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Time For A Serious Discussion on American Healthcare

If time is money, then it's the right place to begin any discussion of healthcare in the United States today. Time *is* money, particularly when it comes to our healthcare system. Time permeates the total fabric of our healthcare. Whether it's the time it takes to get it, pay for it, protect us from error, preserve our privacy, or to determine how and where the financial and labor resources are to be allocated, it all takes time. Finally, it takes time just to figure out who's really in charge, what we're getting back for our time and money, and where it's all going. It's all about money.

What you pay for is what you get, it would seem. But, when it comes to our healthcare, it's hard to find out just what it is we get for the 1.7 trillion dollars Americans spent on healthcare in 2004¹. Properly concerned about this outlay of our personal and governmental resources, it's natural to assume that if we can identify where it all goes, we could address, control and correct the increase accordingly. Except we can't. While it's easy enough to identify our personal healthcare expenses (insurance, out of pocket, co-pays, self-pay, and bills), that's only a portion of our overall healthcare costs. Direct or indirect expenses deriving from taxes or from costs associated with providers covering their own costs all add to what we pay for healthcare. Suffice to say that whatever our individual circumstance, the annual cost for healthcare in the United States in 2004 averaged out at \$5,440 for each member of our population.²

Even accepting the basic premise, "you must be getting something, because you pay so much for it in the first place," the difficult part of that premise is finding out just what the something is. Given what we pay, it would seem that we should have *something* to show for the expense: better health, effective healthcare systems, and evidence that it works well, in other words, *quality*. Accepting for a moment that all the familiar measurements: accreditation by the Joint Commission for Accreditation of Health Care Organizations (JCAHO), various industry recognition (Top 100 Hospitals, quality awards, etc.), we still look to our immediate experience of healthcare.

There is *cost*: Did we really use all that stuff? Do we need all those tests? It costs that much for just a two week supply of that drug? There's also the issue of *control*: Who can I talk to about this? How do I know this is the best thing to do? I don't understand what all of this means. And, of course, there is *time*: I spent all this money, but I also spent all that time waiting. The something that I paid for was not just the care I received, but the way in which I got it—I was always waiting, and everybody's time seemed more

¹ George D. Lundberg MD, "The American Healthcare System in 2005—Part 1: Context," *Medscape General Medicine* 7(1), 2005. Also see: "Healthcare Costs", Chapter 8, *Sourcebook for Journalists 2004*, Alliance for Health Reform, p. 77 (www.allhealth.org), which cites 1.55 trillion spent in the US in 2002 (9.3% increase over 2001), or 14.9% of the GDP. The authors propose that percentage will increase to 18.9% GDP by 2013.

² Alliance for Health Reform, *Sourcebook for Journalists*, p. 77. If you have a good plan, your experience of the cost will be less—your unneeded portion of the \$5,440 (if you are single or responsible only for yourself) will be passed on to someone else, effectively increasing their cost. For example, if my plan only requires a \$9 co-pay on prescription drugs, I can feel good about saving \$89 on a prescription for antibiotics, but the cost is still there for someone else. Everybody pays.

important to them than mine. Accept the basic premise, and then calculate, at your own hourly rate what you paid in time and what you got back. Your time is money as well: what is the ROI? If you're steamed by now, you're ³reading the tea leaves correctly. It is your time and it is your money, but don't take it all so personally. Before you go off on the high cost of healthcare as the result of malpractice lawsuits, consider your recourse for bad or ineffective care. If the cost of paying for the feckless and irresponsible uninsured gets passed along to you, consider the needs of those in less fortunate circumstances than your own. Finally, if the cost of regulation, monitoring, risk reduction, and most recently, privacy—witness the HIPAA regulations—is upsetting, at least be comforted that there are some guidelines in place at all. If their efficacy is not established, ineffective, or unconvincing, and simply incomprehensible, at least it's an effort. If you take the time to consider each of these, they are perfectly logical and reasonable responses to expressed needs—often arising from our own expressed need for control—to assure safe healthcare.

