The
COLORADO
HEALTH
Symposium

Insights

2010 Colorado Health Symposium

Value in Health Care: Improving Quality and Controlling Costs

July 28–30, 2010
Keystone, Colorado

presented by

The Colorado Health Foundation™

Introduction:

In the absence of better access to quality care and control of runaway costs, America's health care system is unsustainable. To help chart the best course for recovery, the Colorado Health Foundation made "Value in Health Care: Improving Quality, Controlling Costs," the theme of its 2010 Colorado Health Symposium, July 28–30 at the Keystone Resort. The sold-out event, which drew more than 400 participants from Colorado and across the country, featured perspectives from policy experts on how the U.S. health care system can deliver better-quality care at a lower cost, while embracing wellness as a core determinant of health.

Using published summaries, social media and blog postings as resources, this report compiles speeches, statistical data and other highlights from the three-day event. Read as a whole, it provides a snapshot of health care's challenges and what the sector must do in moving forward to address them on a local and national level.

Plenary speakers at this year's Symposium included: **Peter J. Neumann**, director of the Center for the Evaluation of Value and Risk in Health, Institute for Clinical Research and Health Policy Studies at Tufts Medical Center; **Dr. Joseph Thompson**, the Surgeon General of Arkansas; **Judith Bell**, president of PolicyLink; **Jodee Kozlak**, executive vice president of Human Resources for Target Corp.; **Dr. Jim Krieger**, chief of the Chronic Disease and Injury Prevention Section of Public Health — Seattle and King County, Wash.; **Dr. Jay Want**, president and CEO of Physician Health Partners LLC; **Harold Miller**, executive director, Center for Healthcare Quality and Payment Reform; **John Rother**, executive vice president of policy and strategy for AARP; **Jason Hwang**, executive director of health care for the Innosight Institute; **Michael Soman**, president and chief medical executive of Group Health Permanente; **Len Nichols**, director of the Center for Health Policy Research and Ethics at George Mason University; **Simon Stevens**, executive vice president of the UnitedHealth Group; **Mark Laitos,** president of the Colorado Medical Society; and **Andrew Webber**, president and CEO of the National Business Coalition on Health. The keynote speakers at the 2010 Colorado Health Symposium were: Oklahoma City Mayor **Mick Cornett**; **Dr. Richard Carmona**, the 17th U.S. Surgeon General; and **Elliott Fisher**, director of population and policy of The Dartmouth Institute.

In what proved to be a lively and engaging new event for the Symposium, some of the sharpest minds and most articulate voices on health policy engaged in an Oxford-style, interactive debate on the question: Does the new health reform law give the federal government too much control over Americans' health care? **Dr. Stuart Butler** of the Heritage Foundation, and Colorado's Attorney General **John Suthers** debated former Colorado Gov. **Richard Lamm** and journalist/author **T.R. Reid** on the wisdom of that resolution. Highlights from the debate are featured on YouTube http://www.youtube.com/coloradohealth. Other highlights from the 2010 Colorado Health Symposium are available on the Colorado Health Foundation's website http://www.coloradohealth.org/symposium_social_media.aspx, where streaming video, blog postings and links to social media tools are still available. During the Symposium, Rocky Mountain PBS taped an episode of "Colorado State of Mind" focused on the future of health care. The segment, which featured speakers from the Symposium, is still available online at http://video.rmpbs.org/video/1555656129/.

Bob Mook
Editorial Manager
The Colorado Health Foundation

Overview:

Whether you're looking at health care from a statewide or national perspective, there's no shortage of challenges when it comes to improving quality and controlling costs.

Despite the trillions of dollars spent on health care in the United States, recent statistics suggest we're not getting much bang from our buck in terms of health care quality. According to the World Health Organization, the United States ranks 30th in life expectancy and 33rd in infant mortality. With the prevalence of low-quality care, acute conditions become chronic and chronic conditions become life-threatening. When health care is not coordinated, patients undergo unnecessary and duplicative testing that slows down treatment and increases costs. Although Colorado is known for its lean and active population, a recent study paints a different picture of the state's progress regarding health care. The Colorado Health Foundation's Health Report Card shows the state losing ground in many areas. Regrettably, the state's most recent grades have not improved since 2006, when the Foundation issued its first report card. Most troubling, the state's overall grade for *Healthy Children* slipped from an already dismal C- to an unacceptably low D+. About 41 percent of Colorado children lack a medical home that provides continuous, comprehensive, family-centered, coordinated and compassionate care. We rank No. 39 among states in delayed or no prenatal care and No. 38 among states where kids receive routine dental prevention care.

The news is no more encouraging with regard to controlling costs. Earlier this year, the Centers for Medicare & Medicaid Services estimated health care accounted for a staggering 17.3 percent of the overall U.S. economy in 2009. And while an estimate from the Commonwealth Fund shows that the reform bill will save $511 billion and reduce the federal budget deficit by $143 billion over a 10-year period, some dispute those numbers and argue the Patient Protection and Affordable Care Act won't do enough to bend the cost curve now and in the future. According to the Commonwealth Fund, total national health expenditures will reach $4.5 trillion by 2019. Without the law, the number would be $4.8 trillion.

