

**Making the Case for Prevention: Tales from the Field
The Alliance for Health Reform and
the Robert Wood Johnson Foundation
June 19, 2009**

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ED HOWARD, J.D.: It's nice to see such a shared interest in this topic. I'm Ed Howard with the Alliance for Health Reform and on behalf of Senator Rickerfeller, Senator Collins and our board of directors; I want to welcome you to this program on prevention and wellness, which is often the left behind part of health and health care. And we're very pleased to see that so many of you believe that either it is not the case or shouldn't be the case and we are going to do something about it.

The last time we talked about health reform, it was all about coverage and access and that is obviously still at the heart of this conversation but we've broadened the conversation to include a cost component and a value component and certainly a quality component, and prevention and wellness is a big part of that discussion.

And I want to thank the Robert Wood Johnson Foundation for providing the raw material and the

intellectual capital as well for moving that discussion off dead center and toward the policy arena. They are also our partners and cosponsors in this briefing.

They are the largest health philanthropy in the country. Their slogan is "Helping Americans Lead Healthier Lives and Get the Care they Need." So, we are encompassing both parts of that in this health reform debate.

We are pleased to have representing the Foundation today Dr. James Marx, who is the senior vice president and director of The Health Group at the Foundation. That's the part of the portfolio that involves a very significant childhood obesity initiative, public health, care and wellbeing for vulnerable populations and a variety of other pieces. He's a veteran of senior posts at the Centers for Disease Control and Prevention. He's a former Assistant Surgeon General here in town and we're very

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pleased to have him representing the foundation here today. Jim?

JIM MARKS: Thank you, Ed. And thank you to the Alliance for hosting today's briefing. I also want to extend a special thanks and welcome to our panelists, three terrific experts on the subject at hand. Each of them will be introduced to you in a moment, but I want to thank you Judy, Ray and Alice for taking time out of your schedules to be with us today.

I also want to thank you in the audience. There are so many of you that have come today. We know you're busy, too, and we appreciate you spending your time with us. And we will look forward to your questions and insights. And, I know that sometimes the insights can't wait until we finish and so for those of you with Twitter accounts, we encourage you to tweet your thoughts about today's briefing [laughter], please use the hash tag "Health Reform."

Like all of you, as I watch the TV and read the newspaper, blogs, tweets and sometimes the tea leaves, I am hopeful that we're on the cusp of medical care reform. I spent most of my career in public health, but as a person who trained and practiced as a pediatrician several careers ago, it's my fondest hope that medical health reform happens so that all Americans do get the health care they need.

But why is today's briefing on prevention so important to us as a foundation and why do we believe it's so important to our nation? Because for the first time in health care reform discussions, there is real talk about the importance of prevention and those things that are beyond medical care that are critical to health. And we at the Robert Wood Johnson Foundation firmly believe that without a transformation toward a more preventatively-oriented approach to health, our nation will not truly move from solely medical care reform to health reform.

Our president, Dr. Risa Lavizzo-Mourey in her annual message said it well: "Covering the uninsured alone will not solve what is ailing the health care system." And she went on to indicate that "certainly we need to cover the uninsured. We need to improve the quality and equality of care and bring down spending."

But she also went on to list three other critical pillars of comprehensive health reform, that we need to prevent disease and promote health, strengthen our public health system and ability to protect and preserve our health, and address the social determinants of our health and that those were central to moving our nation to true health reform.

We are at a watershed time in our nation's history. We spend roughly twice what other industrialized countries spend for medical care and are far less healthy. The size of the difference in spending between us and other countries is sufficiently large that many believe it is

undermining our economic competitiveness as a nation, yet much of our most serious disease could be substantially delayed or even prevented, and likely at a relatively modest cost.

We have to be honest with ourselves as a nation. Technologic advancement where our nation's leadership is unquestioned has failed to reign in the growth in medical care costs. More surprisingly, it has not even enabled us to have better health relative to other countries of similar wealth and development, according to such standard big picture measures of health outcomes as life expectancy or infant mortality. In fact, we have gone down in ranking over the last few decades, that is, other countries are getting healthier faster than we are, despite our rapid increase in dollars spent on medical care.

If we look at the structure of our health care delivery system, we find that after decades of effort and major changes in the organization of

medical care, the net results are that we have not found a large scale within the medical care system way to arrest the climb in health care costs or to make progress in improving our health outcomes faster than other countries have.

We have to face the fact that the likelihood of initially becoming ill or suffering an injury is really about whether a person smokes, what and how much they eat, whether one is active, the safety of a neighborhood, the toxins, microbes, or conditions people are exposed to where they live, work, learn and play.

This must all lead us to conclude that the major disease problems of our society and time will not be solved by the clinical care system alone. What we really need is not more and more expensive treatment, what we really need is less disease. In fact, without less disease, we are fast finding that we cannot afford to provide the best treatments medical care has developed for those who become ill

or injured. Simply put, our nation's quest for good quality medical care for all those who need it has been put at risk by the excess amount of disease and precursor conditions to be managed.

Let me restate that. The likelihood of initially developing a disease or suffering an injury is practically unrelated to access to medical care system, rather it is driven by things that are largely beyond medical care and that is why the discussions we are having today on prevention and public health are so exciting and so needed, especially now.

I want to illustrate this with a little bit of a story. Let's presume we get health insurance that covers everyone with coverage as good as what Congress now has for itself, and looking from the perspective of a poor, 50 year old woman with diabetes. Now that she has health insurance, she can get to see her doctor as often as she needs to, can get her medications and insulin and be taught how to

use them. She can have her blood pressure and her hemoglobin A1C, the measure of glucose control, checked regularly, get her eyes screened so she doesn't get blindness from diabetes, get her feet checked to prevent amputation from uncontrolled diabetes.

She was also probably advised to improve her diet and how important it is that she eat plenty of fresh fruits and vegetables and that she become physically active, probably by walking. But if she lives like so many do in a poor neighborhood where there are no supermarkets that have fresh fruits and vegetables and she may not be able to exercise because she doesn't feel safe walking near where she lives or there aren't nice parks there, that means that her care, even if it were just as good as the best any of us could get, wouldn't be as effective in controlling her blood sugar.

They would have to up the dose of her medications. She would have to have more visits and

perhaps hospitalizations. Her complications in the eyes and feet and kidneys and heart would come more quickly so her medical care would be less effective, more costly, and her life shorter, all due to things that are beyond medical care. And of course if she has a child with the same increased risk of diabetes or other conditions, that child's health could be worse at younger ages than it would be for a child that lives in a healthier place.

Multiply this by millions of people and you'll see why we believe that if we are to get serious about real health reform, we need to think even more about prevention, public health and our societal factors that greatly influence our health. We have to align our system and our nation's communities to reduce the need for medical care, not just improve its efficiency. We need to create communities, that is where we live, work, learn, go to school, play, and that help us stay healthy as long as possible.

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Now no set of government programs can take the place of people making the choices they need to, but it is the role of government to make those choices easier by aligning the incentives to ones that lead to good health when they are followed.

As a nation, we are going to have to think differently and look else where for potential solutions. We believe we have to look to prevention and public health and all that they entail. And we have had an enormous imbalance in our society of where we look for sources of health and illness and sources of disparity.

Equally fundamental is causes of good or ill health, that is as fundamental at the biologic mechanisms, is how our society is organized, designed and built, how communities are zoned with sidewalks and parks or without, where houses and jobs are, near public transportation or not, what foods schools serve our kids, and whether they require physical activity.

Simply put, what our policy supports or inhibits are fundamental determinative causes of good or ill health and it is often the fact that these societal causes are so badly misaligned for different populations that leads to differences in health between groups of our people.

We are at a time when two major forces are converging, the growing awareness of the importance of the social determinants of health as critical to the overall health of a community means that communities that harness these determinants will have their people be healthier and likely have a greater sense of community connectiveness.

