



**Preventing Chronic Disease: The New Public Health  
Alliance for Health Reform  
June 10, 2011**

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**ED HOWARD:** In fact there's some great seats up front. They're the same price as the ones in the back. I'm Ed Howard with the Alliance for Health Reform. Thank you for coming. I want to welcome you to this program, on behalf of Senator Rockefeller and our board of directors, to this program about chronic disease, its impact on America's health and what's being done about it both nationally and in communities around the country.

We've got really an epidemic of chronic disease. It affects 130 million Americans, causes 70-percent of the deaths in this country, and accounts for 75-percent of health spending. Now those are numbers that catch the ear. Congress was listening when it passed the health reform law. Several parts of it speak directly to the question of chronic disease.

One of the most interesting and promising approaches reflected in the Accountable Care Act, though certainly not confined to that act is the focus on improved population health by improving conditions where Americans live, learn, work, play.

This approach that features efforts at prevention is called, by some, the new public health and communities everywhere are beginning to address areas such as tobacco use, obesity, the need for more physical activity, and others as a

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way to improve the health of their populations. Fortunately, our panelists and my co-moderator are very well equipped to help us examine these various initiatives and the promise that they may hold.

Our partner today in sponsoring this briefing is the Robert Wood Johnson Foundation, the nation's largest philanthropy devoted exclusively to, now let me see if I can get the tagline correctly, helping Americans enjoy healthier lives and get the care they need. How's that?

**JAMES MARKS:** Very good.

**ED HOWARD:** Alright. We're pleased to have with us today, as a co-moderator, Dr. Jim Marks who's a Senior Vice President at the Foundation, directs all of the work in the area of health as opposed to healthcare though he knows a little bit about that too. Thanks very much to Jim, to Kate Sullivan-Hare and their colleagues at the Foundation for their support and help in putting this briefing together. It wouldn't have happened without them. Jim, let me turn to you at this point.

**JAMES MARKS:** Thanks Ed. I'm also pleased to be here and I want to extend a special thanks to our panelists and you'll hear from them, four terrific experts on the subject at hand. I also want to thank all of you who've come to join us here today. Ed's already touched on why this briefing is so

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important and especially in the area of chronic disease why prevention is so important to us as a nation but with the Affordable Care Act regardless of your position on that Act, it was, for the first time, that the discussions about medical care reform included real talk about the importance of prevention and those actions that are beyond medical care that are so critical to the health of all Americans.

We, at the Robert Wood Johnson Foundation, firmly believe that we have to transform our nation's approach to health to be much more preventatively oriented, put a better balance between medical care that's subscribes to repair the damage already done by injury or illness in a nation that works to lower the amount of serious illness and injuries that we must try to repair. Regardless of the future of the Affordable Care Act, we cannot continue to delay this transformation in our nation.

Our President, Dr. Risa Lavizzo-Mourey has said covering the uninsured alone will not solve what is ailing the healthcare system. She went on to indicate that we certainly need to cover the uninsured and improve the quality and equality of care and bring down spending but she also went on to list three other critical pillars of comprehensive health reform that we need to prevent disease and promote health behaviors, strengthen our nation's public health systems, and

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its ability to protect and preserve our health and to address those social and community factors that determine all of our future health. All of these are necessary for us to solve our nation's cost and health crises that are so central to our economic strength.

You know the litany; we're at a watershed time in our nation's history. We spend roughly twice what other industrialized countries spend for medical care, about \$4,000 more per person for each year and yet we are far less healthy as a nation. The size of the difference in spending between us and other countries is so large that our business leaders now recognize that it is undermining our economic competitiveness as a nation. This excess cost is related, in part, to the amount of illness we must take care of.

We have the highest rate of obesity among the developed countries, our principle economic competitors. We have the highest rate of hospitalization for diabetes, a disease brought on largely by the effects of obesity and inactivity. I want to be clear as we discuss prevention with you. Preventing the onset of illness is not the only thing that will be needed.

We still have a lot of work to do on medical care, financing, coverage, and efficiency but we have to be honest with ourselves as a nation. Technologic advancement, where a nation's leadership is unquestioned, has failed to reign in the

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growth of medical care costs. I think more surprisingly, it is not even enabled us to have better health relative to other countries of similar wealth.

According to big picture measures of health outcomes such as life expectancy and infant mortality, we do poorer than almost every other developed country. Other countries are frankly getting healthier faster than we are despite our big increase in dollars spent on medical care. The fact is that the likelihood of becoming ill or suffering an injury is really about whether someone smokes, what and how much they eat, whether they're active, the safety of a neighborhood, toxins, microbes, and conditions people are exposed to where they live, learn, work, and play.

This leads us to conclude that the major disease problems and the cost problems that go with those of our society will require us to look for solutions beyond the medical care system. Without less disease, we're finding that we cannot afford to provide the best treatments medical care has developed for those who have become ill or injured. That's why the discussions we're having today on prevention and public health and for chronic diseases are so exciting and so needed.

We need to have our communities become ones that help us stay healthy as long as possible. No set of government programs can take the place of people making healthy personal

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choices but it is the role of government to make those choices easier for our families by aligning the incentives for them, for our businesses, and our local leaders. As a nation, we're going to have to think differently and look elsewhere for potential solutions to prevention, to public health, and all they entail. If we do not do this for the chronic diseases, we're just working at the margins. Ed has already told you that most of our costs come from those chronic diseases.

Now, not long ago, I had dinner with a business school professor from North Carolina who said he has seen industry, when it wants to move to expand in an area or build a plant, is asking how high is the obesity rate for the area it's considering? Business is viewing obesity for a proxy for future healthcare costs and productivity.

If those rates are too high, they stop looking and don't move there. This clear awareness that our national, state, and local economic competitiveness is so closely tied to our health and medical care costs means that those communities that are healthier will be more attractive places to businesses looking to expand just as business is starting to ask whether prospective workforce is healthy, they used to ask about whether they were educated enough for the jobs they're bringing in. We know that with health being such a large cost for them, this is a reasonable factor for them to consider.

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Fortunately, the American public is seeing this as well. In recent polls sponsored by us and others showed that the public support overwhelmingly a greater investment in prevention. That's why we're so excited to help sponsor this briefing and why it's so important that these issues become central to our discussions today and in the future. So I really thank you for being here and I'll turn it back to Ed.

**ED HOWARD:** Thank you Jim. Just a couple of logistical notes, you have materials in your packet and if you haven't looked at one of these packets recently, you should seek out that one sheet, I don't know what the title of it is, but lists additional resources and I would further urge you to go to our website, [allhealth.org](http://allhealth.org), and find that one pager because then you will have direct links to a ton of other resources on this topic that we saved a few hundred trees by not printing and putting it in there.

There'll be a web cast of this briefing available on Monday to our friends at the Kaiser Family Foundation on their website, [kff.org](http://kff.org), and a transcript on our website a few days after that. I would remind you that there are opportunities for you to raise questions both at the microphones that you see in the audience and on the green question cards in your packets, which we will read if we can get through them all.

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There is a blue evaluation form that we would urge you to fill out so that we can make these programs better as we go along.

As Jim has alluded to, we've managed to assemble a world class panel here of people with both national and community level experience and expertise and we're going to hear from them and then you'll get a chance to enter the dialogue. So let's get started. We're going to lead off with Jeff Levi, Executive Director of the Trust for America's Health, where he leads the organization's advocacy effort on behalf of a modernized healthcare system in this country.

He serves on and since April has chaired the President's advisory group on prevention, health promotion, and integrative and public health and sort of on the side, he's a Professor of Health Policy at GW School of Public Health. We've asked him, today, to help us frame the major issues in this area. Jeff thanks very much for being with us.

**JEFFREY LEVI:** Thank you Ed and I'm delighted to be here. What I'm going to do very quickly is try to frame chronic disease and prevention of chronic disease in the context of essentially new strategies that we need to embrace and undertake in order to effectively deal with them. So that's why I sort of call this the new public health. These are growing challenges that require not just different response

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from the healthcare system but also from the prevention world and the public health.

In fact, the challenge of chronic diseases really is that we need to look beyond the biomedical model. We, in the United States, tend to prefer a magic pill, a magic shot, some sort of magic bullet that will make the problem go away. In fact that isn't the case for the chronic diseases that we're talking about, the ones that are driven by physical inactivity, poor nutrition, and tobacco use.

Those chronic diseases are the drivers of healthcare costs in this country. So if we're ever going to bend the cost curve, we're going to have to address these issues. These are really behaviorally-based and have a very, very few clinical interventions.

So that's why there's been this transition within public health and the prevention world, from thinking less about programs and one-on-one interventions and really thinking about the communities in which people live, thinking about policies, thinking about systems, and also thinking about programs that can address these behaviors.

