CHAPTER 2

GROWING TENISONS IN EMERGING HEALTH 2.0 MARKETS

[The Challenging Insurance, Political, IT and Business Ecosystem]

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Heights by great men reached and kept were not obtained by sudden flight but, while their companions slept, they were toiling upward in the night.

Henry Wadsworth Longfellow

Healthcare insurance reform from the Obama Administration - as incremental as it will be on both the Federal Medicare and State Medicaid levels from 2014 to 2018 - forces medical providers to look for more efficient ways to provide services, as well as additional sources of revenue in a margin-diminishing business model. Total federal spending for both programs, under current Office of Management and Budget [OMB] assumptions, are growing. Skepticism is prevalent throughout the healthcare industry about the benefits and the role of market competition in the provision of healthcare services, despite pronouncements by the Federal Trade Commission (FTC) and Department of Justice (DOJ) that competition has positively affected healthcare quality and cost-effectiveness, and recommendations that many of the barriers to competition that prevent it from fully benefiting consumers be removed.

And so, according to Cimasi, Alexander and Zigrang of Health Capital Consultants LLC, and others; this growing economic tension has produced the following

innovative health 2.0 business models and methods of reimbursement [personal communication].

GATEKEEPER SYSTEM AND PATIENT PROTECTION LAWS

The gatekeeper access system, which prevented patients from consulting specialists without first obtaining a referral from a primary care physician (PCP), was a prevalent cost containment measure affecting the practice of medicine. This system tended to elevate the status and value of primary care practices. In the last few years, health plan designs are offering more consumer choices, especially “open access”, or “specialty based” models that do not rely on gatekeepers, but employ other medical management tools to allow patients to see the most appropriate care provider for their condition.

FOR PROFIT VERSUS NOT-FOR-PROFIT HEALTHCARE

A number of controversial studies have investigated the effect of tax status on the relative costs and quality of services at these different types of hospitals. One study, published in the *New England Journal of Medicine* (*NEJM*), compared Medicare spending (adjusted for local costs, patient demographics, and the types and numbers of local healthcare providers and facilities) in markets with only non-profit hospitals, only for-profit hospitals, and those with both types. The results showed that the government spends more for every type of service studied (hospital, physician, home health, and other facility services) in those areas with only for-profit hospitals. Costs for areas with only not-for-profit hospitals were the lowest, with spending in markets with both for-profit and

not-for-profit hospitals falling in the middle of the range. The study also tracked adjusted mean per capita spending for hospitals that had a change in their tax status. For the period 1989-1995, areas where all hospitals were non-profit and remained so, had cost increases of $866 compared with $1,295 for areas where non-profits converted to for-profit status. Areas with only for-profit hospitals had cost increases of $1,166 from 1989-1995, whereas those which changed to non-profit hospital areas had the smallest cost increases of $837. These results may indicate that the tax status of hospitals affects the costs of health services provided by physician providers and other healthcare facilities. Further, this report may be considered detrimental to the public good. In the six years examined by this study, the difference in costs between these market types was indicated to have grown from 12.7% to 16.5%. In 1995, annual Medicare spending was $732 higher per enrollee in markets with only for-profit hospitals than in non-profit markets. This difference may be extrapolated to $5.2 billion dollars in total extra annual costs to Medicare.

COLLAPSE OF THE BUREAUCRATIC COMMAND-CONTROL HIERARCHY

It is not uncommon today to have three generations represented in healthcare. We have the Baby-boomers, Gen X and now, Gen Y. The Baby Boomer generation is saying with some sense of sadness that, “Medicine sure isn’t want it used to be!”, while Generation Xers are saying “It’s about time things changed!”, and the latest generation to enter the medical workforce, Gen Y’s, are saying “Ready or not, we’re here and we are going to do it our way.”

NEW MEDICAL SPECIALTIES AND EMERGING PRACTICE MODELS

Each generation of doctors and medical professionals is extraordinarily complex, bringing various skills, expertise and expectations to the modern medical work environment. Determining the best method to unite such diverse thinking is one of the many challenges faced by physician executives and healthcare leaders today. And, as linguistic evolution occurs, the nomenclature of hospitalist was followed by that of intensivist, proceduralist and nocturnalist, etc [www.MedInnovationBlog.com and Personal communication Richard L. Reece MD]. Is it any wonder that many medical leaders and executive in the Baby Boomer generation find themselves at a loss? The days of functional leadership are gone and suddenly, no one cares about the expertise of the Baby Boomers or how they climbed the corporate ladder, in medicine or elsewhere. Leadership in the new era is no longer about command-control or dictating with intense focus on the bottom line; it is about collaboration, empowerment and communication. And, it is not about titles and nomenclature; it is about lifestyle choice.

What else drives these new-wave specialists? The answer, of course, is the next-generation of physicians and their emerging new medical business and practice models, which include:

- "Ambulists" are doctors that travel locally, have no, or only a sparse physical office presence of their own. They sporadically provide services that are additive to traditional practice models [i.e., endocrinologist in a large family medical office with many diabetics].

- "In-Situ" physicians regularly provide services that are complimentary to existing traditional practice models [i.e., dentists or podiatrists in a medical practice].
- "Laborists" are obstetricians that do not wish to be on-call. First begun in Cape Cod and other Massachusetts hospitals, such obstetricians work regular shifts for the sole purpose of delivering babies.
- "Locum Tenens" doctors travel around the country as itinerants [i.e., cruise ships] as temporary substitutes for another the same specialty.
- "Officists" remain in their own physical practice, and rarely see patients in the hospital, nursing home, patient home, out-patient facility, etc.
- Finally, "dayhawk physicians" mimic the "nighthawk physician" model where radiologists in remote locations read films in the middle of the night as cash-strapped hospitals often find it cheaper to outsource with better services and more timely interpretations in many cases.

Modern Corporate Home Care

Carena, Inc [www.CarenaMD] is a medical company that provides a Health 2.0 perspective to the old model of medical care delivery for innovative, self-insured companies. Seattle-based Carena was founded on the principle that expanding access to medical care improves outcomes and reduces costs. By providing around-the-clock medical care and education at a patient-identified time of need, Carena patients, clients and health plans are reported to experience 30-35% lower costs than traditional ER visits while patients receive the right care – at the right time. Internist Frances Gough MD is the Vice President of Product Development, Ted Conklin MD is founder and Ralph C.

Derrickson is President and CEO. New corporate clients include Costco and the Microsoft Corporation of Redmond, WA. Carena doctors are often called "*housepitalists"*.

On-Site Physicians

Similarly, another integration model is "on-site" employee affiliations that represent an adjustment of the hospitalist concept. This redeployment of existing MDs into the workplace (factory, police station, office building) or retail setting (Walmart, Intel Corp, Cisco, IBM, etc) is another exciting challenge in heath care today. The keys to success are thoughtful implementation and a commitment to measure the results of change and use the data to produce further changes.

