Forces Shaping the Future of Health and Health Care

Jonathan Woodson, MD, MS, FACS
Director, Boston University Institute for Health System Innovation and Policy
No Disclosures
Agenda

- The imperatives for change in the U.S. approach to health care.
- Historical underpinnings for the U.S. health system
- Impact of a digital society and the implications for the work force
- Leadership attributes needed for success
Moving from Health Care to Health
“When health is absent, wisdom cannot reveal itself, art cannot manifest, strength cannot fight, wealth becomes useless, and intelligence cannot be applied.”

Herophilus (325-255 BC)
The “Holy Grail”-What do we want?

- Safe- “Do no harm”
- Effective- evidence based therapy leading to best outcome
- Efficient- limits waste of resources
- Patient-Centered- respectful, responsive, values-based
- Equitable-quality care for everyone in need
- High performing/Learning
- Connected- Link patient, provider care teams, provider organizations and broader political-economic communities…all pulling in the same direction
What value? What Costs?
(imperatives for change)

- HC-3 trillion/yr. (18% GDP); 30% wasted
- 8.6% (27.3 million) uninsured (2016)
- Only 50% of patients received evidenced-based care
- Ranked 37th world outcome metrics
- Millions uninsured or underinsured
- HC expenses #1 cause of personal Bankruptcy
- Limited portability and interoperability of health data
- 2000-98,000 medical error; 2016-250,000

Value = Access + Outcomes
Costs
The Challenge

• Health care costs have grown over the past 50 years
• Costs have consistently grown faster than the rest of the economy and is crowding out other discretionary spending by government and employers.
• HC costs are creating progressive hardship for individuals (low and mid -income) and employer (particularly small business owners)
### National healthcare expenditure comparison and World Bank income classification

<table>
<thead>
<tr>
<th>Country</th>
<th>Healthcare expenditure as % of GDP</th>
<th>Healthcare expenditure per capita</th>
</tr>
</thead>
<tbody>
<tr>
<td>U.S.</td>
<td>17.9</td>
<td>8,230</td>
</tr>
<tr>
<td>UK</td>
<td>9.6</td>
<td>3,502</td>
</tr>
<tr>
<td>Spain</td>
<td>9.5</td>
<td>2,887</td>
</tr>
<tr>
<td>Brazil</td>
<td>9.0</td>
<td>1,006</td>
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<td>Malawi</td>
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<td>24</td>
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<td>Mexico</td>
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<td>584</td>
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<tr>
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<td>525</td>
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<tr>
<td>China</td>
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<td>221</td>
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<tr>
<td>Egypt</td>
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<tr>
<td>India</td>
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<tr>
<td>Thailand</td>
<td>3.9</td>
<td>191</td>
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<tr>
<td>Pakistan</td>
<td>2.2</td>
<td>21</td>
</tr>
</tbody>
</table>

**SOURCE:**
World Health Organisation 2010,
The World Bank
Figure 2

Around the world, health systems face the challenge of breaking the iron triangle and improving affordable access to quality care.

In low and middle-income countries, access to healthcare services is severely limited
- Many lack access to basic services
- Poor access leads to higher mortality from treatable diseases
- Poor access hampers economic growth, limits size of addressable healthcare markets

In all countries, quality is an enduring challenge
- Basic standards of medical care are a challenge in many low to middle-income countries
- Improved cost is not leading to higher quality in high-income countries

In high-income countries, the cost of delivering health care is unsustainable
- Growth in spending on healthcare outstrips GDP growth
- Burden is unsustainable if not checked
- Continued growth in these markets will be challenging for healthcare firms to achieve
Putting it in Perspective: Unified Medical Program (FY 2009-FY 2016)

Between 2009 and 2016, the UMP went up a total of 2.5%, or 0.35% per year on average.
Why no change- “It’s Complicated”

- Limited acknowledgement of the complexity of issues; stakeholders simplify solutions to fit their needs
- Fragmented problem solving
- Technological solutions without understanding the human dimension or organizational reforms necessary for improvement of care.
“One Nation Uninsured”; How did we get here?

