ALLIANCE FOR
HEALTH REFORM

Data, Technology, and Communication in Patient-Centered Care
Anthem, Inc.
Alliance for Health Reform
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ED HOWARD: Good day to you. My name is Ed Howard. I'm with the Alliance for Health Reform and on behalf of Senator Blunt, Senator Cardin, our Board of Directors; I want to welcome you to today's program on the tools available to patients when they're confronted with choices that have to be made about their care.

This is actually the second of a two-part briefing series on how to move toward a consumer and patient-centered healthcare system. You may remember, some of you, that back in July we did a program that focused on the decisions facing consumers as they choose coverage plans or providers, and today what do patients face when they're already in need of care. Now, some care decisions are more susceptible to patient involvement than others. Small story. When I had a cardiac incident a dozen years or so ago, I didn't ask the EMT in the ambulance whether they should take me to Suburban or Washington Hospital Center. I really wasn't in a position to do that. But a whole lot of care decisions are amenable to patient input, even patient decision making, and it's those situations that we want to look at today.

As in the July briefing, we're pleased to have two partners in today's program. Anthem, which, among other parts of its business, operates Blue Cross Blue Shield plans providing coverage for more than 38 million Americans, and the National Consumers League, which is America's oldest consumer organization whose mission it is to protect and promote social and economic justice for consumers and workers.

If I can, let me take a couple of minutes for some housekeeping before we get to the program. You can see on the screen that there is a hash tag (#Tools4Patients) that you can use to engage the Twitter verse, and if you need Wi-Fi to connect before you tweet there are instructions on the screen and on your table on how to do that. Lots of important information in your packets including speaker biographical information are more extensive than I'll have time to give them, and a materials list that includes links to all of the materials you have in your packets and additional ones that we didn't kill trees to put into your hands.

There are those listings, the biographical materials, and all of the slides from our speakers available online at our website, allhealth.org, which is also where you can find a video recording of this briefing, if not tomorrow certainly by Wednesday, and a couple of days later a transcript of the entire event. That's allhealth.org.

There's a green paper and a blue paper I want to call your attention to. The green one is a card that will accommodate a question that you can ask at the appropriate time in the program, and you can also use one of the microphones to ask a question, or even Tweet it to the tools for patients hash tag. And, at the end of the briefing, there's a blue evaluation form in your packets that we would appreciate you filling out so that we can improve these programs for you.

Now, let's get to the program. We have some great panelists today and, as usual, they'll give brief presentations and then we'll save the big chunk of the time to respond to your questions. Let me do very brief introductions serially for all our panelists and then we'll continue without interruption.

We're going to lead off with Benjamin Moulton who is the Senior Vice President for Policy and Advocacy at the Informed Medical Decisions Foundation. Ben is going to lay out what we mean by patient engagement and empowerment, what information patients need, and what the role of shared decision making is, including state and federal policy efforts. Then, Niall Brennan, who is the Chief Data Officer and Director of the Office of Enterprise Data and Analytics at CMS, is going to share the federal perspective on the use of data to drive more patient-centered care. Robin Gelburd will be next. She is President of FAIR Health. Robin is going to discuss her organization's national database of billions of healthcare claims that can be used to promote transparency and patient engagement. And, finally, Tim Skeen, who is Vice President of Marketplace Solutions in the Information Technology division of Anthem, is going to discuss the IT and data infrastructure that's needed to provide patients and consumers with the information tools that they need.

So, let's not delay any further. Let's start with Ben Moulton. Ben.

BENJAMIN MOULTON: Thank you. So, I want to thank you all for spending some of your lunch time with us today, and I want to thank the Alliance for the opportunity to be here.

So I'm going to set the stage by telling you that I think there's something that we all can do that's practical, that is the pinnacle of patient safety and patient-centered care, and that is shared decision making. It's also something which is bipartisan. It's not a red, white, or blue, it is all of those things and it is, in fact, not only patient-centered, but I also think it's perfected in form consent.

Shared decision making has become the standard part of the language for all patient-centered care, both at the federal and state level, and the premise is pretty simple. You can't engage patients unless they have knowledge. You can't impart knowledge unless they are informed about the choices in an understandable format that's before them, and shared decision making with certified—and I want to stress certified—patient decision tools imparts knowledge and allows alignment with the patient's values and preferences.

If you listen to the folks up at Dartmouth that have been studying this for 40 to 50 years, physician variation, they will tell you 25% to 30% of all healthcare is preference sensitive, which means essentially the patient has choices with about the same morbidity and mortality. The term shared decision making is not a medical term. It arose out of a 1982 President's Commission where you had essentially scholars from law, medicine, and bioethics getting together and declaring that informed consent, the legal requirement, was broken, and the only way to repair it was to engage in shared decision making. It's the first time that shared decision making is mentioned. Informed consent was discussed as an ethical obligation that is rooted upon mutual respect. Foundation is based upon open and honest transparent communication and it is not a ritualistic signature on a form, and the patient's entitled to accept or reject whatever is proposed in front of them.

I teach a course at the Harvard School of Public School of Health in law in clinical practice. I will teach you, when we get to informed consent, I stop because most of my students are physicians, and I say, "What's informed consent?" Usually a surgeon's hand goes up and says, "Oh, that's the form the hospital requires me to get from the patient." And then usually a pediatrician or an internist raises their hand and says, "No. It's not the form; it's the signature on the form." And informed consent is supposed to be this bi-directional communication between patient and provider where the provider tells the patient what the risks, benefits, alternatives are and the patient tells the provider what's acceptable to them, in other words, the preferences and values. So it's a two-way communication and shared decision making with the use of quality tools enhances knowledge, prepares the patient to have that discussion and together, patient and provider, arrive at a decision that's right for that patient. Without that you'll have patient preference misdiagnosis, which happens all the time. Give you a quick example. A woman with early stage breast cancer has two choices: mastectomy or lumpectomy. Very different pathways. A man with early stage prostate cancer has several pathways. Unless you take the time to educate, engage, and involve you often are providing the patient with a choice they would not have selected had they been fully informed. That's why certified decision aids are important.

Let's take a look at the data. This is from Mass General. This is Karen Sepucha's work where she asks surgeons who are treating women with early stage breast cancer; tell me what the patient's top values are. And then she asks the patients, what are your top values? Take a look at the discordance. You can see that surgeons rated living as long as possible as the number one value. Not so patients. Quality of life has a lot to do with it. Take a look at prosthesis hassle. Women rated that significantly as being a top value and concern. Not one provider picked it. And this is what we call decisional discordance, in other words, the only way you find out what's important and valuable to the patient is engaging them and making sure what is selected is what the patient would want.

