



Center for Health Transformation
Better health, lower cost

Call to Action: Solutions for Healthcare in Michigan

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Healthcare that Works Outline

The Center for Health Transformation is developing an approach to improve healthcare quality, lower costs, and ultimately insure every American - and there are hundreds of breakthrough practices and solutions that are proven to do just that. If we rebuilt government policies to maximize the rate of migration to these practices and solutions, we would be dramatically healthier and would also save an incredible amount of money. The key components are:

1. Creating a healthcare system that works, in which the federal government and other healthcare stakeholders consistently migrate to best practices. We must ensure that *health* is the driving focus of the health reform debate. The best way to accomplish this is to surface what is actually working today to save lives and save money and then designing public policy to encourage their widespread adoption. Best practices should drive policy—not the other way around. The Center for Health Transformation has compiled a robust collection of best practices that: 1) Improve health and wellness through prevention and personal responsibility; 2) Improve quality, administration and the delivery of care; 3) Lower costs; and/or 4) Expand access to care. For example, according to the *Dartmouth Health Atlas*, the definitive authority on healthcare quality and variation, if the 6,000 hospitals in the country provided care at the Intermountain or Mayo standard, Medicare alone would save 30 percent of total spending ever year – with better health outcomes. We need to make best practice minimum practice.

2. Building a nationwide electronic system in two phases by the end of President Obama's administration. To do anything to transform health—from paying for outcomes to comparative effectiveness to avoiding medical errors—health IT is absolutely essential. No other industry is as antiquated as healthcare. EHRs and other technologies are the only tools that simultaneously reduce costs while improving care. We can first make information more accessible through the Web and then electronically connect all stakeholders with interoperable IT.

3. Dramatically reducing healthcare fraud and changing the budget act so the savings can serve as a major pay-for for health information technology and covering the uninsured. Outright fraud – criminal activity – accounts for as much as 10% of all healthcare spending. That is more than \$200 billion every year. Medicare alone could account for as much as \$40 billion a year. This level of theft and crime can be detected, eliminated, and then prevented with the right kind of electronic resources. As it stands now, it is simply impossible to keep up with fraud in a paper-based system. An electronic system would free tens of billions of dollars to be spent on investing the kind of modern system that will transform healthcare.

4. Implementing science and investment-based budgeting with generation-long scoring. The U.S. government must be able to distinguish cost from investment, and the 1974 Budget Act must be amended to reflect this. Former NIH director Dr. Elias Zerhouni noted in recent testimony before the U.S. House and Senate that \$10 billion invested in basic research on HIV/AIDS between 1985 and 1995 saved the United States \$1.4 trillion in healthcare expenditures – a return on investment of 140 to one. However, according to current scoring models, the \$1.4 trillion saved would not be taken into account, as the \$10 billion would be viewed purely as cost. As it stands, the current budget mechanism is so inadequate and destructive that scoring models must be replaced.

**For detailed information on these four initiatives, please visit:
www.healthtransformation.net/cs/healthcarethatworks**

Healthcare that Works: Best Practices Top Ten Transformational Healthcare Solutions

The following success stories serve as a small sample of what is happening in communities across the country where transformational leaders are creating programs and processes that save lives and save money. The Center for Health Transformation has received more than 100 best practices that 1) Improve individual health and wellness through prevention and personal responsibility; 2) Improve the quality, administration and delivery of care; 3) Lower costs; and/or 4) Expand access to care. The full list of best practices is available at our website, www.healthtransformation.net/cs/healthcarethatworks.

We urge all policymakers to examine them in more detail, seek out similar successes in communities across the country, and then actively design policy and healthcare purchasing decisions to accelerate the adoption of best practices nationwide.

These successes were shared with the Center for Health Transformation by the organizations leading these efforts. While we cannot vouch for the absolute accuracy of these self-reported case studies, we whole-heartedly applaud their efforts to bring better health at lower costs.

Prevention and Wellness

SimplyWell Omaha, NE

Founded by physicians at The Nebraska Medical Center, SimplyWell provides comprehensive, results-driven population health management services to improve health and lower healthcare costs for employers. SimplyWell's model empowers employees with the necessary tools to modify personal health risks, including an electronic personal health record to manage their health, access to lab data, tailored patient education, disease monitoring, a nurse call line, and an annual screening.

One of SimplyWell's 175 employer clients is the Greater Omaha Packing Company, Inc. (GOP). GOP has annual sales of nearly \$1 billion and is ranked 5th in beef processing nationally. GOP is 90 percent non-English speaking with 53.3 percent of the population without a primary physician. Since implementing SimplyWell in 2001, GOP has experienced significant improvement in employee engagement as well as measurable clinical improvement. The majority (89 percent) of their employees have elected to participate in SimplyWell, free of charge, in exchange for a comprehensive group medical insurance program including lower deductible and out-of-pocket employee expenses with minimal employee contribution to their health plan premium costs.

Results

- Repeat participants from 2004 – 2008 experienced a 27% improvement in normal blood pressure readings; 16.7% fewer participants with elevated total cholesterol; 13.2% fewer with elevated LDL levels and 41.3% fewer participants with elevated glucose levels.
- From 2001-2008 this group has experienced an average health care cost increase of 2.4%, far below the national average.
- In the previous plan year, medical plan costs per employee were \$4,259 compared to the industry average of \$8,607, resulting in approximately \$3.4 million dollars in savings compared to the competition.
- As part of their future plans, GOP is opening an onsite clinic staffed with qualified medical professionals to continue this successful program.

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Gulfstream Aerospace: “Partners in Quality” (PIQ)

Savannah, GA

In 2003, Gulfstream Aerospace Corporation partnered with Memorial University Medical Center to create a program called “Partners in Quality” (PIQ), a quality improvement initiative for Memorial’s network of primary care physicians who were delivering care to Gulfstream employees.

After analyzing claims data, Gulfstream realized the majority of participating physicians were not following best practice protocol. This often resulted in increased medical costs due to follow-up visits and/or the onset of chronic disease co-morbidities with possible hospitalizations. The focus of the PIQ program’s measurement process became greater attention to proper, evidence-based treatment protocols for key disease groups: diabetes, breast cancer, cervical cancer and pharmaceutical management.

Gulfstream engaged program participants by offering: lower healthcare costs and increased employee wellness to participating companies; financial incentives and public recognition to participating physician who followed best practice protocols; and the possibility of lower co-pays to employees whose physicians were designated a “Distinguished Quality Physician” (DQP).

To measure program outcomes, Memorial Hospital’s Physician’s Quality Committee defined key measures for each disease group. The measures were then placed on a balanced scorecard which assessed each physician’s performance against each targeted area for improvement. If the physician’s average score was 70 percent or higher, he or she was designated a DQP. After the first set of performance data was distributed only 10 percent of physicians qualified as DQPs.

In 2006, to further reduce costs and increase the health of Gulfstream employees, the company changed its pharmaceutical program to promote the use of generic drugs. It also initiated a companywide, voluntary Health Risk Assessment (HRA) program which helped employees detect previously undiagnosed medical situations. Through this program, Gulfstream’s benefits department has been able to clearly identify what major health risks exist within the organization and has adjusted their healthcare programs to help address those exposures. For example, the decision of the types of drugs to be included in their free generic drug program was greatly influenced by the findings from the HRA summary data.

