Can Customer-Centricity Cure Runaway Healthcare Costs?

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01/2011

If you've had surgery in the U.S. lately, you already realize hospitals are hell-bent on improving internal process. Mitigating risk – not doing the right procedure on the wrong patient or the wrong procedure on the right patient – has become a near obsession. So has sanitizing everything touching the patient – including exacting hand-washing procedures. And data sharing within (but not across) healthcare systems continues expanding. But all these and more new internal improvements are primarily designed to lessen regulatory and legal exposure and cut costs. Customers are the lessor concern.

BTW, I very deliberately say "customer-centric" where you might expect "patient-centric." Over the years, I've developed a near-gag reflex over the term "patient." I won't use it. Instead, I get blank stares when I respond to, "Are you Dr. Jones' patient" with, "No, I'm Dr. Jones' customer." And I'm not playing head games, although it's fun to watch the reactions. "Patient" describes a lord-vassal relationship, where one side orders the other around – and the other doesn't dare question, much less object. We have to mitigate this imbalance for healthcare to heal itself.

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Putting on a customer "face"

I actually did have shoulder surgery last month, and among the "read it while you wait" brochures shoved into my hands were two glossies encouraging patients to "take charge of their own healthcare" by staying informed and asking questions. Very customer-friendly sounding. But asking questions stops far short of "questioning," getting a second opinion, or even saying "no" when appropriate. Informed customers – as opposed to empowered customers – are still easy marks for unnecessary procedures, overtreatment, questionable treatment and even outright incorrect treatment, which is the antithesis of customer-centric.

Am I overreacting? Let me cite several eye-opening examples of customer-unfriendly healthcare I've experienced personally.

Shoulder scam

At the beginning of my shoulder saga (I've now had both rotator cuffs surgically repaired) my primary doc referred me to the system's preferred orthopedics clinic. I now call it a "chop shop" instead of "clinic." At my post-MRI appointment, the surgeon charges in without any film; tells me both shoulders need surgery ASAP, he wants to do the left on first because it's an older injury; and please stop at the scheduling desk to book the left one at the earliest available appointment and the second 90 days later.

When I left I didn't stop anywhere. Instead, I got a referral to a shoulder specialist, not just an orthopod, booked an appointment, and had the film transferred. Surgeon #2 showed me the film, carefully walked me through it, and told me the right shoulder was urgent (obviously scheduled second by surgeon #1 to make sure I'd come back) and my left shoulder might not ever need surgery. Say what!? Eventually, it did need repair, but scheduled at a convenient time for me and my clients.

I guess #1 has a couple of kids in college.

Saving money instead of lives

My ex-GP practiced at a clinic in a system that was big on reducing treatment costs – and his clinic proudly displayed an award for exceptional expense-reduction. As a patient, do I want to see that? Regardless, I'd been having trouble sleeping and my energy level was

falling at an alarming rate. My wife wanted me tested for sleep apnea, but the doc declined because according to him, even if they find you have sleep apnea, they'll just give you a C-PAP machine that no one ever wears. Besides, the tests are expensive, and I'm sure he was thinking of next quarter's awards. Just lose some weight was his solution.

I reached the point where I almost could not work before he finally authorized the overnight sleep apnea test the pulmonary guys do. You sleep "naturally" the first four hours, then with a C-PAP machine the next four, all the time monitored by a gazillion sensors measuring everything oxygen-related. They woke me up after just *one* hour to put me on the C-PAP, saying: "Your blood oxygen level is in the red zone. We can't risk you sleeping like this." The next morning they explained my blood oxygen was in stroke and heart attack territory. It was below 60 where it should have been 90-something.

When I went to the pulmonary clinic to get my C-PAP fitted and adjusted. I heard one medical practitioner swear at another for the first time. When I told the whole story to the physician's assistant, including the part about no one ever wearing the machines, she grabbed a flashlight and looked back at my tonsils and beyond. Then she said: "All the asshole had to do was point a flashlight down your throat. This has nothing to do with weight." And then she confirmed with me I'd snored loudly my whole life, including as a very fit teenager whose snoring caused a friend's father to crawl into our fishing campsite believing a wild animal was in one of the tents.

