The 4th Annual World Health Care Congress
Co-Sponsored By: THE WALL STREET JOURNAL.
The Wall Street Journal is a trademark of Dow Jones L.P.

World Health Care Congress

April 22-24, 2007 • Washington Convention Center • Washington, DC

DAILY BRIEFING • April 23, 2007

Keynote: The World's Top 10 Diseases

Tadataka Yamada, MD, President of the Bill and Melinda Gates Foundation, addressed the issues facing global health.

- In Dr. Yamada's view, the biggest global health problem is **inequality**, evidenced by 10 million children per year dying in developing countries.
- Many diseases in the developing world can be prevented or easily treated through **low tech approaches**.
- Needed are **more money** ($25-$70 billion per year), **people** (1 million health workers), and **political will**. Also, govern-ments in developing countries need to spend more on health care, and individuals need to be more involved in their own health care in developing countries (and the US).
- There is a **big opportunity for the private sector** in developing marketing, in providing and financing health care, and in making products for these markets.
- The Gates Foundation is pursing **public/private partner-ships** that de-risk private sector undertakings. They try to catalyze investments from others, especially governments. Specific activities focus on **infectious diseases, maternal and reproductive issues, and nutrition**.

> *"It matters that 10 million children die each year. We need to embrace these problems and establish equity."*
> —Tadataka Yamada

Keynote: Competition

Professor Michael Porter presented his thinking on a new model for transforming health care. Aetna CEO Ronald Williams and Kaiser CEO George Halverson then shared their reactions.

- The current nature of competition in health care is bad, zero-sum competition. The right type of competition will **increase the value of health care** delivered.
- Fundamental change is needed in the **delivery of care**.
- Needed is **integrated, coordinated care** for "**conditions**" (such as diabetes) over the entire **cycle of care**.
- **Measuring outcome results** will be the most important driver of systemic transformation.

> *"The type of competition that must take place is competition based on value."*
> —Michael Porter

- Mr. Williams and Mr. Halverson both agree with Professor Porter's long-term, big-picture vision. Mr. Williams sees the challenge as one of **bringing about the change**.
- Mr. Halverson sees **two models**: 1) For **acute** care (25% of costs) with a data-rich infrastructure so consumers can make more informed decisions; and 2) For **chronic** care (75% of costs) requiring a coordinated team approach.
- **IT** will play a critical role in the transformation, linking providers and aggregating data for decision making.
- There was agreement on the need to deal with the **uninsured** population.

Executive Congress

The Executive Congress involved a series of panels tackling issues of health care reform, quality, and HSAs. Key points:

- George Halverson argued that reform needs to focus on the **delivery of care; not the financing**.

> *"The focus of the current political debate is on the financing of health care; it needs to be on the delivery of health care."*
> —George Halverson

- **Tools** are needed to transform care. Ideally, an **EMR**, but where not possible, a **PHR** and registries. These link the delivery of care and provide data.
- Reform requires creating a **culture of health** for con-sumers and ending the health system's culture of "control."

- System-wide **incentives must be changed** and physician accountability is required, brought about through **measurement of individual physician results**.
- Much spending is driven by "**supply-sensitive care**" where the amount of care provided is based on available capacity. Instead, **preference-sensitive care** is needed where patients are given information about various options to make a decision based on their preference.
- Panelists disagreed about HSAs. Those in favor cite **lower costs** through greater **patient responsibility**, decreases in unnecessary care, and switching to generics. Opponents cite **high deductibles** (with many employers not providing funds for these deductibles), lower patient satisfaction, and possible avoidances of care.

CEO/COO/CFO Summit

In the Summit's first session, on **patient-centered care**, Dr. Larry Goodman provided a thorough overview of the financial turnaround at Chicago's Rush University Medical Center. Under Dr. Goodman's leadership Rush was able to turn into a profitable system centered around patient satisfaction.

- Dr. Goodman discussed the change in executive management and the need to **change the culture** of the institution.
- Every employee **must believe in the mission** of the company, from the CMO to the elevator operator.
- **Points of improvement** focused on were: managed care, marketing, revenue cycle, sale of Rush-Prudential, operations, and alignment.

