Discussion: health care reform

- Reform: it’s a long, long road…
- Realities and challenges
- Solutions and opportunities
Don’t have a health care system; many systems

US population: ~315M

- Commercial ~170M
- Medicare ~50M
- Medicaid / Public ~65M
- Other ~5m
- Uninsured ~25M

~25M
~5m
~50M
~65M
~315M
Each sub system a unique politic and payor

**UNINSURED**
- Social politic
- Coverage
- Fragmented front

**COMMERCIAL**
- Employer politic
- Cost shifting
- “Sleeping Giant”

**MEDICARE**
- Federal politic
- Benefit levels
- Voting power

**MEDICAID**
- State politic
- Access, costs
- Polarization
Plenty of change, at glacial rates
Warming the glacier? Federal budget trend

Source: CBO Baseline Budget Projection, August 2014
Large Federal programs must change

Revenues:

- Security: Defense 23%
- Security: Income 43%
- Security: Health 31%
- Interest 8%
- Everything Else* 11%

Expenses: $3.9T

*Education, Transportation, Environment, Energy, etc.
Cost containment: past 50 years

• Pay less
  – reduce provider reimbursement
  – restrict health plan profits

• Organize to use less
  – budget and management of populations
  – provider networks, teams and protocols

• Motivate people to use less
  – increase cost sharing, economic care avoidance
  – longer term effectiveness?
Motivating people to use less

Shifting of costs to beneficiaries

Employee Choice Around Defined Contribution Share of Employee Health Insurance, by Plan Type

- Conventional (No Provider network)
- Point of Service plans
- Preferred Provider Organizations
- Health Maintenance Organizations
- High-deductible plans*

Source: Wall Street Journal; data from Kaiser Family Foundation
Securing better prices from tighter networks

Transition from open to performance networks

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High-deductible plans

Source: Wall Street Journal; data from Kaiser Family Foundation
Cutting rates, shifting costs, drives disparity

Payment to Cost Ratio

Uninsured  Medicaid  Medicare  Commercial Royal Family Fly-in

Attribution: Ian Morrison
Organizing to use less: the essential reform

- Hospitals
- Physicians
- Pharmacists
- Nurses
- Health techs
- Community health navigators
- Personal care assistants
- Social workers
- Individuals, Families

Work at “top of capability”

Capture cost savings

Higher

Lower

Access, convenience
Change our professional roles #&!?
Our challenge: the Community of Guilds
Introduction to population health

- Most abused planning term of the past 30 years
- Greatly miscast in most strategic planning processes
- Obscuring the critical role of specialized medicine
- Only true hope for improving our health as a nation
Standing in the consumer’s shoes

• Frameshift to the consumer perspective
  – “individual versus institutional responsibility?”
  – “interrelationship between health and health care?”
Standing in the consumer’s shoes

**INSTITUTIONAL ROLE**
- Hospitals
- Subspecialists
- Ambulatory D&T
- Pediatricians PAs Dentists
- Nurses Pharmacists

**HEALTH CARE**
- Health navigators
- Personal care assistants
- Home monitoring
- Assist devices
- Medications
- Family care

**HEALTH**
- School
- Workplace
- Environment
- Exercise
- Diet
- Stress
- Sleep
- Hygiene

**Lifestyle**
- Education
- Lifestyle programs
- Counseling
- Exercise programs
- Monitoring
- Screening
- Prevention
- Habilitation

**INDIVIDUAL (FAMILY) ROLE**
- Post/sub acute
- Self Care
- Assist devices
- Medications
- Family care
Standing in the consumer’s shoes

**INSTITUTIONAL ROLE**
- Hospitals
  - Subspecialists
  - Ambulatory D&T
- Pediatrics, PAs, Dentists
- Nurses, Pharmacists
- Health navigators
- Personal care assistants
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**INSTITUTIONAL ROLE**
- Counseling
- Exercise programs
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- Preventive care
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Meet your neighbors in the consumer space!
Walmart: built for consumers

- Visits per week: 140,000,000
- # of stores: 5,000
- % population within 20 miles of a store: 90%
- % of U.S. population as customers: 70%
- % of food sold in the U.S: 30%
- Market cap: $250 billion
Where do we fit?

• We’re best-in-the-world capable, ingenious and passionate about saving and improving lives and giving hope to children in need – make miracles happen
• Our campuses are few in number, not very accessible, expensive and justly prioritized to the sickest versus the healthier children
• Why prioritize investments on attempting to manage the low costs of healthy children who don’t need us?
Technology enables demand

- A life at all: 1950s
  - Prematurity, infection, polio, heart defects
- A better, longer life: 2000s
  - Allergies, attention, learning, convenience, cosmetics, mobility, motility, mood
- Perfection? 2050s?
  - Genetics: intelligence, charisma, athletics
  - Will have demand for specialized medicine!
Expectations drive demand: **We Want More!**

- **“Getting along”**
  - Doing more
  - Enhanced skiing, tennis, golf, everything!

- **“Aging well”**
  - Looking good
  - Straighten up, strong voice, smooth faces, pearly whites

- **“Making do”**
  - Feeling better
  - Improved mood, libido, eyesight, hearing

- **“We all Buy the Farm”**
  - Living longer
  - Replacement parts, restore functionality, new organs

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**Lower costs**

**“Life quality”**

**Higher costs**
Complex care is our core business

% of Population

% of Hospital Beds

Clinical Risk Group (CRG)
Innovation in payment and practice?
Our strategic playbook as specialists

- Standardize specialized care around best practice
- Reduce variation and out-perform the non-specialists
- Redefine our relative roles; overcome our guild silos
- *Play our role* in population health
  - use our public bully pulpit to educate and advocate
  - play our direct role where we deliver primary care
  - leaders in managing complex-chronic sub-populations
  - partner to get into the consumer game
Thank you!

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