You'll hear more from others about this but while this appears, at least in the public discourse, to be a relatively new approach, these are evidence-based. We know that if we

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make policy changes and systems' changes, we can make a difference, very simple example.

If you think about encouraging someone to increase physical activity, you can have that conversation in a doctor's office but if the patient, in fact the AMA had a whole campaign about a prescription for exercise and doctors were writing that prescription, but if you leave the doctor's office and you enter a community where it's not safe to be physically active because you don't have sidewalks or because there's violence in your parks or playgrounds, it's not going to happen.

Solving those problems actually are policy solutions and less programmatic solutions not to say that there aren't also programmatic approaches that need to take place but a lot of what needs to take place from a policy perspective and a programmatic perspective has to take place outside the clinical setting.

The other thing that's interesting about this approach is that for chronic diseases at least, we're talking about prevention being very similar to treatment. So if I'm going to prevent becoming obese, prevent developing diabetes, I'm going to be told to eat better. I'm going to be told to be more physically active. Someone is diagnosed with diabetes, how can we successfully actually reverse that diabetes? Diet and exercise.

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So what is, in some respects, being invested in as a primary prevention tool also turns out to be a form of treatment all of which need to occur in a community setting.

So that's nice but as all of you know and the discussions that we have around policy these days, we also have to talk about money. There is certainly a debate, and you will hear more about that later, about whether prevention in and of itself is a cost saver.

The truth of the matter is sometimes prevention saves money, sometimes it doesn't but most of the time, it improves either the quality or the length of the people's lives but when we're thinking about community prevention and when you see some of these studies and some of these debates around the value of prevention, be sure to make a distinction between clinical preventative interventions and community-based prevention because they are a different structure, a different cost, and can have a different economic impact.

So we were curious to see what could we learn about the economic value around healthcare costs alone of community prevention. So we worked with economists at the Urban Institute and colleagues at the New York Academy of Medicine and the Prevention Institute with funding from Robert Wood Johnson Foundation and the California Endowment to see.

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We looked at some of these evidence-based proven community-based interventions around physical activity, nutrition, and tobacco use could we save money. Indeed, the bottom line and you have a link to this report, the bottom line is that if we invested \$10 per person per year, within five years, we'd be saving \$16 billion annually in these chronic disease costs that we are talking about. That's a \$5.60 return on investment for every dollar invested in these types of programs.

So it's a real opportunity. CBO's not scoring it. That's a separate story but from a policy standpoint, one can look at it this way. Indeed, Congress and the administration recognize that and have made a number of new investments to reflect this. So from the prevention and public health fund that was created in the Affordable Care Act over the last two fiscal years, we've seen almost \$400 million going to chronic disease prevention.

That includes investments in the communities putting the prevention to work program, which Dennis will talk about in a little bit and the new community transformation grants, which is going national with a similar approach of using evidence-based strategies to look at policies and systems' change in the community that will have a lasting effect on these high-cost chronic diseases but just as importantly, the Center for

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Medicare and Medicaid Innovation is also investing in community improvement care models.

So part of CMMI is going to be looking at things outside the clinic because Medicare and Medicaid recognize that these are critically important to containing costs. When you think of what is happening with Medicare costs in particular and as the Boomers age on to Medicare and arrive overweight or obese with some of these chronic conditions, which don't shorten life but make treatment much more, annual healthcare costs much more expensive, investing in community programs that will reduce obesity rates, reduce diabetes rates, reduce hypertension, and all those other chronic diseases would make a huge difference for Medicare.

In the next week or so, we'll be seeing the release of the new national prevention strategy, which is coming out of the national Prevention Council. It was created in the Accountable Care Act, which brought 17 federal agencies together to come up with a national strategy on prevention. This is another recognition of the role of prevention outside the clinical setting.

The strategy will say essentially, be a commitment on the part of 17 different federal agencies, only one of whom is the Department of Health and Human Services saying health is part of our mission. Prevention is part of our mission and

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it's not just because we're good soldiers and the President and the Congress had told us to be part of this council but because it's good for our core business. Kids who are healthier do better in school. Young people who arrive for military service healthier are better soldiers. It goes on and on.

So the fact that there are these co-benefits to addressing these kind of prevention interventions is incredibly important. So this is urging the federal government in a sense to think across silos and stop thinking about disease by disease but thinking about kinds of policies that make for a healthier environment and make for healthier choices.

So when we think of something like physical activity, it's actually not just an intervention for obesity or for diabetes or for heart disease but NIDA just put out a report showing that people who are more physically active have an easier time quitting drugs and staying off drugs. We know that physical activity prevents falls among the elderly. We know that physically active kids are less likely to engage in risky sexual behavior. So the list goes on and on.

So we have to stop thinking about disease by disease and really thinking about what are the interventions that work across these silos that brings multiple disease groups together. It also brings multiple agencies together because as we're promoting physical activity, it's not just what the

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health department says. It's also what the zoning authority says. It's what the schools do. It's what the housing and urban development people do.

Now I just made a case for prevention and we have to show cost estimates, all that sort of thing. Intuitively we'll all believe that prevention works and prevention is popular. This is a slide from a series of polling efforts; bipartisan polling by Greenberg Quinlan and public opinion strategies that shows a huge percentage of the American people believing that prevention is worthwhile as an investment. So you see that 70-percent of Americans believe that prevention is a money saver.

Then when you say well what if it isn't a money saver, would you still want to invest in it? The answer is still yes. Actually it goes up a point, 71-percent. So there are very few issues that any of us are engaged in in Washington that get this level of support. So Americans intuitively understand it and I think with things like the prevention strategy and the community transformation grants and the investments in the Prevention of Public Health Fund, we're beginning to see that carried out in policy. It's going to take us a little time to see the results. Thank you.

**ED HOWARD:** Alright. Thank you Jeff [applause].

Incidentally, one of my old mentors, Claude Pepper, who was a member of both the Senate and the House at different times in

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his career actually got into the health issue after World War II when he found that one-third of American boys were failing the physical.

**JEFFREY LEVI:** The sad thing is back then it was they were failing the physical because they were malnourished and now we have very high percentages failing because they're still malnourished but in the opposite direction now [laughter].

**ED HOWARD:** Good observation. We're going to turn next to Christine Ferguson who's actually also a faculty member in the Department of Health Policy at the School of Public Health and Health Services at George Washington. She has run Medicaid programs in two states. She was the principle health advisor for many years to the late Senator John Chafee including the period in the middle of the last health reform debate, and perhaps most relevant to today's discussion, Christy currently serves as the Director for the Stop Obesity Alliance, which is a public-private effort to reverse the trend toward obesity and related conditions. So Christy thanks very much for being part of this discussion.

**CHRISTINE FERGUSON:** Thanks Ed. So I want you to know that I spent, and Jeff will laugh at this because he will know that I have never done this before in my entire life, six hours trying to figure out how to get the right message to you guys in eight minutes today.

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**ED HOWARD:** Take 10.

**CHRISTINE FERGUSON:** I have never, ever, ever, ever spent that much time. It is so important. There are 20 or 30 people in this room who are going to choose to make a difference in their life around healthcare issues. What we are trying to give you are some of the tools to break through all of the noise. So I've been a public health commissioner at the state level. I've worked at the federal level in a legislative job just like you guys.

I'm on the board of the Blue Cross plan. I've been on the IOM, many different commissions on the Institute of Medicine, and I'm on the board of Children, Youth, and Families right now. So I know all the acronyms and all the different words to use and how to make the argument to the intellectuals but at the end of the day, the way that we win on these debates is really understanding how to translate this into English. So that's what I'm going to do today for you and hope that we can inspire a few of you guys to really take this on.

In 1986, before maybe about the time that some of you were being born [laughter], maybe before, maybe slightly after, I wrote a bill for my mentor, John Chafee, Senator John Chafee, called CHIP and it was a Children's Health Insurance Prevention bill, whatever but you know what that bill did?

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It would have required, for the first time, that private companies provide coverage for maternity care, well baby care, immunizations, very simple things that all of you would never imagine wouldn't be in a health plan that you would buy. Same thing with the Medicaid program, it didn't cover any of those things.

So what we're talking about is the next evolution of healthcare. This evolution is not about coverage of certain services although that's part of what we need. It's about how you link all of these pieces together in order to create a healthier population.

So let's start with and I'm using obesity as an example but you could, for many of these things, insert any other chronic disease, diabetes, heart disease, a variety of different things. So if you think about what we are going through right now around the obesity issue, we are moving and Jeff, you're going to kick me if I start to talk too fast and get overly enthusiastic, if we look at overweight and obesity and the way that a lot of us think about it in terms of looks, what we're trying to do is to change that conversation from looks to health.