> *"If there's one thing I learned…the individual physicians, nurses…they're taking a risk in being there; it's just remarkable…how much these individuals care about the places for which they work."*
>
> —Dr. Larry Goodman

- In the Summit's session on consumerism the panel spoke about 4 topics that successful organizations must focus on in the future including: convergence of accounts (HSA, FSA, etc), price and quality transparency, consumer experience, and incentives.
- There is a growing **erosion of the benefits of tax exemption** and the increasing need for hospitals to show they are qualified to receive such breaks.
- 56% of the dollars are through private payers, which will **accelerate the presence of Medicare Advantage**.
- Large organizations have a better chance of survival and ability to attract capital; thus the trend in the future will be toward more consolidation and larger delivery networks

> *"We must get away from point solutions to end-to-end solutions."*
>
> —Consumerism panelist

Public & Private Purchaser Summit

Hannaford Brothers' Peter Hayes introduced a framework for employers to develop and implement quality metrics, improving outcomes while reducing healthcare costs.

Representatives of private and public purchasers, coalition executives, PBMs and provider organizations provided comments and thoughts on how organizations can move to a system that better measures provider performance.

- Employers recognize they must start to develop a **"market-based system**" with effective tools to transform the healthcare market
- Current CDH/cost-sharing strategies fail to solve the underlying causes of health care quality problems and may contribute to cost increases.
- Employer efforts should instead **focus on the quality, efficiency, and performance** of healthcare providers.

Event Highlights

- All audience survey results, speaker presentations, event photos, and much more are all posted to: **www.whcc2007.com/community** (password: whcc20074a)
- 16 interviews filmed in the WHCC Press Studio in the Executive Networking Lounge. Sign up to be interviewed to share you are views and thought leadership.
- 6 active bloggers are at the WHCC '07! Visit the blog for daily updates at: **www.worldhealthcareblog.org**
- Over 30 provider executives engage in a lively discussion during the Invitational Pay-for-Performance dinner, sponsored by BMG.

The 4th Annual World Health Care Congress
Co-Sponsored By: THE WALL STREET JOURNAL.
The Wall Street Journal is a trademark of Dow Jones L.P.

World Health Care Congress

April 22-24, 2007 • Washington Convention Center • Washington, DC

DAILY BRIEFING • April 24, 2007

Provided below are takeaways from yesterday's keynotes, Executive Congress, and selected sessions at the WHCC.

Keynote: Employer Demands for Affordable, Quality Health Care

Representatives of two leading employers—Linda Springer, Director of the Office of Personnel Management (with 8 million enrollees) and Gerald Shaheen, President of Caterpillar and Chairman of the US Chamber of Commerce—expressed their views on health care. Larry Glasscock, CEO of WellPoint—the nation's largest health plan—and Dr. Delos Cosgrove, CEO of the Cleveland Clinic, responded.

- Mr. Shaheen stated 5 principles that guide Caterpillar on health care: 1) Employee **responsibility and accountability**, which requires a culture shift from entitlement to responsibility; 2) With responsibility, employees need **information** and **transparency** around cost and quality; 3) Increased use of **information technology** to provide this transparency; 4) **Wellness** and prevention, with financial incentives to employees to take risk assessments; and 5) **Partnership** between purchasers and providers.
- Ms. Springer agreed. She also emphasized the importance of providing federal employees with **choices** of insurance plans, and **privacy** of personal data.
- Dr. Cosgrove also agreed. He stressed the importance of **measuring quality** (which will be hard and slow but is necessary). He described how Cleveland Clinic is adopting a new patient-centric model where **care will be organized by "institutes"** such as neurology or cardiology and is leading by example in removing trans fats and going smoke free. He sees an **EMR as the patient's property**; Cleveland Clinic is offering a "My Chart" feature where patients can access their information via the Internet.
- Mr. Glasscock also agreed with Mr. Shaheen's principles and with the notion that consumers should own their PHR, which WellPoint is doing. He also pointed out that **CDHPs are moderating costs** without hurting quality and when consumers are more involved in their care they are more likely to engage in healthy behaviors and ask about cost.
- The panel agreed the government has some role to play in addressing the 46 million uninsured, though some of these individuals (perhaps 25% to 30%) could get insurance today and are opting to self insure.

Keynote: CMS' Vision on Quality Standards

Herb Kuhn from CMS shared where CMS is going, with reactions from Dr. William Plested, President-elect of AMA, and John Rother from AARP.

