



The Blue Ridge Academic Health Group

Report 8 | October 2004

CONVERGING ON CONSENSUS?
**Planning the Future of Health
and Health Care**

Mission: The Blue Ridge Academic Health Group seeks to take a societal view of health and health care needs and to identify recommendations for academic health centers (AHCs) to help create greater value for society. The Blue Ridge Group also recommends public policies to enable AHCs to accomplish these ends.

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**Planning the Future of Health
and Health Care**

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CONVERGING ON CONSENSUS? Planning the Future of Health and Health Care is eighth in a series of reports produced by the Blue Ridge Academic Health Group. The recommendations and opinions expressed in this report represent those of the Blue Ridge Academic Health Group and are not official positions of Emory University. This report is not intended to be relied on as a substitute for specific legal and business advice. For questions about this report, contact Michael M.E. Johns at the address listed above.

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The Blue Ridge Academic Health Group *Report 8*

The Blue Ridge Academic Health Group (Blue Ridge Group) has been concerned with the imperative for health care reform since our Group's inception in 1997. Our second report, entitled, *Promoting Value and Expanded Coverage: Good Health is Good Business*, advocated the establishment of a "value-driven" and "evidence-based" health care system, one that "... promotes the health of individuals and the population by providing incentives to health care providers, payers, communities and states to improve population health status and reward cost-effective health management" (BRAHG 1998a). In the intervening years, some progress has been made and a great deal has been learned on the subject of national health care reform based upon these and related principles. Nevertheless, as a nation, we have yet to achieve anything approaching effective, system-wide reform. We have yet to bridge the chasm between the reality and the promise of our health care system.

In this, our 8th report, the Blue Ridge Group reviews the progress of and prospects for comprehensive health system reform and provides an academic health center (AHC) leadership agenda for reaching this critical goal.

- We describe a promising convergence of consensus on both the need and goals for health care reform.
- We describe the major remaining roadblock to successful reform.
- We present a "to do" list of models, initiatives and policy recommendations that AHCs can pursue to lead our nation to a health care system worthy of the name.

Section 1: The Problem: History and Situational Analysis

The 20th Century saw great strides in medicine and the public's health.

- Starting early in the century, health care developed a robust scientific, and increasingly technological, foundation. Public health measures enhanced the overall health of the population and medical care became increasingly effective.
- Mid-century, the establishment of the National Institutes of Health (NIH) initiated a national commitment to the support and advancement of biomedical science, which has endured. This commitment spurred unprecedented discovery and innovation in basic and clinical science, and the ever-increasing promise of greater medical success.
- After the Second World War, in the light of nationwide wage freezes, employer-sponsored health and retirement benefits became a standard mechanism for access to health insurance, while enhancing employee compensation, and equitably spreading costs and risks through large insurance pools.
- With the enactment of the Medicare and Medicaid programs in the mid 1960's, the nation committed to enhancing access to medical care and services by the very poor and the elderly. These programs created publicly financed health care plans for populations that the private sector could not profitably or effectively insure, while attempting to equitably distribute the costs.

However, these national commitments came at a high cost and still left millions of Americans without access to affordable health care. Annual Gross Domestic Product (GDP) attributable to health care spending grew from 5.1 percent of GDP in 1960 to over 13 percent in 1999 (Chernew et al., 2003), with projections that it will grow to 18.4 percent by 2013 (Heffler, et al 2004). 15.6 percent of the U.S. population, or 45.0 million people,

were without health insurance coverage in 2003, and cost pressures have caused most insurance sponsors (for instance, employers) to reduce and limit benefits, and/or to increase premiums, co-pays and related financial obligations of the insured (U.S. Census Bureau 2004).

Several times during the 20th Century, efforts were undertaken to comprehensively address cost and coverage issues by attempting to enact nationwide insurance coverage for health care. This included major efforts by Presidents Franklin D. Roosevelt, Truman, Nixon and Clinton. The Clinton effort was targeted as much towards reining in health care spending (which had grown to over 14 percent of the nation's gross domestic product), as towards ensuring near-universal coverage and access to quality health care. This effort, like those before it, was not successful. The ensuing growth of what is generally referred to as "managed care" is credited with reducing the rate of growth of health expenditures for several years (though not without engendering heated debate about rationing of health care access and services). But by the year 2000, health care costs had resumed their rapid growth (Reinhardt, et. al. 2004).

The most recent effort at reform, the Medicare Prescription Drug Improvement, and Modernization Act of 2003 (Medicare Modernization Act) sponsored and passed by the Bush Administration, surprisingly did not prioritize cost reduction (U.S. Congress 2003). Despite being hailed in some quarters as the most important reform since the enactment of Medicare itself, the final bill, including the manner in which it was passed in the Congress, was extremely controversial. The implementation of many of the Medicare Modernization Act's provisions is not set to begin until the year 2006 and there are wide differences of opinion on how the bill will affect the future of Medicare and the health care system as a whole. But, while agreeing on little else about its potential impact, with costs estimated at well above \$500 billion, most

analysts agree that the bill will result in even higher health system costs (Butler 2003).

Despite this latest infusion of billions of dollars into health care, the house of American medicine remains severely distressed, plagued by a host of structural problems.

As late as the mid-1960's the health care system was a modest bungalow based on a professional model of the solo practitioner and community hospital woven into the fabric of household and community life. It has since metastasized into what is now a vast and unwieldy structure plagued by archaic financing systems, perverse financial incentives, endemic inefficiencies, significant variations in quality, and a host of related deficits in administrative, service, accountability, safety, outcomes and information systems. The result is that, while excellent care is available to many people, the U.S. also has the widest health disparities based on income level, and has the lowest overall health status, of any other industrialized country in such fundamental areas as life expectancy and infant mortality. For example, the most recent Organization of Economic Cooperation and Development (OECD) projections of life expectancy show the U.S. 22nd for males and 26th for females among all industrialized countries (OECD 2004). On top of this, we now suffer from the recently identified public health epidemic of obesity (Burros 2004).

Our nation already pays far more per capita for health care than any other industrialized country (approximately 1.5 times the per capita spending of Canada, which is second to the U.S. in health spending) (Glied 1997,5). Simply investing even more money is clearly not the key to effective reform.

Putting more pressure on this wobbly structure are many factors:

Demographic trends. Our aging society is trending toward a more complex and more costly disease burden. Though the genomic revolution suggests the possibility of someday practicing regenerative and reparative medicine, we will experience escalating cost pres-

ures as a result of our graying population.

Emerging infectious diseases (EIDs). As SARS has recently reminded us, from the third world to the first, new pathogens can emerge and spread quickly, threatening global health while severely taxing our economies and overwhelming our health systems. Further, the continuing spread of preventable diseases, such as AIDS, in much of the world signals that real control and eradication requires a greater response from governments and health professionals than has been forthcoming to date.

The threat of bioterrorism. Along with EIDs, the heightened threat of bioterrorism is driving new demand for readiness and research. We face major gaps in funding and preparedness in our public health infrastructure.

Irrational provider payment systems. The current payment and reimbursement systems for health services are extraordinarily complex and inefficient. In many cases, for patients and providers alike, payment systems create perverse incentives that result in over-, under-, or mis-utilization of health care.

Medical malpractice and patient safety. Tort reform and patient safety remain major problems. Rising premium costs have become a significant burden to health professionals, provider organizations, drug and device manufacturers and others. At the same time, patient safety and quality assurance remain serious issues that have not been adequately addressed by the provider, pharmaceutical, or insurance communities.

The burden of uninsurance. Approximately 45 million Americans were uninsured in 2003. A three-year study by the Institute of Medicine's Committee on the Consequences of Uninsurance found that widespread "uninsurance" has significant society-wide consequences:

- Uninsured children and adults do not receive the care they need. Consequently, they suffer from poorer health and development and are more likely to die prematurely than those with coverage; 18,000 unnecessary deaths are attributable to lack of health coverage every year.

