Targets for Transformation in the Era of Trump

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An underlying theme for this issue of *Healthcare Transformation* is “It’s So Much More Than Access.” Our guiding principle is that incremental steps cannot disrupt and transform a system. Fixing one problem inevitably creates another. As Congress and the President seek to reform, repeal, replace, or rescue the Affordable Care Act (ACA), the need for systems thinking is acute.

So we asked our editorial board for their priorities for transformation. What they gave us are foundational ideas. These are not quick fixes. They are transformational—from attitudes, education, and business, to who we are as human beings. Our experts come from academia and venture capital, from insurance and education, from technology and clinical care. Here’s their “one thing for Trump.”

Gregory P. Shea, PhD:
Make America healthy again

One thing? A difficult request to honor, given the complexity of our healthcare system and the nature of the identified audience. On the one hand, to pick a single thing runs the risk of feeding our current (and counterproductive) national sport of “whack-a-mole.” On the other hand, to have any hope of reaching the identified audience means connecting to the joy of fighting and the thrill of victory, however defined.

“The Mars shot that would have the biggest impact on the health of Americans is guaranteed same or next-day access to primary care.”

—Katherine A. Schneider, MD, MPhil

First and foremost then, we need to invoke (provoke?) the energy to change. No energy to change means no change—implementation, not ideation, being the measure of change. Hence, in the hope of engendering a “we’re losing” reaction, I’d ask Trump to request that a family member conduct a business analysis of just how uncompetitive we are in providing healthcare for, and enabling healthiness of, our citizenry, generally, and for his key constituencies in particular. Then, with energy to change unleashed, we might have a chance to explore and perhaps even to pursue combination “turnaround” approaches to Make America Healthy Again.

Lisa Suennen: *Change the coverage*

I’d like to see us seriously integrate coverage of, and payment for, services that relate to social determinants of health and which we know to be massive contributors to outcome and cost. For instance, housing issues, nutrition/food access, loneliness (a huge one), and transportation—addressing any or all of these can make the difference between a relatively stable patient and a very sick and costly one.

Loneliness has been documented to have the same deleterious effect on health as smoking 15 cigarettes a day, and yet we don’t screen for it. Access to transportation can make the difference between filling a needed prescription and not doing so. The examples go on and on, and yet we separate these problems from “healthcare” and act as if they are not “healthcare’s” problem. It is such a mistake—we are playing the long game. So actions that recognize the import of these issues for all people, not just select populations, and which drive us toward thinking of patients as people, not illnesses, would be a transformational accomplishment.

**Deanna Wathington, MD, MPH:
*The only race is the human race***

I believe a foundational piece of making healthcare better and sending a strong message to the new administration is upending the patterns from which we are set. As scientists and game changers, physicians should be leading the charge to ensure we are *not* making assumptions and/or transmitting information in a non-scientific manner. We should serve as the role models for the interdisciplinary teams on which we work.

With that in mind, I propose a much more basic change—we need to discontinue the use of racial terminology in how we communicate about patients, whether it is via SOAP notes, our records (hard copy and

Lisa Suennen posted a blog in January, “There Will Never Be a New World Order Unless Women Are Part of It.” She was talking about venture capital, but the same is true of leading the healthcare system: <http://venturevalkyrie.com/there-will-never-be-a-new-world-order-until-women-are-a-part-of-it/>

electronic), or our rounding/team meetings. Race is a social construct, *not* a scientific fact. Biological classification edifies this fact for 12-year-old students in biology class. Yet, we, as clinicians, have yet to move beyond the trappings of our societal myths.

This sounds like a small change. But think about the assumptions and often false beliefs that accompany beginning a SOAP note with “a 54-year-old ‘black’ female” are numerous, add nothing to our scientific assessment of the patient, and work to our detriment as practitioners. In this era of precision medicine, the use of race is also outdated and borders on malpractice. For instance, identifying the 54-year-old patient by race may lead the practitioner to assume the woman has an increased risk of hypertension, but in fact it is *not* her African chromosomal contribution that causes this; it is her life as an American (and all of the social, structural, and environmental determinants she and her predecessors deal with on daily basis) that alters her DNA and predisposes her to such a condition. Even though we are aware of the mountain of evidence, we continue to train our successors in the same “old way.”

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As we look to overhaul medical education and even the selection process of who earns the right to become a physician, let us include within that the correct terminology and ensure we reinforce the scientific process. Let us rise above as we are obligated to do. The human race: that is who we treat, care for, operate on, and heal.

Joseph Charles Kvedar, MD:
Bringing health home

I see resistance coming from hospitals as we give them opportunities to keep patients healthy in non-hospital settings, for example the home. I'd suggest a comprehensive policy that would enable hospitals to transition into a networked world, including some way to redeploy brick-and-mortar assets in an orderly fashion so as not to have to worry as much about filling beds to cover overhead costs.