Secondly, now that it's clear in our awareness that our national and state and local economic competitiveness is so closely tied to our health means that those communities that are healthier will be more attractive to business looking to expand or start new facilities and just as a business asks whether a perspective work force in a

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community is well enough educated for the jobs that they are bringing, they are now increasingly asking whether the health of the perspective work force means their health care costs to businesses, direct and indirect, will help them compete.

So, I am especially pleased that our panelists today bring such a variety of those perspectives. You will hear from a leader from the health care sector who will speak to how important the community interventions are to the health of their patients and how it helps their system of medical and health care.

You will hear from a leader from industry who will talk about how important it is to their business to become more preventively oriented and what it offers its employees. And you will hear from a leading public health official who will show how important prevention is to her state's overall health and bottom line.

Fortunately, the public already is getting it. We just supported a public poll two weeks ago that was released that showed that the public supported a greater investment in prevention more than any other aspect of health reform. What was especially striking was that while most believe prevention can help lower health care costs, they support prevention even if it doesn't lower health care costs because it's the right thing to do.

In Europe, speaking of competitiveness, there has been a call for looking at health in all of their major societal policies. We need to have the health impact, whether it's of housing changes or transportation changes, or education, assessed and weighed in public deliberations of those policies. Will we do that here?

The major public health problems of our time will not be solved just by individual actions aimed at individuals, but by individuals coming together to make our society, our community and families one in

which healthy choices are easy and supported by the environment around them and communities where the leadership and policies focus on this will be healthier and more satisfying places to live, work, learn, and play.

And that's why we are so excited to help sponsor this briefing and why it's so important that these issues become so central in our discussion of health reform. Thank you and I look forward to hearing from our panelists. [Applause]

ED HOWARD, J.D.: Thanks very much, Jim, absolutely. And if you heard echoes in what Jim so eloquently described of the discussion that we had last month flowing out of the Foundation-sponsored Commission On A Healthier America, it is the same basic point and we hope to be able to put some meat on the bones of that discussion in the course of the next hour and a half.

A couple of logistical details that many of you have heard me say before but let me twist them a

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little bit. There will be a webcast of this briefing available Monday morning on the Kaiser Family Foundation website, kff.org, along with copies of materials that you have in your kits also available on allhealth.org which is our website and since this briefing was so popular, you may actually not have gotten a kit.

We may have run out before you got here. If that's the case, you can see all of that on the website, either one, and in a few days you can go to our website and you'll be able to see a transcript of this briefing as well as the webcast.

In your kits on the websites you'll find much more extensive biographical information about our speakers than you'll hear from me, just because I don't want to get in the way of them speaking and one last item, there are in your packets a green question card which you can use at the appropriate time to send a question forward and a blue evaluation form

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that I hope you'll fill out to help us improve these programs.

And, as Jim said, we have got three folks who can really tell us what's possible in the real world because that's where they operate and that's what they are doing to improve prevention and wellness and public health and let me just introduce them all at first and then we won't interrupt the flow of the discussion.

We are first going to hear from Dr. Judy Monroe, who is the Indiana State Health Commissioner and by the way the president of the Association of State and Territorial Health Officials and she and Indiana governor Mitch Daniels have teamed up to make Indiana really a national standout in health promotion and prevention among other areas. She is a family physician by training, with experience in National Health Service Corp, which would warm Jay Rockefeller's heart, so we're very happy to have you here.

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Next we will hear from Alice Baker Borelli, who is the director of global health and work force policy for the Intel Corporation. Alice concentrates on health reform and HIT, working with policy makers both here and abroad and she has done similar duties for AT&T. She has done public affairs for a range of for profit and non-profit clients and we are very happy to have you with us, Alice.

Finally, we will hear from Ray Baxter. Raymond Baxter is the senior vice president for Community Benefit Research and Health Policy for Kaiser Permanente. He has got a range of responsibilities including the community based initiatives in a variety of areas, handles international duties for Kaiser Permanente; he's got a long distinguished career managing public health and many other topics.

I just found out by reading that biographical information that you were responsible for the Institute for Public Policy at Kaiser

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Permanente, with whom we have worked so closely on a number of initiatives, so we are very happy to have all of you with us and we have asked Judy to kick off the discussion.

JUDY MONROE: Great, well thank you, Ed.

Let me just say how excited I am to be here today. I love the title, first of all prevention, I'm very passionate about prevention but tales from the field, as Ed said, I've been a practicing family physician in a variety of settings, Appalachia, intercity settings, and ran a residency program, and then I've had the opportunity over the last few years to be a state health official and view things from the state perspective.

So, I wanted to make sure that we all are on the same page and this I think it is really critical that we understand that there is an order of prevention and really the highest order of prevention is primary prevention because that means it never occurs. We have truly prevented it and that does

take place largely in the community settings as Jim has said.

Secondary prevention means that we detect and prevent the progression of disease before it is symptomatic. And then tertiary prevention is when we prevent the progression and complications of disease and symptoms that are already occurring and that falls into when we hear about chronic disease management programs and some of the things around that. In fact, there is an article on Indiana Medicaid where they looked at congestive heart failure and what the cost savings would be with intensive management.

So, what are the domains? Who really kind of does the work around these different orders of prevention? When we look at primary prevention, that largely, not entirely but largely, is the domain of public health. That is what public health does and that's what we focus on in community health, it's a population approach so when you look at employee

wellness, a lot of employers have really taken a population approach around primary prevention.

Secondary prevention is largely the domain of primary care. That's what is happening in the primary care office that's getting the cholesterol test or your blood pressure checked and then tertiary prevention, many times, again not exclusively, subspecialists are doing the work of that tertiary care.

So, I wanted to give you some examples here. And first of all, with primary prevention as a nation we put very little money into primary prevention in the scheme of things, so that's why that \$1 sign is there. So, there is very little funding but primary prevention are things like immunizations and certainly when you think public health that is something that we are very involved with.

Obviously primary care physicians are involved with delivery of that as well so there is crossover but that's primary prevention. My mother

had polio and lived, spent years rehabing from polio. Vaccine came along, she never had to worry about her children having polio and there are multiple examples of that primary prevention.

Weight control and exercise to prevent Type II diabetes, we have a crisis in this country with our children becoming obese and developing type II diabetes at very young ages. That costs a lot of money and has high morbidity and I will tell you, as a practicing physician, that is really hard to do. You get a little bit of time to do a little counseling around nutrition or physical activity; it's what is happening out in the community and in the schools that can really make a difference for that. Folic acid to prevent neural tube defects in newborns would be another example.

If we move to secondary prevention, again and when we look at primary care delivery and I was a primary care physician, we spend more money in that regard certainly than we do in the public health

arena and those examples would be to control the hypertension.

Now, with hypertension you could have primary control if we took more sodium out of the foods. You could back it up to a community and population level and exercise and so forth, but typically that control is diagnosed in the office and then given medications because we want to prevent the stroke that might occur or controlling the cholesterol to prevent the heart disease or having a mammogram so we are detecting disease early so that we can manage better.

So, let me give you some examples of tertiary prevention and this is the lion's share of where we put funding here in the U.S. It's after the disease has already developed, now we are going to try to manage that and prevent the complications, so let's go back to the examples I gave you in primary and secondary.

We now have intensive care of the individual who failed to get a pneumococcal, the pneumovax or pneumococcal vaccine to prevent pneumonia and now they are in the intensive care unit. I've seen this patient. I've seen this patient and they spend weeks on a ventilator but now the goal is to prevent their death, not the disease. Intensive care treatment of diabetes is because we want to prevent an amputation or surgery to prevent complications then of the neural tube defect in that infant that we saw.