- 20th Century-Physicians maintained significant control over health care/systems:
  - Restrict competition
  - Limited regulation
  - Defined standards
  - Controlled information (created, paternalized, priced, interpreted)

- Employer-based insurance was promoted when health care costs were low and wages were frozen (1940s)

- Medicare was accepted because of the accelerating costs to care for older sicker patients and it was seen as a neutral conduit for payment

- Policy decisions to have government support medical research, but not do drug development

  Jill Quadagno, One Nation Uninsured, Oxford Press, 2005
Healthcare-”It’s Complicated”

Gordian knot of historical, economic, law, regulation, politics, culture, technological and professional issues.

Jill Quadango, “One Nation Uninsured, Oxford Univ. Press, 2005
Every system is perfectly designed to get the results it gets.

W. Edwards Deming

source: quotes.deming.org/10141
Contributing Factors to Suboptimal U.S. HealthCare System

• Not a system/not designed
• Rapid advance in science and technology
• Multiple cottage industries interacting w/o coordination
• U.S. market forces support technology development, but not systems innovation
• Lack of systems engineering principles
“A system is a network of interdependent components that work together to try to accomplish the aim of the system. A system must have an aim. Without the aim, there is no system.”

W. Edwards Deming (1900–1993)
American statistician, professor, author, and consultant
Influencing Policy Makers
Health Care Policy

Understanding the variables

Emotion

Optics/Politics

Economics

Practice/Art

Science
Paying For National Health Insurance—And Not Getting It

Taxes pay for a larger share of U.S. health care than most Americans think they do.

by Steffie Woolhandler and David U. Himmelstein

ABSTRACT: The threat of steep tax hikes has torpedoed the debate over national health insurance. Yet according to our calculations, the current tax-financed share of health spending is far higher than most people think: 59.8 percent. This figure (which is about fifteen percentage points higher than the official Centers for Medicare and Medicaid Services [CMS] estimate) includes health care–related tax subsidies and public employees’ health benefits, neither of which are classified as public expenditures in the CMS accounting framework. U.S. tax-financed health spending is now the highest in the world. Indeed, our tax-financed costs exceed total costs in every nation except Switzerland. But the sub rosa character of much tax-financed health spending in the United States obscures its regressivity. Public spending for care of the poor, elderly, and disabled is hotly debated and intensely scrutinized. But tax subsidies that accrue mostly to the affluent and health benefits for middle-class government workers are mostly below the radar screen. National health insurance would require smaller tax increases than most people imagine and would make government’s role in financing care more visible and explicit.
## EXHIBIT 2
Tax-Financed Health Expenditures, Billions Of Dollars, Selected Years 1965–1999

