Promoting and Enabling Healthy Choices: Linking the Desire for Health with the Decisions & Tools that Support Health

Foundation For American Health Care Leadership[sm]

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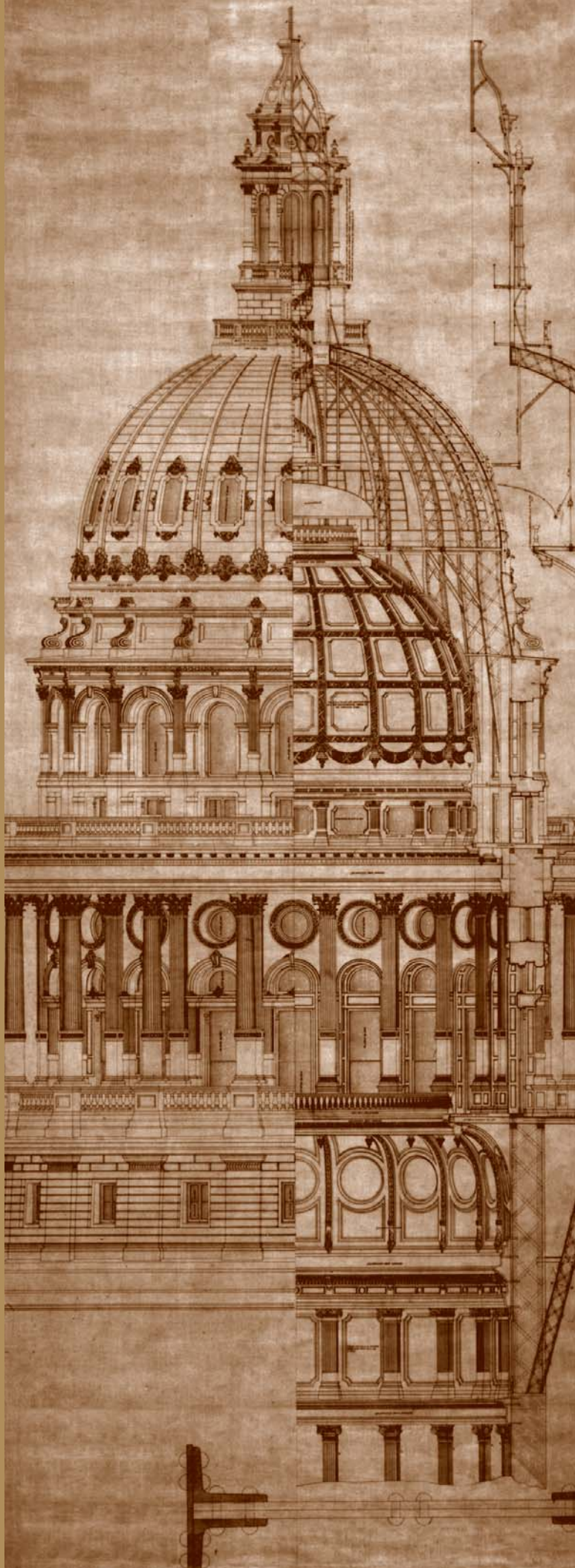
The Broadmoor, Colorado Springs, CO



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Executive Summary

The Foundation for American Health Care's December 2004 retreat at the Broadmoor in Colorado Springs explored the 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 practice? What is needed to create a stronger link between our desire for health on the one hand, and making the appropriate choices on the other? How can we ensure that each of us as an individual and as a member of our community has the motivation and the tools to make good decisions about our health and healthcare?

These questions have significant relevance for us as the health care 'system' struggles with managing escalating costs associated with an aging population and the rising prevalence of chronic health conditions. A growing body of literature suggests that the greatest opportunities to improve health outcomes and lower costs lie in the area of behavioral choices and lifestyle. The Broadmoor meeting explored many opportunities in this area.

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 people about how their personal choices impact the health care system and the available resources upon which we all depend.

The Foundation's June meeting focused on the question *"What is the Economic Value of Health and Healthcare"* and explored each sector's responsibility to demonstrate value. There was broad agreement that institutions should be accountable, measurable and operationally transparent to the consumer. The system also has a responsibility to ensure that patients have the right incentives and information to be truly engaged in their healthcare. Providers can become partners with patients by offering them the decision-support they need to make healthy choices and better understand their treatment options. Government should serve as a broker of information and as a mechanism to ensure a level playing field.

The Broadmoor retreat then focused on the consumer/patient side of the value equation for health care—how changing individual attitudes and behaviors can enable people to practice good health habits that will help maintain and improve their health. We considered the question of individual engagement by examining potential applications of science, art, social, and cultural dynamics. We discussed marketplace tools and opportunities to optimize our healthcare future from various perspectives--that of employers, providers, government, and consumers--with representatives from across the country, as well as individuals with international expertise. These discussions took place in the context of the implications of future trends.

The Behavioral Change Model

Dr. James Prochaska's keynote speech described the application of the transtheoretical model of behavioral change, illustrating that there is a science to enabling lasting change. He pointed out that the mental models of behavioral change that have dominated our society for the past century have been action-oriented models. However, change is a process that unfolds over time, involving progress through a series of stages, from pre-contemplation to contemplation, preparation, action and maintenance. It is highly likely that this is as true for organizations as it is for individuals, a fact that has significant

implications for stimulating a positive evolution in the health care system.

Today, 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. But we are not proactively managing these costs! Most primary care takes place at home, and the majority is behavioral.

Dr. Prochaska highlighted the message of small changes. We need to recognize that people are more likely to take steps to address unhealthy lifestyle behaviors if what is asked of them appears to be reasonable, not overwhelming. The stage of readiness of an individual patient can be assessed in five easy questions, so that the behavioral medicine intervention can be matched to their stage. A realistic goal is to help them progress one stage during a brief interaction, by giving them feedback that they aren't aware of in terms of their decision-making about their own behavior and their own health.

To have an unprecedented impact on the major killers and cost drivers of our time, we need to change several of our paradigms. We need to move from a focus on individual patients to populations; from passive reactive to proactive healthcare; from office-based to home-based delivery; from reliance on clinicians to reliance on teams supported by computers; and from addressing single behaviors to multiple behaviors.

Dr. Prochaska also had several recommendations for public policy related to obesity and behavioral change. First, deal with obesity as a multiple behavior change problem and highlight all the benefits to be gained from the behavior change, not just weight loss. Second, he recommended that more home-based programs be available at affordable rates. Finally, and most fundamentally, he recommended that we make unprecedented investments in these strategies, tacitly recognizing their importance.

Developing a Multi-faceted Campaign

Health is an unstoppable political force if we can reach a 'tipping point' by getting everybody—doctors, hospitals, health plans, employers, and patients—on the same page. But that is hard to do! Successful models for health promotion are based on a holistic approach, facilitating both individual responsibility and a supportive environment for change. Yet, most US programs are 'siloed' and focus strongly on individual responsibility for lifestyle changes, with much less attention paid to creating an enabling environment.

Participants expressed the view that leadership should come from government, which can mobilize public and private resources. We need to work to identify the unique capabilities of government agencies and state health departments in working with private sector healthcare organizations and employers, and develop the necessary partnerships to motivate the public. Some suggested the potential benefits of creating a modern version of the old US office of public information to coordinate messages among state and federal agencies on issues of broad public interest.

There is also a huge opportunity with corporations and communities. Both have a major interest in health and wellness for their employees and residents. A healthy member of society is more productive, requires fewer resources, and generally fosters a more positive attitude among his/her peers.

As a start, examples of past campaigns to change behavior should be carefully studied for the critical success factors and lessons learned. Several of these campaigns and community-based models are highlighted in this report. An artful campaign strategy should be considered, tapping into the creative marketing techniques perfected by companies in the food/beverage and consumer products industries. We should also harness the collective learning from proven campaigns executed by powerhouse

organizations like the disease advocacy groups, American Cancer Society, American Diabetes Association, and American Heart Association. And we should employ the power of art in all its forms as a universal communicator of ideas.

We learned that the campaign should be aimed at the entire population. There is no real 'high risk' group, as most people are doing well at some things and not well at others. Directing efforts on a population basis also raises the likelihood that those who exhibit behaviors we would like to change are getting some social pressure from those who are not engaged in the undesirable behavior.

Health and healthcare are very complex, but messages need to be clear and simple, carefully tailored to different target groups, and delivered using a variety of media. For example, television and radio, journalists, the Internet and the arts, should all be used to reinforce the message. The communication needs to be consistent, encouraging and unavoidable.

Participants strongly agreed with presenters who pointed out that people respond to messages that are human, visual, and aligned with cultural values, social norms and financial incentives. Because we are a society that runs on instant gratification, the tangible and immediate benefits exchange needs to be clear. To make meaningful progress at changing these unhealthy behaviors, it is likely that it will be necessary to move some of our social cultural values, for example, unbridled consumerism, in a different direction. We will need to take advantage of existing strongly held social values and 'higher order' human needs, like the intrinsic desire to belong.

Cultural change to improve health is possible, and the most promising setting in which to initiate such change is within the community. Programs need to reach people where they live and work, with tools they can use. Comprehensive programs also need to consider all aspects of living, including education, recreation, safety, urban planning and transportation, all of which impact our health.

Finally, we need to be realistic. As it generally takes 7 to 10 years to fundamentally change culture, we need to appreciate that a public education campaign of six months to two years is not going to be adequate. We need to be ready to invest for the long haul to improve our lifestyle behaviors and ultimately the health of our nation.

The Status of Tools and Information

Participants agreed that patients are the most important source of continuity in their healthcare. Thus, their active involvement, especially in influencing and implementing decisions relating to prevention and early treatment, is crucial to ensuring healthcare quality. A secure, centralized source of patient information, such as an electronic health record, is an essential tool for helping physicians to provide efficient, quality care and patients to track their progress and make important healthcare decisions. Tools and other interventions should be geared to improving patients' readiness to change.

However, to engage consumers/patients, tools must be responsive to the entire array of people affected by the healthcare system, and recognize disparities of disease, socioeconomic status, geography, and racial and ethnic background. Tools need to be appropriate to specific cultures, languages, capacities, skills and health status. They need to be relevant, timely, specific, measurable, geared to the behavior or goal desired, and supported by both positive and negative incentives.

Multiple tools and exposures are necessary, because study results suggest that patients quickly forget much of the information provided during an encounter with their physician. Further, patients must be surrounded with help. They need access to web-based, telephonic, mail, and print communications, as

well as community advisors and health coaches, to assist them in making healthcare decisions, particularly those involving behavioral change.

One speaker recommended 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.

There is significant support for the concept of 'information therapy,' which integrates clinical care with condition and treatment specific information. It involves the patient in 'homework' and the healthcare professional in checking patient understanding of information they are getting. Today, few physicians are providing adequate information for patients to use at home to prevent or manage chronic disease.

There are a number of potential barriers to engaging consumers/patients actively in their healthcare. The explosion of complex information and the lack of transparency regarding the cost and quality of available care hinder even those with the best intentions from being fully involved. Recently, some people have expressed concern that health savings accounts could be a barrier to prevention, if consumers focus on saving the money by rolling it over from year to year, reducing the likelihood that they will get important screening tests that could aid early diagnosis. Finally, given our fragmented health care system, developing standards to sort out complexities and using technology to amalgamate and readily distribute important information will take a nationally coordinated effort.

The Status of Shared Decision-Making

There was general agreement among speakers and participants that the politics of healthcare pivots on the doctor-patient relationship. Clearly the quality of communication between physicians and their patients is intrinsic to the overall quality of the relationship.

Physician autonomy, a historical tenet of medical training, was a great strength in yesterday's healthcare environment. But it has become a liability today. Access to information has changed the traditional physician-patient balance. There are a lot of smart patients now. Both the growing demands of these empowered patients and the needs of our complex system mean that a significant transition is needed in the role of physicians, such that they become partners with patients, team leaders and coaches. But data suggests that the compliance rate of the typical physician in working with other health professionals to help patients to adopt a healthier lifestyle is about the same as the compliance behavior of the patients themselves. So we have a lot of work to do on both sides of the doctor-patient equation!

The fundamental challenges for the important process of shared decision-making do not rest on difficult patients or difficult doctors. They rest on difficult relationships. It is very important that patients feel they have a part in making decisions, yet the benefits of shared decision-making are seldom realized today. A study of 1,000 patient encounters involving 3,000 decisions found only 9% of the decisions reflected a limited degree of shared decision-making and not one included all six 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.

Effective shared decision-making requires trust, a clinician with good communication skills, time, appropriate incentives, and a larger commitment from the patient and clinician to the value of shared decision-making. Clinicians need to be able to assess the understanding of the patient before providing advice and counsel. They need to build rapport through reflective listening skills and empathetic

communication. Patients assume their physician is competent, so the attributes they value most highly are compassion and a sense of partnership. How a physician presents the 'truth' is crucially important, as there are good ways and bad ways to present the same information to the patient.

Preparing for the Baby Boomers

In this interactive panel discussion, participants learned a good deal about what baby boomers think about aging, what they are doing to prepare, and more importantly what they are NOT doing!

As a society, we are simply not prepared for longevity. We have neither the systems nor the services to take care of the coming wave of seniors, who will face an increasing symptom burden related to chronic illnesses and increasing disability in their later years.

By 2011, the first edge of the baby boomer generation will reach 65, and 76 million boomers will follow. The baby boomers, in general, tell us that aging is not for them. Their bodies might age, but they are healthy and they are never going to get old. Panelists and audience participants agreed that they are largely unwilling to think about the challenges, or opportunities, of aging and believe that a healthy life style now will obviate problems later. Nearly 80% of the boomer generation expects to 'age in place' and continue working at some level.

There are global concerns facing us as the population ages with their needs for significantly more and different health and social services, housing, and economic security being foremost among the challenges. Of all the primary challenges, economic security is the most serious. The financial realities related to the boomers are going to make the need to limit choices and modify behaviors inevitable. Using Prochaska's model we have to gradually bring people along to the inevitability of structural changes. Many people lack an adequate retirement income, and it is not easy to teach people to be financially disciplined. We need to improve population health and lower consumption of resources. But few people seem willing to lesson their demands on the system to free up resources for the less fortunate.

Panelists stressed that they represented only a fraction of the boomers—those who have sufficient economic security to consider options such as retirement and congregate housing. The issues facing those with more limited resources are much more daunting. Among the serious challenges is engaging baby boomers in healthy aging practices and in planning for the years of increasing disability. Health services, in contrast to medical services, and spirituality are key among current boomers' concerns and essential to healthy aging.

Many of the boomers have already experienced the aging process and death with one or both of their parents and want their aging to be fundamentally different. Quality of life concerns will be as important as quantity of life for them.

We have an opportunity to create the kind of environment in which we would like to live as seniors and the services we would like to have available to us. We should begin to create a vision for healthy aging and a vision of a policy and system environment within which healthy aging, as well as increasing chronic illness, can be accommodated effectively.

Integrating Mind and Body

This session focused on what mainstream healthcare can learn from the popularity of a more integrated, mind-body approach to healthcare. For years, consumers have 'gotten it.' They have collectively paid considerable dollars out of their own pockets to get treatments typically labeled as complementary

alternative medicine. Yet it is only recently that traditional practitioners have begun to incorporate these practices into a more holistic treatment approach.

Public recognition of the connection between the physical and psychological has been increasing and people are now starting to realize that the six leading causes of death are related to behavior. 97% of the public recognizes the link between good psychological health and good physical health. 79% prefer to see a physician who works collaboratively with a psychologist because it provides more choices and better access to care.

There has been a dramatic increase in the use of CAM by adults and teens and consumer demand has led to an increase in offerings by hospitals and coverage by health plans. Complementary alternative medicine interventions have been effective in appealing to people's willingness to actively engage in their treatment and in facilitating their motivation to change. At the very core of the approach are holistic behavioral lifestyle and mind/body interventions, which, along with diet, exercise, and stress reduction all have a large return on investment. High-tech aggressive interventions yield a smaller return on investment, yet we are investing far more resources there today.

Alternative providers might also provide some solutions to the shortage of traditional providers. CAM practitioners are less expensive to train, their services are generally less costly, and their approach is especially appreciated in multi-cultural communities.

Despite the trends in consumer demand and generally positive outcomes, many physicians still do not support the use of CAM. This attitude contributes to patients' lack of honesty regarding use of such modalities and an increased risk of interactions and side effects.

We need better data on the effectiveness of CAM. Current research isolates interventions and doesn't use an integrated model to evaluate the best application of these modalities in healthcare delivery by multi-disciplinary teams of conventional and CAM practitioners. Speakers suggested that the integration of CAM with mental health and general medical care could be most easily tested in prepaid group practices or in government-run facilities, where the funding is not so fragmented.

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. The issues are less concrete than considering the value of healthcare interventions and 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 diseases. Key allies in exploring this option include Oxford Vision 2020, CDC, disease advocacy groups, the food and beverage industry, media, and efforts similar to '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 included in our 'Community Leaders Blueprint for Health Care Policy' and will be advanced with the appropriate committee and congressional staff or federal agencies.

Our plan is to invite specific knowledgeable individuals/organizations to participate in a series of conference calls to further identify the most appropriate next steps, if any, in each of these areas. By creating this smaller leadership advisory group we will be better able to discern what is needed and who should do it.

These calls will be summarized, sent to participants for comment, revised, and then shared with all retreat participants for their input. A similar 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. We can develop a 'case study' approach, highlighting examples of effective tools and community or worksite-based programs that facilitate the kinds of 'social changes in health behavior' needed to prepare us for a healthier future.

Meeting Overview

MONDAY, DECEMBER 6, 2004

Welcome
Jon Comola: CEO, WRGH/FAHCL

Welcome. I would like to spend a few minutes 'framing' what we will be doing over the course of the next three days. This is going to be a very interactive series of sessions. We are looking to each of you as an expert in a different aspect of this important topic—How do we motivate people to adopt healthier lifestyles, and how do we ensure that they have the tools and information necessary to do so? We ask that you be as creative as possible in your thinking, and we hope to have a lot of fun.

So why is this issue important for the Foundation? When we did our twelve city community leadership tour, which most of you are familiar with, one of the most consistent themes across the country was the need to engage the pubic in a more meaningful way around their own health and health care.

This meeting is intended to explore examples of behavioral change that resulted from social marketing campaigns, the opportunities to use the arts, broadly defined, to influence behavior, and public and private community-based models that have been successful. We will look at the current status of 'tools', including information and incentives, which can be leveraged to achieve broad-based behavioral change. On the physician side of the equation, we'll talk about the importance of the physician-patient relationship from the perspective of shared decision-making. Given their power in influencing any kind of social change, we'll specifically discuss the 'boomers' and how they are, or are not, taking the steps needed to plan for their future health care and social needs. Finally, we will examine the concept of mind-body, or integrative, medicine. What can we learn from psychology and complementary alternative medicine that has relevance for influencing behavioral change?

Now I want to introduce our friend, colleague, and global futurist, Ian Morrison. Ian has been working with the Foundation, helping us to shape our efforts and to better understand the issues and challenges that we face in health care in this country, and how they overlap with other countries.

Setting the Stage

Ian Morrison: Founding Partner, Strategic Health Initiatives

(presentation slides are available for downloading from www.wrgh.org)

As always, it's a pleasure to be with this group, and Jon and Marcia, thanks again for including me as your resident futurist. For those of you weren't at the last meeting, my definition of a futurist is an economist who couldn't handle calculus.

As you all know, I'm Scottish-Canadian-Californian, which gives me a unique perspective on health care, because the Scots see death as imminent, the Canadians see death as inevitable, and Californians see death as optional. Now, what I'd like to do to tee this up is reflect on four meetings that I've been at in the last month.

Ken Kizer and I were just commiserating about the number of airplane rides we've had since Labor Day. I was deeply struck in these four meetings about what I would call a coming tsunami related to obesity. Now, I am not an expert on obesity and defer to those of you in the room who have spent your careers on this, so please forgive me. We futurists basically make a living stealing other people's power points. Carol Staubach's paper in your meeting packet, I think, deals with this much more eloquently than I can.

One of the four meetings, convened by the Integrated Healthcare Association, was specifically focused on obesity, and Ellen Severoni and I were involved in that meeting. She's one of the board members of the organization. IHA has become nationally prominent for its pay-for-performance initiative in California, and we were struck as a group by some of the alarming trends. I'll share some of the data that we looked at there.

The second meeting was sponsored by the California Healthcare Foundation on chronic care and health information technology, and I'm a proud member of the board of that organization. Again, a number of speakers there, including David Brailer, the President's new health information technology czar, pointed to the challenges we face in terms of the growth in chronic care demand in the future, if you just simply look at the driving forces behind health care.

The third meeting I was at last week was the Harvard Program on Health System Improvement, which was started about three years ago on an inter-faculty basis at Harvard. I sit on one of the stakeholder advisory committees, and they were reviewing what they had learned from a process similar to that which Jon and Marcia have gone through, of going out to the community and running a number of community-oriented meetings. One of the key amongst the many issues facing American health care was this whole problem of obesity and its implications for chronic care, and a lack of effective solutions in the space.

The final meeting was one we held last week for one of our clients, a large biotechnology company. We had some of the largest payers in the country, and in the world, including General Motors, and some other notables from managed care, talking about the intersection of biotechnology and chronic care in the future.

From those meetings, I think there are four issues that come to mind to frame some of the discussion here. One which we are all familiar with is the aging of America. We are mostly middle-aging and very-olding at the current time, and the statistic that I think is telling is that there will be a fifty-percent increase in the number of people in the labor force over 50, over the next decade. That has stunning implications for American employers.

The second, and I'll show you some of the numbers from other people, is this alarming obesity trend, which is not just a U.S. phenomenon – it's a global phenomenon, particularly in the developed nations.

The third is the potential for having available scientific interventions--technological solutions--that are both expensive and effective. At our meeting in California with the IHA, it seemed many people believe that the only sort of systematic solution for obesity is bariatric surgery at $50,000 a pop. I won't name the person, but she's a senior executive of health plans who said that we should be doing it on 14-year olds. She was saying it, as we say in Glasgow, half-joking, full serious, but it is, according to many, the demonstrated intervention that has got scientific evidence behind it. It seems to be a crazy way to run a store, if that's our answer for the future.

Finally, the trend I think that we all worry about is that we're going to have this tsunami of chronic care needs, a wave of diabetes and depression over the land. And we're trying to solve it in a pluralistic, dysfunctional healthcare delivery system where no one talks to one another. So we have a few issues that we have to deal with! Let me with that try and frame some of the challenges ahead.

All of you, I'm sure, are familiar with the obesity measure, the body mass index (BMI). For years, growing up in Britain, I thought BMI was a bad airline in Britain. Actually, it turns out, it does have a specific meaning--weight over height squared. The issue of obesity is expensive. It explains almost as much of the healthcare cost increases as tobacco, and leads to a huge increase in risk of death from many causes. A colleague in a meeting in San Francisco pointed to two, I thought, fairly alarming, 'scientific-type' facts. One is that nine percent of 9 to 11-month old infants eat French fries on a daily basis, according to that distinguished source, the San Francisco Chronicle. The second is that, as a country, we are producing 4,000 calories per person, per day. I don't think the nutritional experts in the room would suggest that we should eat them all!

You're familiar with the increases that have taken place over time. We now have almost 35 percent of the population who are obese or severely obese, and those numbers have risen dramatically, doubled basically, in the last 25 years.

Ken Thorpe, an old friend of mine, has done a regression analysis. He estimates that the increase in proportion of spending on obese people relative to normal weight people accounts for about 27 percent of the rise in inflation adjusted per capita spending, and even higher proportions of spending on hyperlipidemia, diabetes and so forth. So this is a big deal from a financial point of view on a go-forward basis, and its actually gotten attention with the national media. One of the interesting things is that it is a disease of both abundance and scarcity. While the richest country in the world is farther along in having the problems of obesity, it is also true that obesity is, among women, inversely correlated with income. Maybe the experts could shed some light on all of that.

I'm sure all of you have seen Julie Gerberding's slides from the CDC, but just if you haven't, I'll remind you. This is, I think, the highest and best use of Powerpoint in the history of Powerpoint! It basically shows that when you get up to blue, red and yellow, it's bad, okay. It shows the proportion of women with a BMI over 30. I'm starting in 1985 and I'll just pulse through each of the years. So 85, 86, 87, we're starting to get more data, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 2000, 2001. And the trends continue. Does that all look familiar, by the way? Colorado is kind of the exception state.

Again, I stole this from Julie's presentation, which shows people taking their dog for a walk on the side of the car, which says a lot about kind of the sources of much of this, and again, as a non-scientist in this area, let me sort of offer a few, as we say in Glasgow, half-joking, full-serious, suggestions.

Why is this happening? First, we're eating more. Duh, it's not that complicated. We're also eating out more. There's been a profound shift in Americans' eating habits. In 1970, a third of the food budget was consumed outside the home. By the late 90's it rose to almost half, and I guess now, the number is well over fifty percent outside the home. Everything is being super-sized. At home, and at McDonald's, it's not just the fast food industry to blame, or our friends at the consumer products companies. A lot of people don't pay attention to this, but we stopped smoking and all gained 20 pounds. I mean, that's the other trend that's gone on in the last 20 years. We're all working too much, especially those of us in America, and especially women. We don't exercise enough because we're all working too much, and the only people who are exercising and eating right are people who were thin in the first place, or bulimics, celebrities, or rich people who don't work, or French, or some intricate combination of the above. So we have some issues here.

At the IHA meeting, Bruce Wolf, who's a bariatric surgeon, showed that back in 1954, a Burger King burger was 2.8 ounces and 210 calories. Today it is 4.3 ounces with 310 calories. The mother of all examples is a Hardee's 2/3 pound monster, thick burger. This has 1,400 calories and 109 grams of fat. One pundit called it 'food porn'. Young and Nestle, scholars in the public health field, did an analysis of the number of large size portions introduced by the industry over the last 20 years, and you can see portion sizes increasing enormously.

The question is, what would you do about this? This is a really a broader thing to set up the whole meeting, because we're not just talking about obesity at this meeting. We're talking about taking responsibility as a society and as individuals for wellness and health promotion. The point is, where do you go with this? The problem right now, as I see it, is that we are 'medicalizing' many of these conditions and making costs associated with them even more extreme. There was a story in the New York Times on the new drugs that are going to be available that will be sort of cures, if you like, for obesity. But currently, as I said earlier, according to the scientists in the field, the only evidence-based intervention for obesity is bariatric surgery, and we're doing currently 140,000 a year. There are 15 million eligible candidates in the United States, according to the criteria, which is terrifying. I think the analysis that's been done in the literature, and again, I'm no expert on this, has been basically side-by-side comparisons against other kinds of weight-loss programs. That speaks to the point that we need better evidence and support, and I'm certainly not underscoring or endorsing bariatric surgery.

We're also spending a lot of money on goofy stuff, like the two companion pills: 'Fat-Trapper,' and 'Exercise in a Bottle.' If you stay up late tonight and watch infomercials, you'll see this. The commercial is absolutely brilliant. It's always on at 3:00 in the morning. They've got these nubile young people of both genders who are frolicking around in bathing suits, and they're all pounding down cheeseburgers and pizza, and the voice-over says, *"You can eat absolutely anything you want and never gain weight, as long as you take the Fat-Trapper, and Exercise in a Bottle."* These are herbal supplements that are sold under the guise of being good for your body. I think it's ginseng and speed, to be honest. And the FDA can't regulate this stuff because it's not drugs.

Obviously many of you in this room have dedicated your careers to wellness and health promotion. We were commiserating over lunch that if you throw a bunch of money on the floor, and there's a scramble between surgeons and public health people, the surgeons will get more of it than the public health people. So it's really been hard to get attention by both the public and private sector appropriately on these issues.

There are some enormous gains that can be made by public health prevention. Personally, one of the things I find mystifying in a country like America, which is so into athletics, is that we have very low levels of participation in our high schools because we're so obsessed with having the winning team. I grew up in

Britain, where you were made to play rugby, whether you wanted to or not, or soccer, or whatever the game was. So it's kind of a different gig. One of the most intriguing things I came across recently is a little hospital system in Vermont whose CEO took up this clarion cry. He said, *"we're going to give you a 20 percent break in your health premium if you get with the program and sign up for our wellness activities."* It's kind of a fascist model. I mean there's no choice in it. But it certainly is interesting, actually engaging each consumer intelligently.

There's a whole bunch of issues around urban design. Personally, because I'm a Scottish-Canadian, the solution is always some big macro-intervention by government, but I believe in fat taxes not flat taxes. We should be taxing the hell out of Iowa corn farmers. I blame Iowa corn farmers for almost everything. We should essentially get them moved off making corn syrup to making ethanol.

I also have worked outside of health care with some of the re-insurance people, and I've speculated with them that fast food in the next decade will be the tobacco company liability of the 1990's, and that they will have huge liability issues because of the marketing practices of the fast food industry. One could argue that we, in America, subsidize urban sprawl and the fact that nobody walks anywhere anymore, and we should be giving all the money to Head Start and public school P.E. These are extreme interventions.

Let's just put this in context, about this obesity epidemic. We don't have many good tools, apparently, at the macro level beyond bariatric surgery. We're actually going to hear about some great tools in the course of this meeting. But what about our plan for this chronic care tsunami? Well, it's basically what I call consumer-deflected health care, you know, retail care and catastrophic coverage. It's discounted fee for service everywhere. It's silo delivery systems, no incentive for coordination. No IT infrastructure, all delivered through a pluralistic Gong Show of providers in onesies and twosies intent on maximizing their income under the perverse and toxic incentives they face. That should work pretty well. I'm overstating this, because I think there are some challenges on the delivery-system side. Almost everyone who talks about chronic care flashes the images on the right, which is the Ed Wagner model, but the reality is a much more disconnected and dysfunctional health care delivery system.

So, this is just one piece of data to inflame the discussion even more about how we're doing in the current mode, of trying to get people engaged by using high-deductible health plans. My partners at Harris Interactive and the Harvard School Public Health, did what we think is the first real survey, not marketing survey, of people who are in the high deductible health plans. What we found was an alarming increase in compliance problems across a whole bunch of different metrics, compared to the privately-insured population. This is not a knock on some of the emerging consumer-directed models which have been thoughtful about this and included first dollar coverage for preventive services. The compliance issues ameliorate considerably if you put the first dollar coverage in place for preventive services. But generally speaking, high deductible plans tend to lead to lack of compliance on certain issues.

What can we do about it? Well, one solution I've sort of jokingly suggested is that we've had tremendous success with three-tiered formularies. What we should do is have three-tiered fast food formularies. So, in terms of sandwiches, the all-lettuce Whopper would be lettuce and lettuce on a bun. That would be free. The all-lettuce Whopper with cheese, for those of you on the Atkins diet, would be $15.00. And a regular real Whopper with cheese would be $35.00. On drinks, water would be free. I'm old enough to remember when water was free. Diet Coke, which is the beverage of choice at the Harvard School Public Health, would be $.99; a regular Coke would be $15.00. And if you super-size it, it would be $35.00.

Now again, half-joking, full-serious, there have been initiatives in California, an initiative which nearly passed actually at one stage, to put a two cents a can tax on soda and give the money back to the schools. The point

being that, if we don't deal with prevention at the bottom of the pyramid, and we can do all the consumer-deflection we want in the middle, we're going to have enormous catastrophic costs down the line. And we can't simply manage those through disease management or pay-for performance or IT unless we do something about the demand side.

This thing is not sustainable. We cannot have the solution to the American health care crisis being bariatric surgery on 14-year olds. Bariatric surgeons would tell you that too. The other reason we can't do it is we can't afford to pay for it. There are only three sources of money unless we tax the Iraqis or something, and that's business, government and households. Business can't pay any more, government doesn't want to tax anymore, and households can't afford it. So there are really some great limiting factors in this. I think Jon and Marcia should be commended for their leadership and really focusing us on what could we do on the demand side to affect some of these issues.

Information technology is a possible area of improvement. It's a great thing and Ken Kizer's been a pioneer in that area, and I'm a big fan of it, although I have described the electronic medical record as a permanently emerging technology. It's been the future for the last 30 years; it'll be the future for the next 30 years. My only concern is that it won't save money quickly, and the expectations are very high for it, particularly in Washington. But, having said all that, I think you do have to spend on it as one of our best hopes for the future, and it is an area with strong bipartisan support.

I have also been struck by the power of simple disease registries, and the whole area of chronic care, and the fact that you can do a lot without building the all-singing, all-dancing information system.

What I really like about Jon and Marcia is they're not just about holding conferences. They're about trying to get something done, and trying to find initiatives to make change, and that's really why we're all here. It's not just to talk about some of these issues, but to actually conceive of things that one could do, particularly in the context of a disorganized care delivery system.

So, let me just share some data on what we could do to start the discussion. The Harvard Health System Improvement Program ran a series of forums on health that David Gergen moderated across the country. They commissioned a poll from Lake, Snell and Perry, which gives you a good frame of where the American public is in all of this. If you ask them who should play a big role in fighting the obesity epidemic, they think the health care providers should be central in it. But they also see a very significant role for schools, and for government and employers. So it's really everybody's problem in their mind. If you ask them specifically what should be done, more public space where people can exercise, government-funded campaigns on the health risks of obesity, government-funded campaigns about eating right and exercising, requiring restaurants to solicit nutritional info, are all relatively well-supported. Schools play a key role in this. Many believe amongst the public that school lunches need to be improved and schools should provide more education about the risks of obesity and the importance of exercising and eating right. Educating parents is very important, as is physical education in the schools, and getting tough on controlling the school vending machines. Certain school districts in California and elsewhere have been very aggressive in that regard, with some success.

There's less support for my Scottish cynicism about taxing junk food, although it's not insignificant, and less interest in sort of limiting advertising per se, although the French and the Brits have made great strides in that area in the last couple years.

I just want to close with this, really as a plea to consider the space of possibilities. In the Harvard polling, the public was split, as they are on so many things, completely down the line, between 50 percent of Americans roughly, saying this issue of obesity is a private issue. This should be dealt with in terms of

personal responsibility. And 50 percent of Americans saying it's a public issue that requires public policy intervention. If you think about the locus of where intervention takes place between the community, local businesses, corporations, government organizations, and government itself, I think what I would hope that we would hear from all of you in this room who are going to be presenting and talking about your experience and ideas, is that we've got to populate this entire space of possibilities. There is no one answer here. It is not about a government solution, and it's not about simply giving people the responsibility to smarten up. We have a very powerful economic system that is creating obesity and it will be a hard thing to undo if we don't deal with this and other such issues. We are going to be in a situation that is irretrievable in my humble opinion, 25 years from now. So that's why I'm very grateful you're all here, and I hope I managed to insult all the experts in the field by showing both my ignorance and my insensitivity to your important work. So thanks for your attention.

Q&A

A participant raised the point that in looking for the 'villains,' Morrison underplayed the 'physical inactivity industry.' He asserted that because technology drives the economy in many ways, *"we sort of give it a free pass…..we tend to emphasize food because there's a clear face on food,… we know we're eating too much. But we need to start putting a face on the other side of the energy balance equation, because until we get those people to the table, we're not going to be able to make any progress. I think there are tremendous things that can be done with technology to help with the problem, in addition to the inadvertent affects it's having on our activity patterns."*

Morrison agreed. *"Certainly from the perspective of energy balance, we can't just blame the supply side, the food industry, but also need to address the activity side."*

Another participant stated she was struck by the comment that a positive health behavior, stopping smoking, may have inadvertently contributed to the obesity problem. *"It raises the whole issue of trying to look at the impact of whatever we do to see whether it is leading us totally in the right direction, or having consequences that lead to another problem that we're going to have to solve down the pike."*

Morrison replied, *"Amen to that! Bariatric surgery is not without its side effects and longer-term consequences. I was struck by the cautionary tale of Bruce Wolf, one of the fathers of bariatric surgery. When push comes to shove, he acknowledged we should be focusing on prevention."*

An employer representative sounded a cautionary note: *"When we're talking about payers, we're looking at short-term costs, but prevention and reduction of obesity is a long-term solution and it takes a long time to realize the savings. One partial solution is to link obesity with disability which can present more shorter-term savings, to gain payer attention."*

Morrison pointed out that a client, a very large biotech company, tried to make the case to the biggest payers in the country that by investing in their technology in the short run, they would save money in the long run. The payers were not sold by the argument. *"I think both employers and health plans are thinking about this in a very short-sighted way. Employers actually are more likely to be on the hook than health plans. Obese employees with chronic conditions don't leave because they've got pre-existing conditions and no one will hire them. What gets corporate America's attention is the aging workforce. Over the next decade, there will be a 50 percent increase in the labor force of people over 50, most of whom are going to have at least one chronic condition. It's the large employers of America who are going to be on the hook for this, so they've got to get smart. It's part of the cultural change that has to take place. It makes perfect sense for us to invest now and we'll save money later on, but the evidence base required to convince payers to get with that program is a hard one."*

Session I: The Power and Nuance of Social Marketing

Marcia Comstock, MD MPH: COO, WRGH/FAHCL

Our first session on social marketing is one that sets the tone for the entire three days. It's the big picture, if you will. Each of the speakers will focus from a distinct perspective. Dr. Ken Kizer will highlight predominantly state initiatives, based on his experience in California. Dr. John Peters will speak from the perspective of a large consumer products company, but also with the voice of someone who's been actively involved in pubic health and public health campaigns for many years. And Dr. Marsha Vanderford from CDC will talk from the government angle about CDC's current initiatives, as well as their plans for the future.

Ken Kizer, MD MPH: President, National Quality Forum

Hello. Jon and Marcia and I and other folks from IHI [Institute for Healthcare Improvement] and other places have been talking for a couple of years about the need for a social marketing campaign for quality and safety in health care. And the reasons are not dissimilar from other topics, like obesity and some of the other things we're going to talk about. Certainly the health care quality problems are pretty complex and not widely understood. Many of the beliefs that people hold about quality of health care are wrong, like America has the best health care system in the world, or that errors are only committed by bad doctors. There are lots of places where fundamental views need to be changed.

Likewise, there's no shared vision of where we want to go and what actually is a goal that we would all aspire to, so that we can get all the varied stakeholders together around it and move in that direction. Certainly, widespread fundamental cultural change is what is needed.

I was asked to share some of my personal reflections, based on a number of social marketing campaigns that I've been involved in over the years. One of them is the Prop 99 Anti-Tobacco Campaign which is viewed, I think widely, as a very successful social marketing campaign. In 1986 or 7, we started in California the *'5 a Day for Better Health'* campaign: eat 5 servings of fruits and vegetables a day. In 1989 we convinced the National Cancer Institute to take that on as a national campaign. I'm sure many of you have seen in the produce aisle little plastic bags which have the 5-a-day logo. It actually has been successful. I've also been involved in some things on seatbelt usage.

While I was the Chairman of the Board of the California Wellness Foundation, we launched the Violence Prevention Initiative and ended up spending about 70 million dollars over a ten year period, working to prevent youth violence in California. Obviously you can't deal with violence, especially in California, without taking on the handgun industry. You've probably seen books like Ring of Fire which talks about the Saturday Night Special manufacturers that are situated around Los Angeles. That was another campaign that goes down in the success column, as well as others on alcohol and vaccinations.

What we thought might be useful is to take a couple of minutes to show you some of the tools that we used in the California anti-tobacco campaign. This tape is a collage of some of the ads that were done as part of a much larger effort which involved schools and others, and it gives you a sense of what you can do when you have a little bit of money.

Ad: …. *"We need more cigarette smokers, pure and simple. Every day 2,000 Americans stop smoking and another 1,000 also quit. Actually, technically, they died. That means that this business needs 3,000 fresh new volunteers every day. So, forget about cancer, heart disease, emphysema, stroke……. We're not in this business for our health." (evil laughter)*

(voice over) *"Smoking-related disease kills over 42,000 Californians each year. As it is across the United States, smoking is California's leading preventable cause of death. On April 10, 1990, the California Department of Health Services launched an ambitious media campaign designed to reduce tobacco consumption in California by 75 percent by the end of this decade. This goal can only be achieved by keeping you from starting to smoke."*

The campaign focused on prevention and cessation. Additionally, a critical component of the program was reaching all of California's many ethnic populations with messages designed to change how people view tobacco use. The campaign met these challenges by developing numerous broadcast and print ads in 8 different languages. The primary target audiences for the campaign were youth, age 6 to 18, pregnant women smokers and adult smokers. Humor, animation, dramatizations and even rap music were among the numerous advertising approaches used to reach these goals. The ads were intended to convince the target groups that tobacco use is not glamorous or sexy, as it is often portrayed, but rather dirty and deadly. A full page newspaper ad announced the campaign and set the tone for the advertising that followed. In less than a generation, the bad news about cigarettes has become no new news. Most Americans, even the very young, know the unavoidable connection between smoking and cancer, smoking and heart disease, smoking and emphysema and smoking and strokes.

(scary music, kids coughing) "Ronald Marion Guest the third, 9 pounds, 4 ounces. Brittany Lauren Whitlow, 7 pounds, 10 ounces. Christina Ingram, 8 pounds, 6 ounces. Michael David Elliot, 2 pounds, 4 ounces, and 2 packs a day."

This just gives you a sense of the types of ads that we were able to place. Different versions went to the different sub-populations they were aimed at. Some of the critical success factors, for this campaign, as in most everything else: leadership, incredible leadership is critical, if it's going to be effective; funding and other resources, not just money but the technical capability, the know-how. We had to go out and hire an ad firm in Hollywood. I don't know whether they have contracts with P & G, but they're the same types of companies that others use and they were able to come up with very creative messages. Indeed, another critical success factor is getting the right message and then delivering it effectively; finding what is relevant and what's creative; what leaves an impression on people so they remember it. The messages need to be consistent and reinforcing. We have many campaigns that we have embarked upon where the messages actually end up to be contradictory to each other. I was reminded of one the other day that came out of Washington but I probably shouldn't highlight it here.

How do we align the message with cultural values, with other social circumstances, with financial incentives? The tobacco campaign was a good example of alignment of financial incentives, with the increased tax on each pack of cigarettes, which we know disproportionately affects the youth population.

Use of multi-media is important, as is the need to humanize issues, to use stories. It's always impressive how powerful stories are as opposed to facts and figures, much more powerful in changing behavior.

Not only do we have to get the message right, but we have to identify and target the key audiences that have to hear that message. If you haven't read The Tipping Point, that book is all about this

messaging, identifying critical audiences at different times, and creating partnerships, alliances, and collaborations, if we're going to leverage resources.

One reality that I think we often lose sight of in health care is that when health care stakeholders can actually get on the same page, which almost never happens, it's unstoppable. Health is an unstoppable political force if we can get doctors, hospitals, health plans and everybody else on the same page. A great example is the Prop 99 initiative, where, for a brief moment in time,—it rapidly fell apart when the dollars started to flow,—everyone was on the same page and we were actually able to beat an industry that was out-spending us about 50 to 1.

Clearly, for many social marketing campaigns, it's time and duration. If you look at cultural change with corporations and large businesses, it generally takes 7 to 10 years to fundamentally change culture. Typically when we embark on these public education campaigns, we talk about 6 months, a year or 2 years, and that's rarely long enough to actually affect the cultural change that's needed. How do we institutionalize the changes? If we can actually institutionalize them, they stay around, and have a much greater chance of being effective. It's also nice if there isn't any opposition!

I look at the quality issue. It is a great one because no one's opposed to quality. It'd be nice to see how far we could move with quality in a short period of time, as there really aren't that many competing voices.

What about the challenges, as opposed to the critical success factors? Many of them are the same. How do we get the leadership or the political will, the political support, to move forward on these types of campaigns? Just think about what political support would be needed to really deal with obesity. It's not just CDC or AHRQ or some of the other usual suspects who would need to embark upon that. It would need to involve the government across the board, even things like taxes and other things that are probably not likely to happen in the short-term. Other challenges include funding, finding common ground, building trust among folks who are typically more used to shooting at each other than collaborating.

The "I equals E" problem, income equals expenditure. We always have to remember that what is someone's expenditure is somebody else's income. Whenever you go about changing the status quo, there are going to be winners and losers. And we have to build that in. Clearly, with the issues that we've talked about so far here, there are going to be some folks who will be on the losing side of that equation, and there has to be some way of dealing with that. Finding the right message, sustainability, and repeating messages, these are really all merely the flip side of the key success factors.

John Peters, PhD: Head, Nutrition Science Institute, The Proctor & Gamble Company; CEO, Partnership to Promote Healthy Eating and Active Living

(presentation slides are available for downloading from www.wrgh.org)

Thanks, Marcia. Let me start by making a confession. I'm not a marketer. I'm a biochemist. I'm a researcher and something of a kitchen philosopher, so I hope to share with you my own impressions of what's driving the epidemic of obesity, how marketing, looking at it from a consumer products standpoint, may be applied to this problem, and what are some of the barriers that we need to overcome.

Lest I be mistaken for a marketer, I don't have in my pocket the envelope that has the secret formula for how to market broccoli, but as anybody who's ever tried to market a positive health message knows, it's

not an easy thing. You can have a great product, something that's a wonderful thing to look at, in a nice package, and you can say nice things about it, but that doesn't necessarily mean it's going to work with the consumer. I think that's probably the most daunting challenge we face in the country today—getting consumers and the population to buy into health, to come along with us. I think some of the kinds of things that Dr. Kaiser was showing us earlier are right on in terms of trying to portray a health issue to the entire population, such that the fraction of the population for whom we want behavior to change are getting some social pressure from those who are not engaged in the undesirable behavior.

My 25 years of working to combat obesity has really led me to this slide, which shows that we really have a perfect storm for obesity. Obesity is the natural response of our human physiology to the environment that we put ourselves in. And, we've built this environment, so it is us that need to fix it. But a whole host of factors that Ian [Morrison] mentioned in his opening talk—policy, culture, the built environment, the commercial environment—are all part of what is playing against our susceptible biology to cause obesity.

Our biology, which for the last several tens of thousands of years, protected us from basically becoming extinct, is now maladapted for the environment that we are able to create through all of the wonderful technology and things that we're able to bring to the consumer today. I want to emphasize the social cultural environment, because I think it's one of the most important areas that we need to focus on, and I can speak about it with conviction because I'm not a social scientist, so I don't have to adhere to any rules about what's been proven and what hasn't. So I'll share with you my observations and thinking as a way maybe to provoke you into asking some tough questions.

At the heart of it, I think we're going against the biological grain to change the behaviors that we're focusing on now. Whether it be changing eating habits or activity patterns, our genes tell us to eat whenever possible and to rest whenever possible, or at least to consider it. These are very strong biological incentives. It feels good to eat and it feels good to rest. That's why it's something that people find easy to do because they get some positive reinforcement for that behavior right then, it's very immediate. We all know that if you learn how to run, and if you could run miles, you get a wonderful 'high' from the biology that is adapted for that circumstance. But, getting people to do that is not practical, it takes months before you experience that first high, so it is a very difficult thing to do.

