TABLE OF EXPERTS

HEALTH CARE

BY HOLLY DOLEZALEK, CONTRIBUTING WRITER

The Minneapolis/St. Paul Business Journal held a panel discussion on the topic of health care. Panelists included Michael Jones, a managing director in Accenture's health and public service group; Matt Wolf, director of financial advisory services at RSM; Erik Hinz, benefits adviser at Horton Benefit Solutions; Dr. Deb Zurcher, clinical director at Fulcrum Health; and Dr. Emily Chapman, chief medical officer at Children's Minnesota. Frank Jaskulke, vice president of intelligence at Medical Alley Association, served as moderator.

Jaskulke: The first question is really about the macroeconomy. Health care has traditionally been slower to respond to recession. Will it be different this time around, whenever the recession does happen, for health care?

Wolf: If you look at the number of lives covered under Medicare, Medicaid, the proportion that patients are paying out of pocket for their care has by some measures tripled over 10 years, and deductibles are much higher. So while the demand side is unchanged, the same demographics are driving the aging of the population, the patient's ability to finance that care. It might not look the same across the nation; it could be very different as we look at the impact of the tariffs and the trade war. Think about a rural health provider that serves a lot of farmers affected by soybean or auto tariffs or auto strikes; those patients' ability to finance their care may be impacted. We think it's changed significantly and it's too much for us to say that we'll be relatively insulated as we were in past recessions.

Zurcher: There's been so many changes with the high-deductible plans that people are really looking at where they're spending their health care dollars. One of the top three reasons people seek care is for back pain, which is also the third-highest health care cost. The best approach to reduce pain with effective results at a lower cost, is to start with conservative care. This simple approach lowers costly ER visits, imaging, opioids, and other procedures that may not be medically necessary.

Jaskulke: So it could potentially drive greater adoption of things like conservative care.

Zurcher: Correct. I mean, we are starting to see employers choosing benefit coverages with conservative care options, such as massage therapy, chiropractic and acupuncture, first for back pain that may include lower copays and deductibles to drive down health care costs and time spent out of the office. The data is showing if a person with back pain sees a chiropractor first they're 50 percent less likely to have surgery and 21 percent less likely to take opioids. So if we do end up in a recession, we have cost effective options available to employees.

Jones: Recession or not, the health industry will continue to experience disruption because of emerging technologies and should embrace new ideas to reduce patient costs. For example, imagine a health care system that's so good, you might not need to go to the hospital. I think the types of services patients can now use to safely monitor their health and receive services at home will continue to rapidly evolve and grow, especially as hospitals look at how they drive efficiency and reduce operating costs.

Chapman: Potentially this could lead to even better care, because whether it's a geriatric or a pediatric patient, there is a lot of disruption when moving someone from their home environment to an acute care setting and back again. Hopefully we can move in that direction.

Hinz: From an employer perspective, during the recession, it became less about attraction and retention and more about doing whatever was necessary to keep the business open. Fast forward to 2020 and it's really all about designing a benefit plan that keeps deductibles and premiums at a manageable level. It's really a balancing act between cost and employee satisfaction. High-deductible plans have made it hard for employees to afford care when it's necessary and it's also made it more confusing as ever since many employees feel like they're paying all these premiums out of

MODERATOR

Frank Jaskulke
Medical Alley Association

Frank Jaskulke is vice president of intelligence at Medical Alley Association. He started his career on the bioscience committee of the Minnesota House of Representatives before joining Medical Alley in 2005. His education includes a Bachelor of Arts and master's degree in political science, both from the University of Minnesota system, with focuses in technology policy and American Indian governmental relations. In his free time he likes to be a contrarian, read, and play with his two cats, Astra and Zeneca.

