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THE NEXT HEALTHCARE

A WEBINAR FOR SUNTRUST PRIVATE WEALTH MANAGEMENT

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Turbulence and Fluidity

Healthcare has never been in as fluid a state as it is in this precise moment, in the midst of the great healthcare reform debate of 2009. Yet a number of emerging trends allow us to make some reasonable speculation about the future of healthcare, and especially of the future of specialty medical practice, that are not particularly dependent upon the exact details of the current reform.

First we will imagine a trip to a future 10 to 15 years out, and then we will come back to the present, to ask what elements of our current situation are likely to lead to this future.

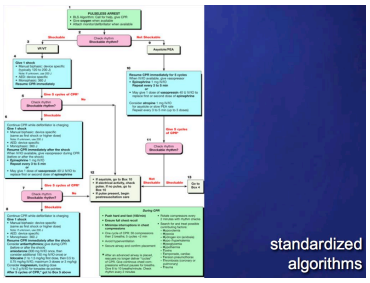
Ten to Fifteen Years Out

Many business models

The most striking thing any practitioner of today might see in a visit to the future would be the proliferation of different business models under which practitioners work. These might include a large specialty hospitals ("solution shops") similar in concept to today's M.D. Anderson in Texas for cancer, or National Jewish in Denver for pulmonary disease. There may be many specialized "hospitals-within-hospitals" joint ventured between healthcare systems and groups of doctors, as well as facilitated patient networks similar to PatientsLikeMe.com, as well as many other business shapes. Many of these models are adapted to particular disease areas or life stages, such as diabetes, cancer, mothers and children, or end-stage multiple-system chronic disease. Today's most common model, the straight fee-for-service individual or group-practice provider, is much less common, as is the general hospital ("We do everything for everyone all the time").

Many business models

Teams



Standardized algorithms

Teams

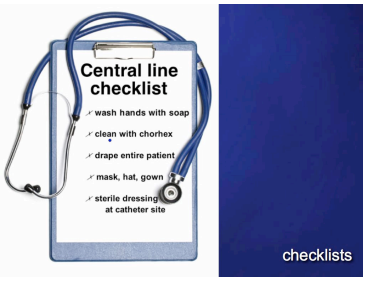
Most practitioners in this future work in multi-disciplinary teams of one kind or another, "integrated practice units"[1] focused on disease areas rather than specialties. A diabetes team, for instance, might include not only the primary care physician for each case and an endocrinologist, but a nephrologist, an ophthalmologist, a podiatrist, a dentist, a diabetes educator, a diabetes nutritionist, and a social worker or psychologist. As a seamless and ordinary part of business, these teams work to improve both their clinical outcomes and the efficiency of their work practices.

Standardization

A great deal of work has been done to pull out what in each specialty actually can be standardized, and what depends on the judgment, intuition, experience, and advanced training of the individual practitioner. Common procedures like putting in a central line are standardized, and tracked by simple checklists. Even more complex and vari-

[1] M Porter, E Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results*, Harvard Business School Press, 2006

able procedural areas such as emergency departments and surgical suites are governed by common, evidence-based clinical baselines, such as giving the patient a perioperative antibiotic, and checking the procedure against the medical record.[2]



Checklists

Digitization and Automation

Transparency

Teams

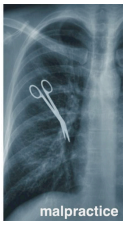
Everything is digitized, from clinical to administrative. Everything that can be automated is automated. Clinicians can see the records in ways that are most useful to them (longitudinal changes, for instance, comparative statistics over multiple encounters, comparisons with similar patients). Patients can see the records in ways that they can understand, system managers in ways that help them see what is working efficiently and effectively, and what might need intervention.

Transparency

A "Healthcare SEC" law forces all providers and payers to publish a standard set of relevant facts. Hospitals have to publish infection rates, for instance, as well as outcomes data for all common procedures. All payers have to publish their medical loss ratio, their payment rates in all markets, rates of rescission (rescinded contracts) and denial of claims.

Malpractice

Such efforts have greatly improved clinical quality. "Never events," drug mistakes, wrong patient or wrong site operations, all kinds of "medical misadventures" are far more rare, and malpractice suits have become much less of concern, due to such standardization, teams, "lean" process improvement, and the transparency and accountability of better medical records.