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>National health expenditures (NHE)</td>
<td>$41.0</td>
<td>$73.1</td>
<td>$129.8</td>
<td>$245.8</td>
<td>$426.5</td>
<td>$695.6</td>
<td>$987.0</td>
<td>$1,210.7</td>
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<td><strong>Federal government</strong></td>
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<tr>
<td>Medicare</td>
<td>0.0</td>
<td>7.7</td>
<td>16.3</td>
<td>37.4</td>
<td>71.8</td>
<td>110.2</td>
<td>184.8</td>
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<td>42.5</td>
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<td>7.0</td>
<td>12.3</td>
<td>19.4</td>
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<td>52.9</td>
<td>63.5</td>
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<td>0.3</td>
<td>1.2</td>
<td>2.2</td>
<td>4.3</td>
<td>9.2</td>
<td>11.3</td>
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<td>Tax subsidies</td>
<td>1.7</td>
<td>3.5</td>
<td>7.0</td>
<td>19.1</td>
<td>31.3</td>
<td>49.8</td>
<td>75.5</td>
<td>95.4</td>
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<td><strong>State/local government</strong></td>
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<tr>
<td>Medicaid</td>
<td>0.0</td>
<td>2.4</td>
<td>6.0</td>
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<td>31.1</td>
<td>57.9</td>
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<td>Other health programs</td>
<td>5.5</td>
<td>7.6</td>
<td>12.9</td>
<td>22.0</td>
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<td>58.7</td>
<td>76.4</td>
<td>84.6</td>
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<tr>
<td>Public employee health benefits*</td>
<td>0.3</td>
<td>0.7</td>
<td>2.2</td>
<td>7.6</td>
<td>18.2</td>
<td>33.5</td>
<td>47.1</td>
<td>52.4</td>
</tr>
<tr>
<td>Tax subsidies</td>
<td>0.1</td>
<td>0.4</td>
<td>0.9</td>
<td>2.5</td>
<td>4.7</td>
<td>6.9</td>
<td>11.9</td>
<td>14.2</td>
</tr>
<tr>
<td><strong>Total tax-financed (billions)</strong></td>
<td>$12.6</td>
<td>$32.4</td>
<td>$66.3</td>
<td>$136.2</td>
<td>$233.1</td>
<td>$383.4</td>
<td>$604.0</td>
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<td><strong>Tax-financed ($ per capita)</strong></td>
<td>$63</td>
<td>$154</td>
<td>$301</td>
<td>$592</td>
<td>$963</td>
<td>$1,509</td>
<td>$2,254</td>
<td>$2,604</td>
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<tr>
<td><strong>Tax-financed as percent of NHE</strong></td>
<td>30.7%</td>
<td>44.4%</td>
<td>51.0%</td>
<td>55.4%</td>
<td>54.6%</td>
<td>55.1%</td>
<td>61.2%</td>
<td>59.8%</td>
</tr>
</tbody>
</table>

**SOURCE:** Authors’ analysis.

*1999 estimate is from a data source that results in lower estimates than data sources used for earlier years.

S. Woodlander and D Himmelstein, Health Care Costs, Health Affairs, 21:4, 2002

Boston University Institute for Health System Innovation & Policy
History of U.S. Health Care Reform Efforts

- 1915-American Association for Labor Legislation
- 1943- Wagner-Murray-Dingell-Federal Social Insurance Trust (Employer/Employee contribution)
- 1965 Medicare/Medicaid Act
- 1970-Kennedy- Griffiths Health Security Act (National Health Insurance)
- 1971-Nixon- Employer mandate
- 1989-Heritage Foundation- Individual Mandate
- 1993- Clinton- Employer mandate
- 2006-Massachusetts- “Romney Care”
- 2010-Affordable Care Act
- Medicare for All???
Performance in the Medicare Shared Savings Program After Accounting for Nonrandom Exit
An Instrumental Variable Analysis

Adam A. Markovitz, BS; John M. Hollingsworth, MD, MS; John Z. Ayanian, MD, MPP; Edward C. Norton, PhD; Phyllis L. Yan, MS; and Andrew M. Ryan, PhD

Background: Accountable care organizations (ACOs) in the Medicare Shared Savings Program (MSSP) are associated with modest savings. However, prior research may overstate this effect if high-cost clinicians exit ACOs.

Objective: To evaluate the effect of the MSSP on spending and quality while accounting for clinicians’ nonrandom exit.

Design: Similar to prior MSSP analyses, this study compared MSSP ACO participants versus control beneficiaries using adjusted longitudinal models that accounted for secular trends, market factors, and beneficiary characteristics. To further account for selection effects, the share of nearby clinicians in the MSSP was used as an instrumental variable. Hip fracture served as a falsification outcome. The authors also tested for compositional changes among MSSP participants.

Setting: Fee-for-service Medicare, 2008 through 2014.

Patients: A 20% sample (97,204,192 beneficiary-quarters).

Measurements: Total spending, 4 quality indicators, and hospitalization for hip fracture.