Health is about preventing, moving up the latter. So if you're normal weight, we don't want you to become overweight

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but if you're overweight, we also don't want you to become obese right?

We want you to lose increments of weight and keep them off. Those are the things that will lead to better health. So it's about health. A lot of people talk about obesity around personal will and responsibility. Yes that's true but it doesn't end there. You have to be able to have an environment to make healthy choices. We don't have that virtually anywhere, the Senate cafeteria included [laughter].

Then if you go back and you think about how people talk about obesity and they talk about preventing gaining weight or for somebody who is obese, losing weight that that's the key that we've got to get people to lose weight but here's the deal, right. Anybody ever tried to lose weight in this room? Anybody really? Come on [laughter]. The real issue is once you might lose that increment of weight is continuing to keep it off. That's not easy because the environment doesn't support it. So you had to really change your behavior in an environment that doesn't support that changing of the behavior.

So I was thrilled when the *Wall Street Journal* had a headline a couple of years ago. We started this about five years ago, a couple years ago had a headline, *Fighting Obesity May Take a Village*. Unbelievable, the *Wall Street Journal*

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headline, and all of the business groups were starting to talk about the cost of obesity.

That's great but when we look at how the Congressional Budget Office begins to score and look at all of the components that are necessary to support those efforts. They don't have any good hard data to show what the healthcare savings are because they're looking at it in a silo. They're looking at it from the perspective of healthcare costs and then over here, they look at economic costs and over here, they look at something else. They don't connect those dots.

So one of the things that we have done is an employer-employee survey and this came out in *Health Affairs* and I think it's in your materials but one of the key things that we found and I did this very specifically because everybody talks about how business gets it right. Now we could argue that but there is a general sense, sometimes on the Hill, that business gets it right, right, because they have a bottom line that they're concerned about.

So let's ask business what do they think about this issue? What they told us was 70-percent of them think that offering obesity-related services are appropriate and effective in the workplace. This is after 90-percent of them said it's the person's fault but basically they then said we don't care

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whose fault it is. It's our problem. We have to help them fix it.

So 70-percent of them view offering obesity-related services as appropriate and effective and 80-percent of employers, employees, regardless of their weight, said the same but less than half of them believe that their company has given enough attention to obesity. So why is this? you would think when you first hear it and when you go through the entire survey, you can see how we led up to the questions but when you go through it, you would think okay so they're worried about healthcare costs right?

Well no. They are worried about healthcare costs at a level of, and these are the large companies, so remember these are the companies who have long-term relationships with their employees. They're generally self-insured meaning that they take the risk of all their healthcare costs and so they're looking at their bottom line comprehensively. They're not buying insurance from somebody else.

So when they look at it, those big insurers, they're looking at it almost equally. I'm taking a little bit of political license here, almost equally, 41-percent and 52-percent, but almost equally between productivity and healthcare costs. That is the message.

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With people who really do measure their bottom line as the entire environment and output of their company, productivity is almost as important and, in some cases in other studies we've seen, more important than healthcare costs. We have no way of measuring that connection in our system of budget estimating. That is at the fundamental root of why we have not connected these two parts of our healthcare system.

So if you think about what you need really and now I'm speaking as a state health commissioner, somebody who worked closely with governors, they're looking at the bottom line. What is their competitive advantage against other states? What is a business' competitive advantage against other businesses?

Those competitive advantages come down to both the cost of their employees and the output of their employees. The same thing is true when you look at obesity as a whole for us, any chronic disease, it's about not only quality of life and improved health but the ability to be a productive member of society and to be able to achieve as much as you can possibly achieve.

This is the same problem as Jim said that we have the children. The investment early doesn't necessarily accrue to any one individual. It accrues to us as a society. So we haven't figured out how to effectively measure it but this is

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where you guys can make the difference in your generation. You have to push on this issue.

At the end of the day, the two things, the things that matter are personal choice and responsibility are absolutely at the core. You cannot do anything unless you are motivated as an individual. No one can do these things for you but you can't put a motivated individual in an environment where there are no grocery stores, they're shooting outside of their door, and the school is failing. You cannot put someone there and expect them to exercise personal responsibility and solve all of their problems.

So you need and businesses understand personal choice and responsibility support an environment where the healthy choice is the easy choice. The healthy choice is the easy choice at the end of the day. Those two things combined equals improved health and improved productivity and overall, for us as a nation, improved competitiveness and that's where we have to go. So the 20 or 30 people out there right now who want to make a difference, this is where you can make your mark.

**ED HOWARD:** Okay [applause] and if it turns out that there are 40 of you that would be alright too. Thank you Christy. Dennis Worsham is our next speaker. He's the Regional Health Officer for Public Health for Seattle King County. He's been active in areas like menu labeling and

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trans-fat elimination in retail food businesses. His current project is, as Christy was referring to, creating healthier corner grocery stores. It's called Healthy Foods Here.

It aims at that supportive environment that Christy was talking about. He's also the current President of the Washington State Public Health Association. On the national level, he's working with partnering with organizations to help shape the new federal nutrition labeling statute that was passed as part of the Affordable Care Act. He gets the award for the farthest distance traveled to be on this panel. Dennis thanks very much for taking the trouble to be with us.

**DENNIS WORSHAM:** Well thank you. I think it's a great honor to be here and to have this opportunity to share a little bit about the project we're doing. Christine's going to be hard to follow. She's a firecracker, so I'll try to be up.

I didn't get in until about one o'clock because of the storms and then didn't really realize the time difference until I had to actually get out of bed this morning so [laughter], so I am grateful to be here and really to be able to talk about a specific example as we talked largely about this move and the shift as we start thinking about policy and system changes to really make impacts in individual people's lives.

I think about when I started in public health 17-18 years ago and really started on the side of communicable

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diseases in a very oversimplified version, it's really about cause and effect.

You find out what the cause is and in public health, we have the ability to really then influence that effect by changing either an intervention, outreach, a treatment of some type. When we really start moving into why people are not having healthy years lived any longer and what are our leading causes of death in our communities, it's really at the crux of this conversation we're having today about obesity and as it relates to chronic disease.

In the last 100 years, we've seen life expectancy really increase about 30 years. A lot of that is really derived from good public health policy. What we're seeing now is people are living longer but the quality of life or healthy years lived are actually less.

So what we're trying to figure out is what, from a systems and policy change and things that we know in public health and a good public health practice, how do we start moving in a direction to make an impact in our communities, to make our communities healthy? So I think it was a nice set up for being able to give a very specific example of one of the projects that I'm working on directly within Seattle and within our county called King County.

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We were funded under the Communities Putting Prevention to Work grant, some of the stimulus dollars, and we were funded to start addressing some things from a policy level on chronic disease, looking at both tobacco, looking at healthy foods, healthy eating, physical activity, tobacco, and a number of other things, healthy and safe environments for example.

I realized that when we started making these changes and started really putting forward some of these things with our community is that it really has taken a collaboration with community. I think it's another big shift that has happened is when you start working around STDs and HIV, it can be individual level and it can be very focused as a public health practice but when you start addressing these other pieces, it really does take a village and a community to become involved.

This particular project I'm going to highlight today in a few slides with you is called Healthy Foods Here and as we talked about earlier, it's really about a focus about how do we get healthy stores within our communities that are accessible.

Seattle, for those who aren't as familiar with Seattle, Seattle's built on seven hills and so transportation sometimes is not just because of lack of transportation because of bus transportation but there's the problem with people not having cars and then there's the walkability of the community based on the geographic aspects of it.

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So we started looking and did a pretty good assessment in our community and basically, roughly this grant that we received was really looking about 304 square miles within our county and targeting specifically 11 communities.

Now if I had another slide here that I often show with this is that if I were to show you a slide of our poorest health outcomes in our community and then I were to show you another slide of our community, which probably has the highest level of poverty, these slides would almost be identical. One of the things that we think that we need to start addressing in this process is from a policy perspective, how do we do an equity piece and an equity lens to this type of work.

So this is our piece that we're focused on with the grocery stores is how do we start working in these communities of these 304 square miles where we're seeing our poorest health outcomes? What we do know and looking at grocery stores is we have higher density in these communities of fast food, higher density of corner stores and fewer large stores and medium-sized stores that offer full ranges of issues of food such as fresh produce and other healthy products.

So one of the things that we decided we were going to really try to do as a group is address these particular goals. We wanted to increase availability of healthy foods in these particular communities including beverages. We wanted to

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increase the business effect of this process as well but it isn't just about getting healthy foods in the community but how could we really make sustainable that when this grant was over that these stores would be successful once we left.