Assurance of safe healthcare is the step immediately beyond cost. According to one observer, “over 45,000,000 Americans are without health insurance.”⁴ While it's easy to fall prey to cultural stereotypes: uninsured elderly, children and ethnic groups the assumption doesn't hold.⁵ Medicare covers the elderly, and State Children Health Insurance Program (SCHIP) children. Adults who do not qualify for these programs make up the uninsured. The more startling revelation; however is that it is not the uninsured African Americans who constitute the bulk of the uninsured, but the more than 75% who are non-Hispanic Americans.⁶ The cause ascribed to the question of assuring safe healthcare through insurance may be and is laid at the foot of the economy and fewer employers offering health care benefits,⁷ but it's more likely that it's simply unaffordable on an individual or self pay basis. In this light, there's no assurance at all.

Nevertheless, granting that cost is a core issue, it's the assumption that healthcare is safe that wants challenging. Begin the challenge with the following question: if healthcare is safe, why are there so many regulations and requirements in place to make sure that it is safe? There are regulations that address informed consents that carefully outline every possible contingency, up to and including death; operational regulations down to checking identification at every step, the presence of any known drug allergies, and a great emphasis on prevention of medication errors.

That these safeguards exist affirms that the causes—unnecessary surgery and unanticipated outcomes, patients receiving treatment intended for someone else, drug and blood reactions, and the wrong medication being administered—precede the outcomes. If indeed healthcare is safe, then why is there such an abundance of attorneys involved in individual and class action suits to compensate from wrongful treatment or results? It seems that the more we attempt to assure safe healthcare, the more we hear of unsafe healthcare delivery.

For every test or procedure conducted either in the physician's office or other healthcare facility (hospital, clinic, emergency department) to identify what is the underlying condition, as many or more are conducted to rule out others. While conducting a battery of tests to uncover something other than the obvious diagnosis used to be the basis of training of physicians for differential assessment, the cost of graduate medical education changed the paradigm. The cost of testing in the clinical setting outside medical schools and residency programs also dictated the change: tests cost the payers or insurers.

⁴ G.D. Lundberg, “American Healthcare System,”

⁵ E. Ben-Porath, B. Goldthorpe, M. McCoy-Roth, “Health Insurance Concerns in America,” *Policy Brief*, Annenberg School for Communication, University of Pennsylvania, 2004, p. 3.

⁶ The actual breakdown is 33% Hispanic American, 20% African American, 19% Asian American and 11% White Americans. “Health Insurance Concerns,” p. 3.

⁷ P. 3.

Nevertheless, Lundberg offers, “You may ask why we spend so much and get so little. Actually, we get a lot, not a little, of testing, technology, medications, surgeries, hospitalizations, and all the rest—often a lot of what we need...only a little.”⁸ In short, it seems that in the absence of assurance that healthcare is safe—there can be no guarantees—the effort and expense go to reducing risk. The emperor’s clothing in this instance begins with covering the emperor’s backside, but the net result remains real exposure.

At this point, it’s obvious that while much of the cost of healthcare lies in secondary issues: risk reduction, multiplication, and often, duplication, of diagnostic and therapeutic effort, we are not getting the results we say we want: safe healthcare. Indeed, if we are hard pressed to understand what the tests and probing all point to, we are even more pressed to understand the results.

There is no clear measure of value, no standard, not even the most basic understanding of what constitutes a reasonable return on the investment we have to make for safe healthcare. While much can be—and is—made of the free market of healthcare services, we look in vain for any kind of standard which would assure us that we are getting the maximum or minimum level of care. We know that it all takes a lot of time, especially for the consumer: patients and family, but also for the provider: surgeons or other physicians, and money. Who has the time? If we’ve got the time (no real choice *there*), who’s got the money?

Time and money are at the center of our serious discussion of American healthcare. And yet, while money indeed talks, in healthcare, no one’s listening. Why is this so? Because no one’s in charge. Lots of time, enormous amounts of money involved in our healthcare system, but no one is in charge. Not the government, which spends the most⁹; nor the insurers who somehow manage to make a profit¹⁰; not the malpractice lawyers who feed off the errors; nor the regulators who measure everything and change nothing; not the physicians and other providers who deliver it; and, last of all, not the people on the paying and receiving end of this system: the consumers, or patients.

The reason, then, that no one is listening or paying attention is that everybody’s involved, but no one is in charge. This is important. We have to have someone—or something—to blame or hold accountable for this mess.

