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This newsletter is designed to inform you about new research and expert opinions in the area of hospital and health system governance, as well as to update you on services and events at The Governance Institute. Please note that you are receiving this newsletter because you are a Governance Institute member or expressed interest at one of our conferences.

Disruptive Innovation in Healthcare: Are You Ready?

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Clayton M. Christensen, Professor of Business Administration at the Harvard Business School popularized the term "disruptive innovation" to mean options that are: lower cost, more convenient and accessible, and of "good enough" quality to satisfy a customer. You may ask, "But don't we want everyone to receive the best that healthcare can offer? Why would anyone want second best?"

The answer lies in the Institute of Medicine's definition of quality in *Crossing the Quality Chasm* that it should be: safe, timely, effective, efficient, equitable, and patient centered. Still today, this is something few organizations offer and even fewer individuals can afford. Thus, the market seeks new options that significantly lower the cost; improve accessibility, efficiency, and service; and don't excessively sacrifice quality. Enter disruptive innovations, which become the new "good enough" options and become the new "normal."

The following are brief examples of how the current business models in healthcare are already being disrupted and why these changes will be significant and swift.

1. The Hospital

The hospital emerged as a fundamental healthcare business model in the early 20th century when scientific progress permitted the effective diagnosis and treatment of common diseases and surgical conditions. Thus, a hospital bed was surrounded by a clinical laboratory, ancillary services, specialty consultants, and operating suites to create a one-stop diagnostic and therapeutic venue within which physicians could ply their craft as individual "experts." The challenges with this traditional model are that care is expensive (high in fixed costs), inefficient (lack of coordination and integration), of mixed quality/safety/service (based upon variation among practitioners and inherent complexity), and slow to respond to market demand (due to cumbersome bureaucracy). As a result, the following innovations are taking place throughout the country:

- Emergence of ambulatory facilities to provide routine high-volume, low-risk procedures for defined entities (routine surgeries, catheterizations, urgent care) at a lower cost, greater efficiency, and more reliable outcomes
- Growth of specialty hospitals and integrated healthcare systems (e.g., Cancer Centers of America, Mayo Clinic) to provide high-quality/low-cost integrated and coordinated healthcare for commonly encountered conditions
- Growth of palliative and hospice care units to provide low-cost and compassionate care to those with terminal conditions
- Growth of retail clinics (e.g., MinuteClinics) to offer individuals 24/7 access to urgent care for commonly acquired conditions
- Growth of domestic and international medical tourism to divert patients to lower-cost/high-quality venues throughout the country and abroad as an alternative and based on

significant cost savings incentives for employees and beneficiaries
- Growth of disease management and population health programs with incentives to significantly reduce inpatient and ED volumes

2. The Physician's Office

The heart and soul of 20th century healthcare was the physician's office and the relationship between the patient and his/her physician. Even the hospital was considered the physician's "workshop" and an adjunct to this core service interaction. This fundamental relationship is being questioned due to: variation among the quality, care, and service that different physicians provide, the increasing cost of maintaining this relationship (e.g., concierge practices), the potential inconvenience (third available appointment rates), the lack of access (shortage of physicians in many areas), and the lack of patient-centered approaches due to the traditional mantra that the "doctor knows best." As a result, the following innovations are taking place:

- Approximately 80 percent of what physicians do can be done by healthcare practitioners with less training and cost (e.g., advanced practice nurses and physician assistants). These individuals typically spend more time with patients, follow evidence-based algorithms, and provide an excellent quality of service.
- Acute and critical care services are now provided by full-time employed physicians in the inpatient setting.
- Approximately 80 percent of what non-physicians do can be performed virtually through cloud-based services. For instance, several organizations implement transactional healthcare services on the Internet or through Web-based applications that enable an individual to be evaluated by a physician or advanced practice nurse through a Webcam, be diagnosed for routine conditions, and be treated, all in the comfort of one's home.
- Ambulatory facilities (walk-in centers and retail clinics) can handle many of the routine clinical conditions that were traditionally handled in a physician's office at lower cost and greater convenience (24/7).
- Domestic and international medical tourism diverts traditionally loyal patients to lower-cost/higher-quality venues through significant financial incentives by large employers and insurance carriers.
- Patient-centered medical homes, accountable care organizations, and acute care episode projects divert patients to lower-cost/higher-quality venues.
- Wireless telehealth technology and implantable monitoring devices permit patients to be monitored and treated at home through centralized home health networks staffed by advanced practice nurses.
- Population health and disease management care requires a complex infrastructure that is beyond what most small physician groups can afford.

3. Fee-for-Service Reimbursement

Many acknowledge that the root cause of our healthcare system being so expensive and our quality outcomes so lackluster is the traditional discounted fee-for-service payment methodology, which rewards physicians and hospitals that provide high-margin care (elective surgeries and ancillary services) at the cost of potentially beneficial preventive healthcare services. Most agree that we will evolve to some form of capitation with incentives. The difficulty is the transition in a world that still rewards those who persist in providing non-evidence-based care that is profitable even if it does not necessarily benefit individuals. Thus, the following payment innovations are occurring:

- Integrated healthcare networks that can offer higher-quality/lower-cost services and sign capitated and bundled agreements with large employers and healthcare carriers (through public and private exchanges), which diverts business away from traditional fee-for-service enterprises and creates new domestic and international medical tourism markets.
- Healthcare systems merge or partner with healthcare carriers to significantly reduce their cost structure and provide lower-cost care by managing their own actuarial risk.
- Healthcare systems consolidate to lower cost and optimize access to high-quality networks.
- Cloud-based services permit access to patients and beneficiaries far outside of traditional service areas at lower cost and greater accessibility.
- Healthcare organizations voluntarily exit fee-for-service to embark upon risk contracts with large employers, healthcare carriers, and CMS.

Conclusion

Disruptive innovation cannot be stopped nor stemmed because it offers services to those who

could neither access nor afford healthcare services in the past. Even physicians and healthcare executives acknowledge that the system no longer works and needs to be redesigned. The question is, will there be a coordinated effort to build a rational, value-based network (commercial ecosystem) that works, or will it happen by chance and become a heterogeneous collection of competing entities with a lack of seamless integration and harmony among the component parts? The only way to achieve the former will be for healthcare leaders to embrace disruptive change and to utilize their traditional clinical, operational, and financial skills to build a new healthcare system based upon a unified vision that works, rather than an accidental system built by default.

The Governance Institute thanks Jon Burroughs, M.D., M.B.A., FACHE, FACPE, president and CEO of The Burroughs Healthcare Consulting Network, Inc., for contributing this article. *He can be reached at jburroughs@burroughshealthcare.com.*