Results: In adjusted longitudinal models, the MSSP was associated with spending reductions (change, −$118 [95% CI, −$151 to −$85] per beneficiary-quarter) and improvements in all 4 quality indicators. In instrumental variable models, the MSSP was not associated with spending (change, $5 [CI, −$51 to $62] per beneficiary-quarter) or quality. In falsification tests, the MSSP was associated with hip fracture in the adjusted model (−0.24 hospitalizations for hip fracture [CI, −0.32 to −0.16 hospitalizations per 1000 beneficiary-quarters] but not in the instrumental variable model (0.05 hospitalizations [CI, −0.10 to 0.20 hospitalizations per 1000 beneficiary-quarters). Compositional changes were driven by high-cost clinicians exiting ACOs: High-cost clinicians (99th percentile) had a 30.4% chance of exiting the MSSP, compared with a 13.8% chance among median-cost clinicians (50th percentile).

Limitation: The study used an observational design and administrative data.

Conclusion: After adjustment for clinicians’ nonrandom exit, the MSSP was not associated with improvements in spending or quality. Selection effects—including exit of high-cost clinicians—may drive estimates of savings in the MSSP.

Primary Funding Source: Horowitz Foundation for Social Policy, Agency for Healthcare Research and Quality, and National Institute on Aging.

For author affiliations, see end of text.
This article was published at Annals.org on 18 June 2019.
Changes In Physician Consolidation With The Spread Of Accountable Care Organizations

ABSTRACT While early evidence suggests that accountable care organizations (ACOs) are associated with higher quality and lower costs, there have been simultaneous concerns that ACOs may incentivize consolidation of physician groups. This is particularly concerning as previous research has shown that consolidation is associated with lower quality and higher prices. Using a difference-in-differences strategy and data from the Medicare Shared Savings Program, which began in 2012, we examined whether physician practices consolidated after ACOs entered health care markets. We observed a 4.0-percentage-point increase in large practices (those with fifty or more physicians) in counties with the greatest ACO penetration, compared to counties with zero ACO penetration, and a 2.7-percentage-point decline in the percentage of small practices (ten or fewer physicians) from 2010 to 2015. The growth of large practices was concentrated in specialty and hospital-owned practices. These findings suggest that ACOs may contribute to the concentration of physician practices.
The Digital World
Using Data to Drive Change
(Learning to fly with instruments)

- Data is everywhere
- How do we create “useable knowledge and wisdom”
- Create interoperability
- Leverage investments
- Advance machine learning
- Match data/information availability to work-flow
- Match data analysis/informatics to operational needs/questions
Disruptive Technologies

**Synthetic Biology & Nanotechnology**
The ability to produce synthetic tissues and organs creates new opportunities for surgical therapy and device production.

**Digital Medicine**
Digital medicine offers smart medication, continuous monitoring, behavior modification, and personalized interventions.

**Genomics & Proteomics**
Understanding the gene structure, function, evolution, and mapping of all living organisms.

**Additive Manufacturing**
3D scanning, digital design, and 3D printing digitize the creation/distribution of products, including body parts.

Permission for use from Dr. Meera Kanhouwa
Disruptive Technologies

**Virtual / Augmented Reality**
Immersive 3D representations to what a person sees to allow advanced simulation or digitally-enhanced problem solving

**Ambient Computing**
Ecosystem of “things” that intelligently respond in real time to business needs through connectivity and sensing

**Data Democratization**
Seamless information exchange facilitating interoperability between payer, provider, pharmacy, and patient

**Cognitive Computing**
Artificial intelligence, natural language processing, semantics computing, predictive algorithms, dark analytics, and machine learning

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Boston University Institute for Health System Innovation & Policy
Disruptive Technologies

**Robotics**
Next generation robotics and automation technologies that can work alongside or replace humans

**Blockchain**
Distributed data repository that brings transparency, disintermediation, trust, and auditability capabilities

