# WYE RIVER GROUP ON HEALTH CARE

# A Dialogue on Access & Coverage: A New Look at an Old Problem

## July 15, 2005

### *EXECUTIVE SUMMARY*

This dialogue among a seasoned group of health care thought leaders began with the question, *"In the context of coverage and access, what are we as a society trying to achieve, and what are the necessary prerequisites to meet our objectives?"*

The group first evaluated a Statement of Principles for Health Policy developed through Wye River Group on Healthcare's initiative, "Communities Shaping a Vision for America's 21st Century Health and Healthcare," as a potential "benchmark" against which health policy proposals should be evaluated. There was a general consensus that the statement, provided here as Addendum 1, provides a sound foundation for a "vision" statement.

Next, we focused on the concepts and value judgements imbedded in the terms 'coverage' and 'access,' in order to enable us to move closer to agreement on specific definitions, goals and priorities. This exercise highlighted to the participants the many individual conceptual interpretations assigned to these terms and the importance of agreement on definitions and dimensions prior to advancing solutions, given that misunderstanding clearly undermines progress.

In order to ground the discussion, we also presented a comprehensive healthcare reform proposal that has been advanced at the state level as a 'strawman'. This proposal purports to have been built upon many of the values highlighted in the Statement of Values and Principles. This exercise enabled us to drill down into specific ideas and gain detailed insight into elements of various perspectives which discussants might otherwise have glossed over.

Finally, we identified actionable steps for which the group would be willing to take ownership. The following have been identified as the most promising next steps:



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⇒ Identifying, reviewing and distilling major healthcare reform proposals being advanced at the state and national levels in order to better understand what ideas have gained acceptance and determine where there is a real or conceptual "making of a consensus." (*see Addendum 2, "Health Policy Reform Scan"* )

⇒ Organizing a series of small group meetings with a diverse group of healthcare leaders representing key stakeholders to create and evaluate the implications of various scenarios for long-term reform. (*see Addendum 3, "Leadership Talks")*

⇒ Holding congressional roundtables on specific access/coverage issues/recommendations (based on the health policy blueprint and others' work), with the imprimatur and involvement of key organizations;

⇒ Developing and gaining support for a process of evaluating legislative/regulatory proposals against the value and principles, a so-called 'Values Test.'

## SESSION I : A Review of Values and Principles

It was not our goal in this session to advance the previously developed Statement of Principles. However, there was general consensus among this group of thought leaders that the statement, developed through the 'communities' initiative, provides a sound foundation for a 'vision' statement.

Two additional points were recommended for the preamble, first that health policy must be a dynamic process, because the health system and health care are not static but dynamic. Second, recognition of the increasing diversity of the nation and the need to effectively address the needs of all of our residents should be explicit.

Many felt that we need to create a greater sense of urgency with the Statement of Principles. 'Should' is not a strong enough word. It was recommended that we broadly use the term 'must.' There is also a sense that the problems of access, cost and quality are unavoidably intertwined. We really cannot solve one without addressing the other two.

Although a number of suggestions were made to add more descriptive words to certain elements in the statement, upon reflection and further discussion, participants generally agreed that as a 'vision' statement, the bulleted items could stand as written. Being pragmatic and focusing on a few simple and clear principles made sense.

The group suggested expanding on some bullets to add clarity, perhaps as an addendum. For example, by defining terms (IOM definitions of quality, safety, etc.), highlighting other issues of importance (e.g., health care costs, patient rights, quality improvement, research and innovation, a stable workforce, prevention and chronic



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disease management, undue regulation), and providing examples of 'tools' (e.g. information technology), to use in implementing the principles. This step will be undertaken by WRGH at a later time.

## SESSION II: What Do the Terms 'Coverage' and 'Access' Mean?

The terms ‘coverage’ and 'access' when referring to healthcare have been broadly politicized. They have been used by both the 'left' and the 'right' of the political spectrum to galvanize public opinion in favor of a specific approach to ensuring we all can get healthcare when we need it.