Moving along, it might be rehabilitation of the stroke victim because we want to prevent them from being wheelchair bound the rest of their life or management after a myocardial infarction because we want them to prevent the next MI that could lead to congestive heart failure or other problems, or treatment of later stage breast cancer.

I will tell you when I practiced in Appalachia I saw a lot of this where women, before we got mammography and some systems in place that were

population based, women were coming in with end stage breast cancer or fungating masses that would be very costly to treat instead of picking up earlier because of delayed diagnosis.

So, why is prevention important to a state's effort? As a state health official, I will tell you it's very important for two primary reasons and one, in Indiana when I came in with Governor Mitch Daniels, we actually changed the mission statement at the health department to say that the mission of our health department was to support the economic prosperity and quality of life of the citizens of Indiana because we want to be able to attract jobs and have a strong economy.

But this just gives you from the data some of the things that I talked about, what the savings would be for every \$1 spent on, as an example, immunizations, that can be up to \$27, or smoking cessation for pregnant women, just to give you a few

examples of where the cost savings would come if we can prevent these things.

And then, why is prevention important to attracting businesses? And I think you will hear more about this in a minute, but a health work force obviously benefits our businesses so you have more productive workers, you decrease the absenteeism, and less injuries by the way, if folks have been doing their exercises and eating better. And health care is obviously a very expensive benefit that our U.S. employers pay, if in fact folks are fortunate enough to have insurance through their employer.

So, I wanted to go over in the last few minutes a few things we've done in Indiana. We started, Governor Daniels kicked off InShape Indiana to raise awareness around nutrition, physical activity, and tobacco control in Indiana because if we can get to those three, we will save a lot of money through primary prevention, again going out into the communities.

We also have stressed with InShape Indiana, we have annual summits in the state, we've got a very robust website. We've got folks that signed on. We've been promoting partnerships and I'm very happy to announce that this past Monday Peyton Manning along with the Peyton Manning Children's Hospital in Indiana and other partners like Ball State University, MARS supermarkets, and other partners came together and announced Project 18 where Peyton Manning is taking on childhood obesity in the state of Indiana, terrific partnerships that have come together with public service announcements.

There is going to be a curriculum in the schools that is part of this and the supermarkets are going to have designated Project 18 foods so that the kids can gravitate toward those healthy foods that have been chosen. So, we are very excited about that, what has happened in Indiana.

We also had leaders in our state come to partner with us through industry, so Anthem and Ely

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Lilly and the Kroger Supermarkets came together and convened other employers to enhance employee wellness programs throughout the state that we, and again InShape Indiana, as government, we convene, we may give technical assistance. I mean, we are supported but we really have called upon everyone to use their influence in helping these community programs and taking a population approach to things.

Our hospital association came on as partners last summer and as part of their strategic plan they have taken on and aligned and I think it's very important, we need alignment with public health, medicine and then our partners so that everything is aligned and so looking at our priorities of childhood obesity, tobacco, immunizations is an example, our hospital association has taken those on as high priorities as well.

We have a state employee wellness program, again, employee program that engages people. There are incentives, financial incentives for the

employees. We have 66-percent of the state employees that have enrolled on a voluntary basis in this program. There is telephone counseling that takes place and they have the financial incentive, but it is very gratifying to see that 86.2-percent of those have signed a no-smoking pledge as part of this program so it's an employee wellness program.

We have an Indiana Healthy, or the Healthy Indiana Plan, insurance that we raised our cigarette tax a couple of years ago, we used part of the funding to help underwrite insurance that is low cost for those that were uninsured but the beauty of the plan is that at the top of the plan are the preventive services, so we are using both primary prevention approaches and secondary in Indiana and folks, no out of pocket expenses for them to be able to get that blood pressure checked, their mammogram, their pap smear, or whatever might be needed.

We have a small employer wellness tax credit so employers that have less than 100 employees that

if they do a wellness program for their employees, they get 50-percent of the cost of that back in a tax credit. And then, lastly, we passed legislation for lactation support in work places last year where employers with 25 or more employees must provide privacy and refrigeration for women to breast feed because we know there is strong evidence that helps with childhood obesity.

So, those are my comments and thank you very much. [Applause]

ED HOWARD, J.D.: Thank you. Let's move to Alice Baker Borelli, who contrary to the tent card in front of her, spells her name with two R's and not three.

ALICE BAKER BORELLI: At least it's not broccoli, sometimes I get that, so. [Laughter]
Well, thank you for asking me to be here today and this is really an impressive crowd. I thought on a Friday afternoon with the sun shining finally, maybe

there wouldn't be so many people. So, it's nice to see you.

Just a few words up front about who Intel is. Hopefully when you open your computer, you immediately know who we are. We are Intel inside. But we are a U.S. manufacturer, 75-percent of our manufacturing is done right here in the U.S. and yet our sales generated are 75-percent outside of the U.S. We have close to 90,000 employees here and a high proportion of engineers and Ph.D.'s in the company and we care about all of their health.

Now, Intel has entered the health and wellness area through four different avenues. The first is a program that just started three years ago and that's the Healthy Risk Assessment for the health for life status program that Intel started. The second is the introduction of a primary care facility and we are piloting this in Arizona.

The third is the development of a collaborative for employers. There are eight

employers in a group called DOCIO, which is a personal health record bank, and the fourth is through our ten years of research on how technology can assist with chronic disease management, health and wellness, and independent living.

So, let's first get started on what our program is for employees. First of all, I think I'm a little ahead of myself, first of all let me just say that as a large employer with 90,000 employees, we see the need to influence the health care system. We realize that the federal government, about 50-percent of the U.S. is covered by the federal government in one way or the other, but employers are the next largest segment of the economy that really have some influence over health care.

And for the last few years, we finally have kicked in and realized that we have a large responsibility in shaping what is happening in the health care system and in one of those areas we have

decided to institute more health and wellness programs.

So the Health for Life program, as I said, started in 2006. We had extensive information from claims as well as pharmaceuticals data to know sort of what our population looks like in a de-identified way, so we decided to start with an assessment that would be free for all employees including the biometric data followed by face to face care.

We looked at the external factors which the growing number of chronic diseases that we have seen nationally certainly applies to large corporations like ours and many are preventable. And we came to the conclusion that health and wellness really is a standard for doing business.

So, the data which Intel thrives on is still gelling. We are still looking at this program and the benefits of it in terms of an ROI and it typically varies, depending on what part of the country you're in and what part of the segment, but

we are seeing promising results. Returns vary from 2:1 to 15:1 with typically a 3:1 savings which would make any company take notice.

So, I wanted to point out the importance of doing a biometric assessment. When we asked employees what was your height, your weight, your blood pressure, etc, they were pretty standard and they got it right on some of those very external factors that are easy to see and you'll see the graphs, the difference between U.S., international, and the pilot.

What really started to point us in the direction of why this is important is when you get to the blood pressure, cholesterol, the triglycerides, and your blood sugar, you can see a spike in that green. That was the pilot group that did the biometric assessment and the difference between what was real and what they thought that their indicators were was really very different so that's what pushed us into doing this kind of assessment.

So we started with the onsite health check, which is primarily a general physical as well as doing the blood work. We did extensive marketing and communications to our employees to get them involved in this. And we worked with them to schedule this onsite in many cases. Of course, sometimes they went for the blood work anyway, but for the rest of the checkups they did have to go to their primary care physician.

The second step was a questionnaire that was online, instant results, and at each stage along the way we had an incentive of a small American Express gift certificate just to get them interested and then finally we concluded with a health coach.

Now, the health coach was really critical because for some people, like the women who designed this program at Intel, her risk factors were she didn't eat enough fruits and vegetables and she drove too fast. Well, those are things that you can probably cope with in a self management program.

