

Smartsourcing Healthcare

The revolution that's driving the future of healthcare

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On the Precipice

Healthcare is on the precipice of enormous transformation brought on by three immutable forces: an aging demographic; the increasing sophistication and volume of diagnostic tools, therapies, and pharmaceuticals; and the exponential rate at which digital technology is advancing.

These changes are creating an unprecedented opportunity to build a future for healthcare that will put the patient at the center of a rich ecosystem with the power to positively impact the quality of life for each of us in dramatic ways.

As the demographics of the US and the world transition to a predominantly-aging population and the diagnostic tools to uncover illnesses become prolific, we will experience a paradigm shift in how we view healthcare: from an acute service meant to deal with injuries and sicknesses to an ongoing service that constantly monitors and maintains our well-being. Simply put, we need to make the transition from "sick care" to "health care."

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With the ability to capture and store data for every healthcare interaction, our digital genomes, and health patterns across vast populations, we will be able to predict disease and illness more accurately than we can currently predict tomorrow's weather forecast. It could be an amazing future in which healthcare becomes not only a fundamental human right but one that is accessible and affordable for everyone.

Note that I said "could be" because healthcare is also at another precipice—one that threatens to send it, and all of this promise, plummeting out of control into an economic abyss.

Runaway administrative costs, dramatically shrinking margins for hospitals, the increasing burden on patients to pay for healthcare out of their own pockets, an equally onerous burden on doctors and clinicians to handle paperwork over patients, and systems that silo data in myriad proprietary repositories are crippling healthcare and the promise it could otherwise deliver.

If we don't do something dramatic, courageous, and deliberate within the next decade, US healthcare will simply become economically unsustainable and unable to provide quality care to an aging population with ever-increasing and ever more complex healthcare needs. What we think of as a crisis in healthcare today will pale in comparison to what lies ahead.

Before we go any further, it's helpful to make what we're discussing a bit more tangible by considering what healthcare could look like if we take the steps outlined in my book.

So let's take a quick jump into the future and imagine a healthcare system where each of the following is the norm.

What if...

...the patient experience and journey are streamlined so that administrative friction, paperwork, documentation, and the burden on the patient of denied claims and erroneous and surprise billing was removed?

...providers actually treated patients like consumers with a simplified experience, alternative ways to access care, and online conveniences.

...providers were able to spend their time focusing exclusively on delivering care and healing rather than spending over half of their time documenting and justifying procedures?

...providers and payers were able to eliminate the friction (effort, cost, and frustration) caused by the endless back and forth to determine the validity of coverage and claims?

...healthcare costs were reduced through the use of analytics and predictive models that leveraged large pools of data to better understand the short- and long-term costs of different outcomes on patient populations and individual patients?

No doubt, it's a stretch to imagine that sort of healthcare system in the next five to ten years. However, the unabashedly bold claim presented here is that all of this is possible. The changes we suggest will not only increase capacity and quality while decreasing the costs of healthcare, but also improve access to healthcare. Granted, that's a tall order, but it is not only achievable, but achievable in the near term without a wholesale restructuring of healthcare, all the while preserving the option of choice for the patient and the benefit of significantly improved outcomes.

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Taking on Healthcare's Ten Culprits

In my book, ***Reimagining Healthcare***, I describe what I call the Ten Culprits. These are the primary impediments to quality and affordable healthcare. However, they have become embedded into the US healthcare system. Taking on these ten culprits, one by one, is essential if we are to put together a strategy for fixing healthcare.

It's important to keep in mind that what I'm suggesting is not a tumultuous change that requires radical shifts in national healthcare policy or extended political debate. Instead, what's needed is the application of sound business process changes that can be enabled by any provider or payer and can be supported by common-sense approaches that have worked in many other industries.

Clearly, healthcare is unique in that it is not, and should not, be driven solely by the same dynamics of a free-market that dictate how we build and sell most other services and products. Healthcare doesn't follow the unyielding rules that govern the production of airplanes and automobiles, nor is it subject to the callousness of single-minded profit-driven motives.

However, giving ourselves a pass by using the uniqueness of healthcare as a way to insulate it from tried and tested approaches to applying technology and process-improvement methods only serves to confine the creativity with which we can make changes—changes that set a course for a sustainable healthcare system and a future for healthcare that lives up to our hopes and expectations as individuals and as a society.

To start, let's review the ten culprits:

1. The Anonymous Patient. Despite all of the effort to create medical records that are portable and shareable, there is still no single continuous repository of patient data that can be used to adequately provide a reliable context for the treatment of patients and the projection of their outcomes.

2. The Asymmetry Between Costs and Outcomes. A lack of visibility into the relationship between costs and outcomes of a healthcare procedure, treatment, or therapy prevents doctors from treating patients in a way that effectively balances cost and risk.

3. The Episodic Care Conundrum. A disconnected healthcare lifecycle creates vast opportunity for errors, redundancy, sub-optimal treatments, and diagnostic failures.