Worksite Clinics

More formal than the onsite physician model, worksite medical clinics are growing rapidly. One-third of Fortune companies with 1,000 or more employees report them in place. By the start of end of 2011, twice the number was said to be installed. Furthermore, these clinics can function in other work places with 150 or so employees, such as: school systems, universities, community colleges, unions, city and country governments, business parks, manufacturers, or service organizations. They lower healthcare delivery costs in these ways:

• Provide routine outpatient care for much lower costs inside the clinic.

• Provide patient management for chronic diseases that consume 70% of health costs.

• Allow physicians to collaborate with pre-selected specialists to reduce expensive

outpatient and inpatient care.

• Integrate personal care with occupational health, workers compensation, human [drug employment testing, retention and recruitment] and resource productivity (absenteeism and presenteism).

• Use salaried primary care doctors who deliver care rather than be distracted by business issues.

•Remove the usual cost barriers to care, such as time off and travels to access care off-site, unpredictable outpatient lab, x-ray and imaging costs, and highly priced prescriptions. Most clinics provide free generic drugs or brand name drugs at cost.

•Use onsite eMR, administrative and clinical group ware IT systems containing best practice information.

Revival of Individual House Call Doctors

From a more personal perspective than the corporate home care model above, most people view house view house calls as a popular practice from the past. Although only slightly less than 5% of the nation's doctors regularly make house calls today, the medical house call industry is swiftly picking up momentum once again. It is a move that is greatly benefiting physicians and patients alike. Why? It’s because we live in a society that has become technology focused. While this emergence has benefited many in terms of medical advancements, there are a growing number of patients who are uncomfortable with next-generation medical practices. These people, particularly the rapidly aging elders of the nation, want to be cared for in a friendly, nurturing, and convenient way. As people age and fall ill, it becomes increasingly difficult to leave the home for office visits. Not to

mention, there are many handicapped patients as well who have to arrange for wheelchair vans or ambulances just to visit the doctor.

Thanks to the desire of physicians seeking to open their own medical house call practices, these patient needs are slowly being met. Many of these physicians are strictly open for house call visits only and have no physical office. They commonly take appointment requests via phone calls and emails with the overall goal to combine the service of an old-time, small town doctor with the latest technology designed to meet people's emotional, and financial, needs. Patients are also able to save a considerable amount of time by not having to leave the house to go to the doctor's office, and not having to fill prescriptions. After all, many medical house call physicians travel along with certain medications that can be dispensed on location. Narcotics, however, will likely need to be filled with a prescription. While highly convenient for patients who wish to receive medical house call services, the reviving industry is fitting for physicians. In recent years, Medicare has increased its level or reimbursements for physicians who travel to patients. Just in the past few years alone, Medicare has been billed approximately $1.5 million annually for house calls. Even nurse practitioners [NPs] and Doctors of Nursing Practice [DNPs] who make a small number of house calls are typically unaware that they can maximize profit potential with medical house calls. Some NPs have even offset operating expenses by offering house calls to make their office based practice more appealing to their patients.

Also, significant advances in technology have enabled popular medical equipment to be smaller and portable. Physicians are able to perform standard procedures, such as skin biopsies and blood draws while outside the office. They are also able to easily access

patient medical records through usage of a laptop, as well as resources such as the Physicians' Desk Reference through usage of a hand-held personal digital assistant. One firm, HouseCall Doctors, established since 1998, educates and supports physicians who are ready to make a transition from office-based positions to medical house call practices. There are no royalty or membership fees, and this is not a franchise. HouseCall Doctors helps transition to a reportedly more pleasing, profitable way to practice medicine today www.mobilemedicalpractice.com

Retail Medical Clinics

The Convenient Care Association [CCA] is comprised of companies, medical providers and healthcare systems that provide patients and consumers with accessible, affordable and quality healthcare in retail-based locations. The CCA works primarily to enhance and sustain the growth of the convenient care industry through sharing of best practices and common standards of operation. The CCA was founded in October 2006 and the first Convenient Care Clinics [CCCs] opened in 2000. The industry grew quickly since then. Today there are approximately 1,060 clinics in operation, and CCA member clinics represent more than 95% of the industry. To date, CCCs have served more than 3.5 million patients with its nurse practitioners [NPs] and physician assistants [PAs]. With this rapid expansion, and projected continued growth, it quickly became clear that the shared concerns and needs of both providers and patients could best be served through an association that allowed for:

- Sharing best practices, common standards of operation, experiences and ideas.
- Developing common standards of operation to ensure the highest quality of care.

- A united voice to advance the needs of CCCs and their customers
- A unified effort to promote the concept of CCCs, and to respond to questions about this evolving industry.
- Reaching out to the existing medical community and creating new partnerships.
- Building synergies with traditional medical service providers.

The Public Health Management Corporation [PHMC], a nonprofit public health institute, provides executive management and administrative support for the Convenient Care Association.

Consumer Directed Health Plans

A recent survey by Watson Wyatt and the National Business Group on Health, found that:

- Approximately half of companies now offer workers a CDHP, up from 47% in 2009, and another 10% are expected to adopt a CDHP by 2012.
- CDHPs are helping employers control costs—companies with at least half of their workers enrolled in a CDHP have a two-year cost trend (4.6%) that is 25% lower than non-CDHP sponsors (6.1%).
- Two-thirds of employers (67%) cite the poor health habits of their employees as a considerable challenge to managing their health costs.
- While companies will be taking a close look at benefit offerings because of the recession, most do not plan major changes.

- Nearly 30% of employers have revamped their healthcare strategy with another 30% planning to do so in 2009.

The growth in CDHPs has made it more important than ever for health plans to provide their members actionable information and pricing transparency to navigate the healthcare system.

Prepaid Preventative and Maintenance Health Care Networks

The "No Insurance Club" feels that private preventative medical contracts may be one possible solution for those Americans going without healthcare; especially the young and healthy. Why? Some pundits are leaning toward universal care which seems too socialized for some. Yet, private insurers continue to increase premiums, which prices healthcare out of reach for the average American. Employers can no longer float the cost of insurance so they pass it on to their employees. Patients aren't the only ones being affected by the current state of healthcare. More and more doctors are going out of business and hospitals are cutting back due to escalating costs and payment defaults. So, current remedies to this dilemma include major medical insurance policies for catastrophic events with high-deductibles to keep monthly premiums down, Medicaid, mini retail-clinics at grocery stores/pharmacies, and emergency room visits for common illnesses. But, preventative healthcare and medical maintenance is not typically address. More than 90 percent of health related issues can be taken care of with preventative care and maintenance but only a small percentage of Americans currently enjoy the benefit of preventative healthcare.