Colorado isn't immune to the cost issue. An economic analysis, supported by the Colorado Health Foundation and The Colorado Trust, showed Colorado has the seventh highest health care costs in the nation. In 2008, health insurance premiums in Colorado represented nearly 22 percent of median family income. Health care also continues to claim a larger share of state budgets. Colorado already spends almost $1.6 billion a year on Medicaid alone — roughly 21 percent of the $7.5 billion in the state's general fund. Yet, the cost of doing nothing is much higher. The study shows that without reform, more Coloradans will be uninsured, fewer will be covered by employer-sponsored insurance and more will rely on Medicaid coverage.

With quality and costs weighing heavily on the minds of health care professionals, community leaders and the general public, the Colorado Health Foundation made "Value in Health Care: Improving Quality, Controlling Costs" the theme of the 2010 Colorado Health Symposium. The sold-out event drew more than 400 participants eager to hear answers from some of the most-respected policy experts in the field. While the three-day conference offered a broad range of perspectives throughout the health care spectrum, most speakers agreed on three key points:

- Payment reform alone won't fix what ails the health care system;
- Prevention needs to be a key area of emphasis;
- Everyone with a stake in health care will need to come together to resolve the conundrum of health care quality and costs.

In making necessary changes, health care professionals, patients, community leaders and payers will need to uncover new solutions together. **Michael Soman**, president and chief medical executive of Group Health Permanente, a consumer-governed, nonprofit health care system based in Seattle, summed it up: "The [current] system will implode if we don't fix it. … And the only way to achieve that is by crossing tribal boundaries." What follows are some breakthrough perspectives, culled from hours of discussions presented at the Symposium on how health care and society as a whole can best cross those boundaries in confronting the challenges the sector faces.

"The [current] system will implode if we don't fix it. … And the only way to achieve that is by crossing tribal boundaries."

— **Michael Soman,** President and Chief Medical Executive of Group Health Permanente

Day One:

Prevention: A Cure for What Ails American Health Care?

There's no argument that encouraging people to adopt healthy habits, reducing obesity rates, maintaining robust public health systems and providing basic preventive care like immunizations and screenings can lead to a healthier population. But do we know which have the biggest impact and whether they actually reduce health spending? Can the return on investment be measured and used to determine which are most cost-effective? And should people who disregard basic prevention pay a penalty?

Those were just a few of the questions tackled by plenary speakers on Day One of the 2010 Colorado Health Symposium. Keeping with the overall theme of the Symposium, the speakers concluded judicious prevention practices can be an effective tool in improving patients' health, but they split on the question of whether prevention actually saves money.

Peter J. Neumann, director of the Center for the Evaluation of Value and Risk in Health, Institute for Clinical Research and Health Policy Studies at Tufts Medical Center, told participants the verdict is out on whether prevention will save money (or if saving money is the point). Neumann cited a Tufts analysis that showed there's no statistical evidence that prevention is any more cost-effective than treatment. But health care professionals shouldn't be discouraged from focusing on prevention, even though it doesn't necessarily save money, Neumann said. He discussed arguments against the points made in his paper, including the suggestion that the study had no real focus on community-wide prevention and the concept that the study is asking the "wrong" question ("why does prevention have to save money to be good?"). Adding that smart, targeted prevention could save lives and improve health, Neumann urged health policy developers to conduct cost-effectiveness analyses to inform decisions about how to target resources to improve health, whether or not those investments save money.

"It's undisputed that healthy people are less expensive to provide care for than people with illness and disease. Whether a preventive program saves money is another question: It may save money, it may not save money."

— **Peter J. Neumann,** Director of the Center for the Evaluation of Value and Risk in Health, *Tufts Medical Center*

By employing preventive practices — particularly in tackling the issue of childhood obesity — communities will avoid more serious health problems in the future, said **Dr. Joseph Thompson**, surgeon general of Arkansas. Thompson discussed how his state slowed obesity rates by raising public awareness, setting physical-education standards and encouraging schools to leave their gyms open over the weekends so kids could have more chances to be active. Given the extent of the obesity problem, the question of whether such initiatives will "save" costs in health care is a moot point. "Cost-avoidance is what we're trying to achieve, not cost savings," Thompson said. Whether it is tight budgets, rising health care costs or addressing obesity, Thompson emphasized that state leaders are tasked with "managing the problems of today, but still plan for the future." He said health needs to be considered in all policies — whether in education, transportation, land-use planning, economic development or health care — to ensure that the healthy choice is the easy choice in our communities now and for years to come.

"Cost-avoidance is what we're trying to achieve, not cost savings."

— **Dr. Joseph Thompson,** Surgeon General of Arkansas

Though recent statistics show obesity is growing in Colorado and nationwide, **Judith Bell**, president of PolicyLink, said she's heartened by recent efforts that could reverse the problem in the near future and improve the overall health of the population. Bell alluded to Michelle Obama's campaign to combat childhood obesity and the growing movement of urban agriculture that provides produce in areas where it's hard to find fresh fruit and vegetables in grocery stores. Bell also cited a chilling fact that there are no major grocery store chains in the city of Detroit, a pattern growing more common across the United States. She took aim at how social class disparities affect the quality of health care people receive. "How healthy you are is directly related to where you live. The middle class die on average three years earlier than the upper class." But Bell noted signs of hope, including a public-private partnership including the Fresh Food Financing Initiative in Pennsylvania, a public-private partnership designed to increase access to fresh foods in underserved communities which has created nearly 5,000 new jobs in the state while providing about 400,000 people with access to healthy food.

