

Appendix E: Health Care Presentations

Invited experts, stakeholders, and citizens have given presentations to the Citizens' Health Care Working Group on a wide array of health care subjects. What follows is a list of those presentations, organized chronologically in order of presentation to the Working Group.

Underlined text denotes a link to an electronic document on our website that contains the presentation, biographical information, or meeting summary.

Wednesday, May 11, 2005; Crystal City, VA

Overview of the American Health Care System

- ["America's Thinning Social Contract," John Iglehart](#), Project Hope. (See summary for [5/11/2005](#).) Provides description of American health care system and health expenditures. Asserts that the United States provides a lower rate of health care coverage than other industrialized countries. Many of the uninsured are employed full time. Health care expenditure growth has been outstripping the rates of increase in wages and non health expenditures. Among 30 countries belonging to the Organization for Economic Development and Cooperation, tax receipts are lowest in the United States, but our expenditures for health care are highest.

Public Insurance Programs: Medicare, Medicaid and SCHIP

- ["Overview of Medicare, Medicaid and State Children's Health Insurance Program," Bill Scanlon](#), Health Policy R&D. (See summary for [5/11/2005](#).) Describes the three major publicly-funded federal and state health care financing programs.

The Uninsured

- ["The Uninsured in America," Peter Cunningham](#), Center for Studying Health System Change. (See summary for [5/11/2005](#).) Provides fundamental background information about the uninsured in America and the difficulties in addressing their needs.

Thursday, May 12, 2005; Crystal City, VA

Private Health Insurance: Employer-Based Insurance and the Individual Market

- ["Employment-Based Health Benefits Among Mid-Sized and Large Employers," Paul Fronstin](#), Employee Benefit Research Institute. (See summary for [5/12/2005](#).) Describes the status of employer-sponsored health insurance and changes taking place that are weakening this form of coverage.
- ["Small-Group and Individual Coverage," Deborah Chollet](#), Mathematica Policy Research. (See summary for [5/12/2005](#).) Describes features of the small group and individual insurance markets

Public Sector Initiatives to Expand Coverage

- ["State Strategies To Expand or Maintain Health Care Coverage," Linda Bilheimer](#), Robert Wood Johnson Foundation. (See summary for [5/12/2005](#).) Identifies numerous state initiatives in process or under consideration tailored to expand or maintain coverage and to constrain costs in State Medicaid programs.
- *National Governors' Association (NGA) Reform Proposal*, [Matt Salo](#), NGA (See summary for [5/12/2005](#).) Describes challenges facing state Medicaid programs from the perspective of the

States and offers some suggestions for change, such as updating federal cost sharing rules, which have not been changed since 1982.

- [“Communities in Charge: Financing and Delivering Health Care to the Uninsured: Lessons from Community-Based Initiatives to Expand Coverage and Improve Care Delivery,” Terry Stoller, Medimetrix.](#) (See summary for [5/12/2005](#).) Describes a four-year Robert Wood Johnson Foundation-funded effort to develop comprehensive community-based health care services for the uninsured and the underinsured.

Private Sector Initiatives to Expand Coverage

- [“National Health Access,” Ken Sperling, CIGNA.](#) (See summary for [5/12/2005](#).) Describes an initiative promoted by the Human Resources Policy Association to address the health care coverage needs of the working uninsured; an effort scheduled to be implemented in 2005 at many U.S. corporations.
- [“Private Initiatives to Expand Coverage,” Anthony Tersigni, Ascension Health.](#) (See summary for [5/12/2005](#).) Describes Ascension Health’s efforts to improve health care for underserved members of their communities, including underlying principles and a model for change at the community level. Includes description of some efforts in communities where Ascension Health facilities are located.

Friday, May 13, 2005; Crystal City, VA

Health Care Costs

- [“Building the Foundation: Health Care Costs,” Jennifer Jenson, Congressional Research Service.](#) (See summary for [5/13/2005](#).) Provides a broad overview of the large issues and fiscal facts regarding health care in the United States and the relative roles of government and the private sector.
- [“National Health Expenditure Accounts,” Rick Foster and Stephen Heffler, Centers for Medicare and Medicaid Services.](#) (See summary for [5/13/2005](#).) Reviews the continuing growth in national health care expenditures in absolute value terms and as a proportion of all national expenditures.

