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Getting to Value in Healthcare

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Executive Summary

IT HAS NOW BECOME ABUNDANTLY CLEAR THAT HEALTHcare is in need of significant change. In response to soaring healthcare costs and rapidly increasing premiums, payers are actively exploring ways to "bend the cost curve" across the system. This includes shifting payments to provider organizations as well as limiting market access and reimbursement for drugs, treatments, and therapies where compelling economic and clinical value are not adequately demonstrated.

Customer expectations are also changing. With the expanded use of high-deductible plans, customers have had to assume greater financial responsibility for their healthcare. As this trend continues, customers will continue to become more engaged in their own care, with even higher expectations for the products and services they purchase and receive.

Increasingly, healthcare organizations are exploring ways to differentiate themselves and generate sustainable competitive advantage. Providers large and small are also looking to create significant market differentiation through strategic partnerships with payers and other providers. Additionally, disruptive providers such as retail clinics could potentially pose a threat in the future as they continue to expand their services and develop partnerships across the market.

As healthcare continues to evolve and the market actively transitions to value-based payment models, providers will need a much more strategic and nuanced approach. This will require organizations to completely rethink the value proposition they provide to the market as well as their underlying business model. This will require a strong understanding of the treatment areas where the organization excels from a cost, quality, and patient satisfaction perspective, as well as what matters most to key stakeholders in these areas.

The "marketing mix" approach detailed in this white paper requires that organizations:

- Clearly define the **product/service** that's being offered and how it fits with stakeholder needs.
- Determine the best **price** to charge to cover costs and optimize revenue.
- Identify the best **channel (or place)** for delivering the product.
- Decide how to **communicate (promote)** the offering in such a way that it resonates with the target customer.
- Ensure the **people** delivering the service have the appropriate skills and that **processes** are in place to enable a consistent experience.
- Provide **physical evidence** demonstrating that the service was delivered.

Using this structured approach to think about healthcare delivery as a business will help organizations gain clarity about their offering and optimize value received.

There are four steps required to prepare a value proposition for payers and employers:

- Identifying the differentiating elements of the care model
- Defining and prioritizing the claims of interest
- Defining and collecting the data supporting the economic and clinical value of the care provided
- Crafting powerful and practical communication tools to make the value case

A strong value proposition needs to reflect a hospital's strengths and offerings as seen through the lens of patients, payers, and employers. Before developing this narrative, an organization must be able to clearly define the elements of its care model that will differentiate it and demonstrate economic and clinical value for these stakeholders.

Discussion Questions for Board Members and Senior Leaders

The following questions serve as a framework for the board's strategic discussion regarding the organization's positioning to provide value in today's healthcare marketplace:

1. Who are our customers? (What customer segments make up our market or service area?)
2. What are our customers' unmet needs?
3. What role do speed, convenience, expertise, and amenities play in addressing those needs?
4. What is our value proposition? How are we differentiating ourselves from our competitors in this regard, beyond providing a high-quality service?
5. Do we know how much certain services cost to provide? What is the variation in cost and quality across our providers/care settings? If there is significant variation, what steps are we taking to reduce/eliminate this?
6. Are we transparent on price? How easy or difficult is it for our customers to get real information on their out-of-pocket costs for any of our services in advance?
7. How well do our current services demonstrate value to our customers? What are some areas for improvement?
8. How well are our partners demonstrating our value proposition? How can we improve what our partners are doing in this regard?
9. Do we have the organizational culture and competencies to provide value consistently across all services? If not, what is required of leadership to move the culture to where it needs to be and develop the necessary competencies?
10. What is our value story/message to customers? Is it meaningful?
11. Based on the answers to the questions above, what is our value strategy? What are our goals, priorities, deliverables, and deadlines?

The Current State of the U.S. Healthcare System

According to the Centers for Medicare and Medicaid Services (CMS), the U.S. healthcare system is on track to reach a dubious milestone in 2015.

FOR THE FIRST TIME EVER, HEALTHCARE SPENDING IS expected to reach $10,000 per person per year.[1] Additional projections from CMS provide even more cause for concern, as healthcare spending is expected to expand from 17 percent to 19 percent of GDP over the next nine years.[2] At the same time, health insurance premiums have surged, especially over the past decade. According to a 2014 study from the Kaiser Family Foundation, premiums increased by an average of 69 percent from 2004 to 2014. Employees have been especially hard-hit, as worker contributions to premiums have increased by 81 percent[3] while middle class incomes have remained mostly stagnant during this time period.[4]

While the U.S. spends far more per capita on healthcare than any other major developed country, it is consistently a laggard across most dimensions of quality and performance. In a recent study by The Commonwealth Fund of 11 OECD nations, the U.S. ranked last in overall care, while spending about twice as much per person when compared to top performers like the U.K., Sweden, and Australia.[5] Another study by the World Bank in 2013 found that the U.S. ranked 26th in life expectancy—right behind Slovenia and just ahead of Chile, the Czech Republic, and Poland.[6]

Given the current state of healthcare in the U.S., it is no wonder that the entire industry has come under intense scrutiny from an increasingly concerned public that is demanding better, more cost-effective solutions. In fact, we are already seeing the start of a radical transformation in healthcare today.

The Transition to Value-Based Payment Models

It has now become abundantly clear that healthcare is in need of significant change. In response to soaring healthcare costs and rapidly increasing premiums, payers are actively exploring ways to "bend the cost curve" across the system. This includes shifting payments to provider organizations as well as limiting market access and reimbursement for drugs, treatments, and therapies where compelling economic and clinical value are not adequately demonstrated.

CMS has increasingly used its influence to facilitate the transition from the current fee-for-service (FFS) payment model (which encourages volume with little consideration for medical outcomes) to one in which payment is linked to performance. Of particular note, the Department of Health and Human Services (HHS) announced in early 2015 a goal of increasing Medicare payments through value-based models—including bundled payments and accountable care-type arrangements—from 20 percent in 2014 to 50 percent in 2018.[7] As part of this announcement, HHS Secretary Sylvia Burwell said, "Whether you are a patient, a provider, a business, a health plan, or a taxpayer, it is in our common interest to build a healthcare system that delivers better care, spends healthcare dollars more wisely, and results in healthier people."[8] In short, the focus is now squarely on delivering "better outcomes at lower cost."

Almost immediately following the announcement from CMS came a similar one from the private sector. The Health Care Transformation Task Force, a 28-member alliance of providers, payers, employers, and various other partners, committed to transitioning 75 percent of its members' healthcare payments to value-based arrangements by 2020. The Task Force includes a number of leading organizations, including Ascension, Aetna, Blue Cross Blue Shield of Massachusetts, and Caesar's

1 Dan Munro, "U.S. Healthcare Spending on Track to Hit $10,000 Per Person This Year," *Forbes,* January 2015. (See www.forbes.com/sites/danmunro/2015/01/04/u-s-healthcare-spending-on-track-to-hit-10000-per-person-this-year/.)

2 Jason Millman, "Here's Exactly How the United States Spends $2.9 Trillion on Health Care," *The Washington Post,* December 2014. (See www.washingtonpost.com/blogs/wonkblog/wp/2014/12/03/heres-exactly-how-the-united-states-spends-2-9-trillion-on-health-care/.)

3 The Henry J. Kaiser Family Foundation and the Health Research & Educational Trust (HRET), "2014 Employer Health Benefits Survey," September 2014. (See http://kff.org/report-section/ehbs-2014-summary-of-findings/.)