One of our ways in addressing that was really through getting people to become WIC eligible, to be able to carry WIC coupons. In order to do that in our state, you have to have 65-percent of staple foods that you carry in order to be able to be WIC-eligible. It builds a clientele for them. The EVT is the same as SNAP for those who are familiar but that increased capacity of store owners to sell their foods as well as create a demand in the community for this type of activity.

So how do we go about doing it? We did a quick survey within the community, what these healthy corner stores would be interested in and some of the things that we learned very quickly was they needed help with just basic things such as merchandising. How do we do a store layout, what is flow? We talked about produce handling. Some had never handled fresh produce before or even how to do inventory for ordering and when do you order too much or less is based on your clientele.

Distribution is a major issue for small, how do you make it affordable? They're not able to buy in bulk and so how do we really start changing the issues around distribution and supply for the chain development stores? They're looking at,

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as I mentioned, the WIC and EVT application and basic things also is bookkeeping, financial systems and marketing and store events. So these are some of the things that we decided really needed to be supportive in changing this and having it be a sustainable change in work that we do.

So what did we do is we put about \$700 in per store to look at produce, they can put in produce scales. They can do baskets to contain their produce. It's just a way to aesthetically make it work for them. Another thing that we do is refrigeration or freezers that we will put up to \$7,500 in order for them to start carrying these produce or frozen items. The store owner puts in about 20-percent of those dollars in order to get this particular capital. Then we also offer to them and refer them to some low-cost loans, which oftentimes they are not eligible for because most of these are very small corner grocery stores that are owned by families that are oftentimes are refugees and immigrants in our community.

So one of the things when looking at policies in particular that we needed to address with this work that we were doing was looking at some of the policy barriers and one of the things that we found very quickly is for those who are familiar with WIC is there's some federal guidelines but then the state has the ability also to do some guidelines.

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The challenges were actually at the state level for us that had put in some pretty strong barriers for some of these corner stores to be able to be WIC-eligible.

So what we've done is we have challenged the state process in trying to influence the changing of some of the WIC policies that are allowing them to do it. A good example I can give for that, talking about where it doesn't really sync up is we have several Halal stores for people who are from East Africa and so one of the requirements in our WIC to be eligible is you have to carry corn tortillas.

In these stores that are serving communities that do not eat corn tortillas, they were buying them in order to be eligible and then these foods were going to waste. So we decided that we really need to address, at a policy level, some of these particular issues.

So we found that stores were very interested. It built a clientele for them. It puts in more customers into their store and helps them to be successful. One of the store owners wrote how grateful he was that he had actually increased his sales of produce over the last three months that we had been working with him and also that he had also increased his clientele that new people were coming into his actual market. Some of the barriers that we also have identified is built environment.

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If you look to the picture to the right or to the left of you, oftentimes in some of our suburban communities, there are not very walkable communities and so one of the big challenges are that you see a lot of strip malls and people become concentrated in strip malls.

If you go into some older communities like here in D.C. and even in the city of Seattle, you have a lot more corner markets in those particular grocery stores that you can run across the street and pick up a few basic items that you needed to do. In some of our suburban communities where our poorest communities are at, because of the developments in the 1940s and 50s, these corner stores didn't really exist.

So we knew that we had another problem within some of these smaller communities is how do we also get fresh produce to them. So we started then increasing our reach out to some mid-sized stores as well. So we primarily focused on corner stores and then we focused on some particular areas of some mid-sized stores.

Another piece that I just wanted to highlight here, which I think is another focus that was great is we also started doing some work with churches who had some poor health outcomes. One of the great models that they started and we've helped enhance is called Clean Greens. It's a church that

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started offering farmer's markets right in their own lots, parking lots on Sundays.

It became so successful they were doing it mostly from pea patches that they bought some land collectively and started providing boxed food to people who were able to buy it at a little higher price within their church to subsidize the food that was coming in the farmer's markets on Sundays.

So we've helped them to be able to buy some hoop houses and those type of things where they can grow produce year round. So it's a good example about when you partner with community and try to address some of these things that you need to be flexible in some of these models that we've addressed getting healthy food into our communities.

Another lesson learned here is around the immigrant entrepreneurs and I mention this and I won't go into a lot of details about this but sometimes when they really serve culturally foods, we had to address that not only with the WIC process but also there's just barriers that when you start working for these immigrant entrepreneurs around never really doing cash handling, licensing permits, and really created some barriers for them in a number of ways. So we're really trying to address, from a systems level, how we can do this to have it be sustainable within their community.

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So one of the things that I want to say in closing is just to reiterate the point that has been made here is that as we move into really looking about chronic disease in these life expectancies, healthy years lived really decreasing is when you start looking at issues such as food and housing and development of communities is often those things live outside the government sector especially around food and housing. It's really going to take us working collaboratively across all of these sectors to make them sustainable, to make these changes within our community.

**ED HOWARD:** Terrific, thank you Dennis [applause]. We turn now to Dr. Steven Woolf who's a Professor of Family Medicine at Virginia Commonwealth University and Director of the VCU Center on Human Needs. He served 16 years as science advisor to and then a member of the U.S. Preventive Services Taskforce. He's a member of the prestigious Institute of Medicine. He also happens to be one of the clearest writers on prevention and public health that you'll ever come across and there's some examples of that skill in your packets. I commend them to you and I commend to you Dr. Steven Woolf. Steve?

**STEVEN WOOLF:** Thank you for the kind introduction. I was reflecting on medical school 30 years ago now and those of you who've been to medical or nursing school remember that a common question on final exams or board exams was what are the

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leading causes of death in the United States? The answer was heart disease, cancer, stroke, and so forth.

Unfortunately those still are the leading causes of death in the United States but it wasn't long after that that the light bulb went off in the medical community and in the public health community and we began to realize that the root causes of those diseases were, in many cases, our health behaviors.

The slide up there may be familiar to you, the leading causes of death showing the number of lives lost in the United States each year from the health behaviors listed but you probably can't see the fine print at the bottom, which is dated 1993. We have known for a long time about this and it's established knowledge in medicine and public health.

In fact, we now know that 38-percent of all deaths in the United States are attributable to the poor health behaviors listed there and again, if you got really good eyesight and could see the footnote, that's 2001. So we've know for a decade about this.

This type of information is instinctive to those of us in medicine and public health. We've got this imprinted somewhere in our brains but why is this important to the health policy community? I think my colleagues have emphasized this point rather well over the last few minutes that as a national

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economic priority, we have to be concerned about the growing prevalence of chronic disease.

This slide forecasts because of demographic shifts and the Baby Boom population and other trends in our society the writing on the wall that we are going to have a steady increase in the prevalence of very costly chronic diseases and that our ability of our healthcare system and our economy to sustain the burden of those chronic illnesses is in jeopardy unless we try to deal with the root cause that's driving this trend and thus the interest in dealing with these health behaviors.

As a family physician, one of the messages I wanted to convey is the fallacy of thinking this can be handled by doctors or by the healthcare system alone. Both the medical community and the public health community long ago moved beyond that notion in understanding that we can't effectively get control over these unhealthy behaviors without collaboration between both sectors. Neither one alone can do it by themselves.

All the cutting edge work is built around linkages and coordination between the medicine, public health, and community organization settings to try to facilitate healthy behaviors. As my colleagues have emphasized, it really is about changing the environments in which we live.

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The cutting edge work examples from our projects at my institutions have involved collaborations between primary care providers and, in this example, commercial weight loss entities like Weight Watchers in a study funded by the Robert Wood Johnson Foundation or partnerships between primary care practices and state quit lines operated by state public health agencies that offer smoking cessation counseling.

Without these types of partnerships, the ability to effectively help patients decrease their smoking habits or help reduce their weight are largely ineffective but as already noted, it really is a larger issue than helping to counsel patients about unhealthy behaviors.

The point's been made repeatedly in the last few minutes and I wholeheartedly agree that giving people advice about the personal choices they should make only goes so far if the environment in which they live is not conducive, if it's not possible to act on those choices. In the case of obesity or many other examples we could cite, it really requires cross-sector collaboration in a community among many different players to effectively change the environment, to help people adopt healthy behaviors. You heard some very good examples of how that is going forward and during the Q&A session maybe we could talk about some other examples.

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I want to turn, for a moment because of the climate that we're having this conversation about the economy and the budget cuts that are now very much on our minds, at the federal level and at the state level, at the municipal level, the same conversation is going on. The need to reduce government spending, to look at discretionary and entitlement spending, to deal with the budget deficit and the growing national debt.

The urgency of trying to get those spending levels under control is forcing reconsideration of various policy priorities of the budget community. This era of fiscal conservatism is driven by a belief that these cuts are necessary for the health of the economy.

