

UST Executive Conference on the Future of Health Care November 7, 2008

Highlights of the Major Addresses

Introduction

The 2008 UST Executive Conference on the Future of Health Care was structured to address two major drivers in the health care system – payment policy and the health care delivery system’s strategic responses. These issues are the key drivers of health care performance into the future.

This highlight section provides an overview of these keynote presentations related to payers and system responses. More detailed information is contained in other sections of this report on the conference.

Payers

Three major payment systems were addressed by the presenters: Medicare, the private insurance system and Medicaid. All three presentations first enumerated many of the widely accepted shortcomings in the American health care system:

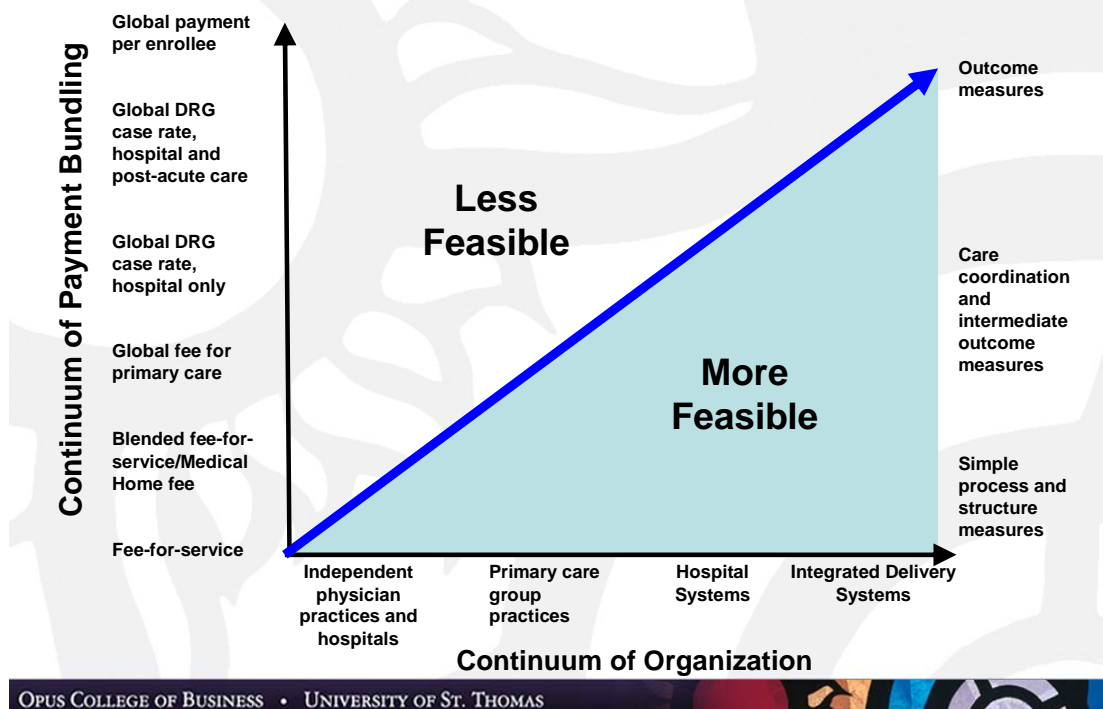
- Highest costs in the world
- US health care costs projected to be \$4.4 trillion by 2017
- Poor performance on quality compared to the developed world
- Purchasers are not the consumers and consumers have a limited voice
- No good mechanism to deliver innovations into the system
- Disparities in the health outcomes for many disadvantaged populations

All three presentations also provided policy change recommendations that were believed to be able to influence the costs and quality of the system.

Stuart Guterman spent much of career as a high level official within the Centers for Medicare and Medicaid Services (CMS). He now is assistant vice president and director of the Program on Medicare’s Future at the Commonwealth Fund. He presented their vision of needed changes in Medicare.

He stated that two major changes would have significant impact on the system – payment to integrated systems of care and bundled payment. Much of the poor performance in the system is due to the fact that there is no “system” in much of the country – only small practices of physicians. Health care reform will only be possible when accountable and integrated systems are formed – and this can be encouraged by changes in Medicare payment policy. Once integrated systems of care are in place a number of sophisticated payment methods may be deployed. His recommendation for payment reform is best illustrated by his diagram below.

Organization and Payment Methods



In addition to the increase in integrated systems and payment reform he also recommended increased quality standards and reporting, transparency, increased use of information technology and the development of national standards for the comparative effectiveness of drugs, devices and procedures.