This is my favorite slide. Here, in the picture shown in the upper-right-hand corner, we have a fitness center whose entrance has both an escalator and stairs and everybody's going up the escalator instead of taking the stairs. This is just a little glimpse, perhaps a caricature, of what the culture has become. Our genes also tell us to like sugar, fat and salt. The only taste preference that's inborn is for sweetness. It's been shown in infants very clearly. Preferences for salt and fat are also very strong. There are a lot of reasons why there are taste preferences for these things from a survival standpoint.

Thousands of years of agricultural development have been designed to make sugar, salt and fat commodities as widely available and as inexpensive as possible. And guess what… we've succeeded. Sugar is the cheapest source of calories on the planet. Fat is right behind it. So it's no wonder that after years and years of experiencing not enough of these ingredients, when we're able to have enough, we go wild with that notion. I love the picture on this slide in the lower-right-hand corner for a restaurant that serves burritos as big as your head. Now that's using your head, right?

Our society embraces technology almost without concern for consequences. Here in the upper right-hand corner of this slide is a picture of the new Segway, a personal transportation device that will, if it succeeds, take the last little bit of required physical activity out of your life. You won't even have to walk

anymore; it even goes up stairs. Isn't that wonderful. In the lower left of this slide is a cartoon that provides another little glimpse into our society, it says, *"These obesity studies have me worried. I'm going to drive next door to get a check-up."* You can see the Medical Arts Clinic is just across the street. So, who would think of walking when there's an alternative that uses technology?

So, the point is that there are essentially no external incentives for the individual, or rewards, for 'doing the right thing.' The motivation has got to come from within the individual right now. Individuals have to get to a state of self-actualization or something and say, *"I'm doing this for myself."* How many people are at that point, where they can spend a lot of time self-actualizing? Probably not the majority of the population has reached this stage, yet. Our society runs on instant gratification. See it now, feel it now, eat it now, buy it now, pay for it later…much later. That's the way our consumer culture operates. We have to see results today. We live for the deal. Where on earth, other than the United States of America, would people spend $10 on gas, driving their Hum-Vee, 30 miles across town, so they can buy toilet paper by the pallet because it's 39 cents a roll cheaper? This happens today. That's what we're becoming as a consumer society. That's why WalMart is the biggest company on the planet now.

However, as a backdrop to this, I think these are merely symptoms of larger forces at work underneath the surface. Our society has undergone a tremendous transformation since the 1950s. There has been a steady loss of social capital. Robert Putnam, a Harvard sociologist, wrote about this in a wonderful book called *Bowling Alone*, which is really about the phenomenon of losing our social connectivity. People are spending more and more of their time by themselves, amusing themselves in front of the computer screen, or with a personal entertainment device. We are disconnected from each other. It's difficult to mount pressure for social change in that kind of an environment, but it's something that we're going to have to do anyway.

So, people are becoming more and more isolated, and of course the economics of our consumer culture working in parallel are extremely powerful forces. These economic forces are highlighted in another book I would recommend to you, written by Robert Reich, Labor Secretary under President Clinton. The book is entitled, *The Future of Success*, and even though it wasn't written about obesity, it provides powerful insights into forces that shape our behaviors and our consumer choices. Reich was talking about the changing nature of the labor force in the world and what that means to people. People are becoming less loyal to their employers and to consumer brands. You can change jobs and get goods with the click of a mouse. We are globally connected as a society so all of the stuff that's cheaper to make somewhere else on the planet you can now have access to, and that's what we want—great deals. He says personal choices about work and about life take place within a larger set of societal changes. Changes in the technology and economy are altering how work is organized and rewarded, which in turn influence how you lead your life, and in America, work is organized and rewarded in a manner that encourages more work. Social changes frame personal choices. And if you look at what's happening in our communities, basically everybody who has a stake in this is looking to find the option that best promotes economic growth and best advances the well-being of consumers, by lowering prices and generating better products. That is what our economy is all about these days.

So if we want to change the way our system works today, we should not be looking externally for a villain. Reich concludes…*"in short, the culprit is not out there, it's in here, in our appetites and what we want to buy and the great deals we want to get."* After reading this book, my takeaway was that the things that best promote economic growth today generally do not encourage healthy behaviors. We have to begin addressing this if we want to make progress here. We need to begin changing the paradigm of how we think about what the good life is in the United States of America.

Now, let me put on my marketing hat and address the question of 'what sells'? Marketing takes advantage of either overt or latent desires of consumers. Yes, you can create an advertisement which portrays a vision of a product that previously didn't exist, and get consumers interested in trying it. That is called appealing to a latent desire. It has to offer a desirable benefit in the first place, or they wouldn't have listened to you. But, our desires are strongly influenced by our biology and our social values. For example, it's easy to sell ice cream. It's easy to sell a Big Mac, because it plays to the biology. These products play to our preferences for sugar, salt and fat. However, despite the high consumer demand for these things, it is still hard to make more money than your competitor, and the value equation has gotten out of whack as a result. So for example, supersizing is a phenomenon that makes great economic sense to both consumers and producers. Since much of the cost of the product goes into paying the labor to prepare and serve the food, not the food ingredient cost, it is easy to offer a larger portion for only a few pennies more. And, getting more product for relatively less money is a value equation that works in the U.S. of A. And it's gotten way out of hand.

In order to succeed in the marketplace today the benefits exchange needs to be very simple, very clear, very tangible. The product offering must deliver on the consumer demand for an immediate reward or benefit, in terms that are relevant to them. And right now, the name of the game is cheaper, bigger, etc. But if you look at the consumer world of goods, there are lots of things that don't offer the immediate rewards of tasty food. For example, how is it possible to sell things like laundry soap? How do you make that inspirational? Well, even producing clean clothes is a relatively short-term and tangible benefit. You can see it now. I can advertise to you something that says, *"Your clothes will be whiter,"* and if they're not, don't buy my product. It takes just one load of laundry worth of labor in order to determine whether that's true or not. However, many health messages promise benefits over a much longer time frame that becomes difficult for consumers to personalize. Many consumers can't wait longer than a few weeks at most to see the benefit, and if you can't deliver, they stop using your product.

For example, Crest White Strips, a tooth whitening product that everybody's probably seen promise whiter teeth in just 1-2 weeks. When P&G first started working on the technology it took a month before noticeable whitening occurred. Consumers said, *"What, are you, nuts? You've got to do this for a month?"* We found that two weeks was an acceptable time frame for consumers to see a benefit where they had to repeat a behavior on faith before they saw some noticeable benefit. Now the product has been further improved so that it delivers results in a week and consumers love it. But this is a real problem in health promotion. People want to see the results today, right now. They spend 30 years becoming obese, and then they want to lose 30 pounds in 30 minutes.

So, how do we market healthy lifestyles? I think from what we've seen and heard here at this meeting, as a public health community, we're getting good at applying the fundamentals. We know how to segment the audience and target them, we know how to tailor the message, we know how to get on the radar screen in terms of inundating them with messaging and we're starting to tap into the emotion. You saw that very well in the anti-tobacco ads Dr. Kaiser showed. But there's something still missing, especially when dealing with eating and physical activity behaviors, when we're working against such powerful biology. What is the clear benefits exchange that's tangible that I can see today? Why do I want to eat the broccoli instead of the Big Mac? What is it going to do for me right now? Does it cost less? Do I get some other tchatchke to go along with it? Is the toy in the Healthy Happy Meal now a television set that maybe says, okay, I'll buy the broccoli. What's the cost to me, in dollars, time and effort? A lot of times we overlook the time cost. We're looking at just the money in the equation. But if somebody has to totally reeducate themselves, learn a whole new set of skills for leading their life, that takes time, and a lot of people are not willing to do that. What are the rewards and the reinforcements

that will keep you doing that behavior once you've experienced it once? And then finally, and this is the tough one. What is the desired behavior choice competing with? So, if you have a thousand and one alternatives that are much more fun and much more enticing, versus the one 'right thing to do', how are you going to get that person to overcome that barrier? It's all about finding incentives that are powerful enough to overcome some of those countervailing forces.

Finally, and Dr. Kaiser mentioned this as well, change takes time. To illustrate the importance of time when looking at development of new population norms, it is instructive to look at the example of the adoption of reduced fat milk consumption. It started back in the late 1970's, when the public health community and nutritionists made a big push to get people to start drinking low-fat milk. It turned out to be a long, slow process and a lot of things had to happen to enable broad change to occur.

First of all, at the time, health authorities agreed that it was a healthy thing to do. Contrast that to our current situation where there is still considerable debate about what is the best strategy for controlling body weight in terms of what to eat and how much exercise to do. Second, in the milk example, the government subsidy structure had to be changed. Farmers used to get paid based on the amount of fat in the milk—which didn't incent them to make low fat milk. So, the government changed the subsidy to be based on the protein content. Okay, now we're getting somewhere. Third, the aesthetics of the reduced fat milk were improved. Remember when skim milk used to be blue? There was some technology that had to be developed to improve consumer acceptance. More milk solids were added that changed the reflectance, so now it looked more like the whole fat milk. And to this day, 25 years later, we still don't have everyone drinking lowfat milk—although usage now represents a significant fraction of the population. So it's a huge advance over where we were, but it took 25 years of effort and all these changes that had to occur. So I think we need to be a little patient. Small changes can make big differences, and it took 25 years for people to condition their taste buds to go down from 3 1/2 percent to 2 percent to 1 percent to 1/2 percent, and now more and more people are even drinking skim milk.

In order to improve eating and physical activity behaviors, I think we really need to take a lesson from noted psychologist, Abraham Maslow, and we need to tap into higher order human needs, to overcome what our biology will otherwise drive us to do. Our biology is driving our behaviors to fulfill those needs at the bottom of the pyramid, and there isn't any way in the near future we're going to rewire the biology, I don't believe. We have to find ways of using those higher order benefits to motivate people to consider making some changes.

To gain some insight here, we have learned a lot from the participants in the National Weight Control Registry, which is a group of several thousand people who have successfully lost a large amount of weight and kept it off for at least five years. They've lost an average of about 65 pounds. We did some wonderful ethnography studies on these people that really looked in depth at what differentiates them from the average person who tries to lose weight and fails. What we found among the ones we studied was that their success with weight management was tied to a transformational experience in their life. The experiences were different, everything from a faith-based transformational experience to a career-based transformational experience, but what was common was that they essentially 'remade' themselves. Losing weight and keeping it off was a profoundly difficult thing for them to do, and that's why I think preventing weight gain in the first place is so important in our society today. I look at what these people had to go through to succeed once they had gained the weight, and I cannot imagine how we would 'treat' the majority of Americans who are now overweight in the same fashion so that they could also succeed at losing weight and keeping it off. I don't think we're looking at a success equation for millions of Americans, unless we can get prevention to work.

Going back to Maslow's hierarchy as a framework to identify ways to motivate change, how might we leverage the strong desire to belong? This desire is likely behind the motivation that propels our kids to sometimes do really goofy things that endanger their lives. Those are the kinds of things we need to really get a better understanding of in order to motivate behavior change in our youth. How do we leverage the early adopters? A lot of these behaviors that are trends in the making are being done by only a few people in the population now, and we can't tell which ones they are. But, at the same time, once we begin to get a sense that what this group is doing seems to be a growing trend, we need to take advantage of that.

In order to make meaningful progress at changing eating and physical activity behaviors on a broad basis I think we need to do a real full-core press on understanding how to begin to move some of our social cultural values, for example, unbridled consumerism, in a different direction and take advantage of existing strongly held social values. For the latter, I use the example of the change in smoke-free environments that occurred in California and around the nation. One of the major factors for change, I believe, was the issuance of the second-hand smoke report in 1986, which called out for the first time, that public smoking violated a non-smokers personal liberty. So if I choose to smoke and you don't, and I'm blowing smoke in your face, then I'm putting your health at risk, and by golly that's un-American. That's a personal liberty issue. And the equivalent in the health care arena would be if you and I are part of a large group insurer, and I choose to sit on the couch and eat junk food, and watch television all day, and you're eating '5 a Day' and getting your exercise and doing the best you can. I don't care what your body weight is, if you're making the effort, then that's not fair for you to be subsidizing my bad behavior. And that's something that's invisible to people today. They don't know that that's happening.

To finish, I'd say it's more than just advertising that drives bad behavior, just to reinforce that social cultural point. Shown here on this slide is evidence of the amazing parallel epidemic of obesity among our pets. I don't know about your dog, but my dog doesn't watch TV, even when Lassie's on. So I don't know how the average dog is getting overweight, other than the average master is overfeeding them and under-exercising them. So it really is a broader social issue than some of the things that we see on the surface. Let me finish by showing you my favorite marketing tag line slide, *"I cuss, you cuss, we all cuss for asparagus."* Thank you.

Marsha Vanderford, PhD: Acting Director of Health Communication, CDC

Good afternoon. Last spring, CDC's director, Dr. Julie Gerberding, announced the creation of a new and innovative center at CDC: the National Center for Health Marketing. The purpose of that center is to ensure that interventions, communication, information, and programs are not only based on the sound and objective science that CDC is well known for but, in addition, that they are based on continuous customer input. In using the term 'customer', Dr. Gerberding was speaking very broadly. Our customers include the public, the public health work force, clinicians, businesses, and academia, as well as anyone who uses CDC information and programs to either improve their own health or the health of others. In addition to ensuring continuous public input, it is our intent that these programs are rigorously evaluated, so that we can really measure their impact on decisions about health.

In the process of setting up the National Center for Health Marketing, lots of people have asked the question, 'why'? For many people, even inside of the agency, the idea of stereotypical marketing is really antithetical to notions of public health. Other people suggested that CDC, along with its partners, have used its traditional approaches very successfully in a number of public health initiatives, for example, to lower the blood levels of children over the past several decades. Other folks indicated that we didn't

need to do this because CDC continues to enjoy its position as the most trusted federal agency in government. So why would we be doing this?

CDC's decision to create a National Health Marketing Center was based on a notion of avoiding the metaphor of controlled flight into terrain. I'm not a pilot, but I suspect that some of you are. Can anyone explain what a controlled flight into terrain is? It is flying into a mountain while your plane is working in perfectly good order. My understanding from pilots I know is that if somebody is flying along in terrain they understand and put the plane on auto-pilot, the plane is working fine, but they're not paying attention to where they're going. That in itself can be a controlled flight into terrain. Like organizations represented here at this meeting, CDC staff understand very clearly that the terrain of public health is changing dramatically. CDC simply cannot afford to continue to do business as usual, while we see these changes, many of which have been mentioned already several times. Our aging population, with its attendant problems with chronic disease management and things like obesity and diabetes, simply doesn't respond to traditional approaches. Other kinds of challenges in our changing terrain include global health threats, such as SARS, Avian Flu, and last year's Monkey Pox.

But the changing terrain offers us opportunities, as well as threats. We know because of advances in science and computer surveillance systems and advances in communication technology as well, that we really are much better able to predict, and control, and contain diseases, and to advance health promotion initiatives than we were even a few years ago. That connectivity really gives us some unprecedented opportunities to partner and to expand our resources. Unfortunately, the way that CDC has been organized has not allowed us always to take advantage of those kinds of opportunities.

I'll share a story with you that occurred about 18 months ago at CDC, when a major manufacturing corporation asked our leadership for some advice. The company wanted to create a healthier work force and help retirees, whose medical benefits they were providing, to live healthier lifestyles, so that the corporation could benefit from decreased absenteeism, lowered health care costs, and so forth.

When those corporate officers came to CDC to meet with our very best scientists, the CDC staff responded eagerly, and about 10 or 12 of our centers came to the table to share their respective programs and ideas about what they were doing that could help. But the corporate officers went away with a potpourri of ideas that weren't synthesized, they weren't targeted, they didn't build on one another. As a result, CDC really missed an opportunity to partner in a very significant way, and to leverage the resources and communication opportunities of reaching, through this corporation, a very large number of workers and retirees to promote public health, as well as the individual heath of those individuals. So when you think about the National Center for Health Marketing, think about it as a way to resolve what we saw at that moment as a missed opportunity. CDC is really looking through the Marketing Center for opportunities to work smarter, especially in the areas of partnership, ways that we can work with others, both in the public and in the private sector, to enhance our response capacity, and to increase the power of our prevention initiatives.

The bottom line in all of this is really to improve our positive health impact. We are really trying to borrow, I think, from business what the government has failed to do in some ways. Democratic governments exist to serve its citizens. Business exists to make money. And yet it is the businesses that search obsessively for new ways to please the public. Most American governments are customer-blind, while McDonalds and Frito Lay are customer-driven. This may be the ultimate indictment of bureaucratic government. So we are, through the Marketing Center, trying to become much more customer-driven as well. CDC is applying core notions from marketing to a lot of our programs across the board. We're

approaching it from a discipline management perspective, from planning all the way through evaluation of our programs, and bringing in the voices of our customers early on and all the way through the delivery of these programs.

A quick comparison I think with McDonalds will help you understand a little bit more how we're focusing. When McDonald's markets its chicken McNuggets Happy Meal, it analyzes its marketing potential and its plan, by the four P's, right? Product, price, place, and promotion. Product is food, hamburgers, French fries and so forth, and a toy. The price is about $3.00, but price is not only the money. Price is also the parents' concern about the nutritional value of what is in that food. The place is 30,000 plus restaurants, and the promotion is advertising, coupons, and so forth. We know that McDonald's is selling food, but it is not marketing food. What is it marketing? You think of a McDonalds commercial and you think about fun, being with friends, not having to cook, the small pleasures of life. Yet those attributes are not the attributes of the food. They're the attributes of the Happy Meal experience that McDonalds wants you to buy. For parents to buy that, they really must value the benefits of the Happy Meal experience more than what it costs them: the $3.00 and the concern about the nutritional value. When they do buy, that's the customer exchange, but everything that leads up to that moment is marketing.

So what is CDC taking from McDonalds and applying across the board? It is really seen as a way to connect all of the functions at CDC, from research to surveillance to programs and services, all the way through communication, in a strategic way that focuses on people's perceived benefits of health. Not looking at health as an end in itself, but instead as a facilitator of the things that people really value in their lives. Things like energy, independence, being able to be active with your children, being around in retirement to really enjoy it. It focuses on behavior change for that health impact.

Although the National Center for Health Marketing is new, health marketing at CDC is not. CDC has been using social marketing in selected and very focused health promotion campaigns for some time, notably, as many of you know, with the VERB campaign, the Youth Media Campaign, begun a couple of years ago. One goal of VERB was to increase and maintain physical activity amongst tweens, a name for kids between 9 and 13 years of age. When CDC began planning the VERB campaign, we started by looking at price. What is the perceived barrier to taking up that new behavior, that activity, versus the benefits. The barriers, we learned in a dialogue with our target audiences, the tweens, included the fact that they like doing some sedentary activities very much. Like computer games and television. They also may lack transportation. They may not be able to get to where they can be physically active. They may not have access to things which would help them be physically active. Their parents may not be able to afford to get them in organized team sports, and we all know that some of our neighborhoods are not safe places for kids to go out and play and be active.

The other part of price, of course, is the perceived benefits. Kids did tell us that some of the benefits that they saw to physical activity included having fun, playing with their friends, active time with their parents, as well as the opportunity to explore and discover the world around them. So the VERB campaign really concentrated on creating messages and opportunities that maximized those benefits and minimized those barriers, using spokespersons and channels that were really credible with tweens.

The two other P's of marketing are place and promotion. CDC worked very hard to find places that would connect with these messages, so that the messages about physical activity would be as ubiquitous as fast food. Working with malls, local billboards, the boys' clubs, the girls' clubs, even with community events like the Albuquerque Gathering of Nations Pow-Wow or the Harvest Moon Festival in Los Angeles, there were VERB-sponsored activity spaces where kids could try out new behaviors. Things like dancing and martial arts.

In terms of promotion, we were fortunate enough to receive congressional funding for part of this campaign, and were able to place advertisements on television and in print media that we knew kids liked. So these messages appeared on Nickelodeon, Cartoon Network, Teen People, Seventeen, Sports Illustrated for Kids. With the paid advertising, we also got donated advertising and donated talent, so that there were endorsements by actors with the Gilmore Girls, Seventh Heaven, school promotions. Sweepstakes and contests also promoted these activities, as well as websites for kids, and their parents and partners.

How did we do? In the evaluation of first-year activities, there were really significant successes. Seventy-five percent of the kids who were surveyed after a year of the campaign, reported knowing VERB and its tagline, 'VERB, it's what you do'. Even higher were those in the high dosage community, where there were extra messages. Both of those levels of awareness were higher than our target goal for the first year, which was fifty percent. We had an unexpected success. We heard that Language Arts teachers for tweens were accepting the tagline, 'It's what you do', as a definition for VERB on school tests. So we felt like that was a really a good success.

The VERB campaign is not the only CDC program to use marketing as a way of supporting health promotion. Smoking prevention, HIV awareness, child seatbelt promotion, and 5 a day, have all used elements of marketing in our programs. Also importantly the public has not been the only group that has been part of the social marketing push. CDC's DES campaign is one of the ones most recently completed that included a clinician-targeted group as well. You may know that CDC's health promotion campaigns very often include health care providers, because we recognize, as do you, that health care providers are the single most influential and credible source of information for most of our target populations. So getting the word out to clinicians is critical to the success of any of our campaigns. With a DES update, we were charged by Congress to ensure that health care providers as well as the public were aware of the latest research on historical exposures to diethylstilbesterol and related increased health effects. So that campaign has just concluded, but I invite you to take a look at the website because it shows a real marketing push towards health care providers in segmented ways, toward Registered Nurses, Nurse Practitioners, and Physician Assistants as well as clinicians.

With specific programs like VERB and CDC's DES update, CDC has really demonstrated to itself that there is promise in this approach, and the marketing center is a way, not only to really promote specific programs, but systematize it across the agency. The marketing center is designed to be CDC's front door to its partners and customers, to put a human face on CDC information, and to conduct ongoing dialogues with all sorts of customers that use our information or add to it in their own way to promote health.

I am really looking forward to learning from all of you some things that we can take back home to CDC as a way of helping us to do better in this area. For anyone who can stay for a few minutes after the conclusion of the formal meeting, I will be talking about how CDC's new partnering initiatives might get us to work with you more closely. And I'm really looking forward in the future to working with you, to achieve CDC's new health promotion goal, that all people will achieve their optimal life span with the best possible quality of life, in every stage of life.

Session I Discussion

Getting the 'traction' for behavioral change

A participant made the point that the anti-smoking ads were not aimed just at smokers, but at the vast

majority of non-smokers to support the other policy changes, and that changed the whole social environment. He noted that when we look at these marketing campaigns, we need to look at *"who's really going to push the buttons that are going to lead to broader change. An anti-obesity campaign wouldn't be aimed just at fat people, but at everyone, so they understand why they should support efforts aimed at reducing obesity."*

Kizer agreed, citing a tactic in the tobacco campaign. *"Because opponents were outspending the proponents by a huge margin and support was dropping in the polls, less than a week before the vote we released a state survey. It showed the cost of tobacco to the entire state, and highlighted the many billions of dollars that everyone was paying, whether or not they were smokers. Starting the next day support began to rise and by vote day it was back up to 58 percent. So it was exactly that point that you were making; you have to appeal to everybody, and I think that's true in all these campaigns."*

Another participant noted that two of the things we do best in the U.S. are innovation and advertising. *"We know how to get people to do things through advertising and we certainly know we need to change health-related behavior. What are the trigger points, the sparks? Where can we begin to get traction?"*

Kizer opined that any number of entities within the federal government could catalyze the movement or campaign, but government doesn't need to run it. *"Government should get it going and mobilize the resources that exist within any number of other sources, public and private. It's a question of leadership at this point,"* he emphasized.

Vanderford pointed out that there are many players in this arena, and not enough resources for all to do the work alone. *"We need to identify the unique capacities of CDC, versus a state health department, versus the workplace, and be able to connect, not compete, but identify and work together on shared goals, even while recognizing that these entities can't be partners on everything,"* she said.

Peters suggested we should *"create a sense of outrage. Leverage the fact that most people don't know that they are somehow subsidizing somebody else's behavior."* He proposed that we *"make the message consonant with values,"* and identify the incentives and disincentives. How big do they have to be to get people to change behaviors that are not easy to overcome?

A participant expressed concern about the notion of creating a sense of outrage. He believes that one problem is that much of the marketing and advertising and messaging for better health is negative. *"It's 'endure pain, make yourself miserable, deny, and stop doing something that you enjoy.'"* He went on to recommend *"a strategic effort to counter unhealthy fast food with healthy food that tastes as good and is as convenient and cheap. We need to make the change transference to an acceptable alternative behavior, not denial in the consumer's mind."*

Peters agreed with the approach. *"You need to start with very small changes to 'recondition' people's taste buds, as happened with milk."* However, he pointed out that *"P&G was unsuccessful in promoting a convenient, great tasting nutritional bar that delivered the nutritional equivalent of two servings of fruit and vegetables. People said they wouldn't buy it because the concept of eating their fruits and vegetables was not new, it was not product innovation to them!"* He added that another big problem in this country is that we have been focusing on one macro nutrient at a time. But there's too much of everything. By thinking fat was the answer and telling the food industry to get rid of we didn't send a message about not replacing it with sugar. And that is what happened. *"You punch the balloon and it bulges out in a different area,"* he said.

A comment was made about the ways that obese individuals experience discrimination, which undoubtedly does not increase motivation! Peters agreed, and pointed to studies which document discrimination even within families. Parents will send the lean child to a much higher-profile, better college than their obese child, apparently believing, subconsciously or consciously, that the child is not going to achieve as much.

A British participant offered a couple of examples of campaigns focused on behavior change from outside the US. First, the mayor of London introduced urban toll charges, called congestion charges, for people who drive in the inner-city area and cycling in London increased 27 percent in the past year. *"That's one example where some government intervention did make a difference,"* he said.

Second, Italy has tapped into its own cultural values and introduced the "slow food" movement. It celebrates the joy of preparing and taking the time to enjoy food.

One negative example he offered is the increase in public litigation related to kids falling and getting hurt in public parks. As a result, some local parks have been shut down.

What interventions will reach the greatest number?

A business representative posed another question. *"We seem to be a culture that needs some sort of other reward than just our better health. The question is, what combination of interventions will reach the greatest percentage and cause behavioral change?"*

Vanderford pointed out that the studies are not very optimistic. It seems the most successful campaigns first create awareness, then positive attitudes, then behavioral change—but this does not always result from the 1st two. *" 'Knowing' does not necessarily translate into 'doing,'"* she said.

Sometimes concern over children can be a powerful motivator to move people, when there doesn't seem to be another incentive. For example, older people can be successfully encouraged to get flu vaccine to protect grandkids. It also worked with tobacco and secondhand smoke.

Another participant offered his personal experience on how messaging on health behaviors that starts with kids can have a positive by-product in influence on parents--and grandparents! *"I used to enjoy a nice cigar once in a while and haven't had one for sometime, because my kindergarten age granddaugher said to me, 'Papa, why are you smoking that?' That's what changed my mind. I bet she could change my mind about some of the other habits I have,"* he said.

On the subject of kids and behavior, a participant expressed the view that *"kids want to run and play and exercise. They do it naturally, and today somehow we're taking that away from them."* Peters agreed, *"We are stifling kids who are naturally active, however, that is a bigger cultural and social issue."*

Vanderford cited the 'five cities studies', which focused on cardiovascular disease, as one of the most successful behavioral change efforts. A sustained local media campaign combined with a multiple message channels across the community over several years took a significant amount of money and a lot of concerted effort to ensure the necessary individual follow-up to achieve results. She concluded, *"This is hard work. It doesn't happen because there's an advertising campaign."*

Peters added: *"Without really knowing the return on investment for different approaches, we can [have]….a lot of expensive false starts [and] we could be wasting an awful lot of money."*

A patient advocate spoke of the research on changing health-related behaviors, which speaks loudly about self-actualization. *"The real challenge is how you get from information and resources and support to self-actualization in health care…[which]may be radically different than self-actualization in buying consumer products, like hamburgers, cars and things like that,"* he said. He then cited *"The Support Economy,"* by Shauna Zuboff, stating it may be relevant to thinking about this, although it has nothing to do with healthcare. *"[The book] talks about personalization at a time when we mass-merchandize everything."*

The role of CDC… and others

A physician executive attendee pointed out that when there are rules that have to be followed in order to get something, it can modify behavior more than either positive or negative incentives. He asked if there is any appetite in the federal government for implementing something *"that has more teeth"* in it, as a model. *"We see it in military medicine and at the VA. Why not implement something in Medicare which accounts for more than 50 percent of the healthcare dollar?"*

Vanderford agreed with the comment regarding 'rules', citing public health's success in been lowering children's blood lead. *"While public health messaging has been important, getting lead out of gasoline has had a greater impact. Combining health promotion messages with structural change in policy is best,"* she said. While CDC is prohibited from lobbying for regulations, it can present science that supports policy changes.

Another participant expressed concern that we don't use CDC modeled campaigns to target those people with specific diseases with information and specific resources. Vanderford agreed that there have not been a lot of high touch campaigns because they are very expensive. However, she did point to some efforts. In California the WIC program works one on one with low-income parents to help healthy behaviors around nutrition to be implanted. CDC's campaigns provide tools for communities to use, for example, to target Hispanic populations with diabetes and help them use exercise as a way to improve their health condition. But communities don't always have the money or resources to make a huge impact. She concluded, *"Small campaigns are being run in multiple places but without the resources to do them in a comprehensive manner."*

Peters cautioned about a perceived 'fairness' issue if the message is somehow received in a way that says 'we are targeting you because you've done something wrong'. *"What we are essentially talking about is targeted disease management, something that is getting a lot of attention from both the public and private sector and is an important part of tertiary prevention."*

An employer representative told the group that Fortune 100 executives do not believe wellness is really where the big money is to be gained. The big issue for employers is the return on investment, and they are skeptical that prevention and disease management initiatives will help them because of increased turnover today. However, he did think business might be able to partner with CDC.

Focusing on the notion that different entities have different expertise, a community health center CEO pointed out that disease prevention is a big priority for CHCs. *"Working with local universities we've made real progress in crafting the message of how to prevent chronic diseases,"* he said. *"CDC can develop a message, but you need the right messenger to get it out to patients, many of whom have very complex psycho-social dynamics that influence behavior change. Many find a comfort zone in the clinic and the providers can create the infrastructure at the community level to deliver whatever message CDC develops in terms of prevention."*

Session II: The Role of the Internet, Media and the Arts in Social Change

Jon Comola

Now we'd like to drill down into one of the most difficult elements of any effort to get a message across, that is, taking the words and concepts and determining how and by whom the message will be delivered. And part of that determination is the decision on what medium to use. We will look at three very different 'media' and consider how each can be leveraged to get health messages across to diverse audiences. First, Tommy Hutchinson will talk about the use of the Internet to reach youth. Next, Andrew Holtz will educate us on how to work with journalists and the media. Finally, Naj Wikoff will describe a variety of ways that the arts can be used to make health messages more appealing and meaningful to different populations and cultures.

Tommy Hutchinson: President, Kickass

(Presentation slides are available for downloading from www.wrgh.org.)

I can't tell you what a privilege it is to come here today, even though it took about 15 hours, changing in Philadelphia, and I said, *"this is a long journey!"* Then I realized that my grandparents' generation came from Ireland, all the way to Oregon and California, on the boat and however else they got across America, and it probably took them a bit longer than me! They didn't have this amazing resort to step off at, so I'm very grateful to Marcia and to Jon for the invitation.

I want to talk briefly about my work and the work I do with others, and then talk about communicating with people more generally, to a large extent with young people where a lot of my focus is.

I head up a charity called Kikass, which is mostly focused on the 16 to 24 age group. I'll show you some 'family' photographs. A lot of the work is not specifically health-related, but some is. Mostly my talk today is about the techniques we use to communicate, rather than specifically being health-orientated. Our main website is *www.kikass.tv*.

We look at safer sex, drugs, and alcohol, but also focus on young people and money, which is a very big issue. We're also working with the government to launch a volunteering program very much like you have in America, the Freedom Corp and the AmeriCorp.

One of our earliest projects was on safer sex, called SuperShagland.com. Somebody back home said to me, *"I don't know if Americans know the word 'shagging',"* but I think I can go back now and give them the answer!

SuperShagland is a computer game, widely marketed by friends passing it to each other over the Internet. You play the game, and then you can go to one of the sections to learn very concise information about safer sex. We launched it with no money, no marketing budget whatsoever. It took about 3,000 pounds [in financing] to build. In practice it really cost about 15,000 pounds, but a lot of people helped us out. We thought maybe 500 people would play this. Today, 2 years later, there are still 120,000 people every month playing the game and taking part in the information. Nine out of 10 would recommend it to their friends, and 38% said they had changed their sexual practices as a result of the Super Shagland campaign.

The government ran a campaign called the Sex Lottery, where they spent between 2 and 4 million

pounds. They don't get 120,000 users a month, they get 24,000 users a month. It's not about money, although believe me when you run a small charity like Kikass, money helps, it's about how you communicate the message. A lot of our work is offline, so, I'm going to show you a couple of photographs. Using the internet we got 200 young people to turn up in the middle of Trafalgar Square on World Aids Day, in ponchos which look a little bit like condoms. We made a lot of noise and had a lot of fun, and we had 2,000 very amused tourists watching them. This is us outside 10 Downing Street. The Prime Minister's office asked us to get a cross-section of people from throughout the country, all different races, sexes, sexuality, and so on, to turn up with 48 hours notice. That's how government works, they work slowly, but they expect everyone else to work fast. But we had a very interesting day. Here we are [in the photo] with Tony Blair, who spent an hour and 15 minutes with us, and the guy standing on the right is Trevor Nelson, who's a famous radio disc jockey. It gave young people a great opportunity to talk about politics and about other issues they care about.

I also run an organization called Eurobandits, which promotes the opportunities of modern Europe, with a heavy emphasis on the ten in Eastern Europe. There are 10 new countries which joined the European Union and we did the official website for the European parliament elections, and now we've just launched this new magazine called Eurobandits.com. It's an online magazine, although we're about to produce an offline version. We communicate messages throughout Europe, mostly about the film and music industry, and also changing trends, such as fashion. One of the slightly unique features about this website is you scroll across horizontally, unlike almost all other websites where you scroll down vertically. So, this one is very much in a magazine format going a couple of pages at a time. Not too much text, because people don't like to read lots of text on the internet. Very graphical, very punchy, and you can also download or purchase movies and music.

It gives us an opportunity to look slightly more subtly at some problems we have in Europe. One problem we have is racism against Roma gypsies, many of them living in Hungary and Romania and places around there. We just happened to fall upon a hip-hop band from the Roma gypsy community. In the next edition we're going to profile the band, talk about their musical approach, and give readers an opportunity to buy and sell the music. It's a subtle way to try to overcome different perceptions, different stereotypes that may already be deeply implanted in history.

We have other projects planned. We're about to look at what the image of Germans and Germany is in the United Kingdom, which is still rather bad, bizarrely, after such a long time since the War. We're also looking at the EU constitution, which is a very complex piece of documentation. We're trying to figure out how we can break it down into a way that is digestible and that people can follow and understand. We've also just recently finished a new short film, which we're trying to get in cinemas, about young people and alcohol. We call it binge drinking. It's quite amusing, about a guy who drinks very heavily, so every time he goes out with his friends or his girlfriend, it seems prudent to carry along his lavatory, which he can use to be sick in.

We also work with Channel 4, one of the main channels in Britain, about the coming election. We're going to get groups of young people to make short films which Channel 4 will show, and we'll have online support, so that you can follow the political issues and debates. It's going to be called El Manifesto. Hopefully it'll be fun.

I'd like to talk, in the few minutes remaining, about some things you may want to think about when you are planning to communicate health issues to a wider population.

The first thing is to clearly define your message. It is amazing how difficult that is for a lot of

organizations, especially in the area of health, as we were talking about earlier. Health is a very complex issue, but there is no point trying to communicate about it unless you can clearly define the message that you want to get across.

The second is, talk to your audience about how they want to receive the information. What is the language they want to use? It might differ between ages and between racial backgrounds and so on. What is the medium they want to receive that information through? And ideally, get your audience to communicate to itself. Get particular communities to go out and communicate health messages through each other. It's not a new concept, indeed most religions practice this technique. You go to church on a Sunday, and then you're encouraged to spread the gospel for the rest of the week. The American music industry is the pioneer of something that we're trying to develop in Kikass called street teams. The music industry sells albums and CD's, by getting 'hip' young people to go out and communicate to their wider peers and friends. Find a way you can get the audience to go and communicate to itself. That is a perfect position to be in, if you're trying to communicate a message. Make it human and make it visual.

A few more quick points. The future lies in the hands of storytellers. People, not surprisingly, relate to people. They do not relate to huge chunks of information and stats. They relate to people in a human sense. Respect cultural differences. The United States is a land where people are fantastic communicators. You speak clearly; you articulate messages in a very clear way. It's interesting to look at your advertisements when I'm over here. Very straight and to the point, you know. This can of Coke is $.03 cheaper than that can of soda over there. Very clear, very concise, it tells you what it is on the tin, yet those adverts would not work in Europe, because in Europe, we communicate to each other and advertise in a much more suggestive way, more based on nuance. Even in Britain and America, where we have enormous similarities, there are still quite surprising differences, even with something as basic as how we advertise. And when young people are asked how they want political information to be communicated to them, they say two things: *"keep it short and keep it simple."* It's very remarkable how many politicians do not understand how to do that. For a group of people whose careers are based on being able to communicate, it's remarkable how bad many of them are at it. Another point, repeat the message again and again and again.

I know this is going to sound a little bit controversial, but unfortunately there are times when you have to use the deepest emotions that exist in people: fear and greed. I was watching from Britain the Presidential elections here, and John Kerry was listening to focus groups. He was listening to his audience, and they were saying, *"we don't want negative campaigning, we want just positive stuff."* Positive, positive, positive! And he was getting nowhere. It was only when he went on attack in a very negative way and started to use fear and greed did he start to get anywhere.

Communications is a complex business. There aren't simple answers. Two final points. One, be authentic. People respect trust. They value trust more than anything else. Many pharmaceutical companies, for instance, are having problems being perceived as trustworthy at the moment. So in that light, if you are going to use celebrities to communicate your messages, think very carefully which ones you use because they must really resonate with the audience. Otherwise, it can backfire. My final comment is from the media industry. Sky News, says *"we're never wrong for long."* If you make a mistake, correct it quickly and move on. Channel 4, who I do some work with, - 19 of the 20 programs most watched between the ages of 16 and 35 come from channel 4 - judge TV programs they commission on three factors. They are: be first; cause trouble; inspire change. I think those are three pretty good criteria we can all use in our work. Thank you very much.

Andrew Holtz, MPH: Past President & Interim Executive Director, Association of Health Care Journalists

After decades of working in television and working CNN and communicating messages using the latest satellite technology to cover the globe, I'm not going to use Power Point. So maybe I've overdosed on technology!

One thing I want you to really think about, here and as you leave, is that what is happening here right now is unusual. We're all in the same room, we're all face to face, we're talking, maybe not quite one on one, but there will be a lot of one on one conversations. Contrast that with how most people are living their lives these days. Where are they getting their messages? Where are they getting their information? They're getting it from the media. They're getting it from television, from radio, from newspapers. They're not getting the real world. They're not experiencing their neighborhoods. They're experiencing the entire globe, distilled down into sound bites and quick voice-overs, of bizarre and unusual occurrences, hitting them again and again and again. This is the world that people live in today.

We think that what we see on television is real, is the real world. It's not. It's a very bizarre world. It's like it's a triple espresso world. It's not real life, and yet that's what we've come to believe and think of as real life. There are numerous studies showing that if you go and ask people about levels of crime in their neighborhood, what's going on in their community, they won't tell you what's actually going on. They'll tell you what they're watching on their local news. And if there's more media coverage of crimes, they'll report that there's more crime, even if all the stats from the police say crime's going down. I mean that's what's happening in this country. Crime is down. Teen pregnancy is down. A lot of things that people say are up are really down. But that's not what they're seeing in the media.

So life experience is increasingly 'mediated'. We're living in a media world. And that's a real problem, because people are beginning to believe that the media world is the real world, and we're not going to change that. You can tell people to turn off their TVs, but it ain't going to work. So you've just got to accept that this is what's going on, and try to deal with it, but understand that people are really beginning from a very warped perspective.

Think about 'stranger danger', this message that's going out to kids all the time. Parents are terrified that if they let their children out of their sight for a second, they're going to be gone, because they see it on TV all the time. They see America's Most Wanted. They see this guy who's made a career, become a celebrity, because his child was stolen. And it doesn't happen very often. You can't say it'll never happen to your kid, but the odds of your child being stolen by a stranger, compared to the odds of your child growing up fat and developing diabetes and heart disease. You guys know which one is the real threat to the next generation. But you talk to most parents and hey, they're telling their kids, *"You get off the school bus, you go inside, you lock the door, don't open the door, don't talk to anybody, don't go out and play in the street, because you might get snatched."* And that's because the media has taken a few hundred cases a year around the country and trumpeted them to the point that everyone believes that that's everyday life.

It didn't used to be that way. It used to be that people were born, lived, grew up and died in the town that their parents were born in, and grew up and died in, and their grandparents grew up and died in. In their world, while they may have heard some stories, they basically operated on what they actually experienced, because people are anecdotal creatures. We're storytellers. We don't understand stats, as Tommy [Hutchinson] said. You can have all the stats in the world, but what people understand are

stories. In the old days, when the stories that they knew, the stories they heard, the things they experienced, were right in their own real world, I think they actually had a better sense of reality than we do today. Today the stories we hear are those media stories, and in order to get our attention, they have to be increasingly bizarre. Because there's so much coming at us that it really has to be special, and different, and new, in order to stand out.

Most health messages are not different, or bizarre, or new. You don't smoke, you fasten your seatbelt, you don't drink too much, be careful about sharing bodily fluids, don't eat too much, get some physical activity. Those are all really important messages but they're not new, they're not different, they're not exciting by themselves, and so how do you break through and get those messages to people so that they understand them? It's a tough challenge. I'm not going to tell you that it's easy. I've been working in television for decades, and the longer I worked, the more frustrated I became. What I knew was important, what I was learning by covering health and medicine, what was really important to do was very simple and not very newsworthy. So how do you tell that in a way that's going to grab people's attention, and get them back to thinking about what's real, what's wholesome. Is that exciting? No. It's tough, but that's the challenge we're faced with. Since we are living in a media world, you're going to have to use the media, like it or not.

There are many important community outreach programs that do things person to person, and those are very important. But if we're talking about the media, which is an essential component of our real world today, it makes it tough and I think there are a few lessons I want to try and touch on in the few minutes we have here.

The first is, I think there is an increasing awareness among health and health care insiders about the role of the media. I was a reviewer on an Institute of Medicine report a couple years ago about the future of the public's health, which devoted a chapter to the media. There was an overt recognition of the role of the media. I had some real problems with what they finally put in that chapter, but at least there was recognition. I keep getting feedback from people who are experts in this area that they understand that they have to engage the media, even if they aren't quite sure how to do it.

The other point is that journalists who are working with the news media, which I'm most familiar with, becoming more aware about the shortcomings of a lot of things that we do, and the things we need to be better at, and we're struggling to try to make it better. That's why we created the Association of Health Care Journalists, to try to raise the level of reporting on health, health care and medicine. It's a tough struggle, because everything about the news business, arguably, works against doing a better job. That's another challenge that takes a long time.

I also want to make clear the point about the difference between health communication and health journalism. Health education and health journalism are not the same thing. A lot of the problems that health experts have in dealing with the media relate to the fact that they want news people to be their mouth pieces. That's not what news people want to do, and they resist doing it. In the pure sense, the news media, the free press as an institution in American society, was created to be an independent outsider that comments and causes trouble. It's a rabble-rouser. It's an iconoclast. We're not supposed to be a mouthpiece for the other institutions of society. Sometimes we are, but we're not supposed to be. And if you try to be too overt in saying, *"Here, I have this message, it's really important, deliver it,"* you will immediately hit resistance that you will not overcome. You have to understand the culture of journalists, and, like any other audience you want to reach and any other community you want to work with, understand the culture of news rooms, which is pretty bizarre.

Understand the care and feeding of reporters, what it is that they need that day, which is a story by deadline, and you will make them your friends and you can work with them. For them, it is not health education the way that health professionals practice it.

So to wrap things up, really think about how strange it is that we live in a world that is dominated by the media, how people are living with this duality between what they see first hand, and all the messages they receive through the mass media. Also accept that you're going to have to learn how to understand the peculiarities of the media business, and the world the media people live in, if you're going to try to engage them in any kind of partnership in spreading messages that may be beneficial to society. Thanks.

Naj Wikoff: President, Society for the Arts in Healthcare

(Presentation slides are available for downloading from www.wrgh.org.)

I want to thank all of you for allowing those of us in the arts to be a part of this dialog. The health industry is facing some very severe challenges, particularly around the issue of chronic care and changing behaviors. I believe, as the previous presenters have shown, the arts can help.

First, I wish to speak to the last issue raised about the media. I believe that people ARE getting health information through the media, but the information they are receiving is that risky behavior is okay. They are learning from the entertainment media that risky behavior is not only okay; it is the right and good thing to do. We need to remember that the news media is only a small part of the media. The entertainment media, movies, video games, television programming, controls the bulk of air-time and it presents violence, smoking and other unhealthy behaviors. Through showing all these things in a positive light, it is communicating that risky behavior is okay. So I think the media is a very powerful means of communication, but we need to modify the content of entertainment as well as seeking to get our stories on news and talk show programs.

I also wish to mention that I work part-time for former Surgeon General C. Everett Koop. The issues of smoking and obesity are extremely important to him. He is very pleased that we are talking about these issues because to him nothing is more important to the future well-being of our society and our health industry.

I have been very impressed by all the presentations and the stories that have been shared both by the presenters and participants during the breaks. I believe that nothing is more motivating than telling stories, as they connect us on a very fundamental level.

I want to start by giving you a quick overview of the arts in healthcare, then focus on some of the ways the arts can help us address the critical issues we face. As Ian [Morrison] was saying earlier, if I somehow step on toes now and then, I apologize. You can just blame me because I'm an artist and from the outside culture.

As you all know, this is a tough time in healthcare. Money is down. Costs are up. There are staffing shortages. Patients are unhappy. It is a tough time to focus on this huge chronic care crisis when your realities and resources are really stretched. Yet, what's very interesting is that within this challenging climate the arts are growing. To give an example, half of my time is spent as the President of the Society of Arts and Healthcare. We're a non-profit organization. Two years ago our membership was 400. Last year it jumped to 600. This year it doubled to 1200. This is tremendous growth just in membership by individuals and organizations wanting to learn more about the use of the arts in healthcare and connect with other like-minded people.

This past year the Society, in partnership with JCAHO (The Joint Commission on Accreditation of Healthcare Organizations) conducted a survey to determine the level and characteristics of arts programs in U.S. hospitals. We learned that over 2500 hospitals have arts programs, and, based on a random phone survey, we consider that number to be very conservative. Frankly, those numbers just knocked our socks off, especially as this level of activity is taking place and growing within this difficult economic climate.

Ninety-six percent of the arts programs are used to serve patients. Seventy-nine percent are also used to create a healing environment and seventy-eight percent to support patient mental and emotional recovery. Fifty-six percent of arts activities are additionally used to serve patient families, fifty-three percent to help patients and families deal with serious illness and fifty-two percent to help build hospital - community relations. Forty-six percent are used as part of the patients' physical recovery.