4 Denver Nicks, "America's Middle Class Falls Behind," *Time,* April 2014. (See http://time.com/72496/middle-class-income-inequality/.)

5 Karen Davis, Kristof Stremikis, David Squires, and Cathy Schoen, "Mirror, Mirror on the Wall, 2014 Update: How the U.S. Health Care System Compares Internationally," *The Commonwealth Fund,* June 2014. (See www.commonwealthfund.org/publications/fund-reports/2014/jun/mirror-mirror.)

6 Sarah Kliff, "The U.S. Ranks 26th for Life Expectancy, Right Behind Slovenia," *The Washington Post,* November 2013. (See www.washingtonpost.com/blogs/wonkblog/wp/2013/11/21/the-u-s-ranks-26th-for-life-expectancy-right-behind-slovenia/.)

7 Rita E. Numerof, "Succeeding Today While Preparing for Tomorrow," *H&HN,* June 2015. (See http://nai-consulting.com/succeeding-today-while-preparing-for-tomorrow/.)

8 Dan Mangan, "Big Change: Feds to Tie More Medicare Payments to 'Value,'" *CNBC,* January 2015. (See www.cnbc.com/id/102368657.)

Entertainment.[9] As part of these efforts, the group plans to make recommendations for improving the accountable care organization (ACO) model, developing a common framework for bundled pricing, and improving care for high-cost patients.[10]

Customer expectations are also changing. With the expanded use of high-deductible plans, customers have had to assume greater financial responsibility for their healthcare. According to a recent survey by America's Health Insurance Plans (AHIP), the number of Americans covered by health savings account/high-deductible health plans (HSA/HDHPs) grew from 3.2 million in 2006 to 17.4 million in 2014, an overall increase of over 400 percent.[11] As this trend continues, customers will continue to become more engaged in their own care, with even higher expectations for the products and services they purchase and receive.[12]

The Shifting Provider Landscape

Driven by mounting pressure from payers and customers as well as increased financial penalties related to clinical quality metrics and expanded regulation, providers are also becoming intensely focused on cost and quality and are responding—at least in part—through standardization and consolidation. In an effort to control variation in cost and quality, hospital executives and administrators are taking a more active role in clinical decision making, with standardized, evidence-based care paths increasingly replacing individual physician discretion. Provider consolidation, which was up 14 percent in 2014, is expected to continue at a strong pace going forward, as systems look to solidify market share, improve economies of scale, and prepare for the increased use of alternative, value-based payment models (e.g., ACOs, bundled payments, and population health).[13] To better position themselves to take on risk across a population, healthcare systems are aggressively acquiring physician practices and ancillary facilities across the care continuum.

However, for organizations insistent on maintaining current business models, scale and competitive consolidation will only go so far as real disruptive innovation lurks around the corner.[14] Large, self-insured companies (e.g., General Electric, Wal-Mart, Lowe's) are now developing "centers of excellence" that work directly with leading medical centers on select procedures, including hip and knee replacements and various forms of cancer. In some cases, providers are offering these procedures through alternative payment models, like bundled pricing, in order to improve transparency and allow for more predictable pricing.[15] As part of these arrangements, nationally recognized healthcare systems like Mayo Clinic and Johns Hopkins are extending their geographic reach and directly competing against providers from all across the country.[16]

For organizations insistent on maintaining current business models, scale and competitive consolidation will only go so far as real disruptive innovation lurks around the corner.

These well-known healthcare systems are not the only ones implementing new strategic models. Increasingly, regional health systems are exploring ways to differentiate themselves and generate sustainable competitive advantage. Even small community hospitals are getting into the game by "owning" a niche that sets them apart from the competition. For example, Olmsted Medical Center in Rochester, Minnesota, has successfully carved out a niche in women's health by focusing on offering a high-quality, cost-effective patient experience through its new, 80,000-square-foot Women's Health Pavilion.[17]

Providers large and small are also looking to create significant market differentiation through strategic partnerships with payers and other providers. In Northern New Jersey, Aetna recently engaged Atlantic Health System, Hackensack University Health Network, and Hunterdon Healthcare in a multi-system collaboration. This effort will extend the reach of the participating institutions' coordinated care experience to a greater geographic area.[18]

More broadly, the line between payers and providers is starting to blur. In the words of Dr. Ezekiel Emanuel, Chairman of the Department of Medical Ethics and Health Policy at the University of Pennsylvania, the healthcare system is beginning

9 Emily Rappleye, "20 Major Health Systems, Payers Pledge to Convert 75% of Business to Value-Based Arrangements by 2020," *Becker's Hospital CFO,* January 2015. (See www.beckershospitalreview.com/finance/20-major-health-systems-payers-pledge-to-convert-75-of-business-to-value-based-arrangements-by-2020.html.)

10 Marisa Torrieri, "Transformation Task Force Members Reveal Program Details," *Healthcare Dive,* February 2015. (See www.healthcaredive.com/news/transformation-task-force-members-reveal-program-details/361484/.)

11 America's Health Insurance Plans, "Health Savings Account Plans: Providing High-Quality Coverage to 17.4 Million People," July 2014. (See www.ahip.org/Press-Room/2014/HSA-Census-Survey/.)

12 Rita E. Numerof, "Considerations for Risk Sharing Agreements," *eyeforpharma,* June 2015. (See http://social.eyeforpharma.com/column/considerations-risk-sharing-agreements.)

13 Knowledge@Wharton, "Hospital Consolidation: Can It Work This Time?" *Wharton School of the University of Pennsylvania,* May 2015. (See http://knowledge.wharton.upenn.edu/article/hospital-consolidation-can-it-work-this-time/.)

14 Rita E. Numerof, "Healthcare Consolidation and What It Means for Manufacturers," *eyeforpharma,* November 2012. (See http://nai-consulting.com/healthcare-consolidation-and-what-it-means-for-manufacturers/.)

15 Bob Herman, "GE Will Steer Workers to Northwestern Memorial for Hips and Knees," *Modern Healthcare,* November 2014. (See www.modernhealthcare.com/article/20141124/NEWS/311249944.)

16 Michael N. Abrams and Michael J. Kuchenreuther, "Five Steps to Monetizing the Value of Your Care," *H&HN,* February 2015. (See www.hhnmag.com/Daily/2015/February/five-steps-monetizing-care-value-article-abrams.)

17 Michael N. Abrams and Michael J. Kuchenreuther, February 2015.

18 Michael N. Abrams and Michael J. Kuchenreuther, February 2015.

to experience a "Kaiserfication," in reference to the Kaiser Permanente model, which combines a health insurance entity with hospital and medical facilities to create a fully integrated healthcare system. For example, Mount Sinai Health System, the largest provider in New York State, recently announced that it will begin offering its own Medicare Advantage plan and will look for other opportunities to bring premium payments directly into the system, rather than first passing them through insurers.[19]

Additionally, in recent years, large retailers including CVS, Walgreens, and Wal-Mart have been looking for ways to further expand into the healthcare provider market, most notably through retail clinics. Driven by price transparency, convenience, and access, the use of retail clinics continues to accelerate. It is expected that there will be 3,000 retail clinics nationwide in 2016, up from about 1,600 in 2014. Although still not a significant factor for providers, retail clinics could potentially pose a threat in the future as they continue to expand their services (e.g., chronic care management) and develop partnerships across the market.[20]

What This Means for Healthcare Delivery

Historically, all care has been generally viewed as the same, regardless of the provider. Differentiation was based primarily on the level of service provided and measured by factors like the appearance of the facility and perks—marble, big windows, and valet parking. In this environment, providers promoted their services through the heavy use of marketing communications, with little focus on the specific economic and clinical benefits most valued by payers, employers, and customers. However, as healthcare continues to evolve and the market actively transitions to value-based payment models, providers will need a much more strategic and nuanced approach. This will require organizations to completely rethink the value proposition they provide to the market as well as their underlying business model.