I think many of us in the room would agree that's probably the case for many areas of spending that important cutbacks are important to achieve fiscal discipline and the health of the economy but this argument starts falling apart when we're talking about cutting programs. So it will result in increased healthcare expenditures.

If we reduce support for programs that will end up sending more patients into the healthcare system with a higher prevalence of the disease, a greater severity of illness, and ultimately a greater cost of care given the importance that the medical spending is now placing in our economic concerns, we're actually shooting ourselves in the foot.

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Some examples, this is from the White House website when the President's budget was released a few months ago. What it shows is that, I will use the pointer here, sorry Ed, about 23-percent of the budget, according to the White House, is going toward healthcare expenditures.

So we're not talking, as all of you in the room know, about an insignificant part of our economy. Any budget cutting decision that ends up building the size of that box is not a good idea for our economy. This is a study recently issued in, if not this month, last month's issue of *Health Affairs*, and if you haven't seen it by Bobby Milstein and colleagues, I'd urge you to take a look at it, using simulation modeling to help us look at different strategies for dealing with our healthcare situation in terms of the number of lives saved and in terms of spending.

They look at three categories of intervention. The first one, the one we've been busy with in the last year, increasing health insurance coverage. The second category, finding ways to improve the delivery of medical care and preventive services, clinical preventive services, but the third, changing our environment to facilitate healthier behaviors what much of us are talking about today.

What you can see and again, I'll use the pointer, is that if you look through up to year '10, there seems to be a

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short-term benefit to increasing healthcare insurance coverage but if you take the long view looking to results through year '25, this third category, which is the category of better behavioral and environmental conditions of the sort that we're discussing today, are ultimately what will save the most lives over time but pay attention over here. This is the category of intervention that would actually reduce costs.

Now this is yet another slide from their study, again showing a layered analysis, this time, of the three different strategies and the important point to draw out here is this curve here, the only one where, over time, total healthcare costs are actually falling.

A separate item we can discuss are the limitations of the CBO scoring window, which might not capture some of those benefits. This is a fundamental problem with us trying to make the right choices but again the larger point is our choice to reduce investments and strategies like the ones being discussed today in making our communities healthier will end up causing serious economic problems because of the health implications that follow from them.

In my remaining minutes, I just want to touch on a point that's been made a few times here about whether prevention saves money. Analyses like this and the one Dr. Levi mentioned suggest that in many cases it can but one of my

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pet peeves is the expectation that prevention should save money that our other investments in healthcare need not.

So if I were to talk to you about a new imaging device, a new antibiotic, a new cancer therapy, you would not ask me does it save money. We don't talk about saving money when we go to the grocery store to buy our groceries. We don't expect to get up to the cash register and get money handed back to us.

We do talk about saving money at the grocery store by getting better value on our dollar. So what we really ought to be thinking about in health policy, whether its prevention or treatment, is are we getting the most health benefit per dollar spent? So it's not so much whether we're saving money but it's the ratio of health benefit per dollar spent.

If you look at prevention, effective forms of preventive services, and look at the cost effectiveness, the actual ratio between the amount of health benefit, number of lives saved per dollar invested, relative to much of what we currently spend in our two-plus trillion dollar healthcare budget, prevention is a very good buy.

We get very good value per dollar for effective preventive services but the larger lesson for us to get control over healthcare spending over time is to try to optimize value in all categories of healthcare, in diagnostic testing, in treatment, in rehabilitative care so that we are able to

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stretch our dollars further and thereby get control over the cost curve.

We can't control the cost curve unless we try to optimize value and when you put that lens on and look at the various programs we're talking about today, you'll find that they come up very favorably in the cost effectiveness perspective because of the amount of health benefit they produce per dollar invested. Thank you [applause].

**ED HOWARD:** Great. Thanks very much. You have the opportunity now to join the conversation. The microphones are here. If you do use the microphone, I ask you to identify yourself and keep your question as brief as you possibly can and as the swarm of Alliance staffers fanning out would indicate if you have a green card question, hold it up and they will bring it forward.

**TRICIA BROOKS:** Hi. Good afternoon. My name is Tricia Brooks and I'm with Novo Nordisk. Thank you for an excellent panel as I think probably all of us in the room are very focused on prevention. I just quickly, I will tell you in our advocacy work, we keep on bumping up against the same walls. So I understand the discussion about not wanting to be disease-specific and yet you can highlight diabetes prevention as a great model.

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Diabetes is a gateway disease to heart disease and blindness and stroke and kidney failure and it's a great model for cost savings because we do have an evidence-based intervention but we keep actually coming up against the same wall about funding because it's disease-specific.

So I just wanted to ask the panel your recommendation on how because we really do believe that if we funded the National Diabetes Prevention Program, we would actually start getting this data showing that the delayed onset of the disease and the delayed onset of the complications associated with the disease that we actually think are a win in the messages for this administration to continue to fund prevention in the way that they propose. So I really look to the panel for ideas on how to help us advocate for funding for this evidence-based program.

**JEFFREY LEVI:** We're in a new era and the truth of the matter is we're not going to see large increases in categorical funding. So I think the diabetes prevention program is a perfect example of something that NIH demonstrated in a more academic setting through a randomized controlled trial.

CDC with partnerships with groups like the YMCA moved it into the community and translated it into something that is feasible on a large scale and so we can bring it to scale. Now it's time for the insurance system to be supporting it and not

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scarce discretionary dollars. In fact, United Healthcare has chosen to do that because they think it is cost effective and I think they're beginning to be discussions with CMS along those same lines.

So my belief is that in this new paradigm, if we really do believe that community prevention programs results in improved health outcomes and potentially reduced costs, the place to pay for those is through the third party payment system and not through categorical programs.

We should be saving scarce categorical dollars for demonstrating what works, for supporting policy change and the kinds of efforts that you see in the communities putting prevention to work but delivery of services, whether it's in a group effort or an individual effort, that should be responsibility of the third party payers.

**CHRISTINE FERGUSON:** I'll just quickly say you're absolutely right. United Health Group has stepped up in a big way to start this, but I do think that as long as, I think that it actually goes to prove the very point that we're discussing, which it must be a really good program that actually is a game changer and actually to have PSAs or the support of the federal government or have a benefit of CMS as you mentioned, I actually think that it's NIH-funded, it's CDC-produced, I think it's amazing when I see the amount of dollars going out of

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prevention and public health trust fund that even a small piece of that hasn't gone to show the support that the federal government has for scaling this. It is scaling. You're absolutely right but much slower than what we would like to see and the fact that the benefits we could have on the ground right now.

**JAMES MARKS:** I'd just like to add a little bit for people who don't know this program, this is a program that showed that people that were close, that were starting to show the early signs of diabetes, they hadn't yet been diagnosed with it, when given counseling about how to lose weight, encouraged to be active 30 minutes a day five days a week, lost 10 to 15 pounds.

It was twice as effective as medication for preventing the onset of disease. At that time, no insurer covered it. They would all have covered the drug even though the drug was half as effective. One of the things that has happened is United Health, as the woman mentioned, is now agreed to fund the YMCA to provide this service outside the medical care system because the Y did its own trials showing they could be just as effective as doctors.

So it is now starting to get out there but it's something that we don't have a way to encourage those kinds of community interventions even when they're shown to be more

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effective than medication, an area where we, without United Health stepping forward, we would have lost a lot of people to the disease because they would've gotten it sooner and worst.

Now we're going to have fewer of it but it's the kind of thing we could've done through Medicare, the kind of thing we could've done through Medicaid, kind of thing we could've done in the military even. All of those things could've happened but they were not part of the way we think about preventing the onset of illness.

**CHRISTINE FERGUSON:** That is absolutely where you guys come in. So the evolution of healthcare just like it evolved significantly in the 80s and 90s is evolving again. Where it is evolving and I'm a board member of a Blue Cross plan, I'm a payer, I've been on Medicaid, I've paid the Medicaid, the issue is what Jim just said about 10 to 15-percent weight loss, that two things have to happen for that to continue.

Number one, we all have to recognize that 10 to 15-percent weight loss actually is success. Anybody who has ever tried to lose weight often would say 10 pounds, 15 pounds not enough. Ten to 15 pounds really does lead to a very significant health impact and we saw that in the diabetes prevention program.

So now the question is how do you create an environment in the rest of the community that allows that person to sustain

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that weight loss over time because it's the sustaining over time that really makes a difference.

Two, how do we get payers like Medicaid, like Medicare, like Blue Cross to emulate some of what United's done but literally bring it into the payment paradigm that they use and insurers are doing this now because of health reform. They are rethinking all of these things. So you have an opportunity to really support those efforts in a way that wouldn't have been possible even five years ago.