- CMS recognizes the **status quo of payment for consumption is not acceptable** and change is needed to achieve better care at lower costs. Payment needs to be based on quality and efficiency, and ultimately on the total care and not the pieces of care. Demonstration projects are under way to find better solutions. (A poll showed 69% of attendees believe Medicare is moving too slowly in advancing performance measurement.)

> *"Medicare is changing from being a passive buyer to an active purchaser."*
> —Herb Kuhn, Acting Deputy Administrator, CMS

- CMS understands that the **buy-in of doctors is essential**; Medicare has to be supported by physicians. Needed is to find a balance between guidelines and evidence-based medicine and physician empowerment.
- Mr. Rother argued that **quality is suboptimal**, improved quality can save money, quality is all about outcomes, and reimbursement should be tied to quality. Improving quality requires measuring it, but questions exist about what is countable and what is the unit of measure.
- Dr. Plested rejects the notion of a crisis in quality and that pay-for-performance is supported by evidence, but **welcomes an emphasis on quality and on measuring performance** (something the AMA initiated before any other entity). He cautioned that **measuring it is very hard** (because of the challenges of "risk adjusted") and that increased quality may increase, not decrease, cost.
- The panel agreed the **tort system needs to be reformed** to encourage reporting of and learning from mistakes.

Created by:
BullsEye RESOURCES
www.bullseyeresources.com

World Health Care Congress

DAILY BRIEFING • April 24, 2007

Keynote: Transformative IT

Experts from employers, providers, and the government described the power of IT to transform health care.

> *"Health care is an information business."*
> —Glen Tullman, CEO, Allscripts

- **Wal-Mart** as an employer, a business with pharmacies and clinics, and a major company wants to **leverage its experiences** to help solve health care's problems. The situation is similar to what retail faced before bar codes, wrestling with standards, investment, and adoption. Today, Wal-Mart uses **bar codes to track every item** in every store, having an unimaginable amount of data to make decisions. They know **health care's problems are solvable**.
- For Pitney Bowes, **technology is an enabler** in value-based health. Their philosophy is to maintain and improve employees' health. Data is used to monitor provider excellence and practice patterns; to develop optimal plan designs; and to identify employees that predictive algorithms indicate have higher risks. Pitney Bowes is undertaking an initiative to provide employees their own PHR.
- At the Department of Defense an **EHR (AHLTA) is transforming how health care is delivered**. This is part of a broader HHS effort to set standards of interoperability.
- At Intermountain, the data collected through the use of an EMR is **driving significant changes in how medicine is practiced** (from an individual to a team sport) leading to new processes and staffing models and resulting in improved outcomes and enormous cost savings.

Keynote: In Pursuit of Transparency in Health Care Delivery

This panel provided perspectives from federal and state governments and a large private plan.

- The panel agreed that **momentum for transparency is building**, pushed by HHS and employers. But, it was stressed that transparency is "**necessary but not sufficient**" to bring about all the changes that are needed.
- Also needed are **changes in incentives** and significant **research that provides data on what works**. Having the infrastructure is not enough; guidelines based on research about what really works are critical and sorely lacking.
- Of great importance is a **common set of goals and metrics**; a **single set of standards**. Carolyn Clancy, Director of AHRQ, believes the various **stakeholders will converge** to arrive at these standards; Phil Bredesen, the Governor of Tennessee, feels the **federal government needs to take the lead** and put a stake in the ground on a simple set of standards.

> *"Enough grants and demonstrations; we need leadership that puts something on the table [for technology standards]."*
> —Governor Phil Bredesen, Tennessee

- Also important: **information must be simple** and in a form that is easy understandable and usable by consumers.

Track 1: Executive Congress

Leaders from the private sector and the federal government joined health care providers to discuss ways to improve the quality of care and rein in health care inflation.

- **Cost and quality** are inexorably linked. It is **not possible to control cost without measuring quality**. The health community—payers, plans, and providers—is just beginning to learn how to do that.
- The key to achieving quality is **transparency**, which requires a willingness by plans and providers to **measure and report outcomes and true costs.** Whether mandated by legislation or done voluntarily, payers agree that **without transparency we will never control costs**.

