CHAPTER 2

My Trip There and Back *or* I Was There When Healthcare Was Reinvented

It's been ten years already!" That was my first reaction when I was asked to attend the anniversary celebration of what is now viewed as the "breakthrough moment" for the new healthcare back in January 2016. As with any momentous event, you always try to relive your thoughts and emotions back when it happened. I'd love to say that we all knew that this meeting would be a turning point in transforming the fragmented, consumer-unfriendly healthcare in America of the early 2000s and 2010s to the bastion of social, economic, and technologic envy of most of the rest of the world. But we didn't. In fact, when I first got the notice asking me to attend an invitation-only summit in Big Sky, Montana, my reaction was more of a virtual eye roll than any anticipation that I would be witnessing history in the making.

Not that the thought of traveling to the mountains for a week and leaving the daily grind and stress of leading an academic medical center was a sacrifice, but in the context of 2016, the chances of anything worthwhile coming out of this was equivalent to the odds that my beloved PHILADELPHIA EAGLES would break their fifty-five-year drought and win the 2016 Super Bowl. Of course they did not, although if I could have seen the future and bet the farm that between 2017 and 2020 they would not only break that streak but become the first team in NFL history to win four Super Bowls in a row, well, I would be flying to the

anniversary in my own private **Elon Musk*** electric jet that just went on sale for the bargain price of $2.5 million.

So, why the reluctance and cynicism? For those of you too young to remember, there was nothing optimistic about the future of healthcare delivery in 2016. In fact, no one was happy. We had spent years breaking the national bank by providing increasingly expensive high-tech care to those who were sick and could afford it. The model seems absolutely primitive by today's standards, where technology has advanced to the point that providers and patients work as a team to promote health in the workplace and at home. And while both care and caring have advanced beyond the wildest dreams of my 2016 self (we didn't even have implantable health chips back then), the real "failure" of the system was not in the lack of high-powered technology for diagnosis and treatment, but rather in the inability of the "humans" to work across specialties and disciplines, to hone their creativity and observation skills to partner with patients in advancing their health and to change course objectively, based on real-time data.

In fact, our failings started at the very beginning in how we chose and educated young physicians and nurses. Believe it or not, it's been less than ten years in which the MCATs (a multiple-choice test proving that an applicant can memorize organic chemistry formulas) was scrapped in favor of the now-national "empathy and self-awareness scale" that every aspiring physician or nurse recognizes as the most important "hurdle" they must overcome to be considered for medical school or nursing school admission. And it certainly came just in the nick of time, as I sit next to my robotic companion born from the Watson project. Simply put, I am no match for him/her/it when it comes to standard cognitive and memorization skills. But I can beat him/her/it hands down when it comes to comforting a patient or "reading between the lines" based on nuanced communication with a human patient.

*Elon Musk: a South African–born engineer, inventor, and investor. He conceptualized Mars Oasis (to build a greenhouse on Mars), Tesla Motors, and Solar City (to help combat global warming).

In fact, the only reason we "humans" are still needed as physicians is because we recognized in the nick of the time "what we bring to the table." We were never going to win the memorization or analytic war with our robotic computer counterparts. But, amazingly, that is how we chose physicians until a few short years ago. In other words, my ability to memorize complicated organic chemistry formulas meant that I had a leg up on remembering the nineteen reasons someone had a headache over the poor *schlub* who did not get into medical school because he/she could only remember fifteen. The fallacy in that old argument was just how easily a non–flesh-and-bones computer could replace that form of "us" by rattling off the differential diagnosis for any set of symptoms and then citing the references supporting the diagnosis, as well as a complete analysis of current treatment options—all in the time it takes me to put down my coffee and contemplate an answer.

There was a great set of movies about time travel almost forty years ago, largely forgotten, called *Back to the Future*, where one or two "aha moments" changed the course of history and set up alternate futures. And while many think the summit of healthcare leaders in 2016 changed the course of healthcare history, I believe it was simply math and uncommon sense.

The math was simple back in 2016 and pretty depressing. We wanted people to be healthy, but we counted on them being sick and using up lots of hospital beds. The real money flowed when people became sick—both profits and costs alike. I remember when I first took the job as an academic medical center president and chief executive officer (CEO). The very strong advice I got is that the two leadership jobs you didn't want to take in 2013 were in *academics* and *healthcare* because for both, the models that have existed for years are stale and impossibly unsustainable in the short term and fraught with pain in the longer term.

How stale and unsustainable was it? Back in 2016, a model entitled "fee for service" still reigned supreme—except there was no expectation of or guarantees of service or outcomes. In fact, it really should have been titled "fee for doing the things the healthcare provider decides you need and the more I do the more I get paid." And we were quite comfortable with that. Back in 2016, value was a futuristic concept and

insurers, providers, and others spoke of moving "from volume to value." To be fair, some of the absurdities of the twentieth century were already being handled before the great summit of 2016. In that century, if I was a surgeon with a robust wound infection rate (perhaps because I did not wash my hands well enough), I earned more, in many cases, than a surgeon who followed careful guidelines. Because, believe it or not, there was a fee for the service of bringing you back to operate on the wound that was infected (in some cases, because of my improper technique).

