Linking the Desire for Health with the Decisions & Tools that Support Health

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Americans are fortunate! We have the resources and knowledge we need to be a healthy society and enjoy a high quality of life. But as the escalating rates of obesity and chronic illness show, there is a widening gap between the "possibilities," what we can do to maintain our health, and the "practices," what many of us are actually doing in our daily lives. Why are things that seem so simple – like eating a healthy diet and getting regular exercise – so difficult for us to implement? What is needed to bridge the gap between our desire for health on the one hand, and the appropriate choices on the other? How can we ensure that each of us as an individual and member of a community has the motivation and the tools to make good decisions about our health and healthcare?

Finding the answers to these questions is a key challenge for the U.S. health care system in the 21st century. In the June Foundation meeting, we focused on how the health care system can create a "framework" so that individuals are more likely to experience good outcomes from health care encounters – in other words, receive "value." However, an equally important side of the value equation is what Americans can do for themselves, as a growing body of literature suggests that the greatest opportunities to improve health outcomes in the US are in the area of behavioral choices and patterns.

As a first step, many believe we need to raise public awareness about each person's ability to influence their own health and well-being, and to educate consumers about how their personal choices impact the health care system and the resources on which we all depend. In addition, we need to ensure that patients have the right incentives and information to be engaged in their healthcare. Providers need to become partners with patients by providing them with the decision-support they need to be healthy.

This retreat focused on the consumer/patient side of the "value equation" for health care -- how changing individual attitudes and behaviors can enable Americans to practice good health habits and use the tools that will help maintain and improve their health. We explored many of the complex implications as well as the opportunities available to us to optimize our healthcare future.

Setting the Stage

Ian Morrison 'set the stage' for the meeting's focus on lifestyle and behavioral issues. He pointed out that almost 35 percent of the population is obese or severely obese, a proportion that has nearly doubled in 25 years. Obesity explains almost as much of the healthcare cost increase as tobacco, and leads to a significant increase in risk of death from many causes. We are becoming obese because we are eating more and we are not exercising, partly because many Americans work too much. We are also eating out more often.

As a result of these trends, we are facing a tsunami of chronic care needs, one that can't be solved in a dysfunctional healthcare delivery system. Part of the problem is that we are 'medicalizing'

many of these conditions and making costs associated with them even more extreme. We need to take responsibility as a society and as individuals for wellness, health promotion and prevention.

Most Americans think health care providers should play a central role in preventive strategies. But they also see important roles for schools, for employers and for government. There is less support for taxing junk food and less interest in limiting advertising. Opinion is split on the question of whether obesity is a private issue that should be dealt with in terms of personal responsibility, or a societal issue that requires public policy intervention.

Session I: The power and nuance of social marketing

Our first session on social marketing set the tone for the entire three days by looking at the 'big picture.' Each of the keynote speakers focused from a distinct perspective to describe critical success factors for high impact marketing.

Dr. Kenneth Kizer highlighted elements of the anti-tobacco campaign as illustrative of a successful approach to behavioral change, although it took decades!

Critical success factors for such campaigns include leadership; funding and technical capability; identification and targeting of key audiences; and relevant messages tailored for diverse populations, consistently delivered effectively, using a variety of tactics to reinforce and leave a lasting impression. The message needs to be aligned with cultural values and other social circumstances. Financial incentives are also useful. Multi-media is important, as is the need to humanize issues. Stories are much more powerful than facts and figures in changing behavior. To leverage resources, it is necessary to create partnerships, alliances, and collaborations. Time and duration also matter for most social marketing campaigns. Cultural change generally takes 7 to 10 years, so typical public education campaigns of 6 months to 2 years are rarely long enough to be effective.

The key challenges are really the opposite of the critical success factors. How do we create the leadership and political will to move forward? Where do we get the funding? How do we find common ground and build trust among folks who are more used to competing than collaborating. What is someone's expenditure is somebody else's income!

Dr. John Peters approached the issue of lifestyle and behavioral change from a public health perspective, informed by consumer products marketing strategies.

Campaigns should be aimed at the whole population, portraying health issues such that those whose behavior we would like to change are getting social pressure from those who are not engaged in the undesirable behavior.

Today we have a 'perfect storm' for obesity. Our biology is maladapted for the environment that we are able to create today through technology. Strong biological incentives tell us to eat and to rest whenever possible. Our genes also tell us to like sugar, fat and salt, commodities that agricultural development has made widely available and inexpensive. There are no external incentives for 'doing the right thing.' Our society runs on instant gratification. The things that promote economic growth today generally do not encourage healthy behaviors.

To succeed in the marketplace today the benefits exchange needs to be very simple, very clear, and very tangible. Many health messages promise benefits over a much longer time frame that becomes difficult for consumers to personalize.

