Elliot Joseph

EDITORS' NOTE *Elliot Joseph is President and Chief Executive Officer of Hartford HealthCare (HHC). In addition, he hosts a monthly radio show,* HealthCare Matters, *which focuses on current health care issues. Prior to his arrival at Hartford, Joseph served as President and Chief Executive Officer of St. John Health (SJH), a $1.8-billion Southeast Michigan health care system. Joseph earned a master's degree in health services administration from the University of Michigan in Ann Arbor and a Bachelor of Science from the State University of New York at Binghamton. He is an alumnus of the Wharton CEO Program for Healthcare Leadership. Joseph is a member of the Connecticut Hospital Association Board of Trustees and chairs the Finance Committee. He also is a member of the Greater New York Hospital Association Board of Governors, the MetroHartford Alliance Board of Directors, and The Bushnell Performing Arts Center Board of Trustees.*

INSTITUTION BRIEF *Hartford HealthCare (www.hartfordhealthcare.org; HHC) aspires to be the next generation of integrated health systems, marked by strong patient focus, heightened efficiency, consistent quality performance, and open and collaborative sharing of best practices. It is dedicated to providing patients with an exceptional, coordinated care experience and a single, high standard of service. A hallmark of HHC's vision is to strengthen access to care close to home for patients by enhancing local health care delivery capabilities. In addition, HHC aims to create a culture and organizational structure where clinical care, education, and research are supported to bring the latest technology and discoveries, clinical excellence, and innovation to the patient and community. With more than 15,600 employees and $2 billion in net revenue, HHC's partners include a tertiary care teaching hospital, three community hospitals, two regional behavioral health centers, a statewide clinical laboratory operation, a large primary care physician practice group, a regional home care system, senior living services, and a physical therapy and rehabilitation network.*

Are you optimistic that we're achieving the type of health care transformation that is necessary today?

I do feel that we're on the first wave of profound sustainable change. Transparency of clinical outcomes and prices coupled with economic incentives encouraging consumerism are leading all purchasers of care toward this transformation.

There is no question that with the spread of electronic health records and data analytics and informatics, it's profoundly different now.

There is a lot of talk about organizations navigating from where they are today to where they want to be. We know that we need to get from point A to point B but are we being thoughtful about how to construct this transformation?

There are a few pieces of the puzzle that I have paid attention to as we have thought about how we're going to make a leap: one is, how we spend our capital.

When I first arrived at this job, the board had a blueprint to build a new tower at our major tertiary facility for $300-plus million. Five years later, we haven't built it, and in the meantime, all of our competitors have spent millions building new towers.

So we took a risk that we would be at a competitive disadvantage on the inpatient side but felt that we should hold our powder dry for other types of capital investments to make this transition.

Over the past five years, we have gone from a billion-dollar organization to $2.4 billion. It's debatable whether that is big enough, but it has given us a pathway to deal with the cost structure piece.

In terms of scale, so much of that is picking the right partners with a common vision. We have talked to a lot of potential partners about joining us and we have attracted some strong organizations that share a common view.

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One CEO I spoke with said that there is a rush to scale going on. He sees people acquiring more acute care and becoming distracted by big M&A as opposed to doing work to transform care delivered to populations and fundamentally reducing the amount of acute care we need. Do you think the urge to scale might be a significant distraction?

I agree. When we were at $1 billion and looking at our marketplace, I did say that I thought we had to get to $3 billion. But fundamentally, scale for scale's sake is a losing game, and only when you can find partners in the right geographies with a common point of view about the future who are willing to cross that chasm does scale make sense.

If we go inside successful models, the acute care goes down but we need more post-acute care, be it home health, palliative, hospice or skilled nursing. Is this being addressed, in terms of where the new capacity needs to be built and how?

A couple of thoughts on the capacity and payer side, because you can't have one without the other in terms of making this move.

One of the bets I'm making here is on home care. We're purposely building scale in our home care network. We have brought probably four or five into the fold and it's like in a lot of other states – many small and fragmented providers currently dot the landscape.

I believe that this is where it's all going – the majority is going to the home, and with all of the technology on the horizon, our ability to aggregate that part of the market so we can manage care from the home rather than the hospital bed is an essential shift for us.

The problem is that home care right now is not a strong business model, so it feels like walking a tightrope as we continue to build our network.

Do you have to transform the business model?

Yes, and change the way we get paid for it because it's a totally commoditized business, particularly in Connecticut. We're making a big play in that arena.

Another piece is, through our affiliates, we now own and operate five skilled nursing facilities and assisted living centers. This is an important part of the continuum and we need to determine whether it's our own or a partner strategy. We're making a big move in the post-hospital marketplace.

Today, most of your profit contribution is coming out of the commercial business on a fee-for-service basis. I'm starting to hear, "Maybe I can keep my commercial fee-for-service margin undisturbed in the short run, and I can convert senior or dual-eligible (Medicare and Medicaid) populations, with whom today I am breaking even or losing, to capitated risk." Where do you start to take risk and how do you sequence your efforts?

I have said to our boards and medical staff that we have to come to terms with the fact that our current business model is disintegrating for several reasons: 50 percent of our revenue comes from the government and they're dramatically decreasing that; the other 50 percent more or less comes from commercial insurers, and we used to make up that loss on cost shift, which is now gone because of exchanges and high deductible plans; and the demand for the core business, inpatient care, is declining.

We are proactively building the capability to provide more effective care to the high utilizers of inpatient care.

A lot of people think population health can only be done in a managed care/HMO/fully attributed way, but if the whole population is going to tree hug PPO and freedom, you're not going to get a wholesale movement of the commercial population into this new formation overnight. There will need to be a lot of behavior change ahead in terms of consumer preference.

Yes. I can see the look in people's eyes when I suggest that fee-for-service medicine is a barrier to the changes we need. We must build a payment system that preserves choice while incenting people to choose wisely. ●