There was agreement among participants that what is meant by these terms is not always clear, and individual views significantly impact perceptions. Agreeing on shared definitions of meaning is a prerequisite to constructive dialogue and consideration of possible solutions.

If we look at coverage as insurance, we need to consider the question, *insurance for what*, remembering that insurance, as third party payment for services, is a key driver of social behavior. On one end of the spectrum is first dollar coverage, which undermines incentives for wise health and healthcare decisions. On the other end is catastrophic coverage, which won't be adequate financial protection for people who do not have the means to pay out of pocket for lesser medical expenses.

As an insurance mechanism, coverage implies some type of 3rd party or risk-sharing arrangement that provides a means for managing the costs of catastrophic events spread across a larger group of insureds. Through insurance, we should provide for protection against financial catastrophe for all residents of the US, because we have a social responsibility to ensure all of our residents have access to quality care, and this is a necessary, though not sufficient prerequisite.

It is virtually universally accepted that a “sponsor” should contribute enough money to make it possible for individuals to access care when they need it, and that personal cost should not be an insurmountable barrier. In virtually all other countries government assumes sponsorship, but in the US sponsorship is divided between those who have coverage through their jobs and those for whom government is the sponsor. And there are those who have no sponsors or for whom sponsorship leaves a premium gap they cannot afford. As yet, we have not been able to reconcile these approaches or pick one over the other.

However, coverage means more than insurance. It is 'protection', 'security' that is defined at the individual level, therefore may differ from person to person, and implies all the factors that allow people to access the health care system and get the services



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that they need. Furthermore, it should be recognized that these factors also vary among individuals, communities, and geography

Discussions about coverage tend to get into value-laden dimensions when they focus on quality, the issue of who pays, medical necessity or cost-effectiveness. While we should debate cost-effectiveness, there really is no good definition of medical necessity, as it changes over time and with the clinical situation. In addition, patients' definitions of medical necessity are influenced by individual value systems. They are not solely based on clinical efficacy.

The source of payment for healthcare is clearly a strong incentive in shaping shape behavior. However, to mitigate the tension between what is needed and who pays and to advance a broader understanding of concepts, we should 'temporarily' uncouple the discussion of financing the coverage from the discussion of what coverage means. It is important to keep the concept of quality within any definition and to add the concept of measurement, which relates to feasibility.

In essence, coverage is similar to a 'menu' of what is made available through an insurance policy. Some menus are comprehensive, some quite limited. In that sense, coverage thus relates to technical *adequacy and assurance* of services. Access refers to whether you can 'order' it, implying that is 'practically' available and encompasses barriers such as *affordability and logistical accessibility*. It may be useful to see coverage as a key to 'opening the door' for access.

After agreeing on definitions, the real question is what is good public policy to promote adequate coverage and access for all? In simple terms, is there a level of health services that everyone should have access to, in order to ensure the health and safety of all and promote worker productivity? Should it be heavily subsidized, e.g., by government and employers? Should individuals with adequate personal funds be allowed to "buy up?" These questions deserve thoughtful discussion.

***Other terms***

Three other terms arose in our discussion, which are important to a clear understanding of access and coverage and which warrant further discussion: *equity, pluralism and rationing*.

While *equity* is broadly supported as a healthcare value, we need to be pragmatic about what we mean and define terms and measures carefully. To many people, equity implies some type of 'entitlement.' However the term more accurately is equated with 'justice' or 'fairness.' Perfect equity will never occur due to individual preferences and simple availability of services and provider choices. However, we can and should work toward ensuring *financial equity,* whereby everyone has comparable financial footing.



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*Pluralism* tends to be 'worshiped' as a virtue in this country, but what do we mean by this term when applying it to healthcare? Pluralism that meets the needs of individuals for the kind of care and setting that is appropriate to them? Pluralism in funding streams? Webster's defines pluralism as: "A state of society in which members of diverse ethnic, racial and religious, or social groups maintain an autonomous participation in and development of their traditional culture or special interest within the confines of a common civilization." For a discussion on coverage and access this appears to be a sound definition.