We have examples essentially through legislation and pilots around the country. This is from Group Health, the Group Health study, about 700,000 patients in the Seattle area. They decided to introduce high quality decision aids, train providers on how to do shared decision making. What were the effects? The effects were that the introduction of high quality aids was associated with a 26% reduction of fewer hip replacements, 38% fewer knee replacements, and 12%-21% lower costs over six months. That really got the attention of policy makers in Washington State. Washington State's now passed three separate pieces of legislation and they are taking it upon themselves, in the absence of action under the ACA, to certify decision aids.

So how about patients? How do they feel about it? It was reported to me that the patient satisfaction surveys from Group Health were the highest in their history. Ninety-six percent of patients said that decision aids helped them understand their treatment choices, 95% said it helped them prepare to talk with their provider and select the decision that was right for them. There is considerable evidence to support shared decision making. We have 130 randomized control trials. I would submit to you it's one of the most studied areas of the clinical interaction. What did we all say in terms of condensing these randomized control trials? First is greater knowledge imparted to the patient, which is a value that we in law highly rate—giving knowledge to patients; more accurate risk perceptions; greater comfort with decisions on behalf of the patient; greater participation in engagement between provider and patient; fewer people remaining undecided; and, fewer patients choosing major surgery. In other words, patients, when they're fully informed, are a lot more conservative about surgical interventions.

Washington state, I think, is a good example of state action in innovation that's going on and that they passed legislation in 2007, they explicitly recognized that shared decision making with a certified decision aid—again, I want to stress certified decision aid—was, in essence, an alternative way to do informed consent. They have incorporated into their Bree Collaborative, which looks at population health issues. In 2012 they said the Chief Medical Officer of the Healthcare Authority can, in fact, certify aids and they're moving forward with it as we speak, and it should be done by the end of this year. Why do I mention it? It's a template. It's a template that others can use.

As we know, CMS has offered to pay for lung cancer screening with low-dose CT scans if shared decision making is used. I expect that CMS will look to other areas of medicine that we consider preference sensitive, in other words, choices with about the same morbidity and mortality. We need to develop a certification criteria equivalent to what Washington state is doing and there are three important constituents you have to satisfy: patients, because they need to know it's conflict free and evidence based; providers, because they're going to want to know that it's evidence based and it's been vetted appropriately; and policy makers. Again, I want to stress, certification, certification, certification. That would be my single take home message. You can do this but you have to assure and attest to the quality of the decision aids.

Why do we do this? First and foremost, is to avoid what Al Mulley at Dartmouth calls "the silent epidemic of misdiagnosis." Patients doing things that they would not have elected to do had they been fully informed. I believe its perfected informed consent. There are studies out there that suggest it's a way to bridge health disparities; that disadvantaged populations with a quality aid gain significant knowledge and are assisted in their choices; and, again, the policy implications of conservative utilization of surgical interventions.

So, with that I'm going to give the mic over with, I think, its 18 seconds left. Niall.

ED HOWARD: Perfect. Go ahead, Niall.

NIALL BRENNAN: Thanks for the invite. Very happy to be here. A little under the weather, so apologies for that. Also, definitely had my share of Alliance for Health Reform sandwiches over the years. This is the first time on the podium so I definitely feel like I've hit the big time, Ed. So I'm an overnight success at 43.

Here’s my presentation. Thank you, Ben, for an excellent presentation in shared decision making. I think it raised a number of very important issues. I’m going to approach it from a data on an information perspective because I think Ben would agree, one of the key things in getting to better shared decision making between providers and patients is better data and information, or turning data into actionable information that both providers can understand about their patients and patients can understand about providers or the procedures that they are discussing.

Just very quickly, overview slide about CMS. This is an educated audience so I’m sure you realized that we’re a very big organization. We directly or indirectly cover many, many people through Medicare and Medicaid and the Health Insurance Marketplaces, and all those people generate data on a pretty vast scale and we’re incorporating new types of data all the time. Beneficiary privacy is obviously one of our most important overarching concerns.

We believe that information is a key driver of delivery system transformation. CMS data can provide really important insights to stakeholders across the spectrum, be it providers or other partners, and certainly beneficiaries and so in order to do this we’ve gone all in on data and analytics in the past couple of years. We’re employing advanced analytics internally to help ourselves run the agency better and understand better what’s going on with our programs, accelerate transparency—I’m going to focus a lot on that, informed policy decisions, and evaluate programs, and we are sharing data with a wide variety of stakeholders in ways that were almost unimaginable a few years ago.

As I said, we’ve gone all in on data transparency. Since 2010 we’ve released an unprecedented amount of data in machine-readable form. I’m going to get into a little bit more detail on that in the next slide. Information on geographic variation, chronic conditions in the Medicare population, and we also, you know, sometimes it’s the simple things. When I got to CMS, as an outsider, I was like you know; it’s really hard to find information about CMS data. A lot of people have validated that for me externally so we launched the CMS Data Navigator, which is a one-stop shop for all the questions about Medicare and Medicaid that you had or were afraid to ask.

One of the things I want to spend a little bit of time focusing on is our Medicare provider utilization and payment data. We started these releases in 2013 with the release of hospital inpatient charge and utilization data and also some hospital outpatient data. We had no idea really what to expect from the release. The response was pretty overwhelming. Jon Stewart called it a miracle of competence in government and it dominated major media outlets for many weeks. And I think there was a widespread shock, but even though well insured folks don’t necessarily pay hospital charges, even for folks who have insurance or the folks who didn’t who may be more subject or susceptible to hospital charges, just was a widespread shock at the variety in hospital charges for the same procedure, oftentimes in the same geographic area.

We followed that a year later with a release of a dataset with more than 9 million records covering every physician providing care in the Medicare program and, again, the reason we think these are important, the reason we think they're important for beneficiary engagement, beneficiary engagement happens in many different ways. One is shared decision making. Another is just addressing the general information asymmetry that continues to pervade the healthcare system. So really prior to the release of this data, people didn't know a lot about how their physicians practiced care. What you knew about your physician was their name, their phone number, and what your best friend's opinion about that physician. So while we acknowledge this is just utilization information, and quality information is important, for the first time we folks can actually see how their physician practices, what is the scope of their practice. And then, finally, a couple of months ago we complimented that with another equally large, larger, dataset that detailed the prescribing patterns of physicians in the Medicare Part D program, so you can see that's more than a million providers and 23 million records. So obviously, there's probably more to come here. Because I work for the government I can't tell you what, but stay tuned.