Without losing the thread of time and money in healthcare, we have to spend a little time on the victims. Anyone taking time to read this piece will have his or her personal testimony to share on how lousy healthcare has become. If not the long wait in offices, waiting rooms, clinics, then in a room waiting to see the doctor or to find out “Just How Bad Is It, Doc?” And if we say, not without reason, as well as passion, we are paying for complications and medical management that is well down the morbidity and mortality pathway and should have been picked up on much earlier, we’d be right. But in all this discussion about time and money and responsibility, we mustn’t overlook a big piece of the problem that

⁸ Lundberg, “The American Healthcare ‘System’ in 2005—Part 2: Who Is in Charge?”, *Medscape General Medicine* 7(1) 2005.

⁹ Lundberg, “Who’s in Charge? *Medscape General Medicine*: “government of all kinds, including Medicare, Medicaid, the Veteran’s Administration, the Public Health Service, and the 50 states and many local health departments—plus the military, government in aggregate constituting nearly 50% of all US healthcare expenditures. Similarly, in their assessment of healthcare costs, the *Sourcebook for Journalists* state that “of every dollar spent on health service in the US in 2002, 46 cents came directly from government sources. (p.77)

¹⁰ Alliance for Health Reform, *Sourcebook for Journalists: Healthcare Costs*, divide expenditures of health care dollars in descending order; Hospitals 31.3%, Physicians and Clinical Services 21.9%, and Retail Prescription Drugs 10.5%. The remainder is divided up into medical durable goods, nursing home care, home health care, dental, etc. However, buried in the minutiae of what percentage of the health care dollar is the administrative costs, 6.8%, next highest healthcare cost *after* retail prescription drugs.

is ours and ours alone. We're not only the victims of healthcare; we are aggregately our own worst enemies.

How much of our time and our conscious healthcare decisions (which cost) did we allow to care or to be prepared to care for ourselves? We have endowed our government, insurers, employers, physicians and others with powers and authority, which at times appear parental. We pay our taxes, premiums, co-pays with full confidence that those institutions or people not only care for us but about us. We spend much on how we look, whether in clothing, transportation or housing decisions, but how much of our time, our resources, and our attention go to maintaining our personal health or planning for what we prefer not to think about?

Many of the healthcare problems we experience are the result of our own, conscious or unconscious, life decisions. Decisions, like words, mean things, and have consequences. Accordingly, before we rush to judgment on our institutions, policy and decision makers, we must acknowledge that much of our healthcare costs could have been prevented or reduced by taking time to assess all of our resources. But our discussion is about time, money, and our system of healthcare in this rich and wonderful country of ours.

There's no system. Someone once called Los Angeles "a collection of suburbs in search of a city," and the same can be said of American healthcare: "a collection of health related activities in search of coherence." It all takes an enormous amount of time and money. There's no surfeit of causes for a responsive and effective health care system.

Hospitals and hospital systems concentrate acute care resources, nominally to provide an economical base for healthcare personnel, technology and equipment that the individual physician or group couldn't afford. And yet, here in Houston, we have the Texas Medical Center with its M.D. Anderson, Methodist, St. Luke's Episcopal, Texas Children's, and Memorial Hermann hospitals, each with its own MRI, cardiac cath labs, heart programs—all separate and all duplication of prohibitively expensive resources.

In other words, even in the largest medical center in the world, with each of its member hospitals representing their own system, there's no single system. Even access to these systems is impeded by the absence of a systematic approach to something as mundane as parking, a problem solved ages ago in the retail world by the introduction of the mall system.

With the advent of for-profit health care organizations, the business assumption was that these organizations would be operated as business with business techniques, whether applied to production, accounting, and standards. It was a convincing argument. Experience teaches us, however, that for-profit healthcare organizations were far better at identification of costs associated with healthcare than they were at reducing these costs themselves. While this may appear to be an over-simplification, consider for a moment the most profitable systems and I'll show you a succession of name changes, acquisitions, divestiture, and, sometimes fraudulent business entities with completely unremarkable healthcare.

One size fits all and therefore nobody. And, for all of the increased capacity of these organizations' cost accounting methodologies, the cost of health insurance premiums—hence healthcare cost-- have continued to outpace inflation and earnings.¹¹

¹¹ Alliance for Health Reform, *Sourcebook for Journalists: Healthcare Costs*, examines cost of insurance premiums, workers earnings, and overall inflation between 1999 and 2003 and demonstrates nearly tripling of premiums (5.3% to 13.9%), while worker earnings and the rate of overall inflation remained constant to diminishing (3.5% to 3.1%, and 2.3% to 2.2%, respectively).

