the customer experience is more urgent than most health systems are prepared to deal with. Moreover, the risk of erosion in the visits of today and the covered lives of tomorrow will only grow if systems are not prepared to respond and change quickly. It is no accident that non-system retail and urgent care have become a \$10 billion industry in just the past five years.¹

Figure 2 displays the concentric nature of a true patient-centric model of care, each layer enabling those within, from a patient contact-level service approach to an all-encompassing technology environment.

Figure 2: True Patient Centricity Is Not Just “Patient Experience”



¹ Michael McCarthy, "Consumer Demand Drives Boom in Urgent Care Centers, Study Finds" (*BMJ*, July 22, 2013).

Value Transparency

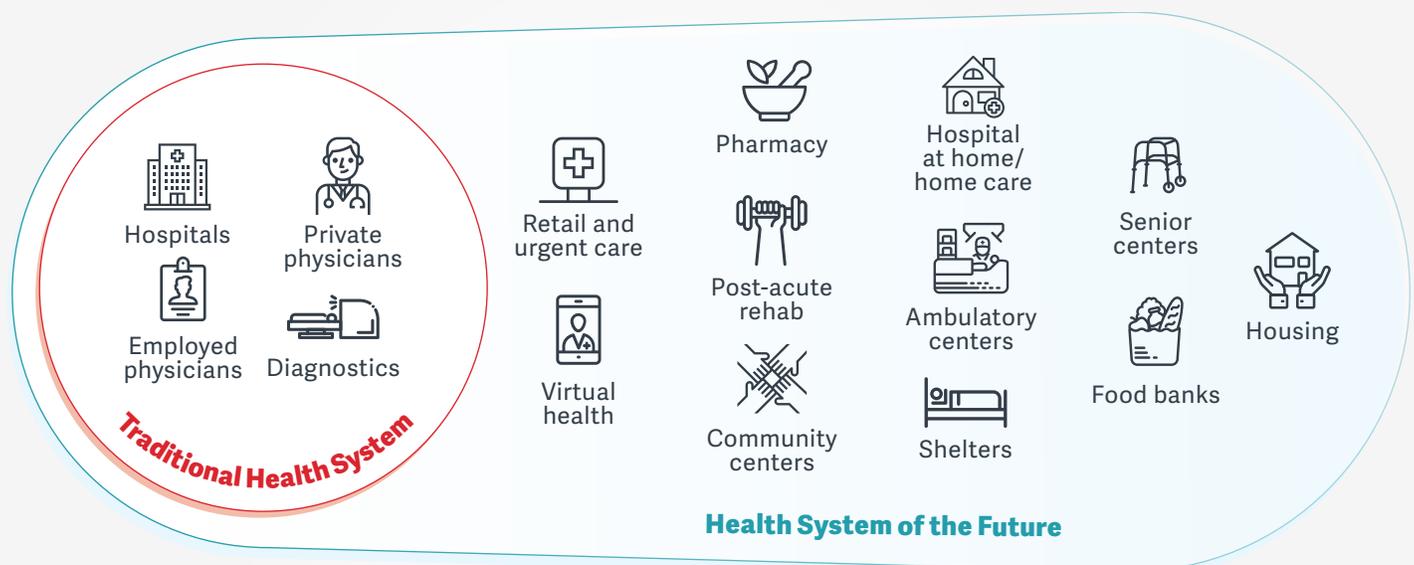
It is easy to understand why it is increasingly important for patients to be able to understand, in advance, the cost of care. The value picture (or at least cost transparency) already has an enormous impact on plan and provider selection, in spite of the fact that data is still scant or dubious on both quality and cost. Nonetheless, it is hard to imagine that when patients and employers are making the choice between the cost of one system of comprehensive care or another, that predictability wouldn't matter. Multiple studies have already demonstrated that transparency matters dramatically in decisions around health plan selection.

While there will always be some level of uncertainty and variability regarding cost, there is still a vast opportunity to improve consumer understanding through standardized pricing. This will require that health systems define the true costs of services provided at the unit level. Despite bundled payment programs and reference pricing efforts, providers still fall short in supplying transparent pricing information to patients. This isn't all that surprising when only 25% of hospitals have cost accounting systems, which often are rudimentary and will

become untenable when providers can't define and manage cost and quality when they are at risk for that cost.

Given these imperatives, how do health systems transform to meet the needs of the future, stay relevant and financially sustainable, and become managers of health rather than generators of health care for the sick? Existing integrated delivery systems may be further along in certain elements of this transformation, but the health system of the future is likely to include even broader federations of capabilities and entities as well as greater integration of socioeconomic and behavioral determinants of health. It is also likely to extend further across the continuum of care (see **figure 3**), with very different allocations of resources. The inner core of the traditional health system encompasses physicians and hospitals, with a variable degree of outpatient diagnostic or surgical environments. The more advanced Health System of the Future will have an extended scope that includes broader services in the community and more patient-centered environments that address not only medical issues but also social determinants of health such as housing and nutrition.