Jodee Kozlak, executive vice president of Human Resources for Target Corp., said the large retailer has invested in an innovative program to encourage its employees to improve their health, resulting in increased participation in vaccination programs and a dramatic shift in the company's culture of wellness. Although preventive care is fully covered through the company's insurance plan, only 29 percent of women and 12 percent of men took advantage of these benefits in 2009. At the same time, 16 percent of employees have chronic conditions that drive 41 percent of the company's health care costs. Responding to those discouraging numbers, Target launched a program that rewards employees with financial incentives to monitor and improve their health. Employees receive regular communications addressing fitness, nutrition, and healthy minds and are connected with local "well-being champions" to help identify resources and navigate benefits. During a question-and-answer session, a doctor from The Children's Hospital pointed out the apparent contradiction between Target's employee wellness initiative and the positioning of Taco Bells and Pizza Huts as the first things customers see when entering a Target store. In answering the doctor's question, Kozlak said Target also will make changes to the kind of food it offers customers during the next few years.

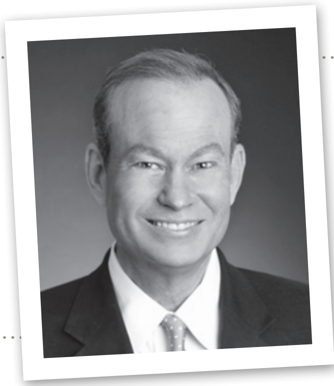
Dr. Jim Krieger, chief of the Chronic Disease and Injury Prevention Section of Public Health — Seattle and King County, Wash., urged policymakers to consider environmental factors, such as housing and air quality, as a means of prevention and improving health. "The educational approach [to prevention] alone doesn't seem to be working," Krieger said. "There is a paradigm shift in public health that focuses on policy, systems and environmental changes." What can we do to improve the health of communities? Krieger said in King County, a community health professional works side-by-side with the child's family to look for asthma triggers in the home, such as tobacco smoke and mold, and to develop an action plan that includes linking the family to a primary care provider and social service resources. Results to date show intervention participants have experienced fewer asthma symptoms and hospitalizations. King County also is implementing several interventions to change the food environment including a requirement that restaurants label menus with caloric information and developing a "community kitchen" where individuals can learn or re-learn how to cook and feed a family for a week on a budget of $60.

Day One Keynote Address: Mick Cornett

It seems nearly all politicians talk about operating "leaner" these days, but Oklahoma City Mayor **Mick Cornett** practices what he preaches. During a July 28 keynote luncheon at the Colorado Health Symposium, Cornett talked about how he changed the culture of obesity in his hometown, beginning with his own 42-pound weight loss, and putting the fast food capital of the country on a diet.

In 2007, Oklahoma City seemed to be on the right track in many respects. The municipality was consistently named as one of the best cities in the country to work and its downtown was increasingly recognized as a thriving and industrious economic center. But a widespread obesity problem threatened to undermine the city's hard-earned economic development progress. Cornett said the "wake-up call" about the obesity problem came when a national magazine short-listed Oklahoma City as one of the most obese cities in the country. "Being on a list of most obese cities can't possibly be good," Cornett said. "Employers will ask: 'Do I want to create jobs in this place?'" Cornett, who was elected in 2004 with the promise of bringing growth and jobs to Oklahoma City, said he couldn't run from his responsibility as the top civic leader.

To promote discussion on the problem, Cornett challenged Oklahoma City to go on a diet with the goal of losing 1 million pounds. At a press conference at the start of 2008 Cornett stood in front of elephants at the local zoo and launched his campaign that included a specially designed website http://www.thiscityisgoingonadiet.com/ aimed at engaging residents of the city. The move generated worldwide media attention for Oklahoma City and landed Cornett on the national talk show circuit. While the campaign was successful in raising awareness on the issue, Cornett maintained it was not politically calculated. "Political instinct is to tell people what they want to hear. Nobody wants to hear they've got to lose weight... Not one of my political advisors said, 'This is a good idea.'"



"Political instinct is to tell people what they want to hear. Nobody wants to hear they've got to lose weight... Not one of my political advisors said, 'This is a good idea.'"

— **Mick Cornett,** Mayor of Oklahoma City

So far, more than 40,000 Oklahomans signed up for the citywide diet, losing more than half a million pounds. But Cornett said meeting the 1 million pound goal is less important than raising awareness of obesity and health. Cornett said the campaign energized a cultural shift in Oklahoma City, which has since developed more parks, pedestrian walkways and bike paths to encourage residents to get active. That means developing more trails instead of roads. "We've got to design a city that revolves around people and stops revolving around cars," he said. Unlike mayors from other cities who took on obesity by setting nutritional standards for restaurants or banning trans-fats, Cornett worked with restaurateurs on the problem. He even endorsed healthier fast food options for Taco Bell. "I knew I wasn't going to stop 35,000 people a day from going to Taco Bell. But even if they go to Taco Bell, there are choices to be made," he said. To recognize his achievements, chefs around the city even added a "Mayor's Special" to their menus — consisting of healthy fare.

Day Two:

It's Broke — Now How Do We Fix It?