So intense has the effort been to reduce costs for the insurers however, that hospitals, insurance panels, and the physicians themselves, are now frantic with the task of keeping revenues ahead of costs. While the business models which formed the basis of getting a handle on healthcare in the United States should have demonstrated the validity of their assumptions, it hasn't worked out that way.

Consulting firms, consulting and consultants have entered into the equation of time and money in healthcare. Appropriately, the bases and methodologies of process improvement, engineering, redesign, etc., derive from accounting principles put into healthcare management and practice. Deliverables and work products of consulting engagements are consistently more quantitative than operational.

Is it ironic, then, that the very means by which healthcare attempts to reduce its costs, consultants, add to the same? But what costs gets measured. It is well established now that the largest single direct cost in healthcare is people. Accordingly, any consulting firm worth its reputation addresses the FTE component because it's impossible to miss, and as impossible to be wrong.

So, how's it working for us? Wrong question. What's wrong with this picture, perhaps? Better, since something more fundamental is missing: what are we getting for all that money all this time? Healthcare has no definable product.¹² Neither does healthcare possess an integrated set of *service products*.¹³ Thus, while there's no question that all those tests, forms, assurances of the privacy of our health information, processes and procedures, we are hard pressed indeed to identify just what it is we're seeking or getting in our healthcare. "Copper", Cosmo Castorini tells us in *Moonstruck*: "it costs money because it *saves* money." Healthcare... it's the same thing, Loretta.

It's important to look at the most visible elements of cost in health care today. One observer notes that "the great majority of total costs are expended on a small number of really sick people."¹⁴ But don't be deluded. This small number of "really sick people" shouldn't obscure what they—or we—are getting for their catastrophic care. That these patients burn up a lot of technology, drugs, critical care and ancillary healthcare providers (doctors, nurses, technicians) shouldn't obscure what we are considering in this discussion: identifiable health care costs.

Overwhelming infections, multiple organ failure, the consequences of trauma, complications or primary disease processes gone out of control—none of this should keep us from asking about the components and quality of heroic measures taken by clinically heroic people. "One foot in the grave and the other on a banana peel", as the saying goes; or "circling the drain (CTD)" identify lost causes. Shock, we should know, "is a momentary pause in the act of death"¹⁵—we know where we're going before we even get there. These are really sick people and we shouldn't begrudge what they clearly need, even if they're not getting it.

¹² Even if good health is determined to be the absence of bad health, is this the result of something which we have bought, paid for, and enjoyed for itself? Any one of us would rush to say that our good health is the result of our good sense and, curiously, in spite of any health care we have received, thank you very much.

¹³ While service is a useful way of describing what we get in the way of healthcare, when one examines the premise, reducing what we get to something like "occasions of service," it soon falls apart under the weight of serious scrutiny. What, for example, takes the longest part of an office visit or a diagnostic test? The length of time we wait. Or, for another example, for every 1,000 medications administered, x% are incorrect, which is OK if you are not within the statistical percentage of error. Try asking St. Maladventure why the nurses and doctors put an "X", or, worse, "No" and "Yes" on proposed operative sites or extremities? At St. Maladventure, We Pride Ourselves On Trying To Be Right Most And/Or All Of The Time...

¹⁴ Lundberg, "American Healthcare 'System'-- Part 3", *Medscape General Medicine* 7(1).

¹⁵ A definition of septic shock so familiar to clinicians it's a classic. First described by John Collins Warren, a pioneer in ether anesthesia, Warren described sepsis as "a momentary pause in the act of death" in 1895. Cited by M.A. Gropper in an editorial in the *British Journal of Anaesthesia* 2001 86(6), 746-749

Allowing a percentage of write-off for catastrophic and chronic disease management, high technology interventions involve a significant element of healthcare cost considerations. Bariatric surgery addresses truly morbid obesity by gastric banding or segmental resection of the stomach and intestine; but it is expensive. This expense is being challenged by the insurers and no amount of arguments about reduction of morbidity and mortality in obesity appears to be moving the bean counters.