On the surface, "value" is a deceptively simple concept. It's defined as the sum of outcomes, benefits, and experience divided by cost (see **Exhibit 1**). In theory, increasing perceived value seems easy—expand the numerator (outcomes, benefits, and patient experience), shrink the denominator (cost), or do a combination of both—but making this a reality can be very challenging.

Exhibit 1. The "Value" Equation

$$\text{Value} = \frac{\text{(Outcomes x Benefits x Experience)}}{\text{Cost}}$$

Providers will need to think carefully about where they want to compete, especially as competitors continue moving towards "owning" market niches and expanding their presence both regionally and nationally. This will require a strong understanding of the treatment areas where the organization excels from a cost, quality, and patient satisfaction perspective, as well as what matters most to key stakeholders in these areas. Providers should keep in mind that demonstrating superior outcomes in select treatment areas will make it easier to justify premium pricing—and protect against commoditization—in these areas.

Going forward, it is clear that providers must develop a strategic, market-based approach that focuses on demonstrating compelling value to key stakeholders. For many providers, this represents a radical shift. Most providers today don't view their offerings as "products," which must be delivered in a consistent, predictable manner with defined outcomes. However, organizations relying on a "wait and see" strategy are at serious risk of being left behind. Given that major transitions are never quick or painless, the time to act is now.

The remaining sections of this white paper will detail a strategic, market-based approach that healthcare systems should consider pursuing in light of the rapidly evolving healthcare environment. We will look at the seven "Ps" of marketing services (product, price, place, promotion, people, processes, and physical evidence), discuss the critical elements for consideration across each component, and provide insights on how boards and leadership teams should be thinking about the services their organizations offer. We will then explore specific actions that can be taken now to prepare for value-based payment models, while also increasing revenue and improving margins in the current environment.

19 Rob Garver, "Hospitals Plot the End of Insurance Companies," *The Fiscal Times,* March 2014. (See www.thefiscaltimes.com/Articles/2014/03/27/Hospitals-Plot-End-Insurance-Companies.)

20 Lisa Zamosky, "What Retail Clinic Growth Can Teach Physicians About Patient Demand," *Medical Economics,* January 2014. (See http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/cvs-caremark/what-retail-clinic-growth-can-teach-physicians-about-pat?page=full.)

Putting the Marketing Mix to Work in Healthcare Delivery

The goal of marketing is to match a company's products and services with the people who need and want them, ensuring profitability. As reimbursement continues to shrink and competition for market share and volume increases, healthcare delivery organizations must become more strategic in their approach to marketing. In order for stakeholders to choose a specific institution, organizations must figure out how to differentiate themselves relative to the competition.

HISTORICALLY, DELIVERY ORGANIZATIONS HAVE GENERALLY relied heavily on marketing communications to attract people to their facilities, promoting services provided to large swaths of individuals (e.g., women's centers) and relying on awards and recognitions received (e.g., Top 10 Hospital as ranked by *U.S. News and World Report*) to generate brand loyalty. While these programs and awards may grow the brand reputation, they do not provide insight into the outcomes the organization provides, nor how it might address specific needs and wants.

Going forward, relying on marketing communications to drive people to your institution will not be sufficient. Payers, employers, and customers will want to optimize their healthcare spend on products and services that provide them with a desired outcome at a transparent price. To ensure they spend their dollars with your institution, a more strategic marketing approach will be required.

A common approach used by companies in other industries is to look at their marketing mix and how the components interrelate to develop approaches to their target markets that enable them to optimize market share and revenue. The marketing mix is not a new concept. It was originally developed in 1953 by Neil Borden, President of the American Marketing Association, to look at product, price, place, and promotion. Since then it has been expanded for service organizations and also considers people, process, and physical evidence.

This approach requires that organizations:

- Clearly define the **product/service** that's being offered and how it fits with stakeholder needs.
- Determine the best **price** to charge to cover costs and optimize revenue.
- Identify the best **channel (or place)** for delivering the product.
- Decide how to **communicate (promote)** the offering in such a way that it resonates with the target customer.
- Ensure the **people** delivering the service have the appropriate skills and that **processes** are in place to enable a consistent experience.
- Provide **physical evidence** demonstrating that the service was delivered.

Using this structured approach to think about healthcare delivery as a business will help organizations gain clarity about their offering and optimize value received.

Define the Product Components

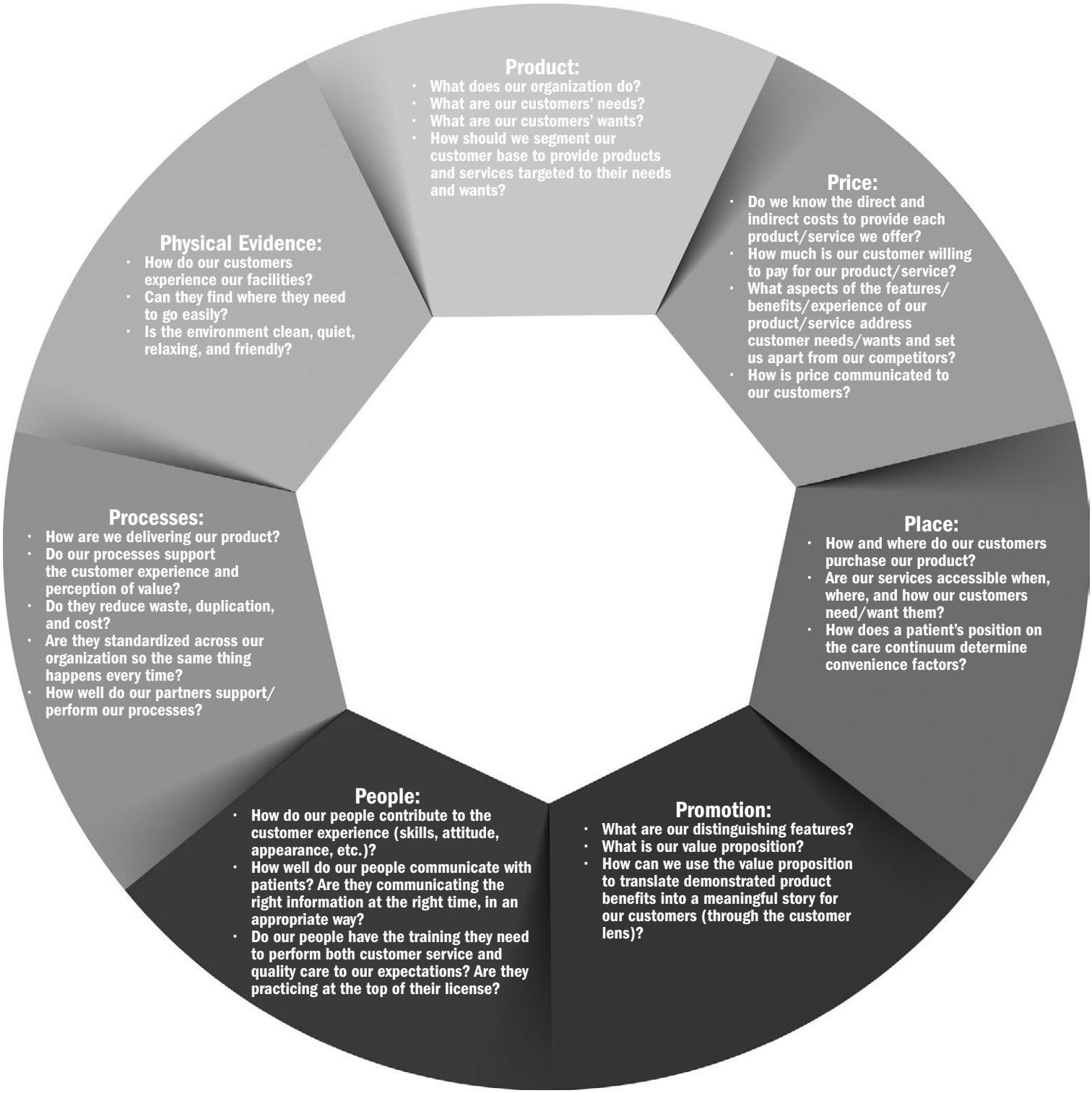
Define the Product: *Brand Reputation Differentiator*