Figure 3: The Scope of the Health System of the Future



SEVEN PILLARS OF TRANSFORMATION

There are seven pillars across which health systems need to transform philosophically, strategically, and operationally to successfully respond to their markets and win the patient-centricity and value transparency competition (see **figure 4** below). A viable Health System of the Future will transform itself across each of the supporting pillars to deliver new capabilities that manage costs and improve outcomes for defined populations.

Using research around emerging disruptors, care models,

and technology trends in systems moving toward this new care model, coupled with 10-year projections of behavioral, clinical, and demographic data, we have defined several prototypes of systems in different market environments. What follows is a summary of the implications we've discovered through this effort and recommended strategies to fortify these systems. At a high level, we have evaluated each of the pillars to support the discussion of key strategies that we believe must be engaged now.

Figure 4: Seven Pillars of the Health System of the Future

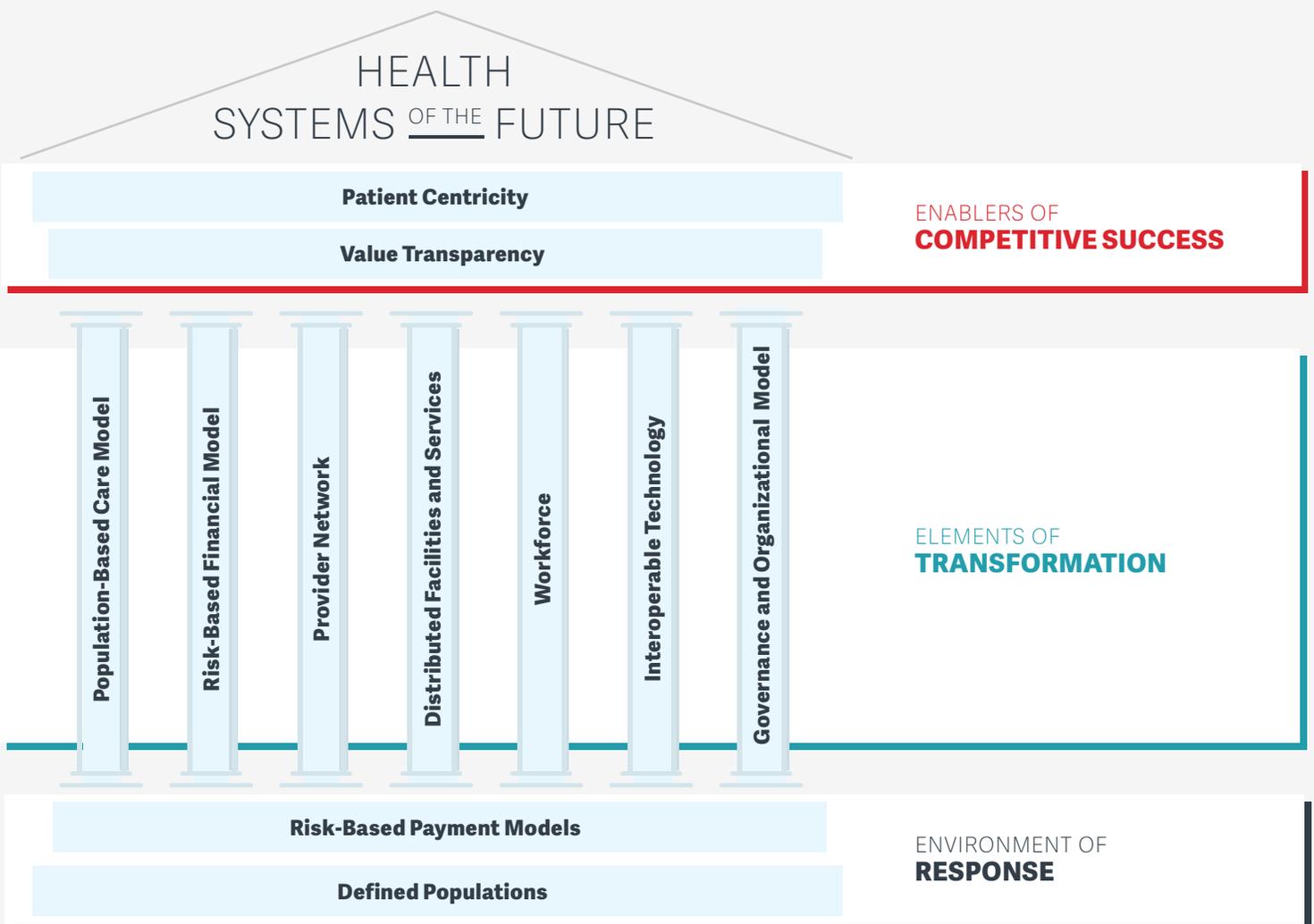


Figure 5: Emerging Innovations in the Care Model



IN-HOME
HOSPITALIZATION
PROGRAMS



MOBILE
TECHNOLOGY



VIRTUAL
TECHNOLOGY

Population-Based Care Model

As health systems move toward bearing increasing risk for the total cost of care, and their performance is measured increasingly by outcomes, they can expect to require radically different distribution of patient care activities and environments to be successful. We're already seeing academic medical centers growing their community presence through alignments and acquisitions, not just to increase their referral base and improve access but to distribute commodity care to lower-cost environments as well. Given both cost and convenience as drivers, coupled with being at risk on a total cost basis, it is inevitable that health systems will seek out the lowest cost and most convenient environments much more often than they do now. If they don't, both their system and non-system competitors will. Beginning with a discussion of the population-based care model, there are potential dramatic shifts in where and how care will occur. Looking at the current care delivery trends shown in **figure 5**, there are already venture-funded innovators moving toward (1) the delivery of services in the home that are currently provided in the