**Telemedicine**
Technology-enabled care delivery that allows for remote communication, diagnosis, and treatment with a physician

**API / Gig Economy**
New ways to engage with both communities and individuals through unique platforms to extract untapped value and harness a changing workforce
Digital Disruption of Healthcare: The Digital Health Matrix

- Every organization think about their future in the digital age.
- Organizations must break free of traditional modes of doing business.
- Every industry is becoming digital.
- Incumbents must think about how they compete and collaborate with digital giants (e.g. Amazon, Google).
Adapt or Die

- Kodak
- Blockbuster
- Borders Books
- Kroger
- Blackberry

*Consumed by fast moving tech companies with innovation in their business DNA*
THREE WINNING MOVES

1. Orchestrate and Participate in Ecosystems
   Health sector will evolve into a set of interconnected ecosystems across different traditional industries. You have to step up to ORCHESTRATE some ecosystems while you PARTICIPATE in others. Your success depends on your ability to orchestrate high-value ecosystems against competition from digital giants and ambitious entrepreneurs.

2. Co-Create Capabilities With Partners
   With pervasive digitization, the health sector will require different companies to simultaneously compete and cooperate—labeled as COOPETITION. You have to manage a portfolio of relationships involving your traditional competitors, digital giants and tech entrepreneurs. You must co-create the required capabilities with others and dynamically adapt your portfolio of relationships.

3. Amplify Human Talent With Powerful Machines
   Design your organization by delineating three zones: (1) AUTOMATION zone, where tasks could be carried out with minimal human intervention (2) AUGMENTATION zone, where human decision processes could be augmented with smart assistants and (3) AMPLIFICATION zone, where innovation is unleashed through combinations of smart humans and powerful machines.
New Ecosystems and Models of Healthcare

- Big Data Analytics/PGHD
- Cognitive computing
- AI/machine learning
- Personal Health Records
- Precision Medicine
- Patient Engagement
- IO(M)T-sensors/monitors/DA
- Chronic Disease Management

- CVS/Aetna
- Aetna/Apple
- Walmart/Humana
- Amazon/Berkshire Hathaway
- Apple/IBM/JNJ/Metronics
- Microsoft
- Alibaba/Tencent
- United HC/DaVita/Optum
Andy Shin, COO, American Hospital Association  
November 7, 2019

“If ‘SDOH’ is the buzzword to encapsulate the need to recognize players outside the four walls of our organizations that also serve patients and our communities, then ‘ecosystem’ is how we systematically integrate these stakeholders into how we innovate at scale.”
Former Aetna CEO Mark Bertolini talks about CVS, the Amazon experience and how insurers stay relevant

"What's needed is to start with the patient, and the patient as a consumer, and add in the relevance of issues outside of a medical conditions."

CVS has allowed the insurer to reach consumers where they are, in its estimated 9,900 pharmacies across the nation. Earlier this year, CVS piloted a test of HealthHubs in Houston. Based on that success, the company said it planned to open additional locations in Houston, Atlanta, Philadelphia, southern New Jersey and Tampa, and have a total of 1,500 HealthHUB locations operating by the end of 2021.
How Walgreens, CVS see the future of pharmacy

Alia Paavola -

As the traditional pharmacy industry gets increasingly difficult to navigate, two of the largest retail pharmacy chains in the U.S. are trying new and starkly different approaches to remain afloat.

CVS has largely bet on healthcare as the way forward, opening HealthHubs focused on managing chronic conditions, acquiring health insurer Aetna and ending cigarette sales. "What we're witnessing is the evolution of the drugstore from what it's been to what it needs to be to meet the needs of consumers," CVS CEO Larry Merlo told Business Insider. "It's time for another evolution. We see us leading that evolution with what we're doing, with our strategy and the drugstore becoming more of a health destination."

Walgreens has been striking up partnerships with companies like Kroger, Jenny Craig weight loss services and a subscription beauty company, Birchbox.
Haven- Amazon, Berkshire Hathaway, JP Morgan

Amazon, and its off-shoot healthcare company Haven, are seen as the disruptors of the industry. But that's the wrong way of looking at it, according to Bertolini.