- Even one uninsured person in a family can put the financial stability and health of the whole family at risk.
- A community's high rate of uninsurance can adversely affect the overall health status of the community, the financial stability of its health care institutions and providers, and the access of its residents to certain services, such as emergency departments and trauma centers (IOM 2003a).

The “market cure.” The efforts over the last decade to impose market discipline on the health care sector have led to an era described by the Institute of Medicine as one of “Brownian motion” — of “mergers, acquisitions and affiliations,” rather than of real progress in securing lasting savings or improvements in delivery systems and health outcomes for the population (IOM 2001:3).

In the face of this constellation of existing and emerging challenges, the question is whether we might soon reach a “tipping point” where the distressed house of health care will come tumbling down, no longer able to accommodate the endless cobbling-together of partial and disparate systems, structures, and reforms.

Section 2: Convergence: Value-Driven Health Care

With so much at stake for the health and well-being of individuals, communities and the nation overall, health care reform has remained a perennial priority on our nation's domestic agenda. This priority has been recognized and championed by a cross-section of health sector and public policy leaders and organizations. At every level, from the local to the national, and in both public and private initiatives, change and innovation continues. Many individuals and organizations have contributed significant research and policy development to this effort.

The Blue Ridge Group has long maintained that if the right actions are taken, e.g., relentlessly pursuing only necessary, appropriate and effective services with an effective information and communications infrastructure, a “value-driven” health care system can emerge (BRAHG 1998a).

A value-driven health system would utilize performance-based incentives and balanced competition in achieving national health goals. It would develop incentives to improve the health of both individuals and populations, while achieving the highest possible value for the dollars invested and spent. A national health information infrastructure would allow secure communication of relevant data for diagnosis, treatment and outcomes tracking by those with a right and need to know.

However, such an incentivized, value-driven health system would work if, and only if, the entire population is in the system. Having all people included means ensuring that everyone has sufficient insurance and access to basic health services, which could be provided competitively by government programs or the private sector, or, better, through a combination of both. Universal health insurance coverage, therefore, is one essential precondition to an effective and efficient U.S. health care system. In a major advance in public policy over the last decade, this premise has been widely accepted, even across traditionally partisan lines.

Recently, the Institute of Medicine sponsored a series of landmark studies that surveyed the full range of research and proposals on the topic of achieving a United States health care system worthy of the name. From the base of fact and analysis reported from these studies, the IOM can be seen as having proposed the adoption of two fundamental national health policy goals that are critical to effective health care reform.

The first urges that our nation should provide “health insurance that will promote

Exhibit 1: **IOM Five basic principles for reaching universal coverage.**

1. Health care coverage should be universal.

- Being uninsured can damage the health of individuals and families. Uninsured children and adults use medical and dental services less often than insured people and are less likely to receive high quality care, as well as preventive and chronic care services.
- Uninsured children risk abnormal long-term development if they do not receive routine care; uninsured adults have worse outcomes for chronic conditions such as diabetes, cardiovascular disease, end-stage renal disease and HIV.
- “Universal” means what it says. Everyone living in the United States should have health insurance.

2. Health care coverage should be continuous.

- Continuous coverage is more likely to lead to improved health outcomes; conversely, gaps in coverage can result in diminished health.
- Achieving coverage well before the onset of an illness can lead to a better health outcome, since the chance of detecting disease early in its course is enhanced.
- Interruptions in coverage interfere with ongoing therapeutic relationships, contribute to missed preventive services for children, and result in inadequate chronic illness care.

3. Health care coverage should be affordable to individuals and families.

- The main reason people give for being uninsured is the high cost of coverage. Lower-income families have little leeway in their budget for health expenditures, so financial assistance will be necessary for them to obtain coverage.

4. The health insurance strategy should be affordable and sustainable for society.

- Politics and economics will determine what society can afford. Any major reform proposal will need mechanisms to control inflation and encourage use of efficacious, cost-effective services.
- Everyone should contribute financially — through taxes, premiums, and cost sharing — because all members of society will benefit from universal health insurance coverage.
- The reform strategy should strive for efficiency and simplicity by eliminating complex eligibility rules, underwriting, billing procedures and regulatory requirements.

5. Health insurance should enhance health and well-being by promoting access to high-quality care that is effective, efficient, safe, timely, patient-centered, and equitable.

- Insurance should be designed to enhance the quality of the health care system by meeting the six aims recommended by the IOM Committee on Quality of Health Care in America (see list below).
- Basic benefit packages should include preventive and screening services, outpatient prescription drugs, and specialty mental health care, as well as outpatient and hospital services.
- Variations in patient cost sharing could be used as an incentive for appropriate service use because this is known to influence patient behavior (IOM 2004).

better overall health by providing financial access for everyone to necessary, appropriate and effective health services” (IOM 2001a).

The second IOM national health policy goal urges that our nation should transform its health care system so that it will be:

- **Safe** – avoiding injuries to patients from the care that is intended to help them.
- **Timely** – reducing waits and harmful delays for both those who receive and those who give care.
- **Effective** – Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding under-utilization and over-utilization, respectively).
- **Efficient** – avoiding waste, including waste of equipment, supplies, ideas, and energy.
- **Equitable** – providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socio-economic status.
- **Patient-centered** – providing care that is respectful and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions (IOM 2001, 41-42).

The Blue Ridge Group believes that the goals of universal coverage and a health care system that is safe, timely, effective, equitable, efficient, and patient-centered (hereinafter, STEEEP) reflect societal aspirations for our nation’s health care system around which it is now possible to discern a convergence of consensus. This convergence presents an unprecedented opportunity for leadership efforts that could effectively reform the U.S. health care system.

A review of leading proposals for health care reform shows that there is reason to believe that significant progress can be made. The opportunity is to build upon commonalities, create the processes needed to resolve the remaining obstacles, and marshal the effort to restructure our health care system.

Converging on Universal Coverage

The 2004 presidential election cycle provides a useful lens through which to view both the policy convergence and the primary roadblock to effective reform. The leading Republican and Democratic proposals for health care illustrate both the opportunities and the remaining obstacles to effective reform.

The Bush Administration Proposals

The Medicare Modernization Act of 2003 was arguably the most important opportunity in decades to move the health coverage and reform consensus forward. Proponents promoted the legislation, in part, as a means to add a pharmaceutical benefit to the coverage

Yet, after years of growing bipartisan consensus for a Medicare drug benefit and a commitment to find at least \$400 billion to provide one, the bill devolved into a highly partisan and controversial measure.

for the Medicare population and to set the stage for the entry of private sector insurance plans as an alternative for seniors in the Medicare market place. Yet, after years of growing bipartisan consensus for a Medicare drug benefit and a commitment to find at least \$400 billion to provide one, the bill devolved into a highly partisan and controversial measure.