**ED HOWARD:** I'm sorry I think he was here at the microphone before you were. So if you'll just hold for a second. Go ahead.

**BOB ROREBRIDGE:** Thanks. Bob Rorebridge, *Medical Journal*, a follow up sort of for Jeff, with the paradigm you described as a responsibility for some of these now being with payers, if the U.S. should adopt a single payer system, does it then become the responsibility of the federal government to do all of this, and less theoretically, what examples can we learn from other governments who are tackling these same issues with very different payment and reimbursement systems?

**JEFFREY LEVI:** It doesn't matter whether you're a universal system or not. It doesn't matter whether you're a single payer or not. You have the same medical challenges in a single payer system, I suppose, the payer is the same entity

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that benefits from the prevention intervention. I think that's the loop that we have failed to close in this country but you don't need a single payer system to be able to make the economic case for it and I wouldn't hold my breath for a single payer system before we start addressing these problems [laughter].

**ED HOWARD:** Yes, go ahead.

**SHANAE MCCLINTON:** Hi, my name is Shanae McClinton and I'm a graduate student in the Health Policy Department at George Washington University. Hi, I don't know if you remember me but we met before Professor Ferguson, you lectured at one of my classes [laughter] but I'm also here with [inaudible].

But my question is, Dr. Levi, you mentioned something about prevention being treatment, which I think is a great idea but it also makes me wonder if everyone was onboard of the prevention agenda, let's say payments were perfect and the insurance company was throwing themselves at paying for preventative services, would our workforce really support that because Catherine Sibelius herself said those people who are most likely to be sick or need healthcare are less likely to get it.

If you don't get some of the health professionals training preventative services, many institutions are just coming into it and we haven't even started talking about cultural

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competent community prevention. So I guess my question is do you think that we should maybe focus on the workforce to support it and if so, do you see anything coming down the pipeline that would kind of help us do that?

**JEFFREY LEVI:** Well there are multiple levels of answering that question. The first is when we think about a prevention workforce, we shouldn't assume that it is medical professionals who are doing that work. That's number one, so community health workers, promators, that kind of model.

Number two, a lot of the prevention interventions that we're talking about like Dennis described in more policy and systems changes and really aren't, they aren't necessarily health workers doing that, having a corner grocery store, know how to better provide healthier foods, you need to get small business school graduates involved as opposed to perhaps public health school graduates or else we in public health schools need to train people differently.

There's yet another way of looking at this is one of the big concerns around health reform is that we're going to have many more people in the system and are we going to have enough doctors, nurses, nurse practitioners, physicians' assistants, so on to take care of people.

Do a better job at prevention, there'll be less demand for those professionals and actually lower cost professionals

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who do prevention work because public health people are always paid less than medical people. I shouldn't say that if you're a public health student then I should be encouraging you [laughter] to continue to pay your tuition.

**CHRISTINE FERGUSON:** [Inaudible] you're going to be paid more [laughter].

**JEFFREY LEVI:** But nonetheless, so it depends on where you want to put your investment, you can actually change that equation as well but there's no doubt that we need more prevention workers.

**ED HOWARD:** Jim?

**JAMES MARKS:** I'm just going to add a little bit to this. I think that a great discussion here, we've already heard that we spend \$4,000 more per person per year in our medical system. So we are going to have to look for where we can find help beyond that. So there's an example in Charlotte where they put in a new light rail and they found that people who started to use that light rail walking to the light rail and to work and back again lost six to seven pounds.

That's pretty good. That's half as effective as the weight loss that was in the prevention program, completely unrelated to medical care costs, not something that was factored in as they were looking at the value of that system. So one of the big areas we think is important are called health

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impact assessments that are becoming much more prominent in Europe where all the major policies are looked at for their health effects and if there are ways that they can be modified to improve those health effects especially at reasonable costs.

You heard about the corner stores and getting fresh fruit and vegetables available and housing, the Federal Reserve is the organization that does a lot of the financing for public housing. Well they can put in sidewalks. They can put in parks. They can put in small grocery stores. They can put in clinics. They've never thought about health as one of the outcomes that they influence.

They're starting to look at that now. Schools, we all know but we got to recognize they are not under the responsibility of the public health agencies but they provide a lot of the calories that children get. Children are there a lot of their waking time when they need some time to be active for their health.

I think a crucial issue that we have to recognize is that many of the most important things for health are going to require leadership to step up but leadership who doesn't have health as their primary purpose. Public health, clinical system is going to have to ask them to do their share to improve health.

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**CHRISTINE FERGUSON:** So one of the interesting things that you could think about in terms of making that actionable is if you think five years from now, think five years back, what technology looked like. What we have a capacity to do now is light years ahead of what we had even five years ago and if you're like me where this electric typewriter with the erase thing was [laughter] the new technology of the age, this is huge.

So if you think about it from the perspective of being able to really track some of these things and look at how they connect together, we have this really extraordinary opportunity to rethink how we do this. We've been struggling with the idea of an impact statement on obesity so that every piece of legislation that was introduced would have to have an impact statement. So obesity is too narrow. Maybe you make it chronic disease. Maybe, and you try to do the same thing with children and children's impact statement.

So if you put a new bill in, what would be the impact on children from an education, a healthcare perspective, etc. What we really struggled with trying to do that because the technology and the information didn't really exist.

I think five years from now, the technology and information will exist and if we're smart about identifying what the categories might be that we need information in, we

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can figure out how to set it up, how to set all of our systems up so that we're drawing that information in and we literally could have impact statements from transportation to education around the effect on chronic disease and how that relates to payers. The payers, as a payer, the payers desperately would love that right now because they're trying to differentiate themselves from each other. These are some of the ways that they can do that.

**ED HOWARD:** Can I just follow up in a more broad sense? We've been talking around this for a long time and a couple of you have mentioned it explicitly, presumably one of the people interested in the impact particularly the fiscal impact are our friends at CBO and yet no one seems to be able to crack the code to make any of the very tangible results that we've heard discussed and that are in the materials including an issue brief we did on a briefing with the Robert Wood Johnson Foundation a couple of years ago translate into scoring savings so that you can put it in a bill and not have it subject to a point of order. Are there strategies that we can point to to try to change that either in the short-term or long-term?

**CHRISTINE FERGUSON:** The one thing I would say, having done it at both the federal and state level, at the federal level the black box that they use and I apologize to any actuaries in the room or anybody from CBO [laughter], the black

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box is really just a series of assumptions. It really is a series of assumptions.

So if somebody is sitting there putting the estimate together, and I had this happen to me, is saying to you if you do this, 100,000 more people are going to go to the doctor than do today even though we know that there's no way that can happen because there's no capacity. At the state level, when I went to the state level, the thing that was most frightening and interesting was literally when we had to do a fiscal statement. I actually was able to figure it out with my budget guy. That was frightening on the one hand but on the other hand, I thought oh my God the world just opened.

So one thing that happens at the state level is particularly, so Massachusetts compared to Rhode Island is night and day, those are the two states that I was in but literally you can do this with governors at the state level with certain governors who are willing to take risks in a way that CBO isn't because CBO is not rewarded for taking a risk.

A governor or a department director at the state level actually is rewarded and if they have that gut feeling of common sense, the truth of the matter is that they're willing to take that risk whereas somebody at CBO might not be. So I wonder if we were to try this in a couple of key states you could model it and then ultimately bring it to the federal

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level. I think it's going to be hard to get CBO to do this but I think the more articles and the more pushing we do on them the better.

**JAMES MARKS:** She's identified what's obviously a very tricky political issue with CBO. CBO, for those of you who don't know, is required to, when it scores a bill, to score it on a 10-year horizon. It can't go longer than that unless really pushed and the only time that I recall them doing it was actually for the Affordable Care Act where they looked at very late, they looked at a 20-year horizon and it turned out to have a very different impression on the cost much lower cost in the longer term.

Steve mentioned the paper by Bobby Milstein that just came out last month that said at 10 years, improved coverage, improved quality had increased costs, saved lives, and so did improved prevention, behavioral prevention, but at 25 years, the behavioral and preventive aspects turned out to save money but it was only at a 25-year horizon. It saved many more lives but in a 25-year horizon it saved money. CBO never would've seen that and would've resisted even trying to show that.

To say that that's an example, it's a good one but even a year earlier, there was another study on prevention of complications from diabetes that showed the same thing.

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Scoring like CBO they had it at 10 years, it was costly to try to prevent those complications and at 25 years, it saved money.

I think that what's happened, the 10-year rule for CBO came out when CBO did in the late 1970s. Our science is a lot better. The ability to make best guesses better guesses than they were is much better. If we don't do that, we will, at CBO, become a serious roadblock to investments in children because anything related to children's health or productivity or education won't score well at 10 years. They're still in school.