"Here's how I would characterize Amazon," Bertolini said. "Amazon doesn't disrupt anything. It creates a customer experience for an unmet need that is convenient, reliably delivered and affordable. And when a customer experiences that, they stop going to other places. It's the customer that disrupts."
Why Apple’s New Health Studies Are So Groundbreaking
And how you can be a part of them.
By Arianna Huffington, Thrive Global Founder & CEO

Apple will be teaming up with leading medical research groups for each study. And the goal of all three studies is to use everyday data to expand our notion of health care. Right now, about 75% of our health care spending goes toward the treatment of chronic, stress-related conditions that can be managed or even prevented. When you include mental health, that goes up to 90%. Instead of focusing only on downstream harm reduction, the granular and real-time data that will be collected in these studies will allow us to go upstream, and address the true causes of these conditions.
“Digital Health is the convergence of digital and genomic technologies with health, healthcare, living, and society to enhance the efficiency of healthcare delivery and make medicine more personalized and precise.”

- Multi-disciplinary
- Engage patients/customers
- Amplify/augment human capabilities
- Optimize clinical care and administrative process
- Transform health

- Precision Medicine
- Wearable computing
- Telehealth/Telemedicine
- M-Health/e-health
- Patient engagement
- Big data/Cloud computing
- gamification
Decades Ago, Pilots Learned to “Fly by Instruments.” Doctors Need to Do the Same

by Jonathan Woodson

MARCH 15, 2018
# Augmenting and Amplifying Human Performance - Man and Machine

<table>
<thead>
<tr>
<th>Discipline</th>
<th>Algorithm</th>
<th>Human</th>
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</thead>
<tbody>
<tr>
<td>Dermatology Melanoma</td>
<td>Accuracy 95% (IBM)</td>
<td>Accuracy 75% - 84%</td>
</tr>
<tr>
<td>Pathology Lung Cancer Tissue</td>
<td>Accuracy 81% (Stanford)</td>
<td>Accuracy 73%</td>
</tr>
<tr>
<td>Radiology Mammographic Screening</td>
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<td>Accuracy 81.1%</td>
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<tr>
<td>Pathology Mammographic Metast.</td>
<td>Accuracy 92.2% (MIT/Stanford)</td>
<td>Accuracy 73.2%</td>
</tr>
<tr>
<td>Diabetic Retinopathy</td>
<td>Accuracy 90% (Google)</td>
<td>Accuracy 87.1%</td>
</tr>
</tbody>
</table>

Your Algorithm is going to see you now!

Literature References on demand


Boston University Institute for Health System Innovation & Policy
Centrally Assisted Collaborative Telecare for Posttraumatic Stress Disorder and Depression Among Military Personnel Attending Primary Care

A Randomized Clinical Trial
HOSPITAL AT HOME INITIATIVES LOOK INCREASINGLY Viable FOR HEALTH SYSTEMS

BY MANDY ROTH  |  JULY 02, 2018

Initiative gathers steam as Medicare ponders 2 APMs and new Mount Sinai study confirms improved outcomes.

With a study by the Icahn School of Medicine at Mount Sinai demonstrating improved outcomes for patients participating in Hospital at Home (HaH) services, and two alternative payment models (APM) under review by Medicare, more healthcare systems may explore the possibility of offering this innovative model of care.
Digital is the “Fourth Space” in Health Care

From Halvorson, G. et al. The Digital Dimension of Healthcare.
Retrieved from: https://xnet.kp.org/.../docs/The%20Digital%20Dimension%20of%Healthcare.pdf

Boston University Institute for Health System Innovation & Policy
Panel 3 - An Earthquake Shakes Up Medical Care

After a large earthquake hit the Sichuan region of China in 2008, healthcare authorities had to choose whether to invest in traditional facilities or develop a new delivery model built around digital technology. They chose the latter, and have proved that medical care and healthcare education can be effectively delivered through digital means.