> *"We need to bring cost and quality together if we are to make informed choices; to do that we must have transparency."*
> —Peter Lee, President and CEO, Pacific Business Group on Health

- Providing **universal access** for the nation's 47 million uninsured is crucial to reduce health costs. Lack of coverage drives up premiums because **the cost of care for the uninsured is passed** to health plans and the government.
- Most employers believe that the **free market, empowered by transparency**, offers a more effective solution to combating health inflation than a single-payer, government-run system. But there is **no single, best solution** to fixing the broken health care system. It requires collaboration among all stakeholders.

> *"There is an urgency to move on with this and to realize we are all in this together."*
> —Reed Tuckson, MD, EVP and Chief of Medical Affairs, United Health Group

Track 2: International Forum

Health experts from several countries shared innovative ideas and practices that can be learned from and exported around the world.

- In the UK, local health commissions can devise **flexible and innovative ways of delivering care**.
- Also in the UK, the Personal Medical Services contract (PMS) is structured so that **30% of payment is based on quality and outcomes**.
- Ethiopia is moving forward with a vision to develop a model of systemic changes through enhanced hospital management.
- In Denmark (a publicly financed health system where health care is 9% of GDP), the country is creating an **interoperable EHR**. Use of electronic records is high, as 30% of hospitals and 95% of primary care physicians use them. Primary care physicians have adopted them because they see benefits in doing so. But, today records are "messaged." The intent is to move to "shared information." Creating interoperability and shared information requires standards for the content and structure of data.

> *"We want to move from 'messaging' to 'shared information.' We want 'semantic interoperability.'"*
> —Arne Kverneland, MD, Head, Department of Health Informatics, National Board of Health, Denmark

- The **US military is one of the leading users of an EHR** in the US. The EHR is called AHLTA. It is used for 9.1 million beneficiaries, including those in combat. All data is stored in a central repository. Since its inception in 2004, 45 million patient encounters have been stored, with 110,000 new encounters stored each day.
- Creating AHLTA required **developing and deploying a set of standards** to make the health records interoperable. HHS hopes that AHLTA's standards can help **drive creation of standards across the entire US health care system**, beyond the military and government.

Track 5: Employer SVP, HR & Corporate Medical Director Summit

Speakers in this track represented leading and innovative employers who are working to transform health care.

- Employers **have to be at the table** in the health care conversation. They will have a louder voice and more power and ability to drive change by **working together in coalitions**. One way is to work together in deriving one consistent set of measures.
- Employers see their priorities for changing health care as: **measuring** provider performance and providing **transparency** by sharing results; providing **tools, information, and incentives** to change consumers' behavior; offering **wellness** programs to improve employees' health; and pushing for implementation of **information technology**.
- It is believed that this combination of strategies **can decrease costs by 30% to 40%** while improving quality.
- Employers are encouraged to **support HHS's value-based purchasing efforts**.

Track 6: Health Plan & Insurer CEO/CFO/CMO/CIO Summit

Representatives of health plans described their companies' successful growth, branding, and business strategies, including lessons learned.

- **Improve consumer education and outreach**. Better-informed consumers make better decisions. The mechanisms for reaching consumers should vary according to individual factors. Personalized and transparent information has significant impact on decision making.

> *"Consumers are smart. If you give them actionable information, they will make wise decisions."*
> —Elizabeth Bierbower, Vice President of Innovation, Humana

- **Segment your market to better understand it**. Breaking down your target market into smaller segments allows you to better understand why they buy the plans they do and why they renew them.
- **Look for opportunities to approach the market differently**. More people are buying individual health policies, and more are buying online. Aetna is marketing plans to African Americans; Asian Americans; Latino/Hispanic Americans; and gay, lesbian, bisexual, and transgendered people—not by offering different products for these groups, but by "meeting them where they buy."
- **Apply the same concepts to branding health plans as to other products**. Determine what consumers want, what

your company can provide, and how your product is distinct. Ensure that the promise inherent in the brand identity is delivered consistently across the board.