Forrest Burke is the President for Public Sector programs at United Healthcare. He provided an overview of the dynamic insurance market and changes now being made in the private health care markets. These include the rise of national networks of care and increasing consumerism. Major trends, including the growth of the working uninsured and the significant increase in consumer directed products, are being seen by all insurance companies.

He suggested that health care reform models could be best tested at the state level where there are a number of interesting experiments currently underway or proposed. In addition to the system changes proposed by Mr. Guterman he also recommended that any national reform legislation should include these key elements:

- Employer-based system and that encourages employers to offer coverage and employees to “take up” coverage
- Everyone in the pool—the “invincibles” and the most vulnerable
- Guaranteed issue tied to an individual mandate
- Sustainable reimbursement levels for providers
- Meaningful payments for quality and wellness
- Tort reform
- Evidence-Based safeguards
- Incentives for individuals to improve their health
- Consumer engagement with “skin” in the game

Dr. Jeff Schiff is the medical director for the state of Minnesota health care programs which includes Medical Assistance and MinnesotaCare. Although he leads a very large state agency, Dr. Schiff's presentation focused on the market and how payers and providers can find alignment in order to deliver high quality, cost effective care.

One of his major premises was that patients needed an "agent" in the system. He felt that primary care providers could be this agent due to their:

- Knowledge and access to clinical knowledge
- Ability to integrate medical complexity
- Ability to integrate patient preferences
- Potential to create a market for their services

To advance this use of primary care, the Minnesota legislature passed a number of reform initiatives in 2008 including: uniform quality incentives, baskets of care/ price transparency, coverage expansions, new public health investments and health care homes

Challenges in implementing these new tools will include finding the correct payment blend and defining robust care coordination for primary care services. Paying for baskets of care may be problematical due to the limits of coverage and the difficulty for providers to understand the system.

It is interesting to note that many of the Medicare reforms advocated by Mr. Guterman are actually being implemented and tested in the public health care programs of Minnesota today.

Provider systems

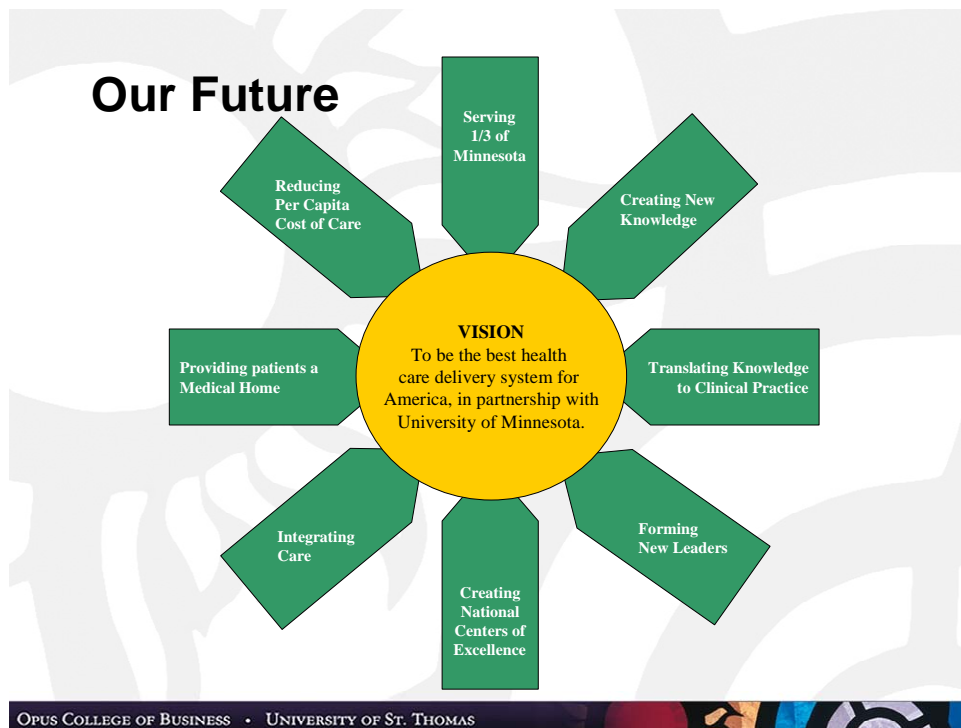
Providers of care also are making significant strategic changes to succeed in the future. This portion of the conference focused on national provider based reform efforts, systemic community engagement by an academic health care system, and intensive efforts at broad scale patient/physician engagement in chronic disease management.