But for some of our employees, we found that they had diabetes, cardiac problems, asthma, depression, a multiple list of problems that they had, it was just too much to tackle on their own, and a face to face health coach helped them prioritize and really delve into solving the problems or addressing the problems.

So, what we found was that after three years, we have 37,000 health checks in the U.S. and we only have about 45,000 employees who live here. We are seeing a return rate of 45-percent. In the second year, we are still tracking, this is the third year. And once in the program, most employees did complete all three steps.

If you look down here at the next two indicators, we are seeing a 95-percent satisfaction range in the first two years and you know with an employee group, you really get that kind of satisfaction in that kind of population. But we are very pleased with that, and the second indicator is

the 21-percent movement of your one to your two of very high risk groupings with reductions in every medical risk factors except blood sugar and all lifestyle risk and then this program has been, we just added this, that it has been really well recognized at Intel for a leading new initiative in the company.

So, in 2008, we expanded internationally. The targeted countries were Malaysia, the Philippines, Israel, Ireland, and Costa Rica. We have the program up and running in all of these areas and of course we had to tailor it based on the existing medical system, their programs that they already had, the culture, the language, etc.

For this year, we are looking at India and the U.K. and China has been approved for us to expand the program through one of our largest offshore areas.

So, we are not quite where Indiana is in terms of the population so we need to take some

lessons from your efforts but we do have a participation rate of 36-percent and there is a higher participation rate internationally than in the U.S. which really prompts us to sort of probe into why there would be such a better take rate outside the U.S. Satisfaction rates are 90-percent globally, and the risk transition we've already discussed, we are seeing a 21-percent movement.

So, based on those results, we move to adding a primary care facility into our Arizona facility and for those of us who have been in the work place for several decades, this is like going back to the future, because when I first started working in corporate America, we had onsite facilities and then that was sort of a thing of the past, but now it's coming back and I think for many of the reasons that we can all, it's easier access, people feel that they can get to their primary care. They don't have to make excuses about don't have enough time to go get a mammogram, it's right there,

so for all of these reasons we are starting to institute some of these primary care, urgent care and physical therapy onsite.

So, let's just move to the next and so far in the first year we are heading some of our numbers the satisfaction rate, we have found that we didn't have the kind of participation that we had expected initially and delving into those numbers we found that there aren't as many physical therapists in Arizona to go around so it was hard finding the kinds of people we wanted to come in and treat our patients. But, we're pleased enough with the progress to continue on and hopefully expand these primary care facilities beyond Arizona.

So, as I said, I think we are ready to continue on and I wanted to spend the next few minutes talking about some other areas that we have been active in on health and wellness and one is the PHR, and of course we know how much effort and funding has gone in to electronic health records and

we're really very pleased to see that initiative that was taken in the stimulus.

But having patient access in real time, making it easily accessible for the patient we think is going to be a really significant cost containment factor because when the patient understands what they are spending, what their options are, is able to compare drug prices online in a very easy way and they have their own records so that there's not the same need for duplicate testing, as you've heard before, we think this is going to make a big difference.

So, the DOCIA Group was founded about three years ago and the companies, there are eight companies who are part of this. Wal-Mart has already gone online. They are offering these personal health records to their employees, very significant firewalls between the employee and the employer, as you would expect. We are supposed to start going online later this year through some trials and we're

just really pleased with the opportunity that provides.

Finally, the research Intel has been doing in the last ten years has really looked at the areas of chronic care disease and how technology can offer solutions for monitoring your vital signs and addressing your chronic care needs in real time without having to do to the doctors, so I think this is a growing area of interest for many companies.

And I think it's one of those really cost containment additions that we would like to see addressed in health care reform, because it really starts giving the employee the patient self-management skills that they haven't had before. The tools are going to be there, it's going to allow a person to take their weight, their blood pressure, do the blood ox, all in the comfort of their own home or their cell phone.

So some would say that if you did what's in and what's out, DMO is out, self management is in.

We need to bind the tools to allow all of our patients nationwide to participate in that and both computers, laptops, cell phones, using the technology that we use for everyday living, let's bring it home to health. Thank you. [Applause]

ED HOWARD, J.D.: Now we'll turn to Ray, whose institution knows something about personal health records as well. Ray Baxter.

RAY BAXTER: Thank you Ed. It's a pleasure to be here with all of you this afternoon. If you hadn't gathered it when you came in, you clearly understand now that prevention is not one thing, prevention is many things. What I would submit to you is that prevention is not just one thing. Prevention is a total perspective on life, on health care, on the management of disease, and on intervention and environments that undermine health. It really is all of those things.

I have the fortune to be in an organization, Kaiser Permanente, which has its roots in prevention.

Kaiser Permanente began over 60 years ago in the shipyards in Richmond, California as a program for the work force there. The picture you see there is a physician and a health educator talking to the work force in the shipyards about the common cold.

If you think about it, an organization that began in a place where workplace safety had to be a top priority, where the health of the workforce had to be a top priority in order to meet extraordinary production schedules in war time, you have some understanding of why prevention and worksite interventions are at the heart and in the history of Kaiser Permanente.

But it also is an organization, it is the original pre-paid integrated delivery system where the incentives were aligned, where the incentives are not aligned toward procedures or toward individual activities or only toward cure, toward total management and total health of the individuals who are part of the program. Everybody who is involved

in the program, physicians and others, are salaried so there are none of the incentives that exist in fee-for-service medicine, for example, which may drive you toward interventions rather than toward prevention.

So, a long history in the organization of being involved not only in the health of its own workforce and its membership, but in the health of the communities that it is part of because that recognition that the health of communities surrounding where our members live is the pivotal in the end, the pivotal force shaping their health.

Where that had led us today is a complete focus on prevention ranging from a focus on becoming the benchmark for preventive activities for individuals and for screenings, the use of advanced electronic health records and health information technology to build tools, to help us engage in tertiary prevention, that is slowing the progression of disease or preventing the complications of pre-

existing disease, and finally direct and complex and long lasting interventions in the health of communities as a whole.

The founding physician of Kaiser Permanente, Dr. Sidney Garfield, was fond of saying we are not a sick plan. We are a health plan. And that kind of ideology has really guided our efforts over the years.

So why so much focus on prevention? This is an almost legendary slide produced by Bill Fahey and Mike McGinnis a number of years ago that first looked in 1990 and then again in 2000 at the actual causes of death, so this is not the usual thing you see, first is heart disease, second is cancer, and so on down the list. This is the root causes of death in the United States.

If you look at it, what is overwhelming in 1990, tobacco, 400,000 deaths, poor diet and physical inactivity, 300,000, look how that's changing a bit in the year 2000 and if we replicated this today, I

am fairly sure that we would see that poor diet and physical inactivity are ranking as the leading root cause of death in the United States.

If you look further down the list, you see the other things that contribute to it. If you think about what we usually think are the causes of disease, they are fairly far down the list compared to tobacco, poor diet and physical inactivity.

Judy talked about the varieties of prevention, of primary prevention, secondary prevention, and tertiary prevention. I want to say a word about each of those because each needs to be a focus of organizations in the health care sector. Many people when they think about prevention think about screenings think about preventive screenings designed to detect disease early if possible. Kaiser Permanente ranks in the 75th or the 90th percentile in just about every preventive activity and screening.

For example, the rate of smoking in our members is now under 9-percent, the U.S. average is

around 14-percent, that is a very significant difference in terms of the future health of your members, but I also want to ground this in a suggestion about what is possible.

The graphic you see up here on breast cancer screening shows where we were, where the United States average was in 2007, where Kaiser Permanente was at 78.4-percent of the population screened, and then in 2008 at 84.6-percent for Kaiser Permanente. We are now in our largest region in Southern California, over 90-percent in terms of effectiveness in breast cancer screening for women.