And so we believe in putting these out. The next two slides, we want to put them out in both a consumer-friendly form so anybody can go to our website, type in first name, last name of a physician and it'll pull up, in a relatively easy to absorb manner, how they're billing Medicare. Another important part of the open data movement, if you will, as we view our role of providing the raw material for others to innovate with the data, whether they be healthcare data journalists, other data entrepreneurs, we participate, when provided data, to hackathons who are obviously enthusiastic participants in the health datapalooza, too. And we believe that this data holds incredible promise. It's been incorporated into some wonderful tools by small start-ups that are starting to match it altogether, combine it with other data to provide information on physicians that, again, just didn't exist previously to the data release.

A quick note on how we're sharing data with Accountable Care Organizations. This is not a public data release, but we are providing Accountable Care Organizations with monthly feeds for their assigned Medicare beneficiaries in the ACO program and, again, linking back to shared decision making, what that is enabling for the first time is patient-centered care in a fee-for-service environment. One of the first thing ACOs came to us and said was, we're very excited about this program. We're willing to take on the risk. We're willing to meet the quality standards, but if we don't know the other providers that these beneficiaries are seeing it's just going to be really hard for us to do our jobs. So that seemed like a pretty reasonable request and that program is working very well.

Another more public facing program is the Qualified Entity program. Again, we think this addresses what had been a failure or a weakness in the public reporting space. Traditionally, individual health insurers in the United States had been-Aetna was producing their own report, United was producing their physician-level report, Humana was producing their report, and Medicare wasn't producing anything. Doctors hated them. Lawsuits abounded. Sample sizes were small, kind of data geek kind of stuff. But a relatively little known provision of the Affordable Care Act established the Qualified

Entity program in which CMS certifies third party entities and provides them with 100% extracts of Medicare, hospital, physician, and drug data but only if they can demonstrate to us that they also have claims data from other payers in their area with the overall goal of producing reports that are significantly more statistically robust and actionable in covering ideally all, or at a minimum, most of a physician's practice. So we have about 12 or 13 qualified entities now around the country and they are doing really interesting work.

I won't linger on this slide very much, only to state that there were some recent changes in the Macro program to the Qualified Entity program that we believe will make the program even stronger.

I'll finish with possibly one of the things I'm most excited about right now. It's the Blue Button program. I don't know how many of you are familiar with BlueButton. Maybe ask for a quick show of hands. Who's heard of BlueButton? Lots of people. Well, about half the room has heard of BlueButton. That's not bad. BlueButton is a way in which patients can download a machine-readable version of their own healthcare history, their own healthcare claims history and ingest it into smart apps on their phone or tablet and also securely share it with their providers. This is something that's been available to Medicare beneficiaries and VA and DOD folks for a couple of years now in a pretty beta type form. I wouldn't say it's the most user-friendly implementation possible, which is why we're going to be devoting some resources over the next 18 months towards restructuring and incorporating a range of more consumer-friendly features to the BlueButton program in the hope of not only encouraging more Medicare beneficiaries to use the information and share it with their caregivers and providers, but also in the hope that private sector insurers will also follow suit and make Blue Button information available to their beneficiaries.

So, I used every one of those extra 18 seconds, Ed, but I am finished. Thank you.

ED HOWARD: Thanks very much, Niall. I rescued the clicker for Robin Gelburd. Robin, thanks for being with us.

ROBIN GELBURD: Okay, thank you. It's a pleasure to be here this afternoon. So, thank you so much for the invitation from the Alliance on a topic of such great importance. I think everyone will agree that we're in the midst of raging reform. Sometimes it feels like we're in Class 5 rapids for all stakeholders in the healthcare industry, particularly consumers who really are struggling to stay in the raft and avoid the rocks. And I think there are a number of reason, many of which are familiar to you, that are giving rise for the need for consumers to make some smart decisions and become much more active in that decision making, whether it's narrow networks causing them to roll up their sleeves, or having to shop on public or private exchanges, high-deductible health plans are becoming much more prevalent. There are shifting sands underneath them with respect to reimbursement models and benefit design, and we're still in a rather challenging economic climate.

So, in the past it really was the consumer back in the chorus line, if you will, with the employer and the plan at center stage making a lot of the decisions about insurance for the consumer. But now, in this sort of new era of reform, the consumers are being pushed to center stage but, unfortunately, they don't really have the script yet to really help navigate through this new insurance play. And so what do they really need to have an effective script that could really allow them to make smart decisions for them? They need a number of things. You probably have seen the same polls we have, of people asked if they know the meaning of premium, deductible, co-pay and so forth—a majority of adults don't even know those basic terms, so glossaries are critical. Insurance principles are critical. The difference between urgent care and emergency care, for example, or PPOs, and HMOs. There are a whole number of principles that really are critical to understanding the health insurance world that they're in. Likewise, they really need robust data, which I'll be spending most of my time talking about in a moment and, as a natural outgrowth of Niall's presentation, which focused more on the Medicare area. Also, they need practical resources. Everyone is intimidated regarding health insurance, really understanding their EOBs, questions to ask their plan representatives or their providers, getting personalized profiles, and really be empowered to become advocates on behalf of themselves.

So, who is FAIR Health? FAIR Health is an organization that was created in 2009 out of an investigation brought by the New York Attorney General's office into certain practices in the health insurance industry. The matter never went to trial because it was agreed that a new era should be created where certain conflicts of interests could be eliminated. And what happened out of that settlement was that it was agreed a new, independent, not-for-profit organization should be created that could maintain a robust database of healthcare claims data, private healthcare claims data, that could be used to inform data products, analytics, informational tools to be really made available to all stakeholders in the industry and allow everyone to exhale and realize that these were independent without bias.

Next, out of the investigation, we were tasked with launching a free consumer platform, which we'll talk about in a moment, as well as the last prong of the settlement. As an independent not-for-profit, we're committed to policy making and research and make our data available to all sectors in the healthcare industry to help folks really ask and answer the hard questions.

So, currently we have over 19 billion records in our repository that date from 2002 to the present for all states in the country as well as Puerto Rico and Guam and the Virgin Islands, and that data really represent the collective claims experience of 151 million covered lives. The data are organized geographically into 493 different geographic regions that tend to track with the first three digits of a zip code. If it meets HIPAA compliance, we can also release data down to the zip code level if that helps policy makers on a macro scale.

It was determined, even though there was this multi-prong mandate that we received, many have referred to our consumer platform as the crown jewel of FAIR Health. It offers a medical cost look-up that allows real visibility into the healthcare market as well as, on the dental side, is a companion that gives you very clear information about dental costs and insurance design features. And, most importantly, we ground that data in an educational platform, a curricula that really provides the necessary language and principles and rudimentary governing ideas regarding insurance so they can make sense as they're navigating out there in the healthcare system.

