

**National Health Day - 2006 Patient Safety  
and Health IT Annual Conference:  
Keynote Presentation and "Driving Down Healthcare Costs:  
Purchasers Who Are Innovating"  
Agency for Healthcare Research and Quality  
June 7, 2006**

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[START RECORDING]

**NEIL TRAUTWEIN:** That's the problem when you get to a health IT meeting. There's always a lot of cross-pollination and interconnectivity and lots of discussion, which is always very positive. I got that southern thing working again.

Well welcome. Our next panel has to do with that ever-popular topic of driving down healthcare cost. Who better to hear from than a panel of leading employers who are helping to drive the change we need to make healthcare more affordable. My name is Neil Trautwein, and I'm a vice president with the National Retail Federation. I'm new with the federation. Most recently I was with the manufacturers, so I've gone from the folks who make things to the folks who sell things in America.

Healthcare is a leading concern to employers large and small as well as our workers and their families. We retailers are particularly, and maybe even notoriously, challenged when it comes to healthcare cost and the ability to provide coverage to a workforce with a very high turnover rate. But common to us all and really the subject du jour is the fact that we've got lots of problems when it comes to healthcare. Health coverage costs way too much. It fails to adequately keep us healthy as a society. Medical errors are far too common and too often deadly in nature.

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As you guys know far too well, healthcare is stubbornly mired in 20<sup>th</sup> century technology. We may even be just one short step ahead of the quill and the ink well. We must and can do better when it comes to healthcare, and our panel will help our part of the solution of driving change in our healthcare system. Our panelists represent a big chunk of the American workforce and collectively spend billions of dollars each year on healthcare. If anybody has the incentive to figure out how to spend more wisely, it's our panelists.

It's now my pleasure to introduce you to our panelists. First we'll hear from Dr. Paul Grundy, the Global Well-being Services and Health Benefits director at IBM. Dr. Grundy is responsible for management of risk reduction programs that contribute to the health, wellness and safety of IBM workers.

Next we'll welcome an old friend to many of us in the healthcare industry, Bruce Bradley, director of Healthcare Strategy and Public Policy for General Motors. Bruce is responsible for healthcare-related strategy and public policy with a focus on quality measurement and improvement, consumer engagement and cost effectiveness.

Finally we'll hear from Dale Whitney, Corporate Health and Welfare manager at UPS. Dale has responsibility

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for the over \$2 billion healthcare and ancillary benefit program investment UPS makes in its workers each and every year. The UPS benefit program has been consistently named as one of the best in America, and he is also, quite importantly to the reform movement, the officer with Bridges to Excellence program. Actually he's the president of the Bridges to Excellence program.

We'll hear from each of our speakers and then we'll look forward to what I hope will be a spirited question and answer period with you all. With that - Paul?

**PAUL GRUNDY, M.D.:** Thank you very much Neil. Thank you ladies and gentlemen for inviting us to this meeting. I think is a really exciting group of folks and what you're doing is really important.

I'm here to tell you that we're at a point where, as we all know, we can't launch a rocket without IT, but we also can't deliver chronic care management without IT. We try to do it. Doctors try to do it, and it doesn't work because it's too complicated. There are too many factors that are interplaying. So we have a few things, and some of it's actually saved us a bit of money in terms of efficiency. But at the bottom line they're really pretty dumb things to do. We do disease management. We do it pretty effectively. We

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take claims data, 6-8 weeks old claims data. We feed that into a nurse call center. And with that inadequate information we do our best to try to do disease management.

What we really want to do at this stage is to buy primary care for our employees that matters where the doc or provider can do disease management, condition management, at the point of care delivery in real time with clinical physician support. I guess we've reached a point where as large employers we're tired of being efficiently able to buy the services of an orthopedist that can do an amputation on a diabetic. And we want to be able to buy connected healthcare that allows a primary care provider to prevent that event from occurring.

The good news is it's there and it works. I had the privilege of doing a deep dive in Denmark, which is probably about 10 years ahead of us. In addition to the little mermaid they've done some really impressive stuff in healthcare. I went to the home of one of our employees who is a diabetic. His name is Hans. And went on this little portal, and he was able to interact with his primary care provider. There was a very robust diabetic management tool that he had on the portal, including by the way, the speedometer information that WI-FI'd his exercise. It included his information from his insulin injections that

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were WI-FI'd into his personal health record. But more impressively was the fact that he could interact with his doctor, and his doctor was paid for that, which was really cool. So he had like emails to his doctor that I could see in which there was a dialogue and an interaction where real disease management was occurring in real time.