Public Sector Initiatives to Control Costs

- [“Controlling Costs in Medicare,” Jack Hoadley, Georgetown University.](#) (See summary for [5/13/2005](#).) Describes ways in which Medicare currently constrains costs and additional options for the future, which include adjustments to the payment system, innovative approaches to purchasing services in the fee-for-service market, and increased enrollment in managed care.
- [“Public Sector Initiatives To Control Costs: Medicaid,” Jim Verdier, Mathematica Policy Research.](#) (See summary for [5/13/2005](#).) Describes major direct cost control mechanisms including: limiting eligibility or benefits covered, increasing copayments and deductibles, implementing disease management programs, instituting mechanisms for controlling pharmacy costs, and limiting possibility of fraud.
- [“Public Sector Initiatives to Control Costs: The State Children’s Health Insurance Program,” Genevieve Kenney, Urban Institute.](#) (See summary for [5/13/2005](#).) Describes some methods that states have used to constrain costs under the program, including enrollment caps and eligibility cutbacks, premium increases, and reduced outreach efforts.

Private Sector Initiatives to Control Costs

- [“Private Sector Initiatives to Control Costs Presentation to Citizens’ Health Care Working Group,” Alice Rosenblatt, WellPoint.](#) (See summary for [5/13/2005](#).) Describes WellPoint’s initiatives to

control costs and provide better information to its health care consumers. Also describes WellPoint's Pay for Performance, pharmacy management, and behavioral health initiatives.

- "[Private Sector Initiatives: Controlling Costs and Empowering Consumers](#)," [Helen Darling](#), Washington Business Group on Health. (See summary for [5/13/2005](#).) Describes employers' efforts to address the growing unsustainability of health care costs, including the introduction and implementation of decision support systems, chronic care management, quality and patient safety efforts, and Health Savings Accounts.

Wednesday, June 8, 2005; Jackson, MS

Access, Safety Net, Health Disparities

- *Rural Health Disparities*, Dr. [Dan Jones](#), Dean and Vice Chancellor, University of Mississippi Medical Center. (See summary for [6/8/2005](#).) Describes the problem of health disparities in the United States, especially for the poor, and how limited access to care is a major cause of this problem. Describes impact of uninsured on his facility and the financial challenges institutions like his face.
- *Mississippi Health Shortages*, [Roy Mitchell](#), Executive Director, Mississippi Health Advocacy Program (See summary for [6/8/2005](#).) Describes widespread uninsured and under-served rural public health conditions, the significant adverse impact any reductions in Medicaid or SCHIP would have on the poor, and the importance of improving the health care safety net in Mississippi.
- *Prevention and Insurance Needed*, Dr. Herman Taylor, Director of the Jackson Heart Study, University of Mississippi Medical Center (6/8/2005.) (See summary for [6/8/2005](#).) Illustrates racial/ethnic health care disparities for cardiovascular disease and other health conditions. He argues for access to preventive care for the nation's 46 million uninsured to lessen "downstream" adverse impacts.

The Reality of Being Uninsured

- *Employer Exclusions and Health Care Needs*, Georgia Rucker. (See summary for [6/8/2005](#).) Narrates personal story of struggling with health care problems and an employer who enforced a restrictive employment clause to deny health care insurance coverage. Ms. Rucker is currently dependent on her family and church for support.
- *Experiencing Uninsured Status*, Richard Dye. (See summary for [6/8/2005](#).) Describes his personal experience of being uninsured and how the help of family and friends sustained him.