These are just the screen shots. We are proud that we have translated our website into Spanish and, in fact, took it upon ourselves, with the support of the AMA but funded ourselves, the translation of CPT codes into Spanish because we wanted to make sure the Hispanic community was brought along as these waters of reform were raging. We also have a mobile app and we're proud that we just introduced our Spanish companion mobile app into the Google Play and Apple stores this week, and all of these tools are free.

We have a built in consumer survey on the website so, in effect, it becomes like a living laboratory where we can really receive feedback in real time about how consumers are using it, and they're using it really to great advantage. We were concerned, as some have complained as they've created some consumer tools, that it's almost like a tree falling in the forest that nobody is using it. We have thousands coming to our site every week and really using it along the full continuum of care, whether they're making an initial decision, whether they're going to go out of network, toward the end when they receive their EOB or medical bill, using it to support reimbursement challenges or constructive conversations with their providers.

And, when you think about it, we're very excited that programs like this are being made available to put policy makers on the macro level, and interested stakeholders, and there's a lot of activity out there in the marketplace, a lot of experimentation and creativity trying to create consumer transparency tools and educational platforms. That we applaud, and that's part of our mission. We just want to make sure that sort of the electricity that sort of powers these tools are sound and what that electricity is, is really having rich, robust data that's credible. And there are a number of attributes to making sure that these consumer tools are powered in a fair and constructive way. You want to make sure that the data is independent and unbiased, that it's geographically rich, that it's constantly updated, that it is subject to a pretty rigorous validation and auditing program so that the data, just like ingredients on a nutritional package, are pure and can be digested properly, and that it's contextualized so consumers understand what they're looking at. Even with the best of intentions, some of these tools can be misleading. It's not clear whether you're looking at in-network or out-of-network pricing, for example, or facility costs or provider costs, and you want something that's trusted by all stakeholders.

As Niall indicated, the CMS data are made available to many out there including healthcare journalists and so forth. Our data, similarly, we feel very privileged to be stewards of this extremely large and the largest private healthcare claims collection in the country, so we make our data available to all. And, in fact, that has really fueled the receptivity of the consumer tools because it's being relied upon of many. Our data are

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actually codified in many statutes around the country, inserted in regulations and official memoranda, to serve as the official source, whether it's the Workers Comp programs, auto liability programs, supporting dispute resolution, payment integrity programs, emergency care pricing. We were very excited – some of you may be aware of the recent New York legislation that became active on March 31st of this year, that affords consumers a number of protections against surprise balance bills, if they receive an unexpected out-of-network bill. They protect consumers against high emergency care bills. They create a number of provisions that speak to the introduction of greater transparency in plan documents and communications, and we were honored because one of the things New York did was to create standardization of language. They recognized that unless you have apples to apples comparisons you're not going to get true transparency, and FAIR Health was codified as the official source for usual and customary costs as a means of referring to UCC, so everyone knows what that definition means.

Finally, in terms of transparency, which is something that's been discussed in the media, on the web, in many different areas, one thing to really underscore is that transparency is a wonderful aspiration, but really the next, what we really strive for at FAIR Health is clarity, and this picture, in effect, shows it to us, to the left that dirty pile of dishes is transparent to the eye but could be meaningless to a consumer. If you take those same elements and array them in a beautifully set table, you can begin to digest the data and begin to make some sound decisions and really understand how that data can help inform your relationship to the healthcare industry.

ED HOWARD: I love it when panelists are so sensitive to the numbers. I guess data really does drive some parts of human behavior. Let's turn now to Tim Skeen.

TIM SKEEN: I'll try not to abuse the time. So, anyway, great to be here. I'm happy to be back in my home town, so it's nice to get some time back in D.C.

Anthem and the industry have definitely recognized that it's changed. That the consumer is the focus and with consumers as a direct buyer, that's going to continue to happen inside the industry and we need to figure out how to empower that consumer to make good decisions on their buying practice as well as how to manage their healthcare.

We believe that there are strategies that we can do to empower consumers as the ultimate stakeholder in their own health through tools and data and to figure out not only how to empower them with that data but to be able to make good decisions and kind of be the CEO of their healthcare.

So I'm in the technology world, so I'll get a little bit into technology eventually, but first I wanted to hit on some of the things we've learned around consumer experience at Anthem and what we're driving as a change within our culture. We think there are three critical drivers that consumers are looking for, at least from a payer standpoint. One is confidence in the coverage, so a belief that we are covered and they have that safety net. The second piece is clarity of benefits, and that's an easy thing to say but, as you've heard from this panel, understanding that glossary and how those benefits translate to you personally is a challenge, so continue to educate and provide that information is critical to a better consumer experience and them having confidence in what their coverage.

The last piece of this is ease of getting health, and that may initially seem like very administratively focused on terms of basics of getting to your doctor, getting payments, premiums, co-pays, those kind of things, but it's driving towards, and what I want to touch on more, is driving towards engagements within their clinical health and their healthcare, what they're doing to manage their heath on a daily and weekly basis, especially those in high needs co-morbidity environments.

Those key elements in what Anthem's been making this journey on is to really focus on redesigning the journey, so figuring out where are the key points in that journey to affect within the consumer, reorienting our business around that consumer-centric view, and then, where the IT guys come in, flexing our platform to be able to support and enable this. And obviously, as you've heard from the panel, data is a big piece of that, and I won't be surprised that you see a lot of that in the different pictures that I'll be walking through.

At a high level, those three things translate to the redesigning the consumer journeys, and so, looking at those critical moments, we've broken those into seven critical moments you see across the top: shopping, post enrollment, urgent and unplanned care, how to handle those moments. The middle piece around flexing our platforms is pretty important, both from what's visible externally but also what happens behind the scenes. So, when you see there around mobile improvements and the digital channels, improving transparency, as Robin was talking about in terms of cost and quality, engagement by giving them data that's relevant in real time, and using things like other portals and other digital channels. Those last three pieces are really particularly exciting for me, but not necessarily for what you see externally, it's around service-oriented architecture, a consumer hub of that data, that I'll talk to later about having a longitudinal patient record that has clinical and administrative data across more than 50 million of our members within Anthem and how that can be leveraged across the enterprise. And then, reorientating our business, so that's around changing how we focus on consumer and service operations and that attention to detail. You mentioned there, one of those pieces is Innovation Lab, which I had the privilege of helping to start last year, is around how do we create innovations inside of our environment and help to assist the ecosystem of interaction between the consumers, the providers, and ourselves as a payer. So, sensing those ideas, funneling those through our different lines of business and different functional areas within the companies is critical to get all ideas out there, shaping those to see how can those affect our solutions and support our consumers and, in many cases, looking at pitches of technology out there, whether they're in healthcare specifically or not, can be used to help that. Defining that into a business plan and operational model is important, then prototyping, developing that, and rolling that out through a distribution process. And really, a critical piece of that agile environment of the Innovation Lab is really trying to fill quickly in those ideas and getting through them as fast as possible to find the ones that work.