The health care delivery system is rife with duplication, unnecessary testing and treatment, and other dysfunctions that lead to poor health outcomes and wasted spending. How can the delivery system be redesigned to improve outcomes and reduce spending? Which practice models are most effective? How do we keep patients at the center of the process? Will Health Information Technology indeed improve care and reduce costs? What barriers exist to system reform? Those and other questions were addressed by plenary speakers on Day Two of the 2010 Colorado Health Symposium. Panelists uniformly agreed that putting patients at the center of health care, with an emphasis on results over services, will help stem the trend of rising costs and declining patient satisfaction. They also agreed that making the shift to a "patient-centered" system will require a concerted effort from health professionals, participation from patients and experimenting with new approaches to see what works.

Likening the current health delivery system to an overfed cat, **Dr. Jay Want**, president and CEO of Physician Health Partners LLC, said compensating health care professionals for what they do rather than the results they achieve is largely responsible for what has become expensive, ineffective clinical care. Over the years, Want said the health care sector has mastered the art of drawing money from third-party payers where economic harm can be hidden or diffused — often at the expense of patients. He gave many examples of unnecessary billable health care expenses, including the time when his daughter fell off her bike and received a CT scan (a common standard of care today) rather than "good old fashioned X-rays" which are much more affordable. He urged leaders in health care to work towards a more patient-centered medical home model that would distribute care across different types of team members including mid-level providers, social workers, psychologists and administrative staff that are cross-trained in many areas. This model, he maintained, will improve patients' access to care, lower health care costs and help reduce the current overload on primary care physicians.

"Making [patients'] bills bigger has been a manifest goal for our industry for quite some time now. It's a game that can't be won, yet it's exactly the game we are playing with the fee-for-service model."

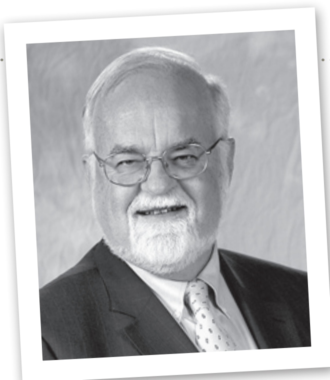
— **Dr. Jay Want,** President and CEO, *Physician Health Partners LLC*

Reducing costs without "rationing" care is the biggest challenge facing the health care delivery system, said **Harold Miller**, executive director, Center for Healthcare Quality and Payment Reform. Miller concurred with Want's assessment of the lopsided payment delivery system. "The system rewards bad outcomes," Miller said. "No one gets paid if patients stay healthy." Miller called for integrated approaches such as "medical homes" that streamline primary and specialty care. He went on to point out six key aspects of primary care delivery critical to optimizing wellness and value and decreasing waste and downstream hospitalizations:

- Primary care physicians need adequate time for diagnosis, treatment, planning, and follow-up;
- Resources for patient education and self-management support (including using registered nurses to fulfill selected physician roles);
- Registries/proactive care;
- Targeting of high-risk patients;
- Coordinated relationships with specialists/hospitals;
- Data and quality control measures.

Miller made the point that none of the current health care delivery models integrate all of these aspects. He concluded that an integrated system must involve primary care physicians and a broad swath of other partners.

John Rother, executive vice president of policy and strategy for AARP, said while health professionals should lead the charge in improving health care, patients also need to work to improve the system. "We all bear responsibility for the breakdown," Rother said. "It's not all about doctors and hospitals. About half of the Medicare patients don't bring questions with them to a doctors' visit. People leave the office feeling confused about what they should do." He urged clinicians to promote more patient engagement. "We need a change in culture, reinforced with clear information. ... The key is to be proactive rather than reactive about managing patient health." Rother said giving patients better incentives for making value-based choices also could rein in costs. In addition to the transformations that need to occur on individual levels, Rother discussed what he feels are necessary, system-wide changes. He noted the need for improved coordination and delivery of care by providers, revision of the current payment systems, improved transitional care opportunities after hospitalizations and further development of the patient-centered medical home concept.



"We all bear responsibility for the breakdown… It's not all about doctors and hospitals. About half of the Medicare patients don't bring questions with them to a doctors' visit."

— **John Rother,** Executive Vice President of Policy and Strategy for AARP

In improving quality and controlling costs, **Dr. Jason Hwang**, executive director of health care for the Innosight Institute, said the health sector should look to other industries. Hwang, co-author of "The Innovator's Prescription: How Disruptive Innovation Can Fix Health Care," cited the computer industry as an example of a good role model for health care. In the development of personal computers, he noted early tech users accepted limitations and trade-offs for technology which became better and more affordable. "In any market, you can graph performance improvement over time." But in order to make needed changes, Hwang said all parties in health care need to embrace "disruptive innovation," wherein ineffective methodologies are replaced over time with more effective ones. So, how do we generate disruptive innovation? Hwang said first, we need to identify gaps or opportunities for growth. In health care, these opportunities include consumers whose needs and wants are largely ignored by the existing market or industry leaders. Second, we need to design new, lower-cost, more-convenient products and services that meet the needs and wants of these individuals. And finally, we need to be flexible and adapt to new or different consumer/market demands at a moment's notice.

Michael Soman, president and chief medical executive of Group Health Permanente, said that embracing innovation paid off for the consumer-governed, nonprofit health care system based in Seattle, which is widely regarded as a leader in the "medical home" concept. But Soman admitted that developing Group Health Permanente's successful approach took time and trial-by-error. He quoted a colleague in identifying what many health practices need to do to improve quality and control costs: "When you discover you're on a dead horse, the best strategy is to dismount. We dismounted." After experimenting with a number of different approaches, Soman said medical homes were developed by establishing principles, processes and accountability of team members while implementing patient-centered, proactive and comprehensive care that is effective and gives a satisfying patient experience. Physicians too are providing better care and experiencing less "burnout." As a result, Soman said Group Health Permanente has concluded that "more and more capable primary care equals lower costs and higher quality." Since making the transformation, ER visits and doctor visits have dramatically declined. Soman said investing in health information technology and educating health providers pays off. He acknowledged changing the way health care is delivered is daunting, but essential. "We're in a struggle with American medicine," Soman said. "The [current] system will implode if we don't fix it. We can only do that if we work together and learn together, with humility, with open minds, with unflinching focus. We can do this."