Dr. Idi Amin

"Idi Amin" is/was a dentist. Shortly after I started seeing him, he informed me that all my wisdom teeth would have to come out – plus I needed crowns on some teeth. I didn't question him. My bad. At the time, he told me another dentist would do the extractions in another office, but when the time came, Idi said he would do it in his office. Again I didn't question. My very bad. During the extraction, he discovered roots that ran under other teeth, and when I woke up from anesthesia he was sweating in panic trying to yank one of them out with a pair of pliers that looked like

they came from Ace Hardware. Finally, he "extracted" them all and sent me on my way, suffering from the worst pain I've ever experienced - with a 45 minute drive to get to my local drugstore to get prescription painkillers. Oh, and he'd told me previously I'd be able to fly the next day. That's why we still call him, "Idi Amin."

But not end of story. Thanks to another referral I found a wonderful new dentist. The crowns Idi claimed I needed? Total B.S.

Broken beyond repair

How broken is the U.S. healthcare system? Consider these widely acknowledged conditions.

Measure	Condition
Per-capita spending	U.S. spends nearly twice as much per capita than any other country
% of GNP	We spend more than countries with universal access systems including Canada and the U.K.
Coverage	Over 30MM people with no coverage
Infant mortality rates	Highest among top seven industrialized countries
Lifespan	Lower than in most other industrialized countries
Medical safety	Last among industrialized nations
% admin cost	Highest among industrialized nations (and perhaps the world)
WHO ranking	37th for overall effectiveness in last World Health Organization ranking (2000)

Abjectly poor performance. But not if you're a doctor, hospital administrator, insurance company, device company or drug company. Our system is skewed towards meeting their financial needs, not customers' healthcare needs. Just today I read new data from Duke University Clinical Research study reporting that 22.5% of defibrillators implanted are in inappropriate patients who they don't benefit – and worse yet people they can harm or even kill. The report stated that a considerable percentage of doctors implanting this device don't know or understand the "when to" and "when not to" guidelines. Of course, the device reps sure aren't going to correct that and cut sales.

Provider mentalities like these are how we wind up with a system we can't afford providing healthcare we can't accept.

How would a customer-centric healthcare model reduce costs (and raise quality)

Virtually all organizations looking to seriously reduce costs will look first at internal process, including organizational design and staffing. However, as the more progressive elements of the process industry have discovered over the past 15 years, letting customer wants and needs drive process design - starting with points of customer involvement and working inward (often called "outside-in" process) - eliminates far more cost than conventional, cost-cutting process design. Why? Because customer-centric process doesn't start with "what is." It starts with what customers need and want. Which is akin to starting over and designing ideal customer process rather than streamlined versions of what's much less than ideal. Paradoxically, customers want organizations to be much more streamlined with less administrative bureaucracy more so than organizations themselves.

Traditional cost-cutting, risk mitigating, efficiency-driving process redesign focuses on *how* work is done. But meeting customer needs and preferences almost always requires changing *what* work is done, *who* (functionally) does it, and the underlying technology that will enable customer-driven *what*, *who,* and *how.* In healthcare, rather than just streamlining and perhaps automating current tasks, customer-centric process design will help determine: the most and least effective procedures; which procedures are best used when; who should manage these procedures (physician, PA, nurse, generalist, specialist, hospital, clinic); how to inform and automate both decision-making and task management - as well as how to work.

Designing work around customers expands opportunities to have the right person (or facility) do the right work at the right time with the right support, with no wasted motion or unnecessary complexity – and preserving only value-adding administrative functions. Healthcare is rife with wasted motion, unnecessary complexity and bloated administration.

What would customer-centric healthcare look like?

Here's a sampling of customer-centric processes and policies contrasted with what's happening today.

Current	Customer-Centric
No coordinated health care program	GP coordinates all providers work
Sick-care model	Prevention & wellness model
Doctors dictate care	Doctors review options with customers
General Practitioners refer to specialists, specialists make decisions	GPs refer to specialists but stay in loop, may request 2nd opinion if questionable rationale for treatment
Providers paid “by the patient or procedure”	Providers paid for successful outcomes
Pharma/device companies influence physician decisions	Companies provide information; FDA reviews; physician decides with customer
Appropriate procedures vary regionally and by physician (huge variances in % of c-section deliveries & many other expensive procedures)	Outcomes research-supported guidelines for treatment and testing; local “review board” for authorizing significant variances
Insurance companies virtually free to deny treatment	Anything within guidelines (or approved by local board) must be covered
Physicians can refer to entities where they have a financial stake	Prohibited
Hyper-expensive life-extending drug treatments (most without quality of living benefits) eat up huge % of healthcare dollars	Every patient has a living will (most will decline these treatments, saving relatives from guilt-ridden decisions)
Partial coverage of base, leaving insured customers stuck with absorbing high cost of hospitals treating uninsured	Universal coverage; coverage required just as for auto insurance

Obviously, a very abbreviated list of customer-centric possibilities, and we could work from several alternative customer-centricity models. But implementing only these changes would produce dramatic effects.