It was pointed out that we should not ignore the advantages associated with a single payer financing mechanism with regard to solidarity. Our costs are much higher than other countries, yet we do not, in general, get better results. Multiple payers and fiscal intermediaries with conflicting priorities may actually add costs and exacerbate quality problems. Healthcare is an issue that impacts on global competitiveness and we need to consider this in seeking solutions to access/coverage.

Finally, it was also noted that while we don't acknowledge it openly, we DO *ration* in this country, but in an irrational manner. There is considerable evidence that individuals do not want cost to limit their care, but rationing by some means has to be part of the discussion. Research confirms that innovation is a huge cost driver and society will not be able to pay for all the innovation individuals want and remain globally competitive. The group agreed that a more broad-based discussion focused on this dynamic would be valuable.

***Possible model for clarifying terms***

A model was proposed whereby 3 types of services are defined with different financing mechanisms and risk-shifting, and different eligibility, cost and personal responsibility structures:

- *Basic or Critical Services* (we should pool risk to pay for these services for everyone)
- *Commodity or Variable Services* (use a variety of different economic models here with a lesser degree of risk- sharing, e.g., HSAs, managed care, fee for service, etc.
- *Optional Services* (use economic models here which are based on individual choice/responsibility)

The following criteria might be applied to the services in each group:

- Existence/accessibility *(physical, staff*, *services, equipment, etc.*
- Affordability
- Quality
- Efficacy
- Appropriateness *(cost-effective, evidence-based, proper site, medical necessity)*



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Depending on the economic model, it may or may not be important to consider the specific disease when determining which category a service would fall into.

***Recommendations for governmental action***
In this part of the discussion, numerous suggestions were made relative to the role of government in improving access and coverage.

⇒ Ensure that reform is *flexible* to accommodate an evolving industry. Solutions need to be tailored to the local community.

⇒ Lower regulatory burdens and consider creating a regulatory mechanism that can quickly adapt to a dynamic industry.

⇒ Ensure adequate funding of research (e.g., AHRQ. NIH) to promote effective clinical performance.

⇒ To lower barriers to competition, consider allowing purchase of insurance across state lines but ensure no 'cherry-picking.' (Many participants expressed the view that we need a better foundation before this would work.)

⇒ Provide assistance with financing, e.g., subsidies like tax credits.

⇒ Encourage/support more training of primary care providers through mechanisms like payment reform to accommodate cognitive services and medical liability reform.

⇒ Use government leverage as a payer and build better partnerships with private payers.

⇒ Decide on a definition of 'basic' care/benefit. In the dichotomy between social and personal responsibility, government's purview is social responsibility.

⇒ Create a level playing field to make competition work, especially in risk adjustment and the burden of the uninsured.

⇒ Help to build (finance) an infrastructure for measurement of performance.

⇒ Encourage a focus on cost, rather than source of payment

⇒ Support development and expansion of coverage/access models and demonstration projects that work.

***Recommendations for healthcare industry action:***
Many other ideas were focused on the industry.



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⇒ Speak with one voice! Recognize that no one sector can move faster than the others--all need to be in sync for meaningful reform.

⇒ Document the crisis and bring it to legislators' attention with stories/vignettes.

⇒ Stop fighting over limited and scarce funds. Try to develop consensus on priorities based on the needs of the population, not just each sector. Come to agreement on a definition of 'basic' benefits.

⇒ Use common quality standard, e.g., those promulgated by NQF, IOM and organizations like the Ambulatory Care Quality Alliance (AQA), which have agreed upon a set of 26 quality indicators.

⇒ Work to promote rational financial incentives, e.g., through pay for performance and pay for quality.

⇒ Help to raise public awareness of healthcare challenges and work to educate consumers about good choices.

⇒ Get more involved in the debate at the local level by working with other community organizations, (e.g., faith-based groups.) Focus more attention on public health and population health issues.

⇒ Push IT demonstrations and enhanced use of such technology, but ensure that IT value is demonstrable and improves outcomes, process and behaviors.

