

WHAT POST-ACUTE PROVIDERS CAN LEARN FROM APPLE

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To say it's been a busy year for the Center for Medicare and Medicaid Innovation (CMMI) is an understatement. With future funding held in the balance by an increasingly mercurial Congress and an election year certain to only make health care politics more polarized; CMMI has realized the time is now to change health care. Hospital systems and physician practices are faced with a dizzying array of options to test the waters of care delivery reform, such as pioneer ACOs, the advanced primary care practice demonstration, and the comprehensive primary care initiative. Though there are some direct leadership opportunities for post-acute providers as well – such as Model 3 of the bundled payment pilot and the health care innovation challenge – the prime opportunity for post-acute providers is to serve as a preferred, high-value partner to hospital systems and physician groups.

By now, a plurality of hospital systems and physician groups recognize the default option – referring patients to the first available post-acute provider – is insufficient to succeed under accountable payment models. Yet, if providers and/or managers within those organizations were asked to describe the ideal post-acute transition for their patients, they would be at a loss. In fact, our primary research suggests the majority of hospital system leaders do not yet fully appreciate the importance of effective post-acute care for either their patients well-being or their own organizational viability. Certainly more immediate priorities abound, not the least of which include achieving meaningful use and interoperability, building a robust primary care network, effectively aligning with a full spectrum of physician specialists, recalibrating physician incentives to deter unnecessary utilization while still thriving under fee-for-service, and preparing for ICD-10 conversion. However, the imminent prospect of significant financial penalties associated with preventable readmissions has awakened hospitals to the reality that admission-to-discharge can no longer be considered discreet and separable from a continuum of patient care.

Fortunately, this emerging recognition of need, yet lack of associated clarity and specificity, presents a tremendous opportunity for post-acute providers. With no accepted standard or tried and true path, post-acute providers can pull a page from Steve Jobs' Apple playbook and define a product their customer didn't know they needed but now can't live without.

MP3 players existed years before Apple launched the iPod, but Steve Jobs gave the device a user-friendly interface that increased total demand for portable music players. Customers with limited technology skills could easily search and download songs from iTunes, making listening to music while walking, driving, etc. commonplace. Similarly, laptops existed prior to the launch of Power Book in 1991, but minor aesthetic adjustments unique to Apple's product, such as ergonomic improvements to the keyboard, made it the laptop capable of convincing diehard desktop users to switch teams.

Post-acute providers face a similar scenario. There are currently "first generation" post-acute care models out there, reminiscent of early MP3 players and laptops. Hospitals and physicians know they could be useful, but they lack a user-friendly interface and unquestionably superior value. Consumers (in this case hospitals and physicians) don't have a compelling reason to jump to a new way of doing business. Stopgap solutions – such as swing beds and discharge clinics – become more palatable than full on commitment to a post-acute partner.

As evidenced by Apple's market share in the smartphone and MP3 player sector, there is a significant first mover advantage for early innovators. So what does a user-friendly interface for post-acute care look like? A full complement of services (formed through either affiliation or acquisition) represented by an integrated entity is an initial must-have. Second, post-acute systems need to provide streamlined education to hospital and practice-based clinicians on how their services fit into the broader care continuum. This education should be supplemented by a clinical liaison team that can collaborate with a complementary multidisciplinary hospital or practice-based care team to ensure post-acute options reflect right time, right place, and right care. This is no longer about "winning the patient" for your facility, but helping other caregivers make the decision that is in the best interest of the patient.

Finally, a user-friendly interface must set up an infrastructure for performance feedback. Though Apple boldly defined their product *for* the consumer, they kept a keen eye on feedback to revise subsequent versions. Similarly, post-acute systems should establish joint operating committees with hospital and physician partners to identify and correct service shortcomings and gaps in care transitions.

Crafting an unquestionably superior value proposition can be summed up in a single word: data. The challenge is to define for hospitals and physicians which metrics matter. Does a hospital CEO need to review your state licensure survey? No. Do they need to know your readmission rate for 65-and-older congestive heart failure patients with multiple comorbidities? Emergency room usage while under your care? Overall cost of episode? Absolutely. The first post-acute systems to define a hospital- and physician-centric clinical outcomes dashboard and collaborate with other post-acute systems to build a benchmarkable database will create the gold standard. Further, such organizations are likely to snap up formative partnerships with pioneer ACOs and hospitals experimenting with the Model 2 bundled payment pilot. By hitching their wagon to early innovators, such systems are guaranteed a steady referral stream for years to come.

Our consulting team has been working with post-acute providers – and increasingly, groups of providers interested in forming a post-acute system – to begin to define this “second generation” product. We invite those of you who are interested in learning more about these endeavors to attend our annual [National Summit on Building the Continuum Essential for Success under Health Care Reform](#), held February 1-3, 2012, in Phoenix, Arizona. Through keynote presentations, offline discussions with hospital executives and physician attendees, and ongoing dialogue, we have designed this meeting to jumpstart the process of care transformation through a focused learning experience.

For those of you unable to attend, but who would like to share your thoughts and salient observations from your own market, I invite you to contact our team. We firmly believe that collaborative learning and shared best practices are the ideal approach for entering this new era of care delivery and hope to make this an ongoing conversation.

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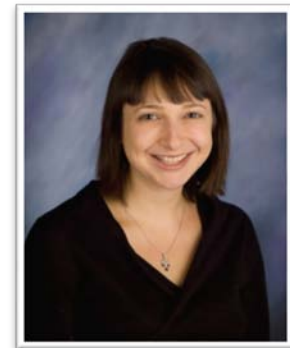
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Neal Peyser provides leadership and direction setting for Health Dimension Group's ever-expanding consulting service lines; client relationships; and functional expertise. As both a consultant and management executive, Neal offers a unique blending of business, financial, operational, and marketing strategies to facilitate transformational change management, competitive positioning, and P&L performance.

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