Public health knows how to segment and target the audience, how to tailor a message, how to get it on the radar screen. When dealing with eating and physical activity behaviors, however, we need to be clear about the tangible benefits exchange that can be seen today. We need to tap into higher order human needs to overcome what our biology will otherwise drive us to do, by leveraging the early adopters and the strong desire to belong. To make meaningful progress at changing these unhealthy behaviors on a broad basis, we need to move some of our social cultural values, like unbridled consumerism, in a different direction, and take advantage of existing strongly held social values.

Dr.Marsha Vanderford introduced a new and innovative CDC center, the National Center for Health Marketing. The purpose of the Center is to ensure that interventions, communication, information, and programs are based not only on sound and objective science, but also on continuous customer input.

For many people, the idea of stereotypical marketing is antithetical to notions of public health, but CDC staff understands that the terrain of public health is changing dramatically, and they cannot afford to continue to do business as usual. The aging population, with its attendant problems with chronic disease, doesn't respond to traditional approaches. But changing terrain offers opportunities, as well as threats

Through the Marketing Center, CDC is looking for opportunities to work smarter, to develop new relationships, and identify untapped opportunities for collaboration with both public and private sectors. The goal is to develop a strategic approach to partnership and engagement of consumer advocates, business, payers, and providers--one that is more proactive--in order to enhance its response capacity, and increase the power of prevention initiatives.

Session II: ***The role of the Internet, media and the arts in social change***
One of the most difficult elements of any effort to get a message across is taking the words and concepts and determining how and by whom the message will be delivered. This session looked at three very different 'media' and considered how each can be leveraged to get health messages across to diverse audiences.

Tommy Hutchinson's orientation is broad messaging with a focus on youth. The first thing he recommends is to clearly define your message. This is not easy with 'health' as it is a very complex issue. The second is to talk to your audience about how they want to receive the information. What is the language they want to use? What is the medium they want to receive that information through? He recommended that we get particular communities to go out and communicate health messages through each other. We can make healthy behavior 'cool' by recognizing that young people, like all of us, want to look good. A second lever might be the role of sport.

The message needs to be human and visual. People, not surprisingly, relate to people, not to huge chunks of information and stats. The future lies in the hands of storytellers! Cultural differences need to be respected and messages need to be repeated. People value authenticity and trust and generally want information in a clear and concise manner. Even using a fantastic media will fail if we mix the social message with the entertainment. Finally, if you make a mistake, correct it quickly and move on.

Andrew Holtz' goal was to promote the effective use of journalism and the news media to get health messages out.

Beliefs used to be shaped by what people actually experienced, which created a better sense of reality than we have today, when we are not getting information from the real world, but from sound bites and quick voice-overs of bizarre and unusual occurrences. People are beginning to believe that the media world is the real world.

How do we in healthcare get the media's attention, when most health messages are not different, or bizarre, or new? We need to remember that the media deals with **A** person, what happens to one person, not the statistics, and health education and health journalism are not the same thing. Successful advocacy groups provide prepackaged stories with good anecdotes and compelling human faces.

Another suggestion is to find out what stories are being covered anyway, and get the health messages into those stories. Radio may be a useful medium to help build bridges with consumers.

Naj Wikoff focused on the role the arts can play as a cost-effective medium to help health professionals deal with job-related stress and promote awareness and positive health messages. While science is necessary to define the appropriate message, the arts can get that message across because the arts communicate full-spectrum with emotion and feeling. Communicating intellectually with facts and numbers frequently fails.

In addition, nothing is more motivating than telling stories, as stories connect us on a very fundamental level. Art-related health events can be a marriage of the message, the medium and the messenger. Learning healthy behaviors can be fun and, when it is, people get motivated.

The 'arts' is an unattended opportunity to move people, because healing is not only about the medical process, it is a spiritual one. In addition, the arts can be an effective way to break down stereotypes, whether about the elderly or about different populations.

***Special Session: Professor Garfield! Reaching Kids through Edu-Tainment*!**
The Garfield comic strip is the most widely syndicated comic strip in the world, with a daily readership of more than 260 million! This session described the plans for an exciting, unique and inspired educational Internet web portal, Professor Garfield, a collaboration between PAWs, Inc and Ball State University (BSU). It is designed to enhance and support classroom learning by providing children, parents, and teachers with free access to motivating health messages in a fun and friendly environment.

Keynote: High Impact Tools for Health Promotion
Dr. James Prochaska pointed out that it is well known that over 50% of all health care costs are due to behaviors like smoking, alcohol abuse, unhealthy diet, sedentary lifestyles, and stress. Compare that to 10% due to pharmaceuticals.