4. The Complexity Crisis. Our healthcare system has simply become too complex and sophisticated for humans to handle on their own without the use of much more sophisticated technologies such as data analytics, artificial intelligence and machine learning, which can quickly interpret the uniqueness of each patient's situation and handle the enormity of administrative work required for each patient.

5. The Missing Link. There is no single inter-organizational entity to coordinate all the pieces of the healthcare system that need to be synchronized among patients, payers, and providers in order to coordinate care that both minimizes costs and optimizes outcomes.

6. Drifting from the Core. Healthcare providers have been forced to take on the responsibility of many administrative aspects of care, such as documentation, coding, and the billing process, which detract them from their core competency of caring for the patient.

7. The Tragedy of the Commons. Healthcare is an inherently complex process that has evolved organically over decades without a clear and well-thought-out overarching architecture. The result is often that patients get caught in the middle of a process that seems to have anything but their best interests in mind.

8. Defensive Medicine. The practice of physicians ordering unnecessary tests and procedures in order to protect themselves from the potential of malpractice accusations, although it has no beneficial impact on the patient, results in up to 25 percent of all healthcare costs.

9. The Primary Care Crisis. There is a growing shortage of primary care physicians.

10. The Aging of America. An aging demographic will multiply the consequences of all of the above culprits dramatically over the next two decades, ultimately making today's healthcare models economically unsustainable.

Focusing on the core

The first step in fixing healthcare is finding ways to help providers focus on what should be their fundamental core competency, the care of the patient. That's easily said, but it needs to be more than a mantra. We need specific tools with which to alleviate the administrative burden that most often stands in the way of quality healthcare.

The first step in fixing healthcare is finding ways to help providers focus on what should be their fundamental core competency, the care of the patient.

At the heart of that solution is the notion of Smartsourcing. In its simplest terms, Smartsourcing is a means of shifting towards partnerships that focus an organization on its core competency and core mission, and to then shed everything else that is not core to the organization's mission to a partner. The processes that are "shed" become the responsibility of another organization for which, in turn, these processes are core. The objective is to make sure that every task in a value chain of activities is ultimately performed by an organization for which it is a core competency.

This was the essence of Smartsourcing, a book that I wrote in 2006. Since that time, I've spoken with countless organizations across a variety of industries and I've been consistently amazed by the degree to which a simple concept such as core competency was nearly absent from their collective vernacular. In many cases, that was because it was just assumed. But core competencies are often much harder to define than any single product or service. They are also necessarily different from one organization to another since they form the competitive bedrock for their respective owners.

We can argue that in the case of healthcare providers, each one could rightfully claim that their core competency is caring for the patient. That's true in part, but it does not mean that there isn't also some aspect of that provider which is unique to their culture, heritage, and history.

In healthcare, the notion of core competency is easier to understand when you think of providers such as the Mayo Clinic, MD Anderson, or Dana-Farber. Each has an obvious brand built around their culture, expertise, and core competency. It may be as general as Mayo's approach to integrated care or as specific as MD Anderson's and Dana-Farber's focus on cancer.

This is where the conversation about fixing healthcare takes an interesting and unanticipated turn.

Large healthcare systems naturally want to achieve internal economies of scale and have a tendency to outsource very little outside of a small set of activities that are entirely peripheral to patient care and patient experience; for example, the food service, security personnel, valet parking, and janitorial services.

In retrospect, the reason for this may be self-evident; large organizations that serve a network of smaller providers build their own solutions in order to maintain control over every aspect of their processes. The reasoning is that their scale gives them leverage in terms of buying power, repeatable use of various processes and technology systems, an interest in coordinating all of their resources across the organization and its members, and standardization of policies, procedures, and practices.

While that all makes sense, even these large institutions are increasingly considering ways to Smartsource many of their non-core activities as technology allows the same, if not better, levels of coordination with partners at lower costs and with better outcomes.

Smartsourcing

Smartsourcing is founded on a fundamental premise, that the cost and friction of maintaining a large vertically integrated infrastructure of non-core activities is greater, and less effective, than the cost of coordinating an external value chain with the same activities among partners who are core in these same areas.

This is key to understanding the shift that is occurring among community hospitals and hospital systems, physicians' groups, and which will ultimately impact all healthcare providers.