Peripheral vascular surgery, like bariatric surgery, has gone minimally invasive in techniques, and meets the surgical and medical management needs of many diabetics, another population with a long term chronic disease process. Similarly, quadruple coronary artery bypass surgery, and even “redos,” attest to the durability of cardiovascular disease.

While many would be quick to point out the genetic components of these diseases, there’s also a matter of personal healthcare choices involved, which should not be overlooked. That prudent choices could have been made much earlier, and thus prevented the consequences of mixing lifestyle choices with genetic givens, need not apply... that was then, this is now. Time and money: so it goes.

So, the time to shop for the best value for your money in the healthcare marketplace is not when you need it. It does make sense, however, to spend a little time, a little money in shopping the healthcare market for what we need. What we need probably reflects on our individual priorities, lifestyle, milieu, resources, and an informed sense of what the chances are in the course of a lifetime for good health and good healthcare.

From this perspective, the “one-size-fits-all” approach advocated by universal health care partisans, or even the actuarial standard populations of the insurance companies will probably never fit everyone. Besides, we like to think that we are more than just a number. Before taking the time and money to shop for the best value in the healthcare marketplace, some consideration must be given to just what it is we’re looking for, especially since what we’re getting now isn’t exactly what we want.

Because healthcare is so large, it’s hard to put it into a recognizable package. Moreover, since healthcare delivery is so similar, it’s equally hard to identify a standard against which it can be measured. A number of systems and healthcare organizations apply their own brand identity and definition and market them aggressively. Beyond the confident smiles of those surgeons and cardiologists with their hands on the hips of their scrubs, or the cluster of uniformed and smiling healthcare professionals looking at you with their arms folded over their chests (Do they *know* something they’re not telling us?), we are hard put to know just what it is this all means.

Since there’s already so much regulation, we know that it must be safe. Because licensure is monitored by federal, state, local, and professional bodies, we know that the people who provide our care are competent. Because accountability is a major concern for providers, witness Compliance Officers, accreditation standards, and bond ratings, not to mention the level of detail on patient and provider statements for services provided, the question of quality is unquestionable. Would that it were so.

In spite of macro and micro monitoring of healthcare, complications and errors happen. For every physician or nurse whose license and privileges to practice is suspended, the ones that make the news convey a litany of reported breaches, warnings, suspensions, and lawsuits. While it’s forthcoming to know that my tonsilectomy involved use of a suction, (Yankauer, Plastic, Disposable) at such and such a cost, what am I to make of it? Could I have just done as well without the additional expense?

To such questions, there really is no satisfactory answer. We have to understand what we’re getting in order to question it. Further, since there’s no question of how much information is readily available with respect to our healthcare, it still doesn’t add up to what information is supposed to do in the first place:

create knowledge and understanding? For all of the regulation, accountability, and standards (which are addressed later,) the organization, infrastructure, processes and outputs are about as clear as the U.S. Tax Code. We cannot evaluate what we don't understand.

Much is being made of the absolute necessity of the electronic medical record (EMR), as if an accessible database on our healthcare would somehow reduce the confusion and duplication of our individual medical history, tests, procedures, progress (or decline) over time. The EMR provides a baseline for continuity of care and possible reduction of medical errors, the argument goes, and since we now have the information technology to support development of the EMR, this seems to be the direction of healthcare systems, providers, insurers. Given full implementation, the EMR could do to our healthcare what credit bureaus have accomplished in commerce and our personal finances. But there is a fallacy here. Credit reporting entities such as Equifax provide less benefit for the consumer as they do for businesses and lenders. While it is not envision that there will be the emergence of a secondary market for our health information, such as "Free Health Report.Com", it's not unlikely that private and personal health information will be in the hands of strangers. As consumers and providers, we are not comforted by such knowledge.

There is a use for such information resources, however, provided that we own our medical history, electronic or not. The lack of continuity Lundberg decries in his evaluation, between the physician's office to the hospital and back to the office is because the care's description is itself fragmented.¹⁶ Everybody gets a piece of this information, except the consumer, the patient, the person to whom the information matters most. We need to maintain this information as it moves with us. For example, when military personnel retire, one of the many packages received is a complete record, from enlistment to the last active duty and station. EKG's for flight physicals administered over 40 years ago are part of that record. They are available for a current primary care physician or a consulting cardiologist may have this information should they have the time or the interest. There it is an *ur-information* artifact. The intent of this example is not to advocate that the military or any part of the government be the keeper of our EMR and its information, we do advocate that personal health care information be retained—and maintained—by the people who can benefit most from accessibility to this information: ourselves.