Outcomes of customer-centric healthcare

Adopting only these customer-centric concepts would change the face of healthcare as we know it in the U.S.

Process/Policy	Positive Outcomes
GP coordinates all treatment	Reduce errors through communication among all providers; reduce duplicate testing; weed out provider-biased treatment plans including unnecessary surgery; curb overuse of expensive medications
Adopt prevention & wellness model	Head off expensive-to-treat chronic illnesses including diabetes; reduce obesity; improve general health to reduce illness and injury
Doctors review options with customers	Involved customers will be more motivated to stick with prescribed treatments and take better care of themselves
GPs refer to specialists but stay in loop, may request 2nd opinion	Reduce unnecessary surgery and testing
Providers paid for successful outcomes	Provider motivation switches from treating illness to preserving good health; much less incentive to initiate treatments for revenue generation purposes
Device/pharma companies provide information, FDA reviews, physician decides with customer	Reduce overuse (such as excess 22.5% of defibulator implants)
Outcomes research-supported guidelines for treatment including testing; local "review board" for requesting variances	Discourage providing unnecessary and overkill treatments that increase provider profits
Anything within guidelines (or approved by local board) must be covered	Give customers warranted treatment
Stop "self-referrals" from physicians to facilities where they own a stake	Curb excess testing and treatment; use most cost-effective resources
Every patient has a living will	Drastically reduce end-of-life spending patients don't want
Universal coverage; coverage required just as for auto coverage	Provide everyone with preventive care (such as pre-natal) that reduces much larger costs of dealing with preventable negative outcomes; greatly reduce the incidence of general medicine practiced in the most expensive of all environment – emergency rooms.

The scale of these benefits is so high it begs the question: "Why not just do it?"

The politics of changing healthcare

We've managed to turn U.S. healthcare into such a political football that all factions have lost rationality and objectivity. For example:

Single payer system: If we convert our current insurance reimbursement system into a single payer system we'll transfer all our current dysfunction over to a new payer. That's about all.

Socialized medicine: The 2010 healthcare legislation the Democrats passed has nary an element of socialized medicine. In fact, it eliminates the most socialistic aspect of our current system – spreading the cost of treating non-insured people across the entire insured consumer base. The problem with the legislation is that it's trying to change outcomes without looking under the hood to see what's driving outcomes – the requisite first step for designing a customer-centric "to-be."

Local control: A good way to say good-by to best practices and encourage local and regional disparities, which are about profits far more than healthcare.

Death panels: Paying a doctor to sit down with willing customers to discuss their end of life treatment invests not only in quality of life for customers and their families but will greatly lower unwanted end-of-life treatment. What's not to like?

Preserving free markets: Healthcare will never be "free market" until we stop insurance companies, profit-motivated physicians, drug companies, medical device companies and others from artificially inflating healthcare costs.

Getting off the dime

Up until now, we've been missing the objective, reasoned discussion needed to identify that putting healthcare customers first is *the best and perhaps the only way* to design our way out of our current mess. Government is far too fractionated to produce rational thought. I do know academia is trying to build new models (I have some first-hand exposure to work underway at University of Minnesota). But academia has far less clout than needed to trigger change, rather than just guide it. Customer anger may help move healthcare off the dime, but most customers remain too subservient to question – much less demand better.

Where will the "big push" towards customer-centricity come from, if at all? Provider self-interest, in all likelihood. When providers (as opposed to all the peripheral players) realize they'll benefit competitively and financially by adopting customer-centric practices, they'll start changing. Plus, the provider community would much rather change itself than told how to change by government.

Provider recognition of "what's in it for them" to go customer-centric may seem a long way off. But perhaps it's not. Sometimes just one hand grenade thrown into the right pocket will

get industry leaders up and moving. In the interim, we have to keep writing, speaking, challenging criticizing – and constantly reinforcing the “what’s in it for them” to healthcare providers. Then, with a push from government and another from academia we might see success sooner rather than later. We’d better see it because our current system is too expensive and broken to let continue.