Local Access Initiatives

- *Coverage Plans for Small Employers*, Bill Croswell, Chamber Plus, Metro Jackson Chamber of Commerce. (See summary for [6/8/2005](#).) Describes activities of Chamber Plus, a subsidiary of the Chamber of Commerce formed in 1996 in response to the need for a health insurance product for employees of small businesses. Chamber Plus now provides group health insurance coverage for 20,000 employees of small firms in the greater Jackson area. Many other chambers of commerce in Mississippi have also adopted this product.
- "[Initiatives at the Community Health Center Level](#)," ([PDF version](#)) Dr. Janice Bacon, G.A. Carmichael Community Health Center. (See summary for [6/8/2005](#).) Briefly summarizes her work at a local community health center and the center's efforts to address chronic conditions such as asthma and diabetes.
- "[The Jackson Medical Mall Foundation](#)," Primus Wheeler, Executive Director, Jackson Medical Mall Foundation. (See summary for [6/8/2005](#).) Focuses on the key elements that allowed the establishment of a central health care facility to work in Jackson, MS. A key factor was the collaboration and cooperation of many individuals who were held together by the shared vision

and active leadership of Dr. Aaron Shirley, an early advocate for and promoter of community health centers.

Friday, July 22, 2005; Salt Lake City, UT

Health Care Challenges: The Federal Perspective

- [“21st Century Health Care Challenges: Unsustainable Trends Necessitate Reforms to Control Spending and Improve Value,”](#) (as [PDF document](#)) [David M. Walker](#), Comptroller General of the United States. (See summary for [7/22/2005](#).) Explains the unsustainability of current cost trends in Medicare and Medicaid, which now represent the fastest growing components of the federal budget, the implications of these rising costs for the future of the federal budget, and potential areas of inquiry to address interrelated problems of cost, access, and quality.

Health Care Quality

- *Comments on “Crossing the Quality Chasm,”* [Donald M. Berwick](#), MD, MPP (by telephone), President and CEO, Institute for Healthcare Improvement. (See summary for [7/22/2005](#).) Describes the “quality chasm,” the gap between the health care quality we have and what we could have, and its six dimensions: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. To get to better quality, three areas must be addressed: emphasizing knowledge-based care, establishing patient-centered care, and enhancing cooperation.
- “Unwarranted Variations in Health Care,” [Part 1](#), [Part 2](#)”, [John E. Wennberg](#), M.D., M.P.H., Dartmouth Medical School. (See summary for [7/22/2005](#).) Describes the existence of geographic and institutional variations in the use of health care services that are unrelated to severity of illness or any demographic variations and that do not result in improved outcomes. Addressing these variations would have important consequences for health care costs and quality.

Health Information Technology Panel

- [“IT Session: Citizens' Health Care Working Group,”](#) [Stanley M. Huff](#), M.D. Senior Medical Informaticist, Intermountain Healthcare. (See summary for [7/22/2005](#).) Describes the clinical information system in use at Intermountain, an integrated health care system in Utah, lessons learned from use of this system and potential directions for future work in health information technology.
- *“Information Technology in Service of Health Care Providers,”* [Eric Pan](#), M.D., Internist, Center for Information Technology Leadership (See summary for [7/22/2005](#).) Presents findings from a study “The Value of Health Care Information Exchange and Interoperability,” including estimates of annual potential cost savings of \$77 billion to the nation’s health care system from the standardization of health care information exchange.
- [“Health Information Technology,”](#) [Scott Williams](#), M.D., Vice President for Health Affairs, HealthInsight, the Quality Improvement Organization (QIO) for Utah and Nevada. (See summary for [7/22/2005](#).) Describes the key components of health information technology (electronic medical records, health information exchange, and clinical support for decision-making); lays out many of the issues related to the provider level business case for implementing different forms of health information technology and explores potential federal roles in health information technology.

Employer/Employee Initiatives

- [“Purchasers' Path to Promoting Higher Value in Health Care,”](#) [Peter Lee](#), Pacific Business Group on Health. (See summary for [7/22/2005](#).) Explains how cost increases and issues of quality can be addressed by purchasers through better information, evaluation, and financial incentives for

both consumers and providers. Examples include consumer support for hospital choice and provider pay for performance mechanisms.