Proponents, primarily Congressional Republicans and President Bush, heralded the addition of a new drug benefit and the beginning of the transformation and modernization of the Medicare program. Cheaper and better overall health insurance coverage would result from a new prescription drug benefit tied to incentives to private sector insurers to offer new coverage for seniors. Private sector and market innovation would catalyze quality improvements that empower individuals and families to become better consumers and lead to lower

Table 1: **Summary of Leading Proposals for Health Care Reform**

Plan	Additional Lives Covered	Cost	Proponents
Karen Davis & Cathy Schoen¹	39 million (if mandatory) 33 million (if allow opt-out)	\$70 billion/yr	Commonwealth Fund
National Coalition for Health Care Reform²	Universal coverage	N/A	94 public and private organizations representing 100 million persons
President Bush³	2.1 – 2.4 million	\$90 billion (2005-2014)	Bush Administration Republican Party
Senator Kerry⁴	27 million (resulting in 95 percent coverage rate)	\$653 billion (2005-2014) [net costs inclusive of savings]	Democratic Party
PATHOS⁵ (Pathways to Healthy Outcomes)	Universal coverage within 5 years	N/A	Paul Ellwood, Jackson Hole Group
Center for Health Transformation⁶	N/A	N/A	Speaker Newt Gingrich and others

1. Davis & Schoen 2. NCHC 2004 3. Thorpe 2004 4. Thorpe 2004 5. Ellwood 2003 6. Gingrich, et al. 2003

Funding/Savings Mechanisms

- Efficiency gains from switch to CHP
- Savings from electronic administration
- Cost incentives in reinsurance trust fund
- Federal costs for CHP premium assistance; CHP reinsurance; Medicare premiums and COBRA; Medicare Part E; expansion of Medicaid

Reduce estimated waste of \$300 - \$500 billion/ yr: savings through effective cost containment can "more than offset" the cost of universal coverage

Federally funded

All costs of expansion federally funded

Substantial savings from:

- Drug spending slowed: HHS negotiates costs of drugs for Medicare recipients
- Administrative overhead: move all transactions from paper to electronic platform
- Promote disease management in both private and public plans (esp. for congestive heart failure, diabetes, hypertension)
- Substantial drop in uncompensated care burden
- Reduce costs of malpractice
- Federal stop-loss pool reduces variances in claims, achieve 10 percent reduction in cost to insurers

Based on Wyden-Hatch proposal: a Citizens Health Care Working Group would be appointed to frame and conduct a national debate, with hearings, on how to provide access to affordable coverage for all Americans, and to make recommendations to the Congress within 3 years

- Reduce inefficiencies
- Improve ROI through promoting better technologies and solutions

Key Features

- Congressional Health Plan (for self-employed, small businesses, long-term uninsured)
- Tax credits for uninsured
- Medicare Part E (for uninsured 60-64, disabled in 2-yr waiting period, Medicare dependents)
- State Family Health Insurance Program open to everyone below 150 percent of poverty line

- Health insurance for all
- Improve quality
- Control total costs, stop cost shifting
- Finance the system more equitably
- Simplify administration

- Refundable income tax credit for those under 65 not covered by employee-sponsored insurance or public health plan
- Tax deductions for premiums paid in high-deductible plans
- Association health plans for small businesses and associations

- Medicaid and SCHIP for children under 300 percent of poverty
- Medicaid and SCHIP for parents under 200 percent of poverty
- Medicaid for childless couples and single adults in poverty
- Small businesses, adults 55-64 and those between jobs can enroll in new insurance pools based on FEHB
- Employers meeting criteria eligible for reinsurance coverage
- Federal stop-loss pool reimburses health plans for 75 percent of catastrophic cases
- Electronic information systems required

- Overhaul health system (electronic health records, prevention and treatment guidelines, health information pathways between physicians and consumers, and outcomes measurement and management technology)
- "Agreement on Responsibility" with severable contract between physician and patient
- Institute for Medical Practice and Consumer Technology

Create a "21st century Intelligent Health System" with following features:

- Information-rich health savings accounts
- Electronic health records with expert systems to minimize errors, maximize care
- New system of health justice
- Create a transparent buyer's market for prescription and OTC drugs
- Create a system for capturing and promoting better solutions with superior outcomes
- Develop real-time research database – make cancer a chronic disease by 2015
- Create "virtual" electronic public health network and bioshield for defense against outbreaks and attacks

costs for insurance and care, enabling far more Americans to afford insurance and to get the care they need (Antos and Calfee 2004).

Opponents, including most Congressional Democrats, saw a deeply flawed drug benefit and large subsidies to private insurers – all designed to hobble the Medicare program and so lead seniors into an insurance marketplace likely to be confusing at best and treacherous at worst (Families USA 2004).

In addition to the Medicare legislation, the Bush Administration has submitted to Congress several proposals designed to address the problem of uninsurance. The three main proposals in President Bush's 2005 budget are built around tax policies that the Administration claims would make health insurance more affordable and hence increase coverage. These include subsidies for individuals and families to help cover the cost of purchasing non-group health insurance, including a tax credit for lower-income people and a new tax deduction for premiums for non-group health insurance policies with high-deductibles. The President has also supported association health plans (AHPs), which allow small businesses and associations to purchase health insurance through large purchasing pools. The plans would be regulated under federal rather than state insurance laws and would be exempt from benefit mandates, and other state regulations not required under federal rules (Thorpe 2004a).

Despite the scope of the Bush Administration legislation, and the stated objectives of significantly increasing coverage and access and lower costs, independent analysis shows that none of these objectives is likely to be reached in the short or medium terms. During the early years of the plan, the three programs in combination would extend coverage to 2.4 million uninsured. However, since the dollar value of the refundable credits declines over time, the number of uninsured covered under the plan will also decline. By the year 2014, the plan would extend coverage to approximately 2.1 million otherwise uninsured at a cost of \$90.5 billion (ibid).

The Bush Administration is committed to significantly expanding coverage and improving our systems of care through mechanisms and incentives that can empower the private sector to take the leadership in achieving these goals through a vigorous marketplace.

The Kerry Proposal

Nine Democratic contenders began the race for the Democratic nomination in 2003. By the time of the writing of this report, Massachusetts Senator John Kerry is the Democratic Party nominee. A comprehensive analysis of all of the Democratic contenders' health care reform proposals was maintained by the

Kerry's plan also proposes a federally funded premium rebate pool designed to protect individuals, families and firms from financial devastation in the case of catastrophic illness or injury.

Commonwealth Fund (See: Collins, et al, 2003).

Senator John Kerry's proposals for expanding health insurance coverage and improving our systems of care build on existing private and public insurance programs and also add a new federal catastrophic insurance program design to reduce the cost of private insurance.

The plan would expand Medicaid and SCHIP eligibility to include both children currently eligible for Medicaid through 300 percent of poverty and also parents of Medicaid and SCHIP kids through 200 percent of poverty; and it would make eligible single adults and childless couples in poverty. New costs would be fully paid by the federal government and states would receive bonus payments during the first three years of the program to enroll both those currently uninsured and those newly eligible.

To deal with the large number of people employed by small firms that currently cannot afford to offer employee health care coverage, Kerry would make the Federal Employees Health Benefit Plan (FEHBP) available to those in firms with 50 or fewer workers and unin-

sured individuals (including workers between jobs). Workers between jobs, and individuals without access to employer-sponsored insurance (and not eligible for public plans), could purchase insurance through the plan, with subsidies provided based on income.

Employers would contribute at least half the premium and would receive a 25 percent refundable tax credit for all workers under 150 percent of poverty, phasing out at 300 percent of poverty.

Senator Kerry's plan also proposes a federally funded premium rebate pool designed to protect individuals, families and firms from financial devastation in the case of catastrophic illness or injury.

Federal costs under the Kerry plans are estimated to be \$895 billion over ten years, extending insurance to 26.7 million persons who are currently not covered. This includes approximately \$230 billion in federal spending for the reinsurance pool that targets those with health insurance and \$665 billion for programs targeting the uninsured (Thorpe 2004).

Table 1 summarizes the Bush and Kerry and several other leading reform proposals that target achieving universal or near-universal health insurance coverage. In addition, The Economic and Social Research Institute (ESRI) has analyzed almost two dozen more proposals for expanded coverage and comprehensive health care reform developed by a broad cross-section of thought-leaders in health policy. These can be reviewed on the ESRI website, available at http://www.esresearch.org/covering_america.php. The ability to evaluate how these and any other proposals might succeed in achieving universal coverage has been advanced significantly by a framework developed by the IOM Committee on the Uninsured. The IOM framework is summarized in Appendix 1.