Results (2004 – 2008)

- The percent of primary care physicians qualified as “Distinguished Quality Physicians” went from 10% to 44%, which represents a 340% quality improvement or an increase from 18 to 80 doctors in Savannah;
- The percent of women age 40 and above receiving annual mammograms went from 44% to 51%, a quality improvement of 16%;
- The percent of diabetics getting two or more HbA1c tests per year went from 39% to 61%, a a quality improvement of 56%;
- The percentage of diabetics getting an annual lipid profile went from 57% to 80%, a a quality improvement of 40%;
- The percentage of diabetics who received an annual dilated pupil eye exam went from 32% to 56%, a a quality improvement of 75%;
- The percentage of women age 21 and above receiving an annual PAP test went from 37% to 63%, a a quality improvement of 70%;
- The generic drug dispensing rate went from 33% to 54%, a quality improvement of 64%;
- There was a 21% reduction in average medical cost per diabetic;
- There was a 2% reduction in diabetic patients with renal failure;
- There was a 43.3% increase in average drug cost per diabetic;
- Gulfstream’s four-year healthcare cost trend was an increase of only 4.3%, far below the national average;
- Gulfstream’s programs have generated an annual healthcare cost avoidance of \$5 to \$6 million.

****Submitted by Bob Holben, Director, Compensation & Benefits Gulfstream Aerospace, bob.holben@gulfstream.com.*

The City of Oklahoma: “This City Is Going on a Diet”

Oklahoma City, OK

On January 1, 2007, prompted by his own personal struggle to lose weight, Oklahoma City Mayor Mick Cornett challenged the citizens of his city to lose one million pounds. Cornett created the challenge in an effort to combat obesity in Oklahoma City, which is among the top ten most obese cities in the United States and the 8th fattest city in America, according to *Men’s Fitness*.

Cornett decided to start his weight loss program at the beginning of the new year when many people attempt to lose weight and adopt healthier lifestyles. As a part of Cornett’s initiative, residents can sign on to the mayor’s interactive website, <http://www.thiscityisgoingonadiet.com>, to set their goals, calculate their body mass indexes, and track their weight loss. The site also serves as an accountability tool because it tracks everyone’s progress. Once participants log on, they can update their information and instantly know if they are doing better or worse.

Additionally, Mick Cornett is attempting to change the culture of Oklahoma City in order to make diet and exercise more appealing. He is increasing the number of bike trails and sidewalks and building new gymnasiums in all 47 of Oklahoma’s inner-city schools. Cornett is also working with local fast food chains to develop more health-conscious choices.

No government money has gone into developing [thiscityisgoingonadiet.com](http://www.thiscityisgoingonadiet.com). It was entirely funded by contributors from the private sector and is a testament to the power that community leaders can have to create a culture of health.

Results (As of 1/13/09)

- There are a total of 25,874 registered participants in the program.
- Since December 31, 2007 participants have lost a total of 305,344 pounds, an average loss of 11.8 pounds per person.

**** Submitted by David Holt, Chief of Staff, Mayor Mick Cornett’s Office, Oklahoma City, OK, david.holt@okc.gov*

Improving the Delivery of Care

CMS Premier Hospital Quality Demonstration Project

The Centers for Medicare and Medicaid Services (CMS) Premier Inc. Healthcare Alliance Hospital Quality Incentive Demonstration (HQID) project is the first national pay-for-performance project to measure hospital performance and offer additional Medicare payment to hospitals for top quality care. The demonstration, which began October 1, 2003, involves a CMS partnership with Premier, a nationwide healthcare quality and cost improvement alliance of more than 2,100 not-for-profit hospitals. During the demo, CMS rewarded the top performing hospitals – in terms of improved coordination of care for chronically ill and high-cost beneficiaries – by increasing their payment for Medicare patients.

The program is voluntary and uses 34 measures, drawn largely from the National Quality Forum endorsed hospital performance measures set, as a basis of examining and rating each hospital. Five clinical focus areas or groups (CFGs) are the evidence-based quality measures used as the basis for hospital top performers:

- Acute myocardial infarction (AMI)
- Congestive heart failure
- Pneumonia
- Coronary artery bypass graft
- Hip and knee replacements

For each CFG, Premier collects data from each participating hospital for a number of process measures, such as the timely administration of antibiotics and outcome measures, such as mortality. The scores for each measure are blended to create a Composite Quality Score, an aggregate of all quality measures within each clinical area, for each CFG. A composite quality score is calculated annually for each demonstration hospital with a minimum sample of 30 cases in a measured clinical quality area. Hospitals receive separate scores for each clinical condition by “rolling-

up” individual process and outcome measures into an overall quality score. CMS then categorizes the distribution of hospital quality scores into deciles to identify top performers for each condition. For each condition, all of the hospitals in the top quality 50 percent of hospitals are publicly reported on CMS’ website.

Bonuses are given based on top performers for each condition. Top 2 deciles are given a 1-2 percent bonus of their Medicare DRG payments for that condition. If the performance in year three does not exceed baseline, the hospital will receive a payment penalty as a cut of 1-2 percent lower DRG payments for conditions below the 9th or 10th percent baseline level.

Results:

- For hospitals participating in the HQID project, the average Composite Quality Score improved by 4.4% between the project’s second and third year for total gains of 15.8% over the project’s first three years:
 - From 87.5% to 96.1% for patients with AMI;
 - From 84.8% to 97.4% for patients with coronary artery bypass graft;
 - From 64.5% to 88.7% for patients with heart failure;
 - From 69.3% to 90.5% for patients with pneumonia;
 - From 84.6% to 96.9% for patients with hip and knee replacement.
- The cost of the incentive bonuses to Medicare for the first three years was about \$24.5 million;
- The bonus incentive payments ranged from \$900 to \$847,000 across the first three years of the project with an average payment of \$70,000;
- 182 providers have received an incentive payment in at least one clinical area over the three years;
- Premier estimates that approximately 2,500 lives were saved in the care of heart attack patients alone across the first three years of the project;
- In addition, patients received approximately 300,000 additional recommended evidence-based clinical quality measures, such as smoking cessation, discharge instructions and pneumococcal vaccination, during that same timeframe;
- CMS extended the project for three additional years to test the effectiveness of new incentive models and ways to improve patient care. The extension will continue to track hospital performance in the clinical areas of pneumonia, heart bypass, heart attack (acute myocardial infarction), heart failure, and hip and knee replacement. New measures such as the AHRQ PSI Composite measure, length of stay, and complications will be tested in these clinical areas. In addition, new areas will be added for testing such as Surgical Care Improvement Project SCIP and Ischemic Stroke. The extension will also allow the testing of new payment models.

****Submitted Eugene Kroch, Ph.D., VP - Chief Scientist, Premier, Inc., Eugene_Kroch@PremierInc.com.*

Bridges to Excellence

Bridges to Excellence (BTE) is a multi-state, multi-employer coalition developed by employers, physicians, healthcare services researchers and other industry experts to reward quality across the healthcare system. Key objectives of the program include:

- Encourage and reward healthcare providers who demonstrate that they deliver safe, timely, effective, efficient and patient-centered care;
- Encourage patients to seek evidence-based care;
- Reward patients with chronic diseases who take an active role in managing their own care and achieve target goals aimed at improving their health.