⇒ Start by defining the problem of access from the community level: is it about insurance, lack of providers of some type; lack of transportation, etc.

⇒ Catalog successful community based models addressing access/coverage.

## SESSION III: Critiquing a "Strawman"

The purpose of focusing discussion on a 'strawman' reform model was to 'nail down' conceptual distinctions advanced by the discussants. The model used is not one advocated by WRGH, rather it is a comprehensive proposal, called the *Oregon Health Assessment Project*, which has been advanced at the state level and purports to address a number of common values articulated in our work and others. As background to the report, a brief overview of some key concepts is set out here:

⇒ Reform must be comprehensive, long term and accommodate all residents;

⇒ Escalating costs and the uninsured issue are interrelated challenges requiring an integrated response;



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⇒ The spectrum of strongly held personal beliefs will not support a single design for the financing and delivery of health care services; and
⇒ The consumer's role in the selection, financing, and overall decision-making related to health care services must be enhanced.

This model calls for**:**
⇒ Creation of an individual *Health Management Fund* ("HMF") for every resident;
⇒ Conversion of government and employer sponsored group health insurance to individual policies selected by the individual;
⇒ Allocation of a portion (10%) of every HMF contribution to improve access to a basic set of effective health care services for those in need; and
⇒ Reorganization of our delivery and financing system into three distinctive segments.

OHAP architects believe these strategies in a voluntary context would move us closer to improved cost control and meaningful universal access.

***Reactions to the model***
A number of general observations were common among participants. First of all, merely reviewing the executive summary raised more questions than it answered. However, as the proposal was used to provide a point of departure, we did not focus on the details or the many unanswered questions.

The overall view among many in the group was that the model, in an attempt to address the common value of 'pluralism', was trying to please too many people. In essence, it tries to make a political choice into a market choice and avoids an important debate--it avoids having to make a decision about which way we as a country want to go.

A number of specific concerns were expressed:
⇒ The creation of three separate systems was perceived as adding to fragmentation, not necessarily creating the opportunity for innovation.

⇒ The model is perceived to create a mandate that would 'require' large employers to provide a rich benefit, while other employers provide nothing. It also largely disengages employers, except as financiers. As long as employers provide funding, they will want a voice, and employees are well served by employer advocacy.

⇒ It is a tiered system….despite the stated goals and intentions. There is great concern about biases toward funding, quality, and the standard of care in the civic segment. There was specific concern about individuals with chronic disease.

⇒ The model makes the subsidy of the uninsured by everyone explicit.

⇒ Explicit coordination of care/system integration is needed in ALL segments but is mentioned only in the civic segment.



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⇒ There was doubt expressed about the effectiveness of stated cost control mechanisms.

⇒ It is disruptive in the sense that people who are happy with their existing coverage at work or through Medicare might have to give it up. Such wholesale reallocaton of funds is tough to build support for.

***Concepts of Value from the Model***

Participants were asked to identify concepts from the model that should be kept in mind when considering a better approach to comprehensive reform. The following were cited by different discussants:

⇒ The model is very useful in launching constructive discussion/debate
⇒ It is helpful in pointing out what NOT to do----what can happen when we try to turn fundamental political/policy decisions into decisions made in the market.
⇒ It provides 'virtual' universal access/care
⇒ Everybody has a stake
⇒ Lifelong portability eliminates segmentation of financing.
⇒ The ability to choose the plan that works for the individual
⇒ It promotes competition

***What is the Market Ready For?***

The group was polled regarding opinions on marketplace readiness for change. It was agreed that there is no consensus over comprehensive change. Rather, Americans like 'small revolutions.' While there is some consensus, we are not ready for anything big. It was pointed out that the 'market' is not ready for anything more than the 'sectors' are ready for, and while some sectors ARE ready for change, most do not appear to be. The group seemed to agree with one participant who expressed hope that we are intellectually ready to solve the uninsured problem, even if the will power has not yet emerged.

Some believe that we are a couple of years into a major 'transformation' of the marketplace, with new models, new products and new players. The market is prepared for a new wave of HSA legislation to facilitate movement toward consumer-centric health benefit models. There are also some examples at the state level, such as health insurance exchanges and the '3-share' program between employers, employees and the government that might be expanded.