An example of that Innovation Lab was something we're rolling out in pilot stage around an ecosystem within a digital environment for diabetics, and that's to support not only the care gap alerting insights of trying to manage their disease, but also putting those with companion apps that can help them with compliance that can interact with BlueTooth enabled glucometers and other data that can be fed into our environment. And what that looks like as an ecosystem, briefly, is you have the consumer, you have these digital channels, whether they're wearables, mobile, portal—that environment—and you have an ecosystem of those apps and devices that can interchange that data both remotely and within the provider environment.

Now, the critical piece about how that flows into Anthem that's important is that dataset we were talking about. So, that longitudinal patient record that basically has that integrated information that we can now apply analytics and machine learning to, to figure out where insights, where critical care gaps that we need to inform not just the patient, but also our partnered providers. And our focus on provider collaboration continues to grow tremendously because that is really the critically combined ecosystem that's going to make us most effective. And so, this data which flows up and down allows that whole ecosystem to interact and take decisions on data that's relevant and broader than just the provider's viewpoint inside their own EMR system.

If we go to another area we've been doing for a while in production is around Telehealth, and focused especially inside of our CareMore environment for Medicare MA and those high needs patients, we're trying to create patient-centric tools which will help self manage, will give them the ability to initiative support, provide patient satisfaction and improve outcomes, both on the clinical outcomes and efficiency tools as well in terms of work flow on the provider side, helping to have less folks having to go directly into our CareMore Care Centers and actually be able to be engaged remotely through Telehealth, and what that ecosystems looks like in this environment, if you see there on the left, a little picture of the home is a patient who has their home wired. So, talking about having various devices, wearables, scales, other things that are wired together within their home for remote monitoring, being able to feed through various transport mechanisms like Blue Tooth into the Cloud, this data that we can now apply natural machine learning to, and look for analytics and insights that will then be able to either, on a interaction real time basis where we need immediate intervention from the care manager, or leveraging those machine learning tools to figure out what at risk that patient may have for future negative health events. That allows the care manager to then follow up directly with those patients, either in a remote way or inside the clinics. Really, what we're feeling, from the consumer standpoint, is that we need to meet them where they are. And there is no wrong channel for getting data and it helps to inform the care of that patient and how we can best support them. That interaction, then, may lead to an event that then feeds back into that Cloud to help inform and redirect what solutions we may either use or improve the algorithms we're using to figure out how to identify, send those care gaps and alerts or insights that helps the patient be more informed. And hopefully do that in a way that's from a terminology and a glossary standpoint they understand what that impact is. And we'll see that more of that technology is going to continue to be, I think, engaged by the consumers and, in particular, that particular case where you're talking about even very sick elderly because you have a whole support family system of parents having their kids, grandkids, helping with this connected environment and being very engaged, especially in the very sick environment, because it means so much in terms of their health and longevity of life and being able to be part of that family. And so, we see that engagement as continuing to happen and the only way to continue to make that engagement stronger is by having that interaction of data and insights that they can trust and believe in, and is comprehensive enough that it's not leaving out what things are happening within other provider systems to that patient.

So we hope to continue to grow that digital healthcare ecosystem and we believe that we will continue through all channels to maximize the collection, aggregation, analysis, and propagation, of course, taking security and usage rights to that, continue to broaden that out within our membership base and even more broadly within the broader membership base to hopefully get greater healthcare improvement within the environment.

So, with that I left 30 seconds. Thanks.

ED HOWARD: So, thanks very much, Tim. And we're going to take all the fragments of the leftover time and give them to you. You have a chance to ask some questions. As I say, there are green question cards in your packets that you can write a question upon and it will be brought forward if you hold it up. There are microphones in the rear of either side of the room and you can use those to ask a question orally. If you do that, we'd ask you to keep the question brief and identify yourself and your affiliation if you have one.

Let me just start off, if I can, going back to some of what Tim had said, I wonder, Tim, at Anthem, have a major component of Medicaid coverage through a merit group and a lot of other low income people, and I wonder whether some of the electronic outreach and usage of tools, that you're finding it equally applicable to that population as it is to the more generalized population?

TIM SKEEN: No, absolutely. It's a great question. I actually came over in the Amerigroup acquisition, so I was the CEO of Amerigroup and have a special, in the past 17 years, mainly focused on Medicaid and Medicare in the government healthcare space is definitely a passion. And I think there was some question around mobile devices, consumer devices—can that be engaged, especially in the Medicaid population, and you're seeing that engagement grow and grow and grow and what we'll continue to do a lot of this, especially from a Telehealth standpoint with our LiveHealth Online environment, is that we're seeing more and more of that leveraged. And what I will say about Medicaid in general is that, from a data richness standpoint, and be able to have that holistic view along with some of the HIEs and HINs that are being pushed and prodded by Medicaid that we're getting a richer data environment. But, you know, I think there's quite a debate between Medicaid and Medicare, which is what I refer to in the CareMore instance for Medicare MA about whether they would engage these technology channels and we'll continue to see that as a benefit.

ED HOWARD: Anybody else have comments on that? Let me turn then to, if I can, both to Robin and Ben. Each of you mentioned state-based reforms that involved the use of data for care purposes and decision making purposes, and I wonder whether A) states other than Washington and New York are proceeding along some of these same lines, and B) whether there are policy lessons for those who are operating at the federal level, whether it's administrative or legislative, that can be drawn from these examples.

ROBIN GELBURD: Sure. I'm happy to take that. So after New York passed its law, the New York Times issued an editorial in September of 2014 because it took a year for it to become implemented, indicating what a ground breaking law this was and other states should take notice and it should, perhaps, become a national model. I think what has happened, and there was a recent Georgetown Policy Institute report that you may have read that really talked a little bit about some of the other balance billing legislation that is being considered by a number of different state houses. Not everyone is in lock step with New York because I think every state brings its own flavor to these issues, but it has gone beyond the Washington sort of New York access where we've received questions from Texas and Colorado and Connecticut has moved in this direction. A number of other states are sort of in the planning stages or trying to push sort of draft legislation through, and it's been an incredibly creative time about how to address these solutions. I think how the federal government could perhaps get involved is, as I mentioned earlier, standardization is so important. If we can rally around certain terms, given that there are so many soft of federal exchanges right now out there, to the extent that kind of information could start getting disseminated and creating some common sort of glossary that allows each company, each health plan, each exchange to retain some creativity and some business features, but at least rally around some common terms that allow the ability for consumers to choose between different plans and to manage their benefits in a more fulsome way.