But something that wasn't really on the map a few years ago is that a large focus is now on staff well-being. Almost forty-one percent of arts activities are designed to serve hospital staff – to help reduce stress and enhance job satisfaction. Of particular interest to the theme of this conference is that thirty-five percent of arts activities are also used to communicate health information. I feel that the results of this survey are very significant.

To give you an example, last year my friend Blair Sadler, the CEO of Children's Hospital in San Diego, faced a potential five million dollar shortfall. Yet he did not cut one dime out of his arts budget. Why? Because he feels if the arts programs can keep just one nurse from walking, it's paid for itself.

Just so you know the type of artists working in care-units, eighty-two percent of the hospitals use musicians. I think they are used the most because music is so flexible and can serve multiple people and multiple needs at once. Forty-six percent use performing artists, about forty percent use visual artists, thirty-two percent use dancers and eleven percent use poets and writers. Seventy-seven percent of the hospitals use arts therapists but sixty-seven also use professional artists. Again, this level of arts programming was not on the radar screen that long ago. This represents huge growth.

Our focus today is communicating health information and changing behaviors. The CDC has told us time and time again that health providers are a critical means of communicating health information. My concern is that if we don't help our healthcare professionals deal with job burnout, ensure that they are healthy and have a satisfying job, and indeed enable them to 'walk the talk', they will not be able to deliver good health information or be good role models.

All of us know doctors and nurses who are stressed out. When we talk about the military coming back from Iraq, we share our concerns about the rise of post-traumatic stress disorder, as our soldiers are operating in a far more challenging situation then they have encountered in the past.

Our health care professionals are no different. They too are burning out. Because hospital stays are so short, they are dealing with one critical case after another, along with many very concerned family members. Their increased caseload of critical patients is really beating them up.

Therefore, I want to talk a little bit about using the arts to care for caregivers. Caregivers can be broken into two basic groups, the professionals—doctors, nurses, therapists—and the informal, including family members and friends. Informal caregivers are providing seventy to eighty percent of care. As we talk about educating doctors and nurses and other professionals about healthy living and communicating, we also need to talk about educating and recruiting as allies the other people who are serving as

caregivers. Look at Nancy Reagan. Everybody was amazed at the incredible care she gave to her husband. Many caregivers are just like her, people who give years of their life caring for another. As it has done for so many in similar circumstances, the experience of caregiving highly motivated her, and now she's become a fanatic about certain aspects of care and probably could be a really great media spokesperson for all of us.

Of those who need long-term care, fifty-three percent are over 65, forty-four percent are between 18 and 64, three percent are under 18. The fastest growing segment is people over 65 and within that, those over eighty-five. Informal caregivers provide seventy-eight percent of the care. One in four households is involved in long-term care, dealing with chronic illness, all these different things we're talking about.

Caregivers, informal and formal, who experience mental and emotional strain have a sixty-three percent higher risk of dying than non-caregivers. Forty-six to fifty-nine percent of informal caregivers are clinically depressed. These are not good stats. We are losing skills, memory, and gifted communicators who have the most access to and are most trusted by patients. The cost of replacing and training new people to take their place is helping to drive up the cost of healthcare, to say nothing of the economic hit informal caregivers absorb. Therefore caring for our caregivers represents the most cost effective means of protecting and enhancing the prime source of delivering health information.

Shanti Norris, the executive director of the Smith Farm Center for the Healing Arts in Washington, DC, said the following, in an article in the book *"Caring for the Caregiver". "In our retreats for doctors, they often speak of the deep caring they felt, but they could not show to their patients or speak of to other physicians. Such behavior is considered unprofessional. Doctors are alone with these emotions and isolated from other physicians and caregivers because of them. In the workshops, this isolation and ensuing loneliness becomes apparent. It is not unusual for a physician to speak about the death of a particular patient, sometimes a death that occurred many years ago, and cry for the first time over it. At one retreat, when asked why he had not cried before, a physician responded, 'Only another physician would understand my loss and who would ever cry in front of another physician?'"*

Our doctors often see death as failure or bottle up basic human emotions to the point that it's destroying them. As I mentioned earlier, a growing use of the arts is to help caregivers. Some examples. At the Dartmouth-Hitchcock Medical Center we developed a marvelous monthly series of lunchtime presentations called 'In Poetry & Prose'. When it first began, just a dozen people showed up and within a year it grew to a couple hundred people coming to hear caregivers present their short stories, poems, plays and experiences. The program helped foster a sense of community. People learned that others shared their feelings. They learned that they were not alone. This program spurred the creation of writing and book clubs that met over the lunch hour. It goes back to the importance of storytelling as a means of connecting people and creating safe spaces.

At the Duke University Medical Center they have an annual staff musical performance led by a professional arts impresario. All the performers come from throughout the hospitals. Every department is involved. It represents an extraordinary investment by the hospital in their employees. It says to employees, *"we care about you."*

The Lombardi Cancer Center has an arts and humanities program that conducts mask-making sessions for doctors and nurses. It's amazing to see the things that come out. You can ask a person to make a mask of how people see you and another mask of how you really are. It's extraordinary what they create and how honestly they express their emotions through the mask. It can bring those emotions out and put them in a safe place.

SHANDS Hospital at the University of Florida, Gainesville, through the Arts in Medicine program and the CAHRE Center, presents 'Days of Renewal'. Every nurse can spend a paid workday during the year doing all sorts of art activities: painting, composing songs, laughter workshops, yoga, creative writing—you name it. It's the hospital's way of investing in the doctors and nurses and other staff members because it makes a difference. The people are learning skills they can use all year long to help them deal with tension and again, they feel valued. Music is great for relaxation. If you lay an electric harp on someone and play music, the vibrations will go through giving them an internal massage of the spirit as well as the muscles.

I think one of the great failures is the very small amount of attention that we give in medical schools to teaching medical students how to take care of themselves, how to use the arts and humanities to tell their stories so that they don't keep them bottled up and become a future suicide case. We could be using the arts to help teach them about the history of medicine. Most medical students do not get a formal course on the history of medicine. You cannot get through art school without knowing about the history of the arts. Artists are always telling stories about what Picasso or other artists did. So many medical students I know at Dartmouth have no clue about who invented aspirin. They have no clue who Gross was. They don't know the history of their own craft. Yet museums are filled with paintings that can be used to showcase the history of their craft and help them explore issues of doctoring.

The arts can also help medical students address their emotions when they are first working on cadavers, a traumatic experience for many. Provide them a pen and paper and, as Dr Sandra Bertman of Boston College, shows in these slides, they will draw their fears ahead of time. You can use drawing to help them work through their emotions and see the beauty of the experience. At Dartmouth we have learned that medical students love participating in life drawing classes concurrent with their anatomy classes, as it provides both insight and a release.

My point is that if caregivers can be the most effective communicators, we need to support them so that they will be good role models and mentors. Now I wish to shift the focus to using the arts to communicate information.

There are many different ways to communicate information. One of course is the outside appearance of a hospital. When a patient comes to your hospital, what does it say to him or her about the quality of the care? Does it create a sense of welcome? This sculpture fountain at San Diego Children's Hospital says this is a place for caring and we're going to take care of you. The Westchester Children's Hospital creates a strong sense of welcome before you even walk in the door. I think it is important to remember that when patients go into a hospital, they expect good surgery. They expect that you're going to give them the right pills. They expect no matter what, that the quality of service will be high. That's their level of expectation of hospitals in America. They don't go in there expecting to get sick or to pick up some other disease. They don't seek out a hospital by price. The difference is, do you care for them? Do you treat them like people? That's what makes a hospital more competitive than another, assuming both have the technology and skills to treat the disease in question. People will travel great distances to go to a hospital that treats them with dignity. So the design and decoration of the physical plant can make a difference, not only on the outside, but in the lobby, waiting rooms, surgical rooms and care units. This Edmonton pediatric nursing station gives a sense of welcome. It say's this is a kid friendly place.

Another way is to use the arts to communicate healthcare information. This can be very effective with the very young. Here is a slide showing pre-med students and art students using arts activities to teach very young kids how their body works. Here they are using collage. As another terrific example, an art

student and medical student went around to elementary schools in New Hampshire taking with them a whole pile of fruit. They would slice it all up to make a heart out of sliced oranges, grapes, apples, bananas, kiwis, pineapple and other fruits showing how blood gets pumped through the heart. The kids would help place the sliced fruit on the tray. Then they all ate it. So they not only showed the kids how a heart works, but they sent the message that eating fruit is important to taking care of your heart and that fruit tastes great. It made a profound impact on the kids and their teachers. They're still talking about it! A lot of these rural kids up around Dartmouth had never eaten a kiwi much less a piece of pineapple before.

Here is an image of a safe play poster created by children for children. As Tommy [Hutchinson] pointed out earlier, getting young people to design the posters for each other can enhance communication. It's a marriage of the message, the medium and the messenger.

Next I wish to show you examples of an effective campaign. It took place in Gateshead, England. They had a huge problem a number of years ago and still do, of course, with heart disease and the other chronic care issues we have been talking about. Gateshead was a mining community and many people were suffering from all sorts of consequences of poor diet, lack of exercise, and smoking. Indeed it had the highest death rate due to coronary heart disease in the country. Government health agencies started with the typical campaign featuring all those health posters you see in hospitals and doctors offices filled with boring graphics, too many words, and all these terrible stats, images of doom and gloom and thou shall not do this and that and the other thing. They learned that their campaign wasn't working. Few were paying attention. The posters were a turn off.

The health agencies developed a pilot program with the city libraries, which often serve as community arts councils in England. The city library hired a group of artists to create a series of health posters. This was part of an overall campaign. They wanted to change public awareness. They wanted to communicate that it is important to take care of your heart, get exercise and eat right. The artists started coming up with these marvelous posters of people dancing for their hearts and other images—bright, colorful, catchy images. Soon they discovered that they were running out of and having to replace the posters. People were stealing posters. Can you imagine stealing health posters and putting them up in your homes and framing them? Wouldn't you love to see that happen? People loved the posters.

The artists then proposed an annual healthy heart parade to further increase awareness, bring people together and get people exercising. They set up open workshops in community centers around the city. Using willow branches, rice paper, Elmer's glue and candles, under the guidance of the artists, people made over two thousand lanterns. They then organized a huge parade that wound its way through the streets of Gateshead and ended with a huge festival at the end that featured fireworks, music and healthy food. They've been holding the annual festival for over seven years now. It has spawned health awareness activities in schools themed to the parade, dramatically increased public knowledge, and fostered community pride. To quote, one participant, *"When the artists came here and said we're all going to make lanterns out of sticks and glue and walk down the streets with them, well I thought you were mad. I'd never have believed what I've seen tonight. Look, it's Friday night and everyone is eating brown bread and soup and enjoying it."* The Gateshead Healthy Heart campaign is an example of arts can bring people together to create community and change behaviors. Now this particular program has been going on for seven years. It's not a quick fix. You do need to be consistent over time. At the core of this event, as much as the arts and health workers are nurturing emotional well-being and communicating health information, people are having a good time. Learning healthy behaviors can be fun and, when it is, people get motivated.

Now I want to talk to you very quickly about several projects that the Society for Arts in Healthcare and Wye are developing.

First, we are working with the Health Research Education Trust and the National Arts Program to develop a pilot project to enhance the working environment of healthcare workers through encouraging annual exhibitions of employee art, such as painting, sculpture, crafts. We currently are seeking hospitals that want to be part of this, hospitals that will reflect a diversity of demographics and location. We plan to include thirty hospitals in the pilot program. We will measure the value of engaging the staff in arts as a means of stimulating increased job satisfaction and greater sense of community.

Another, with Wye River, is to create a pilot program to enhance end-of-life care by integrating the arts into hospice practices using the arts as a means of creating a public dialog about how hospice can enhance quality of life. This is not about dying. It's about living well. The goal is to increase the use of hospice, in particular by minorities. We wish to use the arts to augment patient and family satisfaction, and improve key outcomes, such as sense of dignity, control and self-determination. One of our beliefs that we wish to test is that incorporating the arts in day to day care will increase caregiver sensitivity and awareness of individual, family, and community cultural values at this critical time. In February I will be helping Medical Care Development of Maine and the Maine Arts Commission plan a pilot project on this very topic. Only nine-percent of people in Maine, who are in end-of-life care, use hospice. That's way below the national average. The health organizations in Maine want to change that. A lot of minority groups use hospice very little because they don't understand it's quality care that gives them the opportunity to leave no story unsaid, to pass something on, leave a legacy. We'd love to work with some of you on this.

A third activity, also with Wye River, is to develop a pilot project using the arts to reduce the risk factors that lead to adult onset diabetes in children. We would like to develop a pilot program that would include a partnership between community health agencies, a hospital, a school district and the local arts council. We desire to engage the parents as well as the schools and get the healthcare community working with the arts again to communicate good health information and stimulate people to change. I think this one is really very possible.

Two others very quickly. One is to use the arts to change the stereotypes about aging among medical students as a means to increasing their desire to serve older populations. We are working with the National Institute of Aging to develop a pilot program in this area that will partner museums and medical schools. The other is to use the arts and humanities to reduce use of the Emergency Room as a gateway to hospital care.

In conclusion, my message is that we in the arts and humanities, 1) are affordable, 2) are in all your communities – we are a local resource, and 3) are willing to be your partner to help health agencies tell your stories, motivate change, and enhance well-being. We can help you think out of the box and get media attention. We are about communication. As we discuss the challenges of chronic care over the next couple days, think about the arts and humanities. My two colleagues gave some excellent illustrations of the power of the arts. I think we can be a player and would be happy to do it. Thank you.

Session II Discussion

The importance of honesty in communications

One of the participants opened the discussion by asking Tommy Hutchinson for specific recommendations for marketing to youth. *"How do we make healthy behavior 'cool'?"*

Hutchinson replied by describing Kikass focus groups, called 'beer brainstormers' where young adults sit around with beer and pizza and talk through issues. *"We had quite a big row, to be quite honest, about health, and we really haven't resolved it,"* he said. *"The organization split. Half the people, like myself, said we've gotta do something about this, there's a major epidemic occurring! The other half took the kind of view young people generally do, they're never gonna die, and they don't get ill, and they're always going to be healthy. But a lot of them are overweight, and for them it was more of an issue about having society accept the way they look."*

He went on to point out two factors that might be useful. First of all, young people, like all of us, want to look good. *"Being healthy, and being fit or whatever, is a very powerful emotion. Looking sexy."* The second lever he suggested is the role of sport. *"Whether it's competitive or just having fun, I think sport can play a big part."*

Another attendee was taken by Hutchinson's comment about the importance of people valuing trust and being honest in communications. *"We in this country probably do a better job of spinning than anything else, and that's particularly true with what we're doing with [corporate] health benefits. In human resources we've always feared that employees would get mad and confront us. Do you feel that the more truthful the statement, the more accepted it will become, even if it's unpleasant or unpopular?"*

Hutchinson replied that generally everybody wants information in a clear and concise manner. When organizations speak in a 'uniform code', people see through it. While they know politicians and all communicators are going to put some kind of spin on a message, if it is overdone, they switch off very quickly.

He pointed out that even using a fantastic media that kids are going to 'switch on to', like a computer game, will fail if we mix the social message with the entertainment. *"In Super Shagland we were careful to separate the entertainment bit, which is just the hook, from the basic raw information. And that's very important. So I think people generally want information clearly and concisely."*

Making your reporter your friend

The group moved on with a question for Andrew Holtz, about the importance of health care organizations developing good relationships with their local media, *"so that when you want to sit down with them, there's a rapport."*

Holtz replied *"That's the A #1 message, an important step, and a lot of institutions have trouble doing this."* He went on to stress the importance of being 'low key'. *"If you want to get your message out there, take a reporter to lunch. Just call them up, get to know them, don't ask the reporter for anything or offer them something."* Holtz' view is that pushing to get your story in the paper when you haven't built rapport is likely to fail. It's important to understand what it is that local reporters do day in and day out, and look at their stories. He believes most will end up asking what you do, what you think is important. When they're ready, they'll come to you and ask you for help doing a story. He also advises us not to tell a reporter that calls that we are too busy…you may never get another call! *"Drop what you're doing, give them what they want, and then they'll be your friend."*

How do we get the media's attention?

Another participant asked Holtz for his thoughts on what really gets the media's attention. He pointed out that a story of an airplane crash would make the news on every channel, would be a headline for days and would result in all kinds of investigations. Yet, stories about medical errors that kill many times more people get little attention from the media. *"Why is a story like that not driven by the media*

into the public consciousness to create the kind of change in the delivery of health care that we might all be looking for?"

Holtz replied that plane crashes don't happen very often, so when they happen, they're news. They're also straightforward. *"You hit something going a few hundred miles an hour, it's bad. It's very clear. Things were fine; then they weren't. Problems in health care are not so clear. Where are the victims? You've got 100,000 people dying a year. Name one. What the media deals with is A person, what happens to one person, even when they tell a plane crash story. They find someone who was waiting at the airport for one of the people that didn't arrive. The story is not that 400 people died, it's that the mother of this person on the screen died. It's one person. So when you tell a medical error story, a health care quality story, I don't know what 100,000 means. I don't know what 100,000 looks like. But I know what one person looks like. It's got to be individualized."*

He also pointed out *"there's a difference between epidemics, which are news, and something that's endemic, which is not news. Smoking is not news. Tobacco killing thousands and thousands of people all the time is not news. It became a story when people started filing lawsuits and the Attorneys General got together and had the multi-state settlement. Then the story wasn't that tobacco kills people, it's 'hey, there's billions of dollars to be had here.' That was new, that was a change, so it became a story. It became a story in California because it was a political story, not a health story. It was a fight between the governor wanted to shut it [lawsuits] down and the health experts who said, 'you can't shut it down. We're gonna do what we can to cause trouble and file lawsuits.' It was conflict, it was exciting, there was tension, there was drama. It was a story. Statistics about the number of people killed by tobacco didn't change. It became a story because there was drama and conflict and excitement."*

An attendee echoed Holtz emphasis on personalizing the story. He pointed out that the successful advocacy groups know which buttons to push with reporters. They provide 'prepackaged stories' with good anecdotes and compelling human faces, which makes the life of a reporter very easy. *"When you provide a sympathetic face to an issue, it gets more coverage, it gets more funding. That's the way things have always worked."*

A more subtle approach to the message

A participant followed up by asking *"Should we start learning how to make health care news sensational? Should we start packaging so it gets through, instead of taking 7 or 10 or 20 years to get a message across? Should we try and be shocking the system?"*

Holtz recommended that a different approach might be more useful with health care. Find out what stories are being covered anyway, and get the health messages into those stories, *"so, as Tommy [Hutchinson] said, people don't feel they're being lectured to…..Tobacco became news because of conflicts, because of big money, and because of political fights. But what happened is the messages got repeated over and over again. Suddenly, it becomes common sense understanding that smoking is bad, second-hand smoke is bad….We want to approve clean indoor air laws. There's a gradual cultural shift, which is so slow that there are very few new stories about it, but that's what actually led to a decrease in smoking, rather than any particular news story."*

He talked about how we have changed public perception about automobile 'accidents' by having emergency personnel at the scene talk about 'crashes'. As these people came in contact with reporters and used the language over and over reporters adopted it in their news stories. Because of the campaign, reporters will also mention if victims were wearing seatbelts, if they had been drinking, if kids were properly secured in car seats. It is a routine part of news coverage now.

Similarly, when there is a fire, inspectors on the scene always tell the reporter about fire alarms. *"That gets into the story, and it's another way of getting that message out. By itself it isn't news; it piggybacks on the news."*

Another participant wondered how important it is for us to spend all this time and energy with the media. She suggested that relatively few people today are getting information about health from that source. *"I think in the last twenty years I have seen the importance of the media as an arbiter of this kind of information decrease rather than increase for ordinary people."* She pointed out that Tommy Hutchinson designed a whole different way of getting to the public, little of which has to do with what we would consider the media.

Another participant disagreed, saying that the research he had seen indicates that people are getting most of their information from the media. *"They are getting it from their doctors, their friends, but a big chunk of it is coming from the media…..Whether it is correct information, whether it's specific information, but the general sort of gist of what's going on in the world is at least modulated by the media. The media does not start things. The media generally follows something else that is going on in society. But it amplifies and helps convey things that are going on."*

As an aside, Holtz offered that radio may be a useful medium to help build bridges with consumers. For example, programs could talk about everyday kinds of encounters with the system, or provide information about simple things that support wellness and help limit the impact of some of the dire trends we are seeing. Currently mass media does not have the kind of programming that meets this need.

The value of the arts in communication

The group then turned to the issue of the use of the arts to communicate health information. A participant expressed his pleasure that the arts were included as part of this discussion, commenting that while *"science is absolutely essential in telling us what is really happening and what needs to be done, that science is almost useless in terms of communication. Human communication is gut to gut. If you try to do it intellectually with facts and numbers you will fail almost all the time. If you want to communicate to people it has to be with emotion, with feeling. The arts communicate full-spectrum. ….You need the science to tell you what the messages should be but you have to have the arts and that surround-sound approach to get the message across."*

Another participant raised the issue of 'politically correct' language in communications, specifically referring to the term 'informal caregiver'. While the term is widely used, she pointed out that it is offensive to those caring for loved ones with chronic illness and disability. She recommended using the term 'family caregiver', or simply 'caregiver'. *"If we are going to communicate to a population that is extraordinarily difficult to reach, we have to do we've got to do so in language that's not pejorative…"*

Picking up on the issue of caregiving and attitudes, another attendee spoke about the stereotypes that young people have about working with elderly populations. At Johns Hopkins they developed a serious of arts activities that medical students could do with elder people. They began by surveying the medical students to find out about their attitudes about older people. They also asked how much of their practice they thought would be devoted to caring for older patients. The response was low.

After engaging in a series of art related activities--for example, doing each other's portrait, visiting museums--there was an 80% increase in students wanting to work with older populations. *"So the arts can be a marvelous way to break some of these stereotypes, whether it's about the elderly or it's*

about different populations. When you think about Native American cultures, often the spiritual leaders are also people in the arts who can really help us understand different cultures. There are a lot of different ways that the arts can help us to communicate better and to listen better."

But there is always the issue of resources

Moving on to more pragmatic barriers to these marketing campaigns, another attendee brought up the issue of resources. She pointed out that when it came to addressing tobacco, there was a huge infusion of funds from the tobacco settlement. Even then, she added, it was a real fight to get states to use those funds for prevention and cessation programs.

Another enabler was making it a political issue, so all of a sudden awareness was raised across the board. In considering where there might be resources to mount the kind of campaign we are discussing, she ticked off the different stakeholders. Business leaders don't have a lot of resources to invest in marketing campaigns, as they are trying to get on top of health insurance costs. In healthcare, hospitals and physicians are also struggling with other financial demands for investment. Schools should be a natural ally, but for the most part haven't dealt with vending machine and unhealthy food issues because of contracts that provide revenue. She concluded by asking if others had any thoughts on how we might tap resources in order to create sustainable marketing campaigns.

Wikoff used the opportunity to pitch the affordability of the arts, as a tool. *"[People in the arts] are used to doing so many things with nothing that you are going to get a lot of bang out of your buck. Also the arts can help attract new money to the table." He added that many people who support the arts do so across the board, and would also support arts activities in health care settings as a way to tackle some of these issues. "There are ways in which we in the arts can help raise the dollars."* Another important point he made is that the ability to evaluate and measure that is resident in health care is critical to demonstrating that what we are doing is making sense. He concluded, *"I think we all have a lot to learn from each other and I do think that there are resources available."*

A participant highlighted the problem of misaligned incentives in health care as a barrier to accessing the necessary resources. *"What's the incentive for anybody to invest in these things because the people that are going to pay the money are not the ones to get the benefit. The benefits of long term investments in major cultural and social change accrue to the society at large, not to any individual stakeholder, not to an individual business, not even to an individual sector of the economy….so the investment needs to come from the society as a whole."*

He went on to say, *"I don't think that right now there is a recognition that public sources are paying the majority of the healthcare costs in the country. Most people think that we have a private health care system. We need to make people understand that the public is paying these costs and the public should alter the incentives so that the public gets some benefit….We can get into a lot of debates about exactly the mechanism but there has to be an alignment between who's spending and who's reaping."*

Hutchinson concluded the discussion by offering his perspective. *"The problem [of resources] is a real one, without a doubt. I do, however, find that government, and increasingly companies, are attracted by new ways to communicate. I think some of the success that we've had in Euro-bandits is simply because we are showing Europe in a different way. Many of the British Home Officers have come to charity kickers because they're trying to reach, in this case, young lesbians about drug misuse. The big agencies haven't been able to reach that audience…… So, I think they are attracted if you find new ways to approach old problems."*

Professor Garfield! Reaching Kids through Edu-tainment

Jon Comola

The Garfield comic strip is the most widely syndicated comic strip in the world, with a daily readership of more than 260 million! This 'special session' will describe the plans for an exciting, unique and inspired educational Internet web portal, Professor Garfield. 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. Larry Smith, with Ball State University, will describe the University's partnership with the Professor Garfield Foundation, then Bob Levy with PGF will demo the site.

Larry Smith, PhD: Professor of Elementary Education, Ball State University

Thank you. Bob and I are pleased to have been invited here today to share with you what we believe to be a very exciting venture. Jim Davis, creator of Garfield, and his staff have created the Professor Garfield Foundation (PGF), a non-profit joint venture between its primary partners, Paws Incorporated and Ball State University. The venture will be strengthened through partnerships and alliances with additional content providers, for-profit companies, philanthropic organizations, local, state and federal agencies and other organizations. The purpose of PGF is to provide free learning programs on the internet to children in order to help them improve their learning.

The Professor Garfield Foundation was formed in 2003 in order to provide children, parents and teachers with an opportunity to support and enhance classroom learning with new and innovative ways, while having fun. PGF takes everyone’s favorite feline from entertainment to edutainment, an idea that Jim Davis has nurtured for over 20 years.

Although created with the blessing of Paws, Garfield’s parent company, the Foundation is an entirely separate entity and is not in any way affiliated with Paws Corporation. Paws merely provides legal permission for use of the character in this independent corporation, the intent and purpose of which is establishing a portal for children, parents, mentors and educators to a free and enjoyable pathway to learning.

A major source of viability for Professor Garfield is the pivotal role that Ball State plays in this. We have 950 faculty, 20,000 undergraduate and graduate students, and are a Carnegie research level one intensive university, with areas of excellence in telecommunications, digital media, entrepreneurship, teacher education, computer science, architecture and planning, music technology, wellness, bio-technology and nano-science.

Named one of the nations 20 most wired campuses by Yahoo Magazine, Ball State has few peers in technology. The University’s expertise and long tradition in teacher education will ensure that Professor Garfield provides effective curriculum and is pedagogically sound. It’s commitment to state of the art telecommunications and computer technology guarantee smooth, reliable and straight-forward delivery of the website service. Thus, the partnership between Professor Garfield, Paws and Ball State University guarantees that academic legitimacy is coupled with an entertaining format.

The foundation has been set for a revolutionary educational experience for children. The initial target market is kindergarten through eighth-grade students who are interested in improving their essential skills and knowledge while having fun. A secondary market is elementary school teachers and school

districts which are interested in using this as a supplement to their curriculum. Another market is parents of elementary school children who are actively engaged in the development of their children's reading, writing and learning skills.

The competitive advantages of Professor Garfield include its interactivity, its colorful graphics and game formats, the popularity and notoriety of Garfield the Cat, and the fact that the program offerings are fun and free of charge. Most important, research has demonstrated that through the use of technology, children learn better than they do without the use of technology. Our studies have shown that low achieving students can do as well or better than average performing students when they have good technology programs that allow them to have ample practice and to progress when they have mastered a concept or skill and that provide immediate feedback without public humiliation.

Several educators at Ball State became very interested in investigating the effectiveness of technology in the classroom because of the significant gap in learning among children. For example, children between the ages of 6 months and 6 and a half years who come from homes where language and reading are not valued, may not have more than 200 to 300 hours of language-rich activities when they enter first grade. In contrast, children who come from homes where reading is valued and encouraged are likely to have more than 3,000 hours of language-rich activities. So, how do we address this major gap? We try to use technology. If reading and language arts are taught for 2 hours a day in first grade, that equates to 360 hours of instruction.

What about health? The typical elementary school will split health and science. So if health is taught 90 days a year and is taught for 45 minutes a day, and I'm being generous, that equates to 67.5 hours of health instruction a year in an elementary classroom.

We believe an attraction for educators and parents will be the site's reputation for program quality. This reputation will result from the content development, research and assessment that will be conducted by Teachers College at Ball State.

The initial funding for the venture will come from money raised through local, state and federal grants and philanthropic organizations. In-kind contributions and financial support by the primary partners and content providers have already been contributed to the venture in the amount of $4,000,000. Additional funding will come from private foundations and partnerships and strategic alliances with supporting organizations that will benefit from association with Professor Garfield.

The financial sustainability of Professor Garfield will come from continuing fund-raising activities. Sustainability will also come from alliances with for-profit organizations that seek exposure for their association with the venture. Some funding will come from contracts with additional contempt providers or other organizations that will benefit financially from a relationship with Garfield.

At this time we have some excellent partners, such as Pearson Digital Learning, Charles Schwab Learning Foundation, Scholarship America, NASA, Tom Chapin Children's Music. At this time we do not have any partners from your industry, which is one of the reasons we are here today.

We estimate that by the end of 2005 or early 2006 our operation will be receiving 2,000,000 unique users and 14,000,000 website hits per day. The estimate is further supported by Garfield.com site that delivers content to the comic strip. Garfield.com today has over 12,000,000 page views and approximately 2,000,000 unique visitors each month, all without a single investment in marketing dollars.

Our services can be viewed by anyone on earth with an internet access. The challenge is to entice people to visit Professor Garfield and to discover the various offerings the website has. The free access to all users of the website, the unprecedented portfolio of educational modules, the updated materials and the world-class graphics and illustrations make it extremely likely that this challenge can be successfully met. The art, story and logic found in the creative and educational aspects of the learning modules combined with the state of the art technology and continuing website updates and maintenance ensure frequent visits by all targeted patrons. It is the goal of Professor Garfield to add new educational modules and strategic partnerships during each quarter.

This amount of visibility for an online education website will be second to none. However, Professor Garfield Foundation will not become complacent and rest solely on the Garfield brand for gaining market presence in on-line education. Part of Professor Garfield's strategy is to reach educators through everyone surrounding them. For credibility and visibility among the chief constituency, which is teachers, Professor Garfield Foundation will actively seek endorsements of key education groups. These are the people teachers trust and respond to and can be easily located and reached. Ball State has a long history of excellence in educational research and the training of elementary and secondary teachers and we will play a critical role in developing the assessment tools that are so important for ensuring that the website is effective and educationally sound. With the help of the university, Professor Garfield will also have a growing presence at National Education conferences.

At this time I'd like to introduce Bob Levy, who will show you some of the modules that we are creating for Professor Garfield. Thank you.

Bob Levy: Director of Education and On-Line Initiatives, PAWs, Inc.

(Presentation slides are available for downloading from www.wrgh.org.)

This is an image of the Paws headquarters. It truly is a magical place teaming with energy, excitement and creativity. I've been there for about 5 years. We have a staff of about 60 people and they range from animators, artists, web developers, to sculptors, radio technicians, and TV production crews. Hiding in the background here is Jim Davis, the creator of Garfield the Cat.

Garfield is the largest syndicated comic strip in the world. The comic strip is published in 2,600 newspapers and has 263 million readers a day. It is translated into 28 different languages, published in over 110 countries. We've sold over 140 million books and this current year we released a motion picture through 20th Century Fox that's grossed over 195 million so far this year. The DVD sales are probably close to 100 million on top of that. As you can tell, the movie has been very well received by the public.

One of the reasons why I'm here is that our company has a long history of assisting with educational initiatives and literacy. The timing seemed right to do something on the Internet because we have so much presence on-line and we think we could make a difference. In working with these various online initiatives we have been exposed to a lot of very high profile partners. One of these partners is Ball State University, one of the leading teachers colleges in this country. If you look at this slide, the other partners that are working with us are also very influential organizations.

Health care education is not being addressed sufficiently in the public school system or at home. We feel that we have a platform that everyone in this room could leverage to address health care initiatives. The methodology that we use for websites includes have 5 key ingredients for success: to entertain, to empower, to enlighten, to inform and to inspire. Most websites that kids go to have some of these traits.

But if you have all five ingredients, you have a powerful formula for success and you could really change the landscape of the online educational platform on the Internet.

If you ask ten people what's the most dominant website for learning on the Internet, you'll get 10 different answers. There's a lot of good websites out there but there's not a KEY site that's really setting the standards. That's what we would like to do. This is very similar to the landscape as it was when Sesame Street started in the 60's. There was some educational content on TV, but Sesame Street totally revamped the way people look at education on TV. We think that we have that same opportunity now.

Our projected date for launch is the beginning of second quarter of 2005. To me it's thrilling because two years ago it was just a concept, a dream of several people at Paws and to see where we've come in these past few years, it's astounding.

Video of Jim Davis drawing Garfield: *"Pretty fast, huh? Well I'm not always quite that speedy. In fact, sometimes it takes me a long time to come up with an idea, it's all part of a little thing called the creative process. You also go through the creative process when you're handed a pencil and a blank piece of paper. What are you going to put on that paper? That's what it's all about. That's what I do for a living. I'm Jim Davis and I'm the creator of Garfield. You know what, I have the greatest job in the world and it all started when I was a young boy. When I was a kid we didn't have video games and computers for entertainment. I mostly relied on books and my imagination. My mom would hand me a pencil and piece of paper and tell me to entertain myself. My first drawings were pretty bad but I got better with practice. And somewhere along the way I discovered it was fun to make little pictures and put words with them. So I decided to be a cartoonist and then one day as I was staring at a blank piece of paper I drew a cat, a big fat grouchy cat. I called him Garfield because he kind of reminded me of my grandpa, James A. Garfield David, and the rest as they say is history. I hoped you like to learn to draw Garfield. Tell you what, I'll teach you to draw Garfield. Deal? Let's go."*

We also have a section on the screen for the hearing impaired and you can click on this link and you can have closed captioning for every one of the videos. The next section I'm going to share with you is from Pearson Digital Learning.

(KB Kids Video playing)
We feel very fortunate. Pearson Digital Learning gave us close to 1.5 million dollars worth of content for this section. We have about a 120 different modules in this section each month. It's categorized by grade level. The content is comprised of math, language, science and social studies. I'll play a couple of them so you get a sense of the quality of this.

(Spark Top Video playing)
This section is sponsored by Charles Schwab. Charles Schwab had dyslexia when he was growing up and his children also suffered from dyslexia. This entire module is devoted to children with learning disorders and dyslexia or, another way of saying it, children that learn a little differently.

Regarding health care, we are looking to you to identify the important areas that you feel you could use as a platform for health and wellness. What we've created is a simulation game on health and wellness. Children can go into the kitchen where they can learn about nutrition, by creating a healthy pizza; whether you put lard on the pizza, pineapples, olives or whatever.

We have a teacher and parents section. We also feel it very important to have an offline component to this health and wellness section. Ball State has a wonderful 'Fit Kids' program that's been around

for about 10 years and we can use this as a model.

We have a section dealing with oral health where you can talk about the importance of brushing your teeth. This is geared towards a younger child. It could be geared towards an older clientele as well. This was set up for second to fourth graders.

Larry Smith from Ball State alluded to the traffic that we get on our website, which is quite substantial. Ball State is also a pioneer in on-line interactive education. Ten years ago they started the Best Buy Electronic Field trip program. They work with many of the largest teaching organizations in the country and have established an infrastructure that is second to none. They hold 4 to 5 different field trips a year, and get about 5 to 11 million children to participate in each field trip.

Having this established infrastructure will certainly help us get the word out for Professor Garfield. We think there is a wonderful opportunity to really make a difference in teaching children online in a fun new way!

Keynote: High Impact Tools for Health Promotion

Marcia Comstock

We are truly honored this afternoon to have with us the 'Father' of probably the most widely recognized 'Behavioral Change' model, Dr. James Prochaska. Dr. Prochaska is Director of the Cancer Prevention Research Consortium and Professor of Clinical and Health Psychology at the University of Rhode Island. His name and work is internationally known and quite familiar to all of us who have ever taken a psychology course. We are especially grateful that he was enthusiastic about addressing this group, despite the fact that a hectic schedule necessitates that he fly back tonight on a 'red-eye'. I think that is true dedication! Please join me in welcoming Dr. Prochaska.

James Prochaska, PhD: Director, Cancer Prevention Research Consortium; Professor of Clinical and Health Psychology, University of Rhode Island

(presentation slides are available for downloading from www.wrgh.org)

Thank you very much. For me, the arts are the source of my inspiration and the sciences are the source of my validation so it's a treat to share this stage today with the arts. Now I have 30 minutes to help you change, so hold on to your seats.

We've known for decades that the major causes of chronic disease and premature death are behaviors like smoking, alcohol abuse, unhealthy diet, sedentary lifestyles, stress and the list goes on. In spite of that knowledge it did not lead our health care systems to treat these behaviors seriously. More recently it has become well known that over 50% of all health care costs are due to these behaviors. Compare that to 10% due to pharmaceuticals. And yet pharmaceutical costs are a part of the presidential election. We are starting to get health care systems to start treating these behaviors more seriously but still we are way behind.

A year ago in Chicago, I met with medical directors of 35 of the nation's largest health care systems. I asked them three simple questions. Where does most primary care take place? They debated for a bit and then they quickly agreed: at home. Who provides the most primary care? Again they debated for a

bit and then agreed: when an adult it's the patient; when a child it's the parent; and when an elder it's the daughter. And what is the majority of primary care? Again, they agreed, it's behavior. Then I asked them, what is the quantity and quality of behavior medicine that you send your patients and populations home with to either prevent or manage chronic disease? Again they quickly agreed: the quantity is typically zero and the quality is typically awful. Then I asked them, why are we having such crisis in our health care systems? You simply cannot not manage over half of your costs and then expect your industry to be in good shape. So one of our messages is: if we don't like the way that our patients are behaving, if we don't like the way our employees are behaving, if we don't like the way our population is behaving, then we have to start by changing our own behavior, and that starts with changing our minds.

The mental models of behavior change that have dominated our society for the last century have been action-oriented models. We think of behavior change occurring when somebody quits smoking, when they start to exercise, when they begin anti-hypertension medicine, when they begin to lose weight. So for a century we've developed action-oriented programs. For example, when managed care offers action-oriented smoking cessation clinics for free, removing price as a barrier, the percentage of smokers who participate nationally is 1%. When our tobacco settlement dollars went for free quit lines that smokers could use at home, they were based on the action model of behavior change and I analyzed the RFPs for four states. They budgeted for 1/4 of 1% of their smokers to call each year. With tools like that, we cannot impact the major killers and the major cost drivers of our time.

I will share with you a model of behavior change that was taught to us numbers of years ago by ordinary people. A thousand Rhode Islanders let us follow them for two years. What they taught us was not in any of the 300 theories of counseling and behavior change. What they taught us was that change is a process that unfolds over time and it involves progress through a series of stages.

You'll see that we don't throw out all that we learned about action but rather we integrate action as one of these series of stages. We start with the pre-contemplation stage. This is a stage in which people are not intending to take action in the foreseeable future, often misunderstood as not wanting to change. In the past we called this part of our patient population, non-compliant, not motivated, resistant to change, not ready for our health behavior change programs. We now know that it was us who were not ready for them. It was us who were not motivated to have our health promotion-disease prevention-disease management programs match their needs, rather than expect them to meet our needs.

People can be in this stage for numbers of reasons, such as a sheer lack of awareness. For example, there are millions of Americans who are couch potatoes, who are in pre-contemplation, who cannot imagine that their couch can kill them. The head of our health department in Rhode Island who uses this model was asked by channel 6 for a 30 second spot that could impact on health. She said run this story: *"Man killed by couch, details on the 6:00 news."* She knows how to work with the media. People can be in this stage out of demoralization. Millions of Americans have tried to lose weight too many times and in too many ways. History clearly says they want to change but they become demoralized about their ability to change. So when we go to reach them, what do we say to them? *"A new brief weight program for those who are demoralized about their ability to lose weight."*

When we wanted to reach out to the smokers who are in pre-contemplation, we ran a new announcement: *"New self-help program for smokers who don't want to quit smoking."* We got flooded with requests. And that was replicated in Canada as well. We need to be able to speak the language of these folks and understand where they are at, rather than say, *"we've got another action-oriented program for you."* Why would they possibly do that? They would only fail on that kind of program. We'll see that

people underestimate the benefits of quitting or changing, over-estimate the costs of changing and typically don't realize that they are making that mistake. If we are going to help them to progress, we're going to need to give them feedback that they won't be aware of in terms of their decision-making about their own behavior and their own health.

We'll see that once they progress into contemplation they become more aware of the benefits of changing but they often see an increase in the cons. For example, if I'm seriously intending to start losing weight in the next six months, which would be the definition for contemplation, my pros would go up but also I'm more aware that I may have to give up some of my favorite foods. I may feel deprived. I certainly have to risk failing and that can lead to profound ambivalence. Is it worth it? Is it not? Should I put it off? Should I keep progressing? The average American makes the same New Year's resolution three years in a row before they finally take some effective action. And we're coming up to New Year's again. And we have new solutions for those folks other than to fail. The most common New Year's resolutions are all about health.

Once people progress into preparation they are convinced that the benefits outweigh the costs. Their number one concern is when I act, will I fail? And that's a realistic concern because across chronic behaviors like these, the rule of thumb on any single action attempt is relapse rather than sustained action. One thing we need to do is prepare them for action. For example, the average smoker will think the worst will be over in a few days or a few weeks. Biologically, the worst is over in a few days. Behaviorally and psychologically, it takes about 6 months of sustained effort. So one of the ways we prepare them is to think of this as the behavior equivalent of life saving surgery. If you were going through life saving surgery, would you give yourself 6 months to recover? Would you let others know that you're going to need support and that you're not going to be at your best? That is the kind of prioritizing we need to help them to make it through this most demanding time.

Then as they progress after 6 months into maintenance, we need to prepare them for the number one reason why people are likely to relapse. What do you think that is? Most people would guess stress. We think of it as distress. Times of depression, anxiety, loneliness, boredom, stress. These are the times that we are at our emotional and psychological weakest. And how do average Americans cope with times of distress? We eat more junk foods, drink more alcohol, smoke more cigarettes, take more over-the-counter drugs, under-the-counter drugs. We are a society that copes with emotional distress with some form of oral behavior. So we say to our populations, what's a healthy form of oral behavior that can get you through those distressing times? The answer is talking. We've known for decades that talking or social support is one of the best buffers of stress. So we say who do you have to talk with? Especially with men, who's your intimate? Because many men don't have an intimate, we need to help them find support.

You'll see we try to give people three good choices on each behavior change principal. So besides talking, what's another good way to coping with stress and distress that entire populations can access or at least lots of people? Exercise, right? Recent studies comparing exercise with Zoloft showed outcomes on the Beck depression measure were parallel for changes in depression. The third choice would be some sort of relaxation, whether that be prayer, deep muscle relaxation, yoga, meditation—some way of letting that stress and distress go. What is your plan, because it's going to hit. It's going to hit all of us. How are you going to get through those tough times without going back to unhealthy behaviors?

Now let's quickly apply this to five aspects of intervention. Managed care puts a great deal of emphasis on outcomes and I think appropriately we want evidence-based treatments. We want evidence-based behavior medicine, health promotion, disease prevention, just like we would with medications. But what I say to leaders of managed care is, what difference do outcomes make if all we reach is 1/4 of 1% or 1%

or 5%? We need to start with our reach. One of the reasons we turn to mass media and we turn to social policy, for example, when we go to deal with these kinds of health behaviors on a population basis, is because these population-based interventions are designed to reach entire populations.

Our 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. We proposed to NIH to take and reach out to 5,000 smokers, a representative sample of all different ages, economic groups, and ethnic groups, to offer them a new self-help program. Wherever they were at, we could work with them. Using a traffic light as a metaphor—red light not ready; yellow light getting ready; green light ready—ready or not we can be of help. We were able to recruit 80% of those smokers. The Surgeon General's report of 1994 said forget teenage smokers. They will not participate. We went into schools with multiple behavior programs and recruited over 80% of ninth graders from 22 high schools. That's now been replicated in primary care with Kaiser. When they reached out to teenage smokers they recruited 65% of those smokers. With multiple behavior changes, we'll see those who are the highest risk and highest cost people. We reached out to parents of teenagers who were participating in the program at school. Certainly being a parent of a teen is not the least stressful time for making lifestyle changes. We offered them programs for multiple behavior change programs, and we recruited 84%. We solved that problem. We can have a quantum increase in our ability to reach at risk populations with what we know historically have been our most efficacious treatments, which are individualized and interactive communications.

Why historically do we reach so few? Because even with smoking, the number one public health problem for 40 years, the percentage who are prepared to take action is typically less than 20%. So when we are socially marketing action-oriented programs, we market to a relatively small segment. It doesn't mean that our public health campaigns haven't made a difference. If we looked at statistics from Germany or China we would see that over 70% of smokers are in pre-contemplation and less than 5% in preparation.

When we reached out to a population of alcohol abuse students on campus, the number one health problem on campuses, we were able to recruit over 70%, and they looked like smokers in China. Less than 5% were ready to take action and over 70% were in pre-contemplation. Once we recruit high percentages, will we retain them in our health enhancement programs? Because the skeleton in the closet is across all types of health behavior change programs, we typically have 50% or more drop out quickly and inappropriately. In some areas like weight management it's typically 80%. In alcohol addiction fields it's typically 75%. But that's not unique to behavior medicine. With most of our biological medications, what's the continuation rate across most categories? Actually it's about 50%. So it's a similar kind of pattern there.

I'm not going to have time but if I did I would show you that the number one predictor of who drops or who discontinues is what stage are they at. Because they are typically at a place where they are going to fail. If I'm in pre-contemplation why stay here? It's not going to work for me and one way of saving face is to drop out. What we do is deal with what stage they are in and we try to help set goals that would be realistic for them. We can assess what stage they're in typically in five easy questions and then we can match our behavior medicine to their stage rather than insisting that they match to our program. We set goals and a realistic goal is to help them progress one stage in a brief interaction. That they can do. That can counter their demoralization. That can give them intrinsic reinforcement.