hospital; (2) the extensive use of mobile device platforms for communication, scheduling, payment, and pricing transparency; and (3) the implementation of virtual platforms for telehealth, education, and monitoring that will supplant certain primary, episodic, and follow-up care in ambulatory settings. The impact of the intensive use of virtual care and alternative engagement strategies has already been shown on cost, quality, and patient satisfaction, even in disadvantaged and high-risk or chronic populations.

In our ability to move care closer to the patient, we're already demonstrating that we can improve outcomes, reduce complications, reduce cost structure, and improve the patient experience. The ongoing miniaturization of previously expensive diagnostic platforms and artificial intelligence (AI), combined with the new incentive to provide patient-centric care, will give patients access to same-day diagnosis and treatment for many acute conditions.

The key challenge for existing systems in remaining relevant in the future is to incorporate, co-opt, or otherwise benefit from the disruptors that are offering care in more cost-effective, innovative ways. These foundational changes will then drive other pillars of the health system to adapt, which we will discuss in greater detail below and in subsequent publications.

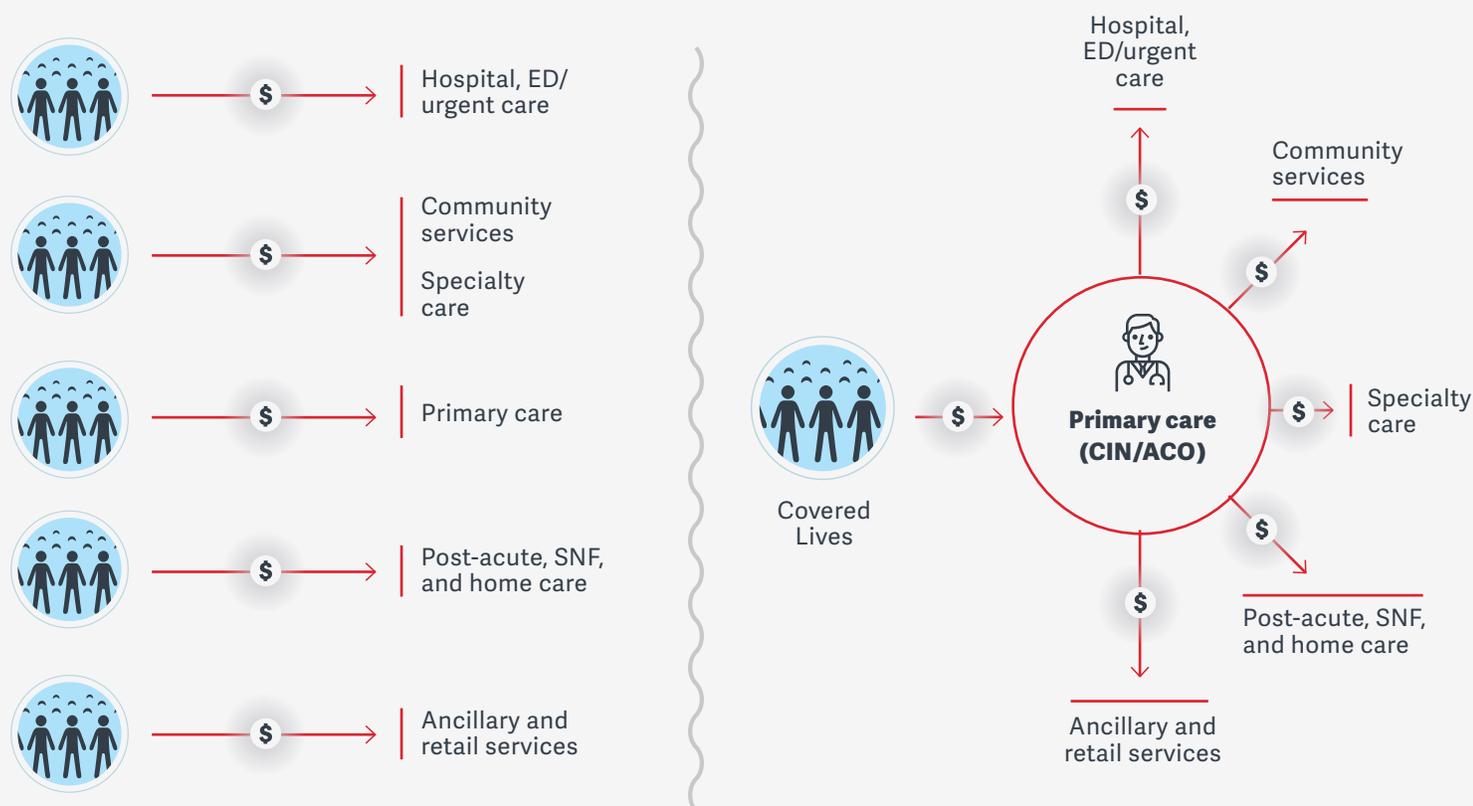
Risk-Based Financial Model

One can look back over the past 100 years of healthcare in the United States and see clearly that “form follows finance.” The reimbursement model has driven the structure and activities of physicians and institutional administrators from the time health plans came into existence in the mid-20th century through the DRG era, into capitation in the 1990s, and continuing to this day—albeit with far more uncertainty about the future.