The No Insurance Club [NIC] rethinks healthcare by offering an affordable alternative to traditional insurance options. The club connects patients with participating board certified physicians that will treat and care for preventative healthcare needs for a one-time prepaid annual membership fee:

- NIC patients make a one-time annual payment that is typically less than a one-month premium with traditional insurance.
- Patients receive up to 12 office visits per year that also include immunizations, $4 or less in-office prescriptions, and additional services including blood tests.
- No deductible, no co-pays, no premiums.
- No surprise bills to patients.
- Viable alternative to COBRA for employees disengaged from work.
- Low cost option for the self-employed.

What's in it for the doctors? How about no insurance clerks, no need to snail mail medical insurance claims or use expensive electronic claims submission clearinghouse services, no bad debts or bad expense write-offs, no ARs; and fast cash [www.NoInsuranceClub.com]

Direct Reimbursement [DR] Plans

Direct Reimbursement [DR] plans provides employees with health care by paying only for benefits received and are best suited for medical Health Reinsurance Activities [HRA], dental and vision plans. Such self-funded plan costs are predictable; with no need to insure/manage costs that are non-catastrophic, and no need to insure/manage costs that

are low-risk and low cost [personal communication, Darrell K. Pruitt; DDS, Fort Worth, TX]. HRAs, when used with a high deductible medical insurance, are also predictable and non-catastrophic. Sample overhead cost reduction comparisons include:

- Indemnity/Insured 15% - 30%
- HMO/DHMO 30% - 40%
- Traditional/self-funded 9% - 13%
- Direct Reimbursement 4% - 8%

Direct Reimbursement Services, Ltd

P.O. Box 292455

Kettering, OH 45429

Tel: 937.428.1046

DirectReimbursement.com

And, RiskManagers.Us is a specialty company in the benefits market that while not an insurance company – works directly with health entities, medical providers and businesses to identify and develop cost-effective benefits packages – emphasizing transparency and fairness in direct reimbursement compensation methods [Personal communication, William Rusteberg; Brwonsville, TX].

RiskManagers.us

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3505 Boca Chica Blvd., Suite 150

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RiskManagers.Us

Cash Only Medical Practices

The average physician today leads a quite hectic lifestyle. Frequently overworked and overtired, physicians are consumed with problems such as high overhead, low reimbursement rates, HMOs and managed care, and the practically inevitable “Universal Healthcare" also known as socialized medicine. Although accepting insurance from patients may be the “norm,” for most physicians, it is certainly not the only option. One could be missing out on what potentially may be the wave of the future in medicine — a cash only medical practice. With over 45 million Americans without health insurance and millions more who are under insured, cash pay medical practices allow these patients to pay out of pocket for quality, and most importantly, affordable medical services. More than 50% of US consumer debt is related to medical bills, 35% of which is accumulated from medical bills that involved acute simple to moderate complexity emergency room visits. These medical bills could have been avoided if the patient had been seen in an office setting by a physician with a cash only medical practice.

For example:

- A simple laceration repair in an emergency room may cost more than $2,000. A simple laceration repair in a cash only medical practice (office based) may be $200-$500

- A simple cold or flu treated in an emergency room may cost $300-$800. A simple cold or flu treated in a cash only medical practice (office based) may be $80-$150

There are many benefits to start a cash only practice. For starters, office overhead lowers significantly as insurance claim processing and patient billing decreases. This means less paperwork for insurance claim filing. Prior authorization for labs and diagnostic studies are not required. Another benefit: there are no third party payers (i.e. insurance companies), forms, ID numbers, or co-payments with which to contend. Additionally, even with fewer patients to see, cash pay medical practices pave the way for increased profits and decreased overhead. These types of practices also allow a physician to spend more valuable time with the patient. Lastly, and perhaps what is the greatest benefit of all, a cash pay medical practice enables a physician to have more free time, most definitely a privilege for those who work in the healthcare industry.

Concierge [Boutique] Medical Practices

The boutique, retainer or concierge medical practice business model requires an annual fee for personalized treatment that includes amenities far beyond those offered in the typical practice, or suggested by physician medical unions. Patients pay annual out-of-pocket fees for top tier service, but also use traditional health insurance to cover allowable expenses, such as inpatient hospital stays, outpatient diagnostics and care, and basic tests and physician exams. Typical annual fees can range from $1,000 to $ 5,000 per patient, to family fees that top $20,000 a year, or more. The concept, initially

developed for busy corporate executives, has now made its way to those desiring such service.

SOCIETY FOR INNOVATIVE MEDICAL PRACTICE DESIGN

The Society for Innovative Medical Practice Design (SIMPD) is an organization of physicians promoting direct financial relationships with their patients in order to restore the integrity of the patient-physician relationship. It is their mission to ensure that physicians and patients retain the right to design and implement practices that enhance the effectiveness, efficiency, service, and value of healthcare www.SIMPD.org

Patient-Centric Medical Homes

According to advocates David C. Kibbe MD, MBA and Joseph C. Kvedar MD, a medical [dental] home is not just a building, house or hospital, but a collaborative and integrated team approach to providing Health 2.0 Care www.MedicalHomeNews.com It originates in a primary health care setting that is family-centered and compassionate. A partnership develops between the family and the primary health care practitioner. Together they access all medical and non-medical services needed by the family to achieve maximum potential. The medical home maintains a centralized, comprehensive record of all health related services to promote continuity of care: http://www.transformed.com

Critics of the concept suggest over dependence on technology given an increasingly mobile society with a core philosophy fixed in the past; especially in light of the Obama Administration's eHR initiatives. [www.MedicalHomeNews.com]

Nevertheless, in May 2009, medical home guidelines were released by the AMA. Four physician organizations developed them to ensure consistency and help define how the patient-centered home model should work. The 16 guidelines include recommendations on who should collaborate on the projects, how they should choose practices to participate, what type of support should be provided to practices, how practices should be reimbursed, and what each project should do to analyze and report results: http://www.ama-assn.org/amednews/2009/05/11/gvse0512.htm

Micro Medical Practices [MMP]

A micro medical practice [MMP] is a low overhead, high-tech, labor reduced and often mobile office model that allows more physician control and patient face-time [Dr. Ramona Seidel, Annapolis, Maryland]. This concept can be extended to those patients who want or need to pay cash for their health care; high deductible health insurance, health insurance with high co pays and residuals, etc. Or, the concept may include that seen with the practice of physician-assistant Cheryl DeMonner PA-C at the Micro Medical Practice of Santa Cruz County. William Morris MD is her supervising physician [www.micromedsc.com].