I went with him to his physician. His physician had a roadmap on his computer in front of his screen, and in one microsecond he say the 36, 37, parameters that he was managing on this particular patient. There were three red dots there. There were a lot of yellows and greens. And the three red dots indicated he needed his eyes examined. He needed his nutrition counselor discussion, and that was arranged in pretty close to real time.

Now this guy has not had an A1C, for those who are clinical oriented out there. It's been above a seven in a really long time. And the rates of hospitalization for diabetes in Denmark is going down rather than up.

So I'm excited about the fact that you see places in the world where it works, it works really well, and it's very encouraging. We've got a long ways to go here.

IBM is very much involved as a large employer in the places where we have cores of our employees in engaging real activities. We're a member of THINK and CHEKA[missspelled?].

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We're very active where we have large employee bases. We're encouraging incenting physicians to have electronic personal health records. And I think probably most importantly - we just really started doing this - is we decided to stop screaming about what we want to buy and actually dialogue with people that provide it, the primary care providers, the American Academy of Family Physicians and the American College of Physicians to see if we can't work together as buyers of healthcare and providers of healthcare to really service what we all want. And what we all want is care that makes a difference in our lives and the tools to allow us to manage more effectively our own care. And we know from what we've seen in other parts of the world where we've done this that it works effectively.

IBM is engaged with the Brothers[mispelled?] organization in doing some innovative interoperable connectivity engagements. And we have one of the four contracts where we're connecting communities in North Carolina, in Carolina, and Mid-Hudson. We're really excited about that, but we're investing a whole lot more than the contract stipulates because as we think it's really important as a large buyer of healthcare that we fix some of these fundamental issues.

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And with that I'll close and pass it on to Bruce Bradley my colleague from General Motors. But I'm really looking forward to the questions.

[Applause]

**BRUCE BRADLEY, M.B.A.:** Thanks Paul. Really thrilled to be here and to see such a terrific crowd. And I especially want to say how much I, and on behalf of General Motors all of us, resonate with the speakers earlier this morning. I think they left us with very key issues and points and I find myself in violent agreement with some of the major messages that came out.

As we all know the United States has an employer-based financing healthcare system. GM covers about 1.1 million lives. For every active employee, two and a half are retired. We spend about four tenths of one percent of the nation's healthcare bill, and we provide coverage actually to nearly one percent of the nation's population.

So given that it's an employer-based system, and those are big numbers for us. But proportionally they're also big numbers for us. All of us in this room are involved as employers in one way or another. And because it's an employer-financed system, we have an imperative to take a

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leadership role in driving improvement in quality and affordability.

So I was asked not to talk so much about IT, but to talk about just some examples of some of the things that we're doing. And what I want to do is I want to build this discussion off of what I call our community initiatives platform. Most of our emphasis at GM on trying to drive healthcare improvement and cost is focused on the delivery system because we really need to get to the root cause issues. The initiatives that I'll be talking about are clearly, in varying degrees, IT-enabled. But the issue for us is not so much IT in and of itself for the sake of it, and I think this was well said by many earlier, but truly the need to have the initiatives work in IT is a key component in addition to leadership and other things to make that happen.

We have five communities at GM where we have population concentrations of active employees and retirees. And in each of those communities we've assigned an executive from the company along with, in three, union partners UAW IUE, and we work in the other communities with unions as well, but those are formal relationships. And their job, essentially, is to serve as our implementation vehicle to make change happen and drive improvement at the community level. That doesn't mean there aren't other national issues

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and other broader-based issues, but I just want to focus on local level because that's where the rubber meets the road, as opposed to where the rubber meets the sky.

In each of the five communities we're heavily engaged in REO[misspelled?] development or REO operation or REO support, depending on the state of the art in the communities. For example in Indiana we're there to just provide whatever support we can because there's wonderful leadership and wonderful things going on. In southeastern Michigan, on the other hand, there has not been a REO until recently, and we've taken quite a leadership role in working collaboratively with the other two autos essentially to drive implementation, and we're also working very well with a major vendor who's done a lot of good work for us there.

We've been able to quickly gather the key stakeholders, especially provider community. We've already got them engaged in significant discussions on use cases - what's the value to them, messaging - and then looking at it over phases, right down to the more nirvana decision support and so on. We've only been at it for a few weeks now, but have made enormous progress and again the point being that if there is a void in a particular area, then someone's got to step in and take the leadership role to fulfill it.