One major focus of BTE is diabetes care. Diabetes is the sixth leading cause of death in the United States, and 20.8 million Americans have the disease. Data shows that diabetics only receive appropriate treatment 50 percent of the time. Public awareness about the seriousness of the disease and the importance of its management is low, and unless changes occur, the Centers for Disease Control (CDC) estimates 1 of 3 Americans born in 2000 may develop diabetes. Based on data for the year 2002, the economic cost of diabetes was \$132 billion: \$92 billion in direct medical costs and \$40 billion in indirect costs such as lost workdays and restricted activity.

To combat these perilous trends, BTE created the Diabetes Care Link (DCL) program to improve the quality of care for patients with diabetes. It offers a suite of products and tools to help diabetic patients get engaged in their care, achieve better outcomes and identify local physicians that meet high performance measures. Additionally, physicians who demonstrate they are top performers in diabetes care, including following best clinical practices, can

earn up to \$200 for each diabetic patient covered by a participating health plan and/or employer. Participants fund these incentives from the savings they achieve through lower health care costs and increased individual productivity that results from delivery of higher quality diabetes care. Therefore, DCL is a win-win-win situation for physicians, plans, employers and patients.

Results

- Independent studies conducted by three national health plans found that physicians participating in the DCL program offered care that was substantially more consistent with best practice guidelines than physicians not participating.
- Additionally, these physicians delivered care at a 10% to 15% lower cost than non-BTE physicians (Approximately \$350 per patient in the initial study year). The majority of the savings came from fewer hospitalizations and fewer trips to the emergency room.
- An analysis by Towers Perrin of the DCL module estimated a maximum savings of up to \$1,059 per patient per year when blood pressure, HbA1c and LDL control measures are met.

**** Submitted by François de Brantes, CEO, Bridges To Excellence, Francois.deBrantes@bridgestoexcellence.org.*

Massachusetts eRx Collaborative

The Massachusetts eRx Collaborative was established in October 2003 as an outgrowth of existing e-prescribing pilot programs at Blue Cross Blue Shield of Massachusetts and Tufts Health Plan, joined later by the Neighborhood Health Plan. Partnering with ZixCorp as the technology provider and later adding DrFirst, the Collaborative has sponsored the deployment of e-prescribing tools to thousands of healthcare providers, offering a turn-key approach to implementing hardware, set-up, training and ongoing support at no cost to the prescribers.

Through use of the e-prescribing tools, physicians are able to access patient-specific prescription drug and medical histories, be alerted of drug-to-drug and drug-allergy interactions; electronically transmit prescriptions directly to a pharmacy, minimizing possible errors from illegible handwriting; view formulary compliance information; and access drug reference guides to review generic alternatives for brand-name prescriptions.

In 2005, the Massachusetts eRx Forum was established by insurers, technology vendors, pharmacies and other organizations to raise awareness of e-prescribing and increase its adoption statewide. The Forum has partnered with the Massachusetts Medical Society to develop a continuing medical education course called “Electronic Prescribing Education: How to Improve Medication Safety and Reduce Drug Costs Through e-Prescribing,” in order to inform practicing physicians of the value of health information technology.

Results:

- Nearly five million prescriptions transmitted electronically in 2007, and more than 13.5 million since the Collaborative’s inception;
- In 2007, approximately 104,000 electronic prescriptions were changed or cancelled because of drug-safety alerts to the physician;
- In 2006, BCBSMA e-prescribers saved five percent on their drug costs compared to prescribers that did not use the technology. Of that savings, BCBSMA members saved \$800,000 in co-payments for their prescriptions resulting from improved formulary compliance and increased use of generic alternatives;
- More than 81 percent of prescribers reported that they would recommend e-prescribing to a colleague, and 71 percent said the technology saves time as a result of its use.

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Lowering Costs

Gundersen Lutheran: “Connected Care”

La Crosse, WI

Gundersen Lutheran Health System, headquartered in La Crosse, WI, has created “Connected Care,” a national model for efficient, high-quality, end-of-life care. This model incorporates all elements of the health system’s advance care directives program to provide the best possible care for patients nearing the end of life. The program has been named Connected Care because the health system uses an electronic medical record to connect patient information on the care planning process, goals, treatment plans, compliance, outcomes and patient satisfaction—regardless of treatment setting.

Connected Care is designed for patients with terminal chronic conditions. Rather than focusing on disease management, this system is designed to efficiently help patients live as well as possible in their last two years of life. Gundersen also incorporates a palliative care program which helps patients with advanced diseases and their families through the physical, psychosocial and spiritual aspects of aging and dying.

Gundersen Lutheran is currently presenting their Connected Care program as a demonstration to the Centers for Medicare and Medicaid Services, as this model may be one answer to the issues of access and cost associated with the retirement of the Baby Boomers.

Results

- The initial findings of the Connected Care program have shown a decrease in utilization of services resulting in decreased costs, increased patient satisfaction and increased access to services for others that may need more acute or specialty care;
- Gundersen’s palliative care program significantly reduces hospital costs, approximately \$3,500 per patient in billed costs. It also increased admissions to hospice care by 32% since 2007 and reduced hospital readmission rates 6%, versus 18% in a control population;
- Studies at Gundersen Lutheran have shown that patients with advance directives used about \$2,000 less in physician and hospital services in the last six months of life;
- The Connected Care model could nationally reduce associated healthcare costs by 25 to 50%;
- In 2008, a study published by *The Dartmouth Atlas*, which analyzed the care of patients with severe chronic illness, including Medicare spending per patient in the last two years of life, Gundersen was recognized as one of three hospital referral regions in the country—out of 306—to achieve the lowest per patient spending. The study also concluded that Medicare spending could have declined by 25% if all U.S. regions safely adopted the practice patterns of the most efficient regions.

**** Submitted by Joan Curran, Chief of Government Relations and External Affairs, Gundersen Lutheran Health System, jlcurran@gundluth.org.*

Allscripts & Fremont Medical Center

Las Vegas, NV

In 2005, after 16 years of using an inefficient and dated medical charting system, Fremont Medical Center partnered with Allscripts to implement a new electronic health record system. Fremont realized an enormous increase in operational efficiency, which helped maximize its limited personnel without increasing workload or jeopardizing service to customers. Overall staffing per physician ratio was reduced by 20 percent, with some practices realizing a decrease of over 30 percent. Many team members were retrained into other areas, thus increasing the overall skill set of the Fremont team. Doing more with less not only helped the hospital save money but also helped increase employee resources to the Las Vegas community.

Results

- Pre-EMR, Fremont’s filing and chart copying staff included 10 full-time equivalents (FTEs) but post-EMR, Fremont retained only one FTE, an \$18,792/ month reduction;

- Pre-EMR, chart supplies, forms expense and transcription costs accounted for \$13,267 per month, \$0.37 per customer and \$6,2000 per month, respectively, while post-EMR those costs are now \$0 per month for supplies, \$0.11 for forms and \$0 per month for transcription services;
- Pre-EMR, Fremont paid \$13,882 per month for corporate office space to a non-related landlord. Post-EMR Fremont eliminated this cost since corporate support staff moved to reclaimed medical records space;
- Pre-EMR, nurse calls and customer service requests reached approximately 1,000 requests per day, but post-EMR that number has decreased to approximately two requests;
- Pre-EMR, prior authorization or managed care insurance company requirements, had an average turnaround time of 36 to 48 hours. Post-EMR that time decreased to less than eight hours;
- Pre-EMR, immunization recall took several days as it was difficult to identify patients, but post-EMR that number has decreased to one hour;
- Pre-EMR, quantifying the outstanding work load of MDs and licensed staff required manual count of linear feet of charts and total inches of paper within an in-box, while post-EMR Fremont uses an electronic count of outstanding lab results, phone calls, consult reports by doctor, by shift, by location and by day.