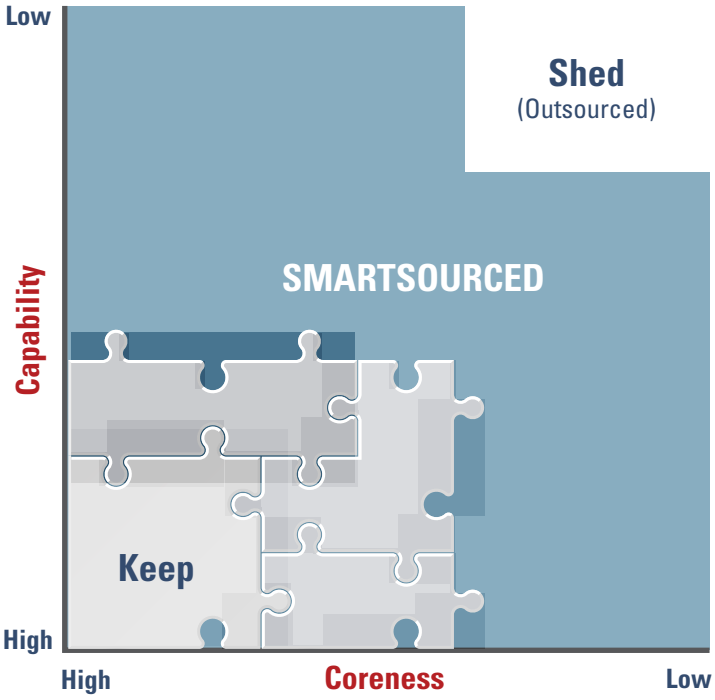
For community hospitals or hospital systems and physicians groups, that expect to survive into the next decade and beyond, there are only two viable options. One is to be acquired and become part of a behemoth healthcare provider system in which they have access to shared services and higher reimbursement rates that will provide economic headroom. Although, as we've already seen, this does little to reduce costs in any significant way beyond just a few percentage points. The second is to Smartsource everything that's not core and become a coordinator of your own ecosystem of core competency providers.

On the surface that second option sounds like outsourcing. But outsourcing typically deals with shedding the extreme non-core activities. Even if a healthcare provider can define the extreme areas that constitute its high-performance core competencies—which it will keep—and its lowest-performing non-core activities —which it will shed—there remains a large collection of activities between those extremes. These activities are difficult if not impossible to outsource since they are tightly woven into many other aspects of the provider's business. For example, the revenue cycle is a distinct activity but it has implications on everything from the patient experience, to the way in which services are determined and coded, to physician burnout.

We should also be clear that while Smartsourcing is critical to the survival of community hospitals and physicians groups it will undoubtedly trickle up to larger healthcare provider systems as the efficiencies it delivers start to be more widely publicized and recognized. That's because the shift to external economies of scope is accelerating across virtually every industry as technology delivers increasing capability to align partners into highly coordinated ecosystems.

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Illustration 1: While an organization may be able to define its core competencies—which it will keep in-house— and its extreme outliers—which it will outsource—the area in-between these two extremes is often difficult to out-source since it is still intimately linked to supporting the organization's core. This is where Smartsourcing plays a critical role.

How Is Smartsourcing different from outsourcing?

The greatest risk in traditional outsourcing is focusing exclusively on costs and ignoring the importance of a concurrent innovation initiative. While outsourcing will often deliver reduced costs initially, the focus of outsourcing is too often on replicating the status quo, along with all of its inherent process flaws. Improving process excellence and promoting innovation are not prime objectives of the outsourcing process. As a result, in my experience, the near-term financial win looks good on paper when justifying the outsourcing arrangement, but rarely lasts more than a few years, since little has changed to provide long-term advantage or innovation.

Outsourcing	Smartsourcing
Cut costs – Focuses on cutting costs	**Cut cost + increase innovation** – Combines cost-cutting with increased innovation
Streamline operations – Focuses on operational areas	**Streamline the value chain** – Considers the entire value chain
Partner on what you know – Works well with defined processes	**Differentiate** – Innovates processes to increase differentiation
Discontinuous – Changes in technology and architecture are disruptive to the business process	**Continuous** – Through leadership combined with constant innovation buffer the business process from technology change
Arms-length partnership –Creates yet another enterprise silo	**Trust-based partnership** – Engenders trust and collaboration leading to greater value

Smartsourcing, on the other hand, is accompanied by a renewed attention on excellence and innovation among the organization's core process initiatives as well as other non-core but critical areas that do have direct impact on clinical outcomes. This sort of partnership not only achieves cost savings for the healthcare provider, but it also establishes preeminence and differentiation in the overall patient experience.

Many organizations that pursue an outsourcing relationship operate under the premise that there are a core group of distinct processes which can be fully separated from the rest of the organization. These are the prime candidates for outsourcing. The thinking is that since these processes are not directly connected to the organization's core activities, they can easily be handed off to a partner. This is classic outsourcing, or what's often referred to as "lift and shift." While this can result in initial cost savings, I've rarely seen it work beyond a few years. Unless the areas being outsourced are indeed distinct from the rest of the organization.

A Smartsourcing strategy creates a much more intimate relationship between the organization and its partner than these sorts of arms-length outsourcing relationships. Smartsourcing increases innovation throughout the range of processes, from core to non-core, allowing organizations to focus on their most critical areas of differentiation and customer value, while also achieving high levels of innovation in non-core operations. This means increasing the differentiation, competency, and value across the spectrum of activities involved in delivering patient care. This is the precise opposite of the commodity label that is often placed on outsourcing services.

Providers that Smartsource also shift from internal economies of scale to external economies of scope. An economy of scope is one in which the benefits of a free market are best leveraged by the coordination of myriad resources, most of which are not owned by the organization but orchestrated by it, since they are owned by other core competency providers. But this requires an entirely new level of transparency and trust between a provider and Smartsourcing partner.