Dr. Michael Rock is the chief medical officer of the Mayo Rochester hospitals. He provided an overview of Mayo's national campaign to reform the system. Mayo staff have been working with stakeholders and conducting meetings throughout the country to advance their ideas. Their basic principles for reform include:

1. Everyone has access to essential medical care
2. Simplify and make affordable and transportable medical coverage
3. Promote health care as apposed to sick care
4. Encourage personal involvement; empower the consumer on health choices, health care
5. Greater social responsibility by health care stakeholders
6. Incent high value integrated health care delivery
7. Expedite and facilitate interconnectivity among health information management system

To achieve these goals 4 major strategies need to be implemented. First all providers in the system need to create value – highest quality care provided efficiently. The next key strategy is the coordination of care – particularly for those with chronic disease. Payment systems need reform as well in order to provide incentives for high value, coordinated care. Finally all Americans must be insured with a broad benefit set, affordable premiums and portability.

Mark Eustis is the president of Fairview Health Services which provides care to one third of Minnesotans and includes the University of Minnesota hospital. The outline of his strategic vision went beyond the traditional health systems goals of providing high quality care to a vision of a system with much stronger connections to the community and knowledge leadership. This is summarized below:



Fairview intends to implement this vision through 6 strategic initiatives which include:

- Greater use of information technology
- Improved business systems
- Continuous performance improvement
- Increases in philanthropy
- Advocacy for reform
- Continuing improvements in facilities and technology

The key drivers of these initiatives are employee engagement, physician alignment and continuing and improving partnerships.

Jim Coleman is the chief operations officer of the Marshfield Clinic. The clinic employs 795 physicians and provides care through 45 regional centers in central Wisconsin. Marshfield's strategic focus is on moving from fee for service, RVU based episodic care to a value based system which will deliver the highest quality and cost effective care to patients.

Elements of this new system include:

- Integrated care delivery/medical home
- Reimbursement to providers are aligned with clinic goals
- Patient centered (Include patients on committees/workgroups)
- Standardization of care processes
- Measurement to improve is the norm
- Improved health/preventive services
- Focus on chronic disease
- Managing the cost of large cases
- Leverage information technology, bioinformatics, education, research capabilities
- Redesign of the delivery of care

Marshfield is already on the road to implementing many important aspects of this new system and is pleased with its success in the CMS Physician Group Practice Demonstration project. Because of a reduction in hospital admissions the Clinic's diabetes management project has saved Medicare approximately \$20 million/year and has significantly improved the quality of life for these Marshfield patients.

Special Issues in Financing: Session 1

The Changing Dynamics of the Health Care Market Place

Speakers: Nancy Rehkamp, Principal, LarsonAllen and Fritz Wenzel, University of St. Thomas

With consumer driven health care people have not limited their spending. People make different decisions when they have to spend their own money. Between 2012 and 2022, more than 30 percent of people will have less than \$30,000 on due to a decrease in pensions.

Older adults have higher incomes and are better educated. Their expectations are higher for health care. Prior generations would work part-time somewhere; this is the first generation of older adults who are focused on enjoying life and leisure.

The decreasing role of family pushes up demand for all services: economic consequences exist if family members stop working to take care of a family member. Typically, 45-64 year old women are caregivers. Younger adults are seeking jobs away from rural settings; many rural communities will have 50 percent or more of their community over the age of 65. Older adults are moving to rural areas so that their dollars will go further. Younger adults will not be able to take care of them.

The customer is changing in three areas. One, the disadvantaged today will be disadvantaged when they reach age 65. The opportunity to get ahead is not an option. They are unprepared; they know they are not prepared but don't know how to become prepared. They are affluent: composition is different than 50 years and older in the past. 401Ks are part of this group's net worth and about half of net worth is help within their home.

As a person ages, it doesn't necessarily mean that they will have frail years. Usually one sees an 18-24 month period of decline in frailty prior to death.

It is anticipated that we will have a 1.2 million RN shortage. Presently Florida has an 8 percent shortage, California a 12 percent shortage and Minnesota is balanced. Even if the retirement age was changed for RNs, there would still be a shortage. The average age in Minnesota for an RN is 49 years. RNs usually leave the bedside between 52 and 55 years. Usually after 2 years of patient care, RNs will leave position – keeping them at the bedside is critical.

When looking at selected Academic Health Centers, the efficiency that occurs at Mayo are often translated throughout Minnesota, but not necessarily throughout the country.

How could you use this information and/or the general session to revise your organization's strategy? What are the dangers ahead?