Aneesh Chopra, BA, MPP:
A trifecta in healthcare

A believable and understandable bill; an actionable health record; and clinicians working at their highest level. We must move toward a patient-directed longitudinal health record that can be shared and updated by anyone on the care team.

Stephen K. Klasko, MD, MBA:
What Needs to Happen Now

In my Editor-in-Chief column, I laid out the 12 disruptors that I believe will transform healthcare delivery. But here, I'm taking the same challenge we asked our board members: what's the key to action during the Trump administration?

Here are my thoughts:

First, let's remember what the ACA is. Using **Clayton Christensen's** new "job theory," we ask, "What job did we hire a service to do?"

The ACA did exactly what we hired it to do—it gave many more people access to a broken, fragmented, expensive, inequitable, and occasionally unsafe healthcare delivery system, and then hoped that healthcare transformation would occur.

It provided subsidies until that happened.

Unfortunately, transformation did not occur, and now the dollars are unsustainable.

Healthcare reform in the Trump administration will happen when we:

- (1) deal with pharma prices and allow CMS to negotiate the costs;
- (2) deal with end-of-life issues in a compassionate but rational manner;
- (3) deal with malpractice issues and defensive medicine;
- (4) recognize that 80% of dollars are spent on 20% of healthcare outcomes, that is, ignoring population and public health issues;
- (5) recognize that it's "hard to get someone to do something when they are getting paid to not do it."
 - (a) dealing with the ridiculous inequity in physician payments between procedures versus cognitive medicine, for example why dermatologists make five times that of internists
 - (b) not rewarding value, for example getting care out of expensive, inefficient hospitals is applauded philosophically but not financially
- (6) incent healthcare to join the consumer revolution by removing statewide barriers to telehealth, decision support and other IT reforms; and
- (7) ensure Medicaid insurance products cannot penalize providers who take care of the most vulnerable due to "adverse selection."

Katherine A. Schneider, MD, MPhil:

Want change? End the tyranny of the office visit

The Mars shot that would have the biggest impact on the health of Americans—including outcomes, cost, and experience—is guaranteed same or next-day access to primary care* for all, including:

1. 100% of evidence-based preventive services (e.g., screenings, immunization, counseling);
2. management of the top 10 chronic conditions for 90% of those that have them (the other 10% have complexity warranting specialist co-management);
3. ambulatory-appropriate episodic illness and injury; and
4. holistic, compassionate care for those whose priority is quality of life, over cure/extension of life.

This is completely doable with the resources and tools that are already available in this country; it just requires vision and determination (the innovation is in the execution). There are powerful stakeholders who will lose in a transformation such as this, but that is inevitable if we are serious about getting better value. Good luck! Make it so!

*The primary-care model is redefined as not only a doctor face-to-face with a patient in an office, but also the use of new kinds of highly coordinated teams and distribution methodology, including physician, nurse, behavioral health, pharmacist, nutrition, navigation, coaching—all *released from the tyranny of the office visit*, and enabled/scaled by technology.

“Optimizing health—whether a person is impacted or “unimpacted” by a chronic condition—must be done using a holistic methodology.”

Summer Knight, MD, MBA:

New healthcare teams: Primary-care use case

In primary care, by leveraging technology, we have the opportunity to redefine healthcare teams offering a more contiguous relationship between the healthcare consumer and their healthcare team. Humans are multidimensional.

Optimizing health—whether a person is impacted or “unimpacted” by a chronic condition—must be done using a holistic methodology. Therefore, we must take a team approach, integrating the many aspects of a person’s life, honoring the inter-relatedness of an individual’s physical, emotional-psychological, spiritual, social, behavioral, and financial healthfulness.

It is key that we are available for our clients when they most need or want our attention and care. Technology is available to leverage resources and expand the

clinical team's presence for a contiguous and engaged relationship. A person's health can also affect their family due to life impact as well as genetic health inheritance. Therefore, it's necessary to offer ways to incorporate their natural care network of family and friends, allowing greater communication and sharing among them and their clinical team at their preference level.

To truly affect one's health status, the majority of the action must come from the individual—at times a daunting and complex job, especially when ill or injured. Therefore, in healthcare, it is our job to empower and educate client-patients and support their natural support network and caregivers.

The many sides of caregiving

Caregiving is a massive endemic issue, as 17% of employees are caregivers. All the planning and foresight intelligence cannot prepare a family for a significant illness. The impact is far reaching beyond the individual's illness, but also on the family over multiple dimensions. Beyond medical, family roles suddenly change or intensify. Personal care must be attended to as well as social interactions, change in life structure, and financial impact. From a financial perspective, for the individual and/or caregiver, there can be a significant loss of capability to work or loss of opportunities due to the situational constraints. This leads on average to \$303,808 in losses per caregiver over the lifetime of the caregiving episode. For employers, caregiving leads to \$38.2 billion in lost productivity and \$13 billion associated healthcare costs due to the stress and illness associated with caregiving.