****Submitted by Ernest G. Barela, President and COO, Fremont Medical Centers, Las Vegas, NV, Ernest.Barela@fmcnv.com & Leigh Burchell, Director, Center for Community Health Leadership, Allscripts, Leigh.Burchell@allscripts.com.*

Increasing Access to Care

Pfizer: Amigos en Salud (“Friends in Health”)

Laredo and Brownsville, TX · Los Angeles, CA · Hartford, CT · Jersey City, NJ

In the United States today, diabetes disproportionately affects the Hispanic population, the largest minority and fastest-growing population group in the country. Prevalence rates are highest among Hispanics whose income falls below the federal poverty level (17.2 percent) and those who are obese (15.5 percent). The prevalence of diabetes is almost twice that of non-Hispanic whites of similar age, and the number of Hispanics diagnosed with diabetes is projected to double between 2002 and 2020.

Amigos en Salud is a culturally relevant education program that improves the health of underserved Hispanics living with diabetes and depression. Using community health workers or “promotores,” the 10-week education program focuses on providing people with the tools they need to manage their disease in a way that complements their culture and lifestyle. Community health workers who teach the course come from similar cultures and help participants overcome the myths and misconceptions about diabetes and depression that may exist within the culture.

Program objectives include:

- Helping participants understand their condition.
- Teaching better patient/physician communication skills.
- Encouraging and sustaining behavior changes such as smoking cessation, exercise and healthy diets.
- Supporting development of self-management skills such as self-testing.

Results:

- Los Angeles, California, QueensCare Family Clinics Program:
 - Lower mean A1c with 64% achieving the goal of <7.0%
 - Average total cholesterol decreased from 214 mg/dL to 199 mg/dL
 - Average LDL cholesterol decreased from 128 mg/dL to 116 mg/dL
 - 30-150% average increase in knowledge of diet, disease process, insulin and blood sugar
- Hartford, Connecticut, Hartford Hospital Program:
 - 13% decrease in mean A1c
 - Average total cholesterol decreased from 199 mg/dL to 173 mg/dL
 - 50-300% average increase in knowledge of diet, disease process, insulin and blood sugar
- Laredo, Texas, Gateway Community Health Center Program:
 - 10% decrease in mean A1c
 - Glucose monitoring increased by an average of 29%

- Depression scores improved by an average of 53%
- Los Angeles, California, Drew University Program:
 - Lower mean A1c with 61% achieving the goal of <7.0%
 - Average LDL cholesterol decreased with 83% meeting goal of <100 mg/dL
 - Average triglycerides decreased with 76% below goal of <150 mg/dL
 - Self-reported behavioral changes were also noted in healthy eating and regular physical activity with an average of 48% reporting regular strenuous exercise
 - Self-reported depression severity score decreased on average from 8.3 at baseline to 4.9 at follow-up

*** Submitted by Ken Babamoto, PharmD, MPH, Director, Program Design, Pfizer Inc, ken.babamoto@pfizer.com.

Memorial Hermann – Health Centers for Schools

Houston, TX

With nearly \$2.5 million in corporate, foundation and individual gifts, Memorial Hermann Healthcare System partnered with three school districts in Houston, TX to create the Memorial Hermann Health Centers for Schools, a group of five school-based clinics that operate Monday through Friday, year-round and provide about 24,000 annual visits.

Memorial Hermann operates the clinics and provides more than \$700,000 in funding each year. Host schools are selected strategically so that students from other nearby schools can access services easily. More than three-quarters of students seen at the clinics have no health insurance at all, while the remainder do not typically access care because of transportation issues or other challenges. The five school-based clinics serve as a medical home for uninsured children and as a secondary access point for those with insurance by offering primary care, mental health counseling, health education, and mobile dental care.

The program diligently collects outcomes data, which strengthens the program and sustains community support. Conscious of making every dollar count, the program is willing to curtail or restructure services that are not meeting objectives and add services that will be most beneficial. The annual performance evaluations of all Health Centers for Schools staff are at least in part tied to strategic objectives.

Results (2006-2007)

- Student asthma exacerbations, ED visits and hospitalizations decreased by 67 percent;
- Cholesterol levels among students in the cholesterol management program declined by 73%;
- Students who received mental health counseling had improved grade point averages and self-reported well-being, along with fewer suspensions, detentions and days absent.

*** Deborah Ganelin, Memorial Hermann, deborah.ganelin@memorialhermann.org.

Top Ten Action Items to Adopt Best Practices: Driving Adoption through Smart Policy and Purchasing

- 1. Value-based healthcare.** Create a cost and comparative effectiveness initiative that certifies public and private evidence-based practices. Government health programs should then reward organizations that adopt these best practices through higher reimbursements.
- 2. New payment models.** Develop a policy roadmap to replace current physician reimbursement models, including the Resource-Based Relative Value Scale (RBRVS) and the Sustainable Growth Rate, with a model rewards the use of best practices, chronic care management tools, information technology and emphasizes patient wellness. The delivery reform proposal released in November 2008 by Kaiser, Intermountain Healthcare and the Mayo Clinic provide a range of options that would be vast improvements over the status quo, including bundled or episode-based payments, accountable care organizations and chronic care coordination payments.
- 3. Liability protection.** Extend federal liability protection to providers who follow established clinical guidelines or use certified best practices.
- 4. Transparency.** Release price and quality information from all government health programs—Medicare, Medicaid, Veterans Affairs, and FEHBP—for all providers, suppliers, health insurers and pharmacy benefit managers that do business with the federal government so that taxpayers/patients can see which organizations provide the best and most efficient care – using transparency as a tool to manage healthcare costs.
- 5. Physician practice.** Improve and then expand nationwide the CMS Group Practice Demonstration.
- 6. Medical home.** Expand provider eligibility for the CMS medical home demonstration.
- 7. Hospital quality.** Expand nationwide the CMS Hospital Quality Incentive Program.
- 8. Provider reporting.** Improve and expand the Physician Quality Reporting Incentive (PQRI) to enroll more eligible physicians.
- 9. Reward health and wellness.** Give private health plans, including those that participate in Medicare and Medicaid, more latitude to design insurance products to encourage, incentivize and reward individual healthy behaviors.
- 10. Medical error reporting.** Provide limited liability protection and incentives to publicly report and publish data on medical errors.