So, it is possible to achieve extremely high rates of screening for the basic preventive services with a concentrated effort, but it isn't just a matter of effort, what we found is there are two critical factors feeding into this, or perhaps there's one that we don't think about that much.

I should mention, first of all we keep our co-pays for preventive activities from zero up to a

maximum of around \$25 or \$30, but the creation of obstacles in either public or private programs to access to routine preventive health measures is a definite deterrent and something that is to be of real concern. So, one of the first steps is create no financial barriers to routine preventive services and preventive screenings.

The second thing that has helped make this achieve these kinds of results is total engagement of the employees so what it took to get up above 90-percent screening here had to do with every single person who has contact with a woman above a certain age and ask the question in as polite a way as possible, have you had your mammogram?

And if the answer is no, not to accept the answer that well, I'll go schedule it now, but to offer, may I schedule that for you now? That gets us into the second capability which is having a complete electronic health record which gives you access to

that information and the ability to schedule at the same time.

So, it is possible with total engagement of the work force and the use of techniques and tools that are available to us now to increase screening rates to a much higher rate than has traditionally been assumed possible.

Let me show you a second example that shows how rapidly rates can be increased. Colorectal cancer screening is one of the things that are known to be among the most cost effective preventive measures to take, but rates of screening in this have typically fallen well below screening in many for most other purposes.

This shows an increase of over 20 points in the screening rates for colorectal cancer screening over a period of less than two years. Again, it is possible with focus, with aggressive measurement and complete engagement of the work force and of your

membership, and I will add a supportive atmosphere in the community, to improve rates considerably.

One thing I will note about this, if you notice, not all these lines, every line has gone up, every line has gone way up almost by the same amount but if you'll notice there are also some disparities that remain. So, addressing racial and ethnic and language based disparities remains a challenge for us that is not addressed simply by coverage and access to care and is not addressed simply by having an aggressive focus on prevention but requires additional measures as well.

Let me turn to another area which is the use of a preventive approach toward chronic disease. After a decade long effort in Northern California, Kaiser Permanente has been able to reach the point where our members in Northern California are 30-percent less likely to die of a heart attack than people who are not members of Kaiser Permanente.

Again, the work that it took to accomplish that is not magic. It's complete engagement of the work force, it's consistency and a focus on doing what is known to be effective, a set of simple things again and again, and doing it for everyone.

We have translated that into a program we call ALL, for high risk diabetics, which consists of the use of aspirin, the ALL stands for aspirin, Lovastatin, and Licinopril, essentially this is the use of aspirin, a generic drug for cholesterol control and a generic drug for blood pressure control for high risk diabetics. The results of the initial implementation of that, which is only 40-percent of the way done at this point was that already we are preventing nearly 1,300 strokes and heart attacks a day in our membership.

If you extrapolate that to the size of our population of at risk diabetics, that could be 8,000 hospitalizations and around \$38 million a year in costs that are avoided but the point here really is

not about the money saved. The point is about lives saved and about effective management and supporting people's health even when they do have chronic disease. We have now extended this program to about 20 safety net partners in four states so the program we are actively disseminating it not only through Kaiser Permanente but through other organizations.

All of this however tends to be still focused on individuals or on groups of like patients and I want to close by talking for a second about the need to intervene in communities. As a care organization we may see you for about an hour or two a year or perhaps a day a year or if you're not well perhaps a week a year. The other 360 days your life, your health is shaped completely by what you do, the choices you make, your behaviors and the environment around you. So, we really have to be engaged in the total spectrum of environments that surround people and that shape their health.

There is an enormous amount of discussion now, in a positive vein, about healthy diet and physical activity. That is not simply a matter of individual choice. There are very powerful forces that shape health behaviors in communities.

This is a real billboard in Oakland, California. Think about the budget that the state of California has to prevent obesity and think about the budget that food companies have at the same time, the mixed message here is one that people confront on a daily basis. For too many people, this is the food environment that they face.

Here is a convenience store. It's all processed food. It's all inexpensive calories, very high density, heavy in salt, heavy in sugar, and not particularly healthy. When this is the principle source of food available to people, expecting them to make healthy choices, to eat their fruits and vegetables every day, is an extraordinary challenge.

There is much evidence around community based interventions to address this sort of thing. It's in the CDC Guide to Community Preventive Services. It's in the IOM's report on health and the balance. It's in the heart association's expert panel review. There is an evidence base to community base prevention that is at our hands at this point.

We have now invested more than \$50 million in 39 sites around the country to work with communities actively to change the food environments, change the physical activity environment, change practices both in private organizations and change public policy in ways that support health and support healthy eating and active living. The Robert Wood Johnson Foundation is a key partner in this work as is the Centers for Disease Control and a group of four other funders.

These are initiatives that are really focused on changing the conditions and making healthy choices possible. Intervening in communities,

primary prevention in community has to be part of the spectrum of prevention that we support. There's a great deal of work to go so far. These projects that were mounted by us and by other funders over the last three or four years are now in implementation.

They are now beginning to bear some results. We can't yet tell you about changes in BMI in those communities. We do already have some very solid evidence about increasing the availability of fresh foods and vegetables, increasing the availability of environments where people can be physically active and feel safe about it and influencing the shape and design of their communities going forward.

So, if I have a message to you today, it is not only support prevention, but don't think of prevention as just clinical prevention and just screenings and just immunizations, those have a critical role as does tertiary prevention to prevent the spread and the complications of disease and the death that could happen, the premature death, but

finally interventions in communities themselves to change the conditions that undermine the health of people. Thank you very much. [Applause]

ED HOWARD, J.D.: Thanks very much, Ray, and now we get to your part of the program. We have microphones set up that you can come to and ask your question verbally. There are green cards in your kits that you can write a question on and hold it up and someone will bring it forward. And, we have enough time to explore a number of questions.

Let me start if I can with a question for Judy and I wonder, was there some sort of ah-ha moment in Indiana where either you or the governor or both of you said oh yeah, we have really got to get into this prevention. It's an economic factor or we're losing a particular employer because of it?

JUDY MONROE: Well, when the governor came in, he wanted to provide more jobs, increase the income of Hoosiers. I mean, that was, it really was an economic driver and he recognized early on that

chronic disease, the burden of obesity, tobacco and so forth in the state of Indiana was costing us too much, and so it was an economic driver and actually in my interview with him before coming, we talked about it in my interview, so this was right out of the gate.

We knew that we wanted to do something and I quite frankly took the job because I, as a practicing physician, was becoming more and more frustrated day after day seeing more and more children coming in with chronic disease and obesity and seeing one patient after another that had preventable disease but in the practice of medicine in the office, I was unable to impact all of that. I needed a wider community approach.

ED HOWARD, J.D.: We've heard and we've seen on your charts both with Alice and with you Judy ROI on particular steps that you've taken. I wonder, CBO is not so sure that prevention in general generates scorable savings especially when you scale it to a

national level. I wonder whether you have comments about their methodology or the reliability long-term and big scale of your results particularly as we're trying to get a bill out of committee in a variety of forums on the House and the Senate side, Alice and Jim too.

ALICE BAKER BORELLI: Well I guess it's, in many ways, savings questions. How do you calculate the savings if they're not going to accrue until another decade or two? And, looking at wellness and prevention programs but at Intel, we are definitely seeing a return. We're seeing a reduction in absenteeism. We're seeing the risk factors being mediated and, as we all know for those chronic disease indicators, these are going to be the most expensive patients, if not for us then they will be for Medicare.

So it's hard to comment on the methodology but it is a long-range engagement that you can't

calculate within a year's savings or 10 year's savings period.

JIM MARKS: I wanted to comment though a little bit as well. I'm going to comment first on the Congressional Budget Office and OMB scoring. They're required to find the savings within 10 years of when a bill passes. That's the way they have to do their work. Make sure that many of the complications, for example, in diabetes occur much later. They can't accrue any of those savings to a bill that has medical costs.