Once we set that goal, what do we see? There is a remarkable meta-analysis across over 50 behaviors:

you name your behavior, it's on here. From 9 different nations, over 60,000 people, over 7 different languages and it shows principles of progress. Clearly in pre-contemplation the cons of changing outweigh the pros. But if you use RAW scores you would see that with smokers the pros would outweigh the cons. This is not a fully rational conscious decision-making process. We need to recognize that when we go to use decision-making we need to use sophisticated models. Last year in economics who won a Nobel Prize? Two psychologists who spent their careers demonstrating that economic decision making was not as conscious and as rational as we would like to think. If that's the case, than imagine health decision-making and how that is. So we give people feedback that they're not aware of about how they are underestimating the benefits of changing. Then we need to see those pros going up because if they are not, it's like not seeing the cholesterol coming down, not seeing the hypertension coming down. It means our behavior medication is not working. Then look at that ambivalence in contemplation. Is it worth it? Is it not? Should I keep progressing? Should I put it off? Once in preparation clearly the pros outweigh the cons and it continues to separate as they go. Now what if a physician takes and pressures a patient to go on anti-hypertensive medication, who came in ambivalent about this? How much side effects could that patient tolerate without being thrown into a negative balance that the cons clearly outweigh the pros? Somebody in preparation could tolerate more of those cons like cost and side effects. Yet every day physicians prescribe medication without recognizing that they are also prescribing behavior medicine. Are you prepared to take this pill every day for the rest of your lives? They don't deal with that. And fifty percent discontinue medication and there is a significant percent that don't fill the prescription in the first place.

Okay, moving ahead. There are pros and cons to physicians practicing behavior medicine. We've reached out proactively and recruited eighty percent of primary care physicians in all of Rhode Island. We found they were as ready to take action with their smokers as the smokers were ready to quit. Not very. What's the number one reason why American physicians as a rule do not practice behavior medicine? Time is number two. Not trained? It's worse than that actually. Reimbursement is number 3. They don't care. Two-thirds of American physicians have come to believe that their patients either cannot change their behavior or will not change their behavior.

If somebody tells you behavior science really doesn't know a whole lot, tell them this truth. We know how to produce noncompliant patients and demoralized physicians and we do it every day. Here's a real case. An obese, sedentary smoker with alcohol abuse and high stress, diagnosed with Type 2 Diabetes. His physician with all good intentions says, *"You have to take and test your blood glucose twice a day. You have to take your medication twice a day. You have to change your diet, start exercising, lose weight, quit drinking, quit smoking, and lower your stress. Good luck."* Right?

Change gets more complicated but we can work with that. Consciousness raising is the next process. What we relied on mostly in the past was education. Information, medical education, health education, diabetes education and nutrition education can start the change process but cannot sustain the change process. Certainly education is a necessary condition, but not a sufficient condition. Dramatic relief is arousing emotions and then relieving those by being able to go toward action. Fear campaigns can start change but cannot sustain it. Certainly important though because these are folks who are stuck, these are folks that need to help be moved out of that stage. Environmental re-evaluation. How am I changing to effect my environment, particularly my social environment, and not just myself?

Here's the California mass media campaign, an important part of the success there. We were flown in overnight to consult and the head of the Los Angeles Agency kept saying, *"I cannot believe that a thirty-million dollar campaign in California is being driven by ideas from Rhode Island."* I didn't take that as an insult.

Here's an example of what they created. A man clearly in grief, saying, *"I always feared that my smoking would lead to an early death. I always worried that my smoking would cause lung cancer. But I never imagined that it would happen to my wife."* And then on a screen, *"50,000 deaths a year due to passive smoking."* Thirty seconds, three sophisticated change processes: consciousness raising -- 50,000 deaths a year in the US due to passive smoking; dramatic relief, you can reduce that fear, you can reduce that worry by moving towards quitting; environmental evaluation, how it helps others as well as self; self-liberation, this is a process that the public calls willpower. Can we increase willpower? Yes. One of the ways we do that is give them choices. You give people only one choice and willpower won't be as strong as if we give them two. For example, talking and exercise. If we give them three choices their willpower will be even stronger. Four doesn't add anything so we always give people three good choices if they are available.

Self-evaluation. How do I think and feel about myself as a passive person? For example, a lot of couch potatoes look at joggers and see them as road hazards, a public nuisance. And who would want to become one of those? So with our mass-media people and with our artists and all, 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.

Okay, moving ahead. Reinforcement management. People expect to be reinforced for changes much more that they will be by others and that starts to make them wonder was it really worth it. I thought quitting smoking was the most important thing that I could do. And my average friend or acquaintance takes me for granted after two reinforcements. We need to help them to reinforce themselves much more. In the area of weight, we used the process creatively. When a women is looking to use weight and she has a teenage daughter, for every pound that the mother loses the teenage daughter gets ten dollars. You want social support? You want social monitoring? Teenagers love to parent their parents. Why do we do that? Who has a healthier diet? Women with children or women without children? With a representative sample eating fruits and vegetables, it was absolutely clear. The biggest odds ratio was if you have a healthier diet you don't have children. More education, income, age, didn't matter nearly as much. We concluded that children are a major risk factor for the family diet.

Helping relationships. Somebody who cares, somebody who understands, somebody I can talk to. All health professionals know how important that relationship is, but we need to see if they have those available outside the office as well.

Counter-conditioning, substituting healthy alternatives for unhealthy alternatives. Here industry is helping us. For example, substituting the patch for smoking, substituting no-fat foods for high-fat foods, giving us more choices that we can offer to our population.

And then, stimulus control. Reengineering the environment in order to evoke healthy responses, removing stimuli that evoke unhealthy responses. For example, one of the things that the arts can do for us is let's put art in the stairwells. Why do we put art on the horizontal floors? We want people to walk the stairwells. Let's put something that will draw them there. Here is a low-cost, proven stimulus control in prevention. Put music in your stairwells and you'll see a dramatic increase in walking the stairs.

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. Americans tend to rely too much just on will power, as an example.

I would like to show you how we take and put this together in tools that we are using in entire

populations. Basically, it's assessing people on each of these processes. What stage they're in, what are the pros and cons, which of these processes you over-utilize, under-utilize, or utilize appropriately. We give them feedback and then at follow-up, we give them more feedback. *"Congratulations. You progressed two stages since we last interacted. That means that you've about tripled the chances you'll be free from this behavior in the next six months."* We guide them through the stages, what they are doing right, what mistakes they are making.

Let me show you one of our trials. This is our first one, and we compared it not against 'no treatment' or placebo but against the American Lung Association's best practice in the literature. We used stage matched manuals, which we have for all types of behaviors including multiple behaviors, plus the computer feedback. Here our best practice is only three computer feedback guides over a 6 month period. Then we added in the fourth group, four pro-active counselor calls. Smoking cessation was the goal. Here are our outcomes. Let's focus on the top two. At the end of six months, computers alone and computers plus counselors were tied. After that the people had no access to either computers or counselors. Notice who leveled off. The computers kept going, our counselors got depressed, and our computers told them to seek social support. Notice also, that the further out you go the further apart they get. When we went to first publish this, our reviewer said, "This has to be wrong. Everybody knows when treatment is over, things go downhill." That's an old paradigm. This is an indication of what we want, that is, people to be empowered, people to be proactive about their health, not people to be dependent on us as professionals, but to keep moving ahead on their own. Our counselors said, *"Give us a second chance."* One of the advantages of counselors is they can learn from clinical experience. They changed their protocol. They felt they were putting too much pressure on people in contemplation. They were right.

At twelve months they were outperforming the computers alone. But then they dropped off and the computers caught up. One hypothesis is that people can become dependent on counselors just like they become dependent on nicotine. And one thing that we would look to do is to fade out the counseling the way we would fade out nicotine.

Now, who will do better, those that call us for help or those who we proactively reach out to help? Same treatment, three computer guides, and a manual. Look how similar the results are. We are significantly better with the reactive, those that call us for help, but proactive has more impact because we reach many more people. One of the things that we need to recognize is that most of us health professionals are socialized to practice passive reactive medicine, to passively wait for patients to come to us and then react. The problem is, passive reactive medicine is appropriate for acute illness. When people are acutely in pain, acutely distressed, acutely sick, they will seek help. But with these major killers, they are typically not in distress yet. They are not sick yet. And we need to think of these as silent killers the way we've learned to think of hypertension. We need to learn to socialize healthcare professionals to be proactive the way they are with hypertension and to reach out to help and not wait for someone to come to them.

Who will do better? Those populations where we treat a single behavior like smoking, or those where we treat multiple behaviors, like smoking and diet and other behaviors? When we treat smoking alone, we typically get about 25 percent abstinence at long-term follow-up. This was the case with adolescents when treating three behaviors. So we had no loss in efficacy for smoking, but what about the other behaviors? With diet, we had 35 percent go from high-fat diet to low-fat diet. With limiting sun exposure to prevent skin cancer, we had about the same amount. So we can treat multiple behaviors and be as effective, but we can have greater impact on health and health care costs.

Now, it's not that we can do anything. At the same time that we used computer-based interactive

programs to treat four behaviors in primary care patients at home, we had two years of primary care counseling to intervene on these same behaviors. Mammography screening was the fourth behavior. With this type of interactive computer-based program, we showed significant impact on all four. With two years of primary care counseling, we showed no signal whatsoever of any change on any of the four behaviors. So it's not like this is easy, but it can be effective.

Some people think these are just for middle-class and privileged populations but populations don't need to have computers. We can take and assess them through the mail, over the telephone, at the physician's office, or at work. What we have shown is when we look across large populations, African American smokers are 7 percentage points higher in their quit rate than Caucasians. When we look at diet, our lowest education group was the most successful of all the education groups. I believe the problem is partly that we tend to stereotype populations. I think the other big problem is lack of access to quality programs and effective programs.

With our school-based programs we know who we are competing against. We're not competing against teachers, we're competing against MTV. So we add art and multimedia capabilities. One of our most recent multimedia programs was violence prevention, an area that is overlooked too often by our healthcare systems. Certainly the number one daily worry and concern in schools is bullying. We went into 25 middle schools and high schools across the country. About half the kids were eligible for free lunch. We predicted that we would get 30 percent going from participating in bullying to not participating. We got that in middle school and in high school we got forty percent. We produced four times as much success in the treatment schools as we did in the control schools.

What are we seeing in this brief presentation? 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.

What was our goal for this 30 minutes? It was to help you progress one stage. If we did that our time was well spent. Thanks very much.

Q&A

A psychologist queried Dr. Prochaska about his views on evidence-based treatment. *"Your comments about population-based methodologies and treatments that affect entire populations have a lot of implications for a broad definition of evidence-based treatment rather than a narrow one."*

Dr. Prochaska referred to an article he has just written, saying, *"Efficacy trials tend to go with homogenious populations. For example, if you are doing a smoking cessation trial, you rule out anyone with mental health problems or who's not motivated, as measured by those studies as not ready to quit the next month. So we get national criteria for treating motivated smokers. We have multiple treatments for those folks. But there are no evidence-based treatments for the majority of people that are not prepared to quit and no evidence-based treatment for smokers with mental health problems, even though we know in our society today that 46 percent of all cigarettes are bought by people with mental health problems. If we were a just society, we would have taken the tobacco settlement money and had 46 percent go for mental health services, including smoking cessation, because smokers are paying the biggest part of that tax. We need to go to effectiveness trials. We need to go to trials where we include people with multiple behaviors, include people with mental*

health problems. We need to include people who are not prepared, because that's who we treat most of the time. Healthcare professionals don't have the kind of exclusivity that researchers have. We can't leave out those who aren't ready, those who have comorbidities, those who have other kinds of complications. Part of the problem with our pharmaceutical industry is that they recruit the most compliant people that they can find. Then those who don't fill the prescription or discontinue the prescription are a major problem for them. Yes, we need to change our science as well as our practice. I used to think science drives practice, but I'm convinced that practice drives science all too much."

A business representative raised a question about Dr. Procahska's comment on the cross-over after 12 months between counseling and the internet, as interventions to reinforce the right behaviors. *"Were you differentiating between counseling support for chronic illness and prevention, or did you kind of lump them together?"*

Dr. Projaska pointed out that except for the bullying prevention program, most of what he reported was not done on the internet, partly because they didn't want to only have people who had access. Furthermore, it is combined paradigms that are most effective. *"Internet is wonderful for individualizing and interactive, but it is a passive modality. We need to have someone proactively reaching out. And that's one of the things that I think primary care is incredibly designed to do, or could do. Most primary care is designed to do diagnosis and prescribe. So, physicians can do the diagnosis and prescribe the kind of behavioral medicine that would be indicated for a particular problem that their patients are facing."*

Another participant asked a question about reaching discouraged primary care physicians. *"Would we have to go and knock on their door and put them into 'computer counseling?'"*

Dr. Projaska replied, *"Michael Goldstein, who works for the Sierra Institute and is a wonderful physician, proactively went out and recruited primary care physicians. We showed that it not only changed their behavior but it ended up changing their patient populations' behavior as well. One of the things we have to do though is to give the same kind of feedback that we give our patients. 'Congratulations, your patient has progressed one stage. That means we have almost doubled the chances that they will be taking effective action next month.' There was a wonderful study of 50 counselors working with 1,000 patients where they gave the counselors feedback after three sessions on what stage the clients were in. Their motivation and the quality of the therapeutic relationship markedly improved and they reduced negative outcomes by 50 percent. But half the counselors didn't want feedback! So there will be barriers to that."*

A participant brought up implementation of the CMS Chronic Care Improvement Program, stating that some of the pilot sites will be announced soon. *"This will be population-based disease management and secondary prevention. They will be responsible for the health of an entire population. Do you have any reactions, any kind of lessons learned that you might want to see applied in that program?"*

Dr. Projaska described a couple of relevant trials. *"We had two population-based trials on disease self-management, one in Canada and one in Hawaii, one with 1,000 and one with 400 patients. We showed the same thing, smoking 25 percent abstinence, diet higher than that, and self monitoring of blood glucose was another one of our targets. If the [CCI] demos are not using a combination of paradigms, they're going to have low impact. It's predictable. You have those who say, 'Look, people can't change their behavior, people won't change behavior, why invest in those kinds of programs?' Because they haven't been designed for populations, they've been designed for individual patients."*

A consultant to business pointed out that Dr. Prochaska gave some very impressive recruitment numbers, as compared with what the norms are. *"Were incentives used in getting 80 percent of the people involved?"*

He answered, *"We did not use incentives but principles that we did use included: 1)You have to be proactive, you have to be able to reach out to them rather than wait for them to come to you; 2) You have to let them know that wherever they're at you can work with them; 3) You have to make it easily accessible, not require them to go to a clinic.*

We're faced with an epidemic of overweight and obesity, and most of our science is action-oriented and clinic-based. Yet, marketing and research shows with overweight and obese Americans, less than 5 percent want clinic-based or group-based treatment. Over 50 percent want home-based treatment. We need to take that seriously. We need to make our programs match what people want, where they're at.

Now, when we go to the internet, I think we're probably going to have to go more heavily with incentives. We just got a grant from CDC where we're going to be crossing three types of recruitment strategies against three types of treatment, and those vary from email to regular mail. We then add incentives, then a personal call, and we are measuring impact. Recruitment and retention historically were seen as scientific research problems, not as intervention dimensions. We now are making them into intervention dimension, in order to increase our impact. We know much more about recruitment and retention than we ever did before because now we're treating them as interventions."

Another participant cited the growing interest in consumer-driven healthcare, where it may be possible for a compliant diabetic or asthmatic to share in the savings to the employer. *"How does that factor into your models and what do you see as the future of behavior change with financial incentives built into healthcare programs?"*

Dr. Projaska expressed some caution. *"I think the second generation consumer healthcare, where we don't just incentivise them, but we also provide them with the tools they need to be able to live healthier lives, has tremendous potential. There are a lot of tricky things about use of contingencies and we need to be aware of how incentives work and when they don't work."*

A health policy expert asked Dr. Prochaska about his top priorities for elected officials on what to do with obesity.

Dr. Projaska offered several. *"Okay. First, we have to recognize that obesity is not a behavior it's an outcome of multiple behaviors."* He pointed out that until recently we had very little scientific knowledge about how to change multiple behaviors in people. Thinking that is based on the 'action paradigm' leads to the conclusion that trying to get people to change more than one behavior at a time is overwhelming. But that is too simplistic. Many individuals who come in to weight loss programs are in 'preparation' for a change in diet. They may also be in 'pre-contemplation' for exercise. *"We need to take and deal with it as a multiple behavior change." Second, we need to take and present these [behavioral changes] for all the benefits that they present, not just for weight….With exercise for example, we know over 50 scientific benefits, weight management just being one…If we want to see those 'pros' going up, if we want to see people staying with it, we need to help them to appreciate just how many benefits that they are getting. Third, we need to reduce the 'cons' by making more home based programs available at affordable rates. Fourth, we need to invest in these problems in a way that we haven't before…. we've got the science, we've got the technology, we have the professionals…."* He pointed out that, in his opinion, a lot more could have been done with the tobacco settlement dollars, had efforts been more proactive. He went on to say, *"I don't buy that we don't have the dollars."* He does believe that we should focus on more than weight. *"Our participants love the fact that we are …not treating [them] as fat persons. We are saying 'we care about your bones, we care about your brain, we care about your immune system, we care about your sleep, we care about your stress, we care about your depression. We*

care about your family as well.' They get treated as fat people often enough. We want to treat them as whole people."

A foundation executive asked if there was any research on stages of change in populations, or *"cultural sea changes."*

Dr. Projaska replied that not nearly enough work has been done on that area. While in most cases organizational leaders have plenty of time to work through the pros and cons of a change initiative, they tend to impose the action on their people. As a result, the number one reason why organizational change missions fail is not financial. *"It is employee resistance to change, because leaders do not 'bring them on board.' They don't have them participate. They don't respect where they're at and help them move ahead."*

In looking at tobacco control policies across six nations, the least restrictive had the most support, namely education, and the most restrictive had the least support. *"But, the further along the people were in the stages [of change] in all six of these nations, the more they supported those tobacco control policies."*

Dr. Prochaska does believe we can prepare populations for social-level interventions. He thinks one of the reasons they have had such success with the bullying prevention program is that everybody was included. *"We include the bully, we include the victim, we include the passive bystander and we say to them, you may not be part of the problem but you're certainly part of the solution."*

He emphasized that by moving entire populations, we can also impact things like norms and culture, but cautions it will require *"multi-level interventions. I'm focusing here on individual level intervention but certainly social marketing is a very important at the social level and policy is a critical part as well….but it amazes me how often we [create] policy with all too little evidence."*

TUESDAY, DECEMBER 7, 2004

Ian Morrison

Let me provide a couple of observations from yesterday. First of all, I thought John Peters picked up on my sweeping generalizations unencumbered by experimental data and actually gave us the real science behind it. What John pointed to is the powerful forces that are creating an opportunity for bad behavior amongst the public, and we're going against economics of the industry and genetics, as well as powerful biological forces. And if we're going to go against that, we're going to have to be pretty sophisticated.

The important message from Ken Keiser's observations was that one intervenes in the area of tobacco, as he was explaining, by being sophisticated and aggressive in social marketing. But let's not lose sight of the fact that there was a source of money for all of this, namely, the tobacco tax. I think in our thinking going forward, we've got to be careful to figure out where the money comes from to sustain the programs. The money doesn't necessarily have to come from a tax, but it's got to come from somewhere, because marketing of any kind is expensive.

Marsha [Vanderford] gave us the CDC perspective, which is a huge opportunity. I know that a lot of my friends in the public healthcare community think marketing smells of commercialism, and business is anathema to the public health community. That's a problem because they and we can learn from each other.

I was also educated by Liz Scanlon [Senator Frist's office] because, as I said in my opening, my natural tendency is to tax the hell out of Iowa corn farmers. She pointed out to me that there are few Iowa senators and congressmen who are in powerful communities. So, it just shows you my lack of understanding of Washington.

When we moved into the area of social marketing, I thought the big message was to know your audience and talk to them in their language. I think Tommy [Hutchinson] is a force of nature and we should give him U.S. citizenship. It amused me that the kind of smart profanity that his organization engenders would be completely politically correct in our current age.

Nobody mentioned the New York Times magazine lead article this weekend on buzz marketing, which is a very powerful new way in which corporations are causing people to change. Your neighbors who recommend things are 'plants,' not paid plants, but voluntary plants who are promoting products that they enjoy. This has become a very powerful way for corporations to market products, particularly in technology, but also in the consumer products area.

I think Andrew [Holtz]'s observation that people are anecdotal creatures is very wise. There has to be a balancing act between science and the ability to touch people by telling stories. And there's a theme that comes out of Naj [Wifoff]'s presentation. The 'arts' is an unattended opportunity for us in health care to move people, because healing is not only about the medical process, but also a spiritual one. Naj pointed out that arts can be very powerful in the healing process, but the people who need the healing are not the people in the hospital. Nobody is in an American hospital for a more than about a half hour. In California we do drive-by everything. I had spinal fusion surgery and I was in on a Monday and out Tuesday at Stanford. My wife had laproscopic gall bladder surgery and she went in at 11am in the morning and was home at 3pm. There's no time for a symphony in that 4 hours, right? The people that need the help are the caregivers. He also pointed out that the

arts are affordable, ubiquitous, and creative, which is more than we can say for most of us in health care!

A theme I took from all of yesterday was the theme of children as an opportunity for social marketing and as an agent and an action item. I was at a meeting with the physician at Kaiser who is responsible for their obesity program. He made a very powerful statement to our group, which was, *"This current generation of kids will be the first generation of Americans who live less long than their parents."* Now, whether that's true or not is another matter, but it's a very powerful statement, because we in America believe in progress. We believe we have the best health system in the world. That's not true. We certainly don't live as long as the French or the Scotts or the Greeks. The Greeks are the ones I like, because they spend nothing on their health care system and they live forever. I think it's because they swallow olive oil and frolic naked in the Mediterranean.

This point about kids as agents of change is important. A lot of people in the social marketing business point to the fact that children can have an enormous impact on parent's behavior, not just the other way around. The Garfield story is amazing. It is a remarkable platform, and the opportunity is certainly something all of you should consider.

I think it was really great that we had the 'father' of the field, Dr. Prochaska, talk about the science and evidence behind behavior change. What I got from his talk is let's base this stuff on the scientific principles that are known to work. I think there is a tendency when you get into 'let's make us all healthier', to focus on a few half-baked ideas based on a powerpoint from a flaky consultant like me, rather than on true science.

So in the spirit of looking for action items going forward:

First, what is the burning platform that's going to cause us as a society to get on to this issue? A lot is being made of the unsafe nature of the food supply. Burger King could sell an Al Quaida burger, which is basically botulism and 1400 calories, and then people wouldn't eat it. So maybe it's motivation through fear rather than greed! That isn't a serious suggestion, but …

The second thing is this notion of a design for consumer engagement on behavioral change based on science, based on the best evidence of how to do that. And constructive engagement amongst, not only consumers, but also the media, the private sector, and the public sector, like CMS. We have an opportunity because of the chronic care experiments are built into the Medicare Act.

I come back to what I said at the beginning of my remarks yesterday. It's not about one actor. It's about a lot of actors working together. So I think we're laying out a series of perspectives, and then trying to find a way for those perspectives to work together. Does that make sense?

Keynote: Capturing Growth at the Intersection

Brock Leach: SVP New Growth Platforms & Chief Innovation Officer, PepsiCo

(presentation slides are available for downloading from www.wrgh.org)

Good morning. I hope you had your Tropicana orange juice and your Quaker Oatmeal this morning, because you know breakfast is important to healthy weight management. It's one of the keys. We have the science behind that, as a matter of fact.

This is really an honor for me to be with you today. I've only been here for about 16 hours, but the fantastic group of people I've met make me want to come back.

As Monty Python would say, *"now for something completely different."* I'm going to approach this subject with a different lens, the lens of the food industry, and in particular, the lens of one company, PepsiCo. I think you're going to see that I will complement some of the behavioral things that Dr. Prochaska talked about last night, which was fantastic. Instead of coming at it from a science point of view, we come at it from the trial and error, down and dirty world of marketing. But you'll see that some of the same ideas bubble up from both directions. His is a much better articulated version than mine, but you'll see that it triangulates a little bit.

I'm going to present what is essentially a PepsiCo case study, knowing that it is not the entirety of what's going in the food business, but it's a relatively competitive business and people don't share exactly what they are doing. I chaired the GMA (Grocer's Manufacturers Committee on Food, Strategy and Health) and most of the leading food companies – the General Mills, the Krafts, the Nestles of the world – are taking the kind of approach we do at PepsiCo. There are a few that are very much playing defense, but they're increasingly in the minority. I'm going to talk about an example, and I think you'll find some of the themes play out across the industry.

The first thing to say, for those of us who have grown up in the food industry, is that obesity is the largest issue we'll ever face. But the flip side of that, 'wellness', is probably the largest opportunity to add value that we've ever seen. It's bigger than anything we've ever run across in the food business. Companies are running at the opportunities, some in less than great ways, but everybody is running at it. They see it as a way to differentiate themselves, and a way to add value. For that reason alone, I think that the private sector in the food industry particularly can be a meaningful part of the solution. The question is, how do you corral all that energy? How do you get consistently constructive? At the end of my presentation, I'll talk about my ideas for doing that. So let me just launch into how we see the world.

This is market research. It's embarrassingly simple minded, but when we look at opportunities to add value in the food business, we really are dealing with three big things. We are dealing with the fact that the population is getting more diverse. This diversity in age, in ethnicity, and in income is really creating differences in how we go to market. There are Wal-Mart consumers and there are Whole Foods consumers, and designing products for those consumers differently is something that even large companies like ours are starting to do. Time pressure is nothing new, that continues unabated, and health concerns are right after that in terms of opportunities to add value. Partly due to obesity, partly due to aging, we can see a shift in prevention happening in food purchasing behavior. You can see that obviously on the Health Foods channel. We can even see it in our own business, which I'll show you in a second.

So we look at opportunities to grow our business and we focus on how you provide different products for different life stages and look at how you bring even more convenience. But in particular, how do you intersect those two things with what is a growing demand for wellness? So when we start with the obesity epidemic, we start with the really simple idea that there is an answer. And the answer is energy balance and it's nothing new to anybody in this room but the challenge is that there is no universal prescription for energy balance, such that individuals can figure out how to do it for themselves. This leads us to the point of view that the solution is partly creating a better environment. We need to create healthy product choices people really want to use, and market them in ways that motivate people to adopt healthy lifestyle habits. The only way to do this is to reach people where they are with the tools they can use to accomplish the change.

So is the food industry as a whole doing that right now? Do you see that beginning to happen? Yes. Now, a lot of people would say PepsiCo health and wellness is like a nonsequitor, explain that to me. I want to give you a little case history about our business.

Today in North American about 40% of our business is from products we call 'better for you' and 'good for you.' Better for you are things that are made healthier because we reduced the calories, the sugar, the fat, the salt, etc. Good for you are those things that are made of essentially healthy ingredients: Quaker oatmeal, Tropicana orange juice, Aquafina water, Lipton-tea, a lot of those kinds of things. Today that business is about 40%, but it's growing about 2 1/2 times the rate of the rest of our business. It was 60% of our revenue growth in the first half of this year. Is there a business case for health and wellness? Absolutely there is. And by the way this is not this year's phenomenon. If you look at if over the last 3 years you can see those trends have continued to escalate.

Interestingly, it hasn't come at the expense of what we call our 'fun for you' or 'indulgent' business. In fact, if you look at other examples, like the quick service restaurant business, if you offer a full spectrum of choices, people are more loyal to you in general. McDonalds, with their premium salad program, has turned around their business performance to the point where they are having their best quarter in 17 years. They are not only selling more salads, they are bringing more families in for a complete spectrum of choices. Subway proved that 3 years ago. We are seeing it in our business. The people that are buying our healthier products are buying twice as much of our total products. We are meeting a larger share of their requirements, so there is a competitive rational.

A quick plug for PepsiCo. We have the three best brands for nutrition from a consumer perception point of view: Quaker, Dole and Tropicana. Gatorade is number 7. We also have a share rational for pushing part of our business because we have share leadership in a lot of these categories. So our focus is on providing healthy product choices and marketing them in a way that motivates healthy lifestyle habits.

Our unique spin on that is, how do you make it easier, more fun, more accessible, more exciting to consumers? That's what we know how to do. Taste is obviously critical, but we also know how to make it fun. So that's what we are working on. I'm going to give you an overview of the kinds of things we are doing right now, which are very similar to what a lot of major food companies are doing.

About two years ago we decided we wanted half of our new products to come from 'better for you' or 'good for you' and we've vastly over delivered on that in the last couple of years. Right now in our pipeline, as of last week, three quarters of our projected revenues for the next 3 years in new products will be 'better for you' or 'good for you' new products. We have major successes and launches in every one of our new divisions. Things like Gatorade Propel, our largest beverage introduction last year. Things like Quaker Breakfast Squares, all the nutrition of instant oatmeal in something that you can take on the road with you. Tropicana Light and Healthy, a big introduction this year. Every one of our divisions has had a lot of success.

One of my challenges is to figure out how to take things like lean proteins – we call it added value proteins: fruits, vegetables and whole grains – and put it in convenient forms, like chips, bars and beverages on the go. Believe it or not we can do that. We've set about to improve the healthfulness of the existing products.

The largest change that we've made was to go into our whole portfolio and remove trans-fats. We took 55 million pounds of trans-fat out of the American diet in one move and I think we're the first company

to have finished that work. It cost us 15 million bucks. A lot of people ask how that is in our business interest. I said we looked ahead and it will cost 500 million dollars if we don't deal with this now because the science is compelling. I would also say that in the last 6 months, we think it's led to an improvement in our base trends. People have become more aware of trans-fats and are starting to pick foods that are reduced in trans-fats.

We have gone to the extent of putting nutrition standards in place for what we call 'smart choices,' and it is having an effect on how we develop products. We are demonstrating that you can sell portion control because people are willing to pay for the convenience of portion control. We're selling a packet of 8 oz. cans that is the same total ounces as our traditional multi-pack of cans of soda. We're charging a slight premium because the packaging cost is higher, but we can't keep it in stock because people are thinking, *"I'd rather have a Pepsi and keep it controlled to 8 oz and I'll pay a little bit of premium on that."* Same is true on the snack size. Instead of selling 12 oz of chips in a bag we're selling 12, 1 oz. bags in a bag. Women in particular like that, because they think, *"I know what I'm eating, I can control it, I can meter it out."* And again it's working. We were one of the first three companies to voluntarily go to total calorie labeling as the FDA had recommended on all of our single serves.

We're doing a lot in schools, because we think that at the end of the day that's where the solution has to begin. We're a fairly big player in schools. We sell beverages and we sell foods. So we've been focused on how we get healthier products available in schools. We're introducing school specific products. An example is called Sobi Synergy, which is 50% juice, filtered water, Splenda, and fortification. It is lower in calories than 100% juice, with more nutrients. The same is true with something called Quaker Milk Chillers which taste like Nesquick but have 130 calories in a 12 ounce can. We put 17,000 Aquafina vending machines in schools last year.

We've also instituted a new set of school marketing policies. We've said that we don't believe that we should be selling anything but our 'better for you' and 'good for you' product choices in elementary schools, largely because kids don't have choices in elementary schools. Most of the products come on a lunch tray anyway. So we're saying to food service customers, put our healthier choices on the trays. In high schools we advocate for choice in the machines, but we say that we'd like half of our vending slots and half of our ala carte placements to be our 'better for you' and 'good for you' products, and we are pushing to emphasize those products in school marketing. And we are doing a lot to promote healthy kids lifestyles. We do a lot of stuff with sports, and we have supported behavioral programs with different institutions.

But probably the largest thing we've done is becoming a national sponsor of America On the Move, which, as you know, is all about energy balance and making it easier. Our particular wrinkle on that is taking the energy balance into elementary schools. We have just introduced this fall a curriculum that is called Balance First, which introduces simple ways to eat better, simple ways to be more active, and the concept of energy balance. We are actually over-subscribed with 3 million kids this fall. We also just struck a deal with Discovery to take it to all middle schools next year, through their schools distribution channel. Finally, we've done a lot with school decision-makers, particularly with people in food service. We are out advocating a program called 'Health is Power'.

These are just some of the things we're working on with regard to new products. Most of what we've done this year is consistent with the need to help people with energy balance. We're still working across all of our businesses on taking fat out and sugar reduction, but also adding positives like nuts and fruits and proteins and fiber. You may have noticed that Splenda is out of capacity because a lot of people are using that ingredient because it performs well.

Here is an example of what I think is to come. How do you take essential healthy ingredients and make them more convenient? This is a product that we've just put in place in Whole Foods. In a test in 26 stores, the first week it blew us out. This is a reflection of the fact that consumers are actually dissatisfied with fresh fruit. If you ask people why they don't eat more fresh fruit, part of is accessibility. Often it doesn't taste as good as it looks. If you get an apple in an airport you're not sure who sneezed on it.

So what happens if you design a product that consistently tastes great, that is 100% fruit, all of the fruit fiber, all of the fruit nutrients, packaged for convenience and cleanliness and hygiene? You have a winning idea that people are willing to pay a little bit more for. Tropicana Fruit Integrity is an example, and so far so good. It's an indication of what I think is possible.

One of the best things we did is realize we didn't know anything about health and wellness. Over the past 2 years, we have been building an advisory board of people from all points of view, obviously a lot of people from the medical community, but also people from government, US and internationally, and people from the fitness side of the equation. We've asked them to tell us what to do before we hear it from the outside. And we pledge to listen. Out of these conversations come a lot of the changes I just talked about, like the trans-fat change. They are forcing us to deal with things that we might otherwise have noticed but not had to confront. One of the first things they said was *"you're doing great things but nobody knows about it. How do you take this story to consumers? How do you have an impact on consumers?"* And the suggestion was, *"why don't you get your chairman on the tube talking about how you care about people?"* We did not think that would give PepsiCo much credibility, because most people don't know who we are. Most people think we're Pepsi. They don't know the brands we have.

So we embarked on a process to promote our identity with our healthier products. But in doing so, we stumbled across the important idea of identifying healthier choices for consumers in a way that makes it easier for them. There is an enormous demand for this. It's about demonstrating to people whether they are in preparation or contemplation or whatever, that it is not that hard. It's an incredibly empowering message.

The result of that work is something that we call 'Smart Spot', a little green dot that says *"smart choices made easy."* Those words were heavily tested and were found to be compelling. We are in the process of installing that symbol on all of our 'better for you' and 'good for you' products, a 6 1/2 billion dollar portfolio of products. We tried all kinds of schemes when we got into this. We tried movie star rating schemes; we tried traffic light schemes, red, yellow, green. We tried all kinds of things. Consumers said *"just get me to the healthier choices and then explain it." What happens with this is that on the front you will see the green symbol and on the back you'll see a panel which says "Tropicana Light and Healthy is a smart choice because it has half the sugar of regular orange juice, one of over 100 choices from PepsiCo. If you want more information visit smartspot.com."*

At this point we've done 20 focus groups, 4 quantitative studies, the last one with 1600 people, and we've heard over and over again the same themes. Consumers said *"keep it simple, keep it optimistic, do not tell me what not to do but encourage me, keep it real, if you're going to do this cut to the chase, have a one liner that says what is it about this product that makes it a good choice and be honest about that and completely straight forward. And then if I want to get more information allow me to do that."* This is how we got to smartspot.com. In this case, the idea that there is a wide range of products is hugely empowering to people. Moms said this is a set of products my family will use. The fact that there is a range makes it easier. If we could expand it beyond PepsiCo products, by the way, it would be even better, but we're introducing it in the context of our products and are in the process of putting it on all of our packaging. We are demonstrating that this concept can work.

This is just one ad for oatmeal: *"It's a delicious way to help lower cholesterol. It's a family tradition that warms you all over. It's the smart spot, the symbol of smart choices made easy. Find it on Quaker Oatmeal, proven to help lower cholesterol in just 30 days. Part of a healthy diet. One of over 100 smart choices from PepsiCo".* We have a series of these ads that run across our whole portfolio that we're breaking in right now.

We are also getting ready in February, back to back with our Super Bowl event, to do our first ever PepsiCo wide retail event around our 'smart spot' products. We have all 16 of our largest customers lined up to do this, which is almost unheard of. We're going to run a 2 week Super Bowl event and then, beginning February 6, we're going to run a 'smart spot' event that will feature all these products. As part of it, we're going to have a national insert in 15 newspapers that will introduce these products as part of a healthy lifestyle and on these displays we are going to have pamphlets that introduce some basic tips for getting started, including getting enrolled in America On the Move, healthy eating tips, etc. We have no idea how this is going to work, because we haven't test marketed it, but the customer demand was such that we decided to give it a whirl and, hopefully, there will be more to come. The 'smart spot' products are what we are going to feature in our school programming.

As you can imagine, if you're a company like ours, and your doing what is the first ever cross-brand marketing effort on any subject, it's subject to a lot of scrutiny. So we've been through an immense amount of research on this. One of the things that was most compelling is that all people saw was the symbol and the explanation on the back panel, and we asked them if they would be any more likely to purchase these products. 50 to 60% of consumers said that they would be more likely to purchase. In consumer research that's amazing. More amazing to me was that there were almost no negatives. My rule is in any market research is 10% of it will be negative. If I say, *"I'm going to give you 5 million dollars,"* 10% of people are going to say *"no, there's something up, I don't want it."* This is a case where we didn't get that. So know we're on to something here and we're going to keep working it until we get it right. Obviously to do this you have to be credible, so we have a huge range of products.

Internally we had a lot of debate about doing a lot of things that could qualify for health claims. It's nice that we've taken trans-fats out of Doritos, but that doesn't make it a health food, it makes it a better indulgent food. A lot of our organic products are just natural, they are not necessarily 'better for you'. We have low carb products, some of which are 'better' and 'good for you', and some of them are just low carb. So, we went through the process of saying, it has to be real, it has to be either truly good for you or truly better for you. And we have to be transparent about that on the back panel.

One of our nutritionists had great wisdom. She pointed out that 3 nutritionists can have 5 opinions. So we went to the National Academy of Sciences and the FDA for our standards. We use FDA's definition of healthy, although we added two enhancements from the National Academy of Sciences. One is a 'no trans-fat' requirement; the other is an added sugar cap. These requirements are not currently in the regs. Our standards require a 'functional benefit claim', which would be an FDA quality claim, or the product has to be better for you, meaning it has a 25% reduction in one of these ingredients [fat, sugar, salt]and not otherwise 'worse' to qualify. We've vetted this with activists, government, and the National Academy of Sciences. So far everybody is saying, *" yes this is directionally making sense."*

We're introducing right now what we would like to be a consumer lifestyle portal. It's not all the way there yet, but it's up and running and you can look at it. We want it to be more like a point by numbers thing, where you come in at whatever stage of behavior change you are in and find the information that you need. So we're evolving, but it has all direct tools, including our nutrition standards.

Our advertising campaign is in full swing. We're going to reach 90% of moms, and 75% of them will see the message three plus times. We just announced yesterday a deal that I'm really proud of with Discovery Communications. Part of that is going to be Discovery in our 'smart spots' productions. They are going to run PSAs across all six of their channels. For example, at 3:00 pm they will run a healthy snack reminder for kids after school across all of their channels for 30 seconds. They are designing it, *"brought to you by PepsiCo."* Similarly, healthy breakfast messages will run primetime.

So what we're doing is bringing together all of our health and wellness efforts in the company—our consumer efforts, our customer efforts, and our first ever health professional campaign.

Coincident with this, about 10 weeks ago, we launched 'Health Roads' which is a web MD powered system for all of our domestic employees. This is really a great tool. It's about individualized communication. We have 60,000 US employees, and we've had 20,000 people sign up. We paid them $100 to fill out the health assessment. Of the 20,000, 6,000 were identified for some kind of intervention. 65% of the people we called agreed to participate in a program, which says that there is something to this idea of individualized intervention. We figured that we'd have to do it inside of the company as well as outside.

Just some thoughts to leave you with. Being a marketer, I think the challenge in this behavior change is how do you get consistent messaging delivered with scale? I offer a couple of different ideas.

First, you make the communication consistent, simple and encouraging and absolutely unavoidable. What we do in marketing is call it vertical integration. We want the same message to appear everywhere you go.

One thing I'm really excited about is that the American Diabetic Association, American Heart Association, and the American Cancer Society have begun to talk about how they could collaborate to ensure consistency of basic message. I was talking to them about the 'smart spot' idea and they asked if we would be willing to share it with other companies. The answer is yes, if everybody has the same standard, absolutely. They asked if this is something they could take on. I'd love it, I'd love it.

Having power house organizations 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, positive encouraging messages to get people started is really important. If we can get the language consistent, a lot of people in the food industry would be willing to support that, I can tell you. They all have an interest in seeing this problem get solved, because if it doesn't, they end up taking the blame. Promoting simple interventions, even if they're not the Holy Grail solution, makes sense. We think America On the Move delivers the message and gets people started.

One of the things I think that needs to be done is to build consensus around the elements of an ideal school environment, in a way that could be translated to an individual school district or to state legislation. Right now what's going on in the states is a huge amalgam of different things. Some of them are interesting but ill-conceived. Some of them are really well thought through, but it's all over the map. For a company like ours it'd be a lot better if there was some consistency and we're doing everything we can to promote any kind of convening around what a healthy school environment would look like. I think the IOM report that was recently issued was great, although it stopped short of a policy recommendation.

Finally, we desperately need to figure out how to pilot lifestyle solutions for African-American and Latino consumers in urban environments. I'm talking about that not only from the point of view of public

health interventions, but from the point of view of product marketing. We're a company that's out there selling a lot of products in the inner-city. We have a store delivery system. We drive routes in the city. We offer all of our products. But our healthier products are not necessarily the ones that sell. So one of the things we're doing is try to figure out how to pilot marketing that delivers the right messages and moves the business. We'd like to do it in conjunction with lifestyle interventions, so we're thinking about how we can pilot some comprehensive studies. We're thinking about Washington DC or the Bronx, or places like that. I think that encouraging the food industry to participate by developing healthier products, by figuring out how to market them more aggressively, and by laying out a framework that's positive and encouraging will have tremendous impact because of the resources that can be applied. I think too much of the discussion leaves the food industry on the outs, unfortunately. So my message today is, I believe with real active partnerships, big change can happen.

Q&A

In response to a question about the value of the Professor Garfield Foundation in reaching kids with health messages, Leach enthusiastically supported the creative approach. But he emphasized the need to look at messaging in the classroom and at home, and not rely solely on a *"cluttered web environment….I love the idea and the way it's executed, but I think it needs to be hooked to…. a curriculum in the schools. It needs to be hooked to a way for parents to participate."*

A participant said he was impressed with the 'smart spot' campaign, but wondered how much something like that costs. Leach acknowledged the high price tag. *"We're going to spend,[about] 20 million bucks, when you put all the moving parts together."* But PepsiCo's 'smart spot' business is 6.5 billion dollars and growing at 10% a year. So it is not hard to find a lot of cash to invest in things that work. He said, *"…our philosophy is we'd rather be betting on the proactive side of this than on the defensive side."*

A journalist ask Leach how he tries to reach people who are concerned about school lunch programs and vending machine contracts and *"who see you and other companies like you as the great Satan and the enemy to be defeated."*

Leach pointed out that the contracts are actually through independent bottlers (distributors,) who do not always have the same philosophy as PepsiCo, which is that schools are customers and should be provided with what they want. Increasingly they want 'smart-spot' products and sometimes that means contracts have to be renegotiated.

Perhaps more germane, according to Leach, is the fact that only one percent of total caloric intake for adolescents comes from vending food. *"So focusing on vending legislation alone is not going to begin to address the problem of childhood obesity, and it can create the illusion of false progress. What we need to be doing is putting together a comprehensive program…."* He went on to point out that PepsiCo is just as happy to sell water and Gatorade and juice as to sell Pepsi. Furthermore, vending products are a revenue source for school districts, and if we legislate change that reduces this, we need to identify alternate revenue streams. *"They [school districts] make orders of magnitude more than we do. Like, 10 to 15 times more than we do in schools."*

A participant commended PepsiCo, as a mother of small children for some 'better for you' products that her kids now ask for. However, picking up on the statement that companies will sell what schools want to buy, she pointed out that kids are incredibly influenced by marketing. *"Can you talk about how much is being spent on 'smart-spot' in comparison with how much is being spent overall in the industry to market*

potato chips, or soft drinks, or whatever. To me, it is the tip of the iceberg and it seems like it's not enough."

Leach agreed it's probably not enough, but it's a beginning. *"I will tell you right now we are disproportionately marketing our healthy product lines --- which are almost 40% of our business. We spend more collectively on that than we do on the balance of our portfolio… Our internal marketing practice guidelines say that we don't market directly to kids under the age of 8….."* According to Leach, PepsiCo also spends 50% of the marketing budget for kids over 8 on their healthier products. *"I don't think the solution is to ban marketing to kids [below] a certain age. I think the solution is to market things in a way that's attractive to them. I use Gatorade as an example of a brand that's gone from being 200 million dollars in 1985 to being 2.7 billion dollars, by marketing healthy lifestyles to teenagers and young adults. It's about aspirational athletic performance….So I think marketing can be part of the solution."*

A consumer advocate said *"I guess I'll be the voice of dissent in the room. I'm 51 years old, have had a family for the past 27 years, and have specifically stayed away from the aisles where your products are sold, along with many others. I don't wish you any harm, but as a consumer advocate, one of the things that I've noted over the past at least 20 years, is that people have just begun to eat more of those products which are identified as 'healthier' for them. I don't think this is the answer to the obesity problem….as much information as you put out there about how to eat these things, I just don't see the public getting it."*

Leach responded, *"I don't think it's the whole answer. I think it's part of the answer, and I think there's a difference between label claims on individual nutrients and a system that helps people identify a set of choices. There's a huge cacophony of information on labels. But I think the idea is to figure out how to help people cut through it to make consistently healthier choices. What we're doing is a prototype, and the science involved will evolve as well."*

A participant pointed out that a state like Arkansas is now doing BMI's and may be ready to do something else. He asked Leach if 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. He emphasized that *"You've got to shape [all facets] of the environment."*

Leach replied, *"Absolutely. The challenge for us is to find the things that we can participate in that look like they can get to scale. But we are very much interested in that. That's why I think the IOM report is a good place to begin, because what they have expressed is a pretty good comprehensive agenda. It just needs to be dialed one level deeper to answer the question, how would you actually implement this at a school level."*

Another participant said she was intrigued by the term *"'make things unavoidable.' I can understand how you can do that in a supermarket, but how do you do that in the larger world?"*

Leach explained, *"I'll just use a marketing example. If we introduce a new product, we take one time frame, and we marshal all of our resources across all of our mediums to make it unavoidable in that time frame. So you'll see it on TV, you'll go to the grocery store and see the same message, you'll see a billboard at the same moment. We may not support it beyond that time window, but we'll make the messaging absolutely unavoidable for that period of time.*

If you applied this to public health, how do you get consistency of messaging? Can you create a product choice scheme, like 'smart-spot,' that is consistently applied across products? Can you get messages down to a couple of points that could be reinforced in school curricula and in product marketing and in the home and in certain interventions at the local level—like America On The Move? I think it can be done, it's just a matter

of the people who know most about the right messaging getting together to help coalesce it.

But we're talking about huge amounts of money, and I don't think it's at all possible unless industry really comes to the table. They are the people with the money and the marketing savvy to make that happen. To get them there, we need a coalition of people that are willing to support what the right messaging should be. That's why I think the three 'Americans' [ACS, AHA, ADA] have a chance at doing that, because collectively they can really bring some power to the forefront … in a way that a lot of the food industry could get behind."