Top Ten Action Items to Create an Electronic Health System

- 1. Health IT adoption.** Invest in physician adoption of information technologies by financially incentivizing its purchase and use. Models could include bonus payments, expanding the CMS Electronic Health Record Demonstration and higher Medicare reimbursement rates, such as the model for encouraging the adoption of electronic prescribing in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). Electronic health records and other technologies purchased using federal dollars must be certified by the Certification Commission for Healthcare Information Technology (CCHIT).
- 2. Interoperability data standards.** Expedite the development, completion and promulgation of key interoperability data standards. Aggressive deadlines should be set for their completion. Value/use cases and subsequent data standards should be prioritized anew.
- 3. Do not refight battles of the past.** Build upon current industry governance, such as CCHIT, Health Information Technology Standards Panel (HITSP), and the National eHealth Collaborative (formerly AHIC). No new parallel organizations should be created to address the problems these entities are tackling.
- 4. Personal health information.** Make patient-protected Medicare data available to beneficiaries, and their providers if patients so choose, via smart-card technology and web portals. Making Medicare claims data available at the point of care will help coordinate care, improve patient safety, and lower costs, particularly for medication management.
- 5. CMS personal health records.** Expand the CMS Personal Health Record pilot to a broader demonstration project and then nationwide. CMS should make claims information accessible through any personal health record that a beneficiary chooses, if the technology is certified by CCHIT.
- 6. Homeland security.** Fund a joint project between HHS and DHS to explore the use of existing federal IT infrastructures, such as the Veterans Administration, Tricare and HHS, with non-governmental networks, such as Internet2 and SureScripts-RxHub, to create a nationwide notification network for extreme disasters. This project should build upon the CDC's Public Health Information Network by including organizations and individual healthcare providers beyond public health.
- 7. Open-source technology.** Promote the use of open-source technologies and collaborations in RFIs or RFPs for taxpayer-funded health infrastructure initiatives. Any developed software created using federal funds should be "owned" by the public and contributed back to open source communities on commercially reasonable terms in accordance with Open Source Initiative approved licenses.
- 8. Coordination.** Coordinate the implementation of ICD-10 diagnosis/procedure codes and HIPAA 5010 transaction codes with the National eHealth Collaborative, HITSP, and other entities. Modernizing this information is crucial to gathering more precise data for reporting and comparative effectiveness, but their implementation must be orderly, organized, and coordinated among all parties, both public and private.
- 9. Administrative simplification.** Migrate all providers to electronic processes for administration, including eligibility verification, claims status inquiry, claims remittance, and electronic payment. CMS must lead by making a real investment in its own electronic processes, followed by rewarding and then requiring their use for all government health programs.
- 10. Innovation.** Invest in promising state and local health information exchanges that are replicable and self-sustaining. Leverage innovation and technology to make healthcare delivery easier and to reduce healthcare costs for all healthcare stakeholders.

Top Ten Action Items to Reduce Fraud and Abuse

- 1. Posting all Medicare and Medicaid claims data online for public access as close to real time as possible.** Currently, the financial accounting and health outcomes of Medicaid are incredibly opaque. Posting *patient-protected, de-identified* claims would reveal billing and practice patterns for all participating providers in both programs, laying bare for all Americans, particularly academic institutions and researchers, the extreme outliers who are likely engaged in fraudulent behavior. Excellent studies such as the Dartmouth Health Atlas show the helpful and even lifesaving information can come from public data. Additionally, transparency would drive quality improvements by shining a spotlight on best practices and providers. For instance, what percentage of poor women over 50 in Medicaid are getting mammograms? (Only 17% in one state.) What percentage of children are getting well child check ups? (Typically less than 50%.)
- 2. Stop using Social Security numbers as each senior's Medicare Beneficiary Identifier.** The Federal Trade Commission tells Americans, "Protect your Social Security Number – do not carry it in your wallet or write it on checks." But on the back of every Medicare card, which includes seniors' Social Security number it says, "Carry this card with you when you are away from home." Having this vital information so prominent makes fraud and identity theft much easier for criminals.
- 3. Fully fund the HHS Office of the Inspector General.** Current temporary funding streams under the Medicaid Integrity Program end at the conclusion of FY 2010 so staff reductions via attrition are already underway. HHS must be given the means necessary to be impactful in combating fraud and abuse.
- 4. Follow MedPAC's recommendation and move Medicare to a program where there is risk adjustment and payment for sticking with best practices and professionally recognized standards of care.** This incentivizes identification of overpayment and recovery.
- 5. Require enhance coordination of benefits and third party liability identification.** California could find huge savings in overall Medicaid costs by simply being more accurate with identifying patients' primary source of insurance. A sizable minority is actually already covered by private insurance, though Medicaid is footing the bill. One insurer recently analyzed Medi-Cal claims coming through its company and found \$250 million in claims to Medicaid when other insurance had been *volunteered* by both the patient and the provider. This is a 1 percent savings, just on volunteered information. Further attention would undoubtedly yield even greater abuse.
- 6. Require enhanced use of electronic remittances/electronic fund transfers for accuracy to and from providers.** Not only does this save on paper postage, but it increases accuracy and timeliness of payments.
- 7. Aggressively utilize predictive modeling for payments.** These technologies catch outlier billing practices before payments are even made. This moves Medicaid way from the "pay and chase" model that criminals loves.

8. **Require biometric identification for Medicaid patients to access provider treatment.** Texas is currently expanding a pilot program that gives Medicaid recipients a plastic card, encoded with eligibility and identity information required by providers. Beneficiaries scan the card and his/her fingerprint at the doctor's office. The system compares readers and verifies the person's identity in seconds. This "smart card" reduces costs, particularly the reduction in mailing paper cards, and protects client information.
9. **Ensure that providers and suppliers meet government standards, and enforce removal from the system of those who do not.** This is particularly a problem in Medicare, as fraudulent durable medical equipment suppliers claimed more than \$1.0 billion in improper payments in just over a year. In addition, it should be ensured that doctors who lose Medicare/Medicaid billing privileges in one particular state must be unable to bill in another.
10. **Emulate best practices in billing and anti-fraud efforts from the credit card industry.** Fraud programs are most effective when they are composed of measures for prevention, detection and mitigation, which requires a number of efforts in each phase of the point of interaction and the payment lifecycle: from Participant participation (e.g. account opening) through authentication and authorization for a transaction to application of back office analysis and customer service.

The necessary component in the Network is a regulatory body – a "Healthcare Network Authority" or HNA. For all Participants in the Network, the HNA's mandate would be to administer regulations, define standards, settle financial accounts, arbitrate discrepancies and assess fines and penalties within the legislative framework that places the importance of the Healthcare System above any Participant or groups of Participants.

- a. **Standards** - The Network must be compatible based on open data format, content standards and definitions for Participants. Compatibility must be enforced (e.g. through financial incentives and penalties).
- b. **Know Your Customer (and Vendor/Supplier)** - Network participation for all Participants is only allowed after initial vetting to ensure proper credentials, soundness and capabilities exist. Ongoing participation is re-assessed both in "real time" and ad-hoc. (For example, a provider's billing volume and/or billing type does not materially exceed established norms for the provider on a daily, weekly or monthly basis.)
- c. **Decentralized Financial Liabilities** - Liabilities are "pushed" down to the lowest level of Participant in the system. In the event the instigator is not financially solvent or cannot be located, the next higher level above the instigator is liable.
- d. **Authenticate and Authorize** - Beginning with each point of interaction, Participants in the process must be uniquely identified and authenticated and provisioning of services must be authorized in real time. The intent would be to monitor activity real time and create an electronic audit trail for transaction traceability and potential payment revocability.
- e. **Carrots & Sticks** - The HNA would use reimbursement rates, pricing, penalties and/or payment terms to incent Participant behavior for not only compliance but to continually enhance and enrich the Network to identify and tackle new forms of fraud, waste, abuse and administrative cost.
- f. **Self-Policing but Enforced** - The HNA would be the option of last resort to resolve disputes between Participants.