Track 7: Pharma & Biotech CEO/CFO Summit

Although addressing a number of disparate topics—expediting product development, using enterprise risk management in pharma, the implications of consumer-driven health plans—speakers reiterated the theme that the old **go-it-alone style that typified the drug industry is ill suited to today's realities,** and that **new partnerships must be forged** to achieve success. Cooperative arrangements should include:

- **Dialogues between drug companies and federal regulators** to enhance the scientific understanding on the part of regulators so when a new compound is presented for approval the learning process is already well under way.
- **Coordination of data bases** among separate government agencies and various insurers **to spot serious adverse events more rapidly** and to better **track off-label use** of medications.
- **Breaking down the silos** that exist in every organization, so potential problems can be spotted and prevented. This will happen by harnessing the insights that each section of an enterprise has into barriers to achieving strategic goals that stem from decisions made elsewhere in the firm.
- **Arrangements between pharma and health insurers** to work together to **develop value comparisons** of competing treatments and to **improve the information flow** to both physicians and patients about **which drug is best for which patient**.

> *"The days of rugged individualism are clearly over…Today the company that cannot partner will not survive."*
> —Joseph Feczko, MD, CMO Pfizer

Track 8: Health System & Hospital CEO/CFO CMO/CIO Summit

Leading executives from health systems and hospitals discussed delivering service excellence, value-based payments, and strategies for improving patient safety.

- Panelists concurred and offered data supporting the fact that **clinical excellence, safety, patient satisfaction, and financial results are all related**.
- There is **much emphasis on safety** as a measurable and actionable way to improve quality.
- At Intermountain—as at many/most health systems—**adverse drug events** are the leading safety issue, nosocomial **infections** are next, and then **pressure wounds**. Intermountain found that these events were **grossly underreported**. (They thought one adverse drug reaction occurred every two months; in reality, they had two per day.)
- There are proven **ways to decrease** adverse drug events, infections, and wounds that **any hospital or health system can do**. They aren't high tech and don't require an EMR. They require measurement, a culture of safety, and follow-through to implement process and system changes. (One change is having pharmacists go on rounds.)

> *"Any hospital could implement this [a program to improve safety] now."*
> —Brent James, MD, VP for Medical Research, Executive Director of the Institute for Health Care Delivery Research, Intermountain Health Care

- There is a strong **business case for safety**: it generates **enormous cost savings**.

Event Highlights

- Yesterday at the WHCC, Bloomberg News interviewed Governor Bredesen (D) of Tennessee about strategies for achieving universal access.
- Bloomberg interviewed Michael Critelli, CEO of Pitney Bowes
- CNBC interviewed Angela Braly of WellPoint live from WHCC.
- In WHCC's Executive Networking Lounge, Jonathan Cohn of *The New Republic* signed his book, *Sick:The Untold Story of America's Health Care Crisis—and the People Who Pay the Price*.

Created by:
BullsEye RESOURCES
www.bullseyeresources.com

The 4th Annual
Co-Sponsored By: THE WALL STREET JOURNAL.
The Wall Street Journal is a trademark of Dow Jones L.P.
World Health Care Congress
April 22-24, 2007 • Washington Convention Center • Washington, DC

DAILY BRIEFING • April 25, 2007

Provided below are takeaways from yesterday's keynotes, Executive Congress, and selected sessions at the WHCC.

Keynote: Consumerism

This panel, with leaders from the world of technology (Intel, Microsoft, and Google) and moderated by the CEO of Consumers Union (publisher of Consumer Reports), discussed the vision of consumerism and the obstacles faced.

- The panel agreed on a **vision** of equipping consumers with **timely, relevant, trustworthy, accessible, and actionable information** to empower them and help them make informed decisions.
- This information will provide consumers the **power** of: **discovery** (about their options), **transparency** (about such things as providers), **choice**, **control**, and ultimately power to **change** the entire health care system.
- The **barriers** to achieving this vision are **not technical**—the technology exists—they are psychological and legal. The psychological barrier is that consumers don't know they can ask for and providers don't realize they can provide to consumers the consumers' own data. The legal barrier is that **consumers are not granted access to the wealth of electronic data that already exists about them** in the health system.
- Craig Barrett of Intel believes that change requires the **major purchasers** (the federal government and major companies) to **demand change** (i.e. to get reimbursed, prescriptions must be electronic). Adam Bosworth from Google believes **consumer demand exists**; consumers just need access to their data. He believes **innovative providers will take the lead** in providing consumers with data, creating a cascading effect where others follow.

> *"The government needs to make it clear that data transfers to consumers are OK and are good, and needs to give consumers a right to the data that's already in the system."*
> —Adam Bosworth, VP, Google

- There was **optimism** that **change will occur rapidly** in the next few years.