Transformation of the financial model is a given, but the implications are even more pervasive than those of the care model. As risk for cost increases, and the need to be cost effective takes precedence, the accounting paradigm must accommodate new dimensions of analysis. As systems become the managers of risk—and ultimately, managers of population health—their need to manage the dollar obviously increases dramatically. Where every element of a diffuse cottage industry was once paid on the basis of its own activities via independent revenue streams, the paradigm has shifted to one in which the dollar is managed on the basis of how care is managed, and it is no coincidence that the primary care provider and the network are at the center of that process (see **figure 6**).

The cash flows illustrated above have broad implications not only for the accounting model but for management

Figure 6: The Cash Flow Shift in Population Management



spans of control, access to services, network and referral management, and internal cost and pricing transparency. Both past experiences and current cost-efficiency research² make it clear that primary care, when doing its job properly, is both the lever with the greatest impact on cost and quality and the core of population health management.

For effective management in this new world, health systems need to think about financial analytics in a different way. While systems will continue to need to understand costs at the facility and unit level, in the population-based model, they will increasingly need to (1) manage cost on a “per life” and “per episode” basis and (2) recognize the impact of decisions made by clinical providers on a longer-term basis in order to understand who is providing care at the correct cost point, particularly among specialists.

P&L Issues

The aggregation of multiple hospitals into “systems” began in the 1980s, but the dramatic acceleration of mergers and acquisitions in the past decade has highlighted the internal and external failures of this model. By and large, expectations of lower costs based on scale have generally not panned out and have more often driven higher prices in the market.³ The effect of increased market leverage has become so axiomatic that regulators now calculate this impact prospectively in considering the acceptability of mergers.

The principal reason behind the health system model failure is that these systems generally do not function as

a cohesive unit, beginning with their approach to finance.

First, few systems routinely account for their costs at a level of detail that is sufficient to manage and price services effectively. This makes it difficult to manage costs, even when there is an incentive to do so. Moreover, almost none of these systems restructure their newly merged hospitals’ and groups’ P&L approaches to operate as components of the system instead of freestanding business entities. The incentive to succeed is therefore not based on operating as a team to improve the overall system but on maximizing one’s individual revenue stream and reducing one’s own costs, which often comes at the expense of overall efficiency. Until incentives are aligned around the cost of a population and business units are accounted for and organized around functionally rational models that support this approach, it is unlikely that health systems will make any progress toward “systemness” or garner any impactful cost benefits.

Alternative Competition

As control of the revenue stream moves away from the hospital, health systems should expect management services organizations like Privia Health, a national physician practice management and population health technology company, to become part of their competitive landscape. Not all of the money pouring in from venture capital is going into technology platforms; some of it is going toward capturing the revenue from covered lives through aggregation of the primary care base, and groups such as Optum are already disrupting markets by

² ME Porter, EA Pabo, and TH Lee, “Redesigning Primary Care: A Strategic Vision to Improve Value by Organizing around Patients’ Needs” (*Health Affairs*; 2013; 32(3):516).

A. Milstein and E. Gilbertson, “American Medical Home Runs” (*Health Affairs*; 2009; 28(5):1317–26).

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EA Bayliss, JL Ellis, JA Shoup, C. Zeng, DB McQuillan, and JF Steiner, “Effect of Continuity of Care on Hospital Utilization for Seniors with Multiple Medical Conditions in an Integrated Health Care System” (*Annals of Family Medicine*; 2015; 13(2):123–9).

³ Alison Evans Cuellar and Paul J. Gertler, “Trends in Hospital Consolidation: The Formation of Local Systems” (*Health Affairs*, Vol. 22, No. 6).

Cory Capps, David Dranove, and Christopher Ody, “The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending” (*Journal of Health Economics*, Vol. 59, May 2018, 139–152).

LC Baker, MK Bundorf, and DP Kessler, “Vertical Integration: Hospital Ownership of Physician Practices is Associated with Higher Prices and Spending” (*Health Affairs*, Vol. 35, No. 5, May 2014).



taking ownership of that base. Plenty of hedge funds see healthcare as a safe bet in uncertain times, as they did in the most recent recession, and other innovative models are emerging to more efficiently do the job that systems should be doing.