Top Ten Shocking Fraud Examples

1. Improper payments - According to a January 2009 GAO report, improper payments to providers that submit inappropriate claims can result in substantial financial losses to states and the federal government. Medicaid payments can be improper for various reasons, such as if people served are not eligible for Medicaid. Measuring improper payments within the Medicaid program is important to recouping and reducing them. For fiscal year 2007, CMS issued its first full-year Medicaid improper payment rate estimate of 10.5 percent, or \$32.7 billion (the federal share is \$18.6 billion). Identifying and reducing improper payments in Medicaid are important first steps toward improving the integrity of the program.¹

2. Deceased Doctors - The Senate Permanent Subcommittee on Investigations recently reviewed Medicare claims from 2000-2007 and found significant payments for medical services ordered by over 16,500 dead doctors – between \$60 million to \$92 million. Some doctors had been deceased for more than 10 years.²

3. Sham Companies - The U.S. Government Accountability Office found that almost \$1 billion of \$10 billion in annual Medicare payments made for durable medical equipment (DME) is improper. GAO highlighted this lack of federal oversight by setting up two fictitious DME supplier companies with no clients or medical inventory to supply to patients, both of which were nonetheless approved by CMS for Medicare billing privileges.³

- A specific individual, after stealing beneficiary numbers and physician identification numbers, submitted \$5.5 million in claims for three fraudulent offices.

4. Abusing Homeless - Facilities in southern California allegedly churned thousands of indigents through their sites and billed Medicare and Medi-Cal for costly and unjustified medical procedures. These facilities ran street-level operations, where runners collected indigents for unnecessary hospital services, and dropped them back off on skid row by ambulance.⁴

5. False claims for HIV Drugs – In southern Florida, dozens of clinics and doctors billed Medicare for more than \$1.1 million in false claims for obsolete HIV-infusion therapy for a *single* Miami-Dade County patient, who then collected thousands of dollars in kickbacks for selling his government-issued healthcare number to them. The patient then used the money to buy crack cocaine.⁵ In fact, in 2007, Florida accounted for 80% of drugs billed across the entire United States for Medicare beneficiaries with HIV/AIDS, even though the region only had about one of 10 eligible patients.⁶

¹ GAO, “High-Risk Series – An Update,” January 2009

² Senate Permanent Subcommittee on Investigations Press Release, “Coleman, Levin Investigate Millions in Medicare Payments for Claims Tied to Deceased Doctors,” July 8, 2008

³ GAO, “Covert Testing Exposes Weaknesses in the Durable Medical Equipment Supplier Screening Process,” July 2008

⁴ LA Times, “3 Southern California hospitals accused of using homeless for fraud,” August 7, 2008

⁵ Miami Herald, “Congress tight with Medicare anti-fraud funds,” August 11, 2008

⁶ Reuters, “Fraud and Florida’s Multimillion-Dollar Wheelchair,” October 22, 2007

6. Goods Never Received - A recent enforcement effort in Miami led to charges against 120 people and a corresponding \$1.4 billion drop in Medicare billing in the area. Federal officials pointed to a red electric wheelchair seized from an illicit company. The wheelchair should cost about \$5,000; by billing Medicare over and over, while never delivering the wheelchair to an actual patient, criminals charged \$5 million for this one item alone. A retired federal judge also got notice from Medicare explaining a recent treatment he had received, including two prosthetic arms. FBI agents came to his house to take pictures of his real arms to prove that they had not, in fact, been amputated. No cross-checks had been made within Medicare to verify whether the patient actually had amputations performed.⁷

7. Stolen Medicare ID – An 82-year-old patient had her Medicare ID stolen. Fake providers then used that number to bill Medicare for tens of thousands of dollars – for care and equipment she never got and didn't need – including AIDS medicine, a wheelchair, and artificial knees, ankles, and an eye. The patient complained to authorities on several occasions, but no prosecutions were ever made.⁸

8. Incomplete Claims – Investigators from the Senate Permanent Subcommittee on Investigations found that, between 1995 and 2006, \$4.8 billion in Medicare payments were made for bills submitted with diagnosis codes that were invalid or blank. Some used smiley faces or exclamation points, but the bills were still paid.⁹

9. Inappropriate Treatments – The Senate Permanent Subcommittee on Investigations reviewed bills submitted by medical suppliers from 2001 through 2006 and found over \$1 billion in questionable claims. For example, there were hundreds of thousands of claims for diabetes-related glucose test strips for patients who were diagnosed with the bubonic plague, leprosy and cholera. Their study also found walkers being issued and claimed for patients whose diagnosis codes included sinus congestion, paraplegia and shoulder injuries.¹⁰

10. One State Alone - In 2005, the New York Times estimated that NY Medicaid fraud reached into the tens of billions.¹¹ Some specific cases:

- A Brooklyn dentist “performed” as many as 991 procedures in a single day
- School officials enrolled tens of thousands of low-income students in speech therapy without the required evaluation, garnering more than \$1 billion in questionable Medicaid payments. One school official sent 4,434 students into speech therapy in a single day.
- Several criminal rings duped Medicaid into paying for an expensive muscle-building drug intended for AIDS patients, which was diverted to bodybuilders at the cost of tens of millions.

Please submit examples of healthcare fraud, including news articles or personal experiences, to fraud@healthtransformation.net.

⁷ NBC News, “Blatant Medicare Fraud Costs Taxpayers Billions,” December 11, 2007

⁸ NBC News, “Criminals Find Medicare Easy to Defraud,” December 12, 2007

⁹ USA Today, “Report: Medicare Spending Billions on Suspicious Claims,” September 25, 2008

¹⁰ USA Today, “Report: Medicare Spending Billions on Suspicious Claims,” September 25, 2008

¹¹ New York Times, “New York Medicaid Fraud May Reach Into Billions,” July 18, 2005

“Be Like Ike as a Healer: Four Healthcare Lessons”

By Newt Gingrich

New York Post – January 16, 2009

PRESIDENT-ELECT Obama has shown that he is not afraid to tackle the nation's toughest problems head on. One of the most pressing and intractable is to drag America's health system out of the Stone Age and into the 21st century through information technology.

The president-elect should be applauded for making this vital priority a key part of his economic stimulus plan, but more importantly, as the starting point of his health reform agenda. Last week he pledged, "We will make the immediate investments necessary to ensure that within five years, all of America's medical records are computerized."

Now comes the hard part: succeeding.

The president-elect should look to his predecessors for guidance, as he is not the first to take on such a massive challenge. He should look no further than President Dwight D. Eisenhower.

Eisenhower faced virtually the same problem in the mid-20th century when he envisioned a nationwide interstate highway system. That creation, which now bears his name, remains one of the most important and significant accomplishments in American history. While such a system had long been a dream, it was Eisenhower who made it a reality when he proposed and then signed the Federal Aid Highway Act, beginning the construction of more than 41,000 miles of interstate highways.