ED HOWARD: Ben, do you have anything to add?

BENJAMIN MOULTON: Yes. I would simply say that Washington state, Massachusetts, Vermont, Minnesota or other states where they are embracing, actually trying to push their decision making as a way to engage patients and address issues around quality of care, I think it's both a carrot and a stick. I think, obviously, legislation can promote and perhaps you can engage providers because there has to be training to do shared decision making. And Washington State has actually been at it since 2007 and, in part, is moving down the road of certifying decision aids and embracing it as a different alternative way to do informed consent because there was stasis at the federal level, 3506 of the ACA mentioned shared decision making, there were no appropriations behind it. The ACO regs all talk about shared decision making. So I think there's an opportunity to promote it but, again, I want to underscore you've got to define it, you've got to measure it, you've got to train providers before you pay for it. And that's what's happening at the state level.

ED HOWARD: Actually, Ben, if I can, that triggers a reference or it segues nicely to a question that came in on a card and it asks: If you could describe the evidence base that supports the development of certified decision tools. In other words, what do you certify? What are the components of certification?

BENJAMIN MOULTON: So, Washington state, in their 2012 legislation, I think in part because there was no action on the federal level, said that you look to IPDAS, which is the International Patient Decision Aid Society, as well as OHRI, the Ottawa Health Research Institute. If you go on the website you can actually see ratings of decision aids. They said the Chief Medical Officer gets to certify but pay attention to these two schemas. And that's exactly what they're doing. They're looking at the evidence of the material, patient engagement, conflict of interest, and they should have, by the end of the year, their schema. I suspect it'll be 1.0 and there'll be other versions but they're taking quite seriously the issue of the integrity of the decision aid product because, as I said, you need to satisfy patients that its evidence based conflict free. You need to assure providers, if they're going to use it, that it's high quality, evidence based and, most importantly, policy makers have to be assured, the attestation of certification, that it's high quality and being done for the right reasons.

ED HOWARD: Okay. Yes, go right ahead.

KATRINA RIOS: Hi. I'm Katrina Rios. I'm jointly affiliated with Johns Hopkins Epidemiology Research Group for Transpontation and actually Peter Levin's company, Media Technology Solutions. I'm very intimately familiar with BlueButton. Really great talk. Thank you all for taking the time to enlighten us about these issues around data and making it actionable wisdom, but with my background in clinical research and medicine I think I'm interested in the middle ground. So we have this wealth of data that exists and all these tools and innovations which is phenomenal and great and being constantly pushed, but I also feel there's this inherent bias that if we create more data and more information patients will automatically become engaged. So I was wondering if any of you can kind of speak to innovations or tangible something—I'm not even sure—on how to link these academic studies that prove efficacy of these decision support tools and everything else being developed and actual everyday efficacy or efficiency, rather, for these interventions and how we take this data and make it actionable to points of care and beyond. And I think that kind of challenges how we define engagement as – do we define it as patients being informed or patients being empowered to actually use this data on their own.

BENJAMIN MOULTON: I would answer both and I think sure decision making does that, and the promise of technology—and we're not there yet—is that you can deliver information to a patient at a point in time where it can be used, helps facilitate them to ask questions and engage with the provider, and then that response gets put back into the EMR and that becomes the template by which not only the current provider uses but subsequent treating providers. So I think there's tremendous promise around technology. But I would say you need both.

NIALL BRENNAN: I agree. I think part of your premise is a lot of what we've been describing as still somewhat aspirational in nature, particularly in terms of widespread patient adoption or patient engagement. I do think that true patient engagement is a little bit of secret sauce, that we're still trying to find. I do think that Tim's presentation, in particular, was very interesting. I think driving as much of this to the palm of their hand and the device that sits in that palm has done wonders in other areas for engagement so I do remain hopeful that if we got the right information in the right form, whether it's reminders or competitions or guilting people to follow certain pieces of advice, that holds a lot of potential.

TIM SKEEN: And I would add to that, that I think there's different pieces of engagement and, when you're saying empowered that's kind of shooting for that empowerment to a certain extent, and so there's kind of two sides of this. There's the, in my opinion, the healthy, you know, the people out there with their FitBits and they're getting information and they're focused, and that's great. Unfortunately, they're not causing the heavy cost in the system from a services standpoint, but having that engagement is still important. And I see that the very sick or the very needy, I see them getting very engaged and when your life is on the line I see that engagement and empowerment hopefully increasing not just because of them but also their loved ones around them in helping that empowerment. I think the middle ground of this, and what Niall is saying, but I think it's a real challenge and it's really just experimenting. It's trying and seeing what works is, you know, that alerting or interaction fatigue, right? So we get a fatigue from telemarketers that we all have experienced. Well, you can do that same fatigue by getting over zealous in the analytics and all the insights that you can generate because who can dream up another million to send out there and this question is whether that that's going to then be counteractive. You know, it's going to counteract the fact that they won't take action on the ones that you care about. So I think it's tough. Technology is a great foundation for this but in terms of the business and clinicians and consumers themselves getting engaged in how to crack that nut I think there's a long ways to go.

ROBIN GELBURD: And I would agree that it really is both. In order to be empowered you need to be informed. And, as I mentioned earlier, we also are very intrigued to see are these tools really working? Are they really doing anything in the day to day which is why we embed ourselves or embed a survey in the consumer website to see in real time how they're using it. And, as mentioned, we receive thousands of responses with very concrete examples how they're using it, and also very creative suggestions about how to make it a better experience. So I think we're not all the way there yet but I think consumers are starting to get their sea legs and starting to flex some of that muscle as they become more informed with the tools that are being made available.

ED HOWARD: I don't know whether this will evoke any further answers because it's certainly on the same topic but we have two different questions on two different cards that are along the same lines as we've just heard comments on. One of them asks: How are providers getting consumers to use all this new tech; and then, we've got a tweeted question that asserts: All the different apps and tools that are out there are great but how do we reduce confusion by patients? #Overwhelmed. And I wonder whether there is any evidence in your experience jointly that would indicate the ability to avoid becoming overwhelmed.

ROBIN GELBURD: I'll just jump in and leave it to everybody else because we have been working with providers and that's an excellent question. Given how much is being required of consumers to pay for their care, that's creating some static in the patient provider relationship as well because providers are needing to come after consumers oftentimes for balanced bills and it's straining that relationship that they used to have which was not really bogged down in that arena, if you will. And so the water level rises for the providers as well as patients, as well as the plans for that matter, when there's more information out there, when there are fewer surprises with what the expectations are. Toward that end, we actually make our educational platform available for free to providers to print out all of our educational content and make available in their offices and so forth and I think they're getting more and more challenged in their examination rooms or as they're checking out with questions from consumers knowing all of these great tools are available. So I think we're starting to see providers come around to the necessity of being part of this conversation.