Most primary care takes place at home, provided by the patient for himself, the parent for the child, and the daughter for an elder. And the majority of primary care is behavioral. Yet, typically physicians provide little if any information for patients to use at home to either prevent or manage chronic disease. So we are not managing over half of health care costs!

The mental models of behavior change that have dominated our society for the last century have been action-oriented models. But change is a process that unfolds over time and it involves progress through a series of stages. Action is just one of them. ***Pre-contemplation*** is a stage in which people are not intending to take action in the foreseeable future. We used to think that they

were not motivated, that they were resistant to change. We now know that our programs didn't match their needs. In ***contemplation*** people become more aware of the benefits of changing but they often see an increase in the cons as well. Once in ***preparation***, people are convinced that the benefits outweigh the costs. Their number one concern is, when I act, will I fail? They need to be prepared for ***action.***

The stage of readiness of an individual patient can be assessed in five easy questions. Then the behavioral medicine intervention can be matched to their stage, rather than insisting that they match to the program. A realistic goal is to help them progress one stage in a brief interaction.

Information can start the change process but cannot sustain it. We need to create images that will draw people to a healthy future just like the tobacco industry and alcohol industry created images to draw young people into an unhealthy future. People expect and need to be reinforced for changes much more than they will by others. Helping relationships with others who care and understand are important. Substituting healthy alternatives for unhealthy alternatives and reengineering the environment to evoke healthy responses, and remove stimuli that evoke unhealthy responses are also key.

No one process though will carry the whole weight. It's different processes at different stages and we don't want to overwhelm any one process. The best interactive, individualized interventions need to first demonstrate that they can reach higher percentages of people if they are going to have impact on these major killers and major cost drives. Marketing action-oriented programs only reaches a relatively small segment.

Physicians do not as a rule practice behavioral medicine for several reasons. They believe patients won't or can't change their behavior. They don't have time. There is no reimbursement. They aren't trained.

To put this together in tools for populations, you need to assess people on each of these processes--the stage they are in, the pros and cons, processes over-utilized, under-utilized, or utilized appropriately.

Although the results are significantly better with those that call for help, being proactive has more impact because we reach many more people. Contrary to commonly held views, we can treat multiple behaviors and be as effective, but we can have greater impact on health and health care costs. The programs are equally effective with minority populations and those with little education.

If we start to change our paradigms and go from an individual patient paradigm to a population paradigm, from passive reactive healthcare to proactive healthcare, from office-based to home-based, from reliance just on clinicians to reliance on computers, from single behaviors to multiple behaviors, we can have unprecedented impacts on the major killers and cost drivers of our time.

<u>Keynote</u>: Capturing Growth at the Intersection

Brock Leach pointed out that obesity is the largest issue the food industry will ever face. But the flip side of that, 'wellness', is probably the largest opportunity to add value that they have ever seen. There is a business case for health and wellness. Today in North American about 40% of PepsiCo's business is from products called 'better for you' and 'good for you' and it is growing about 2 ½ times the rate of the rest of the business.

Diversity in age, in ethnicity, and in income is creating differences in marketing. Time pressure continues unabated and health concerns are right after that in terms of opportunities to add value. The question is, how you provide different products for different groups with more convenience and a focus on the growing demand for wellness? PepsioCo's unique spin on marketing is making products easier, more fun, more accessible, and more exciting to consumers. The Smart Spot campaign recognizes the importance of identifying healthier choices for consumers in a way that makes it easier for them.

The answer to the obesity problem is energy balance. But there is no universal prescription that would allow individuals to figure out how to maintain it themselves. We need to create a better environment with healthy product choices and market them in ways that motivate people to adopt healthy lifestyle habits. We need to reach people where they are with the tools they can use to accomplish the change. The challenge in behavioral change is how do you get consistent messaging delivered with scale? You need to make the communication consistent, simple, encouraging and absolutely unavoidable.

ADA, AHA, and ACS are collaborating on a consistent basic message. Having power house organizations like these come together and create some common standards in language would bring a lot of people in the food industry along. This whole idea of simple steps, energy balance, and positive encouraging messages to get people started is really important.

Too much of the discussion leaves the food industry on the outs. Pepsico would be open to the possibility of leading a demonstration project and inviting others to the table to begin to think about a multi-factorial approach to shape all facets of the environment.

***Session III:* Public and private sector models from here and abroad.**
In this session we heard about public and private models in this country and abroad which are having a positive impact on individual, organizational and community health through a focus on health promotion and other preventive strategies. We learned that whether inside corporate walls or within the environment of a community, the most positive change occurs by design!

Wolf Kirsten provided vignettes on several international countries that are struggling with the same issues of obesity and behavioral change that we are. Research on behavior change does exist, even in emerging countries. However, there is no one magic formula for success.