Converging on Characteristics of a New Health System

In addition to the converging consensus on achieving universal insurance coverage, there is also a clear convergence on the need to reform the structure and functioning of the health care system itself. The evidence of convergence on a creating STEEEP health care system is everywhere to be found.

President Bush has endorsed proposals to improve and standardize medical record keeping, billing, and information systems that would enable the development of more efficient and effective administrative and quality control programs in line with the IOM STEEEP aims. In April 2004, President Bush called for the majority of Americans to have

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interoperable electronic health records within 10 years, and in doing so signed an Executive Order establishing the position of the National Coordinator for Health Information Technology. In May 2004, Dr. David Brailer was appointed the nation's first health care information technology "Czar." He was charged with developing, maintaining, and overseeing a strategic plan to guide nationwide adoption of health information tech-

nology in both the public and private sectors. Secretary of Health and Human Services Tommy Thompson and Dr. Brailer subsequently unveiled four goals and related strategies for bringing health care into the information age over the next decade.

Exhibit 2: Four Goals for HHS Effort to bring Health Care into the Information Age over the Next Decade

Goal 1: Inform Clinical Practice.

Strategy 1. Provide incentives for Electronic Health Record EHR adoption. The transition to safe, more consumer-friendly and regionally integrated care delivery will require shared investments in information tools and changes to current clinical practice.

Strategy 2. Reduce risk of EHR investment. Clinicians who purchase EHRs and who attempt to change their clinical practices and office operations face a variety of risks that make this decision unduly challenging. Low-cost support systems that reduce risk, failure, and partial use of EHRs are needed.

Strategy 3. Promote EHR diffusion in rural and underserved areas. Practices and hospitals in rural and other underserved areas lag in EHR adoption. Technology transfer and other support efforts are needed to ensure widespread adoption.

Goal 2: Interconnect Clinicians.

Strategy 1. Regional collaborations. Local oversight of health information exchange that reflects the needs and goals of a population should be developed.

Strategy 2. Develop a national health information network. A set of common intercommunication tools such as mobile authentication, Web services architecture, and security technologies are needed to support data movement that is inexpensive and secure. A national health information network that can provide low-cost and secure data movement is needed, along with a public-private oversight or management function to ensure adherence to public policy objectives.

Strategy 3. Coordinate federal health information systems. There is a need for federal health information systems to be interoperable and to exchange data so that federal care delivery, reimbursement, and oversight are more efficient and cost-effective. Federal health information systems

will be interoperable and consistent with the national health information network.

Goal 3: Personalize Care.

Strategy 1. Encourage use of Personal Health Records. Consumers are increasingly seeking information about their care as a means of getting better control over their health care experience, and PHRs that provide customized facts and guidance to them are needed.

Strategy 2. Enhance informed consumer choice. Consumers should have the ability to select clinicians and institutions based on what they value and the information to guide their choice, including the quality of care providers deliver.

Strategy 3. Promote use of telehealth systems. The use of telehealth — remote communication technologies — can provide access to health services for consumers and clinicians in rural and underserved areas.

Goal 4: Improve Population Health.

Strategy 1. Unify public health surveillance architectures. An interoperable public health surveillance system is needed that will allow exchange of information, consistent with privacy laws, to better protect against disease.

Strategy 2. Streamline quality and health status monitoring. Many different state and local organizations collect subsets of data for specific purposes and use it in different ways. A streamlined quality-monitoring infrastructure that will allow a complete look at quality and other issues in real-time and at the point of care is needed.

Strategy 3. Accelerate research and dissemination of evidence. Information tools are needed that can accelerate scientific discoveries and their translation into clinically useful products, applications, and knowledge (Thompson and Brailer 2004).

In addition, the Department of Defense, the VHA and the Department of Health and Human Services have been major drivers of the electronic health information effort, through the Consolidated Health Informatics Initiative. Key supporting roles have been played by agencies such as the National Institute for Standards and Technology (NIST) of the Department of Commerce and the Agency for Healthcare Research and Quality (AHRQ). HHS Secretary Tommy Thompson announced in March 2003 that the government had developed the first set of uniform coding standards to be used across all agencies (U.S. DHHS 2003).

John Kerry would also enhance information and quality systems. His health care reform proposal calls for:

- Providing financial incentives to help providers and purchasers invest in quality improvement;
- Rewarding health care organizations and physicians that invest in modern information systems, especially electronic medical records, patient registries, and reminder systems that improve the quality of care and help eliminate wasteful spending - with financial incentives;
- Providing economic incentives to computerize prescribing systems. Such systems can reduce medication errors by 80 percent or more, and yet most hospitals and clinics do not use them;
- Ensuring that all Americans have secure, private electronic medical records by the year 2008; assure federal government adopts modern computerized methods for health care transactions that are widely used in other industries; and
- Requiring private sector insurers to use advanced systems. Private insurers would have to use this simplified technology standard as a condition of doing business with the federal government (Medicare, Medicaid, and the federal employees health benefit program) to make health care transactions less costly (Kerry 2004).

In addition, a number of bills are in the Congress from both sides of the aisle that are focused on improving the communications and IT infrastructure, although it is unlikely that they will move forward during this session.

Over the last two decades, a host of associations and philanthropic organizations have undertaken major efforts to understand and address one or more of the IOM aims.

Sponsors of these efforts include The Commonwealth Fund, The Robert Wood Johnson Fund, The Pew Charitable Trusts, The Kaiser Foundation, The W.K. Kellogg Foundation, the Association of Academic Health Centers (AHC) and many more. In addition, many new and non-traditional organizations have stepped forward to promote one or more of the six aims, including The Jackson Hole Group, The Leapfrog Group, and The National Business Coalition on Health, The National Coalition on Health Care (NCHC) (See Exhibit 1), and others. Federal and State agencies too have stepped-up their focus on the six aims, including the Agency for Health Care Research and Quality (AHRQ), the Medicare program, the Medicaid program through the State Children's Health Improvement Project (SCHIP), and a variety of state-initiated programs.

The Blue Ridge Group believes that all of these efforts demonstrate what is now a broad policy convergence on the imperative to solve the problem of the uninsured and to comprehensively reform our health system to achieve a health system that adequately addresses the STEEP criteria.

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Exhibit 3: **The National Coalition on Health Care Reform Principles**

The National Coalition on Health Care (NCHC) has developed perhaps the most comprehensive and broadly endorsed health reform proposal. The NCHC is the nation's largest and broadest alliance working for the achievement of comprehensive health care reform, representing nearly one hundred of America's largest businesses, unions, health care providers, associations of religious congregations, pension and health funds, insurers, and groups representing patients and consumers. The Coalition's proposal advances five principles:

1. Health Care Coverage for All

- to be achieved within two to three years after the passage of legislation
- defined core benefit package
- employers and individuals able to purchase supplemental coverage beyond core package
- options for insuring all Americans include
 - employer mandates (supplemented with individual mandates as necessary)
 - expansion of existing public programs that cover subsets of the uninsured
 - creation of new programs targeted at subsets of the uninsured
 - establishment of a universal publicly financed program
- mandatory participation
- subsidies for less affluent

2. Cost Management

- within five years, bring increases in the costs and premiums associated with the core benefit package into alignment with increases in per capita gross domestic product
- increase the value for patients that is generated by any given level of health care spending
- measures include:
 - providing more and better information for patients, providers, and purchasers
 - improving quality and outcomes of care and reducing amount of unnecessary and injurious care
 - building national information technology infrastructure for health care
- modernizing and simplifying administration

- urgent need for cost relief requires short-term constraints:
 - rates for reimbursing providers for care encompassed
 - only after those rates take effect, limits on increases in insurance premiums for coverage defined by that package
- to facilitate comparisons, insurers required to set premiums separately for core benefit package and supplemental coverage

3. Improvement of Health Care Quality and Safety

- accelerated development of an integrated national information technology infrastructure for health care, including:
 - protocols for electronic patient records, prescription ordering, and billing
 - standards to protect privacy
 - mechanisms to incentivize and provide capital for the upfront investments necessary to build the infrastructure
- measures of process and outcomes quality to improve accountability and help payers and patients make better choices
- independent national board, with members drawn equally from public and private sectors, to coordinate public and private efforts to improve quality of care
- board also responsible for coordinating development of national practice guidelines
 - guidelines to be based on reviews, by panels of leading health care professionals, of research on impacts of technologies and procedures

Section 3: The Future of Health Policy: Convergence or Continued Conflict?