- Care coordination – medical home and what it means to health care delivery
- PCPs are resistant to care coordinators and pay for performance
- Mental health and chronic conditions - Are PCPs able to handle both? Will physicians value another opinion or will physicians make the referral and then say it's your patient, manage him?
- RN shortage – disconnect between people pursuing RN and what they actually end up doing after receiving their degree. Moving away from direct patient care may be due to work/life challenges, burden with managing complex cases which often leads to RN burnout.

Special Issues in Financing: Session 2

Capitalizing on Capital: How Dollars Impact Your Strategic Plan

Speaker: David Schuh, Principal, LarsonAllen

How to get capital for your health care organization in today's economic times

Health care organizations need to be thoughtful in the message that they are sending to investors when they are requesting capital. We need to be setting our targets at such a level that investors would say that they want to give capital to our organizations. Our operating performance needs to be investment worthy over all else. We should consider whether we need to raise or lower performance targets in order to get capital in this environment. Investors will be scrutinizing our numbers. We need to be aware of what we have in reserve and how to wisely manage revenues.

Early Stage Financial Planning Considerations:

- How much capital does the organization want?
- How much margin does the organization want?
- How long until we hit our margin target?
- How much outside money do we want to put into the equation?

Revenue Defined

Revenue equals volume multiplied by revenue per unit. Health care organizations are paid less per unit in a fee for service environment than in other payment models. We should consider negotiating a 6 percent rate increase if inflation is 5 percent. We also need to take into consideration volume. What are trends telling us about future volume and how are outside market pressures going to impact volumes?

Navigating the Current Environment

In order to continue to navigate in the current health care and economic environment we need to take current factors into consideration but we also have to carefully plan for the future. Capital is not as easy to come by as it was in the past. Lean initiatives may increase efficiency but we are still left with capital needs for building, equipment and technology as reimbursement continues to decline. The demand for skilled, professional staff will continue to drive costs up. We need to consider how the health care system will change and adapt to an aging population all while Medicare reimbursement and enrollment in medical school for primary care physicians is declining. Some organizations may want to consider partnerships, joint ventures and/or mergers as a source of capital given the current economic environment.

A Financial Conundrum

Nobody can predict the future of the health care marketplace. Until payers start reimbursing using cost, quality and outcomes data we will not have the information we need to make informed investments. If we invest in a new technology today, we can't predict whether or not we will realize a return on our investment tomorrow. We need to reduce overall capital spending and reassess whether or not we need so much physical space. We need to focus on the strategies with the highest returns which may mean that more care is delivered in the home or on an outpatient basis versus care delivery in a traditional health care facility. Procedural profitability could change over time which could make current investment in capital inappropriate.

Planning for Tomorrow

We need to educate our staff to follow the dollar today in order to maximize our return on our investment tomorrow. We can't expect staff to be good stewards of our health care dollars if they have no concept of profits and losses. We also need to inform consumers on choice, access and personal responsibility.

Special Issues in Financing: Session 3

Demystifying the HSA and High Deductible Health Insurance: Where is the Value and What Does the Future Hold?

Speaker: David Spalding, Vice President of Medical Banking and Retail Services, BlueCross BlueShield

Dave Spaulding reflected that since his relocation from Florida to Minnesota he can attest to the advanced health care that the state of Minnesota provides.

In his overview of the advantages of Health Spending Accounts, he noted that a large financial advantage for the consumer is the Triple Tax Advantage. By taking advantage of this, the employee can save dollars on a tax free basis, an investment similar to a 401K, and if withdrawn it is not taxed so long as it is used for qualified health expenses. The employer also continues to receive their tax benefits. The Midwest and southern regions have been the earliest adopters of these programs, with Minnesota leading the nation in its market penetration. Dave's opinion on this phenomenon is that Minnesota tends to have innovative employers and an educated work force. There is also a lower rate of uninsured in Minnesota and a healthier workforce.

The popularity of consumer driven health savings plans are growing, as nationally 1 in 3 employees participate in a FSA, HSA or HRA. An EBRI's Health confidence Survey indicates that employees prefer to have greater health care benefits than increased wages. If this trend is likely to continue, employers' strategy might be to offer better health care benefits. Currently 55% of the total national health care expenditures are provided by the commercial sector with 24% of that total expense coming out of the consumer's pocket. Employer surveys indicate positive results in the offering of the HSA, especially in lowering their overall cost of providing health care. However, questions were raised if costs are really decreasing or being shifted to the employee.