Day Two Keynote Address: Richard Carmona

"The value proposition in health care needs to be about delivering the best care to the most people with the least costs," declared **Dr. Richard Carmona**, the 17th U.S. Surgeon General, during the July 29 keynote address at the Colorado Health Symposium. Carmona, who issued the definitive report about the dangers of secondhand smoke and warned about obesity as "a national security threat," said prevention is the key to the sustainability of the health care system.

"No matter what comes out of this health care transformation, the only way we're going to turn this around is through prevention," he said. "We're spending $2.5 trillion [a year] on health care — 75 percent of which is for chronic disease, most of which is preventable. If you were the CEO of a company and

told the board you lost 75 percent of its earnings, how likely do you think it would be that you'd stick around?" Carmona said the United States must change the trajectory of disease or face dire consequences for the economy for generations to come.

Before things improve, the emphasis needs to shift from what Carmona characterized as "sick care" to true "health care." "We have data and science and know where we need to go; what we lack is the political will to do what needs to be done," he said. He cited many paradoxes in U.S. health policy, including how the government subsidizes tobacco but won't provide adequate prenatal care to prevent birth defects. Carmona also talked about the politics of being Surgeon General and crafting effective health policy (despite Washington partisanship) and the Surgeon General's role in delivering authentic and authoritative statements on the status of the nation's health. Serving as only the 17th Surgeon General since the founding of the nation, Dr. Carmona highlighted the power of the office to promote health. This office, he said, has such power because it uses evidence to define which health challenges need to be addressed and the prevention strategies to be implemented to improve the health of the nation. During his tenure, Dr. Carmona faced significant challenges in delivering on the charge of the Surgeon General — to protect, promote, and advance the health and safety of the nation — as a result of partisan politics from both sides of the aisle. In his closing, Dr. Carmona suggested that the Surgeon General should deliver an annual "state of the nation" health report. This report, he stated, should independently and transparently address the status of the nation's health — without political influence.

"We have data and science and know where we need to go; what we lack is the political will to do what needs to be done."

— **Dr. Richard Carmona,** 17th Surgeon General of the United States

A high school dropout who grew up on the mean streets of New York before serving as a Green Beret and joining the medical profession, Carmona called disparities in the health care system "an embarrassment to the richest country in the world." He challenged the audience to drive towards a health care system that promotes prevention, preparedness and health literacy and eliminates health disparities.

Day Three:

You Get What You Pay For: Incentives for Payment Reform

In the current fee-for-service system, we get a lot of exams, tests, prescriptions and procedures — but not the best health outcomes. During Day Three of the 2010 Colorado Health Symposium, a distinguished group of speakers discussed which payment models will incent physicians, hospitals and other providers to deliver the best outcomes in the most cost-effective ways and the role employers and insurance companies can play in reshaping the system. The discussion revealed both hope and concerns about the Patient Protection and Affordable Care Act. But the speakers agreed on one key point: Payment reform alone won't fix what ails the health care system.

Len Nichols, director of the Center for Health Policy Research and Ethics at George Mason University, said while the 2,000-page federal health care reform law isn't perfect, it provides a catalyst for much-needed change. Contrary to popular belief, Nichols said "health reform is not a federal takeover." Rather, health care reform comes down to communities taking back control of their health care systems. A self-described "simple country economist," Nichols talked about Centers for Medicare and Medicaid Services (CMS) — demonstration programs designed to improve quality while reducing costs. However, Nichols pointed out that CMS cannot do all the heavy lifting; it will take creativity, community support and coordination among different stakeholders to make health care reform a success. In Colorado, health policymakers don't need to venture far for good role models. "Just look at Colorado's Grand Junction as one example of a successful process of engaging the community to launch a low-cost health care system," said Nichols. While many of the speakers throughout the Symposium emphasized that patients need to be at the center of health care reform, Nichols pointed out that for reform to really work, the entire community, including physicians, needs to be engaged and involved in the transformation. Though federal reform won't be "smooth sailing," Nichols said it forces the industry to re-evaluate incentive structures that aren't sustainable. Despite the uncertainty and apprehension about federal health care reform, Nichols said he's optimistic about the future. "I've never seen such openness to change," he said.

"The most important thing [about federal health care reform] is the signal it sends. And the signal it sends is that business as usual is over. We can't afford it. The Chinese want their money back."

— **Dr. Len Nichols,** Director of the Center for Health Policy Research and Ethics, *George Mason University*

While he strongly believes the payment system for health care is flawed, **Simon Stevens**, executive vice president of the UnitedHealth Group, said the much-maligned fee-for-service model isn't the only culprit for the disconnect between quality and costs in U.S. health care. "Many other countries use the same model and spend less [on health care]," noted Stevens, who served as health policy director for British Prime Minister Tony Blair. As the lone representative for the insurance industry among Friday's speakers, Stevens identified trade-offs and challenges the new reform law presents. One of the most challenging transitions that must take place in the coming years, Stevens said, is creating the right balance between the supply side of the equation (incentives for providers) with the demand side — driving incentives for consumers to demand higher value from their health care system. He anticipates a tremendous amount of experimentation with new payment models in the coming years. Each "experiment" will require us to make trade-offs between ease and impact. What is the right balance? As Stevens noted, black and white answers are not likely to emerge any time soon. We should all get comfortable with multiple shades of gray.