Determining what your product is going to be requires understanding what your customers' needs and wants are and then developing your product in such a way that it resonates with them. Insights into customer needs and wants can help an organization segment its offering to its target population(s).

The classic definition of a product refers to an item offered for sale. Products are typically composed of multiple components that usually work together well. They are purchased as a single unit. Think about a car. The car has wheels, multiple windows, an engine, panels and doors covered in paint, a braking system, and carpeting—multiple components assembled together, purchased as a package, and typically not made by one manufacturer. When the components are assembled correctly you receive one product—a drivable automobile. By reading the sales sheet you also know what type of vehicle it is (e.g., luxury sedan versus compact car or truck), what to expect from the experience (e.g., how fast the car will go within 60 seconds, average miles per gallon of gas), as well as what is included in the purchase price (e.g., features like anti-lock brakes and side airbags as well as warranties and maintenance plans). Standard features exist and buyers can use them as points of comparison between automobiles of a similar type as they make decisions about preference.

The healthcare industry's product is not as clearly defined. In most instances, the delivery of healthcare has been associated with sickness and treatments aimed at addressing a specific symptom or ailment. It has not looked holistically at the patient. Healthcare delivery also has lots of components, but rather than

Exhibit 2. The Marketing Mix



providing them as a package, a customer (or payer) is charged for each part of the visit—time spent with the doctor, medications provided, additional visits to other providers for further testing, etc. Not only do customers not know what the entire visit will cost upfront, but they are also too often unaware of the components of that cost for which they will be responsible. Furthermore, they typically don't know what procedures will be included as part of the visit, how much time they will spend, how they will be engaged, nor the anticipated outcomes of the visit.

To some extent, hospitals have been good at building brands—they have become known for providing creature comforts, good food, additional services like valet parking, and attractive settings. Yet even in these instances, they have not been able to define their product in terms of material outcomes and provide insight to the associated costs. They made the assumption that patients cannot judge anything but the food, the friendliness, the cleanliness, etc.

Let us take our definition of product one step further and look at it within service businesses. Within these organizations, the product defines what an organization does. A product will vary by different factors wrapped around a predictable set of experiences. To ensure that the experience a customer receives each time he/she visits a hotel is the same, there exists a level of standardization.

> Going forward, relying on marketing communications to drive people to your institution will not be sufficient. Payers, employers, and customers will want to optimize their healthcare spend on products and services that provide them with a desired outcome at a transparent price. To ensure they spend their dollars with your institution, a more strategic marketing approach will be required.

The hotel business is one service industry that is very clear about its product—the service it sells is lodging. Whenever you stay at a hotel, you know you have a place to sleep for the night. However, the sleep experience can and does vary by hotelier, brand, and market. The hotel industry has become really good at segmenting its market and providing different products for different target markets. The experience at each location varies based upon the customers the establishment is trying to attract, the quality of products and services it wants to be known for, and the competitive environment.

Within any city, there are multiple choices with a variety of different offerings—from full-service locations to facilities catering to a professional on a long-term assignment to low-budget, minimal amenity accommodations. The difference in each of these is the experience they've created for the particular segment they want to go after. Whenever you travel from city to city and stay at the same brand of hotel, you can expect to have a very similar

experience to what you had in another city—specific accommodations and layout might be varied, but the experience, amenities, and price will be fairly consistent from location to location. (See sidebar on the next page, "A Case Study: The Marriott Hotel Chain," for more details.)

Each hotel within the brand has a defined market segment, a specific price point, and a different experience and offering. The corporate value proposition reflects the view that the traveling customer should be able to find a hotel within the Marriott family that suits his or her needs.

It is important to note that there isn't a general "Marriott" corporate experience, but rather a consistent, predictable experience within each brand.

But what happens when we go to a hospital or physician office? We might expect to "get well," but what that means varies by individual based upon their circumstances, condition, and expectations. Although we might go in with some basic expectations (e.g., "they will give me something to make me feel better"), we don't know how long it will take to see a doctor, how long it will take to get a result, how the service might be delivered, or even what we will have to pay. We also don't know the likelihood that the prescribed treatment will solve the problem.

Furthermore, when a problem occurs, it is unclear as to how it will be addressed. Before readmission penalties were put in place, if a hospital operated on the wrong body part, you were told to "come back so we can fix our mistake," which also translated into "we will charge you a second time!" Still today, if you don't feel the surgery achieved the anticipated results, the typical provider response is that sometimes there are no guarantees, and you may be left to develop your own solutions or work-arounds. Contrast this to the car and hotel examples. When the car doesn't drive off of the lot or your hotel room has dirty towels, you expect they will fix the problem before you complete the sale. This has not been the case with the business of healthcare delivery.

A Case Study: The Marriott Hotel Chain

The Marriott chain has long been known for its ability to segment the market and develop products that appeal to different audiences. There are 16 Marriott brands that fall into six distinct categories:

THE RITZ-CARLTON

BVLGARI

JW MARRIOTT

Luxury hotel brands are known for exclusive, elegant experiences. Attention to detail is key to success, ensuring a hotel guest's experience is exquisite.

R RENAISSANCE HOTELS

AC HOTELS MARRIOTT

Lifestyle Collection hotels tend to be contemporary sites providing guests a distinctive experience and/or destination.

moxy HOTELS

AUTOGRAPH COLLECTION

EDITION

Marriott

DELTA HOTELS AND RESORTS

Signature hotels are the global flagship brands that "inspire performance on the road" and cater to business professionals.

COURTYARD

PROTEA HOTEL

Select Service brands provide cost-conscious travelers a consistent experience, with basic amenities (e.g., free fitness room and continental breakfast).

SPRINGHILL SUITES Marriott

FAIRFIELD INN & SUITES

Residence Inn

TownePlace SUITES

MARRIOTT EXECUTIVE APARTMENTS

Extended Stay brands are for travelers with long stays.