Eisenhower's leadership created a wave of productivity and prosperity that we continue to ride today. It opened new markets, created a national sense of community, brought the modern world to rural America, enabled families to move and vacation over long distances and drove innovation from coast to coast. The total sum of benefits, both economic and social, is enormous.

Prior to the highway system, Eisenhower described the nation's roads as "an appalling problem of waste, danger and death." This is an apt description of our health-care system today.

Using manual, paper-based processes that are more akin to Eisenhower's era than today's modern world, health care is the largest and most antiquated part of our economy.

A scant 4 percent of physicians use advanced electronic medical records, despite irrefutable evidence and experience that information technology saves lives and saves money.

We can change this if we apply four critical lessons from Eisenhower.

* First, make a significant financial commitment. In 1956, Congress appropriated \$25 billion for highway construction, which was a vast sum of money, considering that total federal spending in 1956 was \$70 billion. Hundreds of billions of dollars were eventually spent, making it one of the nation's highest priorities.

Obama has proposed spending \$50 billion over five years on getting information technology into the hands of doctors and providers. It will take many years to build a nationwide system, but this commitment is more than any other policymaker has pledged. Congress is working to include a down-payment on that promise in the current economic stimulus package.

* Second, ensure that we create an interconnected system. One of the most important components of the highway system was its adherence to uniform standards of construction. This avoided each state building their own highways with their own unique specifications.

Health care runs a similar risk. If billions are spent to equip doctors and hospitals with technology that cannot communicate with each other, we will have laid a lot of track that doesn't connect. Existing efforts to finalize technology standards should be strengthened, and this should be coupled with a requirement that any system purchased with federal dollars must be certified and adhere to these standards.

* Third, create a true collaboration between the private sector, states and the federal government. Even though the federal government paid 90 percent of the costs of building the highway system, the states were responsible for managing the construction and the private sector did the actual work.

A similar approach would work in health IT. Many states are already working with technology companies to connect their health-care communities. Presidential leadership and federal dollars would speed the process.

* Lastly, guarantee long-term funding streams. The interstate highway system was funded by the Highway Trust Fund, providing steady, long-term funding.

Obama's \$50 billion pledge for health IT should be viewed as a transformational down payment. Long-term financing must come by fundamentally changing the way we pay for health-care services. Incentivizing the use of technology, an approach that the Congress used last year by providing financial incentives to doctors who use electronic prescribing tools rather than a prescription pad, should ultimately give way to paying for better quality care, not just a larger quantity of services.

Moving health care into the 21st century is the first step to transforming the system; one that provides every single American more choices of greater quality at lower cost. President Eisenhower showed us a model of success. President-elect Obama can apply these lessons from the past, so we can build this brighter future.

Wayne Sensor, CEO of Alegent Health
Testimony to House Ways and Means Health Subcommittee
May 14, 2008

Good morning Mr. Chairman and thank you for the opportunity to give a brief overview of Alegent Health's experiences with consumer-driven health care. While I recognize that many of you have concerns about high-deductible plans, I would submit that we've had tremendous success with our plans because of the benefits we've wrapped around our HRA and HSA vehicles. And, because we are both an employer and provider of care, I believe we have a unique story to tell. I ask that my full statement be entered into the record.

Alegent Health is a faith-based, not-for-profit health care system that serves eastern Nebraska and western Iowa. Our 9,000 employees and 1,300 physicians are proud of the care we provide in our 9 hospitals and more than 100 sites of service. Each year we serve more than 310,000 patients.

In fact, Alegent Health is the largest non-governmental employer in Nebraska. And we have a very powerful story to tell about the benefits of consumer driven health care and are positioned very distinctively in the ongoing debate.

Alegent Health's story begins in 2004. I was the newly-appointed CEO for Alegent Health, and along with the senior leadership team, we recognized that troubling industry-wide trends were beginning to threaten our ability to carry out our critical mission. Rapid escalation in the number of uninsured patients, unsustainable increases in the cost of health care and other concerning trends were undermining the accessibility, quality and affordability of health care.

Armed with this information, the Alegent Health leadership team embarked on an effort to better understand the forces behind this gathering storm in health care and develop lasting solutions. The result was a fundamental change in thinking about the roles and responsibilities of both health care providers and consumers. We at Alegent Health recognized that to overcome problems clouding the future of the industry, the process of delivering health care at the local level could no longer be business as usual.

In examining the issues facing the health care industry, we soon recognized that the very nature of the third-party payor system was a significant contributor to the problems. By shifting payment responsibilities from patients to insurers, the incentive for patients to analyze the value of care they received had all but disappeared. Even more significantly, the tools that would allow consumers to compare health care quality and cost were virtually non-existent.

To begin changing this dynamic, we drew upon our new strategic plan, known as the Quality Revolution. Our vision is to become a world-class leader in health care by measurably enriching the lives of families we serve through an exceptional commitment to quality. Our strategic plan includes an objective to put consumers at the center of the health care equation by empowering them to take charge of their own health and make informed decisions.

We began our journey to greater consumer involvement in health care when we made a commitment to begin empowering consumers. In early 2005, we began to explore how a health care program could improve the lives of employees and their families while offering sustainable business solutions. The research exposed widespread frustration over the existing benefits package, but also raised concerns that employees would view consumer-driven health care as a reduction in benefits. Elsewhere, consumer-driven plans were already beginning to earn a reputation as a means of cost shifting from employers to employees.

To counter these perceptions, we engaged nationally known health plan designers Watson Wyatt and Lumenos, a leading provider of consumer-driven health plans. We spent a year designing our consumer directed health plans and communicating with our employees what the change would mean to them.

The results have been exceptional:

- As we enter our third plan year, 92 percent of employees who choose our health care benefits have enrolled in either an HSA or HRA plan.
- It is important to note that we did not force employees into a consumer directed health plan. We continue to offer a PPO for employees.

Furthermore, communication was key to the process. We wrapped our innovative plans in robust, ongoing, multi-channel communication and education for our employees, answering their questions, working with them one-on-one, hosting conference calls and benefits fairs and developing Web modeling tools. The effort was critical to share our vision that the consumer-driven plans were about employee health – and not our bottom line. We never intended to save money with our new plans; instead we hoped to slow the growth of future increases in cost.

In pioneering the new benefit plan, Alegant identified three overriding areas where we knew as an employer and provider we could tremendously advance consumer directed health care. The areas are:

- Incentives to encourage preventive care, lifestyle change and management of chronic health conditions
- Tools to make informed decisions in the form of meaningful cost and quality information;
- Access points for care that are innovative, convenient and cost-effective

Incentives for Preventive Care/Lifestyle Change/Chronic Disease Management

HRAs and HSAs are valuable vehicles, but in my view it's what you wrap around those vehicles that make a powerful difference.

There are two important constructs in Alegant Health's consumer driven plans. First, preventative care is free. This ranges from services like annual physicals, and mammographies to childhood immunizations and colonoscopies. If it is preventative, it is free.

And second, through an innovative "Healthy Rewards" program, we pay people to make positive changes in their lifestyles, or to better manage their chronic conditions. And, we offer that assistance free of charge – free weight loss counseling, smoking cessation programs and chronic disease management. For those who need a little extra support, we offer free personal health coaches. If an employee quits smoking, takes a personal health assessment, loses weight or makes other positive changes that affect their lifestyle, Alegant Health deposits money directly into their health savings account.