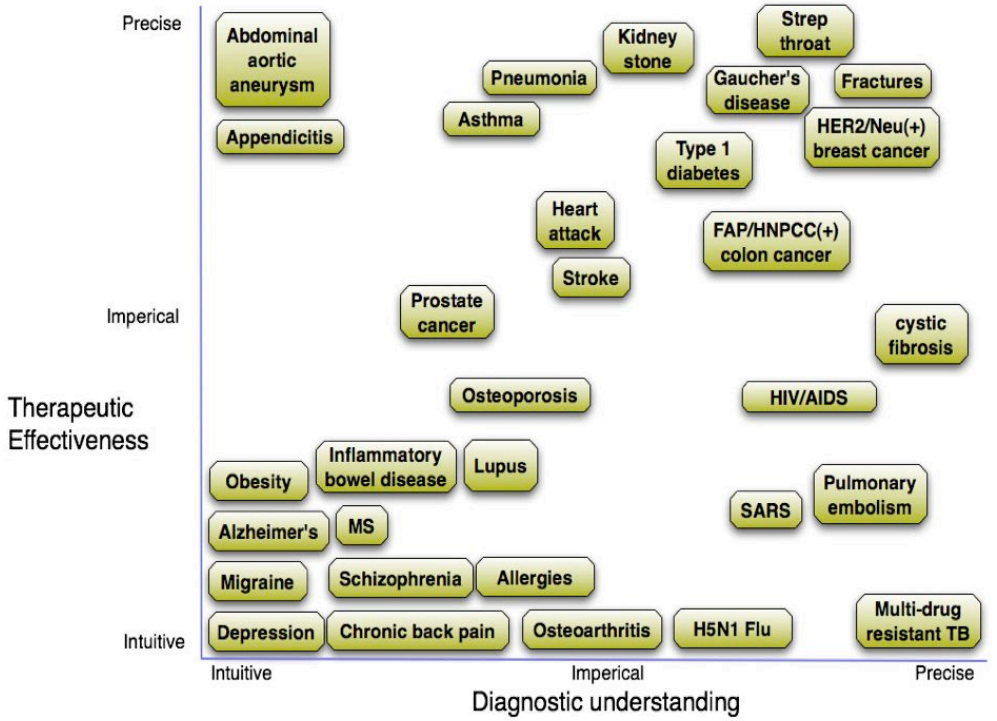
Payment systems

Reformed payment systems (and changes in the Stark Laws) have helped providers tease apart different business models. Take a look at this chart, adapted from Clayton Christensen and his co-authors in *The Innovator's Prescription*.[3] They have arranged various conditions from left to right according to whether diagnosis is uncertain, depending on intuition and trial-and-error, or precise, subject to exact testing algorithms. Similarly, they have arranged conditions from bottom to top according to whether the therapy is based on intuition, or is a known, tested pathway. (The conditions and their positions on the chart are just for illustration of an idea, and may not be completely accurate.) So in the lower left corner, we find conditions for which there are many variables, for which no fully satisfactory and precise diagnostic and therapeutic paths have yet been worked out, and for which the outcome is uncertain, such as de-

[2] AB Haynes et al., N Engl J Med 2009;360:491-9, January 29, 2009, "A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population"

[3] CM Christensen, JH Grossman, MD, J Hwang MD, *The Innovator's Prescription: A Disruptive Solution for Healthcare*, McGraw-Hill 2009

pression and Alzheimer's disease. We might consider this the realm of "intuitive medicine." This area, they argue, will always be paid fee-for-service, since no outcome can be guaranteed. Other conditions, such as (to take a few simple examples from the upper right corner) strep throat, a simple fracture, a vaccination, an uncomplicated birth, a kidney stone, allow little argument about a diagnostic or therapeutic pathway, and the outcome is fairly predictable. These could now be considered "precision medicine." They can be packaged, and sold as "fee-for-outcome," with published prices ("Here is the price for a total hip package, diagnosis to rehab.") and warranties ("If we have to correct some problem in the 90 days after the surgery, if you have to be re-admitted because of a wound infection, for instance, the correction is on us.").

