

Stratis Health Future Scenarios

*Shared with Minnesota Home Care Association for strategic planning purposes
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Pre-determined: Elements of the future which seem highly likely (low uncertainty), and medium to high impact (therefore, are important as part of all four future worlds)

- Increased number of older adults as a percentage of the population, and at the same time, the younger and even larger Millennials generation begins to assume leadership roles (in business, government, policymaking).
- Not only the start of the aging of the Baby Boomers, but the end of era of the aging Baby Boomers (will we have overbuilt health care facilities?)
- Population growth in urban areas
- Consumer demand for better education and real participation in decisions for their health.
- Advancing technologies with significant gains in use of genomics, scanning, and ability to test patients remotely and real time.
- Changes in technology that decrease geographic barriers to care (telehealth, virtual medicine) and corresponding changes in reimbursement for care delivered outside of the clinic (email, phone, media visits).
- Technology developments better align the needs for information tracking and clinical documentation, leading to improved communication across providers and support for clinicians' and caregiver access to comprehensive patient information.
- Data systems advance to comprehensive data repositories, allowing for proactive data mining and greater precision in targeting care for patients, and for patient engagement through portals and registries.
- Sharing economy will offer health care and support services direct to consumers.
- Health care delivery point of access will shift away from bricks-and-mortar to include home-based care and community points of access.

Disruptors

- Current/potential – student loan crisis, potential war, impeachment, demographic shifts, increased life expectancies, sharing economy, Black Lives Matter (will it change the way we think about equality?)
 - Historical – women's movement, civil rights, Occupy Wall Street, WWI & WWII
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Scenario A: “it’s free for all” or “Come and Get It”

In this world, society supports the idea that healthcare access and services should be available to everyone because health care is a public good. However, it is also felt that individuals should be accountable for their own health; and therefore, engagement with the healthcare system is primarily initiated by the individual based on when they need care or based on their goals for their own health. Because healthcare services are seen as a public good, there are options for everyone to access care through public federal and state programs (balance between these is still an issue) as well as options to purchase expanded coverage or additional options.

Because public dollars are supporting healthcare services, yet individuals are accountable for their health, consumer education is an ongoing endeavor to make sure individuals know how to assess their health and when they should (and should not) seek care. There are also efforts to encourage healthy behaviors by stakeholders inside and outside of the healthcare system in order to minimize costs. Payment to healthcare providers continues to be a mix of value-based payment and fee-for-service because of the public-private payment mix and because the healthcare system has limited options for encouraging healthy behaviors or proactive health management. Providers also have an incentive to attract individuals with private insurance. There is widespread use of protocol-driven access to healthcare services provided by nurses or advance-practice clinicians, and access to physicians is better for those with private insurance. There is less focus on the provider-patient relationship and more focus on how individuals can effectively create their own care plan/goals of care.

Personal technology is heavily utilized by individuals, and there are options to choose whether the data are shared with healthcare providers or other practitioners or supporting organizations (e.g., nutritionists). Because of the widespread access to technology, a shrinking workforce in ‘traditional’ healthcare provider roles, and the accountability of individuals to access healthcare services, ‘non-traditional’ health consultants are popular as are technology-based programs to guide self-care management. This creates a need for assessing and monitoring the quality of these services, as well as options for licensure or accreditation of these providers in order to access public funding. Quality of care is measured by individual report cards or dashboards, which reflect progress against an individual’s goals of care.

Scenario B: “Community Investment” or “U.S. Health Care Starts to Look Like the Rest of the Developed World”

In a future within which the U.S. has moved to considering health care access and services a public good and a focus on population health, U.S. health care starts to look like the rest of the developed world.

After the Affordable Care Act was implemented starting in 2010, and the policy fiasco of repeal-and-replace in 2017, the American public finally coalesced around the notion that everyone should have health care coverage and access to care. Congress ultimately responded with a hybrid approach, between Medicare-for-all and a public option to be purchased. As a result, there has been a shift to substantial investment in community, going beyond medical care to support people in their everyday lives (e.g., housing, jobs, and education), a recognition that by addressing social factors in health, wellbeing and outcomes will improve. Yet controlling costs in this environment remains a challenge.

Technology has advanced quickly and been adopted in new creative ways to support health and health care. More and more care is delivered remotely, using inexpensive but accurate monitoring and communication devices. As a result, fewer bricks-and-mortar health care facilities are needed, and hospital care is reserved for the most dire of circumstances. The Amazon and Walmart retailers of the world are meeting health care needs in new ways, delivering medications, services, and devices directly to consumers; while the sharing economy continues to help local communities match and meet needs through health care focused versions of Airbnb and Lyft.