In order to provide an HSA to employees as more than just the "plumbing," Towers Perrin research identifies four cornerstones for success that employers should strive for:

1. Build a new mindset around health
2. Help employees gain confidence in their ability to manage financial risk
3. Have an organizational climate of trust and employee well being
4. Thoughtful change management, communication and visible leadership

By providing these along with employers actively contributing to the HSA accounts, it will help to create an environment where employees will make better decisions regarding their health and use of their plan.

HSA's are one of many tools in the toolbox, not just a single solution. Employers still continue to look at costs with some of them more willing than others to absorb the increased costs. With this you will continue to see variable behavior of employers ranging from absorbing the total cost to total abandonment of insurance coverage to their employees.

Round Table Discussions

Complimenting the morning sessions, the discussion of HSA's and the use of them to promote the change toward consumer driven health care was evident. The use of HSA's as a small but growing option has promise to play a role in the consumer gaining more choices, control and responsibility over their plans.

During the general session, information indicated that health care costs are rising rapidly in the United States. In the breakout session, David Spalding relayed that the rate of growth in health care spending seems to be slowing down in recent years in Minnesota. Although health care costs are still growing in Minnesota, trends show that the rate of growth each year is less than the previous year.

As we look to find value in what HSA's have to offer it becomes important to realize the complexity of how it functions. Insurance stakeholders of this program need to provide education, counseling and access to

information regarding utilization of services, benefit coverage and general health. Some strategies are emerging such as creating call centers and providing an option to pay the provider directly. For provider stakeholders, options need to be improved for providing better transparency of cost information to the consumer. Many hurdles exist due to the complexity of individual employer contracts with various insurers as well as with the provider networks involved. In order to see value over the long term for all involved the employer and insurers need to explore the potential use of multi year contracts. BCBS is now offering a three year contract with their HSA/HDHP. For the consumer to utilize the tool of an HSA to their best ability all stakeholders have to work together to understand the intricacies of this newly emerging health plan.

Final Comments

There is a downward trend in employers offering health coverage benefits to its employees, especially in small business. At the same time the average medical costs for families are increasing at a rate much higher than the Consumer Price Index. While consumer directed health plans such as HSA's are providing an advantage in cost savings to employers, participants in the health plan need to understand how to navigate the complex medical system. Consumers are taking on a new responsibility of directing their own care and need to have health education, transparency, ease of access to health records and most of all an effective agent to assist them in making responsible health care decisions. It will be crucial for the success of health care reform to address this need not just for more effective HSA's but for all consumer directed health care.

Special Lunch Session

Current Conditions in the Capital Markets for Health Care Borrowers

Speakers: Mark Landreville, Managing Director, Public Finance Group, Piper Jaffray
Steven Prosechel, Director of National Health Care Group, Piper Jaffray

During the last decade, health care borrowers have enjoyed the golden era of financing: Low interest rates, open access to capital, tight credit spreads, and cost-effective financial tools created an unparalleled environment for capital opportunities. This atmosphere has obviously been dramatically affected by current global economies.

Interest rate history shows we have spent nearly all of the past 17 years at or below the Bond Buyer Revenue Index average of 7.14% (as averaged from 1979-2007). The credit spread (difference in interest rates) history had an average of 59 bps from 1993-2007, representing the lowest absolute cost for health care borrowers ever seen. This decade also saw a record volume of bond issuance with a peak of 41,159 million dollars in volume in 2007.

Tremendous growth in health care bonds occurred during the years of 2004 – 2007. The attractive health care market drew in many new participants. This activity drove interest rates even lower, further rising the availability of low cost capital and increasingly expanded the capacity of health care organizations to grow.

This highly favorable economic period has left some good and some bad news for organizations as they tread through today's fluctuating markets.

The Good News

- With the high availability and low cost of capital, health systems were able to make many of the needed investments in plant and technology required for future years.
- Health organizations were able to use low cost debt to finance plans while retaining cash and investing in the market during favorable periods.
- Favorable market conditions also brought new financing innovation in the forms of new products and structures. Many of these new tools allowed borrowers to achieve even lower cost funding.

The Bad News

- Record amount of debt issuance is now present on balance sheets and is creating a challenging environment as cash flow levels decrease.
- Heavy reliance on bond insurance, auction rate debt, and utilization of derivative structures provided low funding cost but increased risk.
- Many years of strong market conditions aided in creating an environment of limited disclosure, sloppy analysis by rating agencies, and minimal scrutiny from investors, leading to "easy credit accessibility."
- Many leading bond insurers lost good ratings or completely disappeared.

The Future

- Health care borrowers will continue to be funded, but will face a different rule set.
- Expectations will change: Rating agency scrutiny will increase. Goals and promises will be revisited. Financials, management, and governance will be closely reviewed.
- Credit spreads will continue to increase. As a result of this, weaker creditors will find it more difficult to gain funding. Organizations able to consistently show positive performance will be rewarded.