Provider Network

As risk for cost increases, and the need for a financial management model that recognizes this takes precedence, the most cost-effective elements of the system must be prioritized. As multiple studies demonstrate, primary care is the most productive and cost-effective component of any health system, and not just because it is the most undercompensated. Successful experiences with risk contracts in the 1990s demonstrated the value of comprehensive, coordinated management of complex medical care. Unsuccessful groups often failed due to their dependence on specialty-driven decision-making. Cost-effective specialists are critical to a successful population health management approach, but only primary care physicians, by training and focus, can attend to the full range of social, behavioral, and preventive elements that constitute truly coordinated care. The downstream revenue impact of primary care alignment, even in a FFS environment, goes well beyond the office revenue, up to more than \$2.5 million annually per primary care provider.⁴ When

taking increased risk for a population, those primary care covered lives *are* the system revenue. It is no accident that the HealthCare Partners IPA in California was sold to DaVita Health and then to Optum for billions of dollars. The challenge, however, is that management and governance of these provider networks must be exquisitely sensitive to the revenue model to ensure that the business margin makes sense in the context of this downstream impact. As in this case, a payor acquiring a medical group may not necessarily reduce costs, particularly when the profits on savings accrue to shareholders rather than the patients or employers.

The concept of the provider network itself must also broaden substantially as we think about managing total cost. Where the existing volume-driven model of FFS revenue ascribes individual streams of cash to each service provider based on their activity and billing, experiences from capitation models and emerging models make it clear that the population health manager, usually a network of primary care providers with attributed lives, will be managing a more coherent revenue stream on a per capita basis. This implies that the nature of the network itself is likely to shift, supporting specialists and facilities that are cost effective and moving some care into nontraditional environments that both provide better value and begin to address some social determinants that have a profound

⁴ Merritt Hawkins 2016 Physician Inpatient/Outpatient Revenue Survey, ECG data.

cost impact. Consider a system in which community centers, food pharmacies, long- and short-term housing, and better aligned behavioral health components are intrinsic elements. Financing for these components may also need to evolve as systems adapt their capabilities through grants, public funding, and philanthropy to support a broader purview in managing health for tenuous populations.

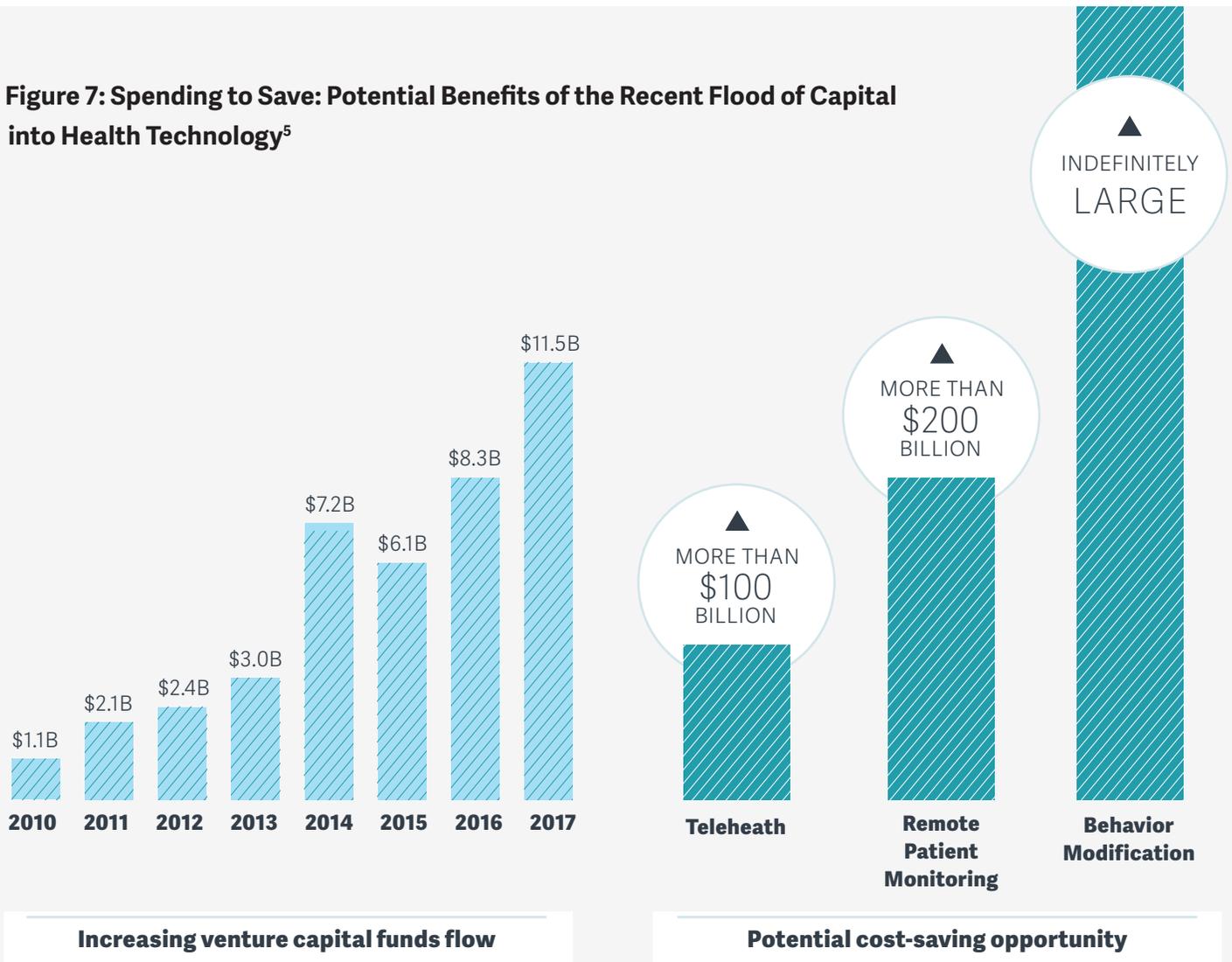
Interoperable Technology

The unprecedented amount of capital going into healthcare technology solutions today is dwarfed only by the expectations of overall cost reduction in the future. Analytics, AI, and enhanced communication platforms

are already beginning to show promise, and if even a small percentage of this potential is realized, we are still talking about billions of dollars, much of which is in the continued reduction of both high-cost and commodity care (see **figure 7**).