"Many other countries use the same model and spend less [on health care]."

— **Simon Stevens,** Executive Vice President of UnitedHealth Group

Steven Summer, president and CEO of the Colorado Hospital Association, characterized the new health care reform law as a mixed bag. "The law is not perfect," he said. "It will have lots of unintended consequences. We will have to change it going forward, but at least we have something in place." He said hospital administrators fear the reform act could launch "managed care 1.0, not managed care 3.0." Summers said improvements to the system can be made when health care professionals work collaboratively in sharing data and insights on best practices and safety to avoid costly medical errors. "We want to move to that brave new world of value over volume," Summer said. "The payment system must push us in this direction." The good news is Colorado is already ahead of the curve in terms of collaboration. "Colorado is unique in that health care stakeholders trust each other, and they sit down and talk often," he said.

Dr. Mark Laitos, president of the Colorado Medical Society, expressed the apprehension that many doctors are feeling about federal health care reform — particularly the portions that pertain to incentives and reimbursement for physicians. Laitos, a family physician from Longmont, cautioned that incentives aren't the only answer to improving health care. "This is not about squeezing every penny we want out of the system — we do want to make our patients better." He acknowledged doctors are skeptical about pay-for-performance arrangements. Naming Grand Junction, Colo. as an example and echoing both Len Nichols and Dr. Jim Krieger of Seattle, Laitos said that real health care reform can only happen if communities are fully on board. He added the reform bill does nothing to limit the threat of large malpractice suits that force doctors to practice "defensive medicine" which drives up costs and skews clinical judgment. "This isn't just a financial issue," he said of defensive medicine. "[Doctors are] concerned they're going to be pulled into court. It's a terrifying primal fear from the doctor. Please don't try to discount it." In order to change the way that physicians run their practices, Laitos said, we will need to focus not only on altering financial incentives, but also on the current culture of medical practice in our country. Physician culture plays a huge role in defining practice tendencies. As Dr. Laitos asserts: "Culture eats incentives for lunch."

"This is not about squeezing every penny we want out of the system — we do want to make our patients better."

— **Dr. Mark Laitos,** President of the Colorado Medical Society

As president and CEO of the National Business Coalition on Health, **Andrew Webber** brought the perspective of more than 7,000 employers to the discussion. Unlike other speakers who extolled non-financial virtues of reform, Webber said the bottom line is key. "If it isn't about controlling costs, then we haven't done the job," he said. Despite their critical role in the system, Webber said employers really only want two things related to health care: They want to improve the health of the workforce in order to increase their productivity and to compete for high-quality workers, and they want to reduce the enormous burden of health care costs on their bottom line. Like other speakers, Webber said consumers need to be at the center of revamping the payment system. "We have let a toxic payment system be created, and we've got to take responsibility for it" Webber said. "We actually pay for medical errors and do-overs; we wouldn't do that in any other part of the economy. Employers need to assume a role and take ownership of the consumer entitlement mentality. Combined with our fee-for-service mentality, you have the perfect storm. Webber called for a four-pillar strategy to engage more employers in the ongoing health care transformation: 1) Standardized performance measurement, including performance of health plans, providers and hospitals along with promoting comparative-effectiveness research; 2) Transparency and reporting, including not just reporting of performance measures but also price transparency; 3) Provider payment reform, with a special emphasis on addressing the huge disparity between primary care and specialist reimbursement, in addition to paying for the outcomes rather than volume of delivered services; and 4) Consumer choice and engagement — with special attention to consumer incentives.

Day Three Keynote Address: Dr. Elliott Fisher

While the Patient Protection and Affordable Care Act won't cure all of the many problems facing the health care sector, there are many areas where the new health care reform law gets it right, said **Elliott Fisher**, director of population and policy of The Dartmouth Institute. Fisher delivered the keynote address on the final day of the Colorado Health Symposium.

"I want to tell the story about why the glass is half full in health care reform." Fisher is credited as the man behind The Dartmouth Atlas, an online database that's widely regarded as the gold standard on how medical resources are used and distributed across the United States.

The Dartmouth Atlas shows that regions spending the most on health care don't enjoy better health outcomes than low-spending regions — debunking the common wisdom that "more is better" in the world of health care. It also shows that patient satisfaction and results are better in communities that focus on coordinated and primary care. Fisher cited Grand Junction, Colo. as a prime example.

"The health reform legislation we passed really creates a window of opportunity," Fisher said. "Reform should accelerate new performance measures and new delivery models — such as accountable care organizations and incentives for providers to work together to improve care and reduce costs."

"The data makes clear more capacity doesn't mean more access."

— **Dr. Elliot Fisher,** Director of Population and Policy, *The Dartmouth Institute*

To "get us out of the woods," Fisher said we need to clarify our goals, gather more information and data, establish organizations accountable for redesigning practices and managing capacity, and re-think our incentives. He highlights promising pilots and projects, while also demonstrating their flaws and the challenges to implementation. He hailed the trend of patient-centered medical homes as "tremendously promising." The concept coordinates primary and specialty care between patients and their personal health care teams. Fisher pointed out that Colorado is already ahead of the curve in shaping the future of health care in the United States, citing the state's Western Slope and safety net clinics as examples.