While there is support for a move toward more individual ownership, it is likely to be under an 'aggregating umbrella', and the market always likely to be a mix of individual and group products.

Finally, participants felt that the market is ready for the building out of the infrastructure.



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## SESSION IV: What Can/Should This Group Do?

During the final discussion the group offered various ideas regarding an appropriate focus for a diverse group of individuals and organizations interested in collaborating to address coverage and access challenges.

Two significant themes surfaced in the meeting that have relevance for next steps. First, the importance of framing an exceedingly complicated debate in terms such that people can understand and get engaged, because such engagement is widely viewed as critical. Second, the need to address the tension between individual responsibility and provider/payer responsibility in whatever proposals are advanced.

There was consensus that there will not be acceptance of a comprehensive proposal in the short-term and that nothing significant is likely to happen until the REAL crisis strikes…possibly in time for the 2008 or 2012 elections.

There was interest in a bifurcated effort that recognizes this reality. The group could support and advance 'small steps' where there is general agreement (e.g., blueprint recommendations; other efforts like the RWJF initiative) but also seize the opportunity to position for the future, by working together to develop a 'time-capsule' proposal to be ready when the crisis strikes.

For such an effort to be effective, a true sense of urgency must be created and healthcare industry leadership must agree that solving the problem of the uninsured *can only be done through a sense of compromise*.

Several steps were recommended to achieve these prerequisites:

⇒ Convene the 'ends of the spectrum' on ideology to see if there are points of commonality;

⇒ Evaluate 'readiness for change' of the various constituencies represented;

⇒ Ask decision-makers in key organizations to review blueprint recommendations and 'sign-on' to one or two that have ramifications BEYOND their immediate self-interest;

⇒ Find out where each constituency is with regard to efforts on the uninsured, as part of a health policy scan; (described separately)

⇒ With the imprimatur and involvement of key organizations hold congressional roundtables on specific access/coverage issues/recommendations;

⇒ Create a 'picture' to raise the awareness of the public and law makers: What does the 'crisis' look like at the local level? How can it be measured? Develop *'5*



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*Measures of Healthcare Crisis'* **,** a matrix by state which shows those most in trouble. Compile data from studies looking at the ripple effect of a large uninsured population on economic development

⇒ Develop and gain support for a process of evaluating legislative/regulatory proposals against the value and principles, a so-called 'Values Test.'

⇒ Develop 'scenarios' (planning) for sector leaders to evaluate, building from fundamental tenants, for example, considering a system financed solely by government, a complete transfer from a group to an individual insurance market, an individual mandate for insurance, etc.

⇒ Money drives change. Reform should focus on cost-efficiency (VALUE) not just cost-containment. We should support research on clinical efficacy and cost-effectiveness.

⇒ Crystallize concepts and definitions discussed by measurement? For example, some organizations have defined *access standards*.

***CONCLUSIONS***

Of the above, WRGH proposes the following as the most 'workable' next steps:

⇒ Identifying, reviewing and distilling major healthcare reform proposals being advanced at the state and national levels in order to better understand what ideas have gained acceptance and determine where there is a real or conceptual "making of a consensus." (see Addendum 2,

⇒ Holding congressional roundtables on specific access/coverage issues/recommendations (based on the health policy blueprint and others' work), with the imprimatur and involvement of key organizations;

⇒ Organizing a series of small group meetings with a diverse group of healthcare leaders representing key stakeholders to create and evaluate the implications of various scenarios for long-term reform. (see addendum 3, "Leadership Talks")

⇒ Developing and gaining support for a process of evaluating legislative/regulatory proposals against the value and principles, a so-called 'Values Test.'



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# ADDENDUM 1

# A STATEMENT OF PRINCIPLES FOR HEALTH POLICY

Health policy must be a dynamic process, because the health system and health care are dynamic. As a prerequisite to developing effective health policy, residents must be engaged in the creation of a shared vision for American healthcare, one that reflects the growing diversity of our nation. Healthy people are vital to the health and well-being of the United States and its economy. Appropriate healthcare is necessary for the well-being of individuals, families, and communities.