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The next area that we've done quite a bit of work in is e-prescribing, and again in Michigan. And again GM took a leadership role. It wasn't me, so I can brag about my colleagues. And working with the three autos again, and you'll see a theme clearly developing here, we have established a electronic prescribing exchange and have brought together, again, multi-stakeholders, employers, physicians, point of care vendor, PBM and have connected essentially the prescribers, mainly the physicians, pharmacies, eligibility systems, history formulary with the carriers and using real time access, provided cash incentives, albeit modest, and essentially had a grant from HHS to do an evaluation to look at the results. We've already seen about a half a million prescriptions written through this system over 800 providers. And some very interesting things - we've seen an increase in generic rates, and we've especially seen 5,000 incidences where there was an intervention because of a conflict. So we're getting right to some of the safety and all those are cost issues.

The next area I just want to mention, and again it's in southeastern Michigan, is Save Lives, Save Dollars. It's program where we have performance measurement reporting and then differential payment to providers. We're about to roll out in July and over the course of the next year and a half

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differential payment based on pay for performance. These are all consensus-based, highly vetted measures. All the stakeholders are at the table. It's under the umbrella of GDAC, Greater Detroit Area Health Counsel. My boss chairs it. The vice-chair is the CEO of the whole Henry Ford health system. And it's a fabulous cooperative relationship. I think there were some stakeholders that needed a little more pulling than others perhaps to participate.

Vice[misspelled?] transparency - in another community we have, working with a carrier, developed a project in which we look at certain procedures and certain tests based on volume, cost, elective component, especially where supply exceeds demand, and developed actually a website with the ability to publish what certain things cost. What's a normal delivery? What's a c-section? Radiology procedures? Normal office visit, and so on? And the next phase of that is developing a consumer-based calculator tool to help consumers look at the direct impact on them. But just getting this stuff out in front has been very helpful. And a coincidental issue in the same community, we also lined up ... one of the major hospitals paid us with a 45 percent rate increase. We're all self-funded, and that was pretty unacceptable to say the least. So we lined up our union partners, other employers in the carrier and really went to town with that

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hospital system that we cannot tolerate any longer a cost-plus or whatever environment. And eventually we got that down to a low single-digit number. But the relationship to the other is that when I looked at the website and saw which hospital system had the highest prices already for some of those procedures, for the transparency it was the same one. So there's an awful lot that we can learn from IT enabling.

The next topic I just want to just quickly mention is in Flint, Michigan. Again data driven, we saw that cardiac care was clearly less than optimal. And put together, again with the community initiatives team leadership that GM and other employers, a project working with eight hospitals to drive improvement in heart failure. And in particular we developed, using the American College of Cardiology and the American Heart Association, a toolkit using evidence-based guidelines, patient education, checklists, teams, performance indicators and so on and implemented a broad-based project. And we have seen significant results that have been quite positive. And some of the process measures clear improvement. We have also seen a reduction in readmissions and a reduction in mortality. Again all this was data driven and evidence-based, and you can't do that without good information technology, although it wasn't the electronic medical record.

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Lean implementation – this is taking manufacturing techniques to get waste out of the system through process improvement. And over the last decade we have done well over 400 week-long workshops bringing our manufacturing teams into various hospitals, accrediting bodies, working on things such as the operating room suit, the emergency room and have helped drive as much as 40 and 50 percent improvement, either through reduction in cost or getting waste out. And the key component of this project is one, relationship with the institution, our community initiatives people because it's got to be voluntary and embraced and wanted by the hospital or whatever the system. And then it's training the trainer. We're not just going in and saying here's how you fix your operating room. What we're really trying to do is train them the manufacturing techniques to drive performance improvement.

And then finally I could talk about a whole slew of other initiatives, and I would be more than glad to deal with some of those in the question and answer section. But what's the take away? The take away is one – and I'm going to use a term that was coined by Maggie O'Kane, or if not coined, she certainly mentioned it and I just resonate all the time with it – and that's the need for collective leadership. I think most of you know Maggie is the president of NCQA. That's

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really key, and we're seeing that happen and work at the community level as well as at the national level. We saw collective leadership this morning. I think it's very important.