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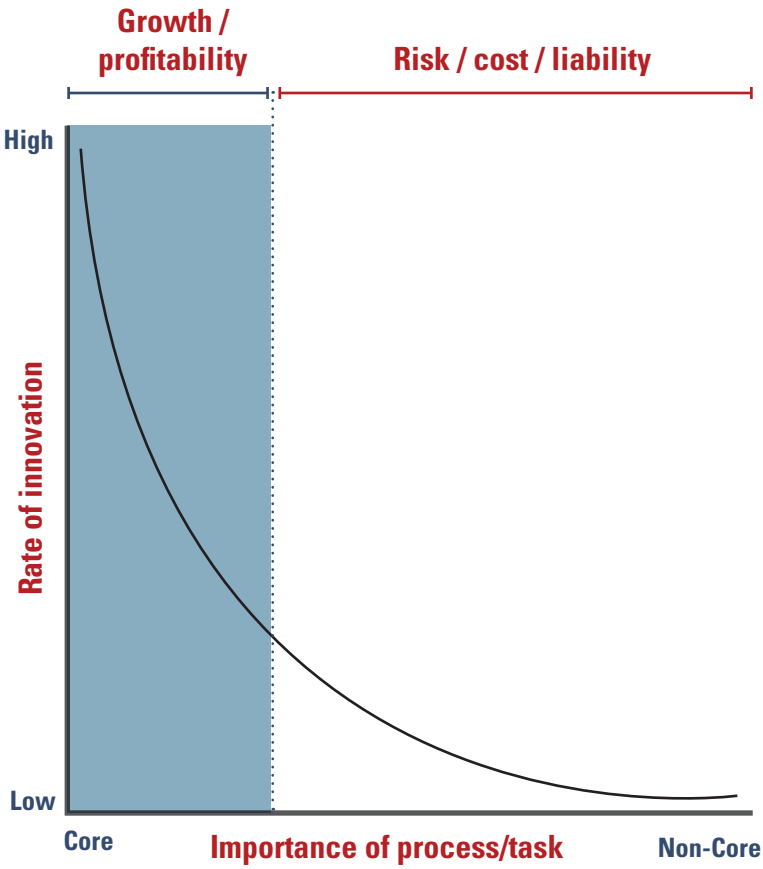


Illustration 3: Innovation in any organization will always be highest in those areas which represent the organization's core competency. These are also the areas that are most likely to deliver the greatest value to the organization and its customers. On the other hand, non-core activities create costs and liabilities that encumber the organization and are rarely where the organization has the ability or skills to innovate.



This level of collaboration blurs the lines between provider and partner. In many ways, the Smartsourcing partner becomes part of the organization. Think of this in the same way that you might think of the hiring process for new talent. When you hire someone, you are not thinking of them as an outsider or a contractor who is simply lending his or her talent to your organization, but rather as an insider who has privy to many areas of sensitive data and processes that would be hidden from the view of anyone outside of the organization.

This is where the role of a new breed of organizations, Healthcare Services Providers (HSPs), changes the landscape of healthcare dramatically.

Evolution of Healthcare Services Providers

The term Healthcare Services Providers (HSPs), represents players that are a relatively new part of the healthcare ecosystem. In the simplest terms, a HSP is a third-party for-profit business that partners with providers to Smartsource areas and processes that are not core for a provider, but which still impact the provider's business and the patient experience.

HSPs also circumvent the risk of having to pick and choose the technology winners for every administrative system, since a large part of the HSP's role is to establish the technology platform. In these cases, the risk is taken off the partner and put onto the HSP.

For example, consider the confused and costly state of affairs in the capture and management of electronic health records. The intent behind electronic health records (EHRs) was simple and elegant: allow the instant transfer of patient data between healthcare providers. Over the past ten years (since President Obama signed a law accelerating the use of EHRs), the US government has put more than $36 billion into the adoption of EHRs, $19 billion of which was invested through the American Recovery and Reinvestment Act of 2009.

From one standpoint, the effort has worked, putting EHRs into 96 percent of all hospitals.[iv] However, there are still seven hundred separate EHR vendors who do not necessarily talk to each other's EHR systems. And the average hospital has sixteen separate EHR systems. And physicians groups, working with hospitals, often have their own EHRs. Repeated efforts to "fix" the system have only created mounting cost and pressure on all sides of the equation, from patients and providers to insurers and payers. And this is just one example of a single healthcare point solution that still involves enormous hurdles.

In a more recent study conducted by the Mayo Clinic gave EHRs an F grade for usability and found a strong correlation between EHR use and doctor burnout. John Halamka, the CIO at Beth Israel Deaconess Medical Center, and also on the EHR standards committees for presidents Bush and Obama, put it succinctly, "Every single idea was well-meaning and potentially of societal benefit, but the combined burden of all of them hitting clinicians simultaneously made office practice basically impossible. In America, we have 11 minutes to see a patient, and, you know, you're going to be empathetic, make eye contact, enter about 100 pieces of data, and never commit malpractice. It's not possible!"