Another participant asked Leach to differentiate between 'better for you' and 'good for you' in terms of 'smart choice' labeling down the road.

Leach acknowledged that the issue was a source of a lot of debate with the board. Although differentiating between the two classifications was tried, consumers found it too complicated. They wanted a 'one-liner'. This has been addressed the back panel of the product with a separate box that says why the product is a 'smart choice'. For example, Diet Pepsi is a smart choice because it has 0 calories, 0 carbs, 0 sugar. Baked Lays is a smart choice because it has 1 _ grams of fat. It says Oatmeal is a 'smart choice' because if you eat it for 30 days, it will lower cholesterol. He concluded, *"So it's very clear language on the back panel. It was simpler to do that than to try to differentiate on the front panel with star systems.…But we are very conscious of the fact that Diet Pepsi's not the same as Tropicana Orange Juice. And we've been careful in our explanation to point out that."*

Jon Comola

I want to thank Brock for his candid and very insightful presentation. We all should consider our options. The dollars allocated to public health messages will always be overshadowed by the marketing dollars available to companies like Peps•Co. Isn't it smarter to exploit the enormous opportunity that would come from leveraging the expertise and resources of companies like PepsiCo to help us move a program forward that will address lifestyle issues like diet and exercise, and at the same time ensure the profitability of their business? The point is to suggest we consider, maybe for the first time, a way in which we could begin to partner with food and beverage companies to encourage them to pursue profitable business models, while supporting our social responsibilities to community health. So, Brock, thank you very much.

Session III: Public and private sector models from here and abroad

Marcia Comstock

In this session, we will hear from private and public sector leaders in the US and abroad who have successfully launched and operationalized models which have had positive impact on individual, organizational and community health, through a focus on health promotion and other preventive strategies. Whether inside corporate walls or within the environment of a community, the most positive change only occurs by design!

Wolf Kirsten will begin by providing an overview of efforts in countries from Europe to South America. Tom Kottke will describe Cardiovision 2020, a community-based initiative in Minnesota modeled after the successful experience in North Karelia, Finland. Then the panelists will provide different perspectives on behavioral change in specific settings: Laura Simonds will tell us about American On the Move, Ted

Borgstadt will describe efforts to promote behavior change in a corporation, using the Prochaska model, then Agnes Hinton will talk about the importance of community health workers in reaching culturally diverse populations with prevention and behavior change messages.

Wolf Kirsten: CEO & President, International Health Consulting

(presentation slides are available for downloading from www.wrgh.org)

Good morning. I want to start with saying thank you to Marcia and Jon for inviting me to speak at this session. I am very glad to be here. We three got to know each other about nine months ago and began exchanging ideas on international healthcare reform - health behavior change in particular - and it's been a very productive and interesting conversation. I look forward to continuing the dialogue in a more formalized, institutionalized way.

What I would like to do in the next 15 minutes is take you on a whirlwind tour of the world with a couple of snapshots and examples that have been fairly successful in creating behavior change. These snapshots are from a variety of different countries.

If you talk about health, one of the major, most well known international measures is life expectancy. This map shows us where we are in terms of life expectancy, with the dark green meaning a higher life expectancy and then the further you go to red having a lower life expectancy. We see an especially big gap, or dichotomy, in terms of sub-Saharan Africa. I think we are all aware of that. And there are some other countries, like Russia for example, with a fairly low life expectancy compared to United States and Europe. But life expectancy is not the only measure, right? I mean there are many other health indicators out there.

I'd like to now draw your attention to Okinawa, Japan. This is the city where people live the longest and are the healthiest in the world, meaning they have the lowest rates of certain disease morbidity. The life expectancy is about 81.2 years, and there have been a number of studies trying to figure out why the people in Okinawa live so long and why they have such low rates of disease. As always, there are many different factors to it. The 'Okinawa Diet' has been commercialized—not unusual, this is true of many other diets—and is reported to promote longevity, but there are also many more factors than diet alone, for example, exercise habits, community belonging and spiritual beliefs. This is an on-going, long-term study which I think is worthwhile to follow.

Poland is also an interesting snapshot. Like many Eastern European countries, Poland went through major political and societal changes in the 1980's and early 1990's. During this time they also had a massive drop in cardiovascular mortality in the 20-44 age group, and to a slightly lesser degree, in the 45-64 age group. This was based on the new availability of fruits and healthy foods and on the decrease of unhealthy foods, like those with lots of animal fat. It's really a tremendous change over a short period of time. This is something to look at and learn from, that dietary changes can really improve health in a short period of time. The bottom line, however, is that this was not by design. There was no national health program that created these changes.

I look forward to hearing from Tom Kottke after me, because he will refer to a very successful program that was implemented by design, the Northern Karelia project in Finland.

Moving on to Brazil, I wanted to show that this emerging country, with major infectious diseases, also has a growing problem with obesity. About 23% of adolescents in Sao Paolo are overweight. So it is a big problem, especially in the cities.

There is a movement in Brazil to address the obesity problem called 'Agita Mundo'. Agita Mundo originally focused on increased physical activity in Brazil, then later in Latin America. It has spread internationally because of its success. Agita Mundo looks at different target groups: students and teenagers, employees, and older adults. They also approach different settings: schools, communities, and companies, who grant some time for employees to be active. A large part of their initiative is press. They have done a number of mega-events with radio and TV.

Agita Mundo uses the 'stages of change' model, and emphasizes the importance of supportive actions and a supportive environment. It has proven successful in increasing physical activity in a number of studies in different environments in the city of Sao Paolo and is now being implemented by a number of other countries. The World Health Organization is also a strong supporter.

So, research on behavior change does exist in emerging countries. However, there is no one magic formula for success. I am very glad that we talked about these issues in yesterday's session, as health promotion needs a real interdisciplinary, inter-sectoral approach in order to succeed. The success factors are: partnership, both intellectual and institutional; a clear, simple, targeted message, I think we've heard that a number of times; an inclusive approach, but focused on the target groups; and evaluation. It needs to be a lot of fun and pleasurable. I think that's really important. It also must be adapted and tailored to cultural groups. You definitely have to look at that. Brazil is somewhat like the U.S. in being very multi-cultural. Finally, have a two hats approach, that is, work with the government sector and also the private sector.

I work with a lot with corporations on wellness and health promotion programs and with nonprofit organizations too, so basically I'm in two worlds. However, I really see a huge opportunity with corporations that have a big interest in health and wellness especially for their own employees. It's prudent, and it's very important.

Moving on to Sweden. You may know Scania as a truck manufacturer. Scania applies Antonovsky's 'Salutogensis' theory as a foundation for their health program. The key factor of this theory is a sense of coherence. Scania looks at comprehensibility, manageability and the meaningfulness of a task. Here you can see the factors that Scania believe determine employee health and what makes them productive. They don't focus on cholesterol or on your blood pressure. They have wellness programs too, you can't totally exclude these, but here are the factors they think are important: pride, clarity of the goals and the results in the organization, stability, which very often doesn't exist in the corporate world today, confirmation of your work, participation in feeling good, work climate, and the relationships with your boss and co-workers. Scania says, *"let's fight ill health by focusing on good health."* This is their approach and they have done well in terms of absenteeism rates and productivity.

Moving on to a different area of the world, Singapore is an interesting case study because it shows you how important culture is. Singapore has a very structured, systematic, in some ways hierarchical approach which works very well with the population and also to some degree with the existing political system. Singapore has a national, comprehensive policy and program for non-communicable diseases. Very few countries have a *comprehensive national policy*. So, this is already a big plus. They have a health promotion board, which is part of the ministry of health, with a clear mission, resources, and committed employees. They also have a number of different awards and programs. Incentives and individual recognition are very important. The national workplace health promotion program is very innovative because they provide some seed money and grants to companies who want to initiate a health promotion program. So, financially, the Singapore government supports health promotion and then looks for a matching grant from the company.

Singapore also has a 'Trim and Fit' program in the schools and the results have been fairly positive. They've had significant smoking and obesity reduction rates. So there is some success but they still have major lifestyle issues in terms of blood pressure. I think the size of the country is noteworthy. Singapore is very small and contained compared to the US, so if you look at how to transfer certain models or learning, that is one aspect to consider. Another factor is centralization – Singapore is quite centralized politically.

Does anyone know where the highest child obesity rates are in Europe? They are in Greece. We talked about Greece earlier on and it's kind of interesting because of the touted success and healthiness of the Mediterranean diet. Southern Europe has big problems with obesity, especially childhood. Following Greece is Italy.

I wanted to mention Germany. I can't really point to a solid success model, but I think it's an interesting case study not only because I live there and it's my home country, but they have very high health care spending, though not quite as high as the US, and are trying to reform the system piece by piece. There is talk about a prevention law. Germany does not have a traditional state run system, rather it is a pseudo-state system with health insurance plans called 'sickness funds' which basically provide the majority of insurance for employees. Everybody must and does have health insurance. The sickness funds were asked by law to spend €2.70 (about $3.00) per member per year on prevention and health promotion. It's not mandatory, but they are encouraged to do it. The insurances only spent €1.56 in 2003, so it highlights where the priorities are in terms of treatment, medical care, prevention and public health spending. So it's still not at the level it could be.

Also interesting is the entitlement mentality that exists with Germans. I think this is the case with a lot of Europeans because they've had great social benefits over the years and they still do, especially compared to the US, but they have slowly been eroding one by one with the financial pressures a lot of these countries have endured and dealt with. So, at the beginning of 2004 Germany introduced a €10 ($13) co-payment if you go to the doctor once per quarter and there was a huge outcry. People have been used to co-payments here in the US for years, for decades, and for Germans it was a huge deal which underlines the existing entitlement mentality that health reformers have to work against.

Also, the issue of tobacco tax in Germany is noteworthy. Officially, tobacco tax was recently increased to improve health and decrease smoking in Germany. Unofficially, I think they tried to make a little more revenue. This is being claimed by many, it's not just my personal opinion. And what happened is 8% of the smokers quit in a fairly short time period. The government introduced this in the beginning of the year and now they are debating whether or not to continue to further increase the taxes, which was the plan, but may mean the government is going to get less revenue. It is unfortunate that health is not the main driver.

I wanted to make a point related to changing behaviors from Canada, where the focus is on the social determinants of health. They offer 10 tips on healthy living and what one should do to be healthy. It's somewhat amusing. *"Don't be poor", "pick your parents well", "graduate from high school", "attend university", "don't be unemployed", "live in a community where you have a sense of belonging", "don't live in a ghetto or near a major air-polluting factory", "learn to make friends and keep them"* are the listed determinants.

These international snapshots I've introduced this morning reflect what I believe is so important to health promotion and to behavior change and that is an inter-disciplinary and inter-sectoral approach. It's really important not only to look at health, and I believe that's somewhat the fallacy of the WHO.

The WHO has a very systematic approach when dealing with the ministries of health around the world. That's the way it is done. But if you only go to the ministry of health, you are not really getting 100% of the picture. You also need to approach and consider education, recreation, safety, business, urban planning and transportation, which all impact our health to a very large degree. I look forward to more discussion with the other panelists and the audience. Thank you.

Tom Kottke, MD MSPH: Clinical Cardiologist, Epidemiologist and Health Services Researcher, HealthPartners Research Foundation

(presentation slides are available for downloading from www.wrgh.org)

Thank you. I appreciate the opportunity to be here for many reasons. Perhaps most of all, to be in a room with fifty activists who want to do something about a very pressing problem—obesity. We talk about obesity as being 'the wolf at the door'. It is paradoxical that our wealth may bring us poverty because obesity is going to knock people out of the labor force.

Also, it is a great honor because community-based health promotion has been part of my life for thirty-one years. It is also simply great to be out here. I was biking this morning before dawn riding up Columbine Canyon and thinking, *"Well, do lions jump out of trees in the morning?"* And I thought, *"These people would be really annoyed if I didn't show up because I had been eaten by a mountain lion."*

(Voiceover/commercial message for CardioVision 2020) *"A healthy heart is one of the keys to a long life. But smoking, a poor diet and lack of exercise can lead to heart disease. Do your heart a favor: don't smoke and avoid second-hand smoke. Eat five servings of fruits and vegetables every day and get thirty minutes of daily physical activity. Make your heart feel great – participate. CardioVision 2020."*

In 1996, then-chief of cardiology at Mayo Clinic, Dr. Jamil Tajik asked me to put together a program because I had been involved with the Finns since 1973. CardioVision 2020 (*http://www.CardioVision2020.org*) is the program that we developed. It is a community self-help program produced by those who reside and work in Olmsted County, Minnesota, who act to improve their own health and the health of their families, friends and neighbors, through personal commitment and community action.

The CardioVision 2020 mission is partnering with clinicians and community organizations to develop information systems, environment, skills, and encouragement to help individuals make informed choices that can lead to primary and secondary prevention of cardiovascular disease. We emphasize *informed choice* so that we don't get labeled as 'health Nazis'. We get labeled as health Nazis anyway, but we want to make sure that the label is not justified!

We kept our message simple, focusing on the important few: 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 (LDL less than 100 mg/dl for those with heart disease); blood pressure less than 130 mm Hg systolic and less than 85 mm Hg diastolic; 30 minutes of physical activity on most if not all days of the week. These recommendations are consistent with Healthy People 2010 because the Healthy People 2010 goals are well thought out and evidence based. If your own program goals vary, then you get stuck in a discussion of, *"Why do they vary? What's more important? What's more right?"* And people don't get going on the action. Action is what we want.

To help the individual achieve and maintain the behavior changes they desire, we've defined a vision for Olmsted County: All public areas are smoke-free, no advertisement or promotion of tobacco products,

and youth are unable to purchase tobacco products from vendors in the community.

To support the nutrition goals, all restaurants provide their customers with meal analysis, all grocery stores provide product analysis for total fat, saturated fat, cholesterol and sodium. Schools offer and promote foods and beverages that meet Healthy People 2010 recommendations, and goal foods cost less per calorie than foods that are high in saturated fat, sodium or sugar.

With the physical activity vision, all residents of Olmsted County can travel safely throughout the county by foot or bicycle. All residents have access to affordable and safe opportunities for physical activity. Affordable and attractive youth activity programs are available for adults, children and adolescents. And finally there is daily physical activity at all levels in schools.

For secondary prevention, case management is available for patients with coronary heart disease, congestive heart failure or critical risk factor levels.

We hear a lot about heart disease and stroke and we ask, *"Where do these come from?"* A lot of people think that they have discovered the Holy Grail when they discover the metabolic syndrome. Well, we need to ask, like Peter Senge suggested, the five 'why's'. And the next why to ask is, *"Why do people develop the metabolic syndrome?"* The metabolic syndrome comes from the 'Lifestyle Syndrome'. The Lifestyle Syndrome is simply too many calories in, too few calories out, physical inactivity, tobacco use and exposure and, you might add, excessive alcohol consumption.

Diseases of the Lifestyle Syndrome include heart disease, stroke, cancer, diabetes, chronic obstructive lung disease, osteoarthritis, depression, and many other diseases, probably leading to sixty percent of all deaths. These behaviors are the root causes of the problem. And so we focus on lifestyle because you can ask the question, *"How can we reassure an individual who has a total serum cholesterol of 190 mg/dl, and a blood pressure of 130/80 if she/he smokes, lives on deep-fried fats, and believes physical activity is season tickets to the local professional sports team?"* I mean this is America! It is not safe!

Because it's the Christmas season I would like to give you nine lessons that we think we've learned from CardioVision 2020. There will be no carols.

I would like to first thank Rebecca Hoffman. She's an educator by training, and an activist by personality. She put the flesh on the bones of the program that I designed. The science of what to do is easy, the science is done. The science of how to do it is marketing. To be successful, you need to get somebody involved who knows marketing.

This is the risk distribution in Olmsted County. Nearly no one meets all five behaviors around tobacco, diet, physical activity, cholesterol and blood pressure, but on the other hand, nearly no one meets none of the behaviors. The vast majority of people meet two, three or four of the behaviors. Nearly all of the disease risk comes from people who meet two, three, or four of the CardioVision 2020 goals. Cardiologists are always looking for a high-risk sub population. There is none of any consequence.

We are making an impact. We have achieved program awareness. We contract with an independent research organization to do a random digit dial survey each year. We started in 1999 with a base line survey, and by 2001, twenty percent of the population spontaneously named our program. When prompted, seventy percent recognized the program after a description.

There was a huge amount of anxiety in the medical community that the program would make people

angry. But we have about ninety-five percent approval. People want these programs. If I were in corporate America, I would sit people down in focus groups and explain to them quite clearly, two things. The first is that we cannot afford for people to be sick. The second is that this is a health behavior issue and not a healthcare issue. I can tell you as a cardiologist that I cannot make up for you with my technology what you can do for yourself with behavior to prevent the disease.

About nine percent of the population reports a behavior change because of CardioVision 2020. The messenger is key to behavior change. The messenger is the message.

Let me show you a video that didn't work and then a video that did work.

(Commercial advertisement voiceover) *"Did you know that thirty minutes of exercise every day can help prevent heart disease? Did you also know that it doesn't have to be this hard. That's right. Something as simple as thirty minutes every day can help prevent heart disease. Make your heart feel great – participate. CardioVision 2020."*

Although this video spot was done by marketers, it violates all principles of communication. Unfortunately people watch the first three seconds and say *"I'm not into pumping iron, I'll go to another channel."* They never get to the tag line.

This next one worked.

(Commercial advertisement voice over) *"CardioVision 2020's Walk and Win can help you get started toward a healthier way of life."*

[Sheriff Steve Borchart speaking] *"You know it was amazingly simple. I started eating smarter, which motivated me to exercise more. As I exercised more, I lost more weight. I learned you really need to do both."*

[Voice over] *"Sign up today and you'll be entered into a drawing for two free airline tickets. Walk with a friend or get a group together and join the healthy rivalry competition. Walk and win. CardioVision 2020."*

Now we know that contests work. Kelly Brownell, Mickey Stunkard and others have documented that they work. Everybody in Olmsted County knows Steve Borchart, the sheriff, and everybody likes him except for the guy sitting in jail for making meth.

The fourth lesson is that if people are going to climb on the wagon they need to know that they can climb off. Everett Rogers calls this 'trialability'. This is why you get sample packs, why you can drive a car before you buy it, or ride a bike for a day to see if you are going to buy it. We started out asking people to take the pledge that they are going to eat five servings of fruit and vegetables, not smoke, be physically active, control their blood pressure and cholesterol. People took this much more seriously than I thought they would. And for a lot of people it was like joining the church of CardioVision 2020.

We've now gone to sixty day campaigns. There's international 'quit and win', physical activity challenges, nutritional challenges, and know your numbers. We conduct monthly media events around these challenges: kick-off events, booster sessions, and then prizes. This keeps us in the community eye.

Our goal is personal behavior change to reduce risk. This is an individual decision. We cannot keep you from eating fried lard in your hotel room. If you want to smoke a big cigar, you can do it. But those people who want to change also need environmental changes that support their personal goals. Most

people do want to live healthier. Brief campaigns and clinical interventions get people to try the new behaviors and at the same time they start learning that it is helpful to have a multi-use trail by their house and to have high quality fruits and vegetables available.

The fifth lesson is if the time line is realistic, big changes can be accomplished. I traveled to North Karelia in 1973 as a medical student. In 1972 they organized the North Karelia project and it was very simple. They had three messages. More fruits and vegetables; less saturated fats; tobacco free; and hypertension control. In 30 years they had an eighty-three percent decline in coronary mortality.

The Finns now live longer than Americans. They blew the myth out of the water that you cannot extend life expectancy any way but by reducing infant mortality. They have extended the life expectancy of women by eight years and for men by six years. And it's explainable by risk factor change. It's the traditional documented risk factors: diet, smoking, hypertension control, cholesterol control that account for the change in mortality rates and life expectancy.

Improvement in the community's health requires continuous effort, resources, leadership and marketing. You've got to keep yourself in front of the public. Otherwise you sink below the vision of the community.

And this brings us to leadership. I am happy that we've heard a lot about leadership. Leadership can either be authority or initiative. In these programs you don't have to be a cardiologist. Once again it's not about health. The health science is there. It's about community leadership. It is about somebody in the community that can take that position of formal or informal leadership. Leadership is energizing. It's biographical and it's teaching other people to be leaders. It's also being brave and breaking some glassware. You can't do chemistry if you are afraid to break the glassware.

The program needs to go where the people live and work. We just heard this from PepsiCo. When we hosted a kick-off party for Quit and Win at a community college, Becky Hoffman, worked her fingers to the bone. We had fruits and vegetables and everything else, but the only way we got anybody to show up was to drag them out of class.

When we asked Cherry Camillieri, a local chef, to cook at noon in a book store, people had to walk around her to get to their books, but it was a great hit. She cooked up a wonderful meal from the Mayo-Williams Sonoma cookbook with a little frying pan. People could smell it and they could taste it. They said *"Hey, this is really good."*

'Eat With the Runner' is another highly successful program. We produced a door sticker that goes on restaurant doors and identify entrees that contain less than a thousand milligrams of sodium, and five hundred or fewer calories, of which seven percent or less come from saturated fat. This is consistent with PepsiCo experience again.

The eighth lesson is get data, data to help make the case and guide the program. We did a survey about attitudes toward tobacco smoke. It showed that seventy percent of Olmsted County residents preferred smoke-free, and we were able to get smoking out of restaurants in Olmsted County.

The ninth lesson is to take care of yourself, take care of your family, take care of your friends and co-workers. Self-care will save you money. If you don't have hypertension you don't need ace inhibitors. If you don't have hyperlipidemia you don't need statins. If you don't have diabetes you don't need glipizide. If you're not obese you don't need Nexium®. The life you save may be your own.

About a year ago, Peter Jennings asked, *"Who is to blame for obesity?"* It is true that lifestyle is more than personal responsibility but the solution does not lie in blaming. The solution of the obesity epidemic lies in personal commitment combined with community action. Thanks, and best wishes.

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Laura Simonds, MS M.Ed: Executive Director, Partnership to Promote Health Eating & Active Living

(presentation slides are available for downloading from www.wrgh.org)

It's great to be here and see such diversity in the audience. I am going to follow up on what Thomas

[Kottke] was talking about with regard to the community piece, but take it to a very large national scope, which is where we are with America On the Move, our national initiative to stop weight gain across America.

As background, our nonprofit organization, The Partnership to Promote Healthy Eating and Active Living, began in the late nineties. We implemented America On the Move in July 2003. I am going to take you through the model of the Partnership, the non-profit, then describe how that was the genesis of America On the Move (AOM).

The Partnership's vision is to inspire people to choose healthier lifestyles. We started by bringing together public and private sectors through a multi-disciplinary approach, addressing healthy eating and active living behaviors. At the time, bringing physical activity experts and nutritionists into a working group was rare, so we decided to hold a summit on this topic. We published the results of our year-long effort and conference in *Nutrition Reviews*. The conference was actually the culmination of eight months of work from about twenty different people in working groups that came from science, public health, public policy, academia, corporate America and other sectors. The working groups created a framework that looks at the individual, the community, and the environmental, and the factors influencing decisions around eating and physical activity behaviors. We then said "this is great, but what we really need to do is look at one of the critical factors in social change which is economics."

Considering economics is very important for creating sustainable social change. So, we held another forum in the spring of 2002 that looked at the economic determinates of eating and physical activity behaviors. And for the first time ever we took the same public-private approach and brought together economists with public health experts. We involved economists from Rand, University of Chicago, Cornell and the Economic Research Service of the USDA together with key researchers and public health people and also corporations. We asked them to consider and create a framework that helps us understand what is sustainable, what is driving behavior, how we can create incentives and what economic factors are influencing individual decision-making and community decisions. The results of the work were published in the American Journal of Preventive Medicine in October 2004.

We were having a wonderful time working on this think-tank approach while at the same time people were asking us for a national outreach to share what we had been learning, a program that we could implement in communities and help individuals start making changes from where they were.

So, we started Colorado On the Move, an initiative in the state of Colorado that took those research practices and applied them in communities, reaching individuals. At the same time, two of our board members, Dr. Peters and Dr. Hill, also the chairman of our board, published findings that supported AOM and its small changes messages in ***Science***. As an overview of the article, ninety percent of the American population is gaining between one and two pounds a year. The reality is, the difference between gaining or not gaining the 1-2 pounds per year is about a hundred calories a day. Based on that premise, AOM was created to bring the science and the Colorado On the Move effort across America and to implement it in communities. The programs of AOM focus on promoting a little more physical activity (moving two thousand more steps over what one is currently doing, which is the equivalent of about a mile or 15 minutes of walking, which we measure using step counters) and reducing intake by one hundred calories each day. Doing these small changes each day is enough to stop weight gain in 90% of the American population.

AOM has taken off like gangbusters. In Colorado, where the Colorado On the Move pilot was done, we

had no marketing budget, no billboards – It was just a grass roots effort. And states all around America said, *"can we get involved?"*

We put together a national approach to reach communities and now have twenty state AOM affiliates. Anyone can go to our website, *www.americaonthemove.org*, to register and get helpful tips on making small changes in eating and lifestyle physical activity at home, work and in the community. The website also allows people to interactively track their own steps and do the same as part of a group, church, worksite, family, etc. AOM has programs for faith-based groups, health professionals that can be used with their patients, schools, and other groups. Our motto is to reach consumers where they are. So, we are reaching them in the worksites, we're reaching them in the schools. We've partnered with our sponsors who are creating products that support healthy lifestyles and we are event partnering with our sponsors to create consumer-reaching programs and initiatives that educate consumers on healthy lifestyles.

We have a few delivery system channels, such as partnerships with like-minded organizations and the AOM affiliate network, where we reach individuals and groups. I'd like to hear your feedback on how we could potentially partner with others.

Challenges going forward are creating more simple tools that people can use, looking at communities and how we can help them with evaluation and with providing their sponsors and funders with a positive return on investment.

Ted Borgstadt: Founder & CEO, TrestleTree

Trestle Tree is a health transformation company: we decrease healthcare costs by working with an organization's marginally motivated, at-risk people, to help them change their toughest health behaviors, for example, obesity, medication persistency, exercise, diet, monitoring of their condition, tobacco. TrestleTree has used Jim Prochaska's research on how people change their health behaviors as a foundation for our company, and constructed a business model that delivers a validated return on investment for the employer, and measurable, sustainable health behavior changes for individuals.

At the core of TrestleTree's model, is a uniquely trained Personal Health Coach. We employ pharmacists, nurses, exercise physiologists, and registered dietitians, who all have great content-expertise. We then train these health professionals to be great 'change-experts.' TrestleTree invests over four hundred hours of training into our coaches in the first six months, two hundred hours of training coming before a Personal Health Coaches has their first contact with a participant. Even though our coaching is telephonic, our model successfully develops intensive one-on-one relationships of trust and influence between the same Personal Health Coach and the same participant.

J.B. Hunt Transportation, one of the countries largest trucking companies, became our first client our years ago. We began services with their corporate headquarter's population, secretarial workers up to senior management. We thought it would take at least a year before JB Hunt would have enough data to expand out to their truck-driving population. Within the first two months of initiating TrestleTree's services, the V.P. of Human Services came to us and said, *"we've never had a program have this much positive feedback before. We want to expand company wide."*

Watson/Wyatt, JB Hunt's benefit consultant, did an independent study on the first year's participant's medical claims and showed a trend of a forty-five percent reduction in medical claims cost for

TrestleTree's participants verses previous year. TrestleTree did not cherry-pick participants for the program. Any employee with a diagnosis of diabetes, high blood pressure, high cholesterol, or asthma could enroll. This took away the regression to the mean concern. JB Hunt was pleased with the ROI.

Another, soon to be published, cost savings study was just completed for another client. This state employee population showed over four to one return on investment in the first year, based strictly on medical and pharmacy claims.

We have expanded our program beyond just disease management. We also work on the preventative side. We work with people with body mass index of over thirty, also those who use tobacco. We also work with all core morbidities when someone comes into the program.

While the cost savings and ROI results are delivering what our clients desire, a parallel satisfaction is happening with each of our participants. The stories that our health coaches hear from their participants are phenomenal. Walking through our coaching center in NW Arkansas I get teary-eyed on a regular basis, listening to the stories of changed lives from our participants.

We built this on Jim Prochaska's lifetime work. We've learned from his research and we have built our software so that we track stage of change, with every participant, in six different goal areas and as they reach action and maintenance we decrease interaction with them. A lot of the leveling off and decrease is trying to maintain a level of intensity and coaching which is appropriate for that individual.

I wanted to share a couple of these stories with you, briefly. In January of this year a retired seventy year old diabetic woman came into Trestle Tree's program. After meeting once a month with her Personal Health Coach for six months, the woman said she had a confession. She said, *"I've been a smoker for sixty years, since I was ten years old. I have been too embarrassed to admit to you that I smoke."* TrestleTree's health coach included smoking cessation as an additional goal area. Over the next three months, an extensive plan was put in place and by the third month, the woman set a quit date. I am happy to say that this 70 year old smoker has now been smoke free for two months. The woman's comment was *"Do you know how proud my grandchildren are of me for quitting?"*

The second story involves a 40 year old ex-Marine who was a truck driver and a young grandfather. He enrolled in TrestleTree's program because he had hypertension and a BMI over 33. I interviewed this young man for a promotional video tape we did to help recruit other employees into the program. He had already lost over 40 pounds and had started exercising for the first time in over 10 years. It took him three takes to answer the question *"why did you join TrestleTree's program?"* He became emotional every time he started to answer. I remember he had a picture of his one year old grandson he held up to the camera. He finally was able to say, *"I'm a young grandfather and with TrestleTree's help I will be an old grandfather."*

He had lost thirty five pounds with Trestle Tree's health coach and had already been taken off of hypertensive medications. But there is a very sad side of this story. The wife of the driver called to reschedule an appointment and said, *"I need to let my health coach know I need to reschedule. My husband, who was also a participant with you was tragically killed two days ago."*

It was a freak accident. He was the driver in a J.B. Hunt cab that caught fire in the middle of the night and was killed. She called at that moment of tragedy in her life to say, *"I'm not bailing and I want you to know how important you also were to my husband."* Now that says something on a connection level, when you can get to that level of influence with someone to be able to drive the behavior change that's needed.

Agnes Hinton, DrPH RD: Professor, Center for Community Health; Co-Director, Center for Sustainable Health Outreach, University of Southern Mississippi
(presentation slides are available for downloading from www.wrgh.org)

Thank you. I am going to talk to you about a very different approach. You've heard a great story of health coaches – health professionals, but I am going to talk about a whole different population, and a way of getting them to those health coaches and keeping them engaged.

I co-direct the Center for Sustainable Health Outreach. We are a collaboration between the University of Southern Mississippi in beautiful Hattiesburg, Mississippi and Georgetown University Law Center in Washington D.C. We really started looking at this area because we saw that cultural and linguistic and economic barriers were keeping U.S. families with the greatest health risk from being appropriately served in our current health care system- or lack of it, some would say. But we also believe that if the problems are in the community then the solutions are in the community, much as we heard about in Minnesota.

I am going to talk about someone who is not a health professional, not in the sense of having gone through formal medical training, but is a professional in knowledge of the community. These are folks that know the cultural, linguistic and other value systems of their community. There are many different terms for community health workers. That's one of the weaknesses of the field right now, and we are trying to work in that arena. You may have heard them referred to as lay health advisors or workers, community health advisors, promotores de salud, community health representatives. We use the definition of Dr. Eng, from the University of North Carolina, Chapel Hill. He has stated that a community health worker is "an individual who is indigenous to his or her community and agrees to be a link between community members and the service delivery system and not just the health service delivery system," because as we have heard there are so many socioeconomic issues that need to be dealt with along with what we might more traditionally think of as health. We do know that community health workers are an effective means of improving community health because they serve as a vital link between communities and the health care system.

A quote from Barnes and Fairbanks: *"Community health workers are not trying to substitute for professionals, but rather act as counterparts to assist health care providers and other professionals in their mission to improve health and social conditions in ways these traditional providers are not able to provide."*

As a traditionally trained, registered dietician with a doctoral degree in public health nutrition, I say 'Amen'. While I think I'm very good, if you take me and add folks from the community the value is out of sight. With four of them plus one of me, I can give you twenty times the return on investment I could with one of me.

Here are some examples of things that community health workers can do. They can educate individuals and communities. They can facilitate access to needed services. They can educate providers in the health system. They can help craft services that are more responsive to community needs. We set up these great classes and programs and then nobody shows up! And we say, *"duh, what's the problem?"* They're noncompliant, you know! Well, in many cases the problem is our programs are not designed right in terms of the messages we are delivering, or in terms of the locations we provide them in, or in terms of the hours. There are so many things that we can learn from members of the community if we just listen to them!

Community health workers work in all areas of public health including maternal and child health, oral health care, chronic disease management, cancer awareness, STD control, even vision, oral health,

mental health. It is a concept that works in all arenas.

There is also a continuum of lay health advisors--again this is from Eng--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. I became engaged in this work, through helping to develop a volunteer lay health worker program in Mississippi called the Community Health Advisor Program.

Let me give you just some examples of different programs that are affiliated with our center, to give you a flavor of some of the programs that are available.

The first is the community health advisor program, which is where I just fell in love with this concept. I had been working as a health professional, wondering why we didn't get better response to our efforts. This program went into the community, identified natural helpers in the community, gave them some training and formal linkages with health providers in the community, then supported them as they developed short-term and long-term objectives for the community. I was blown away by what people are willing to give of their time and resources, and I am talking about low income, low resource, poorly educated people. What they did was phenomenal! Because they designed it, they delivered it, and they saw the changes in their community, they supported it. And fortunately the community supported it as well.

Another program recruits and trains volunteer natural helpers who seek to improve individual and community health by identifying perceived priority health problems. We looked at the health statistics and, in the community where we began this program, teenage pregnancy was very high. But yet the community wanted to start in the area of hypertension control. Now my boss, who then was director of maternal child health, was just having a fit, *"no, we've got to start with teen pregnancy."*

And I said, *"No, we told these folks they were in charge of the program, so we will start with hypertension control."* They started there, made great success, and low and behold before you knew it they were working in teen pregnancy. So, the key is, they did it. The Community Health Advisor program organized self-help action in their communities, link people in need with available health services and give advice and assistance to neighbors, friends and families.

Another example is our Deep South Network for Cancer Control, which has been funded by the National Cancer Institute for the past five years. Hopefully we are about to be renewed for another five years going into a different phase. This program uses volunteer community health workers, primarily African American women in low-income communities in Mississippi and Alabama. In several years we have trained over nine hundred volunteers. We call them community health advisors or research partners, and what they have done is just phenomenal.

Here is another brief vignette of a program where we've partnered with Vanderbilt University. The Maternal Infant Health Outreach Worker Program uses peer educators, moms who go into homes with pregnant women and work with them on health and child development and social issues up until the baby's third birthday.

I will give just a little plug for our Center – we do have some materials at the back. We have a quarterly newsletter, which is free to anyone, if you give us your contact information. We have an annual conference that is spectacular, with people from all over the country, both community health workers and folks in communities and agencies. Another project we are about to launch with funding from W.K.

Kellogg is an inventory project to better describe all the community health worker programs across the United States. We have a listserv of folks interested in trying to support community health workers across the country.

Please contact me with any questions. I want to leave you with our vision statement: *"We see community health workers being valued as essential, integral, powerful promoters of health, wellness and disease prevention in their communities."*

Session III Discussion

Creating an environment for change

Asked to identify the major shortcomings of health promotion programs in the United States, Kirsten responded that most programs lack a holistic approach. Instead, they focus strongly on individual responsibility for lifestyle changes, with much less attention on creating a supportive environment to make change possible. He also emphasized that health promotion programs need to be more interdisciplinary and inter-sectoral, that is, involving other sectors of society besides health care, such as education, recreation, safety, business, and urban planning.

One participant commented that Mississippi has among the nation's highest rates for cardiovascular mortality, diabetes, and obesity. He asked Dr. Hinton about the current governor's plan to create a faith-based outreach that would engage the spouses of ministers statewide to become 'ministers of health'. Dr. Hinton responded that while such faith-based initiatives are excellent, they are not sufficient to solve the state's public health problems. *"It is a solution, but there need to be other solutions,"* she said.

Asked about other worthwhile strategies, Dr. Hinton recommended wider use of grassroots community leaders, such as the Community Health Advisors Program in Mississippi. *"Remember that solutions are in the community,"* she emphasized, adding that programs need to be tailored to the needs and preferences of individual communities. *"The community has to be the one that says 'this is my priority and this is what I want to start on,' rather than us looking from the outside and deciding what needs to be done."*

Hinton also favors legislative changes to improve health outcomes in Mississippi. *"We have one of the lowest tobacco taxes in the United States, and I would love it if cigarettes cost $30 a pack!"* she said half-jokingly. In addition, she recommended legislative changes to improve Mississippi's poor air quality.

Another participant asked Dr. Hinton to describe the usual point of contact between individuals in the community and lay health advisors. *"The primary point of contact can be anywhere,"* such as a person's social network, family, friends and neighbors, the workplace, health clinic, or even street outreach, she responded. Although lay community health volunteers primarily work in face-to-face settings, they also may contact people via the telephone. *"Wherever people are, that's where community health workers are—and need to be,"* she stressed.

Borgstadt added that his company also was exploring the use of lay community health volunteers in an outreach program to improve nutrition among food stamp recipients. He agreed that community-based health volunteers can make an important contribution to public health, such as by helping people to make healthier food choices.

Scaling up programs to reach more people

Another participant asked Borgstadt about the potential to expand the Trestle Tree's program, which

uses trained personal health coaches and is based on the Transtheoretical Stages of Behavior Change model. Because the program is 'high touch' and individualized, she asked how well it could be ramped up to serve a larger population, such as through the use of telephone counseling or an interactive computer program.

Borgstadt answered that the program is scaleable. Although his group's psychologist initially believed that one-on-one counseling would be essential for success, outcomes data showed that telephone contact was just as effective as videoconferencing for promoting positive behavioral change. So, the program is potentially scaleable to anyone who has access to a telephone, he said. *"We even have truck drivers who are stopping at truck stops, getting on pay telephones at a scheduled time, and calling in to their health coaches."* He added that the program has no set ratio of counselors to clients, because participants are stratified according to the severity of their conditions or needs.

Borgstadt acknowledged that implementing a highly individualized, interactive program does cost more *"than just dumping information out on the Internet to somebody."* However, spending money upfront to change unhealthy behaviors can result in long-term savings, such as from reduced utilization of health services. Even though it seems expensive, *"the depth of impact is dramatic as well,"* he said.

Creating cultural change to promote healthy behaviors

The panel was asked to comment on the extent to which culturally embedded behaviors can or should be changed. In other words, is culture immutable? Dr. Kottke responded first by noting that commonly held views, that culture can't be changed and shouldn't be changed, are wrong. He pointed out that many of today's culturally embedded behaviors actually have been imposed on society by outside agents, such as corporations. *"The food industry, the car industry, the cigarette industry, the spectator sport industry, the entertainment industry—all have changed our culture for us,"* he observed.

A lifelong Minnesotan, Dr. Kottke emphasized that to change culture, it is best to work from inside the community. *"I feel I have absolutely every right to change Minnesota culture. You know, my family has lived there for a hundred years so no one can say 'you're messing with our culture,' he commented. "We simply have to believe that we can do it, work hard to do it, and do it from the community [in which] we really do have the license to change culture."*

In a follow up question, Kirsten was asked whether some cultures are easier to change than others. He replied that some cultures have systems in place, such as a particular health or political system, that are more conducive to facilitating cultural change. For example, in Scandinavian nations, the existing culture makes it easier to promote increased physical activity. To change culture efficiently, he recommended identifying the behavior within a given culture that is most likely to improve or change, then work on that first.

Simonds also expressed a strong belief that culture can be changed, even though the process often occurs slowly. Looking back on her own life and the culture in which she was raised, she noted that her parents routinely wear seatbelts and recycle today, but these now commonplace habits were never practiced when she was a child. *"Over the next ten or fifteen or twenty years, I think we are going to find ways in our current technologically driven environment to have a healthier lifestyle,"* she said. *"It's just a matter of believing in it and finding all the right pieces that can make it happen."*

Another participant, who is working to improve health and safety in a company with many Hispanic employees, observed that awareness of and respect for cultural differences is another crucial ingredient for promoting positive change. Along with addressing language barriers, *"a clear message of respect needs to be in place to build trust and allow change to occur"* she said.

Promoting health in a hurried nation

A British participant, commenting as an outside observer of American culture, stated that many Europeans are shocked at how hard Americans work. *"Many of the things that we have been talking about at this conference, such as eating well and exercising, all take time. And many people in America are highly stressed, simply because they work too hard,"* he observed. Work-related issues, such as the number of holidays Americans get and the hours they work per week, are important issues affecting health. Although legislative changes to limit the work week may not be the solution, this key issue should not be overlooked, he emphasized.

Another participant added that many Americans have experienced a convergence of their work and personal lives because of technological advances, such as email, cell phones, and beepers. In America, clear boundaries between people's personal and professional lives are disappearing. *"It has all become one, through technology, mainly,"* he noted.

However, limiting Americans' weekly work hours could have unexpected adverse consequences, cautioned an audience member who works in the health insurance industry. Health insurers generally do not cover employees who work less than thirty hours a week. Therefore, any effort to expand Americans' personal time by reducing work hours needs to consider potential changes in health insurance benefits.

Changing culture through the use of incentives

Another audience member asked the panel about the use of incentives to encourage healthy lifestyle changes, especially among people covered by health insurance plans. For example, an insurer might offer 'carrots' (i.e., cash or other incentives) to those who engage in healthy behaviors and 'sticks', i.e., financial disincentives, to those who persist with unhealthy behaviors, even after working with a health coach.

Dr. Kottke responded that he preferred a system that used positive rewards and worried that use of negative incentives might *"beat people up when they just don't have the resources."* In Olmsted County, for example, 85% of women and 75% of men are concerned about their weight and trying to address the problem. However, *"many people lack the time or resources to make healthy changes,"* he commented. *"They just haven't figured out how to work this into all the other goals in their lives or obligations."*

Dr. Hinton agreed that although the use of incentives could work well for certain groups, such as well-educated professionals, this approach might be lost on many others. In particular, she expressed concern for people of lower socioeconomic status, who often face formidable life challenges and higher risks of chronic health problems. Instead of 'carrots and sticks', these individuals need clear messages and unambiguous information about how to maintain good health and grapple with life's problems, she emphasized.

Session IV: Giving patients a voice

Jon Comola

We are witnessing a sea change in behavior on both sides of the doctor-patient relationship. In this session we will hear from leaders on the front lines working with consumers, business, doctors, health service delivery institutions, and public policy makers to enable the emerging market of information to create individual ownership of health and healthcare. What are the benefits and what are the risks, and

how are consumers responding? Jerry Reeves will present an overview, then our panelists will provide their unique perspectives on this important topic.

Jerry Reeves, MD: President, HEREIU Welfare Fund; Chairman, WorldDoc

(presentation slides are available for downloading from www.wrgh.org)

Thanks, it's a great pleasure for me to be here, especially given the incredible array of folks participating in our sessions. I'm looking forward to learning a lot from you, and I have certainly learned a lot so far.

The nature of the descriptions of 'Giving Patients A Voice' that follow are applications that we are using in a health plan for hotel and restaurant employees in Las Vegas. The Culinary Health Fund is the Taft-Hartley Health and Welfare Trust for about a hundred and twenty thousand lives. About fifty thousand employees work at places like this hotel and some places not quite as fancy as this. And we are the health plan for their union. These folks are immigrants; there are more than twice as many Hispanics than Caucasians, and they have a very rich health benefit that basically covers everything. They have hardly any out of pocket expenses for their health services. Yet, despite that set of challenges and opportunities, we've been able to keep our cost trend to less than two percent year over year for health costs. Some of our employer colleagues have had twenty percent increase in health cost trends this year.

So I'd like to talk to with you some about the kinds of things that we are doing and where I think there are some elements that would work.

First, I am a physician. I remember the very beginning of the quality assurance movement – I was in the Air Force at the time. You may remember that this began with a surgeon at a Navy medical center who was legally blind and was doing cardiovascular surgery. That started the quality movement on a national scale twenty-five years ago and we in the Air Force experienced this up close and personal.

All of those quality assurance efforts have been primarily focused on doctors, hospitals and more recently health plans. I've concluded that using this focus misses the mark, because at the end of the day, doctors only advise. Many advocates, including hospitals and health plans, try to advocate for the patients. But *the patient decides*. At the end of the day, the only person that has continuity with Mrs. Jones is Mrs. Jones. So I want to focus on 'Giving Patients A Voice' to much better to deal with the crisis we are facing.

Despite our twenty-five plus years focusing on doctors, hospitals and health plans, we are not close to hitting Six Sigma performance benchmarks. Six Sigma standards used by industry aim for less than three errors per million. We have substantially higher error rates in health care than three errors per million. And our error rates come too close for comfort as we drill down from the U.S. performance scores to our state and our local level. As you can see from some of the statistics on these slides, we at the Culinary Fund have a much higher rate of care gaps than is the average for our state or is the average for our country. So, we have our work cut out for us.

By the way, I would like to make a disclaimer: I have only been at the Culinary Fund for a year, so give me a few more years and I hope to get the marks up considerably from where they are now.

Healthcare started as a cottage industry, but that cottage has tried to become a mansion by adding rooms. Every room has a different style and every add-on has a different roofline so that now what

started as a patient seeing a physician who wrote some notes down, now it's more like this.

The patient does still see a doctor, but everybody else wants to reach the doctor because they assume the doctor has the information that relates to the patient that they need for their domain. Whether it's the demographic information that they may need for the insurance plan or the pharmacy or the symptoms and objective kinds of findings, his assessment or his plan, everybody has a need to reach the information that they perceive the physician has. Unfortunately in our PPO type of health plan the patient doesn't have a single continuing care physician. The patient has access to physicians in 'quick care' and ERs, has specialists, and has primary care doctors. They don't stick with one medical home. They may have at least five doctors.

So, I believe that if we are going to get our arms around this we are going to have to have the information repository at a place that has proper security and control, but we cannot expect the doctor to be the source of this suite of information tools. I am going to propose to you some other models that we are applying at the Culinary Fund that, I believe, do work and make more sense.

To be fair, we should recognize that improving access to timely, accurate information is not the sole answer to helping Nevada achieve the same high standards of health as our neighbors in Utah. We think that some of the difference in health might be related to the patients themselves who live in Nevada, not just the doctors and hospitals in Nevada. There are a whole variety of characteristics of patients that dramatically color how successful we could be at achieving optimal health outcomes. We've talked about many of these the past twenty-four hours. I think that if we're going to address the trunk of the tree and the roots of the tree rather than the limbs and the leaves, we're going to have to focus here on the patient. We must address availability of insurance coverage, improve health literacy, and adapt health care delivery to the varying demands of different cultures. We see very different cultural requirements, needs, and opportunities in our Hispanic population and our Filipino populations, as compared to our Asian or African American or our Caucasian beneficiaries. So we have to use dramatically different approaches for each of those constituencies.