Keynote: The Global Business Imperative: Sustainable Solutions for Prevention and Quality

Dow Chemical's CEO, Andrew Liveris, offered his comments on the changes needed in health care and described Dow's strategy. GE Healthcare's CEO, Joseph Hogan, and futurist Ian Morrison responded.

- **Fundamental change** of the US health care system is **required**. Mr. Morrison thinks the key is changing the reimbursement system; this will drive other changes.
- The high costs of health care are **hurting US businesses** and the overall economy. The situation is especially **difficult for small businesses**.
- The panelists agreed on the importance of **more emphasis on prevention**. Mr. Hogan divided health care into: prevent, diagnose, treat, and monitor; 75% to 80% of costs are on treating. Improving health and lowering costs requires "early health." Dow is very focused on prevention and quality. The company has strengthened its **preventive benefits** and is offering multiple **prevention programs**; 90% of employees have had **health risk assessments**, which is leading to decreases in risk.
- However, Mr. Morrison commented that the idea of prevention is good, but for individuals to **change behaviors** (i.e. diet, exercise, etc.) is very hard. Company **leaders** play a role in **setting a positive example**.
- The panel agreed on the **importance of transparency**, but Mr. Morrison believes the value will come not because data will be used by consumers, but because poor rankings **will drive providers to improve**.
- The panel agreed: **obesity is an epidemic** and **isn't getting enough attention**. A vast culture change is needed.

Keynote: Universal Access

Oregon Senator Ron Wyden summarized his proposed Healthy Americans Act.

- This proposal provides **guaranteed, lifetime universal coverage**, which cannot be taken away, with health care provided through a **private delivery system**.

> *"This is universal coverage with a private delivery system."*
> —Senator Ron Wyden, Democrat, Oregon

- **Employers will administer** coverage for employees, **but will not pay for it**; **individuals** will choose their health plan and **will pay**.
- As the system **transitions** from employer to individual payment, employers will "cash out" employees by initially providing employees with increased wages for the amount that the company had paid for health insurance; over time, employers will make "**shared responsibility**" payments.
- Ultimately, health insurance will be a **consumer market** as insurers offer differing benefit plans to compete for consumers' business. Insurers will have to **guarantee coverage**, **can't cherry pick** who they cover, and will use community ratings.
- There will be **tax benefits** and **premium reductions**, assisting, for example, people who are unemployed.
- **Medicare** will be improved, but its structure will remain **largely the same**. Medicare Part D is helping people with low income and big bills; it needs to be simplified and improved.
- Proposal is estimated to **save $1.45 trillion** over 10 years.
- This proposal has **support** from several business and union leaders.
- The **conventional wisdom** is major health care change **won't happen until 2009**. Senator Wyden is **pushing for it in 2007**.

Keynote: Health Care in America

Wal-Mart CEO, Lee Scott, shared what Wal-Mart is doing to contribute to improved health care in the US.

- It is **time for real change** in the health system. Health care must be **affordable, accessible, and high quality**.

> *"It's time for real change…the question is how to get there…business can lead."*
> —Lee Scott, CEO, Wal-Mart

- Business needs to **empower consumers** to—in conjunction with their doctors—make better decisions. This involves transparency and better tools and information.
- Wal-Mart's **$4 generic prescriptions** are a way of empowering consumers and providing price transparency. To date this has generated **$290 million in savings** and 30% of prescriptions are being filled by those without insurance.
- The country needs to **invest in health information technology**. For Wal-Mart, IT has streamlined its operations and lowered costs. Wal-Mart has joined with companies such as Intel and Pitney Bowes to create a safe, up-to-date **personal health record** for employees. Other technologies applicable in health care include **bar coding** to improve safety and **RFID**.
- **Everyone needs health coverage**. 90% of Wal-Mart's employees have coverage, which has improved in recent years. Plans are more affordable (as low as $23 per month for employees), with shorter waiting periods, no lifetime max, and no requirements on hours worked to be covered.
- Wal-Mart's **in-store clinics** provide a new form of access to health care. The current experiment has been at 76 stores; it has shown a successful model for customers and communities. This **will grow to 400 stores** in the next year, and in 5-7 years **could be in 2,000 stores**. (There may be opportunities to partner with community hospitals in operating these clinics.) To date, 90% of customers are satisfied; 50% are uninsured; 15% would have gone to the ER; and 20% of patients seen were children.
- Steps employers can take include joining **Dossier** in creating an EHR for employees, and **participating in the Better Health Care Together coalition**.