Satisfaction Guaranteed Medical Care

At the Detroit Medical Center, patient focused medical care is taken to a competitive extreme with this promise:

> "If our patients are not absolutely satisfied with any aspect of their inpatient service or overnight stay in a DMC hospital, we will credit their patient pay balance up to $100."

Guarantee applies to all inpatient (or overnight) stays and all surgery services provided at a DMC hospital. Adjustment/Refund is dependent upon the nature of dissatisfaction as follows:

- ✓ Tier 1 ($25) Problems with physical facilities
- ✓ Tier 2 ($50) Inadequate communication
- ✓ Tier 3 ($75) Excessive wait issues
- ✓ Tier 4 ($100) Poor service from employees

And, they have the twenty-nine minute emergency room guarantee. Source: http://doctorandpatient.blogspot.com/2007/01/29-minute-er-guarantee.html

Internet Enabled Healthcare

The mission of eDocAmerica is to improve health by providing direct, online access to medical services, making it much more convenient to get the information for employees to take better care of themselves. MD Online LLC [dba eDocAmerica] is a fully funded, private company. eDocAmerica has a 'no advertising policy' and therefore does not host or receive funding from advertising from the display of commercial content. It is a HONcode compliant website. (www.hon.ch). eDocAmerica provides an innovative and effective Health 2.0 employee benefit program that purports to:

- Increase employee satisfaction and morale
- Decrease absenteeism
- Save money on health care costs
- Improve employees' health
- Provide online access to board certified physicians.

eDocAmerica allows employees or members to have access to board certified, experienced physicians to consult with them about health care. eDocAmerica physicians provide personal advice, suggest treatment alternatives, use links to websites, provide patient information from other sources, or refer employees to their specialists – all from the workplace desktop computer or from home. The cost of eDocAmerica for a year for one employee is less than one primary care visit. It is a compliment to direct reimbursement and cash only medicine: info@edocamerica.com and phone: 1-866-525-eDoc (3362)

Virtual Competitive Tensions

In his book *Innovation-Driven Health Care* (Jones and Bartlett, 2007) Richard Reece MD gives numerous practical examples of the positive, yet competitive, benefits of virtual medicine:

http://www.medicalhistory.com (symptom presentation prior to visit)

http://www.officeally.com (e-connecting continuum for the small MD office)

http://www.ideallifeonline.com (home-based patient management)

http://www.medencentive.com (reward for responsible performance)

http://www.medadherence.com

http://www.rediclinic.com (nurse practitioner in retail location)

http://www.hpinstitute.com (J&J acquisition)

http://www.healthmedia.com (Wellness and Prevention)

http://www.med-flash.com (e-Patient Health Record)

http://www.lifeonkey.com (e-Patient Health Record)

http://www.digitalunioncorp.com (collaborative software - low cost, high functionality))

http://www.specialistsoncall.com (brings expertise to the hospital ER)

These companies cover much of the virtual medicine competitive landscape. Their central purpose is to help physicians and patients adapt and adopt the new realities in the Health 2.0 landscape.

RISE OF COLLABORATIVE AND PARTICIPATORY HEALTH 2.0

According to Susannah Fox, of the Pew Internet and American Life Project, more than half of the entire adult population in the US used the internet to get involved in the 2008 political process [pewinternet.org]. Blogs, social networking sites, video clips, and plain old email were all used to gather and share political information by what Lee Rainie, Director of the Pew Internet & American Life Project, dubbed a new "participatory class"

By 2010, this participatory class had transitioned to reading medical blogs, listening to healthcare podcasts, updating their social network profile, watching surgical videos, and posting comments. Technology is not an end, but a means to accelerate the

pace of discovery, widen social networks, and sharpen the questions someone might ask when they do get to talk to a health professional. GenY and GenX internet users are the most likely groups to be turning up the network volume in health care, but no connected patient of any age is going back in the box.

Link: http://www.thehealthcareblog.com/the_health_care_blog/2009/04/participatory-democracy-participatory-medicine.html#comments

Emergence of Health 2.0; Health 2.0 plus, and Health 3.0

Ever since the term "web 2.0″ was used in 2004, there has been an inordinate amount of chatter about what web 2.0 really is and its true impact. No one's really defined it clearly, but we think the web evolution relative to healthcare essentially falls into 3 generations:

Health 1.0

This is the traditional healthcare system. Information is communicated from a doctor [medical practice or hospital] to patients [individuals or customers]. This is the basic B2C or [business-to consumer] website. The internet became one big encyclopedia of information by aggregating information silos and knowledge repositories. Doctors, clinics and hospitals aggressively launched websites for an internet presence beyond their brick and mortal virtual establishments.

Health 2.0

According to Matthew Holt, http://www.health2advisors.com and similar other sources, Healthcare 2.0 may be defined as:

"A rapidly developing and powerful new business approach in the health care industry that uses the Web to collect, refine and share information. It is transforming how patients, professionals, and organizations interact with each other and the larger health system. The foundation of healthcare 2.0 is information exchange plus technology. It employs user-generated content, social networks and decision support tools to address the problems of inaccessible, fragmentary or unusable health care information. Healthcare 2.0 connects users to new kinds of information, fundamentally changing the consumer experience (e.g., buying insurance or deciding on/managing treatment), clinical decision-making (e.g., risk identification or use of best practices) and business processes (e.g., supply-chain management or business analytics)".

Medical and related administrative information is communicated between clinic, practice and individual patients, and collaboratively between and among all involved individuals. And so, if health 1.0 was a book, health 2.0 is a live discussion.

Furthermore, Scott Shreeve, MD [http://blog.crossoverhealth.com and personal communication] of *Cross-Over Health* defines health 2.0 as:

"A New concept of healthcare wherein all the constituents (patients, physicians, providers, and payers) focus on healthcare value (outcomes/price) and use competition at the medical condition level over the full cycle of care as the catalyst for improving the safety, efficiency, and quality of health care."