When we are talking about chronic disease, it's about action lists. We don't need fancy disease management and stratification – we do that behind the scenes. But rather a certain set of tasks need to happen each year. Regardless of the combinations of morbidities with their chronic disease, it's all about completing action lists or to-do lists. If we can get the patient to drive more of those 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.

As Dr. Prochaska indicated, another very important element in achieving health improvement is the patient's readiness to change. Our interventions must result in the patient feeling confident that she can make a valid decision; that it's a safe and appropriate decision. Patients have to be ready, but then they have to commit. And it may take an army of helpers around them to get them ready to commit.

There are several cost drivers that influence what our patients choose to do. When they go to the ER we're finding, among more than one hundred ten thousand visits at the university hospital in our town, that only six percent of those visits were for emergencies. The rest were for urgent and mild conditions, and we have urgent care centers with extended hours all over Southern Nevada. In fact, the university hospital has about twenty in our home town that are open extended hours. Fifty-six percent could certainly have gone to the urgent care center. Another thirty-eight percent could have cared for the problem at home or gone to their doctor the next day or perhaps even gotten an extended hours appointment that day.

For those who go to the office, it turns out that a large proportion of those visits could have been managed by phone, or by email or perhaps by self-care, or going to the local pharmacy or grocery store and picking up over-the-counter preparations that are really quite effective. Many present day over the counter medications were once block-buster prescription drugs such as Robitussin DM, Pepcid, and Claritin.

This slide shows results of a couple of studies that look at the proportion of patients seeing a doctor where that encounter results in informed decision-making. And it's woefully inadequate. The first study published in the Journal of the American Medical Association was a study of a thousand office visits where they videotaped the encounter. Then a group of professionals viewed that encounter on video to determine what decisions were called for from the patient in that encounter. What proportion of the time did the physicians provide adequate information for the patient to make an informed decision? Information of low intensity and complexity, for example, if you don't get your mammogram you may develop advanced breast cancer and die, were relatively more frequently done. But when it was more complex, like you have breast cancer and here are the various options and the rationales for why you might choose those options, adequacy of information dramatically decreased. It was almost as if the patients hadn't gone to the doctor.

The other element is, how much do the patients remember of what the doctor said, even if he said it? The second study was done in Great Britain, but I have no reason to believe that we are any more adept at listening in the US compared to England. Within fifteen minutes after leaving the office, fifty to eighty percent of the information provided by the doctor had already been forgotten. Two weeks later, they called back those patients that did remember the information at first. Only fifty percent of that information was still retained correctly at two weeks later. And we wonder why people aren't adhering to the treatments recommended in our offices!

All doctors are not created equal. At least they don't all act the same. We look at data in our health data warehouse that groups episodes according to the whole range of activities that are done during the care of the episode. Let's say it's an ear infection or bronchitis, or a urinary tract infection. We then look at how much we paid these folks, to determine which was the least expensive, say family practitioner, or internist or orthopedist, for that episode. What is the highest cost provider taking care of that episode in our network? And what is the average for those specialists that are taking care of these common episodes? What we find is striking. The most expensive folks in the specialty are between four and ten times as expensive as the least expensive ones in the specialty and we cannot tell the difference in the outcomes for the people who get this care for this episode.

So, there is a major discrepancy. We are not talking three percent or five percent, we're talking a four to ten times difference in the amount of resources utilized for the same outcome. We can't afford those kinds of things. We don't have enough money in the pot to do that. So, it has driven us to make some hard decisions.

Consumers in our health plan and throughout this country want to make their own decisions, thank you. They are frustrated that too often, they believe, the insurers are making more decisions than they are. They believe that they should be making the majority of the decisions. They begrudgingly allow that perhaps it would be okay if the doctors are involved, but then everybody else drops off dramatically in regard to whom they would like to have engaged in their health decisions.

And they make health decisions a lot. You've probably developed a headache sometime in the last two or three weeks and you didn't immediately run to the hospital or doctor for that. You probably made

some judgment as to whether you thought you had a brain tumor or not. I remember whenever I was in medical school every rotation that I took I had that disease for that month. I remember when I was on pulmonology I was sure that I had pneumonia. I remember when I was on neurology I was sure I had a brain tumor, etc.

People make these decisions day in, day out regarding whether something needs to be done right now or not, and is it something I can do. More than six hundred medicines are now available over the counter that used to be by prescription only. And for more than one hundred of the most prevalent and significant conditions, home remedies result in the same outcome as doctor visits. We find that nationwide about seventy percent of the population uses internet. I was surprised to learn that that same statistic holds true for our Culinary union members and their family members. Among more than 55,000 applicants for hotel and restaurant jobs at a new Las Vegas resort, 78% listed their email address. Many of these people with low disposable time or income probably "Google it" to try to find help with their health decisions.

Now if you are going to engage folks in health care decision-making you have to surround them with help. It's like surround sound. We believe that it takes multiple touches – you can't just depend on one methodology. The web can be very effective, as I mentioned, for on-line help and decision support and outreach through e-mail. It can be a great information platform, but it's not enough by itself.

More than ninety percent of the health care transactions that occur in the country occur by phone. Seventy percent of people who call a nurse advice line change their original intent. So the phone can be a very effective tool to help people. We find that when we are trying to get people engaged in doing specific tasks, like getting hemoglobin A1-C or cholesterol measured, that mail works better for our population. It turns out that if we are giving health risk appraisals, even though it's faster to do it on-line at the health fair, many prefer to put the answers on a piece of paper and then we enter the data later.

From the media, we are on average getting surrounded by two hundred and fifty-four messages a day. So, if we are going to use media, we have to do something that gets top of mind awareness. We find that by going to where they are—at the worksite where they spend their waking hours and receive their income and co-worker support—we have a much higher likelihood of touching them and impacting them than we do even at home.

We have talked some about behavior change and decision tools. They need to be specific, measurable, and appropriate to the behavior or the goal that you have. They have to be relevant and timely. A lot of the consumer directed health plans have made decision tools available, but they focus on the fifteen percent of decisions related to the administrative elements of the insurance coverage. What is your insurance benefit? What co-pay do you choose? That's not what most of our folks are worried about. They want to know, what might I have and what should I do? So, I think we need more focus on the health decisions that they are making.

As Agnes [Hinton] mentioned earlier, there is a significant role for community health advisors and other coaches. We are looking forward to rolling out a community health advisor network for our union members. They are very good at organizing and getting behavioral change. If you have ever been on the other side of a picket, you know what that means. But, I think if we can get them organized for health advocacy it can really make a difference. Professionals can touch more patients with group clinics and leverage the community of patients with like needs to help each other cope. And partnering with coalitions of other employers and health plans can accomplish more substantial performance improvement in communities.

In a decision matrix, the patient has a much higher likelihood of being able to implement and influence decisions that relate to prevention and early treatment. The patient wields less influence over late treatment in costly environments like hospitals. The doctor typically does very little in the arena of prevention; she may influence early treatment, but most of her interventions are high cost, complicated late treatments. It doesn't take a rocket scientist to figure out that we should be spending more of our time on the left side of this graph, working on engaging patients, than on the right side trying to influence doctors and hospitals.

It does take incentives – both positive and negative. And it takes, sometimes, rules. Dow Chemical had a very high completion rate of health risk appraisals because they set up a rule that if you want your health insurance to be activated, you complete the health risk appraisal. It works. You make a rule like that, and people will fill out the health risk appraisal. So there are certain kinds of incentive strategies that are more effective than others, but you can't wield them for everything. You can't use rules for everything. It takes a mixture of incentives in order to engage folks in seeing their doctor, taking their treatments, and preventing illness and complications.

There is a handout in the back of the room that I encourage you to get regarding our suite of health decision support tools. We've engaged this suite of health decision support tools from WorldDoc to power the Culinary Fund health site. The case managers, the customer service folks, the hospital discharge planners, the caregivers in the family can use this in addition to the patient herself going in on-line and accessing these. It covers information that helps with things like, What might I have? What should I do? Completing the health-risk appraisal creates your on-line, confidential, secured, personal health record. We enable their using this suite of tools for both on-site health fairs, with interpersonal decision support, and for telephone decision support. And we provide value comparisons and performance comparisons of the hospitals and physicians in our network.

The site has tools that include things for general health, for cancer, for health advice about how to choose a doctor. As you go in further, more tools are available. If you look over on the right you can see that, even though this patient is sixty years old, he has a health age of seventy-two years old. So, his body is older than he thought he was, and it shows him which things are his specific goals and whether he has accomplished those goals. Then if you click on those, like smoking cessation or blood pressure, it will drill down to what specifically I can start doing today to get my health better and my body younger.

Over on the left are the personal evaluation systems that analyze symptoms, and the pharmacy that helps with choosing drugs. When you click on the part of the body that bothers you or click on the symptom it pops up questions developed by physicians in twenty specialties and takes you to the top three possibilities and then a fifth grade explanation of those and the various treatment options.

When you complete the health risk appraisal it generates your on-line personal health record and then we import claims information into that to supplement the information from claims with the self reported information.

We help them choose a physician, including the languages spoken, the location and whether he has a gold star rating. We measure doctors for efficiency, effectiveness and adherence to guidelines, and then those that are top performers get a gold star in the provider directory. When patients are choosing a doctor, they can see which ones are in those top performance tiers.

For questions about medicines, you click the name of the medicine you're taking and click on what you're taking it for, it then shows you the alternatives and their relative costs compared to yours.

We enable e-visits. The health plan pays the doctor for these e-visits, typically twenty-five dollars per e-visit, and he then has all the events documented. The medical malpractice [carriers] prefer this over the phone medicine that is the typical pattern that occurs in America.

We have created a coalition of twenty-two large employers and health trusts in Las Vegas to work together to get more leverage for accomplishing change. We started with hospital contracts, building in performance requirements in those hospital contracts regarding performance on four parameters of quality. We have a quarterly meeting with their CEOs and their senior leadership and then report these to the coalition members. Transparency and accountability has been associated with improved performance.

We have a generics campaign that champions doctors and patients adopting more use of generic drugs. For each one percent increase in generic use, the pharmacy costs decrease about one percent. This has become a major city-wide campaign. We've implemented hospitalist services for our hospitalized patients and we are working on a data sharing process so that we can leverage these tools across the network.

This shows you some of the posters and the bill boards that you may see if you visit Las Vegas in the near future. It's our campaign for this coalition to champion the use of generics. We go to doctor offices and group clinics to explain the benefits, to show them how they are performing on their percent generics and showing the specific alternatives and cost comparisons. Soon we intend to implement mailings directly to the patients so that they can see their options and discuss them with their doctors.

The determinant of success in these kinds of programs relates to getting the word out and getting their attention. You can have an outstanding program, but if nobody knows about it nothing happens. If communication consists of a little piece of paper on the bulletin board in the employee lounge, nothing is going to happen. You have to commit real resources to getting the word out. And the leadership needs to be engaged. We talked some about incentive programs – the more intense the incentives the more effective they are. The most important factor determining success is the understanding by the patient.

Dr. Schick was the inventor of the Schick test, which resulted in ultimately eliminating diphtheria from our population. Though he was born on a rural farm in Austria, he subsequently became a very prominent pediatrician and infectious disease expert and changed the world. In summary, it's as he said, *"First; the patient, second; the patient, third; the patient, fourth; the patient, fifth; the patient, and then maybe comes science. We first do everything for the patient."*

Ron Bachman: Partner, PriceWaterhouseCoopers

(presentation slides are available for downloading from www.wrgh.org)

This presentation is a peek into the future of consumerism and where information decision support tools really should fit into the whole model, so that we are not siloing our discussion about how you change behaviors. There are four identified generations of consumerism. The market is well into the first generation and moving rapidly into the second generation. Future generations are developing with specialty vendors trying to segment the market and expand value-added services.

The first generation focuses on plan design. You've heard about consumer driven health care and high deductible plans. That addresses the eighty percent of the population with twenty percent of the claims,

discretionary expenses, office visits, emergency room visits, and prescription drugs. It doesn't really get to the heart of health care and really changing behaviors – to change costs. But we've got to start.

This is one of the biggest effects, I think, that Wye River Group on Healthcare can take enormous credit for. The birth of consumerism was really June 26, 2002, when the IRS made the declaration of consumer driven health care. We worked very closely with Mark McClellan, who really is one of the fathers of HRAs, when we took the concept to him. So legislation and regulation does change the world.

Consumerism has to move rapidly into the second generation where the emphasis is on behavioral change. Third and fourth generation products and services will develop over the next several years. This is where creativity and market competition will develop to meet employer and individual needs.

There are five building blocks that are really critical to everything that we are talking about and information is only one of those. These personal care accounts, whether they're health reimbursement arrangements or health savings accounts are a critical part, and I would say the most important of the five items. With the HRA regulation of 2002 and the 2003 legislation with HSAs, we have the ability to share savings with employees that allows them to accumulate unused funds for future years. Members no longer have a benefit but have an accumulating asset. It's an entirely different mind set.

Wellness and prevention are critical. We'll hear more about disease management. That's where the real dollars are--with the twenty percent of the population [with chronic diseases] creating eighty percent of the claims and where the real cost savings can be. You'll hear later what CMS is going to be doing in disease management.

Information decision support fits into all of this and I'll describe how I see the future of information factoring into and integrating with all of these other building blocks. Incentives and rewards--we could never do that before. In health care we only had the ability to budget with monthly payments, we had the ability to share risks through pooling and insurance, but we never had a third vehicle, and that is the ability to save from one year to the next. Prior to these new regulations and laws we only had flexible spending accounts or FSAs. The problem with FSAs is the 'use it or lose it' rule. What a great regulation! We increase utilization with unnecessary expenditures when we are trying to decrease utilization. So we have a regulatory financial encouragement to do exactly the opposite of what we should be doing. We now have that corrected with some of the new laws and legislation.

Let's discuss the generations of healthcare and the information decision support systems as a part of those generations. A first generation model with a savings account and a high deductible plan is not attractive to a diabetic. Why would a diabetic be interested in a savings account? That savings account is going to be used up, it's not going to be there, so what do they care if it carries over?

What is happening in the marketplace is a movement to a second generation model where you have the real savings. Second generation focuses on behavior change. How can you get a diabetic interested in a consumer-driven, high deductible plan? If they are compliant with the disease management program you now have the ability to incent them with shared savings. You can give them free prescription drugs for being compliant. That's worth a whole lot to a diabetic. You can give them a hundred dollars a month in an HRA so that they can pay expenses and cover deductibles. So, a person who has diabetes, asthmatic, congestive heart failure – if they are compliant with evidence-based medicine we could give them more money and they could wind up with a hundred percent coverage, not just something that looks like it starts and ends with a high deductible and high out-of-pocket

exposure. People who are compliant can wind up with better care. People who are not compliant are not hurt, they just don't get the full benefit of their coverage.

Third generation focuses on integrated health and performance, by taking health care out of the silo of just health care expenses. How does it affect absenteeism, productivity, disability, workers comp, turn-over rates? If you are doing the right things in health care, you are getting people with a chronic care condition stabilized. They're back to work faster. You have more productivity. You have a lot more bottom line impact if you're actually moving into a third generation model and dealing with issues like stress that have an enormous impact on turn-over, absenteeism, disability – all those corporate metrics that can be positively impacted by putting in a much better health care program.

Fourth generation is where we are going, and that's an exciting part of the future. We are not that far away. Fourth generation gets away from the employer. It is about you as an individual, it's about me, it's about our own lifestyle, it's about our own cultural interests and how we get treated for health care. It's about personal health care based on genomics, predictive modeling. So it is a very personalized health care future: back to the individual.

I should point out that these generations do not replace each other, they build on each other, so you don't lose one generation as you move to the next.

Now that we have this framework for a broader view of consumerism, let's take the topic of information and decision support tools. Where are they going to go in these generational models that we see developing? The real marketplace right now is between first and second generation, but we see some of the other generations developing. WebMD and some of the others vendors are looking at fourth generation and very personalized health care. We've heard some of that discussion over the last day or so here as well.

Due to limited time, we will focus on the information aspects of consumerism. I'd love your input and feedback. Not only on this, which is from the employer's perspective, but how this model would look from a payer and provider perspective or some of the new players that are entering into the market, like banks.

What does a first generation model of information look like? It's passive and not integrated with incentives or other clinical treatments. It's information that does a lot of the things that need to get done as a base for health care selection. It's things like a benefit calculator. Which of the options that the employer offers me should I be looking at? Which one is most valuable for me? What physicians are in my network? What kind of care and treatment might I get if I sign up for this plan? What are the benefits that are structured there? But it's passive information and it focuses more on discretionary costs, not the real high costs that are there.

As you move into the second generation, it becomes more personalized health management with incentives. It's about that diabetic and if they are compliant with care. Are they getting the right care and treatments? Are they getting the clinical information on early intervention, prevention, and treatment options. It's working with incentives so that a personal care account can get built up and maybe covering somebody at a hundred percent, full coverage, if they are doing the right things and following the right activities and evidence based medicine practices to support their own health. So, the mega-trends of personal responsibility, individual ownership, self-help self-care, consumerism, all get built into the information decision support parts of consumerism.

The third generation information decision support tools get to the concept of health and performance. A plan can develop information that integrates with the medical plan. Issues like safety, absence

management, population management are a part of a concept referred to as Integrated Health Management. On issues like production - you can do all sorts of great and wonderful things with the accounts that are out there today to help the broader issues and goals of an organization, not just the health care measurements that are there. And that's what third generation begins to bring in.

Fourth generation is where many new and creative services and specialty vendors are trying to focus. The information is very personalized. It's very much about you. It's stuff that gets with 'push technology.' It is delivered to you because of your conditions or your interests and there are a lot of different ways we could talk about how that might be done.

But the term I really like is 'information therapy'. Information therapy is a term I've seen used by one of the vendors out there, Healthwise. I have kind of adopted it and stolen it, because it means to me that information is not just on the side about what is happening with your health care that you might go and research on the internet. Information therapy is the integration of the clinical care with condition and treatment specific information, so that you are getting homework assignments from your physician or your primary care provider. They are checking your understanding of it. They are asking you to go search and find out more about your condition and care needs. So it really integrates information back into the health care services itself. It's a very exciting process as you move across each of these building blocks into the fourth generation and the same kind of activity can be looked at as you look at each of these building blocks. Thank you.

Wendy Selig: Vice President, Legislative Affairs, American Cancer Society

The American Cancer Society, as I think most of you know, is the largest voluntary health agency in the United States. We are completely volunteer led, and we are in forty-five hundred communities around the country and growing. We raise and spend nine hundred million dollars a year, mostly from fifty-five, sixty-five-dollar average contributions, so we have a pretty large base. I think if you look around this room here today, everybody in this room has been touched by cancer either personally or knows someone, loves someone, cares about someone who's been touched by cancer – very similar to the cardiovascular disease example we heard earlier. And much of what we do in cancer is transferable, translatable to all the chronic diseases and to most people's concerns about the health system.

We try to represent the whole cancer continuum at the American Cancer Society, so not just the patient and the caregiver and the family and the extended family but also the provider, community and all the other stakeholders in the business.

We have a whole array of things that we do. I was asked today about two areas. One, to be the voice of caution on some of the things we've just heard about. Not because it doesn't make absolute sense, because in fact, it does make absolute sense to all of us sitting in this room, staying at the Broadmoor Hotel, who have jobs, who have education, who have, at least some ability to access information. But as we're designing and thinking about the system of the future, it's our job as the American Cancer Society, and I think the responsibility of everyone in this room, to think about what we are doing for the entire array of people who are affected by our health system. It is our job to make sure that what we do in the future, through policies and regulation, doesn't undo something for those people that don't have the ability to do some of the things that we all can.

I want to talk about some of the cautions that the ACS would raise. We have two major areas of focus that are relevant to this discussion. One is information. We've taken it upon ourselves as an organization

to provide good quality information to all people touched by cancer, especially those newly diagnosed with cancer. That's sort of a niche area of focus that we are exploring, and I will talk about some of the tools that the ACS and others that we work with offer.

We also have a challenge for ourselves with regard to disparities. We cannot solve the cancer problem in this country if we do not address the disparities of the disease and the way it impacts different socioeconomic status, different geography, and different racial and ethnic backgrounds. Cancer is a disease that strikes us all, but it strikes certain communities much harder. It's our role at ACS to focus on what we should do about that. Again I think some of that is transferable beyond cancer to general health issues.

There are two ACS policy statements that are relative to this discussion. One is an overarching statement on access to care and the other is a specific statement about consumer-directed health care. I want to thank Marcia [Comstock] for having come to a meeting of the ACS policy process to talk about consumer-directed health care.

I think those terms 'consumer directed' have taken on a life of their own and may in fact be impeding the debate somewhat. We are talking much more about 'patient centered' or 'patient focused' care. This term 'consumer' has taken on some perhaps negative connotations that are getting in the way of people really understanding what we are talking about, which is what Jerry [Reeves] pointed out. It's all about the patient and then the extended family around the patient.

We all intuitively support the idea that the individual needs to be at the center of all things related to health care. I don't think the ACS would disagree with that theory. The question is, how do we make that possible for all different types of individuals? How do we deal with our fragmented system and with the fact that people live in different ways, in different places and have different ways of thinking about things and speaking about things? How do we make that a reality? That's really the challenge.

There are some things we want to think about as we look to design this fourth generation system, which we feel a lot of hope about. First of all we want to think about the full continuum of care. So it's not even just about a patient. Every one of us is a patient. Every one of us needs to be practicing wellness and prevention. There's early detection. You spoke about the diabetic which is clearly easy to see. What about the pre-diabetic? What about the person that doesn't know that they are going to become a diabetic? What about the person at risk for diabetes? So we have to think about the early part of the continuum into this. We also need to bring in conversation about the end of the continuum.

We can't forget about recovery. More and more people are surviving. We have ten million cancer survivors in the world today. More and more people are living with disease. Sixty-seven percent of people that have a diagnosis of cancer are living more than five years. Cancer is becoming a chronic disease. Most people don't think about it that way. We don't know half of what their health issues are going to be, having gone through chemotherapy, having gone through radiation. We are only just beginning to find out. So we also want to talk about survivorship issues.

Then we want to talk about end of life. I think we sometimes forget that that is a really important part of our system, both in terms of cost and in terms of cost to people's quality of life. So we want to think about it in terms of the whole continuum. The first barrier or challenge or caution I would raise is the lack of information available at all these stages. I don't just mean information, there's lots of information

out there, but information that is relevant to a particular individual. Perhaps in the right language, perhaps culturally appropriate, perhaps accessible where they are. So is there enough really useable information out there for all types of people to be able to make these decisions about their own health?

The second, which is the flip side, is the explosion of information. I don't mean to contradict myself, because I think we have both. It's drinking from a fire hose. You go on the internet and type in cancer, Lord only knows what you will come up with. I mean Googling cancer, Googling breast cancer, it's overwhelming.

Talk to people who are educated. Congresswoman Deborah Pryce from Ohio talks about this. Now she's a very high ranking member of the House from a very well educated background. She's a judge. She was confronted with cancer with her daughter. She had no idea what to do. There was too much information. She didn't know how to make sense of all the options – all the choices. And she had access to the NIH. She had access to the National Cancer Institute. It wasn't a question of not enough information; it was a question about how do I make this relevant to me? So that is the second caution I would raise.

The whole system is complicated and confusing. Look at the centerpiece on your table. I think it's a good reminder for us. It's fragmented, there is complexity. Depending on your ability to process information and where you are with your life, that complexity can be something you can manage or it can be something that is completely unmanageable.

Then there is the reality of when you are confronted with a health crisis. When you hear those three words: *"you have cancer,"* even if you are normally very rational, even if you're normally very good at reasoning through a decision and approaching a problem logically, a lot of times things just stop. We can't really understand what it is going to do to us until we get there. We may not be at our best in terms of decision-making ability. That one slide that showed the percentages of people that sit in the doctor's office who either don't hear it or don't get it right or forgot it, is telling. It gets compounded with cancer. Most people don't hear anything after they hear *"you have cancer"* and you have to go back and re-explore and have others help you.

So we are asking that people make rational decisions based on good information. Even if they have all the tools in front of them, at certain moments in their life, they may not be able to do that. So we need to think about that.

Then lastly, I would just say that there is generally a lack of transparency that's useful in terms of cost and quality of services out there. So, even if you have all of these things, just even figuring out where to go to get your mammogram or who to talk to about a clinical trial – that information is not very transparent. Who's going to pay for it? What does it cost? How effective is it going to be? I would just throw this out as food for thought.

With regard to consumer-directed health care, one of the cautions that we have raised about this concept of health spending accounts is this idea of the continuum. People may make rational decisions about spending their money. But they may not know that they are pre-diabetic, or that they carry the gene leading to breast cancer or that they have a hereditary risk. If they do know it, they may not think it's going to happen to them. So will people choose preventive services or early detection? If you have a finite amount of money to spend and you can husband it over time for that day when some acute crisis hits you, are you likely to save it all for that? Or are you going to spend it on smoking cessation or a colonoscopy or those kinds of things?

Again we need to build incentives into the system to get toward the front end where the patient has more control. That's the marketing and the behavior change that we've been talking about for two days.

I want to talk about two other issues. I want to give two examples of where policy is also important, colon cancer and smoking cessation. Smoking cessation and tobacco use has come up a lot in the last couple of days as an individually controllable behavior at least conceptually.

There are almost fifty million adult and youth smokers in the United States. Smoking is responsible for one-third of all cancer deaths. We know that seventy percent of smokers say that they would like to quit. We know that sixty percent of them try each year. We know that three percent are successful. So obviously we have issues, we have people who are far enough along on the continuum of being ready to try, yet we are having trouble with them trying. So this idea that it's all about will power and you just have to make up your mind to do it, is inaccurate. There are more proven tools that we can offer people to help them quit. So I hope that we think about not only giving people the information that smoking is bad and you should try to quit, but also the tools. Certainly policy can help in terms of providing those.

Secondly, on colon cancer. It is the number two cancer killer among men and women, yet it is one of the most preventable cancers out there if we can catch it early. Your 5-year survival, if you are diagnosed with pre-cancerous polyps or early cancer, is 92 percent. If you go to a later symptomatic stage of colon cancer, your 5-year survival rate plummets to 8 percent. Yet, only fifty percent of the population who needs to be screened is currently being screened.

Why is that? There are a lot of reasons. It's not a great topic, the screening is not that much fun, there are insurance barriers, there are cost barriers, there are access barriers. But we as a society need to do something about that. We could prevent a whole lot of needless deaths. I think it's about individuals taking control, but I also think it's about a system that's set up to help make that happen.

In one minute I am going to talk about what ACS does, because it's not just about asking other people to do things. There is a brochure back there about some of the things the America Cancer Society provides in terms of tools to help people navigate through everything I just talked about.

We have a web site and we have a call center. In our last fiscal year we took 1.2 million calls into our call center – it's open twenty-four hours a day, seven days a week, 365 days a year. If you call that number you will get a trained cancer information specialist, you will get navigated into systems within your community, and your questions will be answered. Our web site, *www.cancer.org*, received 17.6 million visitor sessions in that same fiscal year period. That's a lot of visitor sessions to help people get armed with good quality information.

We also do what is called patient navigation, similar to what Agnes [Hinton] was talking about with a different name and a different focus. It's about communities reaching out to communities with people of those communities to not only take care of people when they're sick and help them navigate the system, but also to bring people into the system earlier, before they are sick, and get them on a path of wellness and early detection. We think it's a program that the federal government could put some seed money into to help communities set up more of these programs around the country.

Earlier today it was mentioned that the American Cancer Society, the American Diabetes Association

and the American Heart Association have a partnership. This is something we are very excited about. It's called 'Everyday Choices for a Healthier Life'. These organizations focus on the top four or five killer diseases, chronic diseases in the country. We are coming together around a public health campaign that says *"we're not going to get down into the weeds talking about mammograms verses lipids versus this versus that, we are simply going to deliver four messages to the public: eat right, exercise, don't smoke, and see your doctor."* We've merged together all of our similar messages behind a common campaign and I think you will be seeing a lot more of that. We are working with the Ad Council on some marketing – you will be seeing more of that to try to simplify the messages and get everybody behind a similar set of recommendations.

Clay Ackerly, Special Assistant to the Administrator, CMS

Thank you for the opportunity to speak today. A lot of ground has been covered so far. I will just focus on a couple of projects that we are working on at CMS.

I don't know how many of you have heard Dr. McClellan speak. I know he wishes he were here today. He often talks about the unprecedented opportunities that the Medicare law has provided us to really improve the quality and efficiency of health care. Dr. McClellan has pulled together a quality council, a senior management council within CMS. I'd be happy to talk to any of you about what the quality council is doing. A lot of very interesting things are underway.

I'd like to focus my remarks on the personalization of medicine and the opportunities that we have to really personalize Medicare, what we are doing, and how it relates to how we are implementing the Medicare reform bill. I want to talk about some of the personalized health tools, not necessarily financial incentives, but more 'information therapy' tools that we are trying to provide.

We are exploring two types of activities. The first is providing direct communications to beneficiaries and decision tools online, including the quality and price of health care services. It gets to Wendy [Selig]'s point about transparency. The second is efforts to push the market towards personal health records, really getting to the fourth generation information therapy space that Ron [Bachmann] described.

In the world of beneficiary communications, we are doing a lot of work on quality comparison tools. We already have on-line information on health plans, dialysis facilities, home health agencies, and nursing homes for Medicare beneficiaries. We will have hospital information in early '05. There are many challenges surrounding how to measure and report information on the quality of care to consumers in a way that is meaningful to them. However, we have a dedicated staff that works in continuous contact with stakeholders and experts to ensure that we do so in a way that is consensus-based, valid and meaningful. In addition to quality information, we are trying to explore ways of getting price information out there to beneficiaries more broadly. In particular, we have already focused on the price of prescription drugs through the Medicare Drug Card program, and our Price Compare website.

This website does a lot of things other than support beneficiaries, and help them choose drug cards. It shows different prices across drugs, encourages generic use when generics are available, and even provides some information about potential therapeutic alternatives. But, getting back to Ron [Bachman]'s conceptual model, those are really just first and second generation tools. How do we get to kind of the fourth generation here?

We have two strategies that we are exploring. One is taking the information that CMS has on individuals already, claims information, and building it into effective tools. The next is supporting personal health records, such as WorldDoc, and other programs to include clinical information and patient self-management information, information that is more powerful than administrative and claims information alone.

Last July 21st, when David Brailer, the National Coordinator for Health IT, made his announcement about the administration's IT agenda, CMS announced the Medicare Beneficiary Portal. This portal will soon be piloted in Indiana, and will give Medicare beneficiaries on-line access to all of their claims information. At first blush, this type of tool may be viewed as merely a financial management tool. However, while claims information alone can only go so far, we are exploring ways to maximize the value of this information as a health tool.

One way we are trying to do that is in prevention information. As along as doctors bill Medicare for these services, we will know what preventive services Medicare beneficiaries have received. If individuals qualify for services, based upon U.S. Preventative Services Task Force recommendations, and the greatly expanded coverage of preventive services that Medicare will be offering, they should be receiving them. So when Medicare beneficiaries go on line, they'll see if they have taken the right services, and, if not, they will get reminders to do so.

But these sorts of tools don't really get into a lot of the detailed clinical information. So how do we build fully functional personal health records? We are exploring different ways to do that, looking at standards, financial incentives to physicians to upload information, and data links, for example, with systems like WorldDoc. Right now Medicare holds the claims information for Medicare beneficiaries. Can we share that information with other personal health records as long as we have beneficiary consent? Hopefully, that might spur the creation of personal health tools.

I won't talk in detail about it, but our Chronic Care Improvement Program, or CCIP, has a tremendous amount of potential to improve the care of beneficiaries, including in the areas of personalized health tools. We have provided financial incentives to these new entities and will soon be announcing some pilot sites. I know that a lot of them are creating these personal health tools, and are even reaching out to Medicare beneficiaries with more than just web-based services. And it's really in their best interest to use a 'multi-touch model' of outreach, as was described earlier. So I think we have a lot of potential in this program.

We also recognize that, whether it's thorough the Medicare Beneficiary Portal, or the quality compare web sites, or the price compare web site, we reach only those in the Medicare population who have internet access, or a caregiver who does. Hopefully, over time, access will continue to increase. In the meantime, however, we realize that we have to go beyond the web to reach our beneficiaries, and to empower them to make informed decisions.

So, they can also call and get all of the same information available on the web, over the phone. All they need to do is call1-800-Medicare, which is available 24/7.

We are going to keep moving forward with this agenda. I'm looking forward to the discussion. If any of you have ideas to help to move us forward to the fourth generation, we are eager to explore them. We must personalize medicine for Medicare beneficiaries and all patients, and we are doing all we can to maximize these opportunities that we've been given.

Ellen Severoni, President, California Health Decisions

Thank you. It is interesting that we've used the words pre-contemplative and contemplative because I'm probably going to slow things down just a bit.

First, I am delighted that we are talking in generations, because I love the idea that the younger generations are sitting here between the book ends, because it reminds me that it was 20 years ago when I got started in California with California Health Decisions, which was designed to be a consumer-based research and advocacy firm. I am a nurse by profession, and our original thoughts really had to do with the kinds of ways that consumers could be involved in the development and the design of the health care system. What did consumers think about the present system and how could it be changed?

I have to say that maybe I am feeling just a little bit saddened by the environment that I see around me today, but I think it is a rare occurrence for consumers to be listened to when it comes to designing, implementing and evaluating services and programs. In our experience throughout the years, it's been amazing at how simple the tools are that consumers ask for in order to navigate the system more easily. I have come to learn that if you want to create the best tool, the best program or the best system, all you need to do is ask the users. I have yet to find another industry like the health care industry. We really don't talk to the users.

Very few of us in California have our health care still provided by major employers. So, I am fascinated by the way a large employer can put a system together and actually get people to use the internet. When I talk to the more ordinary person who is with a small or mid-level employer, they're not at all supported by these systems. So I think getting to talk to the population is absolutely critical and it's something that has been resisted constantly for these twenty years.

I can give you an example. If you were to go onto our web site, which is CHD.org, you would see very basic tools regarding how patients use pharmaceuticals. Now, as a not for profit, you are always out raising money. So one of the things that we do is go and talk to a group of patients about what they need to better navigate a system, or to use a health care service, or pharmaceuticals and then come back and talk to appropriate funders about what it is patients are saying that they would like to have. Invariably what we are told is, *"Oh, that is so simplistic. Oh, we did that years ago. That's not what patients need."* They need whatever it is they are trying to market or program next month.

I see a lot of heads nodding. I think there are five V's that I would like you to consider and keep in mind as we go into the discussion period and I would love it if someone would ask me about a recent project we did on giving patients cash incentives to do some screenings. This is the first time we've looked at directly incenting patients with cash to go and do that.

So, the five V's that I am looking at are: Vision, whether you are talking about a large health care policy for the United States, which we don't have. As good as Jon [Comola] and Marcia [Comstock] are, I don't think we are much closer to that today, but I know that they have inspired us to go out there and push for it. Or a vision that people can actually get their arms around. So far we've been unwilling to do that. At the national or the state level you can't really point to a national or even a state-wide health care policy.

Now, I am looking at California, at Governor Schwartzennagar with hope that if anybody may be able to get to this issue of behavior change, it may be him. For those of you who have talked about creating

partnerships, I would tell you that Gov. Schwartzennagar's Secretary of Health and Welfare, Kim Belche, is very innovative and interested in the kinds of things that would put health and behavioral change on the docket for the governor. We are personal friends and I would be happy to put anyone interested in personal contact with her.

But having a vision on the larger policy is absolutely critical, and getting people to create that vision, whether it be a small tool or program or a large state or national policy, requires talking to us.

The second 'V' is values. Values are the way that ordinary folks talk about health care choices, and there are seven values that we've used over and over again these past two days. These values are choice, affordability, personal responsibility, accountability, fairness, dignity and respect and quality. Those are all important values to every consumer or patient you will ever talk to. You can't make any one a priority over another. They are like a tapestry, they all come together and people use them to make trade offs. We know in health we are going to have to make trade offs. Use a values framework and you will get people to be able to do that.

Voice. I've heard that the most successful efforts involve going out and talking to users. Let their voices tell us what it is they want. Using the response works much better than creating programs without it.

Victims. I think it's important to remember that there are victims as a result of the way this health care system or 'uncare' system is currently designed. I'm not on the left side of this political spectrum, which is unusual in health I'm told. I am not one that likes using the word 'victim', but at this conference we heard from Ian [Morrison] that children born since the year 2000 are the first generation of children in America whose life expectancy is not as long as their parents. My daughter is just about to get married and have my grandchildren. I look at that, and I'm really scared and I can see they are the victims of our inaction and sometimes I think our good intentions.

I think that we are all victims right now of a system that has been designed with perverse incentives and we've heard what some of those incentives are. We know that if we were able to talk more to chronically ill people, they would tell us how to make better systems to treat them. But if we do, health care systems are not going to make money, because we are risk averse and we have perverse incentives that mean if I get all of the sick people in my institution because I am doing a good job, I am not going to get the money to treat them. So, I already have a built in incentive not to talk to chronically ill people who could tell me what I need to do for them to get better. So I think that there are many victims in this system.

And finally, victory. I think that victory will be had when we get a full integration of the body, mind and spirit and spiritual aspects of health care. I know we barely skirt around talking about the spirit and the importance of spirituality to the individual, because we are afraid to talk about God, and we are afraid to talk about religion and we are afraid to talk in terms like this. The closest we get is to talk about the Sabbath. People who observe the Sabbath like we do in my house, from Friday night at sundown to Sunday night at sundown when no work is done, could tell you the change that occurs in our family and our family life as a result of that rest period. And it is not all focused on church or synagogue. We do both in our family.

If we want to know why people are spending so much money on alternative health care therapies, it's because they have done well integrating a spiritual component into what they provide. We have a couple of days with the brightest people in the country here, and spirituality is nowhere on our agenda.

Session IV Discussion

Opening new channels for health communication

The discussion began with a participant's comment on how struck he was by studies showing how little patients remember after physician visits—and the dearth of information that physicians typically impart to them. Given the inadequacy of most physician-patient communications, *"does that mean that we should just simply stop worrying about that?"* he asked. *"Should doctors forego providing health education and put their time and energy into more productive patient-care efforts?"*

Dr. Reeves responded that, although good physician-patient communications remain vital, innovative channels for delivering health information need to be opened. Importantly, physicians should not be viewed as the *only* resource for patient education. He noted that in his health plan (the Culinary Health Fund), many Hispanic beneficiaries trust their union and coworkers, who are akin to extended family, more than their doctors. He also pointed out that physicians cannot provide health education if patients do not show up for medical appointments, as often occurs with the diabetes patients in his health plan.

On average, patients visit a pharmacy four times as often as their doctors, he estimated. Moreover, in a physician's office, patients typically have only about 8 minutes of 'face time' to discuss health concerns. *"If you count up the minutes in a year [for doctor-patient interaction], it's not much penetration,"* he observed, particularly when compared with the myriad messages people receive through television and other media. To reach patients, *"we have to take the care to them,"* he emphasized, whether this occurs at a workplace, church, pharmacy, or community event.

Working collaboratively with physicians in the Culinary Health Fund, Dr. Reeves is exploring strategies to better engage patients in health education and self-care strategies. One promising approach is the use of medical assistants in physicians' offices to perform services similar to those of community health advisors. The Culinary Health Fund has created a professional development program for medical assistants, which trains them to oversee the completion of medical task lists for diabetes patients. To help incentivize these patients to comply with follow up care, they also receive coupons that waive co-pays when recommended tasks are performed. By tracking coupon redemptions, the health plan has a way of measuring whether or not the task was done. *"And it gets the task done, because we have found that a $5 difference drives the behavior of our members,"* Dr. Reeves observed.

In addition to medical assistants, *"other health care professionals are very much part of the team, particularly registered nurses in many settings,"* a nurse participant added. She described a recent collaboration between the American Nurses Association and a pharmaceutical company, in which nurses were used to promote public awareness of hypertension and provide blood pressure screenings. During this ten-city tour, which was publicized by media coverage and radio announcements, one patient commented he had learned more about managing hypertension from this nurse-led campaign than from years of seeing his physician and taking blood pressure medications. *"It's a team effort,"* she emphasized, *"and we are all going to have to work together on the pieces that we know and provide continued follow up."*

Severoni pointed out that radio is an especially useful medium for delivering health information to the public. Because driving tends to be a rote activity, people are more likely to be pulled into what they hear and relate to it personally. *"We know that hearing as well as seeing certain things tends to intensify information that we take in,"* she commented.

Emerging internet technology also is poised to deliver more direct and individualized health information to people. Bachman commented on the development of 'push technology' that sends tailored online

information to people based on their needs and interests. With this interactive technology, a profile of the patient's health information preferences is created, then relevant findings are automatically delivered without the need for consumers to search for and sort information. *"You start to get information pushed to you based on your personal needs, rather than having to go out and trying to find the information out there,"* Bachman explained. *"I am very optimistic about where technology can take us in providing access to information that is very personalized to our health care needs."*

Although innovative channels for health 'information therapy' hold much promise, the traditional role of the physician as a health educator should not be neglected, another participant emphasized. Research has shown that patients value the advice they receive from physicians, and they are more likely to comply when the doctor has recommended taking action, such as getting a mammogram or seeing a health coach. Such advice *"only takes a few minutes, and it is a very important role for physicians to validate the supportive services that are available for patients,"* she pointed out.

However, the increasing scarcity of physicians' time with patients poses a major barrier to engaging in this important communication. Dr. Reeves shared that his health plan had conducted focus groups with participants who were grouped according to their ethnic heritage. *"One of the questions asked was, 'who gives the best health care: the doctors in your home country or the doctors here?'"* he recalled. *"And uniformly the doctors in the home country were best. We then asked why, and our participants, who are not highly educated, had very concrete, specific answers. They said 'the doctors here don't sit down; they don't take their hand off the door knob'"* to spend time talking with patients.

In another revealing anecdote, Dr. Reeves recounted his experience running a large group practice in which patients voted annually to choose the best provider. Although the practice employed 130 doctors, *"three years in a row, the award was won either by a nurse practitioner or a physician's assistant,"* he recalled. *"The reason was time—sitting and listening. You just cannot over emphasize the importance of that. But, unfortunately, we physicians have boxed ourselves in by wanting to race to keep having the right amount of money flowing in."* By limiting time with patients, physicians have lost an important tool that could significantly improve health outcomes, he concluded.

Removing other barriers to health communication

In addition to limited time, lack of provider skills and health care jargon also hinder patient-provider communication and understanding, several attendees noted. One participant, a hospice provider, pointed out that health care providers often lack the skill to tell patients the truth in difficult situations. *"Working with certified clinicians in palliative and hospice care, I see every single day patients and families in tears. 'You are the only one that has told me the truth,' they say. 'You are the only one that has given me the benefits and the burdens to my choices. I have four doctors, three case managers. None of them know me, none of them knows my family.'"*

This problem stems not from bad doctors, but from *"the system being so fractured, so broken, and so full of fear that no one finishes the conversations,"* she observed. *"And it's not just about dying, it's about the promise of comfort that our society is able to do. We are able to offer comfort on any level: physical, emotional and spiritual. And the system is not built for it."*

Another participant remarked that the widely used term 'patient' impeded a broader understanding of the diverse issues affecting health. The problem with this term, she noted, is that it *"doesn't allow us to look at the totality of people living their lives. If we always talk in terms of 'patients,' we are not going to see the bigger picture of people's lives and their impediments to taking action or what really involves them."* She urged providers to get away from constant medicalizing and compartmentalizing people when

discussing health and wellness, because so much happens in people's lives outside the narrow arena of health care.

Bachman agreed that choosing the right terminology was key to promoting a full understanding of the issues. For example, in the health benefits world, he recalled it took a long time to move away from use of the term 'defined contribution,' which he views as a very negative term. Often, the media picks up a term, which then becomes embedded in everyday public discussion of issues, for better or worse. *"The reality is that you live with what the press uses over and over again,"* he commented.

Using incentives as tools to change health behaviors

Much discussion focused on the use of financial incentives—and disincentives—to motivate physicians and patients to improve health outcomes. One participant asked Dr. Reeves for more information on his health plan's use of a gold star to designate those physicians who provide the highest quality care. Dr. Reeves explained that his health plan issues a performance report card for network physicians in primary care every six months, and this approach is being expanded to other high-volume practices, such as cardiology, general surgery, and orthopedics. The performance report evaluates physician practices for their efficiency, effectiveness, adherence to guidelines, use of generic medications, work load, and patients' demographic characteristics. These data are adjusted according to each practice's case mix, so physicians can compare their performance with their peers in the health plan. The report card gives much greater weight (three times as much) for the effectiveness (quality) score as for the efficiency score.

The top 50% of performers qualify for a bonus and receive a gold star in the health plan's provider directory, which is reprinted after each profiling. Bonuses are determined as a percentage of a physician's prior six months' income, and those in the top tier of performers get the highest percentage. The bonus can be quite significant: one internist, for example, received a $25,000 bonus after one six-month profiling period. *"It's substantial and it gets attention,"* remarked Dr. Reeves.

A different strategy that really got doctors' attention was the health plan's decision to terminate some physicians from its network based on poor performance. *"It was a gutsy move,"* recalled Dr. Reeves, who added the terminated doctors were *"clamoring to talk with me about 'how dare we do this.'"* Physicians who were dropped from the plan were offered an opportunity to rejoin the network if and when they produced two continuous years of data showing at least equal or superior performance compared with their peers. In summary, *"it sometimes takes positive incentives and sometimes negative incentives—and a lot of information to your participants—to make this work,"* he said.

Severoni commented on the use of incentives to motivate healthier behaviors among patients, based on information from focus groups with adults and adolescents in California. This market research revealed that cash incentives would increase consumers' completion of key health screenings, such as blood tests, mammograms, and, potentially, colonoscopies. Focus group participants also said an incentive to get more exercise would meet with greater success than one for weight loss. Adolescents also were clear about incentives that would motivate them to make positive changes in behaviors, such as their preference for receiving CDs instead of cash as a reward.

Severoni added that if patients qualified for an incentive, they wanted to redeem it immediately and not get bogged down in administrative red tape. Consumers also were concerned about fairness and wanted reassurance that others would not abuse the incentive system. *"They wanted to know that safeguards had been built into the system to prevent people from getting a cash incentive when they had not done what they were supposed to do," she explained. Patients who had Medicaid coverage were not in favor*

of incentives and this population "wanted assurance that there would be not strings attached or a catch to the program," she commented.

With the proper patient support in place, the system can promote greater compliance and achieve fewer re-hospitalizations, less complications, and better recovery rates. *"What we need is a system that looks at holistic care and provides the consumer with the options to do that."* Another participant, a cancer survivor, expressed doubt about the use of financial rewards and disincentives for motivating compliance, especially for patients with serious illnesses. He was concerned about offering monetary 'carrots and sticks' to people who may be too ill and overwhelmed to think about this added task. Speaking from his own experience, he recalled, *"when I went through cancer treatments, compliance was very difficult at times because some of the drugs make you very sick and you can't take it any more. And to have the idea of [dealing with] a financial stick or carrot just makes it psychologically more difficult."*

Bachman, however, expressed confidence that new systems of health care on the horizon will be able to integrate rewards for healthier behavior with a holistic approach that respects and responds to patients' needs. As an example, he mentioned a compliance program on which he worked closely with the American Psychological Association.