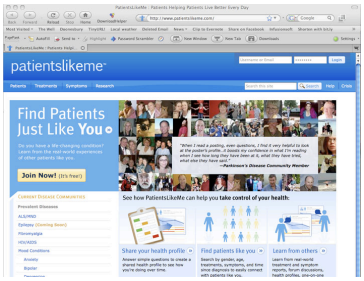


Source: *The Innovator's Prescription: A Disruptive Solution for Health Care*, by Christensen, Grossman, and Hwang (McGraw-Hill 2009)

Over time, as we discover more, conditions tend to move from the area of intuitive medicine more toward precision medicine (ulcers being a prime example).

Bundle, price, warranty

Getting paid



Patient networks

Getting paid

The ways doctors actually make money in this future is far more varied than today. A given doctor, for instance, may participate in a joint venture surgi-center, may be on a specialized team paid through micro-capped subscriptions (such as a diabetes or COPD team), and may advise a network of patients. Yet, compared to today, actual payment is relatively automatic and frictionless, deriving directly from digitized patient records. Arguing with payers, appeals, pre-authorizations, all are things of the past. Not that payers are passive – but they drive toward good medical value through feedback built into the payment system that pays highly for good outcomes based on appropriate, conservative, evidence-based, quality-driven medicine.

Patient networks

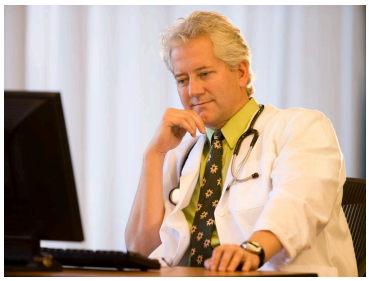
Some specialists spend some or all of their time advising facilitated patient networks, for groups of patients dealing with managing chronic or genetic disease. For conditions which require considerable patients management, patients can often get the most value from communities of "patients like me" advised by a knowledgeable specialist. Such networks would be based on a fee-for-membership or fee-for-transaction model (when members buy care items (medicines, devices, appliances, or supplies) through the network.

Hand-offs

Many specific procedures and diagnostics have been so simplified and standardized (and embodied in inexpensive, easy-to-use technologies) that they have migrated down the medical hierarchy, from specialists to generalists, or to clinic nurses, home health nurses, or even to the patients and their families. Specialists have tended to migrate upward, spending their time, judgment, and expertise on the more intractable conditions.

Primary


Home


Work and income

Work and income

Despite all these changes (hand-offs down the hierarchy, digitization, teams), there is plenty of work (and income) for everyone because of changing demographics. Steadily increasing medical capacity (we can do more things for people), the aging of the baby boom (we have more people in the age group that needs the most medical attention), and

universal coverage (more of the population has easy access to healthcare), coupled with a fall in the number of clinicians (at the very time we need a rise) and a mis-allocation among specialties and geographic areas means that, though many people have had to make career adjustments, you can still make a good living as a medical specialist

What's Happening Now

This could all sound a bit utopian, but it is based on the realities of where we find ourselves at the moment. We will know much more about the shape of reform efforts, and how they effect us as an industry and as individuals, as summer moves into the fall. But beyond the movement toward reform, and underlying it, are several trends that will shape our future no matter the exact shape of reform.

Crisis

Half of the hospitals in the country are in the red. Hospitals are closing at a higher rate than ever. In the current economic crisis, hospitals and health networks can expect, and are already experiencing, this financial environment:

- The number of uninsured rise, and therefore so do bad debt and charity care.
- Co-pays rise, and so more patients skip treatments or necessary medicines because they have to put gas in the truck to get to work, or pay the rent, or buy heating oil.
- Therefore the number of people showing up in the ED with untreated chronic disease (in diabetic shock, or in asthmatic spasms, or in AMI from untreated high blood pressure) goes up dramatically.
- Health plans become even less reliable payers. Some may even fail, while holding millions of dollars of bills.
- Federal reimbursement rates fall further behind private rates, and may even fall in real terms.
- States, constrained by constitutional requirements to balance budgets, severely cut Medicaid and other state healthcare payments
- Accounts receivable both age and decay.
- Bond markets stay unresponsive.
- Endowment and foundation investments stay depressed in value over a long period, due not just to the skittishness of the market, but because the fundamentals of the companies they have invested in have decayed.
- For the same reasons, donations fall off dramatically.
- Suppliers become less reliable; some fail.
- Local governments put their hands out for greater payments in lieu of taxes.
- Profit centers become not-for-profit centers.
- Under the same financial pressures, some competing institutions fail, leaving the survivors to absorb the (often non-paying) volume.