A three-year $50-million public-private partnership involving Cisco Systems and dozens of NGOs set out to re-create health services in the ravaged region. The partnership built three mobile clinics, technology-enabled 66 healthcare organisations and developed 32 “smart” hospitals. It also built four telehealth networks and six regional healthcare internet services that connect rural villages to full-service hospitals. And it created telehealth centres with advanced video-conferencing equipment to enable remote service delivery. More than 7,000 practitioners support nearly 300,000 patients each month using these technologies. Data centres support 60 million medical insurance records and more than 400,000 electronic health records. Through using remote care, patients have saved the equivalent of 22% of their monthly income. Teletraining of physicians has also saved training costs of $245 per physician – the equivalent of a physician’s monthly salary in the county of Wenchuan in Sichuan.

The speedy set-up and the reach of this healthcare system would not have been possible without investment in mobile and broadband infrastructure. This infrastructure provided the backbone on which Cisco and others could build the technological nervous system that has re-established and so greatly improved healthcare and healthcare education in Sichuan.
Entering a New Era of Medicine

Emanuel predicts six ‘megatrends’ in his book *Reinventing American Healthcare*—the most imperative of which is the transformation of medical schools. He notes, “Today’s medical graduates are lacking the skills they need to practice in the coming era of digital medicine…Medical education is probably the slowest-evolving institution in society. This will need to change.” If medical education does not change, we may see history repeat itself—a generation of doctors that are not entirely equipped to deal with the health problems of the future.
**IHSIP Philosophy**
“Embrace complexity and deliver comprehensive solutions”

**IHSIP Operating Model**
- Interdisciplinary research
- Five interconnected domains
- Convene
- Facilitate
- Accelerate
Leading in a VUCA World
VUCA

- Complexity
  Multiple key decision factors
- Volatility
  Rate of change
- Ambiguity
  Lack of clarity about meaning of an event
- Uncertainty
  Unclear about the present

How well can you predict the outcome of your actions?

How much do you know about the situation?
The Meaning of CHAOS THEORY

“An apparent lack of order in a system that nevertheless OBEYS particular LAWS and RULES”

From OldWolf, B. Chaos Theory : A Starter Guide. Owlcation, Feb. 2018
Wicked Problems

- Complex
- Extend outside of authority lines
- Detrimental effects of organizational silos
- Simple solutions often make the problem worse
- Formal networks often do not provide a path to solutions
Changing Healthcare Leadership Requirements

• A dynamic health care industry is driving the need for new leadership that can take on a wider range of responsibility and accountability and navigate more complexity.

• The competencies that executive and strategic healthcare leaders need are broad.

• New curriculum is needed to prepare health care providers with skills to work and succeed in the rapidly changing health care environment and allow health care organizations to meet their mission.

• Health care professionals who desire to become leaders of health care organizations will need to invest in leadership professional development.
Leadership Skills

Black Book Marketing

- Tech/data systems management
- Advanced analytics
- Deployment and execution
- Strategy and planning
- Finance and reimbursement
- Leadership
- Relationship and team building

- Communication
- Change management
- Integrity/values
- Organizational behavior/culture
- Systems design
- Policy
- Sustains self/momentum
Effective Leadership

• Help organizations pivot and thrive in a consumer driven fee for value environment
• Creates enthusiasm for change
• Recognizes the accelerated pace of change
• Assesses the disruptive influences coming from outside the industry
• Make the right strategic investments
• Cultivates the right partnerships
• Develops the workforce to be part of the solution
• Embraces “wicked problems”
Innovation and Leadership

• Move away from directing outcome to developing forum for validating the development of questions and pathways to solutions

• Involves increased risk—may not know where you when end up when you start

• Is taxing emotionally and intellectually

• Involves diverse collaborators

• May feel unnatural
Questions?