Everyone here, as I said, is involved as an employer, and the real call to action is you can make things happen in the community and that everyone here - or their organizations - really need to get engaged at that level. That helps raise the bar, raise all votes. It helps to deal with that issue of somebody else benefits from our work because if everybody benefits it improves and so on.

And finally, again, I just want to say thanks to everyone for being here. I think that if we can really move this needle fast because we have huge challenges ahead of us and a lot at stake. So thank you very much.

[Applause]

**DALE WHITNEY:** I'm technically challenged here. Let's see if I can get this.

Good morning. I too would like to thank HIMIS[misspelled?] for the opportunity to spend some time with you today. And I'd like to spend some time talking about a couple of different things about how employers are engaged in

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the system today, why they're engaged in the system and what you can do to leverage that and use that.

I think if you look at where employers are, they are supporting the transformation of health supply chain right now. And at UPS, obviously we see everything as a supply chain. We see the health system as a supply chain - dysfunctional supply chain, but nevertheless a supply chain. And today I think each company understands more than ever before that their success is not just dependant on what they do internally with their health plans but what they do externally because no matter what you do internally, unless you have done something to impact the system externally, you're still just running on that treadmill to keep up - you're not making any progress.

So I think the implementation of an internal health and HR strategy interwoven with improvements in the supply chain are what's going to bring us to where we need to go to as an employer to stay in this game, to continue to finance healthcare, as Bruce said. And I think a lot of companies have done it, if you listened to what Paul said and what Bruce said. A lot of companies are doing those internal things. In fact I'd go to a CEO and tell them if you're not doing the kinds of things that Paul and Bruce talked about, then your benefits manager should have a new name - it should

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be former benefits manager – because those are things you’ve got to do just to stay in the game. The things that employers have to do now is become involved externally with other stakeholders. And I think we’re seeing that more than ever before.

Purchasers have got to do that because we have to be the ones to put the reward and incentive system in place for change to take place.

Why does health IT resonate with purchasers? Well it’s real simple. If you look at the picture on the left there, that was off our annual report in 1985. And some of you in this room don’t remember this, but some of you probably remember when you used to sign for a package. Used to be a clipboard and piece of paper – used to sign for that package. That was back in 1985. The picture on the right is our most recent digital information acquisition device, or DIAD. What it does is it’s a wireless device. It’s a cellular device. Put it back in the package car and it transmits the information in real time to the computer system. So if you receive a package you can go back and trace the package and it’s going to be in the system before you get from the door to the computer. That system, by the way, the new version is also a GPS. So it tells the driver where they’re at, and it tells them if they’re not at the

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right place delivering a package. So if you deliver a package to the wrong address it lets you know that. It says you can deliver it here, but you might be making a mistake.

Why is this important? Because that's the kind of information technology that we've put in business. And UPS is not the only company that's done this. If you're going to stay in business today, and you're going to be successful, you're leveraging IT. And when we look at the health system and we see the lack of information technology that's been leveraged it's amazing. It's amazing to us, and it's something that we look at and say this has got to change. In order to have a more efficient, more effective system, we have to leverage IT.

But there's two fundamental challenges keeping that from happening: one is this whole idea of the person who's making the decisions - the consumer, the physician - isn't the one paying the bill. We're trying to work on that with something called consumerism, and the financial piece of that called consumer healthcare plans. Okay, so we're trying to do that so that there is alignment of incentives.

But the second item on her is even more important, and that item is if I make an investment at UPS in an IT system, I get the results from them. My customers are happy, they come to me for more shipping, I get more customers, I

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make more money off of it, the savings and the benefits accrue to me.

In the health system it doesn't always work that way because what we've found is that in some of the studies they've shown is that when I make an investment in IT, in the health system, about 30 percent of that comes back to me in improvement in process in my own system. But 70 percent of that is improvement in the quality of care. And that doesn't go back to me - it goes back to Bruce and to Paul and to Dale and to the healthcare plans. Somehow we have to find a way to change that system. And I think what you heard earlier with Mark McClellan talking about how you change the payment structure and where we have to go to.

One of the programs I think that demonstrates how you do a pay-for-performance program to bridge to that new payment system is what we're doing in Georgia right now. This is a Georgia diabetes and obesity project. It started off with basically two employers, UPS, Bell South and the [inaudible], which is Newt Gingrich's group. What we did is we started getting around talking about what is it we need to do or what can we do to try to improve the diabetes situation we have in Georgia. Georgia is far below the average in terms of the treatment and response to that treatment in diabetes in the country.