PANELISTS

Michael Jones
Accenture

Michael Jones is a managing director for Accenture's health and public service practice where he leads the provider consulting market for Minnesota and Wisconsin. He brings over 26 years of experience in corporate health care as a chief information officer and chief technology officer working in the payer, pharmacy benefit manager and health services sectors. He holds a Bachelor of Science in engineering from Iowa State University and an MBA from the University of Texas McCombs School of Business where he was a consortium for graduate study in management fellowship recipient.

Matt Wolf
RSM

Matt Wolf is a director and senior health care analyst with RSM's national health care practice. He has 10 years of business valuation experience and leads the national health care business valuation consulting team. His senior analyst responsibilities include advising the firm's health care clients and client servers as they work to navigate the rapidly changing industry environment. With respect to business valuation, he and his team have provided valuation advisory services for a variety of purposes, including buy and sell-side management planning and financial reporting.

Erik Hinz
Horton Benefit Solutions

With over 20 years of experience providing advisory and consulting services to employers in the Minnesota market, Erik Hinz has served a wide variety of companies ranging from large national entities to small, family-owned businesses. As one of Horton Benefit Solution's advisers, he comes from the employer health care purchasing side, which ultimately leads to his helping these companies employees navigate the complex world of health care. He joined Horton in 2019 and is working to disrupt the Minnesota group insurance market.

Deb Zurcher
Fulcrum Health

Deb Zurcher has been a licensed acupuncturist since 2012 and has over 20 years of chiropractic clinical experience, as well as 16 years as a business owner. In 2003, she founded Eagle Creek Wellness Center in Prior Lake. Her previous roles include liaison faculty in the clinical ed department at Northwestern Health Sciences University, self-management skills guide then operations manager at MOBE. She graduated from Northwestern Health Sciences University with a Doctor of Chiropractic and a master's in acupuncture. She earned a Bachelor of Arts from Gustavus Adolphus College.

Dr. Emily Chapman
Children's Minnesota

Dr. Emily Chapman is chief medical officer at Children's Minnesota, where she oversees quality and safety and education and research. She continues clinical practice as a pediatric hospitalist in the Children's Hospital Medicine Program, which she led for six years through its development and expansion. Additionally, she has served as associate director of medical education at Children's. She trained at Dartmouth Medical School and the University of Minnesota. After residency, she practiced general pediatrics as an owner and president of the Wayzata Children's Clinic.

Erik Hinz, Horton Benefit Solutions

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their paycheck and don't really have any coverage until that big deductible is met.

Wolf: One thing we can say with some confidence about the forthcoming down cycle is that it almost certainly won't be as bad as the Great Recession. The Great Recession was seven to nine standard deviations away from typical economic activity.

Jaskulke: One of the consequences of this 10 years of consistent growth, we have an unemployment rate that's the lowest it's ever been. Has it gotten harder to find and keep doctors, nurses and frontline staff?

Chapman: We certainly know that we're not training enough of any of the above. And we also have a dramatically aging workforce. So how do we expose young and diverse people to different medical jobs? Young people might already be exposed to career possibilities as physicians, for example, but what's more difficult is getting them interested in positions like operating room technicians or RNs with certain specialties, where there aren't enough workers being trained. In Minnesota, we have a very diverse population, and we know that in health care we are not representing our population with our workforce. So how do we partner with communities or schools, for example, to try to get more young people, particularly those from diverse communities, interested in these fields?

Jones: Those are excellent points. We just finished our annual digital health technology vision, and one of the data points said 43 percent of executives believe that over 60 percent of their workforce will have new jobs and new roles in less than three years. This is a monumental challenge for organizations to figure out. How do you prepare people in your organization with the skills required for these new roles let alone the new technologies they will need to use to do their jobs? Also, how do you use this as an opportunity to attract and retain a diverse and future workforce more representative of the broader community? Finally, how do you ensure continuous learning between your current and future workforce so they both grow and advance successfully?

Chapman: Medicine is increasingly a team sport, and we need to bring more visibility to the different roles on a health care team. Over time, we anticipate that the MD will be less and less critical to the delivery of care, so how do we attract people to other health care roles?