They can't allow savings that come from the public health or the community sector or the cost that the community programs have that lead the savings in the medical care sector. They can't allow those to be offset. They can't do it across jurisdictions. That is one of the things that make it very hard for prevention to be scored well, its systemic bias that is in our nation's scoring, a bias

against prevention, a bias against things that are in different areas.

I'll give you a great example. There's a program called the Nurse Family Partnership that is randomized clinical trial evidence, the kind of evidence that's used for cancer drugs. It shows a reduction when women are counseled in the first two years of their child's life about how to raise their children. They find a reduction in juvenile justice needs 15 to 20 years later. Those juvenile justice needs can't be that reduction, those savings cannot be accounted against the Nurse Family Partnership costs because it's a different sector.

I will give you the best example of when people look at it that you know that it is valuable for health and for economics. Mitch Daniels, the Governor of Indiana, used to head OMB and it was against prevention there often. Now as Governor, when he sees the value of it, he's made that a cornerstone

of his program. I actually know of no better example than that.

ED HOWARD, J.D.: Yes, go ahead Ray?

RAY BAXTER: Just a further comment on this. I think we have to be careful not to fall into a trap. Not all prevention is going to save money. Prevention by its very nature casts a very wide net, which means that preventive nature and preventive measures are going to be applied to a much larger population than will actually turn out to have been people who would have developed the disease or the disability and it will detect early illness.

So it's to fall into the trap of letting prevention be subjected to a standard that no other intervention in medicine is subjected to is a dangerous kind of thing because we can lose the whole game. The issue here is, is a preventive intervention providing value? Is it providing greater value over the long-term rather than does it have to pay for itself in terms of its short-term impacts.

ED HOWARD, J.D.: Or as someone said in a meeting I was in this morning, you never asked the cardiac surgeons if bypass surgery saves money. Yes, go ahead and identify yourself.

DINA NASH: My name is Dina Nash. I'm expert in the prevention of health care acquired infections. So I'm very specialized and maybe my comment is not very appropriate but I wanted to stress that you just cannot compare the costs of prevention and the decrease in treatment costs or health care costs because the benefit of prevention, even if you do not see the effect, the cost saving effect right away is so much bigger.

Think of a kid, obese. He is not able or she to perform in their occupational life according to their intellectual capacities. Think of family members that have to support their families financially cannot do so because they are sick all the time, loss wages, and so on and so forth. So I think, in any regard, prevention as long as it is

effective, reducing the disease or illness is always cost efficient or cost effective in the view of the whole of the society.

I know that insurance companies cannot quite calculate that because they do not benefit from the wages that did not get lost but still we have to tackle this problem as a society and have to find incentives to balance these benefits.

Just two minor things: I would like Mr. Baxter to make his talk available on the Internet. We did not have that in our handout if that is possible that would be great because there were a lot of interesting numbers that I just couldn't copy that quick. One further point, last small comment, we have to integrate education into that in schools.

I just heard the other day that in those food banks, they gave canned food, which is in nutritional regard, not a bad thing to Hispanic families. They didn't know how to deal with that because in South America, canned food is a luxury and

these people never ever have access to that. They just left all the cans on the shelves because they didn't know how to prepare it.

Yesterday, I talked to an intelligent woman. She loves potatoes but she only prefers potatoes to French fries. When I told her that you just drop it into water, boil for 20 minutes, that's it, she didn't know that. She was about 35 years old. So we really have to go with these efforts into schools everywhere to teach people.

A farmer's market around the corner does not really make it. They have to know how to use the food. I hope I didn't overuse my time. Thank you.

ED HOWARD, J.D.: Let me just follow up with that with the panel because several of you made the point about the fairness of scoring in one form or other. It seems, in the literature, and not necessarily the economic literature, but a fairly broad consensus and actually Ray, I think you might have said something on this, not all prevention can

be shown to generate savings even if you define it in a broad sense that sometimes you screen so many people that the cost of the screening overwhelms any potential savings among the people who would have gotten the disease.

I wonder if there, and I don't want to get us completely talking about costs, but is there an alternative way of either making a case for prevention or deciding whether it's a valuable piece of any legislation we talk about. Go ahead Jim.

JIM MARKS: Ed I wanted to, your comment on that. I think the key point that Ray was making is that what we need in our health care system, prevention or treatment, is we need to go for the best value. What gets us the most health for the dollar spent? Much in prevention is of good value as far as the amount of health it gets.

Some saves money but much is of good value. There's a lot in treatment that is of good value but there is a lot that is not. What we really need is a

level playing field because prevention is asked to do this all the time. It isn't asked of treatment. I think that that's probably the better way to think of it. When we're looking at being bankrupt as a nation because of the escalating costs of Medicare, we have got to think about what gives us the best value for health whether it's prevention or treatment? That's probably the best way to think about it.

ED HOWARD, J.D.: Yes, Judy and then Ray.

JUDY MONROE: Yes one of the things, when we think about prevention and the cost and one of the things that troubles me, as an educator, there's good evidence for screening tests in certain populations. You need certain risk factors to get the screening test. We live in a culture where there's a real zeal, people really like testing. Then sometimes there's a demand on that and so we overuse the screening tests. We use them inappropriately and that drives up costs.

So an example, if you screen someone for osteoporosis when they're very young and that's not

what the criteria calls for, you can begin to get more false positives, which then drives the cost up or if we do an ultrasound for an abdominal aortic aneurism in someone that's young and a nonsmoker and they don't fit the criteria then we've driven up costs.

That actually happens every day in our country where folks, and part of that is the public, putting the demand on asking for tests that are really inappropriate. They don't match those risk factors. So we really do need to make sure that we're applying good guidelines and evidence and directing the testing appropriately.

ED HOWARD, J.D.: Ray?

RAY BAXTER: Yes, I was going to say I don't mean this fliply but a figure we heard at the outset of the meeting that 72-percent, I think, of the American people think prevention is a value that they may know something that not everyone else knows. There is a lot of common sense to this. I think a lot

of people grasp that. Let me just give one example and I won't get the numbers exactly right on this.

But you asked about ah-ha moments; about a year ago, we did a study in Southern California that looked at 10 years of births. What we found was that the number of young mothers with diabetes had doubled over the period of that 10 years. Now the implications of that, think of that, while we're trying to reduce the rate of increase in health care spending, the implication, by the way there were about 100,000 births I think in this study, so this isn't a small study, the implications of rolling through the years of the burden of illness, both for the mother and for the child going forward and the costs associated with that, is quite scary.

To me, if you think about that, you think about how are you going to offset that, the answers have to go back with how do you deal with root causes in the culture and in the society and in the environment and in individuals' choices that lead to

a doubling of the rate of diabetes in young women giving birth.

So there is an element of this to common sense and I would think it's important here not to get trapped in a small part of the argument and discussion about costs and value of prevention but to look at that total picture.

[The transcript has been edited to omit a series of statements made from the floor at this point by an audience member who made an inflammatory and inaccurate personal charge against President Obama and members of his Administration.]

ED HOWARD, J.D.: Yes, go right ahead.

KATHLEEN BROWN: Hi. I'm Kathleen Brown from the National Alliance of State and Territorial AIDS Directors. My question has to do with the racial and ethnic and other disparities between communities, cities, states in the United States and where our preventative care is going and how we can cause it to go to the communities that need it the most.

There's been a lot of discussion about financial incentives for prevention to either employers or community-based programs especially in the upcoming federal health care legislation. My concern is that there is evidence that sometimes these incentives are not available to your communities that are not able to afford implementing the programs in the first place.

Sorry, just going on a little bit but the poor communities that are not able to afford the changes that will bring them incentives are disadvantaged under these ideas. So it's a fantastic principle but how do you suggest, anybody have any ideas about how to spread that more equally?