The direction is clear. We consumers, currently at the bottom of the enormous healthcare collection of services, need to assume control and responsibility. To do this will involve time and money. We're already wasting both, so the time should begin with our understanding and accepting our role in healthcare and our health care. The money which is assumed by group participation at rates and conditions, over which we have little or no choice, should be applied to informed decisions about our specific needs, present and future. The forces for realignment are already at play in policy making forums and the marketplace.

Today, there is much debate about the ability of American's to have portable health insurance benefits that would follow us from dependency in elementary through higher education to work, from job to job, from the workplace to retirement. Like our own medical records, our health plans and benefits should accompany us throughout our lives, regardless of employment. This is not suggest that it be a "free ride," or subsidized by our employers after we have left their employment.

¹⁶ Lundberg, "Who's in Charge?" asks, "Who can require compatible computerized medical records in the home, the doctor's office, the pharmacy, the emergency room, and the hospital? No one. Who can even require that it be measured? No one can, even if such an implementation would probably save lives and money. Who can ensure that the quality of care provided in the physician's office, where the most care is given, is above a certain standard? No one. Who can even require that it be measured? No one can." *Medscape General Medicine* (7)1.

No one would suggest for a moment that automobile insurance, including liability, be provided by our employers or our government. The same is true for our health insurance. We are required to have it, and to maintain our health as attentively and proactively as we do our auto insurance rates when we get tickets, grow out of high rate adolescence into more moderate rate adulthood: life changes and our plans should do the same.

There is similarly a great deal of debate about privatization of portions of our Social Security. Depending upon one's perspective, it's either a draconian attempt to defraud the elderly or an irresponsible rip off of our younger workers to support the elderly until they themselves become eligible for what will be a bankrupt government program. It's not the position of the writers to advocate or decry either position. We do believe, however, that there is a middle road and the solution should include a healthcare reform. Like legislators and civil servants who enjoy choice in the Federal Employee Benefit Program (FEBP) for health care, the same American taxpayers who pay their salaries should be able to share access to these same benefits.

We are currently taxed on our earnings for two elements: Social Security and Medicare. It would seem timely for the same taxpayers have the opportunity to exercise choice and ownership of our own Social Security and healthcare benefits. These authors envision a scenario where the tax structure is simplified, and the lock box contents under the control of the payers, or consumer. Consumers are free to select among plans that benefit them within their circumstances most.

The time for discussion is now, as is the time for action. American healthcare and American citizens would benefit by assuming responsibility and control now. With continuous Medicaid reductions in the Federal budget, some states are looking at ways to meet the need and for reducing the uninsured, and rightfully so, but we do not need to overburden citizens or accentuate the problems that already exist. The answer is not within the current insurance format...we need to start thinking outside of the box we have made for ourselves. The box is no longer larger enough or strong enough to address the contents of the package. Since we've outgrown the box, it's constricting us further.

A new Citizens' Healthcare Working Group has been commissioned to report to Congress on the needs for healthcare reform... an excellent idea if all citizens become educated and contribute. Further, Congress itself must look beyond itself in its collective responsibility to its less insured constituents. As for the Rest of Us, rather than taking a passive approach to achieving and maintaining—hoping for the best—our own healthcare, American citizens have to be committed and involved in our own “physical destiny.”

Economic and fiscal responsibility should not be the only limiting sources that create a healthier future for everyone. The government can still maintain collection of taxes. However a new benefit paradigm will provide for a greater return on investment for our citizens. Make the options simple to understand.

Finally, for those Americans who would prefer to remain with the current structure and system of benefits, the choice and benefits system would remain unchanged and persist in the pious hope for the best, whatever it is. But for those of us who are serious about improving our own healthcare, and healthcare in general within the United States, we would do well to enlist and apply competitive forces of the marketplace to define worthwhile healthcare services and identifiably valuable healthcare products. We can hold to a familiar, if unworkable, past or move forward to grasp a healthier future. It's high time.

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