Imperatives for tomorrow's health care borrowers

- Commitment to improve cash flows, meet projections and promises.
- Use of a true ROI-based capital decision-making model.
- Show tangible results, especially in areas of expansion, integration and acquisition strategies.

In summary, the strong global economy of the past decade or two has hit a snag (at the least) and is creating a more challenging environment for health care organizations. Capital availability is tightening and will be more costly. Organizations will face stronger regulations and scrutiny when applying for credit and will experience greater pressure to meet projected outcomes.

Special Issues in Delivery: Session 1 Reflection on Enticements, Barriers, and Unintended Consequences

Speakers: Kit Friedemann, J.D., Attorney, Fredrikson & Byron
Greg Hart, M.H.A., Principal, LarsonAllen

Health care leaders and politicians alike seek to repair a broken American health care system. As reformers set out to “do good,” they may unintentionally do just the opposite. Friedemann and Hart explore how doing the right things around health care reform is much more complex and challenging than it sounds.

Doing the Right Thing: Portico

Most agree that health care reform should be focused on:

- Access
- Utilization / cost / quality / value
- Personal responsibility
- Care system structure
- Science

However, each one of these issues carries its own challenges. For example, patients who do not have access to health care services have higher mortality and morbidity, become a burden for providers, and become expensive for all of us (government, employers, insurers, and individuals). In an attempt to address the access issue, Portico was born. Portico is a small health plan in St. Paul that was hospital financed and focused on access for the uninsured, system entry and navigation, and care management through primary care providers and care managers. The Portico mission was to reduce the number of people without coverage for health care services.

Portico’s process included community outreach to organizations and individuals to assess for eligibility and refer to appropriate resources. Portico successfully dropped inpatient visits by 35.3%, reduced ED visits by 32.9% and increase primary care visits by 31.9%. It seemed as though patients were getting the care they needed at the right place and at the right time. Providers, payers and patients were working together to reform the health care system in an innovative, efficient manor. In fact, the return on investment was \$2.55 for every \$1 invested. The bottom line is Portico achieved what it intended to achieve:

- Increased use of consistent primary care providers
- Reduced ED and Hospital visits
- Saved health care system resources and uncompensated care costs
- Made meaningful improvement in quality of life
- Reduced health disparities in the community

Portico is an example of “doing the right thing” in health care, although it is laced with barriers that will need to be overcome for broad implementation. Barriers include outreach efforts that are not reimbursable, activities that are at risk of violating federal anti-kickback laws, primary care providers who are underpaid, and systems that lack integration strategies.

Doing the Right Thing: Advanced Medical Home

New care delivery models like the Advanced Medical Home hope to control health care costs through efficiency and care coordination. This concept targets primary care settings that adopt the chronic care model, use evidenced based care guidelines, apply health information technology, demonstrate best practices, and agree to be measured and held accountable for quality and value (American College of Physicians Monograph, 2006).

The current primary care model is unattractive to physicians for a variety of reasons. Productivity and information management pressures coupled with low incomes, job satisfaction and physician shortages make primary care the last choice for many physicians. The current system is based on episodic care rather than chronic care management. The Advanced Medical Home aims to produce better outcomes with better care management and physician involvement.

In May of 2008, the Minnesota Legislature passed a health care reform package that included adoption of the medical home model. In the law, the model, referred to as the “health care home” model, begins to address payment reform based on care coordination. Under this payment system, physicians would be rewarded for care coordination for patients with chronic and complex conditions through promotion of patient-centered health care home model.

The Advanced Medical Home seems to have a bright future in Minnesota, however financing and payer contracts represent significant barriers. Physicians, the ultimate owners of this model, may be ready and willing to drive the change that is necessary to make this model successful.

Doing the Right Thing: Chronic Disease Management

One way to manage chronic disease is through intensive home monitoring. This was exactly what one health system CEO did for patients with congestive heart failure. The results were an 80% reduction in ED visits and inpatient admissions for this patient population. The unintended consequence was lost revenue for the hospital.

Another example included Physician Managed Care (PMC). PMC provided home infusion care (enteral and parenteral nutrition therapy) under the collaboration of the home infusion company and physician management. These services are reimbursed on a traditional volume basis but physician direction is not reimbursed. PMC realized better outcomes at a lower per visit cost/beneficiary. Unfortunately, PMC was disbanded as the OIG found federal anti-kickback violations. The database and partnership were dissolved. The unintended consequence: anti-kickback violation but the effort was certainly heading in the right direction.