Tools to Facilitate Cost and Quality Transparency

Giving our employees more control required us to make dramatic changes.

First and foremost, we created tools to provide meaningful and relevant cost and quality information. What other good or service do people purchase in this country without knowing how good it is and how much it costs?

In September 2005, well before we were required to do so by law, we began publicly reporting our quality data and, using a composite scoring methodology, shared our performance in the care of heart attacks, heart failure and pneumonia. At that time, our scores were not always the

highest. However, our focus on transparency drove us to raise the bar on quality and sent our scores increasingly higher.

- Our quality reporting goes well beyond Hospital Quality Alliance’s 21 measures. We currently report 30 measures – the CMS 20 and 10 SCIP measures. We will be adding an additional 10 stroke measures beginning July 1 this year.
- To give these scores some context we show how Alegant Health compares to our regional competitors as well as the premier institutions’ like the Mayo Clinic, Cleveland Clinical, and Johns Hopkins.

I’m proud to report our quality is as good as or better than our local competitors and the elite facilities mentioned.

Transparency is a difference maker!

Composite Scores

	AMI	HF	PN	Overall
2005	96%	79%	87%	88%
2007	99%	98%	99%	99%

We didn’t stop by just sharing quality information. In January 2007, we introduced a cost estimating tool – My Cost – which is the first of its kind in the world.

Alegant Health’s approach to cost transparency is even more customized for the consumer. This on-line tool called My Cost provides consumers with the information they need, based on their individual health plan or personal financial situation. It determines the specific costs of the procedure or test to individuals, along with their out-of-pocket costs for more than 500 common medical tests and procedures.

By working with a third party insurance database, My Cost is able to verify insurance policies, deductibles, and provide patients an extremely accurate price estimate on more than 500 medical tests and procedures. In 16 months it has provided nearly 35,000 individuals – employees and members of our community – with estimated cost and out-of-pocket responsibilities for medical services.

As the CEO of a health care provider, I understand the arguments against providing transparency on cost and quality and I reject them. Alegant Health is proof that you can share cost and quality information and not only be competitive, but excel in your marketplace.

Access

Finally, Alegant Health believes it necessary to give consumers more choice in how they access our services. We must follow the lead of nearly every other industry that has told consumers they can “have it their way.” We must radically alter our thinking about where care can and should be provided. While we will always need hospitals to care for the most critically ill, we must continue to pioneer new access points for patients, offering convenient, cost-effective care.

With an emerging retail strategy that offers consumers walk-in clinics located in grocery stores, we have worked with our physician staff to create clinics that offer families easily accessible, low cost and medically sound care for basic illnesses.

Here's how it works: the clinic is open from 9 a.m. to 7:30 p.m. Monday through Friday and from 10 a.m. to 3 p.m. on weekends and holidays. A patient signs in at the Alegant Health Quick Care office and waits his or her turn. In keeping with the streamlined service, the cost for each service is posted at the clinic where cash, checks and credit cards are accepted for payment. Prices range from \$25 to \$53 depending on the service. Our patients love it. It's quick. It's convenient. They know exactly what they are going to pay.

- One exceptional benefit to these clinics is that we found 16% of customers who visit the clinics are uninsured patients who otherwise might have forgone care or waited until the ear ache or sore throat required a trip to the emergency room.

In addition to our convenient Quick Care clinics, we are implementing innovative, more comprehensive solutions to healthcare through our retail strategy.

Our first storefront – Complete Sleep & More – offers a line of leading-edge products designed to improve the quality of sleep through traditional clinical methods and lifestyle enhancements. A second component of our retail strategy includes expanding our already well-respected pharmacy services to our patients and physicians in a way that provides a superior customer experience, differentiates ourselves from “chain” pharmacies and creates deeper patient loyalty.

Results

We now have results from our first two years of consumer-driven health plans for our employees, and we are astounded at the results. Over our first two years, we saw an average increase in our healthcare costs of just 5.1%, despite industry trends in the 10-15% range. Moreover, our employees are healthier.

- Nearly 7% of Alegant Health's health care dollar is spent on prevention, compared to the national average of 2.5%.
- Forty percent of employees participated in an electronic health checkup program, each earning \$100 for their efforts.
- Alegant Health identified 15% of employees who could benefit from personal health coaches. Of these, 3.3 percent enrolled in the program, and 91% of them have graduated successfully, earning financial incentives up to \$500.
- More than 500 health plan participants successfully completed smoking cessation programs.
- Participants in our weight loss programs have lost nearly 13,000 pounds.

When we implemented the health plans on January 1, 2006, Alegant Health's leadership pledged that if employees could achieve a collective improvement in health and slow rapidly rising costs, some of the savings would be returned to them. After the first plan year, Alegant Health did, in fact, return \$700,000 in the form of \$100 rebates to every employee in the health plans because of the significant cost savings achieved. It was a way for Alegant to reinforce that we did not move to a consumer directed model to save money “on employees' backs”, rather we made the transition because we believe it is the model that will dramatically alter how we Americans think about and consume health care.

Digging a bit deeper into results from our two HSA plans – those we would consider pure consumer-driven plans – there is a significantly higher level of engagement among those participants and the results are event greater.

- They consume more preventive care than any other plan we offer.
- More than 45% of HSA participants completed their health risk assessments, compared to just 16 % in our PPO plan.

- Nearly 65% of pharmacy prescriptions for HSA participants were filled with generic drugs, compared to 56% in the PPO plan.

This level of engagement clearly has significant implications for the health of these employees. We have seen a dramatic decrease in costs. From 2006 to 2007, the cost trend in our two HSA plans declined a full 15%!

And, to those who say people are putting off care or not adequately preparing for a future healthcare need, we can refute that as well.

- One hundred twenty employees who make less than \$25,000 have chosen an HSA plan; only 97 employees who make more than \$100,000 have chosen an HSA plan.
- More than 80 percent of our employees in the HSA plans made regular contributions to their HSAs, and 32% have fully funded their deductibles.
- Perhaps most impressive is the fact that our lower wage earning employees -- those who make less than \$25,000 per --year contributed an average of \$1400 to their HSAs last year.

Alegent Health's commitment to innovation and to empowering consumers to make informed health care decisions calls for us to look beyond the region in which we operate and offer our expertise to providers from across the country. We believe inviting consumers into the decision process about their health care will dramatically improve health care quality and lower costs. We have proven this with our own workforce and the people we serve and we want to share our roadmap to price and quality transparency.

Alegent Health has taken its learnings and offered to share them with other providers, in the hopes of accelerating consumer behaviors in health care. In January of this year, we hosted a not-for-profit educational forum designed to help other health care organizations develop the systems and policies to provide consumers the necessary information to make more informed decisions about their care. Using Alegent's own experiences with providing easily understood health care quality scores and personally relevant pricing information, the "Power to the Patient" forum shared Alegent's proprietary methodology and technology developments to the nine health care system that attended. In the future we hope to replicate this effort and continuing sharing our success with any interested parties that chose to attend...

These results we have offered are proof that given the benefit plan, tools and incentives, people can AND DO make informed health care decisions that improve their health and lower their costs. Alegent Health believes in consumer-directed health care and we are happy to have shared with you these tangible examples of how these constructs can and do work just as we have shared them with other interested parties across the country.

Thank you.