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We've now got 15 large employers. We now have eight of the largest health plans in Georgia. We have Governor Perdue, who is a part of this program. We have the three largest hospital systems and physician systems, the Georgia Medical Association, Morehouse School of Medicine, several pharmaceutical manufacturers - they're just excellent in terms of the incentive and reward program - and over three quarters of a million consumers who are now a part of this particular program, the aim of which is to improve the quality and efficiency of care for diabetes in Georgia.

Bridges to Excellence is the incentive and reward program that is the base of this particular program. Diabetes program's a first step for us. We feel that if we can engage the consumers and engage the payers in a program for diabetes and improve diabetes, health IT is the next step, whether that looks in terms of an e-prescribing program or whether that actually moves into the realm of an e-HR, we're not sure yet. But we do know that we're starting to get buy-in from purchasers on this particular program.

Now please don't mistake me - I'm not saying that employers or purchasers are saying that they're going to finance the health IT system because they're not. If you go back to that experience in 1985, that's when we put computers on everybody's desk and said, "Okay we now have IT at UPS."

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We know that doesn't work. But what we do know is if we can put things in place, incentives, for those people who use the health IT to improve efficiency and effectiveness for those physicians and those hospitals and we set up the metrics so that you're being rewarded for improving efficiency and effectiveness and sharing that 70 percent, that way we know that does work. It works for the purchaser, it works for the consumer and it works for those who are out there doing the work. So that's the direction we feel is important.

So thank you very much for the opportunity to spend some time with you, and maybe we can get some questions.

[Applause]

**NEIL TRAUTWEIN:** Thank you. We'll invite questions to the mics. Perhaps I'll take moderator's prerogative and start us off.

It seems to me that with all the wonderful things that employers are doing to help drive change, to work in coalition with others, still the basic unit are some of the most cantankerous players in the healthcare system. We've got physicians who want to be independent and not work in teams. We've got consumers who want to consume and not consume more wisely. As we change this healthcare system, is it a question of incenting, encouraging and listing consumers

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and physicians? Or is this perhaps a way that as payers we have to draft these parties into the effort? I invite comment.

**PAUL GRUNDY, M.D.:** I think it's all of those things you just mentioned. I know at IBM we look at this whole consumer-driven effort as very much an educational process. We rolled out person health records for all of our employees last year, and we incent by giving some monetary remuneration for our folks to go on and do a health risk assessment online and do engage and utilize it. And why? The reason why is because we know it's an educational process that's going to take time for our society to move down, to become better educated about healthcare, healthcare issues and needs. We're moving from a \$10 co-pay mentality to a world in which there's some sense of responsibility, and that's a journey.

**BRUCE BRADLEY, M.B.A.:** I think it goes without saying that the consumer is an absolute key factor in all the strategies that we're doing, whether it be our life-steps program, where we actually provide incentives for our employees to fill out health risk appraisals, we have then been able to evaluate people by - we're doing this with University of Michigan - risk factors. And we know that

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people with many modifiable risk factors cost more than those with few. We've been able to see change again by incenting the consumers and intervening in a number of areas. We've been able to hold people in low risk groups and keep, from an expectation level, people from moving up into the higher ones and are saving money so that we're all fitting that and all the transparency projects that we were talking about.

And at the end of the day I think it's very important to realize that even though the employers are paying the bill, more and more - and I think this trend is rapidly moving - is that the employee is directly affected by the cost to the company, whether it's benefit design changes, whether it's tradeoffs in compensation and so on. So this has all got to be fundamentally focused on benefits to consumer.

**DALE WHITNEY:** I'd like to echo what Bruce and what Paul said. I think a lot of it has to do with alignment of incentives. And the problem is when we are fighting misaligned incentives it becomes much more difficult. So I think we, as purchasers, have to do everything in our power to make sure that we're not putting reverse incentives in place through [inaudible]. But we are putting incentives in place that incent physicians, that incent consumers, that

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incent hospitals to do the right thing. And I think our program – we have a program called Your Health, Your Choice, and I think that the first thing is the first big "A-ha" from that program three years ago for people was you're responsible for your health. It was simple, but people didn't believe that. They believed their doctors were responsible for it. But that was step one, and I think we've made some progress based on that.

I think another piece in the Bridges program is physicians want to be partners. They believe that they can do a better job of taking care of people when someone else is helping incent that patient as well. So we try to partner with Bridges and with other programs with physicians in terms of taking care of the patient.