There's another, uglier, side to EHRs that's rarely talked about. If a large hospital system standardizes on an EHR, then any doctor using that EHR will likely need to stay within that EHR in order to track a patient and all of his or her diagnostics and tests. In many cases, this means that a lab test submitted through the EHR will default to a laboratory integrated into the EHR by the hospital system. Effectively, this creates fortresses that separate health systems and isolate patients rather than bridges with which to seamlessly navigate disparate healthcare providers. Ironically, something intended to address Culprit #1, The Anonymous Patient, has only made sharing data even harder.

A HSP has the potential to bridge this gap by providing translation links between the most common EHR platforms (recall that the average hospital has sixteen EHRs), that creates continuity of care for a patient across providers and over their lifetime.

The other critical aspect of how HSPs deliver value is by investing in the administrative areas of a provider's business in a way no single provider ever could. For example, Optum, invests over

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$3.5 billion annually on technology and innovation that focuses on artificial intelligence, process automation, data and analytics. It holds over ninety patents across the entire healthcare value chain, and it has 240 million de-identified lives (anonymized patients) along with their clinically adjudicated claims. The value of all of this is an ability to look across the healthcare industry and patients in a way no single provider can.

It may well be (and after years of studying and researching the healthcare industry, it's my firm opinion) that the only way to "fix" healthcare is to take transformational risks through investments that no single provider, insurer, or payer would ever undertake on their own. Bridging that gap is ultimately the critical role of the HSP in addressing Culprit #5, The Missing Link.

But let's not be overly naïve; there's a downside to the HSP model, too. The outcome of these efforts always involves a degree of risk, as does any partnership. Some of that risk is actually transferred to the HSP partner as they take on the responsibility for operating and innovating administrative systems. Smartsourcing partnerships also involve a level of transparency and intimate disclosure that can be perceived as being especially precarious if not well thought out. On the other hand, the payback is also considerable. In the case of one northern California provider, John Muir Health, the yearly payback is anticipated to be close to $300 million, And that's on direct costs alone without factoring in the benefit of the reinvesting those savings back into increased quality, new opportunities for care innovation, improved outcomes, and growth to allow for greater access to its healthcare services.

The HSP model may be the single most significant step forward for the evolution of healthcare. While a radical thought, for many who have developed an in-house, vertically integrated view of healthcare, or for behemoth hospital systems that believe they need to own every aspect of the healthcare ecosystem, the idea of Smartsourcing may be anathema. As HSPs become the driving force in determining the most cost-effective way to deliver quality healthcare outcomes to patients, these large vertically integrated providers are also the most likely to be pushed into a precarious situation of untenable and unjustifiable cost structures.

In 2008 the management of a St. Louis Medicare Advantage plan published what's come to be known as CPPM, the collaborative payer provider model. CPPM was a value-based care blueprint for provider and payers. (In the case of CPPM, the provider refers to the primary care physician or team.) The idea behind CPPM is to align the incentives of payers and providers so the success of each was in part based on the success of the other. For example, in a typical CPPM contract the payer would set aside 15 percent of revenues for their payer functions. Claims are then paid from the remaining 85 percent. If claims end up being less than 85 percent the remainder is shared with the provider. The actual amount the provider receives might vary between 60 to 80 percent of the remainder based on pre-established metrics. These sorts of arrangements align performance of payers and providers.

While these models have been tested successfully in Medicare Advantage plans, they still rely on the use of the same foundational systems that have been in place for both providers and payers. It may be more than a bit optimistic to expect that the otherwise-contentious relationship between many payers and providers will support the sort of trust needed to scale CPPM. A better approach may be to have an independent third party, potentially the HSP, acting as an integrator to manage the aligned incentives and to develop claims processes that will concurrently streamline the submission and processing of claims.

The question now becomes, "What services and capabilities are most important to look for in a HSP?"



1. The integration of process management as part of their sphere of core competencies: The success of a Smartsourcing approach is based on how well the complexity of tasks and activities are orchestrated, since it represents a previously unknown level of process integration. Think of the simplicity and process transparency of an online service such as ADP's payroll outsourcing, and then apply this notion to all the touchpoints across a provider's ecosystem.

2. Letting providers share information from process to process: HSPs assume the role of process aggregators, leveraging information across a much broader set of experiences than any single (or collection) of providers could access otherwise.

3. Best practice management: The HSP has deep visibility across the multitude of providers it serves, and therefore has greater insight for the development of new processes, new products, and new services. With this visibility it can identify entirely new innovations that would otherwise be invisible to individual providers. It can also identify payer patterns for claim denials based on how these payers process claims for multiple providers. That can help improve coding and claims processing.

4. Providing broad data sets of patient populations: A HSP should be able to provide large data collections which can be used to identify issues relating to public health trends and demographics. The purpose of this is to cut across larger populations than those available to any single provider. In addition, the HSP should be able to use these data sets to map to the provider's patients and identify at-risk groups, segments of the provider's patient population, data analytics within the provider's patient population, and the ability to create predictive models for the needs of these segmented populations.