Zurcher: That's right. We are seeing this in the providers we represent. An increased demand for noninvasive, conservative options for pain management such as chiropractors, massage therapists and acupuncturists within hospital systems, which emphasizes the team approach. However, figuring out how to pay for this model is a challenge in small clinics.

Jaskulke: It seems like Children's is making a concerted effort at diversifying its workforce. What are the consequences if we don't figure that out?

Chapman: We have a population of patients who are about 50 percent people of color, while our workforce has about 20 percent people of color. We are disproportionately white in our care delivery teams and the fear we have is that we will fail to partner effectively to understand and address the needs of a family or a community in such a way that alienates them from a health care system that is right in their neighborhood. The consequences of that are catastrophic. Mistrust in health care can lead to low immunization rates among certain populations, which leads to devastating illnesses in those communities. That is a failure on the part of the health care system.

I think we are overlooking a tremendous pool of talent by not diversifying our work force. We need to garner interest in health care among people who demonstrate passion in different communities, individuals who might be the first member of their family to pursue higher education, for example. Then we also face the challenge of ensuring that health care is a safe, welcoming place for their career.

Hinz: Just yesterday I was talking to a contact in rural central Minnesota – a 100-person manufacturing firm – that is really struggling to fill $20 to $25 per hour skilled labor positions. If this company doesn't figure out

a way to tap into different populations – old, young, nonwhite – that's full of really good talent, they might not be in business a year from now. It's that critical of an issue, which means they need to really re-work their entire company culture in order to be a more inclusive workforce, because they can't fill orders today. And that is a story that just doesn't end well for them if they don't get better at finding talent.

Zurcher: Well, isn't it the culture of, because every kid today is told that you have to go to college to be anything. In that case, do you need to go to college to be happy in a great job? It's almost like, really getting into the communities at a very young age to establish, what are your gifts and how can we expand on those? It's really true. You don't know the door could be opened if you don't know there's a door.

Jones: You see young kids increasingly not buying into the "go to college so you can be something and do something and have a successful career" concept – maybe in part due to their heightened awareness of student debt. I think we need to get much more creative on what is needed to be prepared for the jobs we need to fill. We also need to reach out and select them in creative ways. There's a former client of ours who used gamification for hiring. It has totally transformed how they look at, recruit and select talent. They also reduced their recruiting cycle from four months to four weeks.

Wolf: That's part of the appeal of digital technology. It will lower hierarchies to where a young person can become accretive and valuable to an organization without even going to college. Maybe in the future, maybe not physicians, but there are areas in health care delivery, front office, back office, wherever, where that kind of atypical career path could be a great way to access traditionally underrepresented communities.

Jaskulke: What does this idea of convergence mean in health care?

Jones: This term is being thrown around a lot, and it means the coming together of different industry sectors like traditional health care organizations – anyone who delivers health plans, health services – and nontraditional players like 3M, Best Buy, Walmart, Google, Apple and Amazon. This second group has data on customers who may trust them more than they trust the health care system. They can take that data, mine it and tell their customers all kinds of interesting information about them as a consumer, as a patient, as a caregiver – and then structure it in a way for them to manage and monitor their information independent of a system they may not trust. That's a shot across the bow for traditional health care, and it is causing major ripples.

Jaskulke: I want to turn to the provider and payer side. How is that playing out in your world?

Hinz: In many instances, we're talking with employers about things completely out of the box such as going direct to providers for their employee care. Logistics and compliance are issues and there are a lot of moving parts, but paying a capitated fee directly to the provider and being able to have your employee and their dependents get all their primary care done at that provider for that capitated fee is a very attractive option. Pulling it off is challenging but can be done with the right partners. In the end, this all leads us into the consumerism question. In 2003, we said that HSAs would force employees to be better shoppers, and I don't really believe that's played out the way we thought it was going to. We don't buy health care the way we do a TV from Amazon.