This Statement of Principles is intended to provide a "benchmark" against which health policy proposals should be evaluated. Given the sensitivity that surrounds language and the use of terms, certain points need to be clarified with regard to the statement.

While the definition of "basic" goes beyond the scope of this document, it must encompass some elements often "siloed" e.g., mental health, oral health and long-term care. The notion of "choice" does not imply that it is without increased cost to the individual. The term "universal coverage" does not refer to benefits, rather it refers to financing of care through health insurance and other mechanisms.

- *Every resident must have the ability to access basic high quality, safe, affordable, culturally appropriate health care services. Every resident must have choice with regard to the provider of these services, and sound, understandable health information to facilitate good choices.*

- *Every resident must have some financial responsibility for the cost of his/her health care, consistent with ability to pay, but must have access to financing mechanisms that protect against financial catastrophe and promote optimal health for each individual.*

- *Universal coverage of basic healthcare services and the elimination of health disparities must be a major goal of national health policy. The strengths of the current public-private system should be used in advancing toward this goal.*

- *Every provider must be responsible for practicing according to current standards of care and, in return, must receive fair reimbursement.*

- *Every resident must be responsible for taking all reasonable steps to preserve his/her health.*

- *To promote stakeholder partnerships that maintain and improve individual health, education about health and the appropriate use of healthcare services must be integral components of the U.S. public educational curricula and our nation's healthcare system.*



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# ADDENDUM 2

# HEALTHCARE REFORM INITIATIVES ENVIRONMENTAL SCAN

**Background:** Wye River Group on Healthcare proposes an environmental scan to capture, through an objective analysis, healthcare reform efforts underway at the national and state level. Two developments have recently occurred that make the proposal especially compelling, the creation of the Medicaid Commission and appointment of the Citizens' Health Care Working Group. Both of these efforts are designed to create momentum for significant change in our nation's health care system.

Various health care reform initiatives have been proposed and tried in state 'incubators' for several decades. Moreover, proposals have been developed and vetted within trade and professional organizations at the national level. We believe a better understanding of the experience to date can inform the health policy debate by providing insight into what is likely to be viable and what should be avoided. A review of past and current efforts would be timely and serve to guide the work of above Commissions. The scan would include a description of each initiative, its mission, the players involved, progress to date, strengths and weaknesses, outcomes and results of any evaluations.

The results will also provide the business community, consumer groups, legislators and other policy makers with apolitical, unbiased information. Scan results may highlight new ideas as well as replicable efforts. It will also allow us to compare the common elements being advanced in each proposal as an indication of potential points of consensus.

**Approach:**

1. Senior Wye River Group on Healthcare staff will work with the sponsors to identify a five-person advisory committee consisting of health policy experts and business and consumer representatives. This committee will:
    a. Identify key informants whom staff will interview.
    b. Review a draft questionnaire to guide interviews and help modify it as needed.
    c. Review and comment on draft findings and final report

2. Using a comprehensive literature search and a "snowball" method, Senior Wye River Group on Healthcare staff will identify additional individuals who are key players in healthcare policy in the following arenas.
    - "Think tanks"
    - National and state legislative organizations
    - Healthcare professional/trade and consumer organizations



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- Business leaders

3. Staff will interview these individuals in person or by phone to determine:
   - How they view current reform initiatives overall
   - Which efforts can they identify
   - Their opinions about the progress and utility of these efforts.

4. Staff will work with the sponsors to determine the specific criteria to be used to select the states and the initiatives for inclusion.

5. When staff have identified a critical mass of initiatives, they will explore each according to predetermined criteria such as mission, description, progress, outcomes, evaluations, etc.

6. Staff then will complete an analysis of the information obtained, including a comparative matrix, and a catalogue containing full descriptions of each initiative reviewed.