Joseph Bakker, of Philips Medical Systems thinks that Health 2.0 is the next evolution in the healthcare electronic domain. He opines that the best way to understand the Health 2.0 trend is to review some of the leading companies in search, social and professional networking. And so, according to Dr. John Luo [Editor-in-Chief of *MDNG: Psychiatry Edition*, and chief of consultation and liaison psychiatry in the department of psychiatry at the UCLA Semel Institute for Neuroscience and Human Behavior] these three platform trends have been identified.

a.] Health Search

Health-specific search engines like Healia, Medstory and Healthline exist on the Internet, with more specific sites like ClinicalTrials.gov with health-related terms from medical taxonomies. Some are free while others require a paid subscription. Taxonomies include Medline's Medical Subject Headings (MeSH), the Systematized Nomenclature of Medicine-Clinical Terms (SNOMED-CT), and the National Cancer Institute (NCI) Thesarus. Some earn Health On the Net (HON) and Utilization Review Accreditation Commission (URAC) certification; while other do not. Health search engines employ specific algorithms to implement the medical taxonomies, as well as utilize health experts to refine the search terms. For example, instead of relying on algorithms and semantic analysis, Organized Wisdom adds the knowledge of trained expert search guides and physician reviewers. And, Val Jones MD, President and CEO of Better Health, LLC and former Senior Medical Director of Revolution Health consumer health portal, was an early internet physician blogger. Prior to Revolution Health, Dr. Jones served as the

founding editor of Clinical Nutrition & Obesity, a peer-reviewed e-section on Medscape medical journal.

b.] Social networking

MySpace, Flickr, Twitter and Facebook are well known consumer social networks. Lesser known networks include Bebo, Friendster, LiveMocha, Orkut, and Yelp. Activities are communicated via e-mail alerts to community news and friends. In the Health 2.0 world, patient social networking has a new meaning. For example, at DailyStrength, patients can create an online journal and members give virtual "hugs" to help support one another, 24/7. PatientsLikeMe focuses on neurologic conditions [Parkinson's disease, multiple sclerosis, amyotropic and primary lateral sclerosis, progressive muscular atrophy, cortical basal degeneration and multiple systems atrophy], immuno-deficiency disorders [HIV/AIDS] endocrine conditions [fibromyalgia, mononucleosis and EB virus], and mood affectation disores [depression, anxiety, bi-polor, obsessive compulsive disorder, and post-traumatic stress disorder]. Patients not only share symptoms, but also treatment data which are redacted tracked. Information is plotted graphically over time to help member see outcomes on specific symptoms. MedHelpalso provides support communities for patients but adds topic-based forums featuring physician experts. And, non-physician blogger Brad Kittredge MBA/MPH - from the Haas School of Business at UC Berkeley and a Brian Maxwell Fellow - developed a patient network for persistent medical non-diagnosis, which he defines as "any patient who experiences clinical symptoms that five or more doctors are unable to diagnose." [http://hyoumanity.blogspot.com]. He believes thousands of Americans are

desperately seeking answers to complex medical conditions that doctors are unable to diagnose [personal communication], as the economic, employment, social and human costs of this seldom address entity are enormous. Finally, PhysiciansforPatients provides support, to vent frustrations and to give each other advice. There is a dedicated physician specialist for each community [disease entity] to answer questions and to help guide discussions. Patients, family, and friends are encouraged to talk to one another.

c.] Professional networking

LinkedIn is a popular professional network that offers job postings and discussion forums. Other professional sites include CIOzone, LiveMinds and NetworkingforProfessionals. These sites are popular with employment recruiters, but the medical community represents a small fraction of total users. In the Health 2.0 space, Sermo.com is the largest online healthcare community, with more than 150,000 verified members. At this site physicians pose questions so that clinical findings and unusual events can be shared, with collective "crowd-sourced" knowledge advancing patient care in a crowd-sourced manner. Active physician licenses are verified upon entrance but doctors can maintain an anonymous profile, thereafter. Pharmaceutical companies pay to access the observations and clinical insights on Sermo - which may now be considered the de-facto national medical membership organization - in as much as fewer than 18 percent of all allopathic physicians belong to the formerly august AMA. In fact, CEO Sermo and Founder Daniel Palestrant MD earned high-praise from the current generation of young physicians, and much ire from the old AMA guard, with recent competitive taunts proclaiming same. And, a new company - Det Norske Veritas - joins the "Joint

Commission" and the American Osteopathic Association as the only national hospital accrediting agency approved by CMS with authority through September 26, 2012.

Ozmosis is another site that pools and shares clinical pearls similar to Sermo, but its revenue comes from medical technology companies that sponsor forums seeking user experiences. iMedExchange also allows members to share clinical points. Within3 offers a more professional focus compared to the sites above. Its goal is simply networking, with individual and institutional members, and groups that facilitating information exchange, whether clinical trials or referrals for care. Other popular professional health networks are Knol, HealthLine, MedNotes, WebMD; BoardCertified, MentalHealt.net; ChainOnLine, Medpedia, HealthProNet.org, HCPLive, and TheDoctorsChannel.com. And yet, Richard Berning MD, founder of PrivatePractice.MD [personal communication], warns that

> *"As much as we doctors like to be self-sufficient, there is only so much time in a day and we really do have more important things to worry about (patients) than how profitable our practice was today. Taking care of patients should be job number one."*

For physicians interested in medical writing, publishing and healthcare journalism; PubMed, MedlinePlus, MayoClinic.com, CDC.gov, amd TuDiabetes.com are popular, while Livestrong.org, CureTogether.com, Roadback.org, ABC News Health and ToxNet are growing. Finally, BiomedExperts purports to be the first literature-based medical-scientific social network bringing right researchers together for online collaboration. And,

when job seeking, physicians may consult AllHealthcareJobs.com and http://www.nejmjobs.org

d.] All Health 2.0 Stakeholders

Electronic platforms that may be used by all healthcare stakeholders [citizen health journalists] to create their own blogs, vlogs, e-forums and networks include Ning, Blogger, WordPress, TypePad,and Trifecta. Lesser-known platforms are Tripod and Squarespace. These are free, or virtually so, and require minimal computer programming skills.

Health 2.0; *plus*

This emerging hybrid bridges the philosophy and technology of contemporary Health 2.0, and futuristic Health 3.0.

Cisco System's HealthPresence is one example developed by the Cisco Internet Business Solutions Group (IBSG) in 2010, by Dr. T. Warner Hudson, and prototyped at the Cisco Technology Centre. Using the network as a platform, Cisco HealthPresence combines state-of-the-art video, audio, and medical information to create an environment similar to what most people experience when they visit their doctor or health specialist.

Health 3.0

Soon, patients will not be seeking only information anymore. It will be actionable intelligence - artificial or virtual intelligence - that will be sought. Patients and

stakeholders will interact with it almost like another patient, doctor, or related stakeholder. The internet won't just blindly do what we tell it do to, it will think for you.

Health 3.0 presents some amazing opportunities in healthcare to the enlightened. For example, imagine being able to be diagnosed by your computer or have your toilet run a SMAC 10 or SMAC 20 on you? Imagine going to Costco® - or your own - scanning a barcode with a web-enabled smart phone, and being instantly notified that your durable medical supply, or antibiotic, purchase is a covered service under your insurance policy or HSA-eligible. One day, you'll type into some (probably Google-like Chrome) search engine or MSFT interface:

"I want to find a female podiatric surgeon who's done at least 100 ankle fusions, who operates every Monday near my house, who takes my insurance at XYZ surgery center, who has never been sued, speaks Farsi and enjoys playing the flute."

Instantly - Your results would be back with an offer to set up an appointment.