- [“Transforming the Health Insurance Delivery Business Model – A Labor-Management Initiative to Manage Care and Targeting Quality,”](#) David Blitzstein, United Food and Commercial Workers International Union. (See summary for [7/22/2005](#).) Describes how improved information collection systems, analysis of costs and outcomes, and making information and results of value analyses available to individuals and organizations can support improved health care service selection.
- [“Controlling Healthcare Costs A New Approach,”](#) Elizabeth Gilbertson, Hotel Employees and Restaurant Employees International Union Welfare Fund. (See summary for [7/22/2005](#).) Explains how her organization, working in the context of an extended health care network (with 1,800 physicians), monitors physician cost and care patterns and how such monitoring can lead to reduced costs, better quality of care, maintaining benefit levels, and higher wages.

Tuesday, July 26, 2005; Houston, TX

Hispanic Health Issues

- [“Health Disparities,”](#) Adela S. Valdez, MD, Valley Baptist Health System. ([PowerPoint slides](#)) (See summary for [7/26/2005](#).) Describes high levels of uninsurance among Hispanics in Texas and the need for more investment in tobacco cessation, nutrition, and encouraging physical activity. The last two health behaviors are especially relevant to reducing the negative consequences of diabetes and obesity. Hispanics have disproportionately high rates of diabetes. In 2004 five of the nation’s “fattest” cities were in Texas. She advocated for increased investments in education as the single most important thing to do to reduce health disparities.
- [“Hispanic Health and Health Care Issues in Texas and the United States,”](#) Karl Eschbach, University of Texas Medical Branch at Galveston. (See summary for [7/26/2005](#).) Describes Hispanic population trends in the United States and Texas and presents the “Hispanic paradox,” a finding of low age-specific mortality rates for the Hispanic population of the United States compared to the non-Hispanic white population, despite the socioeconomic disadvantages of Hispanics. Hispanics have lower heart disease and cancer mortality; and birth outcomes are similar to whites. The Hispanic “advantage” is larger for immigrants than it is for natives and may be attributed to better health habits and selective migration.

Rural Health

- [“Rural and Community Health in Texas,”](#) Patti Patterson, Vice President for Rural and Community Health, Texas Tech University Health Sciences Center, Lubbock. (See summary for [7/26/2005](#).) Describes the realities of large distances in rural Texas and the added difficulties that this introduces when trying to assure that individuals have the health care services they need, or that their health doesn’t suffer directly from their isolation. She also describes strategies for recruiting and retaining health care providers in rural areas.
- [“Fast Facts About Rural Texas,”](#) (PDF document) Ernest R. Parisi, Administrator and Chief Executive Officer, East Texas Medical Center, Quitman. (See summary for [7/26/2005](#).) Describes the challenges of operating a small hospital and local community health network in rural Texas, their dependence upon major public health financing programs such as Medicare and Medicaid, and the impact of the uninsured on these facilities.
- [“Federally Qualified Health Centers,”](#) Rachel Gonzales-Hanson, Chief Executive Officer, Community Health Development, Inc., Uvalde (See summary for [7/26/2005](#).) Describes the critical role that community health centers play in the health safety net, the need for continued funding, and the increasing challenges they must address, especially in rural areas.

Long-Term Care, Home and Community Options

- [“Long-Term Care: Care for Elders,”](#) Nancy Wilson, Huffington Center on Aging, Baylor College of Medicine. (See summary for [7/26/2005](#).) Describes key issues in long-term care, including lifetime risk, costs, the benefits of community versus institutional care, and other issues of concern. She also gave examples of community-based approaches to long-term care and noted that addressing long-term care needs will involve collaboration, strategic planning, and involvement of consumers, providers, and health agencies.
- [“Long-Term Care: A Community Based Approach,”](#) Lanette Gonzales, Sheltering Arms, Houston. (See summary for [7/26/2005](#).) Describes a community-based initiative in Houston, efforts they have made to recruit and retain staff, and the impact of demographic and other trends and their implications for the future.

Retiree Health Care

- [“Addressing the Growing Gap in Retiree Health Coverage,”](#) Paul Dennett, American Benefits Council. (See summary for [7/26/2005](#).) Describes the growing number of retirees without employer-sponsored health insurance and the growing percent of health care costs that retirees have to pay themselves. Recommends several actions, including improving care quality and lowering health care costs.
- [“Health Coverage in Retirement,”](#) Gerry Smolka, AARP. (See summary for [7/26/2005](#).) Describes trends in retirement and retirement health insurance coverage as well as the special problems faced by early retirees (i.e., those younger than 65) in finding and affording health insurance coverage.
- [“US Family Health Plan: Providing High Quality, Cost Effective Healthcare to Military Beneficiaries,”](#) Marshall Bolyard, U.S. Family Health Plan. (See summary for [7/26/2005](#).) Describes a plan available to, and well received by, military beneficiaries, including military retirees.