Half the hospitals

Half the doctors

Half the nurses

These are not temporary conditions. They are likely to pertain for at least the next few years. Reform may bring insurance to more Americans, meaning that, once it is fully implemented (which may take a year or two), more of their

customers can pay for their services. On the other hand, reform is not expected to bring in massive infusions of new cash.

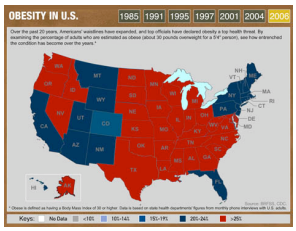
These short-to-medium-term financial constraints are exacerbated by such long-term, unsolved problems as:

- The supply of physicians, especially primary-care physicians, is actually trending downward at the very time we need many more of them. In a recent Physicians Foundation survey,[4] 53% of responding doctors said that within the next three years they want to cut back on hours or on patients, or leave the field entirely. At the same time, the current financial crisis is likely to make physicians more malleable about their future plans, and more willing to look at new business models.
- One-quarter of all RNs in the United States have left the profession, and another quarter have left front-line nursing work, because the job has become so onerous.

Demographics

Baby boomers are just hitting the ages when they will become far more major consumers of healthcare.

Chronic disease



Chronic disease, which is estimated to be the root of some 75% of the costs of U.S. healthcare, is on a long upward trend. One marker of this future might be seen in the growth of obesity, with some third of all Americans by 2006 registering a body mass index higher than 30. In this small picture, the red states are those with more than 25% of the population with a BMI over 30. Systemically, what is important to note that our healthcare system is not set up to deal with chronic, maintenance, and preventive problems; both the payment system and the expectations of practice are set up to deal with acute episodes.

Awareness of waste

Payers, regulators, legislators at the state and federal level, and even the public are becoming more clearly aware that the current system generates an enormous amount of waste. President Obama was so impressed with a major article by Atul Gawande, M.D., in the June 1 *New Yorker*[5] on why healthcare costs so much that he made it required reading in the White House, and has been passing it out to senators and representatives. The Gawande article and many others refer to numerous studies, the most compelling by the Dartmouth Group on Healthcare, that point to a 60% per capita, per year, and per case cost differential between such areas as Miami and places like Minneapolis, with no difference in outcomes - even when the study controls for cost of living, ethnicity, age, acuity, socioeconomic level, and so forth. If all locales managed to do healthcare they way they do it in less expensive parts of the country, the average savings would be about 30%. This year that would amount to $750 billion. Such savings would be large enough not only to pay for health care for all Americans, we could line up all the countries in the world, excuse the other top 10 healthcare spenders, and pay for healthcare for the entire rest of the world, at the rates they are now spending, with what we saved in the U.S.

There are two significant factors to consider in the spreading of this awareness:

- This is not a liberal or conservative issue. Though they do not know exactly what to do about it, both sides of the aisle are fairly energized by the idea that healthcare is wasteful, and should be reined in.

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[4] www.PhysiciansFoundation.org: *"The Physicians' Perspective: Medical Practice in 2008"*

[5] A Gawande, "The Cost Conundrum: What a Texas town can teach us about health care," *The New Yorker,* June 1, 2009

• The studies pin down the cause of the extra spending: The areas that spend more per patient do more per patient, because they have more resources to throw at each case, especially imaging centers and specialists. This turns traditional economic theory on its head - in healthcare, supply seems to drive demand. So we can imagine and expect brute-force legislation and regulations aimed at cutting back on these perceived "extra" resources - such as specialists.