Several of the programs use the stages of change model and emphasize the importance of supportive actions and a supportive environment. Critical success factors include partnership, both intellectual and institutional; a clear, simple, targeted message, an inclusive approach, focused on the target groups; and evaluation. Programs need to adapt and be tailored to cultural groups, and should be fun. Both the government sector and the private sector should be involved. There is a huge opportunity with corporations that have a big interest in health and wellness for their own employees.

Health promotion and behavioral change need an inter-disciplinary and inter-sectoral approach. In addition to health, we need to consider education, recreation, safety, business, urban planning and transportation, which all impact our health to a very large degree. Most US programs lack a holistic approach. Instead, they focus strongly on individual responsibility for lifestyle changes, with much less attention paid to creating a supportive environment to make change possible.

Tom Kottke shared the lessons learned from CardioVision 2020, a community self-help program that emphasizes informed choice. It's mission is partnering with clinicians and community

organizations to develop information systems, environment, skills, and encouragement to help individuals reduce their risk of cardiovascular disease.

The message is simple: tobacco-free; zero exposure to environmental tobacco smoke; five servings of fruits and vegetables a day; only lean or extra lean meats; low-fat or fat free dairy products; serum cholesterol less than 200 mg/dl; blood pressure less than 130/80; 30 minutes of physical activity daily. These goals are supported by the community environment.

CVD and other chronic diseases come from the 'lifestyle syndrome': too many calories in, too few calories out, physical inactivity, tobacco use and exposure. The science of what to do is known; the science of how to do it is marketing. Contrary to common thinking, there is no real 'high risk' population. Most people are doing well in some areas. Successful programs go where the people live and work and recognize that people need to know if they 'climb on the wagon', they can climb off. If the time line is realistic, big changes can be accomplished. Improvement in the community's health requires continuous effort, resources, leadership and marketing. Finally, data is important to both 'make the case' and guide the program.

The solution to the obesity epidemic lies in personal commitment combined with community action. It is a fallacy to think that culture can't be and shouldn't be changed. Many culturally embedded behaviors actually have been imposed on society by outside agents, such as corporations. To change culture, it is best to work from inside the community, starting with the behavior within a given culture that is most likely to improve or change.

Laura Simonds told us that the vision of The Partnership to Promote Healthy Eating and Active Living is to inspire people to choose healthier lifestyles. The Partnership brought together public and private sectors through a multi-disciplinary approach, and created a framework that looks at the individual, the community, and the environmental, and the factors influencing decisions around eating and physical activity behaviors. As economics have a strong influence on sustainable social change, economists and public health experts were brought together to look at the economic determinates of eating and physical activity behaviors.

America on the Move focuses on promoting a message of 'small changes.' 90% of the American population is gaining between one and two pounds a year. A little more physical activity and a reduction of intake by one hundred calories each day, is enough to stop weight gain in 90% of the American population. AOM now has twenty state affiliates, with programs for faith-based groups, for health professionals that can be used with their patients, for schools, and for other groups. The motto is to reach consumers where they are. AOM is working to create simpler tools that people can use, to help communities with evaluation, and to provide sponsors and funders with a positive return on investment.

Ted Borgstad talked about how his company, Trestle Tree, decreases healthcare costs by working with an organization's marginally motivated, at-risk people, to help them change their toughest health behaviors. The business model uses Dr. Prochaska's research on behavior change.

At the core of the model are uniquely trained Personal Health Coachs who are pharmacists, nurses, exercise physiologists, or registered dietitians, who have significant content-expertise. They are trained to also be great change-experts. The coaches develop intensive one-on-one relationships of trust and influence with participants. However, the programs are scaleable because outcomes data show that telephone contact is just as effective as face to face for promoting positive behavioral change. Software is built to track stage of change with every

participant in six different goal areas, and as they reach action and maintenance interaction is decreased.

Within two months, the 1st client JB Hunt expanded the program company wide. After one year, analysis showed a trend of a forty-five percent reduction in medical claims cost for participants verses previous year. Another public sector client showed a four to one return on investment in the first year, based strictly on medical and pharmacy claims. Participants also report that the programs are valuable to them in terms of improvements in their lives.

Agnes Hinton described how The Center for Sustainable Health Outreach was created to address cultural, linguistic and economic barriers that keep families with the greatest health risk from being appropriately served in our current health care system. CSHO sees community health workers (CHWs) as essential, integral, powerful promoters of health, wellness and disease prevention in their communities. If the problems are in the community, then the solutions are in the community as well. CHWs serve as a vital link between communities and the health care system.

CHWs can educate individuals, communities and providers. They can help craft services that are more responsive to community needs and facilitate access to those needed services. CHWs work in all areas of public health. There is a continuum of lay health advisors, from the 'natural helping' or informal, all the way to the more formal end or 'professional helping', the paid health worker who may be in the health system or may be even a peer- educator who is going into the home.