Wolf: Not yet.

Hinz: If I've got a 200-person manufacturing firm in St. Paul that has a really high-quality primary care clinic down the street, it makes a lot of sense to go to that clinic and see if they have a doc or physician's assistant who our employees can visit with anytime they want for no-cost primary care. That sure feels a lot better to the employee than a high deductible, and everything I'm seeing says we can pull it off on the employer side for a much lower cost and even higher quality and better outcomes.

Chapman: The other impact that technology has had is that it's allowed us to spread our resources across a broader geographic area. For instance, at Children's we are now doing essentially a telehealth neonatal resuscitation. So you have a newborn who drops in the lap of a care team in a hospital that's not necessarily prepared for the complexity or the prematurity of that infant. If we have set up a telehealth relationship, we can walk that team through that neonatal resuscitation and stabilization and get that patient transferred or, better yet, identify that that patient can be cared for where they are and not be moved.

Wolf: The demographics are such that we're not producing enough people do all these jobs. Hopefully health care costs will go down but the demand will still be there, so the only way to hopefully bridge that gap will be technology. We need to be able to scale that expertise and allow providers to focus on what they're best at.

Jaskulke: What's been your opinion of the reaction or uptake for augmented or virtual reality in health care? Is it showing up?

Chapman: Pediatrics is a little unique, because adults may adopt virtual care for their own health needs, but they prefer treatment in person for their child. Our outreach through telehealth has been somewhat muted relative to what we were hoping for, because parents want to be face-to-face when dealing with complex conditions.

We have, however, had success in applying telehealth for clinical follow-up across a number of service lines, including eating disorders, pain and palliative, sleep, diabetes, immunology, genetics, psychiatry, and psychology. We have also had luck applying it to things like the telehealth resuscitation I mentioned before.

Wolf: I consider myself an elder millennial and virtual care is just fine for my kids. I remember a time before the internet and I am very pleased to FaceTime when they have a runny nose and someone's like, "We've got to take them to urgent care!" No, it's just fine, look at the PA on my phone. [laughter]

Jones: We see numerous providers experiment with augmented reality goggles. You can use these goggles to determine a patient's pathology by looking beneath the layer of skin to examine muscle, tissue structure, skeletal structure, and determine if there's any type of integrity loss or something wrong with the patient.

Chapman: It's incredible what kinds of things can be done through technology. The advent of 3D printing, for example, has given us the ability to replicate the human body, to identify the pathology and map out a surgical approach before even going to the patient.

Jones: 3D printing definitely is used quite a bit and not just for surgeries, but also as a training tool.

Chapman: Absolutely. And for device management

Hinz: At the end of the day, if you really think about it, medical care is really one of the only services we as consumers purchase where we don't know the cost before we buy it. Anything that technology can do to improve that is going to be a good thing.

Jaskulke: What's the group's view of how genetic testing is advancing or not advancing health care?

Wolf: My maybe cynical view is that people create self-fulfilling feedback loops and it ends up with a bad outcome. New York City used big data to redeploy its police, and figure out where the problem areas are where they needed to send police. Then the data they got was collected by police who went to the areas it told them to go to. Well, this just reinforces the idea that this is where the crime is, so it keeps sending police there! There's no feedback loop to re-evaluate if we are looking at the right proxies that mean good policing, do we need to re-evaluate the model.

From left, Matt Wolf, RSM; Dr. Emily Chapman, Children's Minnesota; Michael Jones, Accenture; Deb Zurcher, Fulcrum Health; Frank Jaskulke, Medical Alley Association; and Erik Hinz, Horton Benefit Solutions

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Zurcher: Genetic testing has the potential to advance care but is not the sole solution; it's just a piece of the puzzle. With chronic conditions, patients may not be sure where to go to find the help they need with the information they have. The patient needs to be engaged in their health in partnership with their physician.