Surveillance data, combined with individual health data, has become important tool to be able to manage health in cost-effective ways. Data are available and used proactively by clinicians and public health professionals to assess risk and identify individuals, groups, and communities who could benefit from prevention, coordination, and/or treatment. EHRs have come and gone, instead, patients now have cards/devices with secure chips with all their health data. Data registries cater to clinicians, patients, and researchers, and have emerged as a powerful tool to manage and improve health, as a sort of cross between a data repository and social media form of patient/clinician interaction. Together, these technology advances have helped hold costs down; although data privacy advocates continue to raise questions and issues about data.

New local and regional governing bodies have emerged to help manage care and control costs, such as regional health boards, which are supporting medical care and social services at a local level. The role of employers is focused on wellness and productivity, but not health insurance purchasing and benefit management. The health care workforce is integrated and coordinated, inclusive of clinicians, social workers, and others. Poor communities require more investment of resources, which causes political and policy fragmentation at the state and national levels.

Quality has come to be defined broadly, as health becomes not just about medical care and services specific to diseases and conditions, but quality of life and life expectancy.

Scenario C: “Figure it out for yourself” or “The haves and have nots”

In this world, access to care and the way healthcare decisions are made don't look or feel much different than 2017. Access to care is pre-qualified – by age (Medicare), by poverty (Medicaid), by employment status, by veteran's status. Americans have failed during these ten years to address the urgency of the rising cost of healthcare and the near crisis of the fiscal cliff. The percentage of GDP devoted to health care continues to rise, affecting other aspects of federal and state spending (e.g., infrastructure, defense, education). Adding to the challenge for payers (government and private) and for health systems to plan for meeting the care needs and costs, is an environment the individual drives much of their care and services. With the dramatic aging of the population, matching the right care and services to patient needs (or perceptions of their needs) is especially difficult. Marketers (of drugs, of devices, of services) have a lot of influence; while patients have “skin in the game” as payment has become even more of a shared accountability in insurance and benefit models in order to manage costs. Consequently, the role of the physician and the patient is making sense of the inundation of messaging, and gate-keeping on care and costs to make smart choices. The health care team now includes experts in insurance benefits, more disciplines which support patients and manage costs, and care navigators or guides. Savvy consumers are able to access non-medical services and supports as they recognize their own need to manage health care costs, while underserved communities become more challenged to understand the complexities of system and access appropriate services, as well as maintain health without better support for social factors of health.

Technology to access care and monitor patients has become ubiquitous. In some ways, this has been an equalizer. At the same time, the more educated a patient is, the better they are able to utilize the information and data to self-manage and advocate for themselves; while the less educated are not as able to use technology and data in sophisticated ways and may be more prone to fall prey to unscrupulous practices. Certain population groups (e.g., elderly, LGBT, cultural communities), facing similar needs and opportunities, have come together to advocate for themselves and create shared demand. Quality measurement has evolved to be less focused on population health measures; and, instead, measurement is driven more at creating value at the individual level, based on that person's goals and preferences.

Scenario D: “Show me the money” or “If you have a ticket” “If you’re not in a group, you don’t count”

In this world, healthcare is available to those who qualify through work, age, or disability (similar to how healthcare is funded in 2017); unlike World Views A or B, healthcare is not provided as a safety net to all. Both access to care, and decisions about the type of care available and how “quality” is defined is polarized and strongly driven by association with the qualifying group – whether that is employment status, age or disability. In this world, goals are set on a population health basis, not for the individual. Individual health is valued, albeit as a member of the larger community. Health care is delivered by larger and fewer provider organizations which offer largely similar care approaches with little differentiation, and begins to look like an oligopoly.

As the health care system assumes greater responsibility for the health of the community, there is an increased reliance on guidelines or protocols created by centralized experts. This comes with stronger oversight for ensuring that care provided follows the guidelines, with less variation accepted due to decisions or values determined within the physician/patient relationship. Tracking of outcomes are more rigorously measured with larger and more complex data repositories. This increases the precision of identifying patient or condition-specific characteristics that relate to better outcomes. For some patients with private insurance or the ability to self-pay, services may improve with this greater ability to identify patients in this way – if a patient meets the guidelines, they get care; and if a patient doesn't meet the guidelines, they are denied that care. For patients receiving government coverage or without coverage, services may be reduced or denied.

The loci of control of patient information, too, follows this shift from the individual to the healthcare system itself. Because of the need to track utilization and outcomes, data are stored centrally, rather than building systems that allow information to follow an individual patient and be transportable by the individual to various providers seen. Care is being provided by integrated teams, however, the composition and approach taken by these teams are driven by cost saving restraints, rather than by patient satisfaction. Care decisions may be based on the increased knowledge of tracking patient characteristics related to outcomes