ED HOWARD, J.D.: Go ahead Ray.

RAY BAXTER: The communities that I described that we're engaged both individually and with some of the other funders are all low-income disadvantaged communities. What it requires in practice is that you have to be willing to accept the

wisdom of communities to a certain extent about the route to the end. So if you're concentrating on bringing fresh fruits and vegetables into a community that's kind of a food desert, you may have to deal with other issues first.

If you're concerned about creating more opportunities for physical activity for young people and there's a widespread feeling in the community that the community's not safe, that violence is a problem for that and that people would rather have their children inside because they think it's safer, you're going to have to deal with both perceptions and realities of safety in the community before you can get to issues of more physical activity for children.

In the same way if you're going to try to deal with how do you have ready access to fresh fruits and vegetables and healthy foods in a community that doesn't have them, you're probably going to have to engage in economic development

issues not simply around can we change the food
that's on the shelf in a particular place.

So I think the answer to your question is I
think in the ways that these are being pursued at
this point, they are tend to be focused more on
communities that don't have access to those kinds of
parts of the community infrastructure. They end up
focusing with the community on how to build that
rather than going straight to the problem of let's
change diets or let's change the food in the school.

ED HOWARD, J.D.: Yes, Jim?

JIM MARKS: I was going to comment, it's not
specifically on AIDS but I want to focus on the
community intervention parts. CDC has a program
called the Racial and Ethnic Approaches to Community
Health to narrow disparities. It was in a number of
communities, 30 or 40 communities, and one of the
largest community programs. They show that over time,
that the racial and ethnic disparities' gaps narrowed

in those communities when they remained the same across the U.S. as a whole.

So there is evidence that these community approaches can materially help reduce the disparities. We know that in the stimulus package, there is money for community interventions and in the health reform legislation there is also consideration of that.

So I think that one of the things we're going to have to do is make sure that we have disparity reduction as a goal but when it is, it with the community involvement can succeed.

ED HOWARD, J.D.: I presume there's some sort of component of education in this if only to tell people that they can boil a potato as well as deep-fry it. Yes, go ahead sir.

LARON PAYNE: Yes, my name is Laron Payne. I'm with the D.C. Medicaid Agency and we're in the process of implementing health information exchange through a transformation grant that we received from

CMS. I wanted to applaud you for your emphasis in addressing prevention. I wanted to make the comment that during this time, this incredible time of multi-billion dollar health reform opportunity, is there a way to make sure that prevention plays a very significant place at the intersection of health reform and health information technology.

Just as an example, in New York City Forezet Mostachari is doing a PCIP program that's coining a term, pay-for-prevention, you've heard of pay-for-performance, where he's actually trying to capture the preventive actions of front-line physicians with an HER. And as they do these things and capture these prevention steps when they're seeing the patient and they document it in the EHR, New York City wants to find a way to actually pay them for those preventive measures.

Can you make a comment on that or other examples like that where you can attempt to try to pay for preventive steps? Thank you.

JUDY MONROE: That's an excellent point. In Indiana, we've done a lot of work around that with the Indiana Health Information Exchange and work with our hospitals so it's on multiple fronts, one I think using health information exchange helps you know what tests were done in another hospital so that you're not duplicating and you're not giving the patient more radiation than they should have so that they're not, in a three-day period, getting multiple x-rays that were already done as an example.

The exchange, what you're getting to, is very exciting and we're looking at, they're in the process in Indiana of doing that, the same thing for pay-for-performance but really with that prevention as the forefront. What excites me about it is that if we really begin to get this exchange built up then physicians can really look at their populations of patients from a public health perspective that they're managing their population and looking at their prevention.

I can tell you I was part of the residency program. I was running a residency program when electronic medical records were first coming in and once we had the EMR and the residency program, I could sit down with a resident and pull up the data on how they were managing all their diabetics, as an example, or all their hypertensive patients.

It was always a surprise because I would ask them, I would say how well are you managing your diabetics? What do you think the average hemoglobin A1C is. They would always grade themselves better than the actual reality. So it's a very robust data collection and ability there that I think it's very exciting. I think it does play into health reform very nicely.

ED HOWARD, J.D.: Alice, do you want to comment?

ALICE BAKER BORELLI: I would like to. It's interesting to hear the panel broaden the definition of prevention today. It's really about every

individual at every stage of the game and that includes people with chronic care disease. Prevention takes the form of avoidance of an ER visit or any other kind of acute episode.

What we've seen in applying technology is that rather than going to that doctor's office to get the incentive, why don't you have assistants set up in the home or in the community center or some place that's more accessible to that patient that allows them to do this kind of ongoing monitoring rather than a regularly scheduled visit or an emergency room visit after the incident has occurred that could have been prevented.

What we're seeing is particularly in what the Veteran's Administration is doing with their patients that are chronic disease patients; they're using this kind of system very effectively. They have seen a 20-percent reduction in the number of hospital admissions and 25-percent reduction in number of bed

days with these chronic care patients that are monitored on a daily basis.

So we would say maybe the incentive needs to be not just for having EHR but making that information transferrable from the home or the community directly to the doctor without a face-to-face visit.

ED HOWARD, J.D.: Yes?

MINDY FLAMHOLZ: Hi. First of all, my name is Mindy Flamholz. I apologize, I was a little bit late. So I'm sorry if anyone addressed this. Going back to the need for prevention occurring in very early ages and you talked about the climb in a lot of the neighborhoods where it's unsafe for kids to play. I'd like to ask everyone a question here. How many of you had recess or physical education when you were in elementary school, show of hands? Okay.

I just finished covering 19 different schools in the Baltimore City area, as a family community engagement specialist, and the majority of

those schools had no recess. Many of them had absolutely no physical education program either even though it's mandated. I'm actually looking now to either join in or start a coalition because I think a lot of recommendations, even one very recently by the Robert Wood Johnson Foundation, is to increase the physical activity in school.

Increasing physical activity through a program like recess, which is different than physical education addresses not only concerns of obesity and health care and preventing chronic diseases but also addresses the needs of social skills in their kids because a lot of the kids are sitting with 29 other children in a classroom all day long with no break. That means they have no mental break.

That means they don't really stop to increase their academic performance even though time is being taken away to increase their academic performance. Sorry, that might not have made a whole lot of sense there, but as far as social skills,

we're dealing with increased bullying, increased gang violence, and these kids don't even learn social skills because they're in classes with kids all day long and they go home, as the gentleman said, to unsafe environments and they're sitting in front of TV sets and video games and things even the environmental part. So my question is, thank you, what do we do to address the needs for recess and our children? Thank you.

ED HOWARD, J.D.: Do you want to start it?

JIM MARKS: Twice now our commission's been mentioned so I want to give people a little background. We asked the distinguished group to look at what were the things that were beyond medical care that would be the most valuable for improving the health of the nation, practical policies that could be implemented. The commission came up with lists, which would sound fairly familiar to you but is quite a stunning group. It included the former head of OMB. It included the former head of CMS. It included

Senator Bill Frist. It included people from Wal-Mart and XM Radio, so a broad group from unions as well.

They recommended schools to become healthy places for children. That meant regarding food served, whether it was in the government programs or competitive foods or vending machines. Physical education needed to be at the school. They didn't address the issue of recess specifically but we, as a foundation, are funding a program called Sports for Kids that helps organize recess in elementary schools in the inner city schools that it's in.

We're working to get that widely applied. What we hear from the teachers and the schools is it has turned recess from a time that was hellish where lots of fights would break out and all that to one that is both popular with the kids but also popular with the teachers because the kids come in, are ready to work just for the audience.

If you don't know, there have been no studies that said time spent on activity, physical

education, or recess have hurt academic performance.