**MALE SPEAKER:** If I could take one more quick stab at that. I would completely agree, and I think we really, as buyers of healthcare, have to try to align the correct payment system so that physicians are empowered to do the kinds of things we want them to do, like answer emails, engage with you, spend time and develop a real primary care ability to provide care to them.

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**DR. BARBARA COOK:** I'm Dr. Barbara Cook a primary care physician, and I run a group of primary care physicians - 120 of us - in Baltimore, Maryland. The elephant in the room for me is the cost of implementation of an enterprise, electronic medical record for our group. For our group practice it's over \$3 million of investment up front. There was an article in Health Affairs for May/June of 2006 looking at the per capita monies that are put into IT in healthcare in first world countries. And we were compared in the United States with Canada, Australia, Germany, Norway, UK - 34 cents per capita in the United States is what we spend on healthcare information technology. And the winner - or loser, however you want to look at it - is Great Britain at \$192 per capita. The kind of money that we're talking about to get these systems in place is huge. It can't be on the backs of primary care physicians. We don't have the capital to do that. So how do we partner with the insurers, with self-employed and self-funded insurance programs and federal government to get money into the hands of primary care so that we can put these programs in place?

**MALE SPEAKER:** You're right on. Speaking from the standpoint of a large employer, we are working aggressively to try to develop incentive programs for the physicians in

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the areas where we have our employment base help reimburse them so that they can afford to have that, and I think Newt said it very well when he said "get a hold of your congressman today and tell him to pass this legislation." There is a role, I think, in my opinion for the federal and state initiatives in New York where we have a large employment base. The state of New York has been very engaged in incenting physicians to have electronic health records with grant proposals. I think it's a combination of federal and private and state.

**BRUCE BRADLEY, M.B.A.:** This is the daunting challenge. From the employer's perspective, whether this is a rational response or not, it's the real response is that there's no more money. Employers are paying more in this country than anywhere else in the world, and when one goes to a CFO and says we need more money to pay for it, the response is not favorable.

So what do we do about it? There are a couple of things that I think are important: one, perhaps to build on the other comment, that our CIO met with a group of CEOs and CIOs with Secretary Leavitt some time ago to talk about ideas, and one of which is that if the use case is there - which we think it is, the return on investment is there - the

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savings to the federal government is so big because they just cover so many lives. And so we are clearly advocating taking a good hard look at making public funds available for an investment. But on a more practical front, and we've seen it with a couple of the reos, and in particular in Cincinnati and other places where they've actually been able to identify how can you save the providers money in areas that are already spending a lot of money - namely exchange - develop an economic case so that the provider comes out financially better off from a funding component. Now that's only a small piece of it, but that's the other approach. It's a tough problem.

**DALE WHITNEY:** When we put together the program Bridges to Excellence, one of the things we looked at was how do we put incentives in place to get us to where we want to go and provide dollars to get people going in the right direction. And there's really three programs with Bridges now. There's the cardiac program, the diabetes program, and the one called Physician Practice Connections. And Physician Practice Connections really is a program trying to get people to e-HR, and using e-HR, having better outcomes based on the e-HR and then sharing those savings with physicians.

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There's three steps to it. You get incentives initially not for having an e-HR, but for having a registry. You get incentives initially for doing those kinds of things that you can do without the great investment in e-HR. Hopefully, and what we've seen happen, is most of those physician organizations are putting those dollars back into the practice so that they will be able to invest in e-HR. It's not the total answer, but it's one way that we as private purchasers can help.

**NEIL TRAUTWEIN:** Why don't we take a question from the mic to my right?

**MATT LEWIS:** My name is Matt Lewis, and I'm a doctoral candidate at Columbia University in health education and informatics in New York City. My question is for Mr. Whitney. In developing the Bridges for Excellence program, how did you consistently encourage patient and perspective consumer buy-in to the program and make sure that their transparency in accessing the informatics portion of the program were persistent?

**DALE WHITNEY:** The program was really set up with multiple stakeholders. There are physicians, there are

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purchasers, there are consumers and many researchers all involved in putting those programs together. The information that's provided, for example, the Physician Practice Connection program is information about physicians. So what we're able to do is we're able to show which physicians are providing, based on self-reported data at this point - it's audited - which physicians are providing the highest quality, most efficient care. And that information is given back to the consumers to make decisions.