The primary question concerning Health 2.0 going forward essentially is: where on the web do you go to interact with others about healthcare-related topics? And, is the digital medical workforce leading, or lagging, in the adoption of social and artificial intelligence cloud computing for healthcare?

HEALTH 2.0 COLLABORATION NOT WITHOUT CURRENT CRITICS

Of course, several drawbacks have been raised in the use of all Health 2.0 technologies. For example, there are limitations for doctors and patients using Google,

Bing, Safari, oneriot, wolfram alpha, aardvark or other internet search engines which may be only marginally effective for unique conditions easily organized as search terms or meta-tags. Ben Hughes even codified these tensions into four major groups: [1] definitional opaqueness, [2] informational errors and lost command-control of physician autonomy; [3] patient safety issues; and [4] issues of privacy and ownership

Source: http://benjaminhughes.net/index.php?title=Publications.

Healthcare Fraud and Abuse Insurance Tensions

It is well know that doctors are slow adopters of health information technology. But, Medicare and private health plans have been "mining" medical claims data for potential fraud, for some time now, and with the help of sophisticated computer technologies. And, such IT will be used more than ever going forward. For example, Department of Health and Human Services Secretary Kathleen Sebelius, and Assistant Attorney General Anthony West, recently launched: www.StopMedicareFraud.gov

Mining Medical Claims Data

Fraud accounts for an estimated 3% to 10% of the $2 trillion spent annually on healthcare in the US. Within the past few years, companies including Fair Isaac, IBM, ViPS and Ingenix, a subsidiary of UnitedHealth Group, have developed software that detects suspicious patterns in claims data.

According to the CMS, their technique is called "spider-webbing. In other words, find one common denominator and follow the thread. "Red flags" indicating possible fraud include medical providers charging more than peers; providers who administer

more tests or procedures per patient than peers; providers who conduct medically "unlikely" procedures; providers who bill for more expensive procedures and equipment when there are cheaper options; and patients who travel long distances for treatment. Of course, private insurers typically follow CMS, as Aetna reported its fraud-detection software helped the insurer prevent more than $89 million in fraudulent reimbursements from being paid, in 2009, compared with $15 million it was able to recover after fraudulent payments were already made. Companies are able to save far more money by detecting fraud before claims are paid than recovering the money after the fact.

The Federal False Claims Act Recovery

Since 1986, False Claims Act [FCA] judgments and settlements totaled over $20 billion dollars. Below are the top 20 alleged FCA recoveries in 2009. Notice that all twenty, of the top 20, are healthcare and big Pharma related.

1. Tenet Heath Care - $900,000,000
2. HCA - $731,400,000
3. Merck - $650,000
4. HCA - $631,000,000
5. Serono - $567,000,000
6. Taketa Abbott Pharmaceutical Products Inc - $559,483,560
7. Schering Plough - $255,000,000
8. Abbott Labs - $400,000,000
9. Fresenius Medical Care (National Medical Care) - $385,000,000
10. Cephalon - $375,000,000
11. Bristol Myers Squib - $328,000,000
12. SmithKline Beecham [DBA] GlaxoSmith Kline - $325,000,000
13. HealthSouth - $325,000,000
14. National Medical Enterprises - $324,200,000

15. Gambro Healthcare - $310,000,000

16. Schering-Plough - $292,969,482

17. AstraZeneca Pharmaceuticals - $266,127,844

18. St. Barnabas Hospitals - $265,000,000

19. Bayer Corporation - $257,200,000

20. Schering Plough - $255,000,000

Governmental Anti-Fraud Success

As the federal government has also grown increasingly effective at Medicare fraud recovery, its' return on investment improved to nearly 9-to-1 by 2009. And, it recovered $2.85 billion Medicare and collected $115 million in Medicaid fraud recoveries during 2005-2009. According to Robert Laszewski, of The Health Care Blog however, the big losers are doctors as medical societies will have less reason to challenge the customary and reasonable system than they did before. Source: msnbc.com on Jan. 13th, 2009.

The Recovery Asset Contractor Program

In 2008, under the beta version of the Recovery Asset Contractor [RAC] program, CMS paid auditors a fee based on the amount of improper payments discovered. Hospital officials worried that this "bounty hunter" approach - the second for CMS after medical practice audits - creates a bias in auditors to focus only on collecting government overpayments. Other hospitals point to a pilot audit program in New York, Florida, South Carolina and California, which found $357.2 million in overpayments and just $14.3 million in underpayments. Medicare estimates its error rate at 3.9 percent in 2007, down

from 9.8 percent in 2003, but still totaling $10.8 billion in improper payments. RAC auditor were working in every state by 2010

Patient Bounty Hunters

Under the Health Insurance Portability Accountability Act, the Department of Health and Human Service (DHHS) has operated an "Incentive Program for Fraud and Abuse Information", since January 1999. Under this program, HHS pays $ 100-1,000 to Medicare recipients who report abuse in the program. To assist patients in spotting fraud, HHS has published examples of potential fraud, which include:

- Medical services not provided.
- Duplicate services or procedures
- More expenses services or procedures than provided (upcoding/billing).
- Misused Medicare cards and numbers.
- Medical telemarketing scams
- Non-medical necessity

The OIG has oversight responsibility for patient bounty hunters. The agency performed or oversaw 2,372 audits, conducted 70 evaluations of department programs, and opened 1,654 new civil and criminal cases, bringing to more than 2,700 the number of active OIG investigations the last decade. Additionally, the OIG excluded 3,448 individuals and entities from participation in Medicare, Medicaid and other federally sponsored health care programs, and its enforcement efforts resulted in 517 criminal convictions and 236 successful civil actions. To discourage flagrant allegations,

regulations require that information be directly contributed to monetary recovery for activities not already under investigation. Nevertheless, expect a further erosion of patient confidence, as they begin to view healthcare providers in the same light as “bounty hunters”.

POLITICS AND THE AMERICAN RECOVERY AND REINVESTMENT ACT

On February 17, 2009, President Barack H. Obama signed into law the American Recovery and Reinvestment Act [ARRA]. The 1,100 page document, the most sweeping economic legislation in the history of our country, provides funding for health information technology initiatives for physicians, clinics, hospitals and healthcare organizations. At about $20 billion, there has never been such an investment in HIT at one time. Some money will flow into the current calendar year, some dollars will flow in subsequent years, and some funding will be available until spent.

According to Steve Lieber, President of the Health Information Management Systems Society [HIMSS.org], these nine healthcare administration areas received HIT funding in 2009:

1. The Office of National Coordinator of HIT [ONCHIT] received $2 billion to fund HIT initiatives.
2. Medicare and Medicaid funded HIT initiatives to physicians and hospitals beginning in 2011.
3. $1.1 billion allocated to the Agency for Healthcare Research and Quality [AHRQ] for clinical practice effectiveness research.
4. The Indian Health Service [HIS] received unknown funding.