Session IV: Giving patients a voice

During this session, panelists and participants explored ways to engage consumers/patients actively in improving their health status and obtaining maximum benefit from their healthcare. Discussion revolved around the advantages of active consumer/patient involvement, the characteristics of tools that can encourage such engagement and barriers to the use of these tools.

Jerry Reeves pointed out that doctors only advise, the patient decides. Everybody in the healthcare transaction has a need to reach the information that they perceive the physician has, but patients may have many doctors. The information repository needs to have proper security and control, but we cannot expect the doctor to be the source of this suite of information tools.

With chronic disease, we need action lists, not fancy disease management and stratification. If we can get the patient to drive more of those tasks that need to be done every year, we have a higher success rate than if we depend on the physicians who don't have any infrastructure in their offices to enable this.

Looking at studies of healthcare cost drivers, only 6% of ER visits were for emergencies. A large proportion of office visits could have been managed by phone, or by email or perhaps by self-care, going to the local pharmacy for OTC preparations that are really quite effective.

The patient has more influence over decisions related to prevention and early treatment than late treatment in costly environments like hospitals. Incentives are important, and sometimes rules. If you are going to engage folks in health care decision-making you have to surround them with help. It takes multiple touches – you can't just depend on one methodology. And it is important to reach them where they are, for example, at work.

Decision tool need to be specific, measurable, appropriate and focused on the health decision that needs to be made, not just focused on administrative elements. They have to be relevant and timely. WorldDoc's decision support tools are useful for case managers, customer service folks, the hospital discharge planners, and family caregivers, in addition to the patient. The tools help patients assess what their symptoms might be, and what they should do about them.

Ron Bachman discussed the four generations of consumer-directed health care (CDHC) benefits, the building blocks for which include information decision support, personal care accounts, wellness and prevention, disease management, incentives and rewards.

The 1st generation focuses on plan design. The model of information is passive and not integrated with incentives or other clinical treatments. It focuses on benefits and discretionary costs. This model addresses the eighty percent of the population with twenty percent of the claims, but doesn't really change behavior or influence costs.

In the 2nd generation the emphasis is on behavioral change through more personalized health management with incentives. The diabetic can be incented with shared savings if they are compliant with disease management. The mega-trends of personal responsibility, individual ownership, self-help self-care, and consumerism, all get built into the information decision support parts of consumerism here.

3rd generation information decision support tools get to the concept of health and performance. Issues like safety, absence management, and population management are a part of a concept referred to as Integrated Health Management.

The 4th generation is where many new and creative services and specialty vendors are trying to focus. The information is very personalized and uses 'push technology' to send tailored online information to people based on their needs and interests. It's about personal health care based on genomics, predictive modeling.

It is important to recognize that these generations do not replace each other, they build on each other.

Wendy Selig shared some of ACS's concerns about CDHC. We should talk about 'patient centered' or 'patient focused' care. As we look to design this fourth generation system, we should think about the full continuum of care—wellness, prevention, early detection, persons at risk, those in recovery, end of life. Information needs to be accessible, transparent, relevant and culturally appropriate. Depending on one's ability to process information and where one is with a disease, the complexity of the system may or may not be manageable.

One caution with health spending accounts is this idea of the continuum. Will people choose preventive services or early detection? We need to build incentives into the system to get toward the front end where the patient has more control.

ACS, AHA, and ADA are working together on a public health campaign, 'Everyday Choices for a Healthier Life'. The initiative aims to simplify common messages and get everybody behind a similar set of recommendations.

Clay Ackerly talked about what CMS is doing to really personalize Medicare. Direct communications to beneficiaries and decision tools are provided online or by telephone, including

quality comparison tools on health plans, dialysis facilities, home health agencies, nursing homes, and soon, hospitals. Price information is currently focused on the price of prescription drugs.

CMS is also pushing personal health records. The claims information that CMS has needs to be built into effective tools to include clinical information and patient self-management information.

The Medicare Beneficiary Portal will soon be piloted and will give Medicare beneficiaries on-line access to all of their claims information. Prevention information will be tracked and reminders sent as appropriate.

Finally, the Chronic Care Improvement Program has tremendous potential to improve care.

Ellen Severoni pointed out that consumers are rarely listened to when it comes to designing, implementing and evaluating services and programs. Yet, the tools that consumers ask for in order to navigate the system more easily are very simple.

She recommends that consumer/patient engagement efforts be focused around the "Five Vs": (1) a vision of a healthcare system that is achievable; (2) the values of choice, affordability, personal responsibility, accountability, fairness, dignity, respect and quality; (3) the voice of the consumer/patient; (4) healthcare system changes based on the needs of the system's current victims; and (5) victory that includes a full integration of body, mind and spirit.