5. The use of advanced technologies such as AI to eliminate denials and assist in coding and clinical support: A HSP brings world-class technology competency and talent to a provider that would otherwise simply be inaccessible due to the provider's scale or their tight industry focus. For example, the enormous burden of claims denials on the healthcare system. Much of this is due to the complexity of coding as well as the back and forth of determining medical necessity. Using technology, such as, clinically intelligent natural language processing (NLP)—a form of AI recognizes the clinical implications of identifying documentation gaps and then advises clinicians on how to improve documentation. This is key, since the point of most AI is to scale what may be a rarely used best practice (due to human resources constraints) and apply it to every patient interaction, EHR update, and claim. And all of this is done at the point of care in real-time, not as an afterthought.

By using technologies, such as NLP and AI, a HSP is able to offload the burden on clinicians, significantly reduce friction, and continuously innovate a provider's technology systems so that they can focus on patient care.

The reason this is becoming so much more important going forward is that new risk-based models have introduced intricate rules that impact documentation, coding, and reimbursement. Reimbursement is increasingly being tied to quality and outcomes that need to be accurately reported based on clinical documentation. The ratings and penalties not only have financial impact but also impact the provider's brand in the community.

The ultimate objective of AI in these sorts of scenarios is to offload the clinicians so that they can focus on patient care, rather than being mired in the documentation of that care.

One area where each of these benefits of working with a HSP can have the greatest impact, is by helping providers focus on their core competency rather than getting entangled in administrative friction with payers.

The fundamental challenge is the lack of trust between providers and payers which leads to both doing the best they can to protect themselves (Culprit #8 Defensive Medicine). Think of this as a sort of tug-of-war (illustration 4). Both sides are pulling as hard as they can to move the rope in their direction in order to gain even a slight advantage. There's no malice or fraud involved, both parties are playing by the rules they've been given. But without transparency into the other side's processes, documentation, or decision-making all they can do is pull as hard as possible.

The Payer/Provider Tug-of-war

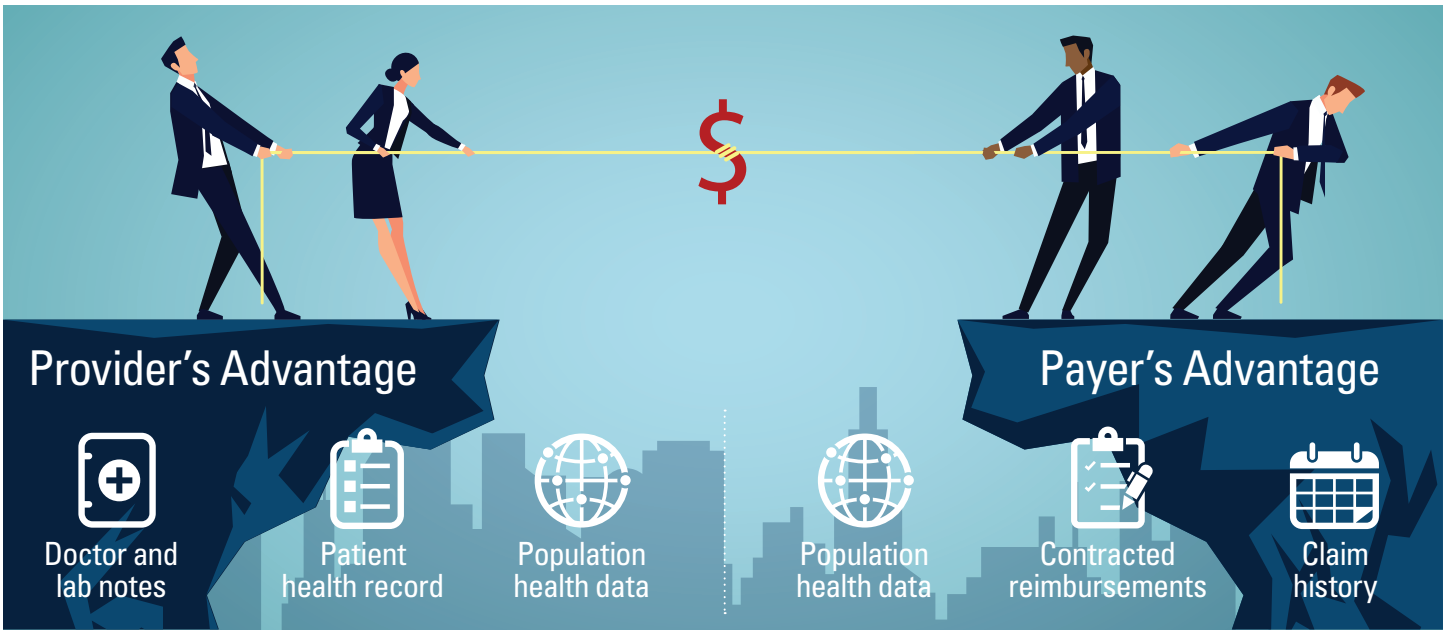


Illustration 4: Today's claims processing is often portrayed as a tug-of-war between provider and payer in which each side is attempting to shift the advantage to their side of the equation using their proprietary data and making assumptions about the other party's process. Providers want to increase "Revenue Integrity" to make sure they get paid fairly. Payers want to increase "Payment Integrity," to make sure they only pay for covered claims.