With the goals for national health reform well defined and widely shared, the remaining challenge is to address the major remaining roadblock to comprehensive health care reform: As a nation, we have been unable to resolve the place of health care in our national life.

As a nation, we have enacted discreet policies and programs (like Medicare and Medicaid) that treat affordable health care as a basic necessity. But we also continue to treat health care as if it were a utility or

As a nation, we have been unable to resolve the place of health care in our national life.

service to be turned on or off, like water or heat, depending on the individual's ability to pay. Our inability as a nation to resolve the place of health care in

our national life is partly due to some practical (primarily economic) issues and partly due to political (and ideological) issues.

On the practical side, there are two significant issues. The first issue is that health care can be expensive. Providing and paying for universal health care requires wide agreement (or at least acquiescence) concerning the need to find the means to pay for it. A second practical roadblock to health care reform is the fact that any proposed change in public policy with respect to the health system affects the economic interests of many powerful stakeholders. Every level of government, from the local through the federal, is implicated in service, regulation, administration and/or care delivery. The total workforce involved in health care is estimated to be about 20 million, or about 14 percent of the workforce (U.S. BLS 2004). Total spending is estimated at \$1.5 trillion, or 16 percent of GDP (Heffler, et al 2004). Consequently, designing effective reforms is a complex and high-stakes challenge. The political "capital"

- guidelines could be cited in malpractice cases as evidence of best medical practice

- board to update core benefit package to reflect changes in practice guidelines

4. Equitable Financing

- measures to reduce or eliminate cost-shifting across categories of insurance programs and payers
- mechanisms or sources that could be used, individually or in combination, to fund program costs include:
 - general revenues
 - earmarked taxes and/or fees
 - contributions required from employers
 - contributions required from individuals and families
- financial obligations to be adjusted, or subsidies provided, based on relative ability to pay for less affluent individuals, families, and employers

5. Simplified Administration

- assurance of coverage for all Americans and establishment of core benefit package to create consistent set of ground rules and reduce variations that now draw time and resources away from protection and advancement of health
- creation of an integrated national information technology infrastructure – including electronic patient records, prescription ordering, and billing
 - to reduce administrative complexity, costs, and medical errors
- national practice guidelines to reduce variability of care and billing and improve quality of care (NCHC 2004).

necessary to effect significant reform is often well beyond the threshold that many policy makers are willing to risk or invest.

On the political and ideological side, there is an ongoing standoff principally between those who believe that the government and public sector must be involved in any successful comprehensive solutions to our health system problems and those who believe that government should have little or no role in providing access to and in allocating health insurance and services and that these responsibilities should be transferred to the private sector and the competitive market place. As any observer of American politics knows, the proposal to treat health care as a right or to provide for universal access in the U.S. has, in every instance, been met with vigorous

Where are the solutions and the leadership that can resolve these remaining political and practical roadblocks to health care reform?

resistance from influential individuals and institutions who believe that strengthening or broadening governmental health services moves America towards “socialized medicine.”

This ongoing ideological divide, appears to have deepened in

recent years. Where are the solutions and the leadership that can resolve these remaining political and practical roadblocks to health care reform? Is there any hope of resolving the place of health care in American life?

The Blue Ridge Group believes that there is hope. Public policy consensus continues to grow in favor of a STEEEP health care system; and this growing consensus continues to push both state and federal policy makers to find better solutions. However, the “tipping point” has not yet been reached where it is possible to overcome the ongoing practical and political barriers to significant reform. To reach this tipping point will require courageous leadership that can galvanize and leverage the broadest constituency of stakeholders around the necessity of STEEEP health care reform. This leader-

ship must come, in largest part, from the health professions themselves. Academic health center leaders and leaders throughout medicine and the health professions must come together and step forward to provide the kind of *decisive* leadership that is so desperately needed to advance a consensus agenda for national health care reform.

The Role of Academic Health Centers in Furthering Consensus for a STEEEP Health Care System

Providing this decisive leadership will not be easy. Over the last two decades, AHCs have been among the most vulnerable of the major health care system stakeholders, which include public and private payors and providers, health care professionals, and employers, among others. AHCs have had to demonstrate their capacity for change and leadership in a new health care environment. The Blue Ridge Group itself was formed in large part to help enable AHC success in the new environment; and our past reports have addressed changes and innovations both required of and pioneered by some AHCs over the last decade. To date, most AHCs have been successful in adapting to the competitive market place and in preserving critical sources of support. They have accomplished significant reforms throughout their missions and operations. They are starting to focus on leading a new century of advances in health and healing, through pioneering work in genomics, nano-medicine, prospective medicine, and evidence-based care.

Time to Take the Offensive

The challenge now for leaders in the AHCs and in the health professions is to emerge from an era of intense inward-looking focus on their own institutional challenges and to take the next steps in leading STEEEP health care reform.

AHCs and their leaders, and other leaders in medicine, are now poised to move from the defensive to an offensive posture.

AHCs must take the lead in modeling

and developing STEEEP approaches to—and systems of—care that can demonstrate proof of concept in the widest possible array of populations, disease states and settings. At the same time, leaders in the medical and other health professions must take the lead in advocating for better systems of care and a national focus on better health and better public health preparedness.

Through our own innovations and demonstrations and in partnership with the public and private sectors, we must demonstrate and advocate for the vast improvements in health services and population status that are possible in a system that is STEEEP and accessible to all.

A prime opportunity for AHCs is to focus on what no STEEEP system can do without: a basic set of necessary, appropriate and effective health services, built on a sound base of science, practice and policy. Policy advocates have circled around the concept of ‘minimal essential services’ for years but no group has been either courageous or committed enough to comprehensively address this crucial issue.

Vital elements and precursors and examples of such necessary, appropriate and effective health services can be found in pilot initiatives and models that have been and are being sponsored by and with AHCs in localities and states throughout the nation. A number of prime examples follow:

AHCs As Innovators in Employee Health

In January 2004, Duke University Health System unveiled a new employee health plan, Prospective Health Care, which will create individualized profiles of health status and health risk, targeted to early detection and prevention of diseases and conditions. Participants will receive an individual health plan and health coaching, and persons who are at highest risk will be assigned to nurse care managers. Duke's program was acclaimed as "pioneering" by The Wall Street Journal, which noted that similar work is underway in some managed care groups (such as the Group Health cooperative in Seattle)

and is being studied at other AHCs (Landro, WSJ, 2004). Duke is offering the plan to 31,000 employees, along with its partners Physician WebLink, the Duke Center for Integrative Medicine, and PrimaHealth IA Physicians.

Duke University Health System is moving progressively across several fronts to show how an academic medical center can be both a research-intensive creator of future-oriented approaches to health care, as well as a major employer that administers its own medicine to employees. In 2003, Duke and The Center for the Advancement of Genomics (TCAG) announced that they would collaborate to create "genomic-based prospective medicine," keyed to the specific genetic profile and risk factors of individual patients. The collaboration is focused on research in cardiovascular, hematologic, and infectious diseases, to determine whether genomic predictors could support interventions in defined patient populations to prevent disease or begin treating it earlier in its course.