Using health savings accounts to drive change

As history has clearly shown, information alone often is not sufficient to change people's behaviors, Bachman pointed out. A more effective model would be to integrate the use of information with other tools to encourage positive behavioral change. *"It seems as though people are not as interested in their own good health as they are in financial incentives, which are really starting to play out very strongly,"* he commented.

Bachman cited employers' growing interest in Health Reimbursement Arrangements (HRAs) as helping to spur the evolution of a new system of consumer-driven health care. *"HRAs have created a tipping point in the employer marketplace,"* he remarked. This type of benefit plan design typically combines high deductible medical insurance plans with a health savings account that beneficiaries can use to offset insurance cost sharing, such as for copays and deductibles. Employers contribute money to the health savings accounts, and untapped savings can be rolled over from year to year. Although HRAs are in an early stage of adoption, they have enormous potential, Bachman said. *"The movement in the commercial marketplace on this is enormous."*

However, one participant raised a concern that some people may be reluctant to spend the money in these accounts. Instead, their goal may be to save the money by rolling it over from year to year, reducing the likelihood that they will get important screening tests that could aid early diagnosis or prompt visits to a physician. Bachman responded that this worry is *"one of the myths that just doesn't exist in the marketplace today."* In fact, he said, these accounts typically are attached to health insurance plans that offer full coverage for preventive care services. Moreover, as this type of health benefit evolves, there has been increasing emphasis on incentives for wellness and early diagnosis, he said.

Because employers fund HRAs, these accounts provide a powerful tool to incentivize patient behavior, Bachman noted. For example, *"employers could offer a higher contribution level to reward healthy behaviors. For patients in disease management programs, combining this type of financial incentive with health information can generate far greater cost savings than just the information alone,"* he emphasized.

To really drive change in the nation's health care system, Bachman advocated creating a consumer-driven approach to health care that would be available for everyone, not just those covered by

employer-sponsored plans. He predicted that the nation will not achieve a successful new model of health care without devising solutions for uninsured Americans and revamping policies for Medicare and Medicaid beneficiaries.

He recommended two specific changes in Medicare that could drive tremendous savings in the health care system. His first recommendation would be to eliminate limits on the number of hospital days in Medicare Part A. *"There is no reason for that except that it helps to sell Medigap policies, which people waste their money on,"* he remarked. If the money people currently spend on Medigap policies instead were put into a tax-advantaged health savings account to pay for medications, for example, *"we wouldn't need a whole new federal program to pay for prescription drugs,"* he said.

Bachman also recommended that beneficiaries should have a zero balance HRAs attached to their policies. Within these accounts, money could be added based on the patient's compliance with recommended care. *"There are probably eight or ten different ways to reward and incentivize people for doing the right things,"* he commented. *"In the Medicare population, the move is away from a fee-for-service system to one that has consumer involvement. As long as the beneficiary or the employee does not have a financial stake in the game, they are not going to change behaviors."* When it comes to providing information alone, *"you can talk until you're blue in the face, but it's just not going to get you there."*

A human resources executive provided an overview of key steps to reform the current system of health care, from an employer's perspective. *"The first is to increase our focus on consumerism,"* he emphasized, such as through the use of personal health coaches, incentives to increase health screenings, health risk assessments, and strategies to get and keep patients with chronic conditions in disease management programs. He also called for greater disclosure of health plan outcomes, so both consumers and purchasers could better evaluate care in terms of quality, efficiency, equity, and patient satisfaction. Other factors that employers are focusing on are 'pay for performance' (e.g., rewarding providers for quality) and wellness promotion. *"Employers are moving in the direction of these four items with a strong belief that we've got to fix the system that is really broken for all of us,"* he commented.

Bachman added that employers also need to implement benefit plan designs that provide financial incentives and rewards for patients. *"You don't want to lose out on the potential of a financial incentive, which seems to really drive a lot of folks,"* he remarked. Especially, *"don't overlook the idea of an HRA, which is the most flexible vehicle ever created by regulation,"* he advised. These vehicles have enormous potential and are poised to become *"the next frequent flyer program to incent and reward behavior change."*

Session V: From the Classroom to the Clinic

Marcia Comstock

The next session will focus on an issue which has come up several times so far at this meeting. It is all well and good to provide information and incentives to people to change their behavior, to become compliant with treatment, to do the right thing. But what if the doctor doesn't go along with it? So, we are going to be hearing from several people about their ideas on engaging physicians.

Gregory Caroll with the Bayer Institute for Health Care Communication knows a thing or two about how to talk to doctors and how to change their behavior. Andrew Robinson knows a thing or two about being a patient, and has some very cogent comments for what he thinks need to happen to enable doctors to become more engaged with their patients. And Dave Kendall knows a thing or two about health policy,

and will speak from the perspective of what needs to change to support this kind of movement.

Greg Carroll, PhD: CEO, Bayer Institute for Health Care Communications

(Presentation slides are available for downloading from www.wrgh.org.)

Good afternoon, everyone. It's a real pleasure to be here and presenting with the likes of Dr. Prochaska and Dr. Reeves and others. I must say they prepared the way very well for me. My hope is not so much to cover a lot of points today, but as a good ol' professor friend of mine once advised me, try to uncover a little bit of ground, rather than putting a cover over the whole thing.

I did take the liberty of preparing a few slides. I also have a few very brief video vignettes that I am going to show you and ask those of you that are not clinicians to take the role and pretend that you are. I am going to show you three of most clinicians' least favorite patient presentations, the ones that are so-called 'difficult patients'. And I am going to ask you to choose A, B or C as a bit of an experiential quiz, and also to lend some support to my thesis that it's not difficult patients, it's not even difficult doctors. It's about difficult relationships, like in many other avenues of life.

Finally, I promised to also say just a bit about the Bayer Institute and our program 'Beyond Informed Consent', which is all about shared decision making. We published an article about the program in June of last year in the *Journal of Clinical Outcomes Management*. I brought enough copies for everybody. If you would like to know more about how the Bayer Institute works with many of our 200+ program partners or health care organizations, I brought copies of the latest case study which involves the COPIC Insurance Company in Denver.

The news is grim when it comes to the scientific research on just how frequently and just how deeply the average physician gets into shared decision making with the average patient. One facet of the 1999 Braddock et al. study that was shown on the slide just before lunch by Dr. Jerry Reeves, referred to a little over a thousand patient visits that were recorded and analyzed by independent trained observers. Over 3000 medical decisions were involved in those 1,000 visits. Braddock's group looked in each case at what they considered six elements of informed consent or shared decision-making.

The first element was that the decision itself was raised and discussed during the course of the visit. Second, that there was some discussion of alternatives. Third, a discussion took place about pros and cons. Fourth, there was a discussion of any uncertainties. Fifth, and this is the key, an attempt was made to assess the patient's understanding of the decision or the decision implications. Finally, there was some exploration of patient preferences.

On the slide you saw earlier, there was the finding that only nine percent of all the decisions reflected even a fairly limited degree of shared decision-making. When you look at those six elements, which are pretty reasonable as elements for a decision-making discussion, only fifty-one percent of all those decisions being discussed had one element discussed. Only twenty-four percent included two elements, only six percent included three elements. Are you getting my drift?

Not one out of three thousand included all six elements, not one. The one element that is probably the most important, both in terms of developing and strengthening the doctor-patient relationship and the one leading to a higher likelihood of patient adherence or compliance, is a discussion and an exploration of the patient's understanding. That element was the least frequently noted of the six elements, appearing only two percent of the time.

So we've got a problem here. It's graphically like this centerpiece on your table, which might be also a facsimile of the model of collaborative clinician-patient decision-making.

I want to suggest as a sub-title for Beyond Informed Consent or shared decision-making, *'What's a clinician to do in today's health care world?'* My presumption is if and when there's going to be decision-making that is really shared between clinician and patient, a lot of the things are going to be required. A high level of trust is a key essential ingredient. A good working relationship would be helpful. Sometimes that's tough when you're working with someone in the ER or a hospital, because trust often takes a long time to develop.

Obviously there need to be good communication skills on the part of the clinician. There needs to be adequate time, and there also need to be incentives in place to practice those communication skills and actually put them to good use. And finally, there needs to be a continued commitment and a conviction from both parties as to the value and the need for the shared decision-making.

We have a major problem as Dr. Prochaska said so well yesterday evening. We have health care organizations and health care settings which all too often seem to be producing non-compliant patients and demoralized clinicians, and that's not conducive to the kind of shared decision-making that we think would be ideal.

Let me say a word or two about the Bayer Institute for Health Care Communication, since it may not be a household word just yet around your offices. We were created by the Bayer Pharmaceutical Division back in 1987. I joined the fray in 1989 as the first full time manager for the program. We began training clinicians in half-day workshops in 1989, and we became a separately incorporated non-profit organization in 1992. At the current time about one-third of our funding annually comes from Bayer as a grant, and the other two-thirds comes primarily from our client organizations.

We have developed, since 1989, about a dozen different communication training programs. One of them is Beyond Informed Consent. Another one I am going to talk about is Difficult Clinician Patient Relationships. We've trained in over 800 faculty across the United States in various health care organizations who are certified to teach these programs and to provide the follow up coaching. Since 1989 we've administered half-day to one week programs to upwards of a hundred thousand clinicians.

We also conduct research on the topic and have a pretty active advocacy program, including a project we just concluded with a grant from the Robert Wood Johnson Foundation that was written up as a 150 page supplement in August in the *American Journal of Preventive Medicine*.

I'd like to pick up where Dr. Prochaska left off and talk about what I would call 'lower case' decision-making, the day to day on-going decisions about exercise, diet, smoking cessation, and other health behaviors made by patients. As aptly pointed out this morning, it's the doctors that advise and it's the systems that reimburse, but it is the patient that decides.

We do know that tremendously important outcomes ensue from improving the quality of communication between clinician and patient. Among them, for patients, research shows improvement in satisfaction with the interaction, as well as improvement in health status. Family and friends even benefit when communication works well because they have an opportunity to be more included. For the clinicians, research confirms better satisfaction with their practice. Reduced health care costs are also confirmed, and employers can see the benefits of this.

This slide simply shows the five steps the Dr. Prochaska talked about as a spiral staircase leading to what some people consider a sixth stage. If you are fully ensconced in the maintenance level you actually identify yourself as a runner, a non-smoker, etc. We made it a spiral staircase to show the strong possibility of cycling back and moving back down the staircase. So there's nothing to prevent me as I'm zooming along in the action stage from relapsing on any given health behavior back into not only contemplation but even pre-contemplation.

Dr. Prochaska mentioned that not only do we have the different stages we go through, they vary from one behavior to the next. It's quite clear from decades of research that without really good behavioral health communication programs in place, as a group, patients really don't adhere very well, particularly when it comes to long-term regimens.

Dr. Prochaska gave the example of a newly diagnosed patient with diabetes and heart failure where treatment is also multifaceted. It's particularly difficult when there are no symptoms. All of these things contribute to increase the likelihood of non compliance, unless something happens to make it more likely.

One of the things we talk about with our 'lower case' decision-making with people that attend our workshops or who become members of our faculty is, what is this experience like for the clinician? What is the compliance rate of the typical physician in United States care in terms of complying with the directive to help patients adopt a healthier lifestyle? This is quite parallel to what's happening in patient compliance. In fact, the same types of compliance problems manifest themselves in the physician behavior as in patients.

In our workshops, we ask clinicians to consider the following question: *"How good am I at communicating with and helping to persuade and support patients who want to stop smoking, or lose weight, and so on?"* We ask the clinicians, as they interview each other, to consider a couple of simple questions. *"In the course of your medical practice, how convinced are you that you need to be doing this as a regular, ongoing, integral part of your routine? Give a number from zero to ten, and put it on a vertical axis."*

Then we ask, *"Completely independent of that, how confident are you that you have the resources that you need to do it?"* That goes on the horizontal axis. This exercise puts people very quickly into one of four quadrants. Then we begin to talk to them about what would help them move from maybe a two on the conviction scale to maybe a five on the conviction scale. Or what would it take for them to move from a four on the confidence scale to maybe a ten on the confidence scale? Obviously, as you move to the upper right quadrant you're showing higher conviction, higher confidence, much more likelihood in both the Prochaska model and the Miller and Rollnick model of Motivational Interviewing, to achieve behavior change.

This exercise helps clinicians to realize that their predicament is really not too different when it comes to complying with these directives about helping patients change, as compared with the predicament that patients themselves are in with the need to change all these behaviors.

There are three basic skills that apply in this conversation with patients about behavior change: first, asking before telling, that is, assess the understanding of the patient before you start giving the message. Second, build rapport and add reflective listening skills and also empathic communication. Third, tailor the message and method to the individual's situation. We find that clinicians report that they are all over the place in this continuum of confidence and conviction.

We then ask the clinicians to turn it around and do the same thing with patients. Have patients identify on a zero to ten scale where they are with conviction and confidence, and where that puts them on this four quadrant grid.

It becomes apparent that the challenge for the clinician can be quite different in different situations. The challenge is not necessarily to get the patient to stop smoking in the next three minutes. The challenge may now be reframed into what can do as a clinician, over the course of time, to move me from a two in confidence to a ten, or at least a seven or eight. Or more difficult, what must happen to move me from a three to perhaps an eight or a nine?

One patient may be stuck in the lower right quadrant because he is skeptical, but is a 10 for confidence because he believes that he can stop smoking any time he wants to. *"What's the big deal? I stopped last week. It wasn't hard, but why should I?"* For many clinicians this becomes a very sticky point. For others it may be more difficult to work with patients who are frustrated because they have the conviction, but they just don't have the confidence to do it.

To give you more of a perspective on this from the clinician's perspective, I would like to show you three vignettes. These were chosen from a video of about fifteen that we unleash on clinicians when they spend a half day in our Difficult Relationships workshop. I think this may underscore for many of you how tough it can be, given all the system requirements and the insurance issues and all the other things that a clinician has to be worried about today. Many clinicians who find it so difficult to have these discussions because of time and other reasons are, to some extent, also traumatized by some of the worst interactions they've had with so called 'difficult patients.'

I'm going to show you three. I'd like you to just jot down on a piece of paper, which one of these gives you the MOST immediate desire to go home. Not that the other two will be easy, but which one gives you the most difficulty: A, B, or C. I am going to ask for a show of hands.

Video A: Female: *"I can't believe this is happening. This replacement therapy is driving me crazy. I've tried very hard to go along with you. I never thought that this could happen. Three months ago I was thinking I would have a child. You told me you didn't think you'd have to take my ovaries. You quoted me statistics – you said you were sure I'd be fine. Now I'll never have a child, I'm a wreck. It's impossible to have sex. You act as if though you could care less that you left me totally worthless without anything to live for. You've ruined my life and you promised me that I'd be fine. I can't believe the way you're acting, you just don't care!"*

Video B: Female: *"It's really not so bad you know. He didn't mean to hurt anybody. He really can be a very nice man and a good father to the children. He bought them some new toys last week. Please don't report him. We can't live without him. He brings in the only money the family has. Please? It was partially my fault. My eye…. it's not so bad. Please, just, uh, give me some pills for my nerves so I can sleep. It's so tough, you know? You gave me some last time and I lost them so I haven't been able to take them. It's so difficult. Do you think I will need a cast for my arm?"*

Video C: Male: *"Don't mind me with these positions. It's my back. It's like before, I would be talking and then all of a sudden I'll move and then it will just lock up on me. It's like someone is twisting a knife in my back. I know it's the disk and I don't want to see a surgeon and I don't want any extensive work done on it. At work they are making noises about me and about this particular injury, so I think it's time that we claim this as a disability. I brought these papers with me for you to sign."*

In our workshops, we show twelve more cases. We ask participants to vote on the top 5 of the 15. Then

we ask *"Does anybody see a pattern? Look at the five choices you made. Does anybody see a trend or a consistency that they would like to talk about?"*

And every hand in the room goes up and people notice different trends. Let me try to test the thesis. How many of you, if you were a clinician, would have voted for case A, *'You just don't care?'* I'm seeing close to half the room.

How many for B, *'Please don't report him, he's the only income we have?'* At least a third of the room.

How many with the bad back, *'Just sign these papers…I'll get disability?'* About a third of the room.

These vignettes are all based on actual cases. Nobody can agree on which is most difficult. There is no such thing as an objective 'difficult patient,' it's the relationship. And that all depends on what we bring to the story—our eyes, our ears, our hearts and our minds. So, recognizing and managing these things, and finding out what our hot buttons is a big step toward getting to a more collaborative relationship with patients.

Andrew Robinson, JD: Founder & CEO, Patient2Patient, LLC

I was a trial attorney for many years. The one thing you never wanted to do as a trial attorney was to sum up after lunch. You would do anything. You would hold a witness for hours, you would come in lame. And somehow my karma is I'm speaking after lunch again.

I've got a number of different areas that I would like to touch on. The patient/physician relationship isn't an area that I talk about much anymore. I am more of an information tools wannabe. So I've tried to put things together and reflect what's been discussed. My remarks may be a little disjointed but I think they will better reflect where we are now.

I'll tell you a quick story. A patient goes into his physician and the physician has been running a number of tests, and says, *"Look I've got very bad news, you've got less than six months to live." The patient is devastated and says, "How can this be, I've got a family, I've got my life, my work. In six months I couldn't even pay your medical bills!"* The doctor thinks about this for a moment and says, *"All right I'll give you another six months."*

I have one prejudice as a patient which will be reflected in this discussion concerning physicians. It's not what you think - Physicians are my heroes. I would not be here. More importantly, I wouldn't be going home to my family if not for the unbelievable work, dedication and perseverance of doctors. As far as I am concerned you can't pay doctors enough. You can't do enough for them. What doctors do is incredible, and unfortunately, the way the health care system has been developing, doctors have become kind of the 'point of fault'. When I do talk about some of the shortcomings of doctors it's only in light of gratitude.

I'm talking about the physician-consumer relationship. Except it's supposed to be the physician-patient relationship. And it raises a question: When did I become a consumer? I don't consider myself a consumer. What I go through doesn't have to do with being a consumer. Why is that important? Because we now have this consumer overview, which is important, and it's valid because there are economic issues, but you need to be very careful when you start using the wrong lens to look at people. It's very easy to call people consumers. It's a box, it's simple, it's glib, but it's also very unemotional. It

doesn't take into account the real struggle and drama that people go through. So when you go back to your organizations, when you're looking at things, be very careful about making that distinction.

One of the difficulties is, in this level of audience, we have to look at the large view of what's going on. It has to be theoretical. It has to be large groups, but you tend then to start losing the focus on the individual. And everything we are talking about is *'what helps patients'*, both for the real value for their lives and the lives of their families, and I would say secondarily, although it becomes more of a concern, the economics.

Another difficulty I've experienced and we have been discussing, is that we want physicians to listen to patients. It's important for physicians to listen to patients and we get very upset when we see that they are not listening to us. But you have to look in the mirror at your own organization, group, or corporation. Are you listening to patients? Are there patients on your advisory board? Where do patients fit into your strategic planning? You need to start bringing the input of patients into your decision-making process.

I've been to conferences where I've stood up as a patient and people have looked at me like – *"Oh, a patient. What's he doing here?"* Unfortunately, it's really been like that.

There are a lot of smart patients now. Patients can give you the feedback and things you need to know, so you want to try to bring us in. It's like having a civil rights meeting without any minorities there. We have to start realizing it really has that kind of import.

We are talking about physician-patient shared decision making. Again, what is the idea of shared decision making? When you go to buy a car, you don't go to the salesman, and the salesman says, *"Great, I'm glad you came, we're going to share this decision making process of you buying a car."* You would say, *"You're nuts. I'm deciding what car I'm buying and you're giving me information."*

From my perspective as an engaged patient, I'm not sharing this decision with anyone. I'm the one in the hospital room at three o'clock in the morning in pain, lonely, frightened when the doctor is gone, the nurses are not around, my family is asleep…its just me. I am the one that is ultimately responsible.

An important thing to understand is, even if the patient's making the decision doesn't affect the outcome, it is everything for the patient to feel that he is the one that is guiding his own destiny. it's very important that patients have that sense of decision-making, that they're empowered. Because whatever the outcome--good or bad or somewhere in between—it makes all the difference to the person how they are going through this.

The dynamic has changed. It used to be the physician said this and the patient did that. But now patients have so much more information. We have the Internet, we have all of the resources, and information equals knowledge equals power. I can go in and have more information on certain things than my doctor does because I have more time, I have more access, and I can talk to other patients about the real world viability of what's happening. So that's how the balance has started to change.

The other factor is that often times the physician can't be certain what the best course of treatment is. We look for evidence-based medicine. But medicine is always changing. Look at breast cancer. A physician can't say for breast cancer what is the best procedure. It's not clear. So it's as much the patient's decision as the physician's. Neither one has a superior basis for decision-making. I need the physician to be able to tell me what the different probabilities are, what their experience is, but

ultimately they don't know the answer any more than I do.

As far as shared decision-making goes, there was a major HMO study done about four or five years ago, about what qualities patients most valued in physicians. So think about that for a moment. What do you think the top things are going to be? Ninety-eight percent - Compassion. Ninety-six percent - Partnership. Questions of quality or competence weren't even on the screen. People assume that.

So when we're talking about shared decision-making, what we're really talking about is feeling that there is a relationship with the physician. I'm putting my life in your hands. I don't know what the right thing is. All I know is that I am facing cancer or a diagnosis that is going to affect my ability to do things for the rest of my life. I want some relationship with you. I want to feel that you see me as a person, and that is the basis of your consideration.

There is a sense I get in the physician community that you don't want to give patients false hope. I would say the real problem is false despair. From my own experience, ten years ago I was out west on a camping trip and went in for a blood test because I was a little sick. Doctor came back, introduced himself as an oncologist, told me that I had a terminal and incurable form of leukemia and less than five years to live. And that was the conversation. He said you don't have to hurry back to New York because they can't do anything for you.

Okay, what he said was the "truth". What he could have said was, *"You have a very rare disease for someone your age. The statistics that we have are for people over seventy years of age. We don't know how long you might be able to live but we have a lot of new chemotherapies and medications which can extend your life for a very long time and during that time we might find a cure."* Which is, in fact, what happened. They started doing bone marrow transplants for people my age with this disease. Same information, same truth, presented differently.

Not only does it have an incredible personal impact, because nothing will make you tailspin more than getting hit with that kind of news. But if you keep getting hammered with it enough times, and I have seen it with many patients, the whole mind set, compliance and everything else, you just start going down. You just go into this cycle of depression, despair, frustration and it's very hard to get patients to do anything to break out of that cycle when it's reinforced by their doctor.

So, how do we reshape the doctor-patient relationship? I think you have to differentiate between new doctors and old doctors. New doctors need training on how to talk to patients. I see it more and more. The new doctors are coming in – they're kind of cute, they're kind of funny. They ask *"So - how are you feeling?"* But they are making efforts to relate on that level. I think what we need to accomplish is at the medical school level. All of the medical schools have training programs, but my sense is, it's kind of a throw away. *"Yes, we have a training program..."* We need to encourage the best training programs, the best practices, either through journals, publications, organizations, government grants, so we get the best training possible for all up and coming medical students.

The question is, with the older doctors, however you define older, that's always kind of a moving number, how do we change that dynamic? And I think it's behavior modification. What have we been talking about here? It's ego and money.

Here's my suggestion, have a patient rating system. My company, Patient2Patient, started years ago and maybe we were a little ahead of the track. Some health care organizations are already doing it for different physician qualities. Let the patients fill out a form that lists: did the doctor do this, did he talk

to you, did you feel that you were informed… Get enough responses and put it into a database. For ego reasons doctors don't want to see that they are on the bottom. In addition put in monetary incentives just like you do for other quality initiatives.

If anyone wants to talk about that, we've done a lot of work on it. I would be happy to speak with anyone in that capacity, health care organization, corporation. It's not an expensive tool to put into place.

The biggest problem that we have been talking about is time. I am going to suggest a much different approach, because if you have doctors with eleven minutes for an office visit, okay, it's not going to happen. You are not going to have an effective and meaningful patient/physician dialogue. It just can't happen. I mean, you take any one of the patient situations we just saw and that is not an eight-minute conversation.

I would rather spend twenty minutes with a clinical nurse really talking about what's going on than eight minutes with a 'drive-by doctor'. A 'drive-by doctor' is a doctor that is walking out of the room as soon as he gets in the room. My wife and I have a technique when we are meeting with a new doctor. She goes and stands by the door. And finally they figure out that they are not getting out of there until we get the answers. If it's a continuing problem, then I am not going to see that doctor again.

Any of the demonstration patient videos we just saw are not a discussion for a doctor. It's not their training, it's not their background. We need to bring in more nurses, other health care people, intermediaries. And the doctor needs to come in on the top tier to help resolve the medical aspects of those problems. To come in where the doctor needs to come in and talk about the advanced treatments, medicines and things like that. The patients need to be trained as well so they come in knowledgeably, but I think the whole system has to change and the patient/physician relationship needs to broaden to include other health care providers.

In Africa where they don't have enough doctors they are using trained health care assistants to go through and do a lot of the diagnosis. The clinical studies have shown they are doing just as good as the doctors. They have clinical assistants doing cesarean sections. They're doing better than the doctors because the people that are doing it have better hand skills.

That's not going to happen here, but there is certainly a long way that we can go toward taking the doctor out of where he/she shouldn't be and having a different interface with health care professionals – specialists in the needs that are being expressed.

As far as the patient's perspective, there are more engaged and less engaged patients. Less engaged patients don't understand the system and need more help and training. That was talked about at the last meeting. There needs to be more health care coaching available. For engaged patients, the baby boomers who are fairly bright, they want and need tools.

What my company does, Patient2Patient, is we put together Internet Health WebGuides. All this information on the Internet, but no one can find it. We have a health staff that goes through, looks at thousands of listings, hundreds of sites, and we pull out the best sites, five in each of twenty-four different categories of information. A patient can then look at one of our WebGuides and say *"Oh, for Alzheimer's here's the level of information I'm interested in, I like this source of information, let me go right there."* You have a quick and easy channel right to the best information.

As far as information goes, you need to consider, what is the point of intervention for information for patients? Should it come from the doctor? Should it come from the health care group? Where is the

most effective place to try and reach patients so they start becoming informed? If a patient goes into a meeting with a doctor and doesn't know the background, then the doctor's time is going to be wasted on explaining the basics. That's not a good use of the doctor's time or the patient's time. The patients need to have the information ahead of time so the doctors can speak knowledgeably and it can be a higher level conversation.

Another thing I want to talk about that I think is very important is health care coaches. Trying to navigate the health system is impossible. There are twenty-four different categories of problems that patients, suddenly diagnosed with an acute illness, are running into. Treatment, finding a doctor, family problems, legal problems, insurance problems, insurance problems, insurance problems. And finding on-line and other support groups and things like that. You need people who are trained in the system and there should be training programs. A one year associates degree or a two year degree so you can train other people so they have that intermediary. I think that could be put in place as part of the programs that people are developing now.

The last comment is on content. Most of the content out there is terrible. If you're in charge of finding and buying consumer medical content for a group or organization, look at it – see if you understand it. Most of it written in medical-ese because people think that's what's credible. It's not really easily understood. So you have to use your common sense and make sure that you are providing patients, your members, your groups, with something they can actually understand. Thanks.

Dave Kendall, Senior Fellow for Health Policy, Progressive Policy Institute

This is the part of the program where I am most frustrated. I love coming to Wye River meetings as I have been for several years now, and I've enjoyed all of them. This is one of my favorite ones because I've learned a great deal. But this is also the point of the program where I really want to say *'what are we going to do? What can we all agree on?'* I want to work through some of the key issues and then make my suggestion for what we should do.

First of all, I am from Montana and I work for a Washington, DC-based think tank as a telecommuter. Montana is the home base for the Great Harvest Bread Company, and it's already solved the problem that we talked about earlier. It fires any worker in the company that works more than forty hours a week. That's their company policy. They have already solved the problem of over working. In Montana we don't have any problems with overworking by choice because we have a lot of distractions including hiking, hunting and skiing. Maybe we should all move to Montana. But that would ruin the state, so let's talk about that idea some other time.

The think tank I work for is the Progressive Policy Institute, which is related to the Democratic Leadership Council. I've been feeling a little humbled this last month, and have to admit that we were beaten badly in the November election. One development in Democratic politics that gives me hope is that fact that all the Democratic presidential primary candidates except for two marginal candidates, were for centrist health care policies. So when the charge came from conservatives, *"oh, you're from big government health care,"* it didn't stick.

What we didn't do as Democrats, and Kerry specifically didn't do, was to use his centrist health care policy to show that we are not like old Democrats who believe in government run health care. He didn't say we want to expand coverage without expanding bureaucracy. Politically, Democrats still have some lessons to learn on health care.

On the question of what should we do when doctors say *"I don't want to engage,"* the answer we had ten years ago was *"don't let them."* That's what the idea of managed care became. It said let's control what doctors do from a centralized managed care organization. Many of us believed that managed care would solve all of the problems. Well, we know that story: it didn't work.

So now we're searching for something new. The theme that I think we to need to use for this kind of discussion is high-tech, high-touch. I personally want a health care system that gives me all the ability of the classic technology, also the high tech in terms of the Internet and the information technology, plus I still want to have a strong relationship with my doctor. I want to be able to talk with my doctor or another health care professional and get advice that I can trust.

There are three categories of policy tools that we should think about. The first is communication tools, like e-mail and on-line scheduling. We want these kinds of tools that make health care more convenient and make it easier to engage with our providers in an ongoing relationship. The second category includes patient tools, like information therapy and decision support tools, along with incentives to providers to engage their patients. And the third category is infrastructure, specifically the ability to exchange information efficiently.

In each of these three categories, many good policy ideas are proceeding, and many good people are working hard. Clay Ackerly at CMS, and others are doing some good work. In fact we have at least one organization in this country that has already put into operation practices that cover all three categories for policy development: Group Health Puget Sound. And Kaiser Permanente is close behind. And there are several other organizations, like WorldDoc, that have implemented key parts of an overall strategy.

In most cases, however, there is far to go because of the fragmented health care system. If we are going to replicate the best practices across the board, we will need a national strategy.

So what should we do? To start, politicians have to have something to promise. President Bush has promised electronic health records for every American. It was great that he did that, but I would question the popularity of that position. A couple weeks after the election, funding for the President's major proposal for advancing electronic health records was zeroed out by the Congress' final budget appropriations bill.

There are lots of reasons for that and maybe Clay [Ackerly] can fill me in on what happened. Why wasn't this initiative more popular? Did Congress not understand the importance? My point is that electronic health records are just not enough as a platform for a larger strategy to achieve a high tech, high touch health care system.

What we do know is that the public doesn't want to deal with the details of health policy. They want to hear that somebody is going to fix these problems. They can be inspired by the idea of having more control, more comfort, more convenience, better care. Here's my answer.

Every one in this country should have a health home, with both a virtual component and a real component. The virtual component would be all the tools that we've been talking about: the personal health record, the ability to have the information that's filtered according to your personal characteristics so you can get the information for your situation. This health home could also possibly include all of your personal health care transactions, manage your health savings accounts, your benefit claims. The other component is that everyone in this country should have somebody whom he or she trusts and who acts as a health advisor. For most people that would be their doctor, but it could possibly include community health workers.

A simple concept like a health home is one way to make it easy for politicians to talk about this issue and begin to advance the debate.

My last point is that the politics of health care often hinges on the politics of the doctor – patient relationship. Managed care, the last big change in health care, came about because the public lost some of its trust in doctors, and began to see them as more interested in money than in the health of their patients. Managed care tried to replace or at least control patients' relationships with doctors. It turned out, of course, that most people want a relationship with a doctor or other health care professional. The politician who can explain how he is going to restore a relationship between you and your health care professional in a way that is both high tech and high touch is the one who is going to win. Thanks.

Session V Discussion

A medical home for everyone

The discussion began with a physician participant asking how we could afford the goal of everyone having a medical home, an idea that emerged from the conference. He wondered if any politician would be willing to pursue this idea in light of its costs.

Kendall acknowledged that it would not be easy to accomplish. But, in line with the idea of having community health coaches, he said we already have case managers, a similar, if not identical, element in the system. Even if we don't yet have all the answers for getting there *"this is a productive conversation for us to have…the right goal,"* he said.

A participant pointed out that Humana Health Care is experimenting with this approach. They have defined a new category of health care worker called the personal nurse, a person assigned to coach, by telephone, those patients who are about to be discharged from the hospital. Early results are promising: patients accept the procedure and value it and Humana is finding it cost effective insofar as it prevents subsequent hospitalizations and other costs. It is a model to watch.

A consumer advocate commented on the idea of coaches and the need for human interaction in giving people information. People need more than facts about a disease or condition. Care coordinators working in the health care system can bridge into the area of social services. *"You don't need this all the time, but you do need it in times of crisis or transitions,"* she emphasized.

One participant objected to the notion that treatment information is readily accessible on the Internet. He said the Rand Institute had done a study showing that four out of five patients could not find the information they were looking for there. As for the health care coach, this person needs to be available at the moment of greatest need, for example at the moment of diagnosis. Later in the discussion a participant suggested that for serious, potentially life-threatening conditions, pre-counseling should be built into the process. But, as someone observed, it is difficult to select the appropriate moment for that intervention. In the case of cancer, do you provide that information before the tests that are being done because the doctor is concerned about something?

What about the policy-makers?

A policy expert chose to pursue the political perspective raised by Kendall. Both sides of the political aisle recognize the importance of information tools, she said, but emphasized that we need to remember that there are very few policymakers who have any intense interaction with our health care system. So when

we talk about policy changes, *"there's a fair amount of education that needs to go on," she said. "Policymakers are hearing proposals from so many perspectives that they find it confusing. Yet these are the people who are making significant decisions about care, how it's paid for, who gets it, what they get, and so on,"* she observed.

One participant took exception to the statement that policymakers understand little about the health care system. *"You are wrong,"* she said. *"Policymakers are patients, they're parents, they're care givers, they get sick, they take medication, they have chronic diseases."* She pointed out that they are also payers, since *"everything comes out of our pockets, including over-the-counter medication and membership in the gym."* In some cases a policymaker may even be a provider. *"But not all providers in elected office are necessarily enlightened providers or good communicators."*

Robinson brought up the issue of medical malpractice and its importance for patients. In Florida, 5% of the doctors commit 50% of the malpractice. *"That's where we should be focusing if we are trying to help people,"* he said. *"We need to get these doctors out of the system, and studies have shown that most doctors would be happy to see that happen. So there needs to be some policy discussion to explore how this can be made to happen."*

Kendall agreed with the earlier emphasis on the importance of educating policymakers, pointing out that many politicians just say *"we want a health care system with lower costs, higher quality, and more access."* So they need to have more understanding of real-life experiences behind policy recommendations.

An executive from a not for profit foundation expressed his belief that to get social change you need the three P's: a Policy that can effect change, the Political will to adopt the change, and Public willingness to sustain that change over time. He said the discussion demonstrated that *"we don't have a shared vision about what the doctor-patient relationship is even supposed to look like."* In light of that, *"how is a policy person supposed to have influence? How is a person showing up at the doctor's even supposed to know what their relationship is supposed to be?"* He proposed having a social marketing effort to explain what the doctor-patient relationship is. But another participant said he thought this would be difficult to do. Another argued that we are already defining the doctor-patient relationship, through the way we handle reimbursement.

Constraints of cultural and mental health factors

A psychologist had two reactions to the presentation on shared decision-making. She observed that surveys show that people from other cultures do not want or expect informed consent in a doctor-patient relationship. She also pointed out the mental health factors that come into play in shared decision making, problems like anxiety, depression, trauma, and psychosis.

Carroll responded by emphasizing the doctor's need to assess not only what the patient already knows but what he or she needs to learn and is likely to learn— and this is not only cognitive but is related to beliefs. Beliefs, Carroll pointed out, *"are at the root of all forms of health behavior."* The doctor must not overlook the step of determining what the patient already knows and how comfortable he or she is with a given level of involvement in decision making. This assessment helps in dealing with cultural and personal differences.

In connection with mental health factors, Carroll said, there is the question of when and to what degree a third party needs to get involved in the conversation, and who decides. Determining who is the judge, and who should make the decision, can be quite complicated.

Constraints of time

A hospital association executive proposed returning to the issue of time and some of the other constraints on shared decision-making. A former faculty member at the University of South Florida, she found that during their first year, students were very good at learning how to save time and much less skilled at establishing the kinds of relationships discussed during the conference. She and her colleagues also studied physicians who had been in practice from one to 20 years. These physicians said the underlying issue for them was time, especially with their most challenging patients who were either angry, or unable to understand things, or dealing with pain that could not be diagnosed. She concluded by asking, *"What is the Bayer Institute doing to help physicians with these overwhelming concerns about time and, at the same time, establish the relationships needed for patient satisfaction?"*

Carroll responded, saying the issue of time is probably the single most potent block to behavior change for physicians in busy practices. He said that he and others have found that physicians, as a group, are highly responsive to data. A study done about 15-20 years ago at a primary care clinic in metropolitan Detroit showed that the doctor interrupted the patient after 18 seconds. A follow-up study a few years ago showed progress: *"Now it's 22 seconds," said Carroll. "We point out in our workshops how subjective the perception of time is. When physicians are surveyed about how much time they spend educating patients, they say that a third to a half of their typical visit is spent educating patients. When you get out the stop watch, it's less than a minute."*

Carroll said that he and his colleagues encourage all physicians, regardless of type of practice, to devote as much of the first two minutes as they can to eliciting a narrative and getting patients to tell a story. *"Most physicians hearing that are about ready to pass out, because that's 8%, 10%, 12%, 20% of their total time."* But some of the physicians train themselves, even using a sand timer, forcing themselves to take the two minutes to elicit the story.

Following up, Robinson underscored this point: *"We want to be heard…and not necessarily by doctors. I just need to be heard by someone in the system."* His second point was that the best early, effective, cheap intervention for patients is access to an online support group. *"This approach may not work for everyone, but it works for a lot of people."*

Gaps in medical training

A participant suggested that doctors should learn what Bayer teaches, but starting in freshman year of medical school.

Another participant, in her comments on providers, emphasized the importance of both written and verbal communication. *"I am amazed at the number of people that get out of college and can't write a letter. Maybe we shouldn't let people get out of medical school without being able to have a conversation,"* she said.

Another attendee, an academic physician, made the point that some progress has been made in medical schools. In 1976 there was only a 50-50 chance that anyone going through four years of schooling would be observed by a single faculty member doing a history or seeing a patient. *"The medical schools have come a very long way,"* he concluded. The National Board of Medical Examiners has adopted a nationwide requirement for a new exam in clinical skills. It goes into effect this year and will affect every graduate of every medical school in the country. Among the clinical skills in the exam is a specific, live, face-to-face measure of communications skills. Opponents to the new exam felt this was the province of the medical schools but concerns were so great that the change was adopted. *"Still, there is much work to be done."*

Carroll echoed that sentiment. *"When I think about my 15 years of experience teaching physicians all these communication skills…….I think it's clear that we have a large segment of the 'American Medical Trained Licensed Establishment,' that doesn't know 1/10th of what Dr. Prochaska was talking about and doesn't know how to counsel people. There's a fundamental lack of knowledge…..[and]lack of skill."*

He suggested that, perhaps as part of the national clinical skills exam for medical students, this type of skill should be tested. *"To find out how far off the mark we are, a representative sample of practicing physicians could be required to be tested. Depending on the results,"* he added, *"we could look at the possibility of having every national specialty undergo a re-licensure exam that focuses on counseling regarding behavioral change, perhaps every 10 years."*

Summation

Ian Morrison

It's an overwhelming task to try to summarize, so this is the meta-meta analysis version of it. Let me just say first of all that one of the great things that Jon and Marcia have done with these meetings is really engage a very interesting group of people that don't normally get to hang out together, and I think that is very powerful. I mean I go to a lot of meetings and they're typically policy wonks from the blue states bemoaning the fact that Americans are not Canadian. Which is all true, I guess….

But typically the stake holders are all there – the usual cast of characters, the ten big health plans, you know the big hospital systems, the large employers and Wonk World as I call it.

So, it's really good that we engage much more broadly both geographically with a diverse group of people with smart ideas including some of those key stakeholders.

I did a little mini summary of what I heard yesterday and I'll incorporate some of that so I won't repeat what I said.

There is kind of an irony here. The loud message that I heard is that we know the problems. The problems are we're eating too much, we not exercising enough, we're smoking or in some cases drinking. As my uncle John used to say in Scotland, 'if you don't engage in all those bad behaviors, it's not that you'll live forever it will just seem that way.' That's a certain amount of cynicism from a Scot. But we do know the problems lie partly in our individual and collective behavior.

But, what I was most impressed by listening to the experts, is that we actually know the solutions. This is kind of the bizarre thing. We heard from the wisest and smartest people in the industry around behavioral management and there are science-based solutions. We heard from a lot of different folks, the benefits of a holistic approach. We heard both yesterday and today about the benefit of simple, clear messages. We heard about the power of targeted messages, targeted interventions, of intense interventions, but balancing that with community based, multi parameter, system wide tools for prevention.

So why is it if we both know the problem and we know-how to fix it, we don't do it? And that, I think, is why John and Marcia's call to action at the end is important. Let's not leave the room without saying that we're going to do something, because it seems to me that when you're in that feasible region of both knowing what to do and recognizing a problem, that's a great opportunity for action.

So, taking a leaf from my good friend Ellen Severoni's book, I have three M's, five P's and a couple of I's. Is that good enough?

The first M that I kind of heard was **Motive**. I think you've always got to look at motive to do any kind of change, whether it is systemic or individual, and I think there are some very powerful motives. When I start off as an outsider on the issue of obesity—and a lot of people here have been trying to resolve this—unless I am missing something, this is a big problem that we ain't going to fix unless we get with program quickly.

So I think there is a societal motive that is enormous. I think there are individual motives. It's clear, from all we heard, that at the level of the individual we'd be better off if we had better behavior. There's no question about that. While it's hard to engage employers, no matter how sophisticated in investing in the workforce, there are enlightened folk out there. I think more and more of the employer community and the health plan community recognize that simply paying for bariatric surgery after the event is not necessarily the smartest, best and highest use of society's resources in dealing with the problem. So I think on the motive side, we could violently agree that there is sufficient motive to do something.

The second is **Money**. I think it's really unfortunate that David Brailer didn't get his money, but I think part of the problem with the whole IT area, and with case management and disease management and, for that matter, consumer directed health care, is that there is a 'pixie dust' quality to it. It is as if all we have to do is sprinkle pixie dust on things and it will be resolved. That is generally not the case. Aneurin Bevan who reformed the British health system in the post war period said : "how did you get the doctors to go along? We stuffed their mouths with gold."

The same is true here. It takes money, either money to buy off people to do things one way or another, or money to invest in social marketing. I think one of the things that you should listen for throughout the course of the meeting, and I did, is where is the money coming from? I came up with a couple of good ideas. My best idea was PepsiCo, and I will come back to that at the very conclusion.

The money can be there, because, first, we are spending a lot on these patients right now. Second, there are powerful reasons why the private sector should liberate some resources, whether they be the PepsiCo side of the equation or on the health plan and payer side. And I think there is money from government. There will be real money attached to these chronic care demonstrations. I think we'd be nuts if we, as a community, didn't harness some positive energy in that space to deal with some of these behavioral issues.

So Money is the second M. The third M is **Marketing**, the kind of brilliant marketing that PepsiCo does to sell its product. If that kind of initiative and that kind of resources could be channeled in a positive direction, I think that would be good.

As I said this morning, I think it's terrific that CDC is taking on a marketing role. We learned the power of marketing in a social marketing sense, and we really heard some experts in the last day and a half tell us how it can be done more effectively. That was an important set of lessons and I certainly learned a lot from that. I won't even pretend to demonstrate the greatest hits of that, suffice it to say that any of you that have taken notes will have a lot of ideas about the specifics of those marketing initiatives.

In terms of the four P's, the first one that I came to was **Partnerships**. I think this is uniquely American. At the Harvard Forums on Health which David Gergen ran across the country, he made a very good point about the nature of the American experience. That is, there is a belief in public and private

partnership. We are not really quite as ideological as we sometimes pretend, and there is power in partnerships, particularly at a level that create unlikely coalitions. In other words, when you can put together, for example, the pharmaceutical industry with the public health industry, or you can put together PepsiCo with public health people, I think that is a powerful coalition in the American context. When you can do it at a local level it becomes enormously powerful. That's why your [Dr. Reeves] experience in Las Vegas is very instructive and also in Olstead County, Minnesota [Dr. Kottke]. When you can bring together various partners in a local community where they're not distant stake holders, but they are friends and neighbors that can be a very, very powerful shift. So partnerships are important.

The second P is **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. There are a lot of very good examples, from some of the international ones that were talked about to those in the U.S.

The third P may be a little bit of a stretch, but it is **Positive Spirals**. I was taught in regional economics about a classic paper called 'Circular and Cumulative Causation' what some people call 'virtuous cycles'. There are a number different ways of describing this, but basically it means that when you get things going in the right direction, that's good; similarly when you get things going in the wrong direction, that's bad. Jim Collins, the management guru, has talked a lot about spinning the fly wheel, so I was really struck by the potential of positive spirals to be created by combining programs, motives and so forth, in a positive direction, particularly if that was targeted at a local level.

The fourth P is the **Power of Traditional Medical Forces**. The traditional 'wonk world' candidates from Don Berwick to Kaiser to others, are very important to harness in this conversation. The health plans are acutely aware of this – Kaiser has identified obesity as a very big issue for them. They are doing a lot internally. George Halvorson came from Minnesota, so maybe it's your influence Tom [Kottke], but we in California are very interested in these issues and working in that regard.

I was at the Robert Wood Johnson Foundation about a month or so ago and RWJF's CEO said to me that obesity and consumer engagement around some of these issues is perhaps one of the highest order priorities of the Foundation. I know that the California Health Care Foundation, which I am on the board of, is very interested in chronic care and what that means to the longer run. So I think that it would be wrong to ignore the traditional actors who have the money and the responsibility in the system.

And the final P is **PepsiCo**, literally. Transferring the demon to being the solution is hugely powerful. I really applaud their leadership, Brock [Leach]'s leadership, for being here. I think the greatest 'ah ha' I got out of the meeting was the fact that they can be harnessed to move in the right direction.

I was hired about three years ago by the CEO of General Mills to speak about the future of health care to his management group. I did some homework and they were seeing 'health foods' as an opportunity to make money.

I said, 'Yeah, maybe, but you should stop putting bloody sugar on the Honey Nut Cheerios, for God's sake, because here is a healthy food that now you're demonizing. Instead of rampaging off on low calorie land and low fat land maybe you should fix the product lines you have.' Well, they didn't invite me back, they did pay me but they didn't invite me back.

So, I think what I really heard was a compelling business case for improving our food, although I think there are mixed motives there still. So PepsiCo I'm excited about a lot.