Executive Seminar: Consumer-Centric Approaches to Engagement

Experts in engaging consumers shared approaches they are using and how they are working.

- Dr. E. Dale Collins from Dartmouth-Hitchcock Medical Center described a r**edesigned care process** for breast cancer treatment. It engages consumers by using **decision aids** (risk assessment, video with information and data, advice sessions, etc.) to help them **understand options** and data, and **make better decisions**.
- Dr. David Cochran described some of Harvard Pilgrim Health Care's efforts to engage its members in their own

health care. Examples included **mailing wallet cards to diabetic patients** containing key questions for them to discuss with their physician, and an **automated, interactive phone system** that calls consumers and walks them through a series of questions. The specific example shared was an osteoporosis outreach program aimed at engaging a targeted group of women. This program reached 80% of the target; 87% continued with the call; 53% wanted health tips; and osteoporosis testing rates subsequently increased by 25%.

> *"Members, when educated about and armed with the right questions, will drive physician behavior."*
> —David Cochran, MD, SVP Strategic Development, Harvard Pilgrim Health Care

- Maryann Stump explained "**Health Facts**," a web-based program **modeled after nutrition labeling** that engages consumers by providing simple, useful, actionable, easy-to-understand information about providers that is actually supplied by providers. (Providers support this because it is done with them, not to them.) Efforts are under way to supplement the factual information with information about patients' experiences.

Track 1: Executive Congress

Physicians, quality care measurement experts, health plan officials, and employers met to discuss the need for chronic care management and universal health coverage.

- Helping diabetes patients manage their diseases is **a critical cost-containment responsibility**. It must be shared by providers, health plans, employers, and patients. Encouraging implementation of **evidence-based clinical guidelines** is a critical first step in that endeavor.
- Process and outcomes can and should be **measured** to ensure quality care. It is **impossible to control costs without measurement**.
- Preventive care is **a vital element of health care treatment**. Wellness programs sponsored by employers are **indispensable** for controlling health costs.

> *"Prevention is really the way we need to go. It is a crucial part of effective diabetes management."*
> —Richard Kahn, PhD, Chief Scientific and Medical Officer, American Diabetes Association

- Universal coverage, ensuring access to health treatment for everyone, is **an idea whose time has come**. A **collaborative effort** by federal/state governments, employers, health plans, and providers is required if universal coverage is to fulfill its promise of lowering costs.

Track 2: International Health Forum

In the Forum's final session experts on Asian health care discussed the increased globalization of health care.

- Curtis Schroeder, Group CEO of Bumrungrad International in Thailand, told why 60,000 Americans have traveled more than 10,000 miles and paid out of pocket to go to this hospital (and why hundreds of thousands more patients from the Middle East and Asia no longer flock to the US for care). It is because the **quality and service** are high and **cost is far lower**, often 10% to 20% of the cost in the US. This is **appealing to the US uninsured** (30% of whom make more than $75,000 per year) and is attractive to some with insurance that has limits, restrictions, and high deductibles.
- This type of global health care **has been B2C**, attracting consumers who pay out of pocket. Mr. Schroeder believes there will be an **evolution to "medical outsourcing"** which is **B2B** in that employers will use global health care to lower costs (as has occurred in other business tasks).

> *"Corporations are looking at international health care as a way to decrease cost."*
> —Curtis Schroeder, Group CEO, Bumrungrad Intl.

- Dr. Jason Yap, Director (Healthcare Services) of Singapore's Tourism Board, said that Singapore is **engaged not in medical tourism**, but in **medical travel** (the difference: this is not for vacation and is very high-quality care.) Singapore's approach is **not about competing** (its capacity is not sufficient to pose a competitive threat) but **collaborating**. Patients (often from other Asian countries) tend to be referred by their physicians because the care available is higher quality than available to patients elsewhere. Dr. Yap said Singapore is analogous to being an "out of network provider" which is just a bit further out of the network.