Wednesday, August 17, 2005; Boston, MA

Mental Health

- [“Department of Mental Health: Commonwealth of Massachusetts,”](#) Elizabeth Childs, M.D., Commissioner, Massachusetts Department of Mental Health. (See summary for [8/17/2005](#).) Describes the work of the Massachusetts Department of Mental Health, giving key statistics about the department and its beneficiaries. She also describes three current initiatives and the department's efforts to address stigma as the chief barrier to individuals receiving mental health treatment.
- [“Beacon Health Strategies, LLC,”](#) Deborah Nelson, Ph.D., Beacon Health Strategies. (See summary for [8/17/2005](#).) Describes this managed behavioral health plan and the challenges it faces in providing mental health services.
- [“The State of Mental Health Services in Massachusetts: The Impact of Inadequate Funding,”](#) Toby Fisher, Executive Director, National Alliance for the Mentally Ill. (See summary for [8/17/2005](#).) Describes some of the difficulties that result from inadequate funding, which include long waits for services, especially troubling when children must wait, and inadequate pharmaceutical benefits. He also described the successful integration of federal, state, and local policies and initiatives from the perspective of a grass roots, advocacy organization.

State, County, and Local Initiatives

- [“Cost, Quality And Access: A System Approach,”](#) Trish Riley, Director, Governor's Office of Health Policy and Finance, Maine. (See summary for [8/17/2005](#).) Describes efforts in Maine to

address cost, quality, and access with a special focus on Dirigo Health Care, an effort to expand health insurance coverage to low-income people in Maine.

- [“Access Health: Closing the Gap Between Public and Private Insurance Coverage,”](#) [Vondie Woodbury](#), Director, Muskegon Community Health, MI. (See summary for [8/17/2005](#).) Describes a local county program designed to provide health care coverage to those who would otherwise not have it. The program is targeted at small businesses in particular. The premium costs are shared by the employee (30 percent), employer (30 percent) and the community (40 percent).

End of Life

- [“Dying in America: A Generation’s Crisis and Opportunity,”](#) Ira Byock, M.D., Director of Palliative Medicine, Dartmouth Hitchcock Center, NH. (See summary for [8/17/2005](#).) Describes trends in aging in America, the shrinking pool of caregivers, and the need to shift services for those approaching death away from institutions and toward care in the home. Most people want to live and die at home, not in institutions. For this to happen, there needs to be an emphasis on palliative, rather than on life-extending, but not enhancing, aggressive medical intervention. Hospices can help in reaching this objective and more caretakers will be needed.
- [“Research Findings About End of Life,”](#) [Nicholas Christakis](#), M.D., Harvard Medical School. (See summary for [8/17/2005](#).) Describes the components of a “good” death: individuals want to know what to expect, as well as freedom from pain, not being a burden to their families, having a doctor who listens, and the ability to choose to die at home.
- [“Defining and Reforming ‘End of Life’ Care,”](#) [Joanne Lynn](#), M.D., Rand, Washington DC. (See summary for [8/17/2005](#).) Proposes a model of care for the ill that gradually decreases “curative” care while increasing “palliative” care proportionately. The timing of these changes should be based on the predicted life duration, even though it is difficult to forecast exactly when a person will die. More support for family caregivers is essential.

Employer Initiatives: Leapfrog and Bridges to Excellence

- “Bridges to Excellence” (Part 1) and “The Leapfrog Group” (Part 2), [Jeffrey R. Hanson](#), Regional Healthcare Manager, Verizon Communications. (See summary for [8/17/2005](#).) Describes two employer-based initiatives for improving health care quality. Bridges to Excellence is a system of rewarding high quality performance of providers and encouraging consumers to purchase high quality care. The initial efforts have focused on diabetes and cardiovascular disease. Leapfrog is an initiative of over 150 purchasers that has focused on identifying specific actions that can result in improved care delivery and on setting up a system of rewards for top performers.