**Timing**: The anticipated time frame for this effort is six months.

**Budget**: The budget for the project will depend on the depth of the research and the inclusion of a Congressional/Media briefing to release the results. We are targeting an exclusive number of sponsors. The basic budget would include:

- Senior staff compensation
- Literature searches, article retrieval
- Phone costs, copying, postage, other direct costs
- Editing, graphic design, printing and dissemination of report
- Overhead

We also anticipate creating a protocol based on the results of the scan that would be used to prioritize the relevance and utility of state based reforms for national consideration, through the use of *ASL* or similar electronic brainstorming technology. This protocol would be put before trade and professional association executives and health policy experts for their consideration and voting. This element would be priced separately from the actual scan.



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# ADDENDUM 3

# America's Health Care Leadership Talks

## (Draft)

**Background:**

Today American healthcare policy is frozen in a healthcare debate that is unlikely to yield any significant change in our approach to addressing our healthcare system challenges. Yet, it is well recognized that unless we chart and advance a fundamentally new course of action, we are well on a path to health system collapse.

There is broad agreement that maintaining the current course of inaction is unacceptable from a cost, quality, and social responsibility standpoint. Ignoring growing pressures will result in a crisis that may force policy makers, courts or regulators to hastily correct the imbalance, which could result in disruption of current business practices and undercut our financial and social interests. In short, it is in the industry's self interest to develop contingency plans that set out a viable set of policy options for health and healthcare.

However, currently there is no well-accepted cross-sector *process* for identifying these options or for engaging in constructive long-term planning. Wye River Group on Healthcare and the Foundation for American Health Care Leadership propose a series of steps that will enable creation of these plans for American healthcare policy.

This project will be designed with our sponsors and will build on learning from and relationships developed through WRGH's "Communities Shaping a Vision for America's 21st Century Health and Healthcare" initiative and the FAHCL health policy blueprint, as well as the work of IOM and other credible sources. It will comprise four elements: a baseline health policy scan; an initial series of meetings designed to examine viable options relevant to key healthcare issues; follow on sessions focused on scenario planning; and development of a workable set of contingency plans, aided by the use of electronic brainstorming technology.

The process described will ensure that thoughtful deliberations have occurred prior to a flash point or crisis occurring in the US healthcare system. The scenarios will provide leaders with a set of thoughtful operational plans ready to be advanced at the appropriate time.

**Operational overview**



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WRGH/FAHCL will identify 10 lead sponsors to help us design and execute the 'Health Care Leadership Talks' initiative to be complete by the inauguration of the next Presidential administration. Each lead sponsor will provide an equal amount of financial support and will have the same benefits. The sponsors will represent a balanced cross section of healthcare interests. Reports will be created following each meeting and a series of comprehensive healthcare public policy "scenarios" will be developed and converted into a set of contingency plans. The traditional WRGH consensus building process will be employed throughout and the principals at WRGH will take primary responsibility for all work.

Each sponsor will have one representative participate at each of the seven meetings to be scheduled between now and 2008. Sensitive to involving community leaders the remainder of discussants will be chosen based on the topic, ensuring broad representation of interests: physician leaders, hospital and health system executives, insurance executives, allied health professionals, community and public health officials, pharmaceutical representatives, business leaders, academia, consumer advocates and government officials. We will also work to ensure that the interests of important constituencies, e.g., the elderly, the uninsured, minorities and those with chronic disease and mental health issues are represented.

**Baseline Environmental Scan**

As background for the "leadership talks", WRGH/FAHCL will undertake a baseline scan to capture healthcare reform concepts/recommendations already developed. We recognize that many organizations have put considerable effort into articulating sustainable long-term solutions to our nation's challenges. Proposals have been developed and vetted within trade and professional organizations at the national level. In addition, over several decades, various healthcare reform initiatives have been tried in state "incubators." Examining the results of these efforts clearly has merit and they should be carefully considered as a part of leadership deliberations. We believe a better understanding of experience to date can inform the health policy debate by providing insight into what is likely to be viable and what should be avoided.