This is a public health and welfare situation that is beyond the health insurance conversation as good, hard-working Americans can be completely caught off-guard by such situations leading them into financial distress, which in turn leads them into emotional distress, which leads to a higher incidence of medical issues—a vicious cycle.

Donna Petersen, DSc:
You want to think big?

Then think about the effect our society has on an individual's health. We desperately need population health approaches to the social determinants of health—now.

Mark C. Lester, MD, MBA:
Fostering leaders

The need for physician leadership development has not received proper emphasis in healthcare reform. We simply cannot develop new care models for populations across the

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continuum without competent physician leadership. Classical medical training has not properly prepared physicians with the necessary leadership capabilities. Non-clinical leaders lack the skills to build and implement new care models central to reform efforts. Moving forward with healthcare reform requires new skills and leadership capabilities among physicians. We cannot confine these efforts to physician executives and administrators alone, but must develop these skills and capabilities broadly among physicians in all areas of healthcare and clinical practice.

How about the triple aim?

The issue of payment reform facilitating the triple aim remains central. MACRA, with its strong bipartisan Congressional support, has already accelerated payment reform. A surprising number of large healthcare systems are moving to two-sided risk alternative payment models much more rapidly than predicted. The assumption of financial risk for the care of populations drives changes in how we develop and deliver care. These changes will involve collaborative, team-based care, and will positively affect both quality and cost.

Our evolving healthcare system should explicitly address these two needs. Physician leadership development and payment reform with assumption of risk will both drive outcomes. I believe we'll need continued bold moves in these directions and should not pull back from our existing efforts. We should work hard to rationalize the kaleidoscope of mental models we all carry for healthcare, discarding those not moving us strongly to better outcomes and reduced cost.

Ninfa M. Saunders, DHA:
Change can mean new business models

I want to suggest that the model in Figure 1 is something worth exploring and thinking about.

As private equity firms are busy exploring the healthcare space with the hope of disrupting the traditional business model (see Figure 1), the new business model shown is manifesting itself in the marketplace and getting some traction. It may get more traction under Trump.

New business models during this new administration brings up a few questions, including:

- How do we see ourselves navigating this new business, which will fundamentally disrupt the current state and make the distribution channel much different from what we know today but akin to a commoditized product?

“The assumption of financial risk for the care of populations drives changes in how we develop and deliver care.”

- What would the 5 Ps—product, place, price, promotion, and packaging—evolve to and look like?
- Would healthcare as a provider be better or worse off? How about the patient-turned-consumer? And what happens to the payers, governmental and commercial? Might this model be more attractive for the government side?

Figure 1.

Antonia F. Chen, MD, MBA:
Faster, better, value-based education

Focus on medical education. We don't need smart students—they're all smart. Student selection should start with innovation, motivation, compassion, and honesty. Students should not just be tested on their knowledge, but on how quickly they think on their feet, how they want to change healthcare, their concern and care for patients, and their honesty—to themselves and to others.

Education should fall along the same lines. Instead of sitting in classes for hours at a time, they should be interactive. Not just with patients, but with one another and the community. Yes, they should learn clotting cascade because it's important to have that knowledge, but how can they use basic knowledge to change the face of medicine? Modeling medical school like business school, where there

are case studies and group building, may improve medical education. Finally, medical training and residency can be shortened. From college to med school to internship to residency to fellowships, the amount of repetition and waste is tremendous. Students should be able to select a shorter pathway that teaches them information that is relevant to their future career.

Ronald A. Williams, MS:
New guides for the profession

One issue that needs attention is thorough evidence-based review of scope of practice laws to provide guidelines on the skill sets for the entire clinical professional healthcare system.

If each professional worked at her or his highest level, the capacity of the system would be greater, costs would be lower, and more of the underserved areas would be served. This applies to all medical and dental professionals.

Judd E. Hollander, MD:
It's not just the money, it's the transparency

My vision for the big bold change in healthcare is price transparency, along with reasonable prices. I would love to see a health system charge reasonable prices to everyone—regardless of who is paying. Why do we charge poor uninsured self-pay patients more than wealthy insured patients? Why can't we just set a fair and just rate and let people and payors pay that rate? You need your gallbladder taken out? It costs x number of dollars. It doesn't matter how you, the patient, pay for it or whether you delegate that payment to a third party. You want to charge your insurance? Go ahead. You want to pay cash? Go ahead. You know what we charge you in advance, you can shop around easily for best price. I never thought I would wish health insurance worked like car insurance—but I know how much it costs to fix the body of my car. ■■■

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