Gaylord brand is Destination Entertainment, providing "everything in one place" and celebrating the local heritage.

GAYLORD HOTELS

Customer Needs versus Customer Wants

Determining what your product is going to be requires understanding what your customers' needs and wants are and then developing your product in such a way that it resonates with them. Needs reflect the problem the customer wants solved—like "my knee hurts" or "I can't breathe." Wants may be different from the need and reflect how customers want the desired outcome to be delivered—like "make the pain go away quickly so that I can play in my soccer game tomorrow." It is important to note that needs and wants vary by customer.

A urologist colleague provided us with an excellent example that highlights the criticality of understanding customer needs and wants. He had two male patients about the same age that presented with testicular cancer. Both "needed" their cancer to go away, but how they wanted to accomplish it was different based upon the experience each desired from treatment. When presented with options, one man absolutely did not want radiation because he didn't want to risk a reduced sex drive. Another patient wanted to be around for his grandchildren, so he was willing to do whatever it took to extend his life and was interested in radiation treatment.

Both patients recognized that the treatment they selected presented a different statistical probability of life. Length of life was more important to one man than the other; quality was defined very differently. This demonstrates that there are other outcomes that also matter to patients. It's important that hospitals and health systems understand that the outcomes that matter should be defined by patients, and they will vary by individual. Insights into customer needs and wants can help an organization segment its offering to its target population(s).

Determine the Price (and Understand Your Costs)

Determine the Price: *Transparency*

Developing a price requires activity-based costing—understanding the direct and indirect costs to provide the product—as well as how much customers are willing to pay for the specific product or service offering. A customer's perception of value will take into consideration features/benefits/experience of the product, how well they relate to a customer's needs and wants, and how they compare to the competition.

In most industries, pricing discipline looks at how much it costs to develop or produce a product with a mark-up based on perceived value. Developing a price requires understanding the direct and indirect costs to develop the product as well as how much customers are willing to pay for the specific product or service offering. Willingness to pay will be based on a customer's perception of value. This will take into consideration features/benefits/experience of the product, how well they relate to a customer's needs and wants, and how they compare to the competition.

The airline industry understands its costs and has developed an intricate pricing system. The major carriers know what it costs to put a plane in the air and take into consideration fixed and variable costs associated with routes and plane size when making strategic pricing decisions. Fixed costs include things like gate licenses and salaries, while a significant variable cost is fuel (due to passenger and baggage weight). They've studied the market and are able to determine when traffic is likely to be heaviest. Using these insights, they've developed algorithms that determine how much each seat is worth based upon the day of travel, time of year, and how far in advance the seat is reserved. They can set and adjust pricing based upon this information. They recognize that a business traveler who needs to get from Boston to San Francisco in the next three days is willing to pay significantly more than a vacationer planning a trip three months in advance.

But that's not how it works in healthcare delivery. Few organizations understand the true nature of their costs and whether or not they are making money for providing a particular service. Costs are often rolled up to such a macro level it's difficult to unwind them to identify true cost drivers. Rather than evaluating and rethinking the underlying care delivery processes that are driving costs, organizations tend to look at big "buckets" of cost like staffing, facilities, supplies, and equipment, and make decisions that can have a negative impact.

One organization learned the hard way that not paying attention to underlying costs can have a significant impact on the

organization. In a small local hospital, a process was developed that reduced congestive heart failure (CHF) readmissions from 24 percent to 0.8 percent. This change had a significant impact on the system's readmission penalties as well. However, implementing the change required the addition of 1.5 FTEs. When the organization was looking to reduce costs to prepare for a pending merger, it looked at where headcount had been recently added and made broad-sweeping cuts without understanding how those cuts would impact other results. Needless to say, the readmissions savings went away.

The absence of activity-based costing discipline means that it is difficult for organizations to understand the indirect costs such as facilities, overhead, and management, as well as direct costs like the staff time to deliver such services. Insights like these can enable organizations to develop an understanding of the precise costs for individual encounters, procedures, and episodes of care. With this information in hand, providers can hone in on specific clinical, technical, and process elements, all of which make up the total cost of healthcare. This focus will enable organizations to conduct accurate assessments of the profitability of individual service lines, provider relationships, or clinical management of specific patient populations and then make informed decisions about where to invest, especially if they are looking for ways to differentiate from the competition.[21]

Once costs are determined, then focus can turn to setting an appropriate price. Within delivery, pricing is opaque and depends on contract negotiations. Today, institutions create a price list (the "chargemaster") and set inflated prices for everything they sell. They negotiate with payers and employers on the discount those organizations will receive off of the chargemaster. But there is no consistency in how the chargemaster is set, nor the prices included. To make matters worse, the information is not shared—organizations negotiate the discount. This lack of transparency makes it difficult for payers and employers to draw comparisons on how a discount at one institution compares to another.

This lack of pricing transparency is then transferred to the end customer. Since negotiated discounts vary by plan, institutions have a difficult time informing customers of what their cost will be. As high-deductible health plans are becoming more common, customers who have non-acute needs and can plan for their services have difficulty determining what their cost will be in advance of treatment. Not only is it difficult to find prices, but also it is hard to identify the outcomes associated with that price. When this lack of clarity exists, purchasers automatically assume the service is the same at each location and then focus on price. Consequently, organizations that have developed particular expertise or are able to deliver better-than-normal outcomes aren't rewarded for that advantage, as purchasers have no information to justify the increase and see no value in paying a different price from one institution to the next.

To see just how difficult it is to get comparative pricing and outcomes data, our organization conducted "mystery shopper research." (See sidebar on the next page, "Case Study: What Will Treatment Cost Me?") While we didn't expect to find extensive information about the cost and quality of a particular service among recognized leading organizations, we were surprised at how little information was available.

Clearly, when it comes to moving to a market-based, customer-centric model of healthcare delivery, this scenario illustrates just how much work still needs to be done! There is some good news in the story, however. As so little information is available, leading organizations have an opportunity to differentiate themselves if they can provide transparent information about cost and quality, including outcomes of interest to patients (e.g., length and quality of life). They can further differentiate themselves by offering fixed price options to payers and ultimately to customers. And, as customers shoulder more and more of the cost burden, this information will be critical in their decision making about where to seek treatment.

21 Rita E. Numerof, June 2015.

Case Study: What Will Treatment Cost Me?

We put ourselves in the role of a relative of a patient who had been told they needed a cancer treatment—stem cell transplant (SCT)—and wanted to know beforehand what to expect regarding the course of treatment and its cost. We targeted top-rated national and regional cancer institutions to identify "the best" regarding available information on:

- Cost
- Treatment scope (what services were included, and whether any were offered at a fixed or bundled price)
- Outcomes
- Patient experience

We approached our research as any customer would—with a review of online information that would be expected to be credible, followed by phone calls to fill in what we couldn't learn from what we found on the Web.

The quality and availability of information regarding SCT on the providers' Web sites were varied. But none of the Web sites provided any information on what exactly was included, outcomes, or cost. When we called the institutions, we were able to speak with stem cell transplant representatives at half of the institutions. We spoke with call center representatives at one-third of the institutions. Surprisingly, we were unable to speak to anyone at 12 percent of the facilities, despite multiple attempts to reach them.