NIALL BRENNAN: Tim touched on this in his previous comments relating to the alert fatigue. I mean, the reality is, we're moving very, very rapidly from a world in which consumers had little to no information to a world in which there's a lot more information available. But I still think we're figuring out what the right engagement points are because sometimes it's too much information or sometimes it's not the information that they want. So this is all definitely, I would think, a work in progress. I think everybody on the panel would agree.

TIM SKEEN: And what I would say is we're, at least through the Innovation Lab and things we're doing, we're trying to spend a lot of time out there whether it's Silicon Valley or whatever in terms of start-ups that are thinking about and understand how to get people engaged and some of that is about having a thousand apps that are here tomorrow and they're gone a week from now with a thousand more new ones. So I think that is difficult. So what Anthem, as a focus is doing on, I talked a little bit about that critical part that isn't very sexy is that service is API layer, right? So, it's taking that data element, allowing us to publish and subscribe to that data and intermix that data with other services that are out there from, you know, Walgreens, CVS, I mean that data element is out there that you can bring together on a patient-centered view. The question, and I don't think I have an answer for it otherwise I'd be out on my own, is what is that app that's going to, or that environment or that solution, that's going to connect the patient to the data as well as to the provider and get that provider connection. I'm interested, since I'm not from the clinical side, is getting—you're right—getting the providers to want to take that step and take that time and get that interaction. Where is that next step that it's going to move to because whether it's, you know, meaningful use and forcing HR and PHRs – that's not doing it, right, so what is going to get to the next level to make those providers connect?

ED HOWARD: And it strikes me that these next questions, both Niall and Tim may have some insights into, but it has to do with getting the providers you're working with to have, since electronic records seem to be such a key to being able to take advantage of these tools, how do you come to grips with what several of the committees in Congress are not wrestling with, and that is the barrier of interoperability. I can't even believe I can say that without stumbling, but the barriers to interoperability that exist from provider to provider? How are you promoting communication? How are you effecting communication from your platforms to the folks who are going to interact directly with the patients?

NIALL BRENNAN: I think happens in a couple of different ways. Obviously your standard bureaucratic answer. We're very committed to solving the interoperability challenges that remain, you know, manifest itself in a number of different ways whether it's regulatory approaches or the fact that we set up an e-mail address/hotline call, you know, no information blocking, so do people feel that information isn't being shared they can report it directly to us so we can take action.

I think the other important component of this is that as alternative payment mechanisms become more and more prevalent throughout the healthcare system, you know, obviously we have the ACO program, we're aggressively expanding that. We've got primary care medical homes and many, many other interventions. It's creating really an imperative for providers to share data and demand data sharing from the other folks that they're doing business with.

TIM SKEEN: You're hitting the nail on the head. I mean, we got in early and Anthem did in terms of provider collaboration and putting those value-based payment arrangements together. It may have been initially financially focused and that promotes that data sharing, but it's moving towards quality and how you're paying for that quality and empowering that and realizing that both sides are dependent on each other to be effective in those programs. And we're way past the 30 plus percent of membership and we're driving towards 50% in the next three years to have those value-based arrangements where that provider interaction is critical to that sharing of information.

What I'll say is, some encouragement, since thinking about HIE's for the past decade and where that was going to head is that there is some traction being made there in terms of a number of states and other regions with health information exchanges where that richness of data can come in, and I think we're making some progress. There are obviously some standards that are making significant jumps. I'm very hopeful about FiRe 2.0 and where that's going to go from a standard standpoint. It's about the demand. We've all known this from the interoperability standpoint, at least on the technology side, for a long time. It's the wave of demand from the other side, the consumer and the provider side, that's going to engage that and I agree that the value-based payments and those arrangements are going to get the incentive that helps push that along.

ED HOWARD: Speaking of value. Some analysts contend, the questioner writes, that cost data is only useful when paired with quality data, presumably to yield a value rating.

Would the panelists comment on that and how hard it is to do it in practice. And, in passing, I would add to that I'd love to hear the panelists' judgment about the quality of the quality information that we have and the measurement tools that we're now using.

BENJAMIN MOULTON: In part, the reason, why Group Health accelerated and actually made shared decision making with leadership and cultural imperative for the organization was the response rate they got from patients in their patient survey. And I think it is possible not only to wed doing the right thing with cost information but also clearly in terms of quality of the decision that's being made. So I think we have work to do on quality measures but it is something that I know NQF, certainly folks like Karen Sepucha at Mass General are working on, and I think we can strive for a more perfect world where we wed decision quality and costs and embed it overall into the shared decision making matrix.

ROBIN GELBURD: I'm happy to jump in as well. We would certainly agree at FAIR Health that quality information is important as well as costs. Our mandate obviously coming out of the investigation we had was very clear, at least to start with bringing some transparency and pulling the curtain back on costs because the appetite of consumers was overwhelming in really not understanding why they were being kept in the dark with respect to cost, and that's a challenge unto itself, obviously, to shape billings of claims into a meaningful story with respect to cost. And it's a starting point, obviously. Quality is very complex. I think there's a lot of disagreement as to what those quality indices should be. I think it's a conversation that's happening now that's pretty vibrant and it goes both to quality of care in terms of clinical, but we're also hearing a lot of feedback in terms of the kinds of things millennials and other people are getting used to in terms of convenience with respect to the services that they seek. So, now people are getting used to OpenTable, for example, with respect to making restaurant reservations. Now consumers are really interested in knowing does my physician allow for, you know, e-mail communications? Can I make e-mail appointments? Are there electronic health records? All the other sort of elements that add to the experience in addition to the clinical quality as well as the cost component.

So I think there's going to be a lot of movement in unveiling all of these different kinds of measures. I think on the quality side it's much more in the infancy stage as people, in good faith, try to come up with those things that should be or could be most meaningful to a patient.

ED HOWARD: Niall, I don't want to put you on the spot, but the Secretary of HHS has set some thresholds for value-based payment. Are you satisfied that the measures of value are there for you to be able to hit those thresholds?

NIALL BRENNAN: I'm very satisfied with the thresholds the Secretary has established.

ED HOWARD: Excellent. Excellent choice. Okay, I'll stop there. This is kind of a fundamental question coming at it from the other side and this person says that it's exciting to hear of all the innovative consumer platforms that have been created but I'd like to hear the panel speak to what gaps exist in the current tools that they're seeking to address in the development of their tools and in looking over the availability of others.