Session V: Shared decision-making

Physician autonomy, a historical tenet of medical training, was a great strength in yesterday's healthcare environment. But it has become a liability today. Both the growing demands of empowered patients and the needs of our complex system will require significant transition in the role of physicians, such that they become partners with patients, team leaders and coaches. This session focused on the importance of communication in the doctor-patient relationship and the brave new world of 'shared decision making'.

Greg Carroll described the work of the Bayer Institute for Health Care Communication and its work with providers. He cited several key elements of informed consent or shared decision-making: the decision itself was raised and discussed; alternatives with pros and cons and uncertainties were discussed; the patient's understanding of the decision implications was assessed; and patient preferences were explored.

In a study of 1,000 patient visits encompassing approximately 3000 decisions, only 9% of the decisions reflected a limited degree of shared decision-making. Not one out of 3,000 included all 6 elements. The element most important to the relationship and to patient compliance, an exploration of the patient's understanding, was noted only 2% of the time.

Essential ingredients for shared decision-making include a high level of trust; a good working relationship; good clinician communication skills; adequate time; incentives; and conviction from both parties as to the value of shared decision-making.

Several positive outcomes accrue from improving the quality of communication between clinician and patient: improvement in patient and clinician satisfaction with the interaction; improvement in health care status as well as reduced health care costs; and more involvement of family and friends.

The ability to assess the understanding of the patient before starting to give advice or counsel and to build rapport through reflective listening and empathic communication are important skills to hone to improve the quality of communications. Tailoring the message and method to the individual's situation is also important.

Many clinicians who claim to find it so difficult to have discussions because of time are traumatized by uncomfortable interactions with so called 'difficult patients.' But there is no such thing as an objective 'difficult patient.' It's the relationship that is difficult.

Andrew Robinson approached the subject of behavioral change from the perspective of a patient. He pointed out that we need to be careful when we talk about the physician-consumer relationship, rather than the physician-patient relationship. What patients go through doesn't have anything to do with being a consumer! Physicians and health care institutions should listen to patients and institutions should have patients on advisory boards.

An engaged patient is not really sharing healthcare decisions with anyone. The balance has begun to shift because now patients have access to more information on certain things than physicians, and the time to access it. Even if the patient's making the decision doesn't affect the outcome, the patient needs to feel that he or she is the one guiding their own destiny. Patients need the physician to tell them what the different probabilities are and what their experience is, but ultimately they don't know the answer for a given patient.

A major study showed patients most value compassion and partnership in their relationship with physicians. Physicians seem to be concerned about giving false hope, but the real problem is false despair. *How* a physician presents the 'truth' is crucially important. There are good ways and bad ways to present the same basic information to the patient.

The whole system has to change and the patient/physician relationship needs to broaden to include other health care providers as intermediaries. Health care coaches are especially important because trying to navigate the health system is impossible.

As a policy expert, **Dave Kendall** opined that a good theme for this discussion is high-tech, high-touch--a health care system with classic technology and information technology, plus strong relationships with a personal health care professional whose advice is trusted.

His policy recommendations can be grouped into three categories: communication (e-mail, online scheduling, etc.); patient tools like information therapy, decision support tools, incentives to engage people; infrastructure (the ability to exchange this information in an efficient way).

Very few organizations are close to putting into operation practices that cover all three categories because of the fragmented health care system. To replicate the best practices across the board, we will need a national strategy. Electronic health records are not enough as a platform for a larger strategy to achieve a high tech, high touch health care system.

The public doesn't want to deal with the details of health policy, but they can be inspired by the idea of having more control, more comfort, more convenience. Every one should have a health home, with both a virtual component ('tools') and a real component (a trusted health advisor.) A simple concept like a health home would make it easier for politicians to talk about this issue and begin to advance the debate.

The politics of health care often hinges on the politics of the doctor – patient relationship. The politician who can explain how he is going to restore that relationship in a way that is both high tech and high touch is the one who is going to win!

Summation

Ian Morrsion provided the following summation of the first two days' sessions. We know the problems, and they lie partly in our individual and collective behavior. And we actually know the solutions: a holistic approach; simple, clear, targeted messages and interventions, balanced with community-based, multi parameter, system wide tools for prevention.

He offered three M's, five P's and a couple of I's for consideration.

- **Motive:** There is a societal motive that is enormous, business motives, and there are individual motives.

- **Money:** It can be there, because we are spending a lot on these people now and there are powerful reasons why the private sector and government should liberate some resources.

- **Marketing:** We need to channel the resources to the kind of brilliant marketing that PepsiCo does to sell its product in a positive direction.

- **Partnerships:** There is an American belief in public and private partnership, especially in unlikely coalitions.