Jones: There are some fantastic implications to genetic testing. The ethical responsibility is also enormous. What if a provider said, "We can do a test but we can get more money if we do another test instead?" Would that happen? I don't know. But people are going to be skeptical. What if genetic testing information is available to a health plan and there are members in the plan who are predisposed to hypertension or heart disease. A health plan could, hypothetically, increase their coverage rates three times the normal amount based on understanding a member's risk profile – or even deny them coverage altogether! This scenario highlights the ethical responsibility that the health care industry must reconcile as a result of having and using advanced genetic testing for various reasons.

Jaskulke: Deb, you talked about conservative care and cost containment [for employers]. Are these sort of pressures creating greater interest or opportunity for what Fulcrum's doing?

Zurcher: Yes, we are seeing more demand delivering a high-quality network with our programs to help people get to appropriate care. As a non-profit and in fulfillment of our mission, we showcase the great work that chiropractors, acupuncturists, massage therapists are doing, which drives costs down. Our Centers of Excellence Program is designed to recognize clinics that use standardized clinical protocols and an integrated, collaborative approach in achieving positive outcomes and improved quality of life for patients. Our network is a multiyear recipient of the Press Ganey award, which means it's above 95th percentile of patients loving who they're seeing. So, when you're with an employer group, manufacturing for example, and can give employees easy, quick access to conservative care and reduce the need to have back surgery, it's amazing. Plus, you have this network of quality providers people can go to that will keep people in the workplace. Maybe on-site, close to their house, maybe in neighborhoods that need the care, because these providers are part of the communities.

Jaskulke: We've had some new entrants in the health insurance market. What's the impact?

Hinz: More competition is overall a very good thing. I think for the most part the most positive thing it has brought so far is that the incumbents that have been in the market for a long time have been force to sharpen their pencils and take care of their current block of business better. There has always been a bit of complacency in that we were really limited to three to four major players for most employers. Looking forward into the future, with six good carriers in the market, it feels like the increased competition is going to force innovation in products offered. Companies that were forced to have a fully insured plan in the past for example, undoubtedly now have more options then they've been used to. If you're an employer and you're not looking at different ways to finance your health plan, you're missing out. There are a lot of great new ideas out there that are new and different.

Jaskulke: There's been a lot going on in the employer-sponsored, self-funded groups. What are some of the more unique things they're doing to put together plans that solve for cost and low unemployment and still trying to keep employees happy and healthy?

Hinz: Employers need to be open to considering nontraditional ways to solve the health care puzzle. Direct primary care, direct contracting, reference-based pricing, carved out stop loss, carved out pharmacy – all of these are coming to this market if not already here in one form or another. Many of the tools that have only been available to jumbo employers in the past are now available and/or are becoming available to companies in the middle-market space.

Jaskulke: We've seen medication shortages in the past couple of years. How is that impacting care today?

Chapman: We certainly have been struggling with this. Being a first-world country and having the kind of health care spend we have, you make the assumption that this isn't going to happen. We assume that you're not going to have a patient in a hospital and real-

Michael Jones and Matt Wolf during the discussion

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ize that you have two vials of medication left on the shelf and they're both dependent on it.

There's been consolidation of manufacturers, and when something goes from a branded med to a generic, the margin really goes away for that company. So we are vulnerable to companies deciding not to manufacture what's now a low-margin medication for them. I think it's yet another example of the broken-ness of our system.

We went through a period of time when we couldn't get bags of normal saline! There's no profit there. Part of this challenge is identifying the different constituencies and understanding their motivations.

Wolf: We look at what's going on on the various fronts of the trade war, and saline, all these other medically necessary ingredients are exempted from the current tariffs. And even if they were taxed, people would still buy them if they were available. But 70 percent of active pharmaceutical ingredients used in the United States are manufactured in China. So if there was some actual flow disruption, it's incredible how that could metastasize throughout the industry. It's scary. We're watching that too, and hopefully it never happens.