Remote monitoring, scheduling, and secure video health platforms are already beginning to improve outcomes, access, and costs by selectively allowing acute care to be delivered in the home. So, unless we position ourselves to make technology a net benefit by taking on the risk for that cost, someone else will realize that benefit. Embracing and investing in technology is the only option.

Figure 7: Spending to Save: Potential Benefits of the Recent Flood of Capital into Health Technology⁵



From the perspective of patient centrality, the distributed facilities and services pillar is also one of the key elements in defining a new competitive approach by providing an opportunity to design space that is patient friendly, reduces stress and effort for the patient, and supports healing.

Distributed Facilities and Services

With the exception of a few markets and sectors, such as pediatrics, we've already seen construction and capital move significantly away from acute hospitals into ambulatory surgery centers, multispecialty facilities, and some microhospitals, and current trends aren't likely to change that trajectory. In some cases, we've even seen more aggressive systems downsize their acute footprints dramatically in anticipation of more population-focused, home-based care delivery. Once again, the impetus to be rewarded for reducing the total cost of care is a key ingredient. But from the perspective of patient centrality, the distributed facilities and services pillar is also one of the key elements in defining a new competitive approach by providing an opportunity to design space that is patient friendly, reduces stress and effort for the patient, and supports healing. While this setting is often best achieved in the home, there will always be a need for procedural and interventional environments when care is highly complex or intensive, as well as socially supportive environments, such as assisted living and adult day care, when components of medical intervention need to be integrated more efficiently with behavioral and social determinants.

Healthcare facility planning should embrace adaptability in design, from inpatient rooms that can convert from acute to critical care environments, to interventional platforms with shared prep and recovery space for aggregated anesthesia-based services that enable a shift from "open" to "closed" procedural cases over time. With an expected useful life of 30 to 40 years for most healthcare facilities, health systems will need to continue these adaptations as well as consider more radical, lower-cost alternatives to care settings or standards of construction. Given the evolving nature of care delivery and responding functions, the many forms of today's healthcare ecosystem must respond accordingly, with a view on the far horizon and a recognition of the risk with traditional brick-and-mortar capital investment.

The distribution of services in the Health System of the Future will need to follow more of a community-based intensity model (see **figure 8** below), in which planning for different levels of service focuses more on meeting the patient's/consumer's needs in the most patient-centric, cost-effective way and less on the basis of individual facility P&Ls or unsustainable capital juggernauts. The downtown mega-campus must give way to the neighborhood community center with built-in primary care and easy access to the local specialty clinic or medical office building. In addition to putting the right facility and services in the right place based on population needs, health systems need to design flexibility into their facilities, which, in many cases, will allow for lower development costs while using space more efficiently. Reducing fixed costs also leaves more room for the system to manage the evolving grey tsunami and compete effectively. As the focus of operating margins shifts away from hospital services to effective management of patient

populations, the capital structure of the Health System of the Future will shift from brick-and-mortar ownership to space as an operational expense and capital investment based around acquisition and management of attributable lives. Moving toward a more balanced portfolio of facilities that brings services closer to the patient and into the home also answers the documented desires of consumers for more convenient access.

In addition to the considerations above, this is an area where technology is already seeing an exponential impact. The need for facilities where providers and patients engage in face-to-face visits, as well as the financial incentive to do so, is likely to decline dramatically with the advent of secure video appointments. But that is not where the technology revolution impact ends. Imagine an MRI machine that can be easily driven to a patient's home in a small van, or a single-use diagnostic testing kit that can be mailed, used, and discarded, avoiding the need for a visit to the phlebotomy site.