TIM SKEEN: I would say one of the key areas is around provider scheduling. So in terms of the ecosystem and no data standard or interchange between the provider environment with pairs to help assist in that scheduling and connectivity environment in an electronic way, in my opinion, it's a huge step that would give a lot of value to the ecosystem in terms of bringing those folks together and not having to have so much person to person, facts to facts interaction to coordinate an interdisciplinary care team across multiple entities. And it goes broader than just providers because as we continue to see, even more importantly, whether it's social workers and family members and transportation, other entities that aren't clinical is so critical to that full environment. So I think, to me, that's a big piece of it. And then, as being part of, you know, the enemy is ourselves is that some of the sharing interaction of multi payer environments inside of a provider world is understandably challenging if you're a provider and having to manage different systems and different interactions and policies and incentives with the multiple payers that you're having to deal with. So trying to make some progress in that area, I think, is important as well.

ROBIN GELBURD: I think one of the new challenges, and it's exciting, it sort of started on the clinical side in terms of personalized medicine, looking at the DNA to understand what kind of treatments and protocols work best with different diseases and bringing patients down to that individual level with respect to therapeutics and so forth, I think the same thing is going to start happening in the healthcare arena with respect to costs and insurance and sort of value-based information so that we'll see more personalized profiles that are directed at consumers so they can look at information and say that looks like my needs. So whether you have a chronic disease or you're planning a family or you know you're in store for some kind of orthopedic surgery we'll see much more bundled episodes, episodes of care, personalized profiles that would be packaged in a way that can be more easily digested by consumers. I know we're excited. We're working with HCI3 now and incorporating their episodes of care into our data. In other words, their episodes are almost like the skeleton in our data, like the muscle and flesh on that skeleton, and we're really excited to start bringing that out to the consumers.

NIALL BRENNAN: I think, just very briefly, the challenge is eliminating the hassle factor. There's still a lot of hassle, whether it's scheduling doctor appointments or whatever it is. I mean, this information needs to be rooted to the patient in a seamless, hassle-free way where it becomes, you know, almost an afterthought. Certainly not a hassle.

BENJAMIN MOULTON: I'm just going to jump in and, again, underscore the importance of certification. So you can give patients information in a format that's understandable, that addresses issues around numeracy, literacy, risk arrays and I think those things are essential to really have good decision aids so patients can take the information in, comprehend it, and I would hope that is something that we do going forward, not only in the federal but the state level.

ED HOWARD: Okay. Let me just make the observation that microphones are seldom as available as they are right now. So if you have a question we're getting near the end and you will be certain to get a good answer, a direct answer, if you ask your question yourself. And secondly, while we finish up here I would ask you to pull out that blue evaluation form and fill it out as we finish up. In the meantime, a question asked here for the panel's thoughts on how all of this relates to culture competency? How would all these tools address situations depicted in the classic—classic, by the way that I've never heard of—The Spirit Catches You and You Fall Down? But quite apart from the currency of the classic, what about cultural competency? Are we doing these tools in representative languages? Are we trying to make sure that providers are tuned in to the cultural needs of the people they're trying to provide care to?

NIALL BRENNAN: Obviously that's a pretty broad based question and the answers could go in any number of directions. One thing that we believe in with our mass public data releases is, again, it gets to the raw material. And if we put it out in machine-readable format that means that anybody can take the data and manipulate it and present it in any way to meet any audience that they are trying to reach. That's certainly one way that we feel it promotes profound adaptability in how the data is used.

ROBIN GELBURD: I think that was an excellent question. We feel very strongly about that which is what has fueled our interest in not only bringing forth the Spanish translation of the CBT codes but all of our content. With respect to our Spanish mobile app, what we've learned in terms of trying to bring cultural sensitivity to these tools is that many in the Hispanic community rely more upon their smart phones than websites. We've worked with the Hispanic Federation and the various consulates—Mexican and Dominican Republic, a number of them—to really get a flavor for the cultural pathways because otherwise consumers can just be nonporous and you can't get through if you're not sort of using the right cultural approach and it's critical if you want to have any impact in what you're bringing to market to really be attentive to those unique features.

ED HOWARD: Tim, you must have a few non-English speakers or non-English cultural people out of that 38 million folks.

TIM SKEEN: Without a doubt and in many of the states, especially as you know, with Medicaid in particular, you have requirements in some cases to be able to provide materials up to 23 or 24 different languages and California comes to mind. So I think those challenges continue to be ours. How those translate through our mobile and portal environment, we're doing that, checking the box maybe you would say in terms of that translation, but I think getting to the inherent cultural changes and needs and specific interactions, specific we'll say disease environments inside some of the cultures and how to be more effective in terms of changing the curve there I think there's a long ways to go and I wouldn't say as a technology guy and especially as a payer that that's necessarily our forte, but we're absolutely trying to support as much of that from a language standpoint. Absolutely.

BENJAMIN MOULTON: It is and I think, obviously, we're attentive to it. Healthwise has delivered 1.5 billion incidents of patient information to patients and it's available in multiple languages.

NIALL BRENNAN: I think beyond language, too, with shared decision making, different cultural attitudes to different, you know, post good care and intellect care, you know, that can be really important.

BENJAMIN MOULTON: Absolutely.

ED HOWARD: Yes. With what I believe will be the last question.

ANITA BALAN: Hi. Thank you. My name is Anita Balan with American College of Preventive Medicine. My question, once again, touches upon the exciting idea of certified physician aids and you've spoken a little bit about the certification and other things that Washington and other states are looking into. The immediate idea that came to mind relates closely to that is the community health workers and how Medicaid has authorized states to amend the Medicaid plan to include community health workers and if that is something that that space and that physician aid can be filled by community health workers or are there other options being looked at by the states, because as it is not all states are reimbursing community health workers. There are different options being examined. I can automatically see such a similar challenge that will be faced by providers and payers for certified physician aids.

BENJAMIN MOULTON: Right. So, you start with the premise of trying to have certification so you can be assured or, the word I use, at a station, that it's a good quality aid, but one of the things you're touching upon is you need two things. You need quality decision aids that inform and engage patients. You also need providers trained in the communication techniques of listening to the patient, eliciting the preference and values and together risk benefits alternatives are described and you elicit the patient's response so it aligns with preferences and values. What you're touching upon is actually a very important point which is, in terms of providers, it can be nurse practitioners, it could be community health workers, it can be people who are trained to do it, and that gives tremendous lift to shared decision making, not only at a state level but also at a federal level.

ED HOWARD: Okay. Well, thank you for some very good input, both on your cards and on the oral questions. I want to thank our friends at the National Consumer League and Anthem for allowing us to put this program together and I want you to pause in your filling out of the evaluation forms long enough to join me in thanking the panel for a really terrific discussion.

[Applause]