Doing the Right Thing: Surgical Avoidance

A Minnesota-based physician owned company has implemented a care delivery model focused around exercise protocol for patients with chronic low back pain. Most, if not all of these patients have been referred for surgical intervention of their back pain. More than 75% of the patients avoided surgery using this company’s exercise protocol. Surgical costs, imaging costs, and social costs have all been reduced under this model of care. The unintended consequence is lost surgical revenue for hospitals and ambulatory surgery centers. Orthopedic surgeons lose but health plans and the patients win.

Conclusion

All agree that our health care system is broken, but even as we contemplate well-intentioned reform, we encounter barriers and unintended consequences. The effort is not lost on barriers and unintended consequences. With each effort we grow closer to answers that we did not have yesterday.

Special Issues in Delivery: Session 2

What Makes One Health Care Organization More Marketable than Another? How to Demonstrate Value to Gain Competitive Advantage

Speaker: Jack Militello, PhD, University of St. Thomas

In this break out seminar, Dr. Jack Militello, Professor of Management, encouraged participants to reflect on the marketing strategies currently present in our health care industry. The morning panel presentations stressed standardization and best practices; however, the notion of differentiation is an important consideration that should not be overlooked, especially in a competitive health care marketplace. The morning sessions, from one vantage point, encouraged sameness (e.g., policy, finance, optimization, standardization); however, the more one standardizes, the less differentiation can occur.

In order to realign our marketing strategies, Dr. Militello suggested that value will be created from differentiation and a clear understanding of market direction; we don't however all value the same things. Strategic advantage can be realized when organizations surrender the idea that they can or need to be all things to all people – this leads to moderate results. For example, consumers make decisions every day about what products to purchase, what services to receive, etc. These decisions can be based on aligning our needs with the value inherent in the product or service. Three main value propositions are at play in these decisions: highest reputation/ most notable, best cost, or most convenient. Each decision means that a trade-off will occur; some will trade cost for reputation, and so on. The key for the organization is to realize the uniqueness that is offered and deliver this; health care leaders should be listening to Michael Porter and his emphasis on delivering value to consumers. Differentiation occurs from a different vantage point, supported by internal variables such as operational know how, culture, and strategy; this type of alignment is essential.

Most every successful company has found a way to differentiate itself from its competitors. It is important that organizations don't fall into the "stuck in the middle" trap in which there is low differentiation, and lack of clear strategy. For example, Dr. Militello's research suggests that approximately 33% of organizations (n=450) are in this category. They may want to hire the best employees, but then lack the creativity necessary to innovate and deliver a product, service, or vision that truly gives the consumer a unique experience.

In order to highlight these points, several mission statements from orthopedic facilities were displayed for audience feedback on the messages' points of differentiation. Audience members noted the following themes: long community history, strong relationships, and best care. In one case, the audience could not find a point of differentiation inherent in the mission statement. It was clear that consumers make different types of health care decisions based on a range of values.

A discussion then ensued about how the elderly make health care decisions. Members noted that most often direction is taken from family, friends, and health care providers. The implication was that the points of differentiation and the clear messages surrounding this must also be communicated to those assisting others in making health care decisions.

Audience members commented on the issues that some health care organizations' strategies are to become big. Certainly, the morning presentations on integrated health care delivery models are in line with this presumption. However, this opens up a potential marketing edge for those organizations that want to compete on the small, personal differentiation. Perhaps the notion of the medical home will push some to innovate and consider ways to compete on this value.

In sum, this session highlighted the importance of including a differentiation strategy in the health care arena. In an era defined largely by standardization and integration, organizations that can recognize their inherent uniqueness and align strategy, marketing, and vision with the goal of delivering value to the consumer will be better positioned to remain competitive.

Special Issues in Delivery: Session 3

How Baby Boomers Will Change the Face of Long-term Care

Speaker: Steve Shields, President and CEO, Manhattan Retirement Foundation

Steve Shields, President and CEO of Manhattan Retirement Foundation, told a very compelling story of how his organization has changed the way long-term care is viewed in his community. Their main premise is to keep people living independently as long as possible. Steve stated that those of us in the health care industry were all inspired to be in this field for one reason or another, and for most it was not a business decision. There is a great disparity in what called us to this caring profession and what we have learned of the profession over time. We all want to turn the system around to get back to the reason that we got into the field.