Some of us, as employers, have put incentives in place for employees to go to those particular physicians. For example, UPS, if you go to an endocrinologist, for example, your co-pay is cut in half if they are a diabetic provider recognition program ETE endocrinologist.

**MATT LEWIS:** Thank you.

**NEIL TRAUTWEIN:** Perhaps the rear mic.

**KEN SLOCOM[misspelled?]:** Ken Slocom, AstraZenica. Compliments to all three of you for good presentations, and this is for Dale. As you know, Dale, AstraZenica is a Bridges to Excellence member as an employer. We're strongly supportive of HIT. We want to walk the talk as an employer

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and as a seller of healthcare services. We're trying to do both.

One of the frustrations we see with BTE and HIT specifically is that the incentives around IT adoption in BTE are not enough to get over the first lady's question about the elephant in the living room. So there's almost a catch 22 in here even with the things that have been talked about by Francois and other people about the pay for use incentives, it's not enough to get the doctor over the CAPEX, that first CAPEX question. And we're wondering, are there ways that we can work or innovate within the BTE program, which we think is the premier private sector program out there now that's multi-employer based, to see if we can fix some of that CAPEX problem, to get people through that initial 30-some thousand dollar nut and make this better so we don't wind up with simply the rich getting richer. People are already automated and can document the quality of their care, making all the money off the BTE program, but we're not pulling the mean up as much as we should.

**DALE WHITNEY:** Excellent point. I think part of the issue is that the private purchasers in a given market, unless you have all of the private purchasers, all of the healthcare plans together, as well as public purchasers,

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there's just not enough of them to provide enough dollars. As Bruce said, employers aren't interested in putting more dollars out there. Many employers are still in that mindset that I'm already paying more than I should for product that is less than a high quality product. So I think what's really important to see happen, and I'm glad we saw this happen in Georgia, is when you start to take public purchasers and put them together - if you heard Dr. McClelland talk about DOQIT, doctor office quality IT program. If you look at that program, and you look at what they're asking physicians to do and you look at the BTE program and you put them side by side - guess what? You can do the same thing and get rewarded in both programs. So I think directionally that's what we need to do is have more of a tie in where the programs are asking physicians to do the same thing and the rewards are coming from both public and private.

**NEIL TRAUTWEIN:** Our front mic.

**MALE SPEAKER:** I'm a physician and director of medical informatics for a hospital in Bloomington, Indiana. And listening to the story about GM and working with hospital systems to work on their process it sounds like rocket

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science to me. It doesn't sound real compared to what I see. We are doing a lot of work with our provider community to get consensus as part of community planning. You can call it internal audit REO or whatever you want to call it. And that's been very hard work amongst the provider side. And I think we've made a lot of progress on that, but we really haven't - despite some efforts - gotten the employers engaged in that conversation. And obviously it's vital to have that happen. You guys have gotten a lot accomplished. I mean you've gotten a trust relationship apparently between leadership of a hospital and leadership of a purchaser. I just wonder how that happened. How can that happen in other communities?

**BRUCE BRADLEY, M.B.A.:** I think you touched on - one of the key issues is relationships. Having an executive in our company or just whatever. Build a good relationship, and a collaborative, positive relationship, not always the usual adversarial stuff, although that's real, and I'm not denying it doesn't happen. That's the primary tool. Secondly is to be able to show that our interest is aligned, namely the belief that if a hospital's processes are improved and quality is improved, that saves money. And with the Detroit Medical Center we actually had a financial arrangement where

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they saved a lot of money and we got a rebate. And then third is that the hospital administrator or CEO, medical leadership has got to really want this to happen. We just can't go marching in and say we're going to tell you how to fix your operation. And then the key component there to make it happen for the hospital is - and we require this as a condition. This is voluntary, we do not charge for it. And that is that it's got to be training the trainer, meaning we will teach from our experience, but it really needs to be the hospital or the other - whatever institution, it doesn't have to be a hospital - that takes over the leadership and institutionalizes the programs.

**NEIL TRAUTWEIN:** Unfortunately I'm getting the paper hook. Sooner or later they'll figure out a way to shock the moderator into an electronic hook. Please join me in thanking our wonderful panel.

[Applause]

I do have a couple of housekeeping issues. For those of you who want to print out the handouts for the afternoon summit session, there are a total of 10 printer stations and you'll find those out beyond the exhibit area. And there are also five surf the net stations in case you are Blackberry

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deprived and want to go check email elsewhere. Thank you  
once more.

[Applause]

[END RECORDING]