Friday, September 23, 2005; Portland, OR

The Oregon Health Plan

- [“White Paper distributed at Citizens’ Health Care Working Group hearing” \(PDF version\),](#) [John Kitzhaber](#), M.D., Center for Evidence Based Policy, Oregon Health & Science University, former Governor of Oregon. (See summary for [9/23/05](#).) Sets forth his belief in the need to change the health care system from one that rations people to one that rations care. He asserts that major change is needed, incremental change will not suffice.
- [“Oregon Health Decisions: Community Meetings Process,”](#) [Michael J. Garland](#), D. Sc. Rel., Oregon Health & Science University. (See summary for [9/23/05](#).) Describes the efforts by a variety of individuals in Oregon to conduct public discussions, formulate a new system for organizing care, and pursue it through to partial enactment and implementation within the state.

- *[No title or slides]*, Ralph Crawshaw, Co-founder Oregon Health Decisions (Co-presented with M. Garland - See summary for [9/23/05](#).) Describes the process they went through to hold community level meetings in developing the Oregon Health Plan and the impact of these meetings on developing the plan and on the meeting participants.

The Health Services Commission: Prioritizing Benefits

- [“The Work of the Health Services Commission – Prioritizing Benefits,” Alison S. Little, M.D.](#), Oregon Health Services Commission. (See summary for [9/23/05](#).) Describes the process the Commission used to develop a prioritized list of benefits that formed the core of the Oregon health plan.
- [“White paper distributed at Citizens' Health Care Working Group hearing” \(PDF version\)](#), Ellen C. Lowe, Oregon Health Services Commission. (See summary for [9/23/05](#).) Offers a personal perspective on Oregon’s outreach efforts to develop the Oregon Health Plan, based on her experiences as the citizen member of the Oregon Health Services Commission.
- *[No title or slides]*, [Diane Lovell](#), Oregon Public Employees Benefit Board and Oregon Health and Sciences University Employee Benefits Council. (See summary for [9/23/05](#).) Describes the open, public, and transparent process employed in Oregon in developing the Oregon Health Plan and emphasizes the importance of these characteristics.
- [“Methods for Comparative Evidence Reviews,”](#) Dr. Marian McDonagh, Oregon Evidence-based Practice Center for the Drug Effectiveness Review Project. (See summary for [9/23/05](#).) Describes the technical process of review and decision-making regarding selection of pharmaceuticals that are covered by Medicaid. The methodology is intended to be transparent, systematic, and unchallengeable. Participants in the process make sure that the information is very readable. Oregon wants to make sure that its researchers have high standards and are impartial in their evaluation of what constituted equivalent drugs for treatments.
- *“Lessons Learned from the Oregon Experience,”* [Bruce Goldberg](#), M.D., Oregon Office for Health Policy and Research. (See summary for [9/23/05](#).) Summarizes the lessons learned from the effort in Oregon to develop an alternative approach to providing insurance coverage.

Lessons Learned

- [“White paper distributed at Citizens' Health Care Working Group hearing” \(PDF version\)](#), [John Santa](#), M.D., M.P.H., Center for Evidence-based Policy, Oregon Health & Sciences University. Attachment to paper - M. Gold article ([PDF only](#)); see also [related article](#) online. (See summary for [9/23/05](#).) Describes the values and central priorities that continue to motivate those seeking to further the purposes of the Oregon Health Plan, including equity, transparency, value, explicit decision-making, and local control.
- *[No title or slides]*, Mark Ganz, President and CEO, the Regence Group (See summary for [9/23/05](#).) Describes some of the activities his firm is undertaking, including efforts to develop an electronic health record for the group's members.

Public Sector/Private Sector Perspectives

- [“Lessons Learned from Health Care Reform,”](#) [Jean I. Thorne](#), Oregon Public Employees’ Benefit Board. (See summary for [9/23/05](#).) Former Oregon Medicaid Director reviews the process that Oregon followed and candidly describes the successes and failures of the state’s efforts.