- **Programs:** We have to be able to translate willingness to change and the general notion of motive, through marketing, into very specific programs which are science-based and can actually be implemented.

- **Positive Spirals:** There is great potential in positive spirals to be created by combining programs, motives, etc., in a positive direction, particularly if targeted at a local level.

- **Power of Traditional Medical Forces:** Harness the traditional 'wonk world' candidates in this conversation, the traditional actors who have the money and the responsibility in the system.

- **PepsiCo:** Transferring the demon to being the solution is powerful.

- **Incentives:** Research on the consumer's ability to navigate the health system suggests they have the incentives. They don't have the tools and the infrastructure.

- **Information**: Consumers/patients don't yet have meaningful information.

Session VI: A conversation with Baby Boomers

The purpose of this session was to involve participants in discussing the barriers preventing baby boomers from planning for their elder years and consider ways to eliminate these barriers and engage the boomers in active planning for healthy aging. That is, to unmask the power of 76 million people to build the right kind of structure for an aging population.

Panel Discussion

Every town in America, by 2020 to 2025, will look like Florida does today. We as a society are not prepared for the longevity of the baby boomers. We need to engage everyone in better

planning NOW for the services we're going to need, because it takes a long time to get these services in place. We should look at some of the models in South Florida that are relevant to where the country is going to be, in terms of aging and ethnic diversity.

This 'pig in the python' phenomenon will bankrupt the health care system as it's currently organized if the boomers don't do something collectively that promotes healthy aging. Many acknowledge that they are much more interested in quality than quantity when it comes to how long I want to live. However, despite 'compression of morbidity,' there is little evidence at the present that we are doing less when the morbidity happens.

People need to invest in their health as an asset, to preserve their wealth. Lifestyle change is possibly the best single investment one can make in terms of the future. Perhaps a web-accessed decision support tool could impress on people how much small changes can matter.

A vision and mission statement for life can help reaffirm that life doesn't stop at 62 or 65, and we should continue to maximize our life experiences and opportunities.

We need to not think and talk about older people as burdens, rather focus on them as an incredible asset, in terms of wisdom and experience and ability. In Finland they are trying to use the wisdom and experience of the older worker to teach younger workers certain skills, and the younger ones to teach the older, for example tech skills. There's also a workability index, a tool that employees use to estimate their own workability at the current time in their job and projected years ahead.

80% of boomers say they're going to age in place, and 80% say that they want to continue working, at least at some level. One of the issues that people need to think about is building a new community at this stage of life.

Before we can talk about what would work to get this issue on the radar screen of boomers and keep it there, we need a vision. We need to envision what life could be like if we are planning, and what life would be like if we're not planning. But getting the message heard when boomers don't want to think about these issues is challenging.

After the vision, when we need goals, like moving people forward from whatever stage they are in with regard to thinking about and preparing for aging, on both the health side and the financial side.

The behavioral stages of change model can be applied to aging: from the physical, financial, social, community-building, relationships, etc., perspective. Resources/services for people in a contemplative stage on aging include housing options; medical care, (outpatient, inpatient and pharmaceuticals); money and financial planning; transportation; spiritual options; and caregiving.

Aging becomes a very personal thing to us, primarily through our familial experiences. We experience aging only when it becomes real, when we have to deal with it in a very concrete way. Boomers are motivated both by the fear of aging and the potential joy. They really want to avoid some things but they want to be able to continue to do other things.

Boomers are asking for something from the medical care system that it is still not geared up to give, which is health. The boomer population will change America as it ages and it will demand that we think about how to deliver care in very different ways.

Family caregivers are an important asset and adjunct to the healthcare system. They provide over 80% of all home care in this country today. There are more than 50 million people who are providing some level of care. The burden in family caregiving is an effect caused by the lack of appropriate supports in our healthcare and social service systems.

An extremely conservative estimate of the economic impact of family caregiving of $257 billion a year in 2000 was developed. That is twice what is paid out in formal home care and nursing home services combined, and is comparable to all Medicare spending in 2002.

Session VII: Integrating mind and body

This session focused on trends in mind-body approaches and the use of complementary and alternative modalities, and the potential that exists for increasing patient compliance, improving care and advancing prevention by adopting a more holistic approach to healthcare

Russ Newman believes we have a lot to build on with the connection we now have between lifestyle, behavior, and health, perhaps even a connection between mental health and physical health care. Mind and body have been considered separate in western culture. In our health care system, we've actually built structures to keep mental health separate from physical health care and there is also a different financial system for behavioral health services.

Public recognition of the connection between the physical and psychological has been increasing. People are now starting to recognize that the six leading causes of death are related to behavior -- heart disease, cancer, liver disease, lung disease, accidents and suicides. 60 - 90% of visits to medical doctors are considered to be for stress-related complaints.