There are some that say they can't detect a difference but most say it's associated with a better academic performance.

So that's an area where we think is important whether it is physical education or recess but it is fundamentally about getting schools to be healthy places. That's the kind of thing that's beyond medical care. That's really important for the health of our nation.

ED HOWARD, J.D.: Okay. Sorry that Alice Borelli had to leave us a little bit early. It sort of makes you into our employer representative but it's a series of questions that have swirled around this area for the last couple of days. That has to do with the trust between employers and employees when these kinds of programs are put in place.

Alice was describing the firewalls between the employer and the employee's health information. There was a coach involved in one of her slides and

one would wonder to whom the coach reported. Who is the athletic director in that particular arrangement?

You mentioned, Judy, in your presentation that there were some financial incentives to help participation in the programs that you folks put together. How did you structure that so that the firewall remained and the apparent separation remained between coercion on the one hand and an invitation to get better on the other?

JUDY MONROE: Yes well and it really is the invitation to get better, I think, when you look at good employee wellness programs and set up where you help incentivize. So as an example, in Indiana, it's voluntary for starters. Not everyone has to be in the particular program but if they do then there's a financial incentive and then, as far as the coaching or the telephone, that's confidential.

Obviously you would keep, there is that firewall for the individual data but aggregate data, and we deal with this with public health a lot where

we will deal with population level or aggregate data but not the individual data. So that is really the way you distinguish that.

Then in terms of cost savings though, the way we measure a lot of that, we look at emergency department use, hospitalization, utilization data, claims data, we have some really wonderful stories, I know with not just state employee but with goodwill industries, as an example, in Indiana about four or five years ago, decided that they would really become aggressive with their employee wellness and they decreased the cost per employee quite significantly because of putting coaching and wellness into place. So that's kind of the way we've approached it.

The other thing, with Indiana with our employees, because it's voluntary, we then have the aggregate data; we know what it costs for those individuals that are not part of the program that involves the wellness and those that do. There is a cost difference.

ED HOWARD, J.D.: Thank you. Ray, how do you deal with that in the context of the health plan?

RAY BAXTER: Well we're also an employer. So I can speak from that—

ED HOWARD, J.D.: Fair enough.

RAY BAXTER: Since we have about 140,000 employees. We also had a health risk assessment we called a total health assessment. It's voluntary. I just did mine recently.

ED HOWARD, J.D.: How are you doing or is that confidential [laughter]?

RAY BAXTER: Well alright, I'll tell you about it. I actually was very interested by one of Alice's slides that showed the difference when you have biometric data between people's self perception or their recollection of what their numbers were versus the reality. When I finished doing the total health assessment because I thought if I'm talking about this, I ought to do that, it gave me the option, it said do you want this integrated with your

medical record or do you want to keep it separate? I opted to have it as part of my medical record.

Then they asked me a set of questions, which I won't go into but they asked me a set of questions that offered more information if I was interested in learning more. So I said fine. So now every morning when I get up, I've got this blinking thing at the top of the list, which is from my fitness coach with a tip for the day that I read before I go to the gym and it prompts me to go to the gym if I wasn't going to go to the gym that particular morning.

But I noticed when I had my annual physical a few weeks ago, when I went in, the nurse who was looking at, now my record's already there, everything else, so said by the way, I noticed that there's a difference between what you reported on your total health assessment about such and such versus what we had in the record.

What should the record say? I said well let me see what the record says and I would look to the

screen. We agreed on what it should say. That struck me as that's an important kind of triangulation both of what's going on with me but also the individuals trying to have some power over what's in your medical record. So a number of these pieces are starting to come together. I don't think we can completely predict the ways in which they will be used.

There are absolutely genuine concerns people have about the information being used inappropriately by their employer or potentially by their health plan but there are also a lot of people that are starting to put more of that information online and are interested in the uses of it and how they can participate in shaping it and so forth. So I think that the story's not over on how some of this is going to play out.

ED HOWARD, J.D.: Good. We have just a couple of minutes left and I would ask you to pull those blue sheets out and fill the evaluation form out if you would to help us improve these programs in

the future. What I'd like to do is to give each of our panelists a chance to really connect this on to the policy world that is around us within a mile or so in any direction.

Which piece or pieces do you think are the most important in this area that we ought to make sure that the policy makers who are making policy as we speak pay attention to? I note that a lot of the plans, including the leader's project that was just announced yesterday with the former majority leaders for both parties in the Senate had, along with a number of some of the other plans that are being worked on, cost sharing incentives so that they're either minimal or no cost sharing for the preventive services that have been certified as high priority.

There are other pieces that we've been talking about. There are proposals to increase the allowable rewards and penalties that employers can give or impose on employees to improve participation in some of these programs. Which of these ought we to

be making sure that the policy makers know are most important? Anyone want to start? Jim, you want to get us going on this?

JIM MARKS: Sure. I think the most important thing that was touched on here is that much of what's important for health occurs in our communities, not just in the doctor's office and that if we don't start to align our societies' policies and programs that are outside the medical care system towards fostering health, we will not be able to succeed in medical care reform and convert that to truly health reform. That's central to our future as a nation. So I would say first of all, recognize how much we need to have in our communities, that same [inaudible] prevention not just in the medical care system.

Probably related to that is that as we look at broad policies that I mentioned whether it's in housing or transportation or agriculture or others that we build into that an assessment of the health impacts of those policy changes for our nation. It

doesn't mean the health will always trump the other needs but if it isn't in the discussion, it becomes too easy to overlook it. It might be relatively modest changes can make for much healthier policies in those other sectors.

I think longer term or broader, we're going to have to be aware that much of what is law that is important to health is beyond the responsibility of public health. It can be very important and probably the best example are clean indoor air laws where we know that protecting workers in business settings, whether it's restaurants, bars, or others actually materially helps their health and the health of the people who use those settings.

The responsibility for those laws is not under the jurisdiction of public health or medical care. There are a lot of opportunities like that that we haven't harnessed as a society. So those would be three areas.

ED HOWARD, J.D.: Very good. Judy?

JUDY MONROE: Well I would just about echo that because you asked the question, alignment really comes to mind. We've got to align incentives. We've got to keep our eye on the ball for the primary prevention. That is again the highest order and we've, for too long in this country, not put the resources behind what we know we can do to make a difference.

So it really is health in all policies. It is across more than just health as Jim just said; I think is very, very important, so just viewing population health as opposed to individual health as we have so focused on in this country.

ED HOWARD, J.D.: Great.

RAY BAXTER: I would concur with those views. I think there are important prevention provisions that are being proposed at this point that involve significant funding for prevention including primary prevention and community-based prevention, which are important.

But second, I would say it is very important for prevention not to be simply a one provision or a separate part. In order to address that on a much larger scale, we do have to realign incentives, which means looking at the payment system so that choices for prevention, when they're called for, are easy to make rather than ones that are disincented.

Third, I think that the job of health reform, given the discussion we've had here when it comes to prevention, is not done with health bills that what is in the farm bill and the transportation bill and the elementary and secondary education bills will also be very important to the shaping of health in our communities.

ED HOWARD, J.D.: Good. Pretty good way to conclude this discussion, which I think I certainly have learned a lot from. Thank you for paying such good attention and asking such good questions. By the way, the gentleman who was asking the question about

the Nuremberg trials is downstairs passing out fliers
and recruiting jurors.

So be careful as you leave [laughter] but
beyond that, I want to reiterate the thanks to the
Robert Wood Johnson Foundation for its interest in
this subject in the first place. It supported the
briefing and co-sponsorship thereof and its
contribution of and incredibly valuable panelists
along with the other panelists that have helped us
too, what I think has been a very rich discussion
about this important issue. I'd ask you to join me in
thanking them [applause].

[END RECORDING]