He cautioned there's still much work to be done. "Health care reform is at a very fragile moment," Fisher said. "New payment models are vulnerable to rising costs, which could reverse coverage gains. You guys are already stepping forward." To continue moving forward, he urged health care leaders to be bold and creative in trying new ideas, work to reduce empty rooms in hospitals that are driving up costs and even establish a "cash for clunkers" program that will let providers sell unnecessary expensive medical equipment.

Again asking if the glass is "half-full or half-empty," Fisher reiterated the work of truly reforming a broken system is in our hands. "We can sit back and wait for Washington," he said, "or we can move forward now."

Interactive Debate:

ObamaCare Gives the Federal Government Too Much Control Over America's Health Care

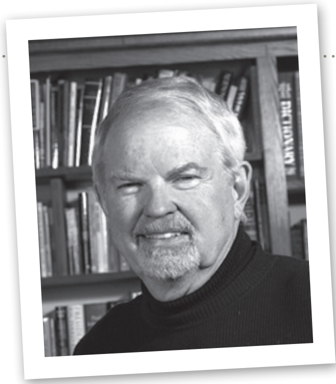
With health care reform weighing heavily on the minds of many participants, the resolution of the Colorado Health Symposium's first-ever interactive debate ("ObamaCare gives the federal government too much control over America's health care") was provocative. During the Oxford-style debate, **Dr. Stuart Butler** of the Heritage Foundation and Colorado's Attorney General **John Suthers** defended the resolution. Former Colorado Gov. **Richard Lamm** and journalist/author **T.R. Reid** countered the argument. The results of the discussion were lively, engaging, often humorous, but always civil and thought-provoking — rare qualities in today's rancorous political environment.

Good intentions aside, Butler questioned whether the Patient Protection and Affordable Care Act is the right path for the health care system. He said ObamaCare seeks to run American health care — which, if costs were considered by themselves, would be the equivalent of the 6th largest economy in the world — from Washington, D.C. Butler argues that we should decentralize health care and leave it to the states just as with welfare and education. What level of government should determine how physicians are paid? Do we need the creation of the 183 new federal programs, councils and advisory boards that are contained in the new Patient Protection and Affordable Care Act? Butler argued that we don't.

"We feel the road we should take is one that complies with American values, that also fits in with American attitudes to who should have ultimate power over fundamental decisions of their life .. This legislation violates the critical elements of what the right road should be."

— **Dr. Stuart Butler,** The Heritage Foundation

On the opposing side of the resolution, former Colorado Gov. Lamm contended that Congress decided on an individual mandate to reach universal health care — a Republican idea, he points out — in an attempt to get consumers health care with minimal federal control. He reminded the audience that it doesn't seek to replace private or public health insurance and expands the market-based system. Don't forget that the states run the health exchanges, he says — an important component to keeping them closer to the people. As long as we don't want people dying in the streets, we need to set up some type of system.



"What you have is this dilemma. If you want universal health care, what are the preconditions for having universal health care? I think one of them is you have to get everybody in the system with a stake in the system and subject to the same rules."

— **Richard Lamm,** Former Colorado Governor

Countering Lamm's arguments, Suthers called those who support the new health care reform law "coercive utopians." He touted the importance of federalism, in which federal government can only exercise express powers given to it. As Suthers argued, the mandate provision in the Patient Protection and Affordable Care Act represents the first time the feds have said "we will punish [citizens'] economic inactivity." Suthers said. Congress can — and often does — tax our economic activity, but it has never before exercised control over your economic inactivity.

"The fact of the matter is, we have a unique Constitutional system in our country. …We're not Europe. We can't have the federal government reaching out and telling you you've got to buy a product."

— **John Suthers,** Attorney General, *The State of Colorado*

Reid, who has debated at the Oxford Union Hall in England, argued that United States law gives most of the power to the states. But, he reminded the audience that no public option was included in the health care reform law. He maintained that if the public option were part of the package, everyone in the United States would pay less for health insurance. He argued that "ObamaCare" gives too little control to the feds in multiple ways. Control over the exchanges is handed to the states. But as Reid puts it, mandates for responsible behavior — like requiring citizens to buy health insurance — are part and parcel of being in a civilized society.

What did the audience think? When polled about their concerns about the new law, nearly half indicated that they worry most about the new law's effectiveness and nearly a quarter have concerns about the costs involved with implementation. The final post-debate polling numbers that demonstrated that 157 opposed the resolution, 57 supported it and 15 were undecided. At the end of the debate, the audience was asked, "Which debater are you most surprised to find yourself agreeing with?" Suthers won out with 38 percent of the crowd finding themselves surprised to have nodded along with his arguments.

Highlights from the debate are featured on YouTube http://www.youtube.com/coloradohealth.

"There are a lot of mandates in American life. As [Attorney] General Suthers knows, it's against the law anywhere in Colorado — even Boulder — to walk down the street naked. That's a mandate to buy clothes. There are lots of mandates and they have one thing in common: Personal responsibility."