Track 6: Health Plan & Insurer CEO/CFO/CMO/CIO Summit

Speakers described lessons learned through corporate efforts to enhance consumerism to bring health care costs in

line, and assessed how IT can encourage active consumer participation and ultimately improve care.

- Use **simple incentives** to motivate participants (cash works) and **be aware of employees' unique needs**, including logistic and psychological barriers to participation in programs such as disease management.
- **Integrate information and use it more broadly**. The PHR can identify gaps in care and stimulate online self-monitoring, with information flowing to case managers and health care providers for evaluation. Trained disease management staff can serve as trusted sources of information and advice on using health resources wisely.

> *"Health information technology can allow better communication among all providers—physicians, case managers, nurses, disease managers, health coaches—so they're all pulling in the same direction for the best outcomes for the patient."*
>
> —Charles Kennedy, MD, VP, Health Information Technology and Research, WellPoint

- **Use health information technology to facilitate more interaction and provide needed information.** For example, at the point where care decisions are being made, the physician and patient can use HIT to understand relevant health plan programs—e.g., formulary rules, disease management—instead of after the fact. Pilot programs are putting more clinical data on patients in the hands of physicians and nurses in emergency departments who are seeing those patients for the first time.

Track 7: Pharma & Biotech CEO/CFO Summit

Structures that have served the US pharma industry well for decades **will not fit** the changes on the horizon in how health care is assessed and delivered. Companies, regulators, and academia must find **new processes and priorities** as medical advances in the way diseases are diagnosed and treated make the current repayment methodologies outmoded. But no one has a handle yet on what the new models will, or should, look like. Among the most pressing issues the new design must deal with are:

- **Apportioning** between internal development, academic development, and use of outside contractors **new patient-tailored treatments** where there must be a biomarker aspect, a diagnostic aspect, and then a treatment aspect.
- Finding ways to **incentivize** health plan **enrollees to take the drugs** that are truly beneficial and forgo those that are of little use.
- Coping with **genomic testing** that is going to show a huge percentage of the population at risk for something, with little sense of the probabilities or treatment indications.
- Dealing with a serious **lack of understanding** by patients about the real impact of new medical breakthroughs and a growing shortage of specialists trained in helping them understand.
- The growing **overlap** between self-administered specialty pharmaceuticals and those delivered by home infusion firms, and the disparate ways the two delivery systems are regulated.
- Creating **appropriate payment formulae** for delivery of drugs with an essential service component, when the control approaches of drug coverage and major medical insurance have been traditionally quite different.

> *"What is the business model for personalized medicine? I don't know and I don't think my company knows. There are lots of questions here and no one knows the answers."*
>
> —Wayne A. Rosenkrans, Jr., PhD, Scientific & Medical Strategy Director, AstraZeneca Pharmaceuticals

Track 8: Health System and Hospital CEO/CFO/CMO/CIO Summit

This track's final session involved the CEO of a group of community hospitals and the CEO of National Surgical Hospitals sharing their differing perspectives on physician-owned specialty hospitals.

- James Hinton, CEO of Presbyterian Healthcare Services in New Mexico, argued that limited service specialty hospitals **don't improve health care**—they are **about the physician; not the patient**. These entities further fragment the delivery of care (versus improving coordination), cherry pick the most profitable cases, have processes structured around physician efficiency as opposed to being patient-centric, increase utilization, lack transparency, and at times are dangerous to patients.

> *"There is no evidence that fragmented, disconnected niche players improve quality or costs."*
>
> —James Hinton, President and CEO, Presbyterian Healthcare Services

- John Rex-Waller, Chairman and CEO of National Surgical Hospitals, offered a very different perspective. He argued that **specialization improves quality** and that **competition spurs all providers to improve the care delivered**. He stated that specialty hospitals desire to compete on quality, cost, and service—which benefits patients and the health care system. He argued that **physician ownership is more about autonomy, control, and efficiency** than finances, contending that the financial benefits of ownership are relatively small in relation to what such specialist physicians are earning anyway, in no way influencing medical decisions. In his view, the fact that specialty hospitals provide services in areas which have been profitable for community hospitals and which have cross-subsidized other areas of the hospital is a **reimbursement system problem that needs to be fixed**. He cited research that specialty hospitals had not hurt community hospitals. He also noted that while community hospitals are often perceived as saints, they are ferocious competitors.