It only will score well on a longer term horizon and it's a bias against prevention. So we've got to find a way and this is not a criticism of CBO but of the rules under which they have to operate. CBO will do the best it can within the rules and constraints it has to operate under but many of you may have a chance to ask it in certain areas to look longer and to say can we use that information? Does it give us a different perspective but I think it's time that we started to do that.

**JEFFREY LEVI:** Let me add just a couple of sort of policy things. One is in addition to that 10-year horizon, CBO is restricted to look just within certain health accounts. So the productivity increases don't get scored even if the savings

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saved in social security disability payments that doesn't get scored.

One of the challenges we have with some of the community prevention activities is those are discretionary dollars and the savings will show up on the mandatory side and that say you can't cross that wall either, that blood-brain barrier I guess it is and I won't ask which is blood and which is brain [laughter].

So there are all sorts of constraints. Those are rules that the Congress has set. This isn't a methodology issue lacking science. Those are rules that could be looked at differently because those savings are real and are real to the federal budget.

I think in fairness, this is to Christy's comment about we don't have the box to provide the analytic framework; we have it for the biomedical model, whether we agree with all of it or not doesn't matter. It's there. Bringing in these community prevention activities really is a different kind of complexity.

It's not one drug that you're adding to the mix. It's actually multiple interventions and gee which mix of interventions used in every community is different and I've actually had this conversation with folks from CBO where they said okay but of all those things which is the one thing that

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makes a difference and there isn't that. That answer doesn't work.

So we need to come up with that new box. One of the things that actually the announcement came out today, the Institute of Medicine is doing a study that's funded by RWJ and a number of other funders to look at the value of community-based prevention and to see whether we can find an economic model that then can help us answer these questions better in a frame that may ultimately maybe be useful to CBO.

**ED HOWARD:** Steve, did you have something you wanted to add?

**STEVEN WOOLF:** I did want to make another remark but I'm feeling sorry for the man at the microphone. He's standing there a long time.

**ED HOWARD:** Don't worry, he's a physician [laughter]. He can take it.

**STEVEN WOOLF:** I think the CBO issue, we've hit that point pretty well. I want to get back to the questioner who was no longer at the microphone because there was a subtle nuance in her question I think it's important to come back to. I'm not sure it's been that articulated clearly enough nor whether I will succeed but there's a gravitational pull that healthcare has on health issues.

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We automatically are drawn to that as the solution. When we're talking about payers, whether private or government agencies, paying for prevention, there is sort of a habit, an instinct that was have of thinking that we're talking about a covered benefit that healthcare professionals or the healthcare community or even the public health system would implement that the payers would be covering. That's important.

There is an important role for that and as a physician, I could talk about the evidence suggesting that messages from physicians are important in motivating people to change their health behaviors but the nuance that I think we're trying to get to here is the logic behind payers covering community-based interventions that maybe have some involvement of the healthcare community.

But in some cases as in the example for the corner stores and other settings are firmly planted in the community but payers have recognized the business argument for why it's ultimately going to improve their bottom line in healthcare expenses for their members if they change the community environment. So the programs and policies we're talking about payers potentially covering are not necessarily in the box that we normally think of as insurance-covered benefits.

**JAMES MARKS:** I'm just going to add one little bit to that. You all know that the larger companies are doing what

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they can for prevention for their employees. Having communities be healthier places because of the kinds of things that Steve mentioned helps small businesses, which will never be able to take advantage of the kinds of programs that the large companies can. So if you're concerned about job growth, if you're concerned about the helpless small businesses, it's having the communities that they are trying to grow in be healthier will help them long-term.

**ED HOWARD:** The patient Dr. Miller.

**MIKE MILLER:** Thanks Ed. Mike Miller, I'm a physician and health policy consultant. One quick observation and one quick question. The observation is talking about this CBO conundrum how you get a community impact, I just thought that maybe a model you might want to look at is the Paperwork Reduction Act where OMB has to look at the real world impact of any law that gets passed and the administration implements. You could perhaps model something on that where they have to look at what's the public health impact of any law whether it's transportation, education, or direct healthcare. I'll just throw that out there.

The quick question I have is getting back to what United Healthcare's doing and other insurers could possibly do in paying for non-traditional medical-type preventive interventions, the diabetes program specific. I've been

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working in a Midwest community that actually has a CPPW grant and we're developing community strategies to address the quality of healthcare.

One of the challenges is and I feel I can say this as a physician, is trying to get physicians to think about how they deal with their patients in a community sense because a lot of times they say I don't want to be responsible for this patient's A1C or their diet or their obesity or their heart failure because I can't control what they're doing. I just prescribe the meds and everything else.

Can you guys talk about ways we might try and get physicians engaged and feel responsible for these kind of community environmental things you've been talking about in terms of walking, food access, and everything else. As the insurers are now feeling it's their responsibility to look at these things, how can we get the community level physicians to say this is part of my job, part of my responsibility in caring for patients? Thank you.

**STEVEN WOOLF:** I'll jump on that one. I think that you hit on a very good point and I think one of the challenges is what you just articulated is that a paradigm shift for physicians and other healthcare professionals to begin thinking about new ways of caring for patients that involve these types of collaborations.

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To some extent, it's an attitudinal shift. So for example, physicians are perfectly comfortable referring a patient out to a gastroenterologist in the community for a colonoscopy or to their friendly endocrinologist to help with managing thyroid disease but the idea of referring them out to the public health department or to the YMCA or to these other partners that we've talked about is not necessarily a natural reflex at this point but as the paradigm shift is going forward, I mentioned that this is where the cutting edge is right now in the field, the new generation of healthcare professionals are going to begin to be thinking that way.

As important as the attitudinal barrier is that you've identified, I think the more important obstacle is infrastructure. So the physician who gets that and understands that's a really cool idea instead of me having the burden of trying to change behaviors that I'm not under control for, I'm going to engage partners in the community who have the time, the skills, the resources to do this. I'm going to get the local Y involved. How do I do that? What's their phone number? Where are they located? What's the program? How do I get my patients there? How do I get follow up?

The work that we've done in our university to set up these systems and practice-based research networks has enlightened us to the cost of building that infrastructure,

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getting the HIPPA issues worked out, getting the IT issues worked out so that information could be transmitted with the click of a button.

Those infrastructure expenses, they're an upfront expense that we believe ultimately payers should ultimately cover because once that investment in infrastructure's put in place then not only the attitudinal barrier's removed but the implementational barrier is removed to make it easy for this type of collaboration to go forward.

One final point I'll make is one that Dr. Levi made at the beginning of his remarks. Once that platform is built, it's not only a tool for improving the delivery of preventive care; it then becomes a platform for managing chronic illnesses.

You can do a better job of taking care of your heart failure patients, your diabetes patients, your cancer patients, your cancer survivors because that platform that you've now established allows easy collaboration with the community partners that are necessary for them to manage their conditions.

**JAMES MARKS:** I'm just going to add a little bit. Anybody here from Kansas? Alright, well Mayor Joe Reardon of Kansas City, Kansas found out when the county health rankings came out a little over a year ago the first time that his

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county, his city and county ranked dead last in the state of Kansas. He took this on as something that he had to do. He thought they would do much better because they had a good medical school and several good hospitals.

He went to the heads of those hospitals, so it's in the context that you've asked your question, and they said they weren't surprised. Now they knew that they did good quality care for the patients that came there but the likelihood of people needing to come was beyond their responsibility. So they were quite willing to help him look at what he could do to make Kansas City a healthier place to live. So they became partners rather than being defensive.

Under the Affordable Care Act, hospitals, nonprofit hospitals, cannot count charitable care any longer as part of their community benefit. So they're looking at what they can do and increasingly they're saying can they partner with the public health agency and community health improvement plans and things like that. What's their role that they can play?

Mayor Reardon, for example, brought a supermarket into an area of the town that hadn't had one before. He got his transportation agency to say whenever they're going to go and fix the roads that needed a lot of work in an area of the city, they would also look at putting in the sidewalks and the cutouts in the sidewalks and the crosswalks to make those more

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walkable communities, something they had talked about, always felt that he hadn't had the money but now they put in what they called a complete streets policy.

They did the things like the promators but he realized, and that's why I think we all have to realize, these are not going to be solved by the public health agency alone. A mayor, a governor has the ability to bring transportation or schools or the business community to the table or the clinical community as partners to the table. I think that that's the kind of thing we're going to need to see in more communities. We are starting to see it but that's the context in which I think physicians can fit more easily is perhaps through their hospitals and their overall medical groups.