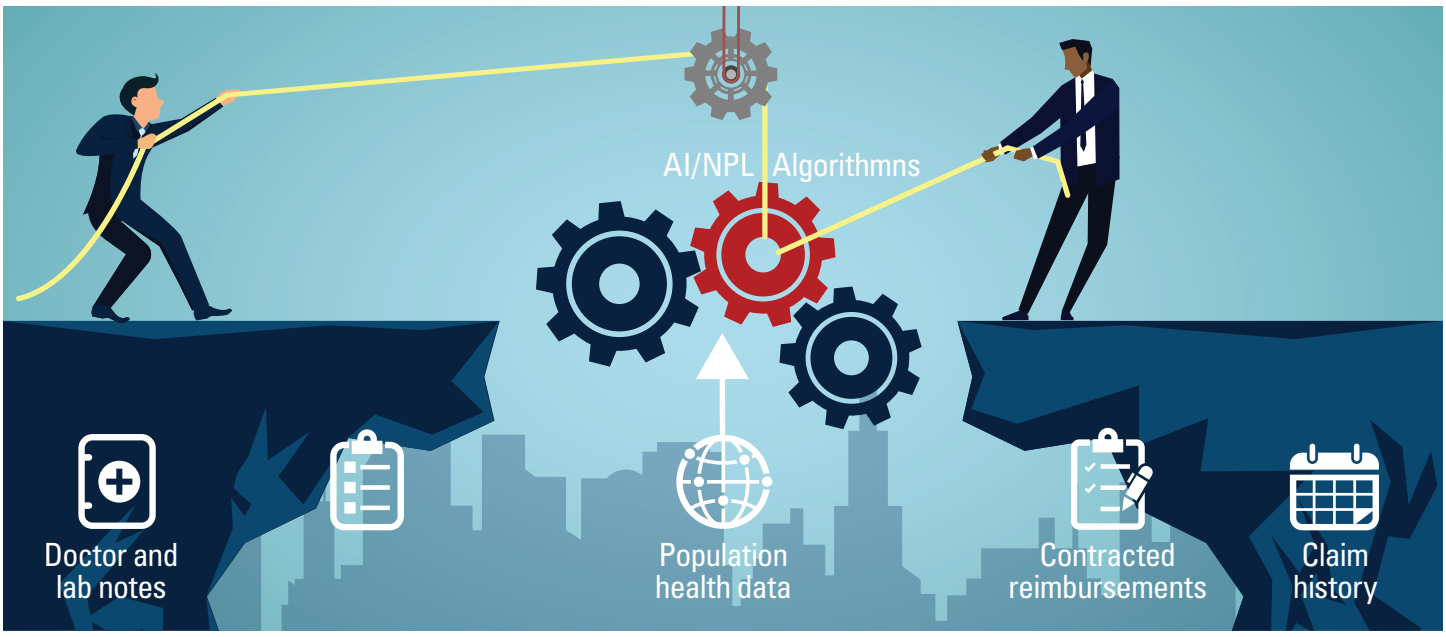


Illustration 5: A HSP could act as a trusted intermediary with access to all of the data and documentation needed, from either party, to determine accurate and fair reimbursements, alleviating the tension and cost in the current model of coding and claims. Most importantly it reduces the friction that otherwise typifies the claims process.

Now, what if one side of that tug-of-war yelled over to the other side. "Stop pulling for a minute so that we can share our strategy with you to see if there's a way to resolve this?" What would your first thought be if you were on the side being asked that question? If you're like most people, it would likely be along the lines of, "How can I trust them to not suddenly pull when I let go?" That's effectively what's happening within the current system.

However, let's change the relationship between provider and payer by introducing a HSP as a trusted intermediary which has the ability to access and understand all of the information available to both sides; the patient data, documentation, doctor's notes and lab results, query the patient's health record, and then determine how all of this maps to a payer's coverage (illustration 5).

I realize that this may sound a bit Orwellian at first glance. But the HSP's algorithms would have access to significantly more data about how claims are processed, what constitutes medical necessity, and the probabilities of the outcome associated with millions of other diagnosis and treatment combinations across vast collections of claims data.

In many ways the role of the HSP is to be a trusted intermediary who makes sure everyone plays by the rules and constantly coordinate all available data to achieve the best outcomes for provider, payer, and patient.

Will these sorts of advances allow HSPs to succeed where the healthcare industry in general has failed? I believe they will, but it will require reaching critical mass. Since the HSP model benefits from the dynamic of increasing returns (economies of scope): the more organizations within the healthcare industry that use it, the more valuable it becomes to participants.