That reward for failure was already being replaced with "pay for performance" and readmission penalties that at least did not *reward* poor technique and outcomes. In fact, the old math of the last century in healthcare has either been to promote and reward *overutilization* (volume) or some brief forays with promoting *underutilization* (managed care of the 1990s). One of the precepts that we take for granted now that was a direct outgrowth of the vapor-induced summit (more on the vapor part in a moment) of 2016 is that *optimal utilization*, which results in healthier populations, will be recognized and rewarded. As with so many logical ideas of 2026 (such as ending the *Rocky* franchise when **Sylvester Stallone** reached 75) that replaced bad ideas back in 2016 (not ending the **Kardashians'** TV reign soon enough), the concept of rewarding optimal utilization now seems as natural as stem cell hair replacement.

The old math plaguing healthcare is much older than the twentieth century and had its roots in the most fundamental precepts first described by **Euclid** in A.D. 300, when he described the unassailable facts regarding what later came to be known as Euclidian geometry. The fact Euclid recognized and articulated for the first time is that, as you think about a triangle, changing one angle—by definition—forces an inverse change in one of the other angles.

Fast-forward to 1970, when **William Kissick*** from the WHARTON SCHOOL OF BUSINESS at UNIVERSITY OF PENNSYLVANIA spoke of

*Iron Triangle: concept of healthcare first introduced in William Kissick's book *Medicine's Dilemmas: Infinite Needs Versus Finite Resources* in 1994. Kissick was also one of my professors at the WHARTON SCHOOL.

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an "iron triangle of healthcare" around cost, access, and quality. As any ninth-grader versed in Euclidian geometry can tell you, if you increase an angle in said triangle, you need to decrease another. That translated to healthcare in this way. If you want to increase access, you need to increase cost or decrease quality. If you want to increase quality, you face either increased costs or decreased access . . . and so on.

The iron triangle is the Gordian knot of healthcare. It remains solid unless you take a sword to the geometry or, as **Einstein** said, "We can't solve problems by using the same kind of thinking we used when we created them." We needed to start thinking in terms of *fundamentally* transforming the *system* and changing the geometry, the way we think.

This challenge remained largely academic and festered under the surface until what is now known as the universal access bill of 2010 became law. At the time, it was called the Affordable Care Act. It wasn't affordable as it turns out and didn't do much to transform how care was delivered, but it did mandate near-universal access. The name was academic to its opponents (they called it Obamacare), many of whom wanted to go back to the "wondrous" days of the world's best healthcare system.

In fact, back in 2016, "we have the world's best healthcare system," easily rolled off the tongue of those whose interests were fortified by believing that statement. Conversely, "our public health parameters rank us among several third world countries while we pay for the world's most expensive system," countered those who wanted an extreme makeover. Undeniably, the national organization of America's healthcare system was marked by pessimism among graduating physicians, fear among hospital administrators who were not prepared to be judged based on a new value system, frustration by nurses and public health professionals, confusion by the public, and an almost slapstick melee between our legislators and executive branch, each arguing they knew what was best for the citizenry and finding real-life healthcare professionals (or at least actors wearing white coats) to support their positions.

Everyone, deep in their hearts, knew it even back then: The bubble needed to be burst and rebuilt into a much stronger and more sustainable structure. It just never happened. To create a new model for

something as complicated and full of passion (and egos) as the American healthcare system would require *all* stakeholders to get together in a manner that had never been done before. But it never happened. Until January 2016.

Yes, I would love to say it was vision, amazing leadership, or an unprecedented level of collaboration between politicians and healthcare professionals. But that would be a lie . . . and revisionist history. And ever since the demise of Fox News and MSNBC, when people decided to stop being angry all the time and actually listen to other's opinions, facts have taken on a whole new level of importance in public discourse. So, the summit was born out of desperation, pure and simple.

President Obama realized that he had nothing to lose by calling together one last shot to preserve his legacy as the "healthcare president." I think what probably sent him over the edge (or at least got him to listen to the holographic **Harry Truman**) was the national presidential debates. At a time when healthcare was desperately in need of transformation and disruption, the cries of "Repeal Obamacare" and "Republicans Hate Women's Health" were about as creative as we got. So he rolled the dice. With the national debate regarding Obamacare roiling nearly six years after its passage and on the eve of a contentious national election, representatives of all major healthcare stakeholder groups were invited to a national conference on healthcare, appropriately called the "Last Big Shot at True Healthcare Reform at Big Sky" Summit, held in Montana.

Invited conference attendees/stakeholders in America's healthcare system included government representatives (state and federal), physicians (specialists and primary care), nurse and non-physician caregivers, public and population health professionals, hospital CEOs, insurance and payor leaders, employers (big and small), patients (acute, chronic, end of life), medical school and other healthcare school leaders (dean, faculty, student), pharmaceutical executives, medical device and information technology representatives, and attorneys (plaintiffs and defense). Fifty of the best and brightest (many of whom had many financial and other reasons to not fundamentally change the math that existed) were sent personal invitations by the president.

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Why did everyone go along and decide to spend a weekend in Montana? Two individuals who chose *not* to attend the summit needed significant psychologic/psychiatric counseling to reconcile missing the most significant event of the twenty-first century (services that are much more easily obtained after the omnibus mental health tele-health act of 2018).

I think the real reason that almost everyone invited attended was that we were all tired of the almost universal pessimism about the future of healthcare. As one of my colleagues paraphrased **Woody Allen**, "We are at a crossroads—one road leads to total destruction, the other utter despair—let's hope we choose the right one." Not unlike all previous attempts to create a new model, this "last big shot summit" (which one of my more cynical colleagues called the "last *long* shot summit") initially went through the motions of tinkering around the edges talking about pay for performance models, bundled payments and accountable care organizations—all of which further exacerbated the depressing feeling that we were saving a system that needed to be scrapped and fanned the flickering hope that we might actually do something good.