Steve discussed how as an industry we are good at making the fundamental diagnosis, but it is always aimed at symptom management. If we believe that we have the ability to regenerate and be well as a health care system, then we have to start looking at the roots. Steve's organization has done just that; they have dug for the "root" of the matter and have isolated three reasons for the problems in their organization:

- We know what's best for You
- The system drives what you experience
- How we organize ourselves—beliefs/values—created the first two

The structure or how we organize is further broken down into two issues:

- Silo thinking—no one has the ability to systemically approach an individual or system; there is too much fragmentation
- Hierarchy—effects behavior of all

Steve claims that these combined create a toxic environment and change cannot occur until both of these areas are addressed.

To create change, Steve looked at what he felt was one of the weakest links in health care—nursing homes. Steve feels that traditional nursing homes create "institutional homelessness" and they are the "ugliest, most regulated" places in health care. Most people do not want their loved ones to go to a nursing home. Steve asked the group to share what comes to their mind when they think of a nursing home and most people had the image of a person sitting in a wheelchair, slumped over to the side, alone. Steve has given more than 1,500 lectures on this topic and in each case this same image was offered; it is this loss of human spirit and dignity that has motivated Steve to create transformational change.

Residents of nursing homes most often have a complete loss of self; they do not decide when to eat, they do not plan their own activities and they are told when to go to bed, etc. Physicians do not come to nursing homes; if there is a problem, the patients are brought to the clinic or hospital. Family members are also largely absent in nursing homes; they too are called if there is an emergency but beyond that, the resident is left to their own, diminishing capabilities. The potential for transformation disappears in a nursing home. Steve and his organization believe that people need to drive their own lives—even if they don't remember their own name.

Steve and his organization created a model that has the personal wellness of the residents in the center. They took patients out of the large, institutional nursing homes and created individual homes with twenty or fewer residents. People live in these homes, with a supportive medical staff, and live as they want to; they "drive their own lives" according to Steve. The staff does not dictate when they eat or what time they get up in the morning. The residents make their own decisions and have the support of a self-led team, who are taught the judgment that the tops of the silos usually manage. This breaks down the hierarchy

and creates autonomous teams that are part of the residents' lives. The teams also cross train to an extent so that they can understand each other's roles; this creates a better sense of collegiality and teamwork.

When parents age, it is the daughter or other women of the family who tends to manage their care. With this in mind, each patient who lives in one of these houses has a "Nurse Daughter" assigned to them to oversee the entire care plan. This person becomes a surrogate, trusted daughter to the patient who provides continuity of care for each resident. Nurse daughters become the patient's primary relationship (to help with outside teams/systems—like the hospital). Along with this, there is an entire team of providers and wellness partners who coordinate to manage the care of the residents. The MD can be the quarterback when his skills are needed, but is also willing to be in the "huddle" with the patient and the rest of the team. This system completely eliminates the traditional hierarchy.

These interconnecting teams, align people on purpose where everyone understands what each other is doing and more importantly understand the goal for the residents—a true coordination of care. The end result of this plan, according to Steve, has been "profound." To date, there are more than 800 homes that are using this model. Doctors and other team members come to these homes as needed to partner in the coordinated care for the residents. Family members come and enjoy spending time in these homes. Steve stated that many families will come to the homes for holiday celebrations, which is a complete turnaround of behaviors compared to institutional nursing homes.

The greatest reward for Steve has been the change it has made on the residents. After 18 months of transition into houses he has witnesses people come out of their nursing home "stupors" and they are no longer left leaning alone in a wheelchair. Putting the person who needs the services in the driver's seat is the key to their success. As a result of these efforts, emergency room visits are down more than 60% for this population and hospital re-admissions are also drastically lower.

General Comments

The themes from the general session fit well with Steve's mission:

- Seamless integration
- Need for advocacy
- Need for case management

What does not fit with Steve's philosophies is the discussion on the shortage of primary care physicians. One idea that was discussed to "fix" the issue was that every licensed professional is going to have to work to the top of his/her license and that more physician extenders would be needed to support the system. PA/NPs would essentially take over primary care leaving MDs to staff specialty centers. Creating more extenders will make the system even larger. Steve believes that is the wrong way to go. The health care system is already too big, fraught with silos and hierarchy, and is too expensive. His idea of breaking down nursing homes and partnering in care actually reduces the number of staff needed and decreases costs. CMS agrees with him and is completely behind this nursing home idea because it saves money in long run and it creates healthier lives by allowing patients to stay in control. Our system is based on acute care; but we are not an acutely ill society. We need chronic treatment and prevention plans. Steve believes that hospitals need to be looked at as the ancillary care service instead of as primary care.