Deficit reduction vs. health care reform

Since the election, there have been three camps within Obama's team. The reform hawks were led by former Senator Tom Daschle (and other people he brought into the administration. Their mantra has been: We must have health care reform, period. The deficit hawks are led by Joe Biden, saying: We must get the economy under control and bring down the deficit before we can take on health care reform. The third point of view, led by Budget Director Peter Orszag and his health care adviser Dr. Ezekiel Emanuel (Rahm's older brother), is informed by the Dartmouth studies. They say: health care reform equals deficit reform. They view bringing down health care costs as nothing less than the key to the future of the American economy. This point of view, while not much talked about on the talk shows or in the headlines, is central to Obama's view of reform, and may become the most important driver of health care policy over the next few years.

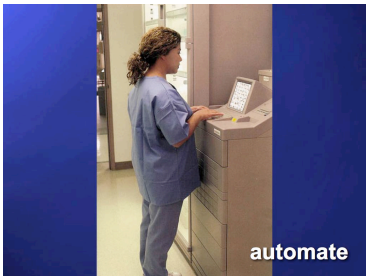
Tom Daschle, reform hawk

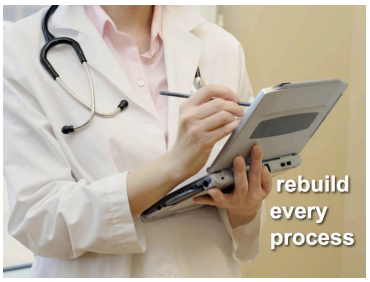
Joe Biden, deficit hawk

Peter Orszag

Process improvement

The first level of our response to this must be process improvement: Doing what we do now better, faster, cheaper. The first step is digitization. Besides all the usual reasons adduced in support of digitization, the reality is that you can improve a system's processes if you don't know what they are. Healthcare is far too complex to track on paper. Digitization gives providers the ability to track outcomes and processes to a fine level of detail, to improve clinical quality and reduce costs.





The second level is automation, the way airlines have automated buying a ticket and banks have automated tellers. Lots of processes in healthcare would be done much better and cheaper by machine, and should be.

The third level is to use "lean" management techniques to rebuild every process in healthcare, allowing those who are actually involved in each process to find ways to do it better and cheaper.

Value

But process improvement will not get us where we need to go. Healthcare over the coming years will be increasingly driven by the "Value Question," the kind of questions you confront every time you buy a shirt, a latte, or a stock: "How good is this thing? How much will it cost? To be specific, how much will it cost me? How much it will it cost me, really? How much will the whole thing cost me? What are my alternatives?" Under our usual business models and payment structures, and without any way to get real information, most of those questions are unanswerable in healthcare. We have few real measures of value, few real prices, and little opportunity to even find out what "the whole thing" we are buying is. And the most common "alternative" is doing nothing.

Business models

To get to the "Value Question," we need new business models. Look back to the graphic on page four, and imagine new business models to support different positions on the graphic. These would include 'solution shops" for the hard but intuitive cases, such as the Cleveland Clinic's various institutes for neurology, cardiovascular diseases, and other areas, which assemble highly skilled multi-specialty teams for individualized support. On the other hand, we can picture "value added process" shops, which do one thing over and over, things for which the diagnosis is certain, the outcome fairly certain, and the clinical pathway definite, reproducible, and improvable, processes like cataract surgery and hip replacement. Here the processes can be packaged, priced, and warrantied. Currently, with the business models of these different kinds of processes (and other processes, such as patient networks) mixed together in one model, it is impossible for any one process to profit from improvement. Separated, they can find their proper value, and mitigate the problem of doing "too much medicine."

Many of these new models - and much about the new environment in general - demand some level of clinical integration. All the examples of higher quality and lower cost being bruited about in the debate (such as Kaiser, Mayo, Cleveland Clinic, Geisinger, and Intermountain) have one significant clinical integration. But there are many models already in existence (and others no one has tried yet) for the level and type of business integration beyond the clinical integration. For some things, and in some markets, a fully-integrated Kaiser-style staff-model HMO with its own financing makes sense. In others, joint ventures limited to particular types of operations (such as an ortho clinic) make more sense.

Physicians are striving to find new models of care and new business models, both as alternative ways of making a living and ways to give their patients better value. This exploration and experimentation is likely to accelerate considerably in the coming few years.