The Blue Ridge Group applauds this and other such efforts. Never has the ancient maxim seemed more apropos: Physician, heal thyself. In many major urban areas, AHCs are both among the largest private employers, and the owners of the largest and most comprehensive healthcare systems. We can use and evaluate emerging techniques of health promotion, disease prevention and management, and increasingly, restorative or regenerative medicine to manage costs and improve health in our own employee populations, with our own doctors and treatment facilities. (See: <http://www.dukemednews.org/mediakits/detail.php?id=7388#summary>)

The AHC as Partner with Private Sector and Local and State Government in Defining and Rewarding Appropriate Care: The University of Virginia (See: Garson 2004a)

The Institute of Medicine has recommended that state models be developed as demonstration building-blocks for nationwide health care reform (IOM 2004). Working at the state level, it is possible to create specific programs and models to expand access, decrease cost and improve quality.

In Charlottesville, Virginia, The University of Virginia Medical Center (UVMC) is working in partnership with Anthem Health Care to significantly improve Medicaid patient care and outcomes. The University of Virginia has created a proposal and is working with Anthem and Medicaid on a reimbursement system with an incentive to physicians that is rooted in practice guidelines created by medical specialty societies and tied to quality-based reimbursement.

The proposal is based on the understanding that attainment of the STEEP aims must be based in providing the most appropriate care possible. Such care can be informed by practice guidelines that are carefully developed by representative groups of physicians and professional societies, and based on evidence. Despite the widespread development of guidelines, physician practice does not always match the guidelines, and there is wide variation across the country. While practice guidelines do not completely define appropriate care for every individual, in most cases, practice guidelines provide the best information for the individual patient. To improve physician compliance with guidelines, the UVMC partnership with Anthem and Medicaid proposes to reward physicians for compliance with guidelines and achievement of yearly performance measures centered on the top ten Medicaid diagnoses. Additionally, where relevant guidelines do not indicate a particular test or treatment is not indicated, that test or treatment will not be reimbursed. The entire program is built on the participation of all relevant professional associations and nationally recognized guidelines maintained by the AHRQ National Guideline Clearing House and professional societies. A fuller outline of this proposal is presented in Appendix 2.

The AHC in Partnership for Adopting Common Electronic Data Standards by CONNECTING FOR HEALTH

(See: <http://www.connectingforhealth.org>)

Sponsored by the Markle Foundation with initial funding of \$2 million, Connecting for Health is a significant collaborative effort of

more than 100 agencies and organizations from both the private and public sectors, launched in 2002. The project has a goal of speeding adoption of common electronic data standards, while protecting privacy and security, in order to free the health care system from dependence on paper and realize all the economic and quality advantages of a system based on electronic health records. Along with representatives of major government agencies such as CDC, the FDA, the Veterans Health Administration, and the Office of Disease Prevention and Health Promotion, and HHS, Connecting for Health's steering group has representation from the AAMC, Partners Healthcare, Cleveland Clinic, New York-Presbyterian, and scores of other private as well as public groups. A demonstration project called the Healthcare Collaborative Network joins New York Presbyterian Hospitals, Vanderbilt University Medical Center, and Wishard Memorial Hospital, among others. In this initiative, data from certain laboratory tests and other procedures at participating hospitals will be shared with the CDC (for infectious disease surveillance), with the FDA (for tracking adverse reactions to medications), and with CMS (for quality of care tracking of Medicare beneficiaries).

Most recently, the Robert Wood Johnson Foundation joined with the Markle Foundation to support the next phase of this work, which includes an incremental "road map" of specific action steps to be taken going forward.

The AHC as a Partner in Major Nationwide e-HEALTH INITIATIVE

(See: www.ehealthinitiative.org)

Also representing the combined efforts of some 100 organizations, the The eHealth Initiative and the Foundation for eHealth Initiative, launched in 2001, are working to promote the development and adoption of interoperable electronic health records with appropriate levels of access by consumers, providers, payers, and public health agencies. The adoption of modern information technology holds great promise for reducing errors, improving the quality of care delivered, reducing costs, and empowering patients and

families to better understand and address their own health care needs. The ability to fulfill this promise is hindered by the proliferation of competing and incompatible information and records systems and the failure to develop and adopt nationwide clinical data standards. The mission of the eHealth Initiative and the Foundation for eHealth Initiative is to drive improvement in the quality, safety, and efficiency of healthcare through information and information technology by engaging hospitals and other healthcare organizations, clinician groups, employers and purchasers, health plans, healthcare information technology organizations, manufacturers, public health agencies, academic and research institutions, and public sector stakeholders.

Sponsoring organizations include a number of academic medical centers, including New York Presbyterian Hospital, the University Hospitals of Columbia and Cornell, East Carolina University, Georgetown University Medical Center, The Johns Hopkins University Medical Center, Duke University Health System, and the universities of Pittsburgh, Tennessee, Texas, and Virginia. Public sector partners include the AHRQ, Department of Defense, National Library of Medicine, and many leading corporations, professional societies and health advocacy organizations.

The eHealth Initiative is addressing these problems through advocacy, education and other informational activities. Programs supported by the eHealth Initiative and Foundation for eHealth Initiative include:

- **Accelerating the Adoption of Computerized Prescribing in the Ambulatory Environment.** This initiative engages stakeholders from across every sector of the prescribing chain to develop design, implementation and incentives recommendations that will facilitate the effective and rapid adoption of electronic prescribing in the ambulatory environment.
- **Connecting Communities for Better Health Program.** This program provides seed funding and support to multi-stakeholder collaboratives

within communities who are using IT and health information exchange to address quality, safety and efficiency goals. This program will demonstrate value and evaluate impact of IT and further the development of strategies and tools to facilitate an electronic health information infrastructure.

- **The EHR Collaborative.** This is a consortium of health care information technology-related associations working together to achieve common goals related to the adoption of standards across the healthcare community.
- **The Healthcare Collaborative Network.** This network has launched a national demonstration project involving large hospitals, leading healthcare technology leaders, and three federal agencies, which is designed to demonstrate both the feasibility and value of an electronic model of standardized data interchange to support public health, quality and safety goals.
- **Investing in America's Health.** This project is a large-scale communications campaign designed to raise national awareness of the role of information technology in addressing quality, safety and efficiency challenges in the U.S. healthcare system.
- **The Leadership in Global Health Technology Initiative** is facilitating an international dialogue among both industrialized and developing countries regarding policies and methods to implement a health information infrastructure to support common quality, safety, and efficiency goals.
- Through a coordinated **Outreach to Employers**, the eHealth Initiative has employers in a dialogue to foster and support employer and purchaser efforts to advance the safety, quality and efficiency of healthcare through the adoption of an interconnected, electronic health information infrastructure. Representatives from sixteen large private employers came to Washington D.C. in July 2003; to begin laying

the foundation for a long-standing, collaborative relationship between eHI and employers.

- **The Public-Private Sector Collaboration for Public Health.** *This initiative has engaged multiple stakeholders across every sector of health-care to develop strategies and methods for leveraging standards-based information systems to support public health surveillance, management and response.*

The AHC as Partner with Private Industry for Disease Management: The University of Michigan, GM and Ford

(See: <http://www.med.umich.edu/partnershiphealth/> and <http://conferences.mc.duke.edu/2002dpssc.nsf/contentnum/bh.>)

Since 1997, the University of Michigan has worked in a pioneering partnership with both the Ford Motor Company and with General Motors to develop and implement innovative employee health plans featuring high intensity medical and disease management. Current UMHS programs include Partnership Health, a collaboration with Ford, and Activecare, a collaboration with GM. John E. Billi, M.D., Associate Dean for Clinical Affairs of the University of Michigan Medical School, and Associate Vice President for Medical Affairs of the University of Michigan, serves as co-chair of two regional evidence-based quality improvement initiatives including the Southeast Michigan Quality Forum and the Michigan Quality Improvement Consortium.