Most facilities were unwilling to be specific about the costs of treatment until after they had performed an evaluation. While understandable due to many unknowns (cancer type, staging, protocols, health status, etc.), patients who want to make a decision about where to be treated prior to evaluation would be frustrated. As it is unlikely that a patient would choose a separate institution for their treatment once they had been evaluated, this compounds the importance of making the best choice from the start.

Of those facilities that were willing and/or able to discuss cost, none were able to explain what might be included in the rough figures they quoted nor were they able to discuss outcomes. Those that asserted that they were superior had no evidence to support their claims.

Source: Numerof market research.

Identify the Best Place

The Best Place: *Convenience and Access*

Organizations must ensure their product is offered at the right place at the right time, where it is convenient for the customer to access it. In order to determine the best location, it's important to understand how and where a customer purchases a product.

The third "P" of the marketing mix refers to ensuring the product is offered at the right place at the right time so the customer can purchase it. Another way to state this is providing the product at a place where it is convenient for the customer to access it. In order to determine the best location, it's important to understand how and where a customer purchases a product.

Retail stores conduct extensive market research to understand how customers purchase products and factors that influence that decision. Premium space on store shelves is reserved for those products that bring in the highest margins. Grocery stores are also designed around strategic product placement of staple items to ensure customers pass by other items that weren't necessarily on the shopping list. Think about the last time you went to the grocery store—were you able to walk in and grab eggs, a loaf of bread, or milk from one of the shelves near the front of the store? Probably not. But when you did get to the appropriate section, the best sellers and high-priced items were in your line of sight.

Convenience is a critical part of ensuring a customer selects a product, and it's key for companies committed to market disruption. Think of the taxi business. Until Uber came along, hailing a taxi required standing on the street and finding one that was available, or hoping to catch one just as it unloads. Sometimes you could walk three blocks and not see a single taxi available and then come to a hotel where multiple taxis sat in a row awaiting the next fare.

Uber was started on the premise of helping the customer quickly find the closest available taxi—and pricing fares based on demand. Customers were willing to pay a premium, particularly during high-demand times like rainstorms! Uber's technology and model ensures customers' needs for quick and safe transportation are met quickly. As a result of its success, taxi companies are now fighting to keep Uber from expanding into their markets and making changes to improve their level of service. The convenience factor has created a new kind of competition for them.

It is worth noting that the Uber model is facing some regulatory issues (e.g., basic screening for safety, driver competency, etc.). Our reference to this model is purely to illustrate that its attention to "place" has disrupted the taxi market. We anticipate that regardless of how some of the regulatory issues are resolved, the Uber model will create significant changes within the marketplace.

Convenience has factored into the success of urgent care clinics, like CVS's Minute Clinic and Walgreens Healthcare Clinic. These facilities are located in high-traffic areas and provide basic services to customers. What customers like about them is access: they don't have to wait three days to see a healthcare professional and they can go to a location close to home or the office. The challenge for healthcare delivery organizations is that these clinics are "stealing" lucrative business in that some of the offered services are high margin and often with cash pay or commercial pay customers.

As we stated earlier, the traditional hospital product has been associated with sickness—fixing or addressing a specific symptom or ailment. It has been built on an expert model—zeroing in on a particular component of treatment and the specialist providing it. As a result, care models have been developed around the healthcare expert setting hours that are more convenient to the care provider than the customer. Hours of operation are like the banking industry in the 1980s and 90s—open from 9:00 a.m. to 5:00 p.m. Monday through Friday and possibly some service at select locations on Saturday. As many healthcare administrators have told us over the years, the worst time to get sick is on the weekend as the best providers aren't there to help them!

A patient's position along the continuum of care plays a role in determining convenience. Individuals on a maintenance plan will increase adherence if barriers to obtaining treatment are removed. To the extent the service can be provided at home or near work and minimize disruptions to their normal day, there is greater likelihood that patients will adhere to the treatment regimen.

As such, the healthcare organization's customers have come to expect poor service in the form of long wait times, multiple delays, repeated questions, and duplicate paperwork. This is not a customer-focused service.

Instead, consideration should be given to the best timing and location for that customer to receive healthcare: in the home, within the neighborhood, at a hospital, or at another location. The patient's position along the continuum of care will likely play a role in determining the convenience factor. Individuals on a maintenance plan will increase adherence if barriers to obtaining treatment are removed. To the extent the service can be provided at home or near work and minimize disruptions to their normal day, there is greater likelihood that patients will adhere to the treatment regimen. Simply put, this represents a customer-centered approach to thinking about the right service for the right patient at the right time and in the right location.

We would be remiss in not acknowledging that some specialty facilities have done an excellent job of putting the customer at the center of their model, and cancer centers tend to be among the most advanced. As an example, Cancer Treatment Centers of America (CTCA) has developed a model for the diagnosis and treatment of cancers, particularly those difficult to treat. The system recognizes that when an individual faces a serious diagnosis like cancer, anxiety goes up. In light of this, CTCA has designed its model to minimize patient anxiety so that it can achieve significant treatment results and provide its customers with an experience and outcomes that matter. All services that touch the customer have been designed to lower stress—from ensuring that a patient sees everyone he/she needs to during one visit and has a treatment plan identified by the visit's conclusion, to helping with transportation and caregiver lodging. Putting the customer at the center of its model is how CTCA is able to create and build its reputation on customer service.

Determine How to Promote Your Product

Promotion: *The Value Proposition*

Communicating how the product addresses customers' needs and wants requires creating a value proposition that translates demonstrated product benefits into a story that resonates with customers.

The promotion aspect of the marketing mix refers to how an organization communicates how its product addresses customers' needs and wants. It requires creating a value proposition that translates demonstrated product benefits into a story that resonates with customers. Promotion helps to identify what is unique about a product and provide the customer with information, including facts and data, to support product purchase.

One of the most well-known labels in the customer goods business is the Good Housekeeping Seal of Approval. Starting in 1909, Good Housekeeping began testing products to determine if they performed as intended and, if so, agreed to provide a warranty on the product. The warranty covers the cost to replace or repair the product up to $2,000.[22] Manufacturers that obtain this seal of approval can use it in promotions of their product to provide the customer with validation and confidence that the product works.

Promotion is particularly important in a competitive environment to draw attention to distinguishing features. When the Volvo company was founded in 1927, its leaders determined that they wanted its value proposition to focus on one particular feature—product safety. As Managing Director Assar Gabrielsson and Technical Director Gustaf Larson stated, "Cars are driven

22 Good Housekeeping Institute, "About the GH Limited Warranty Seal," March 2014. (See www.goodhousekeeping.com/institute/about-the-institute/a22148/about-good-housekeeping-seal/.)

by people. The guiding principle behind everything we make at Volvo, therefore, is and must remain, safety." This became the company's credo and for decades the company exceeded many other manufacturers in industry tests on safety performance. The company leveraged this recognition in its promotional campaigns and used it to attract customers that wanted to be assured of the safest driving experience possible.

The need to draw attention to distinguishing features is particularly true in service industries where it is not as easy to see the product difference before making a purchase decision.

One of the most well-known service company differentiation campaigns is the Avis "We try harder" campaign. In 1962, the automobile rental company was a distant number two in market share behind Hertz. The ad campaign drew attention to a unique aspect of the company's offering, its customer service platform. The company's value proposition was that it would put the customer first and do "whatever it takes" to meet customer needs.