Figure 8: Community-Based Intensity Model

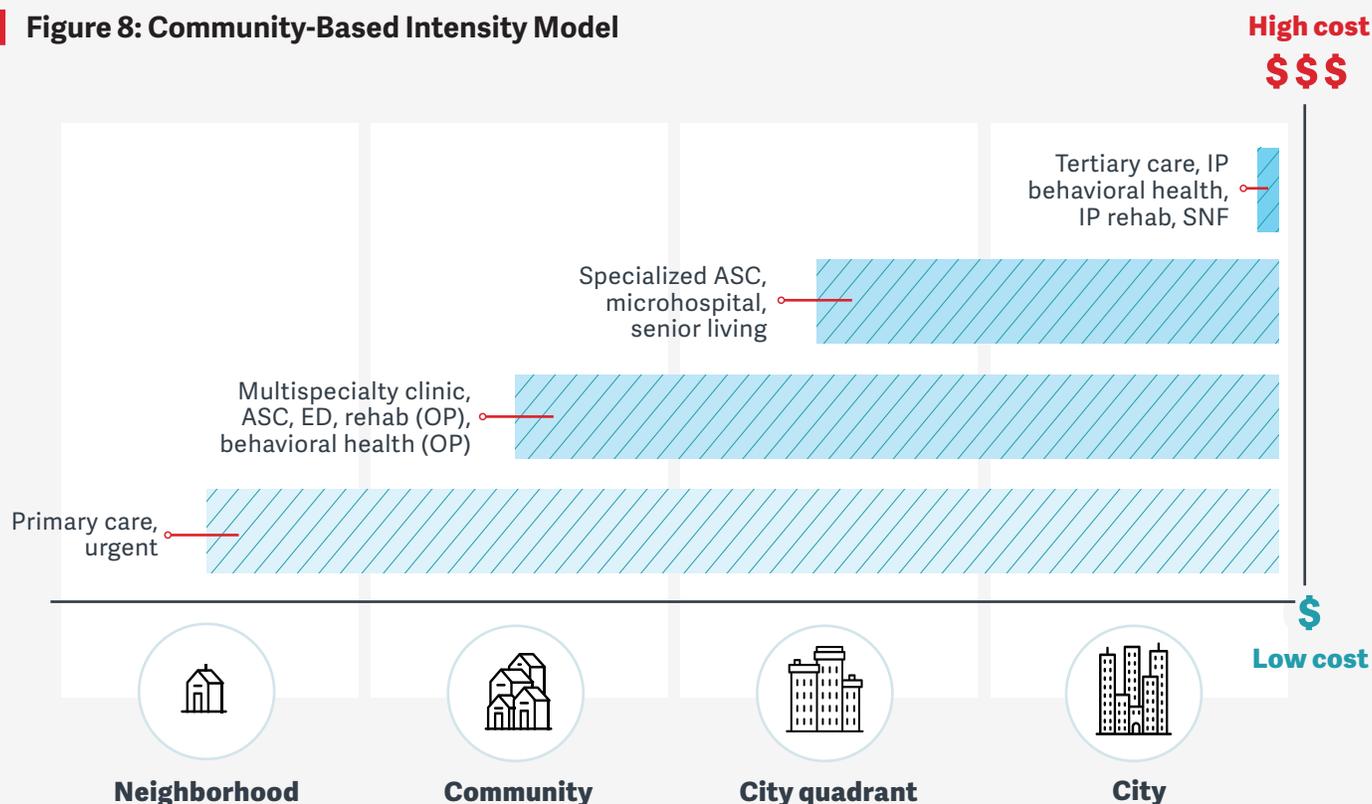


Figure 9: Impact of Transformation on the Provider Workforce

		
Drivers	Disappear	New Roles
Payment models based on per-life basis, not volume	90% of billers and coders	Population data scientists (may be outsourced)
Machine learning or “AI”	80% of radiologists, 90% of pathologists, 50% of anesthesiologists ⁶	
Decreased acute utilization	25% of hospitalists	Extensivists, Mobile Acute Medical Technicians
Autonomous robotics	20% of surgeons 50% of pharmacists	

One system in Australia is already diverting 6% of its acute admissions to hospital-at-home programs, in turn providing higher levels of safety and patient satisfaction and realizing savings of more than \$2,500 per case. Most of the United States’ current prototype programs estimate that 25% of current admissions would be medically appropriate for a hospital-at-home model.

Workforce

What does all of this mean for the provider workforce? It means radical transformation, including in the roles of some physicians (see **figure 9** above). Leading thinkers in specialty societies and technology are already predicting that many existing roles and specialties in our current model will virtually disappear overnight as intelligent automation passes the tipping point. Some roles can shift fairly easily, such as hospitalists becoming

“extensivists,” but what happens when technology that can read images and biometric data with 10 times the predictive accuracy of human beings makes radiology, pathology, and anesthesiology virtually anachronistic? When will autonomous intelligent robotics dramatically reduce the need for pharmacists, surgeons, and other proceduralists? As preposterous as this idea may seem to some, self-driving cars, which are already here, perform much more complicated tasks than a large percentage of provider-performed procedures. Moreover, despite some high-profile incidents, robotics fail much less often than humans do.

The new roles are likely to be just as diverse as those that disappear or decline. The need for financial and clinical analytics expertise will certainly not decrease, even if borrowed from payor organizations with which systems partner to take on the population health

⁶ Gideon Caplan, Nur Sulaiman, Dee Mangin, Nicoletta Ricauda, Andrew Wilson, and Louise Barclay, “A Meta-Analysis of ‘Hospital in the Home’” (*Medical Journal of Australia*, Vol. 197, No. 9, November 5, 2012, 512–519), <https://www.mja.com.au/journal/2012/197/9/meta-analysis-hospital-home>.

management role. It is also likely that there will be new roles developed for the provision of cost-effective care at home and online, as well as a shift in skill levels in post-acute facilities to take care of higher-acuity patients in those settings. Many of the roles that work now in fixed bases of operations, such as radiology departments, will probably become almost completely mobile. As the network of providers expands in the community, we may also see community health coaches and other roles emerge to prevent interaction with the costlier elements of the system whenever possible.