A public opinion survey found that 97% recognized the link between good psychological health and good physical health. 79% said they'd prefer to see a physician who worked collaboratively with a psychologist because they would have more choices and better access to care. Complementary and alternative medicine interventions have been effective in appealing to people's motivation to actively engage in their treatment and appeal to their motivation to change.

Milt Hammerly approached his comments on integrative medicine from the perspective of a traditionally trained physician who has come to recognize the value of a holistic approach to care.

Lifestyle interventions, mind/body interventions, the behavioral interventions, diet, exercise, stress reduction, etc. all have a large return on investment. High-tech aggressive interventions yield a smaller return on investment, but we're investing far more resources there.

When patients ask about options, generally physicians are not supportive of the use of CAM approaches. How physicians query patients determines if they get the truth about the use of CAM. By not invalidating their belief system, you can get at the truth and prevent potentially dangerous interactions between medications and supplements and actually enhance compliance with traditional treatments dramatically.

A person-centered care model requires provision of holistic, comprehensive, personalized body/mind/spirit care, an approach that requires collaboration. The term person-centered vs patient-centered recognize values, preferences, beliefs, connections, all those things which help us think of individuals as persons as opposed to patients.

CAM practitioners tend to have a more holistic philosophy and they are also less expensive. At the very core of the approach is behavioral lifestyle intervention.

The 3-legged stool of professional care, self-care, and coaching is best supported by coalitions, collaborations, and infrastructure. What is on top of the stool is the person and his or her needs.

Sita Ananth provided background on current trends in CAM. A CDC survey in 2004 found that 42% of Americans are using some form of alternative modality, from vitamin therapy to acupuncture to relaxation techniques, a 25% increase from 1997. 50% of kids in their teens are using some type of alternative medicine.

The number of hospitals that offer complementary services has doubled from 8% in 1998 to 16% in 2003. The primary reason for offering these services was to respond to the communities and to differentiate themselves in the market. The majority of hospital-based CAM services are paid for out-of-pocket, so the poor can't access them and could very well use them.

A survey of insurers between 2000 and 2003 found some were covering acupuncture, chiropractic and biofeedback. The motivator was employee and employer demand.

60 or 65 medical schools are offering an elective in CAM, which is extremely popular. But there's no standardization.

Research on patient satisfaction isn't very well documented. One 1998 study found the most influential factor in the decision to use CAM was the perceived efficacy and belief that CAM actually promoted health rather than a focus on illness.

NEXT STEPS

In reviewing the richness of the information and insights that emerged from the Broadmoor sessions, we recognized that looking at the value equation from the perspective of consumers, and considering how best to promote and engage them in wise health and healthcare decisions is a very broad challenge. This issue is less concrete than considering the value of healthcare interventions, therefore our approach to next steps needs to take this fact into account. We decided that it would be best to explore the options in several areas further, before determining the appropriate role for the Foundation.

We have identified three key topical areas:

1.) Broad-based social marketing and the possibility of a public-private campaign around healthy lifestyles, focused primarily on diet and exercise to address the obesity epidemic and the associated increase in chronic disease, such as diabetes. Key allies in exploring this option include CDC, disease advocacy groups, the food and beverage industry, media, and efforts like America on the Move.

2.) Tools and incentives to promote greater 'engagement.' This area should further consider advancements in consumer-directed health benefits and health savings accounts; progress in facilitating physician support of shared decision-making; and advancement in research and implementation of integrative medicine. Key stakeholders include employers, academic medicine, researchers, etc.

3.) Preparing for the baby boomers. This effort should begin with an environmental scan to confirm the 'state of the state' with regard to financial planning, care delivery and community–based models.

In addition, a number of specific policy recommendations emerged from the meeting, several of which are a part of our "Community Leaders Blueprint for Health Care Policy" and will be advanced with the appropriate committee and congressional staff or federal agency.

Our plan is to invite specific key individuals/organizations to participate with us in a series of conference calls to further identify the most appropriate next steps, if any, in each of these areas. We hope by creating this smaller 'leadership group' in each area to be able to discern what is needed and who should do it.

These calls will be summarized, sent to participants for comment, edited and then shared with all retreat participants for their input. This approach proved to be very effective at capturing and distilling broad input during Phase I of the "Communities Shaping a Vision for America's 21st Century Health & Healthcare initiative, when we created Advisory Boards on the topics of access, infrastructure, quality, incentives, public health and cultural change.

At a minimum, we believe that the Foundation can serve as a catalyst to promote thinking in this area and develop a "case study" approach, highlighting examples of effective tools, community, or worksite-based programs that facilitate or address the kinds of 'social changes in health behavior' needed to prepare us for a healthier future.