Throughout the organization, employees actively sought ways to fulfill and promote this value proposition. As an example, recognizing that business travelers might like to fly into a city and do business for a day before flying out again, an initiative was begun to establish rental locations at airports, a first for the industry. This feature enabled customers to drive themselves to their destination rather than have to rely on taxis or other transportation. Over the first four years of the ad campaign, the company closed the market share gap between it and Hertz from 29 vs. 61 percent to 36 vs. 49 percent, and continued the promotion for the next 50 years.

Within healthcare delivery, it is hard for a customer or payer to identify the value proposition or distinguishing characteristics of hospitals and health systems. In a small town, local systems have usually been "the only game in town" and relied on that fact to bring customers to their organizations. In large cities where multiple systems exist, a customer can drive down the street and see billboards for each system that advertise its "top status" as defined by an external body. However, the criteria used in making those selections are not well known to the customer. In addition, since each facility is advertising a "top" list, it's difficult to distinguish any differences between the facilities.

One healthcare organization, Cleveland Clinic, has begun to expand its presence and is building a value proposition around outcomes that matter. For years, the company has focused on building its internal processes that enable it to deliver consistent outcomes. It has leveraged this experience and its results to create bundled payment opportunities with companies like Boeing and Lowe's, and to draw employees out of their local markets and to its facilities. In addition, it is promoting its outcomes and providing guarantees to patients that they will achieve a certain outcome if serviced at their facility.

Organizations like Cleveland Clinic, destination medical centers, major retailer clinics, and others are creating new forms of competition. In order to compete and distinguish themselves from these and other competitors, healthcare delivery organizations need to develop a value proposition that will resonate with key stakeholders.

Preparing the Value Proposition

There are four steps[23] required to prepare a value proposition for payers and employers:

- Identifying the differentiating elements of the care model
- Defining and prioritizing the claims of interest
- Defining and collecting the data supporting the economic and clinical value of the care provided
- Crafting powerful and practical communication tools to make the value case

A strong value proposition needs to reflect a hospital's strengths and offerings as seen through the lens of patients, payers, and employers. Before developing this narrative, an organization must be able to clearly define the elements of its care model that will differentiate it and demonstrate economic and clinical value for these stakeholders. These elements can be broad or narrow in scope as long as they help answer the question, "Why should anyone come to our facility instead of another?" Hospitals that understand which processes and capabilities are unique to their organization (and matter to payers and employers) will be well-positioned to get started relative to their competitors.

Creating a Customer Experience with People, Processes, and Physical Evidence

When the product is a physical good, the four Ps are sufficient to determine how to market it. But services are different from tangible products because they are often time-based and the customer doesn't typically take ownership of any of the physical elements involved. Instead, service customers receive value from access to goods, labor, professional skills, facilities, networks, and systems.

23 Numerof & Associates, Inc., "How to Get Premium Reimbursement for Premium Care," April 2014. (See http://nai-consulting.com/healthcare-brief-15-how-to-get-premium-reimbursement-for-premium-care/.)

Since customers don't always touch or feel a service product, it's difficult for customers to compare products. Instead, they must trust that the service will be delivered as promised. This means organizations must ensure consistency of the service being offered because, when it doesn't deliver as expected, it can tarnish the reputation and have a strong impact on future sales.

Since a service cannot be returned, when a customer doesn't receive the expected product, it's not only the cost of acquiring the product that's concerning, it's also time wasted—and in the case of healthcare delivery, potential serious harm. In order to assure that the service will be delivered as expected, organizations must give thought to three additional parts of the marketing mix: the people who deliver the service, the processes used to ensure consistent delivery of the service, and the physical evidence that reflects the environment in which the service is delivered. These three additional Ps enhance customer experience and can have a significant impact on a customer's perception of value.

Let's look at one organization well known for its ability to create a unique customer experience through its people, processes, and physical evidence: Walt Disney Parks. By training its people appropriately, developing processes to handle normal procedures and disruptions, and maintaining appearances consistent with its brand, Walt Disney Parks makes every guest feel extremely important and adds positively to the overall experience.

Through its training program, employees are taught to be "assertively friendly" and seek out opportunities to help rather than wait for a guest to request assistance. For example, if employees see someone looking confused, they are taught to step in and ask if they can help before the guest gets frustrated about not finding the fastest way to an attraction.

Employees are also taught processes for handling activity disruptions. They are expected to be good communicators and when schedules go awry, to notify customers immediately of the delay, why it is occurring, and how quickly they anticipate it will be resolved. This means the customer isn't left trying to understand what is happening and drawing their own conclusions.

As part of the effort to create a "magical experience," custodial crews work around the clock to ensure a clean environment. Trash that falls to the ground or left on tables is immediately picked up and disposed of by staff. All staff members are pleasant and dressed in costumes fitting their character or the sector of the park they represent. These different activities help to create the overall experience the organization wants to give its customers.[24]

People Play a Significant Role

There are many that believe people are the most important part of a service as they have a direct impact on perceptions of how well, or how poorly, a service is delivered. Skill, attitude, and appearance are all critical components of success. This means ensuring that the people involved have the appropriate training needed in order to perform the service sufficiently and provide the level of quality the organization wants to deliver. Sometimes, the problem isn't the service, but the person delivering it. Think back to the last time you had a problem at a restaurant—how the wait staff or management addressed this problem likely had a big impact on the overall impression of the experience.

Within healthcare delivery, people play a key role as their experience and expertise are called upon to determine the underlying problem, identify the best solution, and manage the process to get to better health. Healthcare professionals are required to obtain and maintain credentialing and skills within their designated fields. However, as competition grows for different service lines and services, this training and experience is only part of what organizations need to address to attract customers. Organizations must also focus on the way in which these skills are delivered to individuals. This includes looking at more than just the time a patient is with a healthcare professional; it includes everyone they encounter while working with the organization. Many organizations promote the extensive training their physicians and other healthcare professionals have had. What is less apparent is how those physicians, other healthcare professionals, as well as employees throughout the organization are taught to interact with customers.

Another part of the "people" component is ensuring that the right person is providing the right service. In other words, this means that people are operating at the top of their license. At one of our client organizations we found master's-level nurses doing intake and scheduling. The organization explained that they were there to answer patients' questions. However, as we looked at how time was spent on calls, most of it was spent capturing general information and coordinating calendars—not on addressing patient concerns. We recommended that the organization use lesser skilled individuals to manage these calls and train them to recognize when the individual needed to be connected to someone else. Doing this freed up time for the nurses to focus on more patient care activities and also reduced costs.

Processes Ensure Consistent Performance

Processes address how the product is delivered to the customer. They support the customer experience to ensure that the service is delivered effectively and consistently. Processes can be direct activities that touch the customer, or indirect activities like back-office procedures that support the overall experience before, during, and after the time of service. Process standardization ensures that the customer can expect the same performance on a consistent basis.

Fast-food companies have developed processes to ensure they can provide food to customers quickly and consistently. One of the most well-known companies for delivering consistent products on a consistent basis is McDonald's. The company is one of the most successful and longest-operating fast-food establishments. This can be attributed in part to its process-driven culture. In 1961, the company founded its first Hamburger University.

24 Carmine Gallo, "Customer Service the Disney Way," *Forbes,* April 2011. (See www.forbes.com/sites/carminegallo/2011/04/14/customer-service-the-disney-way/.)