The AHCs as Catalysts of Change and Progress

The foregoing is a just a sample of the hundreds of vitally important programs and initiatives being pursued and modeled by AHCs and their public and private partners. They are doing their part in the national challenge to create a STEEEP health care system. Yet, it is

likely that most of this good work remains unknown to the public or even to policy experts or other interested parties who are not directly involved in it. Even as and when one or another effort gains some public exposure, it is seldom linked to other similar or complementary efforts.

AHCs and others are truly pioneering tomorrow's health and health care systems. But traditional academic and other local "ownership" boundaries contribute to a lack of common knowledge, coordination or other timely, systematic and structured sharing of methods and outcomes among these many efforts. This means that they fail to play the role that they could and should in promoting the health policy convergence and in moving public policy past the remaining political and practical roadblocks to significant health system reform and health status improvement. Overwhelmingly, this is because each of our centers has operated as if they were castles in separate nation-states rather than being national resources facing and addressing common problems and opportunities.

AHCs and their partners have the capacity to change this. The Blue Ridge Group believes that the time has come to dramatically increase and improve the coordination, sharing and cooperation between and among AHCs. At present there are several associations that play important roles in coordinating common areas of policy and advocacy. But their agendas historically have not accommodated the degree of collaboration we feel is needed.

The Blue Ridge Group recommends that the following steps be taken to focus AHCs and their professional and other human resources on realizing the goal of achieving a STEEEP health system, accessible and affordable to all.

Recommendations

1. All AHCs should formally adopt the goal of achieving a reformed health system and proceed to develop the research and educational agenda needed to assure that our nation provides:
 - a. health insurance that will promote better overall health by providing financial access for everyone to necessary, appropriate and effective health services, and
 - b. a health care system that is safe, timely, effective, efficient, equitable and patient-centered (STEEEP).
2. This implies that AHCs identify and adopt in each of their missions best practices that lead to promotion of universal coverage and each of the IOM's STEEEP aims. This includes programs that promote these goals and values in programs involving:
 - a. student and resident education and training
 - b. patient education
 - c. community outreach and partnerships
 - d. clinical services
 - e. the conduct of translational research and development
3. AHCs should adopt the IOM's STEEEP aims in their roles as employers.
 - a. Many AHCs have some of the largest and most comprehensive health care delivery systems and are among the largest private employers in their regions. Both as employers and as health care providers, AHCs have a special opportunity and responsibility to be leaders in health promotion and chronic disease management with their own their employees.
4. AHCs have a responsibility to be both leaders and partners in the adoption and improvement of IT systems in education, clinical care and research for their regions.
5. AHC and professional leaders can be seen to have a special responsibility to sustain and promote achievement of a STEEEP health system not just at the local and state levels, but at the national level as well. National-level leadership from those at the highest levels of practice, administration, and innovation is indispensable to bringing about meaningful and lasting change.

With respect to recommendation #5, the Blue Ridge Group believes that AHC and professional and academic leaders should take a further, unprecedented step. AHC and professional and academic leaders must, as a group, move to a more cooperative and common agenda for national health reform. They must align and coordinate resources and agendas so that, as a group, they can act as the major leadership force that the AHC and medical community must be in determining the future of the health care system. While many AHCs are quite different from others, all share the difficulties of achieving best practices in health care, education and research within the current environment. AHCs should build on their commonalities to develop a much more shared sense of vision and collaboration.

6. The Blue Ridge Group recommends an AHC STEEEP Leadership Summit. The objective of the planning process for the summit, its agenda, and ultimate execution will be to create the policy consensus and the resource and organizational capabilities to make the AHC and health professions community a major leadership force for the future of the American national health care reform.
 - a. We propose the following as a roadmap for this process:
 1. AHC STEEEP Leadership Congresses should be designed to bring together AHC and health professions leaders, on an 18 month timeline, in regional and/or in other relevant groupings to define a common leadership vision and agenda for American health care for 2020.
 2. These Congresses should establish requisite working groups with timelines to develop a consensus vision, agenda and proposed action plans and required resources over a period of 12 months.

3. Out of these Regional congresses a leadership steering committee should be formed to plan for an AHC STEEEP Reform Leadership Summit. The STEEEP Steering Committee would be charged with defining a consensus vision and an action plan, and to plan the Summit, perhaps by forming an executive planning committee.
4. An AHC STEEEP Reform Leadership Summit would be convened where the vision, plans and resource requirements would be presented, refined and ratified.

Out of this process, the goal would be for the AHC community to develop the resources, structures and/or organizational and institutional capability to be a major leadership force for future of the American health care system.

This proposal contemplates that the existing organizations that represent various aspects of the AHC will be significant actors in this effort, including the AAMC, the AHC, the AMA and many other provider and professional organizations. The call for a Summit is in no way meant to suggest that one or another or some combination of existing organizations might not be identified as the right and best organization or entity through which to organize and coordinate the STEEEP Reform Summit. But it is to say that our current coordination and leadership capabilities and mindsets are not nearly sufficient to what is required of us. Either one or more of our existing organizations must be vastly strengthened and resource-enhanced, or else combined – or we must find the new organizational form or nexus with which we can become the pro-active and effective leadership force that is required.

The convergence of public and policy consensus around the need for universal health insurance coverage and a health system that is safe, timely, effective, efficient, equitable, and patient-centered is at risk of devolving into a new era of partisan dysfunction. Achieving the promise of a healthy future requires the leadership that only a strong, visionary and unified AHC community of leadership can provide. It is time to step up and provide that leadership.

Appendix 1. Principles Developed by IOM Committee by which to Evaluate Proposals for Universal or Near-universal Access to Affordable Health Coverage.

Four Prototype Reform Strategies

In its final report, the IOM Committee on the Uninsured made a bold attempt to address this road-block. It developed a model approach that stakeholders could adopt in evaluating how well different approaches to health care reform might address the problem of uninsurance. The Committee analyzed the range of health care reform proposals and divided them into four basic approaches. It then applied its five basic principles for health care reform (see Exhibit 1 above) to each in order to begin to characterize how each approach might perform with respect to each principle.

The IOM committee's approach illustrates the possibilities for systematically evaluating the ability of particular reform proposals to achieve universal or near-universal insurance coverage and the "six aims."

Each of the four prototypes would require system change, ranging from least to most.

Prototype 1: Major public program expansion and new tax credit

The current favorable tax treatment for employment-based private insurance would remain. Employers would not be required to offer coverage. Medicaid and SCHIP would be combined; Medicare would be extended to 55 year olds who pay a premium. A tax credit would be provided for moderate-income individuals to purchase private insurance; the tax credit would be both refundable if a person owes no taxes and available as a credit when the policy is purchased.

Prototype 2: **Employer mandate, premium subsidy, and individual mandate**

Employers would be required to offer coverage and contribute to their workers' premiums, although a federal premium subsidy would be available for employers of low-wage workers. Medicaid and SCHIP would be merged, and Medicare would remain as it is. Individuals would be required to obtain coverage through work, through enrollment in a public program, or through individual purchase.

Prototype 3: **Individual mandate and tax credit**

It would be the responsibility of individuals to provide health insurance for themselves and their families through the private market. Each person would become eligible for an advance, refundable tax credit. The federal government would administer the tax credit. However, insurance regulation would remain at the state level. Medicaid and SCHIP would be eliminated, but Medicare would remain as is.