5. Construction funds to the Health Resources and Services Administration [HRSA] for community health centers.

6. $500 million allocated to the Social Security Administration [SSA] to upgrade HIT systems.

7. The Veterans Administration [VA] funded, in part, from the ARRA.

8. The Department of Agriculture received money for distance-learning and broadband health applications.

9. Finally, $4.7 billion to the National Telecommunications Administration [NTA], for telemedicine diffusion.

Of course, time is of the essence if physicians and hospitals are to receive the full incentive payment for HIT adoption beginning in 2011. The monies are significant for physicians as full payment between 2011 and 2015 will range between $44-K and $75-K. For each year a physician is not in the program, the incentive payments decline by 1% each year. The ultimate calculation of payments to physicians is based on Medicare patient volume.

For doctors and hospitals, the incentive payment begins at $2 million in 2011, with additional payments based on Medicare volumes. The physician incentives stop in 2015. In 2015, there will be penalties for providers not participating in the program. Thus, ARRA is not only an economic stimulus bill. It's an HIT stimulus bill for the early-adoption by medical providers.

HITECH ACT OF 2009

According to some, ARRA provided an opportunity to transform healthcare in the United States by providing $19 billion in health information technology [HIT] funding to ensure widespread adoption and use of interoperable HIT systems. Obama's signing of the Health Information Technology for Economic and Clinical Health (HITECH) Act [a portion of the ARRA stimulus package] recognized the importance of HIT as the foundation for health care reform and cost savings. To others however, it may become an economic black hole with an estimate cost to physicians of $35-75,000 each. Nevertheless, this initiative effectively launched the modern Health 2.0 and Health 3.0 collaborative scenes.

http://democrats.science.house.gov/Media/File/Commdocs/HealthIT%20Bill.pdf

Among other groups taking the leap into eHRs are Microsoft and Google. Both have launched products called personal health records in recent years. Both Microsoft Health Vault and Google Health, as they're called, allow patients to store their own personal health histories online. Like all of their other apps, they are both free to consumers. Here's how they work:

1) Create an account or sign-in.

2) Enter and/or modify health history and upload data from devices like blood sugar meters.

3) Pull records from medical centers, doctors' groups or insurers that have agreements with the company.

Other private companies include healthrecordcorp.com and medkaz.com from Merele J. Bushkin and Michael F. Epstein MD of the Harvard School of Engineering and Applied Sciences.

Governmental HIT Initiatives for the Elderly and Poor

Some pundits suggest that a rapid learning health information data network could close gaps in medical knowledge and cut costs for Medicare and Medicaid recipients. In a letter to Congress in 2009, a group of health policy experts urged creation of a network to share information on Medicare and Medicaid patients in order to improve treatment received. In particular, Lynn Etheredge, one signatory of the letter, wants information to be shared on "dual eligible's." This term is defined as low income, elderly patients who receive money for medical care from both Medicare [Federal] and Medicaid [State] sources. Numerically, there are 7 million such dually-eligible patients in the US, which represents 40 percent of Medicaid spending, and 25 percent of Medicare spending and such a network backed by government policy would hasten treatments for everyone.

Others who signed the letter include Kenneth Kizer, who created the health-records system for the Department of Veteran Affairs; Commonwealth Fund President Karen Davis; National Quality Forum [NQF] President and CEO Janet Corrigan and National Committee for Quality Assurance [NCQA] President Margaret O'Kane. And, even before the current economic crisis, working families and individuals found their health care in jeopardy as the cost of employer-sponsored coverage rose beyond the means of businesses - particularly small businesses - and workers alike" [FIGURE 1.1].

[Insert Figure 2.1]

Uninsured Hospitalizations

The lack of health insurance has serious consequences on individuals and producing societal tensions. For example, the uninsured may be more likely to delay or forgo necessary medical care until eventual hospitalization makes care much more expensive.

Yet, the number of uninsured hospitalizations increased by 34%, thru 2010 over the last 10-year period, and the number of Medicaid hospitalizations increased by 36%. However, a report from the Agency for Healthcare Research and Quality (AHRQ) suggested the number of privately insured hospitalizations remained about the same. Hospital charges increased for the uninsured faster than for overall hospital charges (76% for compared with 69% for all hospital stays). The average hospital charge for an uninsured stay in 2006 was $19,400 compared to $11,000 in 1997 (after adjusting for inflation). The average length of stay for the uninsured remained the same at about 4 days per hospital visit. Other findings included:

- Compared to all hospital stays, uninsured hospitalizations begin in the emergency department much more frequently (60% for the uninsured compared to 44% for all hospital stays).
- The number of uninsured hospitalizations for skin infections rose sharply over the 10-year period, increasing from about 28,000 stays in 1997 to about 75,000 stays in 2006. Early appropriate outpatient treatment for skin infections can usually prevent the need for hospitalization.

- There was a 36% increase in hospitalizations billed to Medicaid during the 10-year period.
- The average the costs (not charges) to provide hospital care to the uninsured are about $1,500 less expensive ($6,800 vs. $8,400 per hospital stay) than costs for all other hospital stays.

Intuitively, as spending on Medicaid increases; the number of uninsured hospitalizations ought to decrease proportionally—adjusted for population increases. Unfortunately however the opposite has occurred in the private sector too, as health insurance premium continue to increase [FIGURE 1.2 and FIGURE 1.3]

[Insert Figure 2.2]

[Insert Figure 2.3]

Sustainable Growth Rates

By 2011 small medical group practices and solo and/or independent physicians were reported by some to have benefited little from the Obama Administration's healthcare budget. In it, Congress allocated $76.8 billion for the Department of Health and Human Services [DHHS]. Some funding was due to changes in the way healthcare was provided, with a new emphasis on pay-for-performance [P4P] for Medicare providers. Under this budget, Medicare Advantage were revamped; physicians and hospitals were paid more for performance [P4P] under Medicare; pharmaceutical companies faced steeper competition

from generic drug companies and the government began to clamp down on inadvertent and fraudulent overpayments under Medicare.

http://www.healthcarefinancenews.com/news/small-physician-practices-can-expect-real-changes-healthcare

Economist Peter Orzag PhD, from The Congressional Budget Office [CBO] budget also called for “comprehensive, but fiscally responsible reforms” to the physician payment formula [Sustainable Growth Rate], moving toward rewarding doctors for efficient quality care. The goal seems to be equalization with the per capita healthcare spending, on par with other countries [Figure 2.4].