— **T.R. Reid,** Journalist/author

About the Colorado Health Symposium:

The Colorado Health Symposium is one of the leading national health policy conferences in the United States. For 29 years, the annual event has attracted cutting-edge thinkers in health care policy and reform efforts to share their ideas, debate policy and interact with leaders from the health care industry, government, business, academia and the nonprofit sector.

About this Report:

"Value in Health Care" was compiled by **Bob Mook**, editorial manager of the Colorado Health Foundation. Mook also authored and co-edited *Symposium Today* http://www.coloradohealth.org/symposiumtoday.aspx, a daily e-mail newsletter distributed to participants of the Colorado Health Symposium and other friends of the Foundation during the three-day event. This report references excerpts from *Symposium Today*, along with blogs and other social media highlighting the event. Bloggers for the Colorado Health Symposium included the following:

Dr. Claire Baumgartner, a third-year resident at Swedish Family Medicine Residency; **Leslie Chadwick**, the manager of internal communications for the Colorado Health Foundation; **Leanne Clark**, a social worker and case manager for the Presbyterian/St. Luke's High Street Primary Care Center; **Hillary Fulton**, a program officer with the Colorado Health Foundation's *Healthy Living* team; **Dr. Daniel Jones**, an attending physician with the Swedish Family Medicine Residency program; **Regina Kilkenny**, the senior medical education officer at the Colorado Health Foundation; **Dr. Rudy Kimmerling**, a resident in CU's internal medicine primary care track and cares for patients at Presbyterian/St. Luke's High Street Primary Care Center; **Amy Latham**, the senior program officer for the Colorado Health Foundation's *Health Coverage* team; **Monica Lyle**, an associate program officer with the Colorado Health Foundation's *Healthy Living* team; **Dan Martin**, a program officer with the Colorado Health Foundation's *Health Care* team; **Dr. Meghan Mont**, a class of 2011 resident with the Rose Family Medicine Residency in Denver; **Amy Neustadt**, a program officer for the Colorado Health Foundation's *Health Coverage* team; **Khanh Nguyen**, the senior program officer with the Colorado Health Foundation's *Healthy Living* team; **Colleen Quinn-Church**, a program officer for the Colorado Health Foundation's *Health Care* team; **Cassidy Smith**, a program officer with the Colorado Health Foundation's *Health Care* team; **Dr. Pete Smith**, a physician faculty member at the Rose Family Medicine Residency in Denver; and **Erica Snow**, a program officer for the Colorado Health Foundation's *Health Coverage* team;

Foundation staff who contributed to the Colorado Health Symposiums' communications and social media efforts included the following:

Suzanne Beranek, communications director — policy and philanthropy; **Elena Harman**, evaluation associate; **Lisa Harris**, communications manager — technology and new media; **Caren Henderson**, communications director — creative services; **Peter Manetta**, communications and database specialist; **Chuck Reyman**, vice president of Communications; **Brenda Sears**, program officer for the *Health Care* team; and **Lauren Varner**, communications coordinator — publications and special projects.

The Colorado Health Symposium was coordinated by **Debra Thomas**, executive liaison, with help from **Sarah Porter Osborn**, event consultant.

About the Colorado Health Foundation:

The Colorado Health Foundation works to make Colorado the healthiest state in the nation by increasing the number of Coloradans with health insurance, ensuring they have access to quality, coordinated care and encouraging healthy living. The Foundation invests in the community through grants and initiatives to health-related nonprofits that focus on these goals, as well as operating medical education programs to increase the health care workforce. The Foundation's assets of $1.1 billion include an investment portfolio as well as an ownership interest in Denver's HealthONE hospital system. For more information, please visit www.ColoradoHealth.org.

Resources for Revisiting the Symposium

While the 2010 Colorado Health Symposium has come and gone, readers can revisit the event through various social media tools, including:

Streaming video on Ustream
http://www.ustream.tv/channel/the-2010-colorado-health-symposium

Footage of many of the plenary speakers is hosted on this site, which allows participants to input comments and link up with Twitter.

Connect with us on Facebook http://www.facebook.com/coloradohealth

Dig deep into the Foundation's Facebook page to find insights, postings and relevant information about the Symposium.

Visit the Colorado Health Symposium Blog
http://coloradohealth.typepad.com/health_symposium

This blog encourages the lively exchange of ideas. Daily session summaries were posted during the Symposium.

Follow Us on Twitter @HealthSymposium http://twitter.com/HealthSymposium

We used the #10CHS hashtag for posts from the 2010 Symposium.

View Speaker Interviews and Interactive Debate Highlights on YouTube
http://www.youtube.com/user/coloradohealth

Get behind-the-scenes with the Symposium on YouTube by viewing selected speaker video clips and highlights of our first-ever interactive debate.

Symposium Today http://www.coloradohealth.org/symposium_today.aspx

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WRITER:
Bob Mook, *Editorial Manager, The Colorado Health Foundation*

EDITORS:
Leslie Chadwick, *Manager of Internal Communications, The Colorado Health Foundation*
Caren Henderson, *Communications Director — Creative Services, The Colorado Health Foundation*
Shepard Nevel, *Vice President of Policy and Operations, The Colorado Health Foundation*
Chuck Reyman, *Vice President of Communications, The Colorado Health Foundation*

Submitted by The Colorado Health Foundation
501 South Cherry Street, Suite 1100 ◦ Denver, Colorado 80246-1325
TEL: 303.953.3600 ◦ **TOLL-FREE:** 877.225.0839
www.ColoradoHealth.org