Thus, a methodical healthcare environmental scan will provide a launch point for developing the planning documents. Working with our sponsors we will set the parameters for the scan, for example, issues to be considered, the criteria for selecting reform initiatives for review, and the organization and presentation of the research. Among other considerations, the scan will include a description of each initiative, its mission, the players involved, progress to date, strengths and weaknesses, outcomes, and results of any evaluations.

The results of the scan will provide the health industry, the business community, consumer groups, legislators and policy makers with apolitical, unbiased information. Scan results may highlight new ideas as well as replicable efforts. It will also allow us to



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compare the common elements being advanced in each proposal as an indication of potential points of consensus.

**Leadership Launch**

Initially we will assemble the CEO (or COO) from each sponsoring organization to develop an outline to guide the deliberations. We will provide a summary of background documents, including an overview of the reform scan, findings from the Community Leadership and Blueprint initiatives, and other pertinent information as preparatory reading to stimulate thinking. WRGH/FAHCL principals will facilitate a half-day session designed to identify the key drivers needed to support the health system long term, while realistically meeting current challenges and growing demands. We will develop a "15,000 foot" comprehensive outline from diverse perspectives, which identifies the most salient opportunities, and organize the ideas into a framework for use in follow-on work sessions.

The CEO/COOS will discuss the following issues:

- The 'social contract' for healthcare in this country;
- A vision for our healthcare future;
- How we can work together to avoid a crisis;
- Elements of the current system that must be preserved;
- Elements that must change;
- Major areas of concern relative to health system reform;
- The current versus future role for their sector;
- The appropriate role for government in enabling constructive change.

**Work Sessions**

For these meetings WRGH/FAHCL will assemble senior staff representing project sponsors, along with policy experts, government and community representatives. The discussions will "flesh-out" the fundamentals articulated in the outline.

Each session will be limited to a day and will be tightly facilitated. In preparation for the meetings, participants will receive an overview of topics/issues that form the basis for discussion, and appropriate materials to stimulate thought.

The topics for each session will be set out in advance and will cover the fundamentals for a comprehensive vision and for reform planning scenarios: system design; workforce; financing/funding; coverage and access; resource allocation; incentives; disparities; public health, etc. The first session will begin by reviewing the findings from phase I of the ‘communities’ initiative on values and principles and deliberating on the social contract for healthcare, the attributes of a well-functioning healthcare system, and engaging the public in their own health and healthcare.



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A professional writer will capture the ideas advanced in the dialogues and a report will be issued following each session. All participants will be given the opportunity to edit the reports.

**Scenario Planning**

Following the four work sessions, WRGH/FAHCL will aggregate the information and develop a protocol for consideration and ranking through an electronic brainstorming session, a unique aspect of this effort. This tool, developed by the Advanced Strategy Lab (ASL) was used in the creation of the "Blueprint for Health Care Policy". It allows us to take a very complex set of concepts and distill them into actionable steps, based on the 'making of a consensus'. Participants in the ASL sessions utilize laptop computers with advanced software from GroupSystems.com. Guided with expert facilitation, participants can respond simultaneously and anonymously to critical planning and input questions. Rapid identification of ideas, development of key themes, prioritization of themes and electronic survey support create clear outcomes and ensure a high level of valued input from all participants. The end result is not only a comprehensive planning/input document, but a high level of buy in and commitment to the results.

This 'tool' will enable the creation of two or three different scenarios and may involve both a senior executive and the CEO/COO from each participating organization. In the final meeting, the scenarios will be presented to all of the participants for evaluation and discussion to identify the one most likely to complement both the needs of industry and of our society. Importantly, the development and consideration of these scenarios will be managed below the radar screen, and will not be publicly or politically vetted unless and until the sponsors determine that is the appropriate action.

**Contingency Plans**

Based on the output of the final meeting, WRGH/FAHCL principals will prepare a draft set of contingency planning documents that will be provided to sponsoring organizations. Based on feedback, the need for further deliberations as well as the appropriate use of the planning documents will be determined.

**Timeline**

It is our objective to have these documents prepared prior to the next Presidential inauguration.



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