[Insert Figure 2.4]

On November 19, 2009, the House of Representatives passed the Medicare and Physician Payment reform Act of 2009 ("H.R. 3961"). The bill reforms the Medicare physician payment formula, called the Sustainable Growth Rate ("SGR"). Under the formula, Medicare payment rates for physicians' services were cut by about 21 percent in 2010 and additional cuts would occur annually.

The Congressional Budget Office ("CBO") summarized H.R. 3961's changes to the SGR as follows:

- The update for 2010 was the percentage increase in the Medicare economic index (MEI), which is 1.2 percent, as specified in the final rule.

- Beginning in 2011, there are separate target growth rates and conversion factor updates for two categories of service: evaluation, management, and preventive services, and all other services.
- The SGR formula would take into account spending for each category of service since 2009 or—beginning in 2014—for the past five years. (The prior SGR formula took into account spending since 1996.)
- Only physician services, and not other services provided incident to the physician visit (such as laboratory services), would be counted in each category.

THE PHYSICIAN HEALTH CARE REFORM "BACKLASH"

According to a study by The MEDSTAT Group and JD Power and Associates, which surveyed nearly 30,000 physicians, participating in 150 healthcare plans, and located in 22 different markets; nearly seven of ten physicians considered them-selves "anti-managed care", with capitation accounts declining in nearly every HMO category.

Di-satisfaction with financial reimbursement was the leading factor, but 4 other major factors drive physician's rating of health plans, as listed below:

- Satisfaction with financial reimbursement
- Administration
- Policies impacting on care quality
- Support of clinical practice
- Limits on care

Nevertheless, some HMOs have not been unresponsive to this managed care backlash. Since 1998, managed care companies and their allies fought against restrictive new proposed regulations and spent more than $ 112,000 per lawmaker to lobby Congress. This 60 million dollar outlay was four times the $14 million plus spent by medical organizations, trial lawyers ($1 million), unions ($1.4 million) and consumer groups ($8 million) to press for passage of the failed Patients Bill of Rights. The $60 million dollar lobbying tab is 50 percent higher than the $40 million dollars that tobacco interests spent to kill legislature to raise cigarette taxes to curb teenage smoking!

"Don't Give Up Medical Practice, Yet!"

It is no wonder then that according to Dr. Regina E. Herzlinger, the Nancy R. McPherson professor of business administration chair at the Harvard Business School, mother of a physician daughter and author of the books, *Creating New Healthcare Ventures* and *Market Term in Healthcare*, believes that many medical professionals become depressed and want to give up their careers, entirely.

For example, Gigi Hirsch, MD, a former ER physician and instructor at Harvard Medical School grew so disenchanted with clinical medicine, that she ditched her career and started her own business, MD IntelliNet, in Brookline Massachusetts, more than a decade ago. The company places doctors in non-traditional jobs by pairing them with venture capitalists and other businesses seeking physicians [personal communication].

In the same light, Michael Burry MD, a promising young neurologist from Stanford and Vanderbilt University, rejected his medical career to become a private portfolio manager for his start-up Scion Capital Management, and then became an off-

Wall Street legend after correctly calling the collateralized debt obligation [CDO] debacle of 2008, and garnering the notice of Alan Greenspan former Chairman of the US Federal Reserve, from 1987 to 2006 [personal communication]. Harvard trained radiologist, Faraz Naqvi MD, a former fund manager for Dresdner RCM Biotechnology Fund; along with Dr. Dimitri Sogoloff MBA of Alexandra Investment Management LLC [personal communication] ran unrelated hedge funds. Kenneth Shuben-Stein MD, CFA©, of Promethean Investing, did the same at a hedge fund in New York City [personal communications].

Source: http://medicalexecutivepost.com/2010/03/24/video-on-hedge-fund-manager-michael-burry-md/

Arnold Kim MD even traded gossip, rumors and facts about Apple Computer, the notoriously secretive company, on his Web site, MacRumors, for more than a decade. His blogging become so lucrative that Kim switched careers. The site attracts more than five million people and 40 million page views a month, making it one of the most popular technology Web sites. It too was enough to make Dr. Kim hang up his stethoscope completely.

Finally, Dr. Gary L. Bode ditched his podiatry practice and is now a corporate CFO and practicing CPA with Master's Degree in Accounting; as did fellow reconstructive foot surgeon Dr William P. Scherer MS, founder of the internet based company, TestTools® [personal communication].

But, Herzlinger still implores in her book, Market Driven Healthcare, "don't give up practice, yet", although she herself is not without controversy. In 2009 she allegedly

sold $2.3 million worth of Wellcare stock, as a BOD member, three months before the FBI arrived.

Nevertheless, the ability to balance time in clinical practice with personal interests and commitments is becoming an increasingly important factor of physician job satisfaction.

CAREER BALANCE AND EARLY HEALTH 2.0 PHYSICIAN ADOPTERS

And, some early adopting physicians are succeeding despite a tension filled Health 2.0 job balance.

For example, Ron Dixon MD is the Director of Massachusetts General Hospital's Virtual Practice Project. He uses email office visits with current research focusing on a randomized comparative trial of video-conferenced *versus* face-to-face [F2F] office visits.

Dr. Peggy Latare is Chief of Family Medicine at the Hawaii Kaiser Permanente Medical Group. She leads the implementation of HealthConnect in the Hawaii region. For two years she has used Kaiser's online tools on a daily basis for communicating with, and caring for, her patients.

Jay Parkinson, MD is a physician based in Williamsburg - Brooklyn - New York. He works with Hello Health, an innovative healthcare start-up that matches online patient visits with convenient neighborhood locations. Jay has been featured speaker at various health 2.0 conferences. His physician partners with new-wave “fly” include: Devlyn Corrigan DO; Sean Khozin MD; and Catherine DeGood, DO.

Dr. Michele Shimizu, is a family physician who uses the American Well platform for Online Care to maintain relationships with former patients more than 100 miles

away. She uses the web-based Telehealth system made available through HMSA, and Blue Cross Blue Shield, on average three times a day - mostly in the evenings.

ASSESSMENT

It is important for doctors to stay current on the volatile direction that the highly competitive health care industry is taking. And, it is vital for every physician to learn as much about medically related business, information technology and new-wave e-commerce topics as possible.

CONCLUSION

To help doctors compete, several medical schools have initiated business certification and degree programs; and the private sector is doing the same. This will allow the profession to make the transition from a supply based medical system, back to a more balanced and more appropriate "patient-centric" and demand driven one. It will reduce a tension filled marketplace, and ensure that medical practices are operated as strategic business units (SBU), and not like the "home office" medical practices of the past. Hopefully this knowledge will decrease contentious competitive tensions for all stakeholders.

COLLABORATE NOW: Continue discussing this chapter online with the author(s), editor(s) and other readers at: www.BusinessofMedicalPractice.com

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THE END