This training program was established to emphasize consistent restaurant operations, procedures, service, quality, and cleanliness. As part of this training program, the company has developed strict processes that define how its food will be prepared and requires all employees and franchisees to adhere to its guidelines. These processes ensure that when an individual goes to a McDonald's location, they have the same, consistent experience each time.

Now think about healthcare. Some of the processes, like patient intake and billing, have been standardized. The processes in place to move a patient through the system or the care continuum are less consistent. One particular area where inconsistency presents major business risk is in care transitions. Lack of communication about patient status and needs between settings, as well as failure to schedule appropriate services and follow-up upon discharge, can and do result in errors, unnecessary readmissions, and customer dissatisfaction.

One health system known for managing patient flow is Mayo Clinic. Mayo was founded on the idea that healthcare professionals would work together to provide team-based patient care. When a patient comes to the facility for a diagnosis, rather than shuffling the patient from one building to the next, healthcare professionals come to the patient. This approach minimizes the customer's frustration with having to find his/her way across the expansive campus and helps facilitate the integration of the different components of care.

Not only do organizations need to develop processes for moving the patient effectively through the system, they also need to look at moving the patient through the care continuum. Helping a patient achieve his or her healthcare goals might involve care in settings outside a system's direct control. Achieving the goal of "wellness" may mean intervening with potential customers before they even become sick. This holistic approach to healthcare delivery means intervening before there is a problem (prevention), determining what or if there is a problem (diagnosis), identifying the best course of action (treatment), and/or providing ongoing management to minimize problems associated with chronic diseases. Organizations don't have to own all the services across the continuum, but they can and should create partnerships and alliances with other organizations across the continuum.

Identifying and engaging with a good partner are only the first steps. Organizations must clearly define their respective responsibilities and accountabilities and the necessary processes to ensure they operate as expected. Problems often occur as patients make care transitions from one setting to another as it is unclear how a patient will be moved, to where and when, and what data will be transferred. When these issues are not managed effectively, problems like readmissions occur, driving up costs and customer frustration.

Helping a patient achieve his or her healthcare goals might involve care in settings outside a system's direct control. Achieving the goal of "wellness" may mean intervening with potential customers before they even become sick. Organizations don't have to own all the services across the continuum, but they can and should create partnerships and alliances with other organizations across the continuum.

Creating Physical Evidence

Physical evidence reflects the things a customer can see that impact the overall experience. Think of an entertainment venue like a baseball game. The physical evidence includes the uniforms, the logos around the ballpark, the location of seating near restrooms, and games and other activities played between innings. Each of these items contributes to the excitement of the venue and overall experience the customer receives.

Within healthcare delivery, physical evidence has centered on the first impression to create a welcoming environment. But once an individual gets beyond the reception area, appearances quickly change. Helping people navigate the labyrinth of a healthcare delivery organization is another way to create physical evidence. After all, if they can't find their way to an appointment, they will only remember the frustration and aggravation of getting there.

We have a client who recognized that given the age, structure, and location of his hospital, he couldn't do much to the layout to improve patient flow from one point of service to another. However, he did understand that he could influence their experience as they traveled from one location to another. To create a positive, soothing experience he hung artwork along the halls and walkways throughout the organization. A relationship with local museums and artists enabled him to change the artwork periodically so that people requiring services there on a consistent basis would have new things to look at and something to look forward to. He understood that the physical impression of their facilities was important and he could use it to help overcome a dread that might be associated with frequent visits.

Putting It All Together

SUCCESSFUL HEALTHCARE DELIVERY ORGANIZATIONS understand that all potential customers expect to come to their facility for safe care. As they assume more financial responsibility for their healthcare, they'll make decisions with their feet about where they go for services. By using the marketing concepts explored in the previous section, hospitals and health system leaders can broaden their thinking about what they do and how they do it. New thinking will unlock new opportunities to achieve sustainability and profitability now.

Achieving success requires that organizations understand who their customer is, their unmet needs, and the role of speed, convenience, expertise, and amenities in addressing those needs. With insights into target market segments, organizations can develop product sets and service lines that allow them to differentiate in markets of choice. They also need to capture the economic and clinical evidence that demonstrates how well they are able to meet customer wants and needs.

In order to consistently deliver these product sets, hospitals and health systems will need to manage variation in cost and quality. One challenge they face is having reliable information about costs of service delivery across the continuum in a way that ensures accuracy and predictability. While the specifics of how to do this are beyond the scope of this paper, organizations should adopt activity-based costing disciplines. As mentioned earlier, insights from activity-based costing can help an organization quickly zero in on true cost drivers and make focused decisions on clinical, technical, and process changes. Such insights also point to where investments will be most advantageous.

An organization's ability to manage variation also depends on its compliance with evidence-based care paths. Care paths are tools that define the critical actions and decision points across a patient's course of medical treatment. When optimally developed, care paths provide the much-needed link between clinical activities (including variability) and associated costs for delivering on clinical care.[25] But they should not be considered purely a clinical activity—administrative involvement in their development is an essential part of linking costs to quality.

To accomplish the tasks identified here, organizations must gain alignment across individual providers and administrative functions, as well as internal and external partners. Moving to a value-based model for healthcare requires individuals at all levels of an organization—and across the continuum—to think and act differently. It challenges traditional norms and requires new competencies. The enormity of the cultural shift that's required should not be underestimated.

Assuming the disciplines identified here are in place, an organization is positioned to negotiate confidently with traditional and non-traditional payers—able to monetize the value of its care model. It can go to market with a compelling value story, which is the ultimate tool in an effective retail market strategy.

How Does a Customer View Your Organization?

Take this self-test. Put yourself in your customer's shoes and walk around your facility. As you explore the premises and watch the activities occurring, ask yourself the following questions:

- How have we defined our product?
  - » How easy is it for the customer to access it? Is it being delivered consistently throughout the organization?
  - » Does it deliver the economic and clinical value that customers and purchasers of care seek?
- Is our price competitive and consistent with our value? Does it cover our costs?
  - » Do we know the costs of each part of the service being delivered? Is it easy for a customer to determine the price he or she will pay? Do they know what's included in that price? Or will they get multiple bills for the different components?
- Is our product being delivered in the most effective location? Are we meeting the customer where they are? Or are we requiring them to come to us at our convenience and find their way through a maze?
  - » If we have partnerships in place, how well are our partners supporting our overall value proposition? Do customers feel as if service is seamless between us and our partner?
- What evidence do we have to demonstrate that we deliver our product consistently? Does that evidence demonstrate clinical value? Does it tie clinical benefits to economic value? Is it easy for a customer to understand?
- Do our people have the skills, talents, and experience to support our product? Are cultures or attitudes interfering with a customer's experience?
- Do our processes flow smoothly? When a customer enters our facility, do they know where to go? How do people greet them? How are back-office services like billing questions handled?
- What's the overall environment or experience? Is our facility a place someone wants to go?

The better you get at thinking about your product from a customer's eyes, the better you'll also be at delivering a product that matters to payers—and putting yourself in a position to negotiate rates that capture value for the service you are delivering.

25 Michael N. Abrams, Simone M. Cummings, and Dana Hage, "Clinical Care Paths—A Foray into Clinical Decision-Making for the Finance Professional," *hfm Magazine,* December 2012. (See http://nai-consulting.com/clinical-care-paths-a-foray-into-clinical-decision-making-for-the-finance-professional/.)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