Prototype 4: **Single payer**

Everyone would be enrolled in a single, comprehensive benefit package, but persons could purchase supplemental policies for non-covered services. This approach would be administered and funded federally but would use contractors and private health plans to review claims and process payments, much as Medicare does now. A "global budget" would help control aggregate health care spending. Medicaid and SCHIP would be eliminated; those currently eligible for Medicare could be folded into the single payer model.

Assessing Reform Strategies Using the Principles

Each prototype meets some principles better than others. For example:

- **Universality.** Universal coverage is more likely to be reached through any model with mandated coverage, compared to the voluntary approach of Prototype 1.
- **Continuity.** Continuity and portability of coverage remain issues for Prototypes 1 and 2, particularly when a person changes jobs or family relationships change. The single payer model, Prototype 4, would most successfully eliminate gaps in coverage.
- **Affordability and Sustainability.** Affordability of any plan to individuals, families, and the country would depend on the size of subsidies or tax credits and cost sharing requirements. Tax credits going to low and moderate income individuals would be more progressive and equitable than current tax exemptions for employment-based coverage. One value of a tax credit is that the federal income tax is a relatively sustainable source of revenue compared to current funding sources.
- **Enhancing Access to High Quality Care.** There would be more federal leverage in designing a comprehensive benefit package in Prototypes 3 and 4. Single payer models, much like Medicare, are generally considered to have substantially lower administrative costs than private insurance plans, since the need for advertising, underwriting, and much eligibility and billing work disappears.

Implementation of comprehensive reform based on any of these four prototypes could more nearly achieve each principle than does the current hodgepodge of insurance mechanisms.

Appendix 2. Leadership and Innovation for the Future of Health Care

The University of Virginia: AHC as Partner with Private Sector and Local and State Government IMPROVING QUALITY OF CARE: A PARTNERSHIP OF MEDICAID WITH PHYSICIANS

The dimensions of “quality” have been defined by the Institute of Medicine as effectiveness, efficiency, safety, timeliness, patient-centeredness and equity. Many of these can be improved by providing the most appropriate care possible; such care can be informed by practice guidelines that are developed by representative groups of physicians, and based on evidence. Most certainly, practice guidelines do not completely define appropriate care since patients are individuals and care must fit the patient. Nonetheless, in more cases than not, practice guidelines provide the best information for the individual patient.

Despite the presence of guidelines, physician practice does not always match the guidelines, and there is wide variation across the country. Numerous attempts have been made to improve physician compliance with guidelines, including chart reminders, preprinted orders, patient reminders and visits with physicians from known experts. It has been hypothesized that payment may be a stimulus that could lead to better compliance. The Institute of Medicine has endorsed this practice, recognizing that care may not be permitted to fall below a certain standard, but that it would be appropriate to pay for quality above that standard.

Accordingly, this proposal is made in which payment will be tied to practice guidelines. To incent positive use of the guidelines, performance measures derived from national guidelines will be the benchmark, and after a lower limit of performance is chosen, payment will be made for measures above this level (e.g. after acute myocardial infarction, 85% of patients receive beta blockers). Additionally, to incent the reduction in waste, if a national organization has recommended that a test or treatment is not indicated, this test or treatment will not be reimbursed.

METHODS

1. To make the greatest impact, the 30 most costly Medicaid diagnoses in Virginia (10 highest inpatient, outpatient and emergency room) were tabulated.
2. These diagnoses were submitted to the US Agency for Healthcare Research and Quality Guidelines Clearing House, and 10 diagnoses were chosen that had national guidelines and performance measures that were based on data as much as possible and that had the most consistent guidelines across different organizations preparing them.

The diagnoses were:

1. Asthma
2. Congestive heart failure
3. Acute respiratory failure—adult
4. Pneumonia
5. Chronic renal failure
6. Sickle cell disease with crisis
7. Newborn respiratory distress syndrome
8. Neonatal jaundice
9. Schizophrenic disorders
10. Dementia

3. Since these guidelines will now be used for payment, it will be important to be certain the performance measures and non-reimbursed tests and procedures are current and that experts from Virginia validate these as applicable.
 - a. The president of the physician specialty society in Virginia that is most closely allied with the diagnosis will be contacted.
 - i. Willingness to participate in a session of “vetting” the guideline in their area of expertise will be assessed.
 - b. For those willing to participate, the guidelines and performance measures will be sent to 6 specialists in the field chosen by the president; additionally, 4 generalists will be asked to participate, from Virginians nominated by the American Academy of Family Practice, American College of Physicians, and American Academy of Pediatrics.
 - i. Individuals will be asked initially to choose 5 performance measures for positive reinforcement and 5 tests/treatments for non-reimbursement.
 1. For the initial pilots, inpatient measures may be more efficient to measure and report
 2. They will be asked to choose those performance measures that, in their opinion, are not being done consistently; and for non-reimbursed tests/treatments, those that are being performed, but should not be.
 3. For drugs, an evidence-based formulary (based on guidelines) will be needed for pharmacists; the percent of a physician’s prescriptions for a given condition that meet the evidence-based criteria could serve as one of the performance measures
 4. A telephone conference call will then be held and a modified-Delphi approach will be used to achieve consensus on between 3-5 measures in each category.
4. Three diagnoses will then be piloted. The cardiologists have agreed to pilot congestive heart failure.
 - a. Methodology for the following will need to be developed:
 - i. Data collection and analysis—must be HIPAA compliant
 1. For performance measures, an aggregate will be required at the end of the year. This is to be collected by either a. physician self-report, or b. concurrent data transmission.
 - a. Physician self-report
 - i. There would be no pre-approvals.
 - ii. Physicians are paid through the year for each patient.
 - iii. Software would be developed and provided by Medicaid. This would contain a form that would list applicable performance measures as well as Class III indications. For each patient on the list, physician (or staff) would mark applicable performance measures (e.g. patient had ventricular function test during the year, etc). If the patient had a Class III indication, the physician could indicate a reason for an exception (why this should be paid). Otherwise, Class III would not be paid (and would result in a need for reimbursement to Medicaid).
 - iv. The physician’s office would keep the record concurrently with each patient visit.
 - v. At the end of each year, Medicaid would send each physician/physician group a list of patients with the diagnosis from ICD-9 codes. Those patients would be downloaded from the software.

1. Return of the form would trigger a payment by Medicaid for the time taken to collect the data (“payment for structure”).
 2. Payment would also be made for the aggregate performance measures. Any non-payment for Class III would be deducted. At least in the first year of the program, if the deductions for Class III exceeded positives for performance measures, the physician would not be asked to repay.
 3. Physicians choosing not to participate would not be required to do so.
- b. Concurrent data transmission
- i. Electronic methods could be available to tie a test/treatment to a guideline electronically (e.g. a test would require coupling to a diagnosis).
 1. Concurrent review using electronic methodology could be developed related to practice guidelines.
 2. A methodology for dealing with exceptions will need to be developed. Certain patients do not fit the guidelines and exceptions must be granted. The medical director would ultimately grant these exceptions using the guidelines developed by the physician advisory committee for that condition.
 3. This could be done by a web-based tool using a screen similar to current preapproval screens, but where the physician could log the exception on the web. In any event, exceptions must be noted in the chart (ie, the reason that the patient does not fit the guideline).

—*Note: enhanced FMAP is available for Medicaid Information Technology*
- c. For either method, random audits would be performed
- i. Auditing could be done by telephone after a letter/email was sent with the names of the charts to be audited.
 2. Pilot physician groups will be chosen (3). The adherence to guidelines will be measured in those groups before and after the program goes into effect.
 3. Payment amount and methodology. It is recommended that for positive change, a 10% premium is needed for CPT codes involved in performance measures.
 4. Calculation of cost of the program and both financial benefit as well as medical effectiveness.
 5. Communication with physicians about the program.

These pilots will last for one year, following which other physician groups and diagnoses will be added.

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