Despite technological advances, it is likely that the healthcare workforce will continue to grow. In many

surgeon to satisfy a service line strategy is multiplied by the need to have backup coverage (i.e., three spine surgeons). As technology enables scale, there will be some solutions for force multiplication, but there will also be limits, particularly in the near term, requiring creative solutions.

Another key factor for meeting demand will be the requirement for all providers to operate at the top of their training and licensure, regardless of setting. This applies from the office medical assistant (who may eventually be the “mobile medical technician”), to the primary care physician, to the general surgeon.



Governance and Organizational Model

Is there a future for not-for-profit organizations as Health Systems of the Future? We expect that the healthcare provider sector will follow a path similar to those of other industries that have experienced significant levels of technological and operational transformation and reached a generally consolidated state. However, what differentiates healthcare from most other industries is that the foundational element of its business model is rooted primarily in a local or regional caregiver-to-patient. This historical model is what gave birth to the

areas, the healthcare industry is already the largest or second largest employer. We see this as a continuing trend as the scope of what constitutes healthcare continues to expand and demographics change. This growth will present its own challenges to systems attempting to compete effectively. The trend toward hyper-specialization in many specialties already places a significant strain on communities of 100,000 people or less, wherein the clinical demand for one spine

community-based, not-for-profit ownership model that characterizes most of healthcare today. The healthcare provider space will continue to aggregate into super-regional, multistate, and even national systems, but we do not anticipate witnessing a wholesale conversion of not-for-profit systems to for-profit models in the next decade. It is hard to say if the not-for-profit ownership model will last indefinitely. Many communities are already challenging exemption from local taxes, and, under enough budget pressure,

the federal government may too, although the tax revenue to be generated would hardly compare to the value of charitable care provided by these organizations. Access to tax-exempt financing may be another long-term challenge. However, we posit that the organizational model, management, and governance structures must change for these organizations to survive in the future.

Organizational models must be more centralized and standardized to reduce costs. Health systems will need much more control over the full continuum of care if they are going to be successful in managing population health. While that doesn't necessarily mean that they need to own it all, they are going to need much tighter alignment between traditionally diverse elements such as DME, pharmacy, home care, post-acute services, and community-based sites (e.g., adult day care). Systems will end up in arrangements that potentially look more like vendor contracts than voluntarily cooperative entities.

In addition, a wide range of capabilities that are currently considered payor competencies, such as member enrollment, network contracting, actuarial analysis, utilization management, and so on, will have to be managed. Somewhere, we will need to build, rent, or partner for these services, and understanding what model to use for each will be specific to each organization's needs and starting points.

Management and governance models must change as well. Leadership must be truly visionary to guide the necessary transition to become the Health System of the Future, while at the same time management must be singularly focused on achieving results and ruthlessly held accountable for performance. Boards must understand and appreciate the difference between leadership and management. Different expertise will be needed in many management roles, and for that matter, different roles with newly defined spans of control will emerge. We're already seeing roles such as "Chief Experience Officer" and "VP of Population Health," but most of these roles are nebulous, and few have hard

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to become the Health System of the Future, while at the same time management must be singularly focused on achieving results and ruthlessly held accountable for performance.

signature authority at this point. That isn't to say that a matrixed organization won't be the rule, but when we consider the expanded scope of capabilities that such a system needs and the dramatically diminished role of acute care, the most successful models may look very different from what we have today. Governance is already shifting away from representative models to competency-based models, and we believe the next iteration of governance will move to a compensated board structure that is based on acquiring both the necessary expertise from within industry and functional expertise from across industries.



WHAT'S NEXT

As the Health System of the Future brings more capability into the home, office, community, and primary care environments, it extends its reach and reduces the cost structure while enhancing the patient experience and competing effectively. However, systems can only accomplish these goals if they are managing and benefiting as partners in the cost equation. There are a variety of strategies that span the continuum from “no regrets” to highly “market sensitive,” as described in **table 2** below.

The possibilities for extending control over the continuum from wellness to hospice are limited only by how health systems contract effectively with payors, partners, and patients themselves. If we are not focused in some way on reimbursement being tied to total cost, a system’s risk of being commoditized rises dramatically as its competitors figure it out. Systems can tackle this challenge incrementally, but in doing so, they risk being overtaken by competitors as their markets pass the tipping point in moving to value.

Table 2: Strategies in Moving Toward a Health System of the Future

<p>No Regrets</p> 	<p>Pushing Forward</p> 	<p>Regulatory Sensitive</p> 	<p>Market Sensitive</p> 
<ul style="list-style-type: none"> ■ Move toward patient centricity. ■ Develop digital and telehealth strategy. ■ Secure primary care base. ■ Focus on clinical excellence. 	<ul style="list-style-type: none"> ■ Develop post-acute management strategy. ■ Drive employee health management. ■ Establish TME-based contracts. 	<ul style="list-style-type: none"> ■ Build delivery environments in a community-based intensity model. ■ Move care into the home. 	<ul style="list-style-type: none"> ■ Build provider-sponsored health plan. ■ Develop shared risk arrangements. ■ Establish direct-to-employer contracts.

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