Conclusions

I began this paper with a simple premise, that healthcare is on the precipice of enormous transformation brought on by three immutable forces: an aging demographic; the increasing sophistication and volume of diagnostic tools, therapies, and pharmaceuticals; and the exponential rate at which digital technology is advancing.

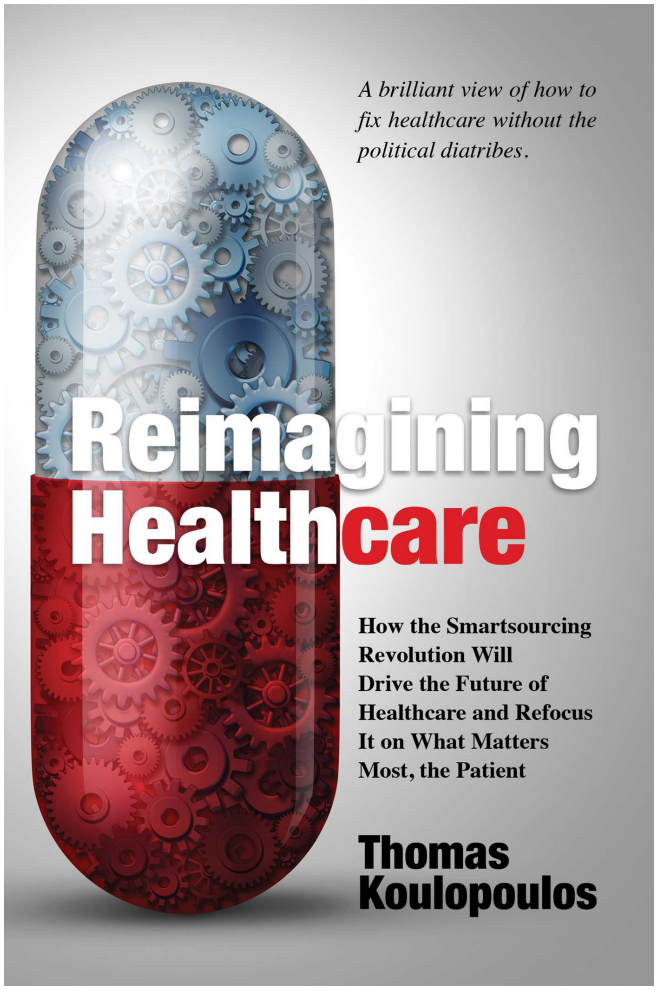
Making that promise a reality has never been more important. The administrative burden on every provider is impeding the progress, innovation, and new business models for healthcare that will be required to manage the Ten Culprits.

It's important to keep in mind that the recent healthcare crisis brought on by COVID-19 has only served to amplify pre-existing conditions that have been undermining healthcare. It's also made painfully clear how intimately attached healthcare is to our economic and social well-being. It has also accelerated the enormous economic pressure on all providers, especially those already running on very thin margins. Providers that may have had the benefit of time to consider the ideas spelled out in this paper and my book, will now need to move quickly if they are to survive.

The bottom line is that the challenges that hinder the deliver of quality affordable healthcare, and which threaten many providers existence, are well known and deeply entrenched in the current healthcare system. Trying to address these challenges in the same ways that we have in the past will only yield the same results. To fix healthcare, and to refocus it on the patient, we need to reimagine the role of providers.

Resolve and courage will clearly be needed to do that, but so will the basic tools and methods to enact change, such as HSPs and Smartsourcing.

One thing is clear. The complexity of healthcare and the changing demands of the population are a mandate for us to step outside of the constraints of the last one hundred years to reimagine and rebuild a future for healthcare that allows the entire system—patients, providers, and payers—to focus on what's most important, what has always been the noble aspiration of every caregiver: the health and well-being of, you, the patient.



Excerpted and adapted from Reimaging Healthcare: How the Smartsourcing Revolution will drive the Future of Healthcare and Refocus it On What Matters Most, The Patient, by Thomas Koulopoulos, Post Hill Press, May 2020 Find out more at www.reimagining.health

[i] Christine Sinsky et al., "Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties," Annals of Internal Medicine 165, no. 11 (2016): 753–60.

[ii] [Fred Schulte and Erika Fry, "Death By 1,000 Clicks: Where Electronic Health Records Went Wrong," Kaiser Health News, March 18, 2019.

[iii] Alok Prasad, "EMR & The American Recovery and Reinvestment Act of 2009," MedCityNews, March 8, 2014.

[iv] http://www.eweek.com/it-management/u.s.-adoption-of-electronic-health-records-nears-100-percent.html

[v] https://www.mayoclinicproceedings.org/article/S0025-6196(19)30836-5/pdf

[vi] Fred Schulte and Erika Fry, "Death By 1,000 Clicks: Where Electronic Health Records Went Wrong," Kaiser Health News, March 18, 2019.

[vii] https://www.healthcareitnews.com/news/why-ehr-data-interoperability-such-mess-3-charts