**CHRISTINE FERGUSON:** So we did do this actually about, I want to say five to 10 years ago. We did exactly this piece in one state that I was in and here Steve absolutely articulates where the challenges are. Keeping that material very interactive and up-to-date and accessible so that it's easy for physicians was almost such a barrier to doing it 5-10 years ago, it's not anywhere close to as much of a barrier, the technology, but the need to be able to keep it up-to-date and to make it relevant and easy and accessible is expensive.

So that is something that you could literally do from an actionable item moving forward is to think about how you

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might make some of those investments at both the federal and the state level but again what we're talking about here might sound very, very, very kind of loose and hard to reign in and figure out how do I use this for what I need to do for my boss or for what I need to do for my state or whatever.

The way to think about this is literally five years from now, I promise you there is not a primary care physician in this country who can do anything close to what we are all at the federal level talking about them doing. These guys and women are at their wits end.

So the barrier to having non-physician people providing care and services and the need for the YMCAs and the other parts of the communities to come in and really start supporting what's happening in the medical system and in the prevention arena is so profound and it's so different than it has been in the past that you really literally can make some pretty directed investments if you can get people to look at what the savings or the overall increase in productivity, increase in educational achievement to be as important as what you might save from the healthcare costs. That's where you have the ability to use the process and to use some of the technology that exists today in terms of investing in those things.

On that line again, I would say if you're trying to make that case, literally businesses don't invest in things

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that don't lead them to a better outcome. They just don't do it.

They are investing hand over fist in these kinds of community outreach and expanded services internally because they know it affects their productivity even if that bottom line is harder to measure. So what you need to say to your boss is basically hey business is figuring out that they want to take a little bit of a risk and they're learning how to measure it, shouldn't we? Shouldn't we be thinking about that to be a little bit out there?

**ED HOWARD:** Okay, we have a couple people at the microphones. I have an incredible array of questions on green cards that I'm afraid we're not going to get to. So I would urge you to first of all for the folks at the microphones, to be brief in their questions. I believe Bob the lady behind you is in front of you and second, while we're doing all this, we have only a few minutes and I'd ask you to both listen and fill out those blue evaluation forms while you're listening. Yes, quickly.

**CLAIRE CLOKIN:** Thank you. My name is Claire Clokin. I work for the National Council for Community Behavioral Healthcare. I just wanted to make two brief points. The first is that I appreciate you touching on the point about what Mayor Reardon did in Kansas. I think it's a wonderful point for all

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of us to take in terms of how we can reach out and how we can be effective constituents in reaching out to our elected officials. At the state and regional level, I think that that can be a very effective means in terms of communicating this and really pushing for this.

The second point that I want to make and has been touched on a little bit especially with the question by the physician is not only the point of collaboration between community and clinical settings but also within the healthcare system, collaboration within the healthcare system, as a whole.

Some of the opportunities that are available with the Affordable Care Act and how these collaborative and integrated models can be utilized so that we really can make sure that we are addressing the whole patient as opposed to just fragmented components. So I guess that's more of a statement than a question but I just wanted to make those points.

**ED HOWARD:** You wrap it up by saying don't you agree [laughter].

**CLAIRE CLOKIN:** Exactly.

**JAMES MARKS:** And we agree.

**ED HOWARD:** Yes go ahead.

**BOB GRISS:** Bob Griss with the Institute of Social Medicine and Community Health. Is there a danger that we can do prevention so well that we will really reduce healthcare

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costs but not actually change the healthcare delivery system in which case healthcare costs will not decrease but will just continue because of the infrastructure that exists now to grow in healthcare and we find new tertiary care uses for working.

What I'm really asking by this question is whether the infrastructure exists linking medical care and community health planning in such a way that we can actually have the community benefit from the potential that you're all describing.

When Christine is describing the benefits to the employer to promote wellness programs, Jim appropriately points out that a lot of small employers won't be able to do that. So I'm wondering whether the infrastructure really exists to integrate medical care and community health interventions so that we can equally benefit throughout communities and society from the very important potential that you're describing.

**CHRISTINE FERGUSON:** It's happening. It's happening Bob. I mean honestly, as a payer in a bunch of different places, it is happening in ways that we're not even aware of in D.C. It really is happening and we really are going to get the benefit of it.

**ED HOWARD:** Jim?

**JAMES MARKS:** I would agree. To say it's happening is not to say it's happening enough. So in Somerville, Massachusetts, the mayor there got very concerned about their

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high rates of obesity, both got support from a number of places, got Tufts nutrition school to work with them and they've lowered the rate of obesity in their community.

In Madison County, Tennessee, the Chamber of Commerce has started to get involved about trying to make their county a healthier place, a more hospitable place for business and for those of you who haven't heard Governor Mitch Daniels talk about his interest in prevention, it's fascinating. He said, as a governor, his job is to bring jobs to Indiana recently.

He's got a great story to tell and he goes through that but our healthcare costs are higher than elsewhere. So he went and pushed his Republican legislature to raise tobacco taxes so he could use that money for preventative services for the working poor as well as reinstating their tobacco control program.

So I think, and for those of you who don't know Mitch Daniels, he was the head of OMB. He was the head of Eli Lilly. He's a businessman who gets the bottom line. That's where he put a lot of his early efforts. So it is there. It's not happening fast enough. So is the infrastructure there?

It may not be in enough places but I think we have to move towards a better balance in how we're approaching health and healthcare here. I don't think it'll ever be so successful that we won't have fiscal pressures on the medical care side

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but if we don't take off some of those pressures, we will cover fewer and fewer people or cover fewer and fewer services or pay less and less for the services we do try to cover. We need to have as one of those stools on that policy, one of the legs on that policy stool until we have less disease than we have now.

**ED HOWARD:** Actually I was about to read a card question that was directed to you Steve. We have time, I feel very guilty sitting on this stack of cards. So let me read one of them and it refers to your very first slide. What does the leading causes of death slide imply for NIH priorities and funding?

**STEVEN WOOLF:** Well the leading cause of death on that slide was tobacco use and it would imply that a large priority for NIH funding ought to be strategies for reducing tobacco consumption. I don't think that message has been lost on the NIH. I think a lot of work is going into that area.

Much of the kind of interventions that we're talking about, however, to address tobacco use or obesity really require research on community-based interventions and that's typically not been a high priority for NIH. I think the enlightened leadership there are beginning to focus more of their research dollars in that area but again, it's not where we'd like it to be. So I think that's a valid concern.

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Going back to your earlier comment, the reason I was pulling the microphone over is I wanted to endorse your larger point, which is the need to think comprehensively about the benefits of these types of investments and not think within a particular sector. It's so easy for us to compartmentalize our thinking on this.

To think of this, you've just been to a briefing on community prevention and to think that you haven't been to a briefing about overutilization of healthcare services, accountable care organizations, and how we reduce the incentives for overuse of expensive healthcare technology. I'd like to make a point to try to anchor all this together. The rational approach across the board for all these issues is to make wise use of our healthcare dollars.

We're trying to reduce the burden of suffering from these major diseases and the cost of caring for them whether we're talking about what's done in ICUs or whether we're talking about what's done at corner stores. The question is what's the most effective investments to accomplish that? The strategies for reforming the way we deliver healthcare in hospitals and doctors' offices should be focused on how to maximize efficiency and get the most health benefit per dollar.

The point we're trying to make here today is that these investments in the community are a highly competitive strategy

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for accomplishing the same goal and perhaps more effective than the large investments that are being made in attempting to reduce that suffering in clinical settings.

**ED HOWARD:** Jim, you had one more point that you wanted to make.

**JAMES MARKS:** We have heard a lot about new public health and the framing and for those of you who didn't see it on the way in, we have a new forum called [newpublichealth.org](http://newpublichealth.org) that's going to have news roundups, ideas, conversations, questions and answers about the new discussions in public health, some of which are reflected here but there are many others and I encourage you to look at that and participate.

**ED HOWARD:** Great. Thank you. We've just about come to the end of our time and while you're filling out your blue evaluation form, let me just take a minute if I can. I want to say a word of thanks to some people who are at their last Alliance briefing as an Alliance staff member. Kevin Arts, Laura Covington, and Kate Wobbekind, have they pulled disappearing acts?

Kevin is here and the others have—in the back standing up there [applause] please. Now it is not true that they are leaving because they found out that my wife and I are going on a cruise this fall to the Greek Islands [laughter]. They are going to graduate school and other pursuits. We're going to

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miss them. They've done a great job and they have been terrific to work with. Thank you all [applause].

Also thanks to you for coming to a program that's on a topic, as our panelists have observed, is not necessarily the most popular health reform topic. Thanks to our colleagues at the Robert Wood Johnson Foundation, particularly Jim Marks, for making this program possible and making it better and ask you to join me in thanking the panelists for an extremely rich conversation about a very good topic [applause].

[END RECORDING]

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