The two I's are **Incentives** and **Information**. In almost any discussion about health care, about anything, you come back to incentives and information. We heard a lot about positive and negative incentives, particularly financial incentives.

The other thing you've got to remember was the word 'rules.' The point was made earlier that we should not under attend to the power of rules. The reason we don't get smacked up in car crashes like we used to is because there are rules about wearing seatbelts. So I would be very loathe to say that there isn't a role for government or regulation in all of this. I think there is a very powerful role, but we should be smart in our regulations. I think we in America are incredibly dumb in our regulations. We create regulations that cause administrative pluralism and anxiety. And we're not very good at having simple and deep rules as complexity theorists would talk about: doing the right thing based on a few simple deep rules. It doesn't mean that there aren't opportunities for government to act both in a regulatory and financing way. Some of this is not summary but editorial comment, as you can probably determine!

I just want to point out that information is incredibly important, as is the discussion that we got into this afternoon about what are the information sources. The research we've done on the consumer's ability to navigate through the health system is that they have the incentives. We are at stage one as others have pointed out. They don't have the tools and the infrastructure – they're completely clueless. In surveys we've done of the insured population, half of Americans say they've got some access to tools, half of those half have used the tools and half of that half have found it useful. So it's not brilliant yet, but we are going to move in that direction.

Now for three or four challenges or tensions that I think we have to address in our solutions. The first tension is between scaleability and pluralism. We heard a number of people including PepsiCo talk about scale, scaleability, national standards, making it the same, standardization. That kind of discussion. At the same time, one of the things we do like in America is pluralism, local community – all those good words. So I am not going to prescribe a solution here, but just indicate that you have to resolve the tension between the national scaleable standards and pluralism and local community.

The second tension that we have to resolve is around too little versus too much. It's really around this notion that we'd like a system that is incredibly personalized and customized for us, where we have unbelievable amounts of time with the doctor. But we don't collectively want to pay for that. So it's the tension between what we want as individuals and what we are prepared for as a society.

I think it's best indicated in the third tension which we concluded our discussion with—the tension between time and money. A lot was made of the belief that doctors don't have time. The *Annals of Internal Medicine* at the turn of the millennium did a special issue on time and medicine, in which they asked me to write an essay on the future of physicians' time. I basically described what I saw as 'hamster care.' This is not an American phenomenon, there are British hamsters and German hamsters and Canadian hamsters. Doctors everywhere are hamsters on a treadmill of discounted fee for service. And what bothers me a great deal about the transformative notion of consumer directed health care is, *'we ain't changin' nothin' babe about hamster care.'*

VIP medicine is the upscale version of hamster care. Quite frankly a friend of mine, Dr. Raquel Burgos, at Stanford who was my daughter's pediatrician, called me up and said, *"I'm thinking of joining a VIP medicine crowd. I've got twelve hundred patients currently and I've got an opportunity to go down to three hundred and look after the rich kids of Woodside and Portolla Valley."* I said, *"Do it, just don't invest any of your own money in the company, but do it."* I talked to her mentor last week and he said,

"well, she's really enjoying it, but she doesn't have enough time, because the rich people are calling her up all the time."

So I don't care what kind of structure you put together, this problem of not having enough time with care givers is a huge issue, and my suggestion to you is that we have to get creative about the complete and total redesign of the encounter and the series of encounters. There is surprisingly little attention paid to the need of re-engineering care at the very lowest level of encounter with care givers. I just throw that out as more of a conclusion or a framing of what we have to worry about.

In the final analysis, what we really heard was that it's important for us to remember that it's not just about consumers, it's about patients. Andy [Robinson]'s experience was very instructive and moving. What do you really need when you are encountering a very serious illness and in what ways can we [the health system] support that? At the same time how can we move farther downstream to intervene earlier, so that those difficult conversations are made somewhat easier because we make better choices ahead of time.

So that was my take, Jon and Marcia, on what I heard. I thought this was terrific, by the way. Everyone who spoke was both eloquent and well informed and interesting, in the sense that it was points of view and perspectives I wasn't familiar with, and I'm around a wee bit. So I take my hat off to you guys for organizing all of this.

Roundtable Discussion

To set the stage for the overall discussion, Jon Comola asked the group to think of recommendations that could be advanced in the broad context of what had been heard during the two days of meetings. *"Let's focus in this discussion on what we have. What can we build with what we have in this room? As a start, we have a natural asset and a commitment by the most trusted federal agency that our nation has by all polling, CDC."*

He recommended that everyone get behind CDC's new marketing campaign and its interest in looking to non traditional players for partnering. *"We should consider what each of us has to offer that effort, and take that message back home to our work place."* Comola pointed out that the CDC effort *"plays into what Ian was saying with regard to partnerships and the ability to not only approach it on a national scale, but also at the local community."*

The 'big picture'

A physician tried to take a step back, stating that he saw three global issues under discussion. First, how do we produce health, essentially the mirror image of how do we deal with the obesity epidemic; second, how do we ensure access to responsible health care; and third, how do we finance one and two.

"As somebody who makes my living in behavioral medicine," said a psychologist, *"finally seeing lifestyle behaviors, prevention, health promotion, wellness, and disease management being not just talked about but the target of resources and ideas is amazing."* He asserted that two years ago when these issues were initially discussed during the healthcare leadership roundtables that were held in communities as part of Wye River Group on Healthcare's "community leadership" initiative, *"they were 'tag ons.' And now they are front and center. But without dollars going in to these efforts, none of this is going to go anywhere."*

Looking at problems in health as singular, in silos, and administering 'tweaks' to address a specific problem has created several more problems that weren't envisioned, because of the ripple effect. On the other hand, we've tried *"comprehensive health reform,"* and *"it was so overwhelming it failed miserably for a lot of reasons,"* he said.

"This is a really complex undertaking," he observed. *"At the end of the June Foundation meeting on the 'value proposition,' we concluded that we need a comprehensive, strategic reform plan, which sets out direction. But we can't try and take it on all at one time. We need specific short and long term goals. The plan has to be flexible, as there will be adjustments and revisions necessary along the way."* He concluded that without a strategic approach to systematically dealing with the interplay among many complex variables, we will never solve our health care dilemma.

Another participant cited the diversity of people at the table as 'very healthy', and a key asset that has been so lacking in the past. *"To make something significant happen, it works well to really envision where you want to be, perhaps out twenty years, to the point where you can really see it, taste it, feel it, and hear it – really get it. And then imagine yourself at that place and look back and see how you got there. That to me is often a way of developing a strategy,"* he said. He acknowledged that there is always, of course, a lot of resistance to change. However, he agreed with Brock Leach from PepsiCo, who talked about seeing both crisis and opportunity.

"We tend to jump between two worlds in our conversations," said a hospital system executive. *"One is the public health world of wellness, reducing injury and illness, and making sure that people own their own health care. The other is the world of the sickness-based healthcare system."* It is difficult to make promises on the prevention side assuming we will gain some immediate reward and cost savings on the healthcare side. It is unrealistic. However, the public health/prevention efforts are the right things morally and ethically for society.

He recommended setting out 5 goals in the public health arena and getting behind them. *"Health systems, who are huge employers and understand the need for prevention will engage, even if it takes a long time to see the benefits in cost reductions,"* he opined. *"We need to also set measurable goals on the healthcare side, recognizing that they interplay, for example, for greater efficiency and effectiveness."*

An overarching vision, that all could support, with specific actionable interventions, was recommended by a physician executive. *"Our overarching goal or vision is to change our expectations of organized personal care, as determined by personal needs."*

However, there is a chasm between the world of *"knowledgeable, passionate, informed, creative people who know a lot about what's really going on in healthcare and the 'real world' of the public,"* said a participant. He feels little will happen until that chasm is bridged, because people out there in the real world, have a lot of concerns. They know that the current system is not meeting their needs when they have an illness. They see the statistics about some looming obesity epidemic and yet they have no clue what to do about it. *"Everyday people have to be engaged, but don't expect them to become experts, he went on. "Most people in the country lack the basic language tools to even frame their frustration, to express what they're feeling."*

Corporations and communities

Turning to the role of employers, a human resources executive expressed the opinion that there does not seem to be a good appreciation of what employers have been doing to bring about health care

quality and patient satisfaction. He asserted that there are sixty different organizations, including purchasers and consumer organizations, which are working to develop and provide a Consumers' Report style of report card, using measurements approved by the National Quality Forum. The group plans to implement the report card in conjunction with 'pay for performance.'

He went on to say that he believes business would also support education at all grade levels on how to be healthy, as well as education on selecting a health plan and a doctor, and even on personal financial security. Another area of interest is working with media, but not necessarily the press. He offered an example, *"When a creative math instructor put math concepts to rap music all of the kids in the classroom learned the math. There may be things the Foundation [FAHCL]can do to identify and stimulate media that could push forward with some of these concepts whether it be movies, or music or TV or web sites. Garfield is a great example of that."*

A physician pointed out that one very positive thing is the number of excellent examples of companies and communities that have produced health, and exhorted business leaders to *"understand that it's about leadership, it's about marketing. The science is there, the CDC has the Community Guide to Prevention and docs have to be on board but they don't have to be the leaders. Companies can say this is something that we need to do. Good health is good business. And we're in this together. The demon is not obese people, the demon is obesity. We need to separate those two things. Everybody can do something to help, we can move forward and I am actually very optimistic,"* he concluded.

Physicians have been stepping up to the plate more as role models in the last few years. Similar to what happened with smoking. They were the 1st to quit, then the business leaders started to quit, etc. A physician participant believes doctors are, to some extent, leading efforts to address obesity. *"I think people are becoming informed about the obesity epidemic and we have to ensure it 'trickles down'. I see in my practice that the enthusiasm and the optimism that 'down and out' people have when they are able to do something to improve their health, like lose 30 pounds, is wonderful,"* he said. *"But business leaders should understand that this is not a health care issue, it's a health issue and they can stand up and demand action from the health care community to contribute."*

A former business CEO and senior chamber executive emphatically stated that employers invest in their work force all the time, a point that has to be appreciated if we're going to have a solution to these problems. Local chambers, local business organizations, rotary clubs, will be engaged and they are wonderful vehicles to help to catalyze efforts. *"Ten years ago when you talked about cost shift, employers' eyes glazed over. They understand it now, they are interested in health care costs. ….they can provide tremendous leadership on these issues, if they are invited, it's in their economic interest, it's in their personal interest. This is a very complicated subject for us business types. We need help so if you come say 'lets work together,' it can happen."* He added, *"America is not comprised primarily of Motorola and Pepsi-Co. and other larger employers. It is largely small businesses that are having a tough time and need help from people like those in this room."*

The head of a 'Healthy Communities Initiative' agreed that getting both business and community coalitions involved is a challenge but *"that's where the rubber meets the road. The messages and information must relate to the world of those you are trying to engage in your community. We need to understand what the issues and barriers are for employers—where they are coming from. Similarly, you must understand the issues for the health care system in the community in order to engage them."* She went on to say that she sees herself as a change agent and a leader in creating awareness of specific organizations where there is actually a model that can be applied, and then determining how to 'sew the fabric' of a real community coalition.

Another participant provided a slightly different perspective. First, she pointed out that, although meeting participants reflected a broad diversity of backgrounds, perspectives and ideas, *"we haven't had as much diversity in our racial and ethnic backgrounds. That is so needed."*

She went on to remind the group not to forget to involve very key players at the community level, the informal grass roots leaders, who can help to reach at risk people. She described how to start by providing some education about health problems and resources, then linking them into the more formal community leadership, *"including health care providers, health services providers, education leaders, as well as civic leaders, elected officials, faith representatives, the business Chamber of Commerce representatives. That type of coalition together is dynamite. Too often we think [only] of the typical suits, the rotaries. And they're walking around trying to figure out what to do. These folks down [at the grassroots level] know what they need, ask them. And then let the rotary help figure out how to get it to them."*

Teams, tools and relationships

A consumer representative brought the group back to the key issue that the most basic element in healthcare is the provider-patient interaction, and asserted that if we could fix that, the monies saved could be used to address other problems. She advocated for defined standards for health care interactions, based on amount of time and interaction needed for different types of health care encounters. For example, what is needed for a regular check up is very different from what is needed in a visit for a chronic health condition. To create pluralism at the local level, she recommended that we ensure support and payment for the delivery of services by different types of professional and lay advisors, in the most appropriate setting.

A nursing executive expressed the opinion that not enough attention has been paid to IOM reports that have been coming out over the last few years focused on the relationship between providers and patients. One key focus has been the importance of developing multidisciplinary teams. *"It is not only about the physician and the patient, or the nurse and the patient, or the social worker and the patient. It is about a very coordinated and highly functioning team,"* she said. Creating effective teams does not happen overnight. Each discipline has been educated in its own silo and taught to practice within its own discipline, yet it's assumed that the different disciplines will 'magically' work together as a team when we they complete training. *"We have an opportunity to look at our education together, to look at the way we train together, to look at how we vision together around really changing the way we structure health care to focus on that core relationship, because it isn't as stable as it needs to be."*

In a similar vein, another participant advocated for the restructuring of the patient-physician relationship by the introduction of third parties. As an example, using 'health care coaches' to take over more of the 'social' issues so that physicians can be involved at the top tier can be very effective. *"What I keep hearing is the importance of awareness tools and support in getting people to pursue healthier lifestyles. Along these lines, I think this concept should be factored in to different kinds of consumer-based health programs."*

Also, he advised that we should recognize the importance of on-line support groups. There are other on-line tools that can be helpful to consumers and patients, including patient 'web guides' produced by Patient2Patient, LLC, *"which have gotten terrific feedback from physicians groups, corporations, health care organizations but we are far outside the mainstream. Any assistance with connections that could help us develop partnerships for funding would be most appreciated,"* he added.

Who and what needs to change?

"I have a healthy sense of cynicism, and in order to lay out a plan here I think I have to point out two areas

of my cynicism," said a participant. This first area he cited is the question of who needs to change? "The answer I keep coming back to is, everyone. " His belief is that any 'interest group' can provide a plan to fix healthcare. *"They gore only one ox and you'd get the job done. …You can attack and make a demon out of any interest group, and probably actually fix the problem. But that interest group is not going to go down that way. So I would argue that we all have to change, purely from a buy-in stand point, just to make sure all of us are working in the same direction."* His second area of cynicism related to comments about PepsiCo's 'mixed motives'. *"All organizational motives are mixed—not just PepsiCo's,"* he said.

Another participant heartily agreed. *"The mixed motive issue doesn't bother me. Most partnerships involve mixed motives, including most marriages, and many work out!"*

On a more serious note a business consultant began, *"I hope everybody ….got a little uncomfortable during the last two days because I think we are talking about transforming health and health care, and I suspect everybody's ox will be gored before it's over…I heard a lot of tension between government intervention, more taxes to do things, verses market reforms and business solutions. And between personal responsibility, i.e., individuals are responsible for themselves, for the most part, and trying to find some sort of a caregiver to 'spoon feed' people information and support."*

His view is that *"you need to make cultural change within your own culture."* He suggested, as a starting point, that the group think about the American culture around health care. He asserted that three words are starting to come together in dialogue: personal responsibility, ownership and dreams. *"We do take responsibility in this country, we prefer ownership to renting or borrowing, and we are a nation of dreamers. I think those characterize a lot of American culture, and there ought to be a way to pull those together in terms of establishing a structure for health care,"* he recommended. Mega-trends that are a part of health care, but cross broader areas, include personal responsibility, self help/self care, individual health care, individual ownership, portability and consumerism. He believes that we can build on these with some specific programs.

"I am uncomfortable that much of what we talked about falls under the rubric of reform. I think the system is broken and needs transformation," he emphasized, *"not efforts to make a broken system function more efficiently or more effectively by using the internet or information technology."*

As a core problem, this attendee cited third party reimbursement. To make the system work, he said, *"we need to get the economics in place in health care that work everywhere else in our economy. Current tax policies distort the economics as well, and the employer-based health care system is also partly the culprit because people don't own their own policies."*

And what about next steps?

A number of participants had specific, concrete ideas with regard to actionable next steps for the Foundation and its supporters.

An arts representative suggested a couple of different approaches that he thinks have merit. 1st, he recommended that we identify a lot of examples of what works in a variety of different settings and really celebrate them. 2nd, he proposed *"the FDR approach. He could envision the goal, but he didn't quite know how to get there. So he unleashed creativity in a whole array of different ways all at once to see what worked. It was a little bit messy, but a lot of good things came out. Sometimes it is easy to envision the goal, but hard to figure out all of the different things that will be roadblocks."*

In terms of resources, he agreed it is important to work on the community level, so something

ubiquitous, like a rotary club, is important. A lot of service clubs aren't doing as well as in the past and they need a bold mission. *"We can help provide them one,"* he added.

Another idea is to find hospital CEOs who want to stand out as stellar examples of taking care of their employees. When doctors, nurses and everybody in the hospital is well taken care of, they can become agents for change.

Finally, he reminded us that we have another resource in the creative community. *"The arts are about listening skills, they are about thinking outside the box, they are about taking incredible risks, they are about making gold out of straw – all those different things. SAH [Society for the Arts in Healthcare] is very happy to work with any organization that wants to develop some stellar examples that we can celebrate,* he concluded.

Another participant had three specific recommendations for WRGH and the Foundation.
The first is to focus on regulatory and tax policies. He pointed out that the group has been very effective in this arena in the past. In the next two years the uninsured, Medicare, consumerism, mental health parity are issues that ought to be looked at and addressed, if common ground can be found. The process of bringing thinking from 'the field' to actual policy makers can be very helpful.

The second area relates to public policy and development of a relationship with CDC. As it was pointed out that many people aren't really sure what a patient/provider relationship should be, he proposed a public policy campaign starting with commercials or advertisements with sample examples of what a patient/physician interaction should look like. *"People don't have a model in their mind about how they should interact with their physician. They don't know what to expect or necessarily feel comfortable asking questions. CDC has the credibility to make that kind of information campaign useful."*

The third recommendation was for WRGH and the Foundation to become more of a central hub for identifying best practices and distributing the ideas to a broader, varied constituency, including many of the groups participating in the Broadmoor meeting. *"We've heard a lot of terrific ideas and sometimes they spark interest but then get lost and don't really get leveraged out in the community on a broader basis,"* he said.

Another participant opined that it helps first to distinguish the goals from the solutions or implementation steps. With regard to goals he cited: first, healthy individuals, and, second, the achievement of that goal through the most cost-effective means.

Looking at implementation, there are both private sector and public sector efforts. He emphasized that we need to be clear on what is going to be the private sector approach and what is going to be the public sector approach.

He further drilled down into private sector implementation, focusing on the need to identify roles for those who are providing care, those who are paying for it, and those who are receiving the care. He pointed out that he hadn't heard much from the payers, specifically private insurers. *"If you've got data to show that you can get a return on an investment, you will bring in the payers [employers and insurers] who will start implementing a lot of these steps that have been described."*

He recommends pushing the public sector on policy. What are the single most relevant overarching policies and how do you start implementing them? *"I heard a lot of rich ideas, but we need to be clear on who is going to set the policy, where is that policy going to be set, and who's is going to be the group*

responsible for implementing that policy," he asserted. *"We need to take the solutions proposed in this rich environment and categorize them in order to determine how we get them into the right organizational framework to start implementing."*

Another participant provided a different set of recommendations. As a first step, he recommended that Wye River Group and the Foundation pull together the national foundations and create an essential services list, for health care and public health, then look at the socioeconomic side, including food, housing and jobs. *"Just what are the things that one needs in order to be healthy," he asked? "Creating agreement on those things among a group of organizations that most assume are focused on the public good would be a great starting point."*

To create a starting point for community coalitions, he thinks we need to identify what needs to happen and in what order. Who ought to be involved and what should they do? To accomplish this, we need to determine which sector is best at doing what. Individuals are really good at doing some things, government is good at doing some things, and businesses, including PepsiCo, and employers are best at still other things.

He concluded that this brings in the issue of mixed motives. *"We need to be willing to sell our 'white hat' proposition,* he stated. Having disease oriented organizations, like ACS, AHA, and ADA, create certain standards and recommend preventive interventions gives it a 'white hat' perception and companies like PepsiCo and employers see that is smart. He went on, *"If we can publicly recognize when these sectors are doing the things we want them to do through some type of 'Good Housekeeping Seal of Approval', it could create incentives for the food industry and payer organizations to support preventive efforts and to help pay for the community organizations that need to get together to do this work. We have to recognize them for taking small steps, just as Dr. Prochaska encouraged when it comes to individuals trying to change their behavior."*

Discussion Wrap-up

Ian Morrison

Let me just make five quick points, some of which have been made. I'm glad many of you reacted to my generalizations. That's always my goal in life: to provoke response.

Our charge was not to reform American health care but to look at this issue of behavioral change. I had 5 learnings that I would suggest that you all follow up on.

One thing we could do would be to make BMI the new cholesterol, and to have attention paid to BMI by parents, by health professionals, by press, by patients and by physicians in their encounters with patients. You don't fix things you don't measure, so that would be my first suggestion.

Second, we should leverage the PepsiCos. Despite all the mixed motives which were mentioned, they have billions of dollars and marketing muscle that could be harnessed. If you could tilt that positively in one direction, that is hugely powerful.

The third suggestion is to pick a geographic place and fix it. Americans love to see examples of things that work. My recommendation would be pick a state with no people in it, like Maine or Vermont. Generally speaking, these are healthier states. If you look at the list of healthy states, if you look at the

high performing states, on the basis of cost and quality, they all happen to be states with no people in them. So there's a lesson there that we could follow up on. But I think there are examples, such as Omstead County, Minnesota and the work being done in Nevada, which are very powerful. This approach is very consistent with the American psyche of trying to fix things in the local community.

The fourth is to leverage technology and willing team substitutes. Some of the most exciting and effective chronic care management programs have been developed when resources were given to pharmacists, or nurse practitioners, rather than to doctors, and I think we have defaulted to the doctor model way too quickly.

The final idea is to exploit the power of leadership groups, and I would start with the White House. Or perhaps the governor in California. Either could really say something about this issue and get national attention. That would be hugely powerful. I think CDC and CMS can play enormous roles, and we should embrace them and advise them, encourage them to do all the things possible that we've talked about in the last couple of days.

I believe that the single most positive set of forces in American health care right now is the sophisticated group purchasing initiatives that are going on. What we've got to do is harness the energy of the sophisticated employers, particularly around this issue of obesity. But it's also incredibly important that we provide some sort of solution for the small employers of America, because in every survey we've done of the small group market, the single most important issue is the cost of insurance. And all the other value propositions you want to weigh are just not there. It's not that people don't care about their employees, it's just they can't afford to make those investments.

So I think we need to find ways to harness business coalitions, the value purchasing movement, and local leaders, particularly local business leaders and we should be reaching out much more to the rotaries of the world and to the business round tables. I also think that it is important to engage what I would call the 'wonk world', the elite in this effort, because there is common ground, and it's quite important that everybody gets involved in this. We should get national leaders who are talking about redesign for the health system to more broadly embrace these issues of behavioral change.

It was mentioned that an awful lot of work is already being done, for example, by the Institute of Medicine. My joke is there are only three groups not on board with the Institute of Medicine, doctors, consumers and most employers. Apart from that, everybody's behind it. I think there is a proselytizing quality to this group.

Let me make 2 statements by 2 wise philosophers in closing. The first comes from one of my countrymen, Winston Churchill, who said that Americans can be relied upon to do the right thing after they exhaust all possible other alternatives. The second comes from a very wise American philosopher, George Carlin, who said there's no problem, no matter how big, that Americans, when they roll up their sleeves, can't completely ignore. So the point is, let's make sure we get on the right side of this issue and not on the wrong side.

WEDNESDAY, DECEMBER 8, 2004

Session VI: "We May Age But We Won't Grow Old" A Conversation With Baby Boomers

Karen Kaplan, ScD: Director, Special Initiatives, WRGH; Mt. Sinai School of Medicine

David Gobble and I have a very important treat for you. This whole conference is focused on engagement. How do we engage consumers, how do we engage health care professionals, how do we engage the media?

One of the groups that seriously need engagement is the 'boomers.' We handed out a little quiz that Robin Golden, from Hilary Clinton's office, created called 'Mapping Your Future' and it is going to be published by Springer the first quarter of the year in a book called *Can My Eighties be like My Fifties?* So, look for it.

How many of you are boomers? Clearly, most of you. I'm actually about 27 minutes short of being a boomer.

Today we're going to talk about engaging us – all of us. But first, I'll tell you a story. About six months ago, a friend and I had dinner. She's 87. She's a healthcare professional and up until a year ago, she worked five days a week--long days. Evenings were spent at the office, at the theater, in meetings, at dinner parties. On the weekends she went to her country home where she gardened and swam and exercised. She lived alone, independently, in terrific health. She had always taken very good care of herself.

About a year ago, she had surgery for a thyroid tumor, and then she had a coronary. Then she had two procedures to place and then replace stents. All of a sudden things changed for her. She wasn't able to work five days a week. In fact, it was hard for her to get in two relatively short days. She had to sell her home in the country because she couldn't manage the trip back and forth very well. She had to wear one of those life line necklaces at home so that she could be in touch with people if she was in trouble. Life really was dramatically and suddenly different. She was appropriately depressed. But all of her friends and her colleagues thought she was doing pretty well.

The night we had dinner she was in a horrible mood. She was cranky about everything. The food was too hot, it was too cold. The waiter was too slow, he was too fast. The restaurant was too noisy, it was too quiet. People could hear what she was talking about. And worst of all, I had the wrong color of lipstick on. She was just in a terrible mood. I finally said, *"You know, we've been friends for a long time, lady. What's going on here? What's wrong?"* And there was silence. She thought for a bit, and then said, *"I'm old. I've gotten old and I don't know how to do it. I don't know how to do this."* She was unprepared. She hadn't considered it. She hadn't thought about it. She hadn't planned for it. She had taken such good care of herself, she hadn't anticipated ever, ever being old.

Now at 87 my friend is not a boomer, but her attitude and her experience are representative of what the boomers are telling us. They're telling us that old age is not for them. They are healthy. Their bodies may age but they're never going to get old. The problem of course, is that they are--all 76 million of them. And, unfortunately, we are a society that is not prepared for their longevity. We have a huge

elderly population coming up. In 2011, the edge of us will be over 65, and the 76 million will follow. We can barely take care of our elderly now, so what are we going to do when we're older and we're faced with multitudes, older still? So our problem is, how do we to get these people – including us – who are saying, *"old age is not for me,"* engaged in planning the services that we are going to use when we do get older?

Today, we have gathered some of our colleagues from amongst us and guests who have agreed to join our group, and we're going to talk with them. We're going to talk about why it is that the boomers think they're not ever going to get old. We're going to talk about what we can do to engage every one of us in better planning NOW for the services we're going to need. It takes a long time to get these services in place. We are in trouble if we don't start now. We are going to talk about the barriers that prevent us from planning now, and the action steps we can take to get society prepared and ready for us. My colleague, David Gobble, whom you've had a chance to meet, is going to lead this group with me and when we're finished talking, in about 35-40 minutes, David's going to sum up some of the issues that have come up in the discussion.

Then, I've asked Suzanne Mintz to talk to us for a few minutes about a very special issue that has to do with the boomers getting older, and that is caregiving. A lot of caregiving now is done by families, and many of us are taking care of older relatives. But families are changing. For example, my children are nowhere near me, and they're not going to be able to take care of me. Who's going to do that? Suzanne is going to address those issues and then we're going to open it up so that you all join in. Please make a note as we go along of topics you'd like us to return to you and things you'd like to add. We all need to leave here prepared to take some action.

David Gobble, PhD: Director, Fisher Center for Gerontology, Ball State University

Good morning. Isn't this a great place to be talking about aging? If you have to talk about aging, this is about as good a place as you can be. I'm going to tee this discussion up, and I'd like to go all the way back to the opening statements by Ian [Morrison] about the tsunami that's going to wash over us. He talked about two things, one was the obesity epidemic and the other one was the inevitability of an aging population. The Baby Boomers, 1946 – 1964, that 76 million people we're talking about, includes most of us in this room, so we are really talking about us today, instead of talking about the others out there. It's really a personal dialogue so we really want you to be thinking about your personal response to the questions. So please probe the panel and share your thinking in this time we have together.

One interesting thing about 'boomers' is that about 80%--and this may be representative of the people we have here today--say they're going to age in place. And 80% of that same boomer population say that they want to continue working, at least at some level, so they're not going to retire like previous generations have retired. They're already conscious of the longevity phenomenon, so they're going to age in place, and continue to work.

The metaphor that's been used to describe the boomers is *'the pig in the python'*. We really are the pig in the python, this generation, the youngest being about 40, the oldest being about 58, 59. This pig in the python phenomenon has changed public schools; it's changed marketing for every product; it drove the housing boom; it'll drive the housing retirement industry; it will drive everything, and obviously if the boomers don't do something collectively that promotes healthy aging, we'll bankrupt the health care system as it's currently organized. We know we have some work cut out for us, so we'll touch on some of those issues as we go forward today.

To start with our panel introductions, I'm going to throw out an easy question. I'd like each panel member to introduce themselves, and in a couple sentences, tell us who you are, where you are in this aging cycle of boomers, and share maybe one specific thing that has influenced your concept of your own aging in the last 5 or 10 years. Something that's really focused you on thinking, *"I really am beginning this aging process."*

Panelists

Gary Allen

I'm Gary Allen and I'm a dentist. I work for a large dental group practice based in 3 states. I'm here today because I made the mistake of sitting down beside David at lunch yesterday. And he was recruiting another gentleman for this panel. But I do fit the profile obviously, from a demographic standpoint, and also from a psychological standpoint. I don't think about aging, and I don't want to think about aging. I'm resentful of the fact that I'm up here having to think about it, and when I leave this conference I probably won't think about it again.

But thinking about the things that have shaped my life, #1, my military career for 26 years has probably had the biggest influence on my life, as far as pursuing a healthy lifestyle, maintaining physical fitness, etc. As far as an epiphany in my life within the last 10 years, it was the death of my parents, mother and father, within a year of each other. I don't think that they died particularly of old age. They were in their early 70's, but both of them were in poor health from a chronic disease standpoint. My father had diabetes, which he had not cared for, and my mother was a life-long smoker. It wasn't the fact that they died that made me think about aging, or that made me think about impending death. What impacted me the most was the recognition that with these chronic disease states—as Ian [Morrison] said earlier, you can't choose your parents—I have inherited some bad genes from my parents. I have some chronic conditions that I have to monitor and be on medications for. I did that reasonably well, but it was their death that caused me to pay more attention to my health as I age, not to think about aging.

My father died of a massive stroke and my mother died of a pulmonary embolism. But she had emphysema and some physical disabilities from smoking. It dawned on me that if I didn't take better care of my health, then I perhaps would be a burden to my children and to society due to the chronic conditions that I'd inherited from my parents. So that started me thinking more about my health as I age. But I'm not thinking about aging and getting older, and I probably won't.

Marsha Gobble

I've been a public school teacher for 33 years. I just retired last spring. I taught in the primary grades and my last 14 years were in kindergarten. I'm here because my name happens to be the same last name as the gentleman that has been talking to you and when we arrived on Saturday, he said *"we are going to need you on the panel."* I said, *"okay, that'd be fine."* I guess I am going to 'do' old, because the alternative is not good. We don't have a choice here. You're either going to age or you're not going to age, you're going to die. So I think I do want to do old, but like Gary, I don't get up every morning and think hmm, lemme think, how am I going to get old today? I'm going to fight it tooth and nail as long as I can. I watched my mother live 4 years in assisted living and slowly decline, and I think I'm going to do everything I can to put that off as long as I can. I'm motivated, obviously, being married to David. We lead a pretty active lifestyle. I have to run a lot to keep up with him. So, I'm just doing whatever I can to stay as healthy as I can, as long as I can, and when I get to the point that I can't, I guess I'll deal with it then or else let my kids worry about it.

Ted Borgstadt

I was born in 1960, which puts me as one of the younger baby boomers. I have a lovely wife and 2 fabulous boys. Sam is 10 years old and Cole is 8. When I think about aging, I think in terms of a family continuum. On one end of the continuum, I think in terms of my wife and children. On the other end of the family continuum are my aging parents and my in-laws. The overriding context for my family continuum is preparation: financial, health, parenting, care-giving. Each of these areas of preparation is interchangeable with either end of the continuum, both in content and levels of worry. My concern for aging is not for myself, but about making sure the future is secure for my wife and boys, and that the future is secure for my Mom and Dad.

Suzanne Mintz

I might be the only person on this panel who actually really knows what it is like to age because I, to some extent, live an aging lifestyle now because my husband is disabled and needs help with all the activities of daily living. So we deal with issues of accessible transportation. We deal with issues of accessibility in everything we do. In fact we're getting ready to do a major renovation on our house to accommodate Steven's disability. So at a time when I should be looking toward retirement, instead I'm looking at a bigger mortgage, but we're also looking at aging in place because the renovated house will allow us to do that. The 'new house' will accommodate Steven even if he can't move a thing, and there will also be space where we could have a live-in graduate student, that's where my head is going right now, someone who's physically there. The kind of help we need, and lots of other people need, isn't something you can schedule. And you don't necessarily need 4 hours of time, which is what you have to buy in the market place, so for me part of the aging thought process has to do with a lot of flexibility and it also has to do with having some money. It is hell to be ill and poor. We could not be going through this major renovation if we didn't have some means.

Steven and I could not continue to have any semblance of normalcy in our lives if we didn't have a converted mini-van. But a converted mini-van is very expensive. I sometimes joke and tell people I drive a Mercedes Dodge because you've got the cost of the mini-van and the cost of the conversion, and when you add them together, you've bought a Mercedes. There really are no programs that help with the cost of transportation. You can only deduct visits to the doctor from your taxes as a medical expense

So if you are ill or disabled, having money can make the difference between a life with some quality and a life of isolation and dreariness. Based on my experiences, I have come to think of my own aging as an issue of levels of quality of life. You can be disabled and still have a decent quality of life, but you can also be so compromised by your illness or disability that living longer isn't necessarily the most important thing. I am much more interested in quality than quantity when it comes to how long I want to live.

Janice Bailey

I'm Janice Bailey, and smack in the middle of boomers. I'm 49. I have a teaching degree but I usually worked in the corporate world, part-time, while I was raising my daughter. She's at college now, so I'm really an empty-nester. I still do my part-time work and I should have the time to pull my life together, be it fitness-wise, spiritual-wise, and just learning to live in the moment and not worry about stuff that doesn't matter. So life is good. I don't consider myself old at all but my husband is older and planning to retire. So that's kind of cool. He's been down paths that I haven't had to address yet.

We've been working on the will, we've found a retirement home we like. For us, thinking of the future, we want to live where we can be active, enjoy the climate and stay fit and healthy. Colorado does seem

to be one of our choices. I try to stay fit so that I can maintain a body that will function. I had a grandmother live on her own until she was 99 before she went into any kind of nursing home. Now they have home health that comes in, so I have those expectations for myself, that I will be able to live pretty much on my own too, maybe with some kind of help to keep me on my own as long as possible. This is assuming I'm going to live a long life. My parents are 83 and they're volunteering, riding motor bikes, square-dancing. I kind of have some good models to follow so I'm trying to do some tennis and things that keep me strong, keep the bones going.

Suzanne Mintz
Good models and good genes. And spirituality. What is the role that you see for spirituality in aging healthfully and being old?

With me it's peace of mind that the world works the way I see it in my spirituality and my belief in God and strength I can rely on there. It is the calmness it gives to my mind, and the lessons of letting the small stuff go, and trying to live and love. It just brings a real good perspective to how you treat others and how you go about your daily life.

I think about some folks that are maybe in their 70's, my parents' age, one couple in particular, that lived with some hardship, but also lived in bitterness and in regret, compared with my parents who don't live in that. Part of spirituality is being able to have reconciliation and restoration. As you grow older, if you're able to put those things in order, they don't accumulate and paralyze your ability to be joyful and to live life at its fullness.

About 5 years ago, we joined a Synagogue. We never belonged to one before. When our daughter was little, we gave her some religious education but we didn't belong to a community. But I decided now I needed one. I wanted us to belong to a community because I wanted to have a place to potentially turn to if we needed some community help. We also started celebrating the Jewish Sabbath, which for us means lighting candles on Friday night, talking about the week in review, and saying what we're grateful for that week. It could be that the weather was great, or it could be that Steven felt less fatigued. It could be anything. And then we eat Chinese food.

Marsha, you were talking about your plan with your friends for your community. Do you want to share that?

Marsha Gobble
It started about 10 years ago at a high school class reunion. I am fortunate enough to live in the town where I graduated from high school, so I've stayed in contact with a lot of high school friends. We just started talking at our 35th class reunion about when we're getting older. Of course there are always more women there than men.

Then at our 40th class reunion, this last summer, we were talking a little more seriously because we are noticing that we're aging. We were looking back at these pictures from the 5, 10, 15, 20 [year reunions] and thinking, *"oh my gosh, I didn't know I looked so good back then, what do I look like now?"* The girls were talking about what's going to happen when we're older. I say "girls" cause that's just what we feel that we are, we don't feel like we're old ladies. We had invited one of our teachers to come to the reunion, and there aren't many to invite anymore that are still living, or even coherent. And we began to wonder, what are we going to do when we are that age?

So we have a plan. Our husbands are all going to die sooner, that's just a probability statistic. Even

David [Gobble] tells me, *"you will probably live longer than I do and we'll have to plan for that."* Well I'm planning with the girls. We're all going to live together in Linda's house, and she's going to cook. I love to be outside, so I'll do the garden work. We just have this plan that we're going to live together as long as we can, and take care of each other. My boys don't live in our state now, and I doubt that they will then and I don't want to be a burden. Nobody knows what the future's going to be, and that's probably a good thing, but we're planning for what we do know and after that we'll have to hope God knows best.

Suzanne Mintz

It's interesting to hear that because it may be a trend. I even had a call from a reporter asking me if I could put her in touch with people who are actually putting together congregate housing in which a group of friends come together. Everybody has their own room but they get together for communal activities and share things. I was kidding around with the vice president of our operations, who I also think of as a friend. She's also a caregiver, and Crystal doesn't like to cook but she likes to clean. That's how she gets out some of her stress. Well, forget the cleaning, but I love to cook. So just kiddingly, I said, *"boy we would be great roommates."* I think people are beginning to think about scenarios that are very different than past scenarios. My parents retired in their 50s and moved down to Florida. They lived in Bayside, New York. Way down in Florida they had a Bayside Club because so many of their friends moved to the same place.

In planning for retirement, I don't think that's going to happen with our generation. People will go off in different places. I think one of the issues that people need to think about is building a new community at this stage of life. It's not like you have kids to pull you together. It's very difficult, but people are just looking for new living arrangements, and I think people are looking at assisted living and saying, *"I don't think that's so cool."* Don't buy stock.

We've been talking for the last day and a half about various models of delivery of care and revamping our health and medical care systems. One of the introductory models was behavioral stages of change model, and you can apply that to aging. Think about all the different things we have to consider as we think about aging: physical, financial, social, community-building, relationships, it goes on and on. Consider it an action stage. Are we really ready to do that now? But there's a pre-contemplation and a contemplation stage: not really ready to do it. For anybody on the panel, what are some examples of things you're really 'in action' about now that capture your stage of aging? And what are you not even thinking about that you should be?

Gary Allen

Beyond health care, financial planning and financial security is one of the things that we certainly need to start thinking about. I guess I've had some advantage being a military retiree. I have a secure retirement. I don't have to think about that. What I may think about every once in a while is further building some wealth so, when I finally do retire, (though I have a hunch I'm going to work until I die), if I should get there, I can travel to places like this. Maybe that's a goal that I might want to try to achieve, but it's not an important goal to me.

Right now probably the most important thing I'm working on, you've heard the theme, is maintaining my health so I can be active, so I can work, so I can be a role model to my children. I have a grandchild on the way now, and I have to start thinking about that. I think that's an important role that we aging baby-boomers need to take on, quite frankly. I look at my own children and although we introduced them to a healthy lifestyle as they were growing up, as they got on their own, they slipped back. Both my daughters are a little bit overweight. I worry about my older daughter who's pregnant maintaining

her health through her pregnancy. I still have to provide the health care and health promotion message to them, and living it, I think, is more important than telling them.

Ted Borgstadt

I am one of the younger baby boomers. When I think of aging and health, I tend to think in financial terms and the limiting factor that an unforeseen health event would have on my ability to provide some level of financial security for my wife and two young sons.

I wonder if the average baby boomer is worried about their own connection between their physical health and financial health? The chances are that the average boomer is either obese, hypertensive, diabetic, or may have other chronic health conditions, too. Also consider that the average baby boomer is roughly 53 years of age, has an annual income of $55,000 with $53,000 in their 401K plan. What does a 'healthy' retirement look like for the masses of boomers?

I am not an actuary, but it would be interesting to see the impact of this 53 year old boomer's financial retirement status under two different scenarios. First, what if she realized she was going to fall short on having enough money to live off of if she wanted to retire, so she doubled the amount of her 401K withholding from 3% (the maximum her employer would match) to 6%. The second scenario is she began to actually do the things her family physician has been asking her to do the past ten years. What if she started going through the process of changing her tough health behaviors, such as obesity and smoking, which contributed to her diagnosis of hypertension and adult onset diabetes. If she returned her BMI to a normal range, stopped smoking, and began to exercise regularly, which in turn reversed her diagnosis of both hypertension and adult onset diabetes, I wonder how would this impact her net fixed monthly income when she was 70 years of age?

My sense is that if an actuary would compare these two scenarios, that it would come to light that the most lucrative investment someone can make in their 401K retirement plan would actually be to change their at risk health behaviors of today.

Karen Kaplan

As boomers, if we're going to succeed in managing our health savings account and be healthy over the long term, what would the health care system have to provide you to do that? What can we do to keep this issue in front of the boomers, keep them doing something about it?

Janice Bailey

Just publicize information to help us all know what we do need to do and there could be this mushroom problem if we don't change our lifestyles. Publications are OK, but also bring in media and empower us to take charge of our own lives more. Say, *"here are steps, here are easy things you can do to change your lifestyle."*

Suzanne Mintz

Before we can talk about what would work, we need a vision. I think we need to envision what life could be like if we are planning, and what life would be like if we're not planning, and problems and scenarios in the middle. It gets back to that old adage, if you don't know where you want to go, no one will take you there. It is really impossible to imagine for yourself what it is like to be old, because you haven't experienced it yet. So just sitting here and individually talking about it doesn't really get at the heart of the matter, that we really do need to do some visioning work. And then look at goals and so on.

We've had some moments over the last couple of days where we seemed very unified, and there are a

lot of the health care pieces of this elephant that are in the room today. And there have been times when it seemed, as it does now, that we are very different pieces of this health care puzzle.

A couple things. One is moving people forward in whatever stage they are in with regard to thinking about and preparing for aging, on both the health side and the financial side. There might be a tie-in there that could be used to elevate awareness that we have not yet tried. Second, cut yourself some slack in how you quantify impact. Make sure you're judging the right thing. We may only want to start raising someone's awareness from 'pre-contemplation' to 'contemplation,' to a point where someone's picking up on a conversation.

Gary Allen

I have to agree. How many of you just wake up every day and think, *"okay now I'm going to think about aging today."* Most people do not. If it's in the media, television, that's a good way to get the message across. I do think you have to have a vision first, but you have to raise awareness so people do start thinking about it. It's not something I thought about until I saw my mother and my father die many years ago, but I saw my mother age in a way that I knew I didn't want to do, if I could help it. So I think that you do have to get public awareness with a vision.

How do you get a message to a very diverse population? How do you get a message to us knowing that we don't want to think about it? That's a very difficult question. It can't be one size fits all. You have to take into account different learning styles of people and how they seek information and how they retain information, whether they are visual learners or they like the written word, or the spoken word. I think you have to take into account the diversity of value systems. We talked about spirituality, and a sense of community, and to me again, because of my military experience, community was wherever I was at. Spirituality is a journey. I'm still exploring that. In my stage of life the most important thing to me is not a physician, it's a personal trainer, or a physical therapist, to help keep me from hurting myself as I'm trying to maintain my health. So the message has to look at the diverse nature of the population and have a lot of different campaigns out there.

David Gobble

You know, dealing with the Boomers is always a fascinating phenomenon. You can see how diverse they are, even in this small select sample, so you can imagine the challenge we face as a culture. We're talking about the most diverse aging population ever, the baby boom population. We have to think about how these themes would play out as this population ages, and just to make sure we're in context here, nobody in this room will escape this phenomenon, but regardless of where you live. It's coming so quickly that these issues we're talking about now will play out in your home town.

Every town in America, by 2020 to 2025, will look like Florida does today. Maybe not the same climate, but the same age demographics, so we will all be living in retirement communities. About 1 in 5 of our population is over 65, and that will increase dramatically in just a few years. So what you're hearing here is coming home to you both on a personal level and a socio-cultural level. We've got to be prepared to respond.

There are lots of themes that came out here and I am humbled to try to capture them. It's clear that 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. Aging is a very abstract phenomenon. Something literally has to stop us in place. It can be the demise of a parent or a sibling. For some of us it is a personal or familial disability issue that forces us to change what has been sort of an autopilot way of living.

So the boomers are now breaking out of that autopilot mode, and they really are a wonderful target market right now. The older boomer, that first wave boomer that was born between about 1946 and 1951-52, is the population that's really sensitive to these messages. The very young boomer, the 40 – 46 year old is still pretty much on autopilot. So we really have to segment out the boomer population to make these issues real.

The interesting issue about spirituality, the whole concept of meaning and purpose, is that it continues to be a dominant theme when you talk to boomers, whether it's traditional spirituality or something else. Boomers begin to ask those really important questions, either because they lost something that they cherish, or because something that they used to do that took their time no longer is interesting to them. Now they have more free time to deal with these larger, deeper questions of life and meaning. So spirituality continues to be a theme.

Obviously, the issue is complex and multi-dimensional, with financial, physical, social, and relationship components, and boomers are going to have to sort that out. There aren't many role models for them, because their parents have aged differently than they think they're going to age. The boomers are really further along in the life cycle, still living a full life, but a more complex, multi-dimensional life than their parents. It's clear that this panel is representative of what we've talked about, as the already emerging awareness issue of their lifestyle will be critical for their long-term health and well-being. I think boomers--and it came across in the panel--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 will want to stay engaged, and I think you heard that in the panel, in the workplace and in recreation and larger life.

The other thing you heard from the panel was that the health care system is not geared up to serve the boomer. The health care system as we talked about it over the last day and a half is a medical care system. Probably nobody in this room yet knows how to get to a true health care system. I apologize if maybe you do, and if I appear to diminish your expertise. But, it seems clear to me that the boomers are asking for something from the medical care system that it is still not geared up to give, which is health. The personal trainer, the exercise specialist, the physical therapist, the messages that are appropriate. The boomers are asking for that but the medical care system is set up to deal with the old model of aging, which is the disease model of aging, and not the 'possibility' model of aging. I think the boomers are really thinking an awful lot about the 'possibility' model of aging, so I think that's going to be really critical.

So connecting with this vision is critical for all boomers, who are, right now, envisioning their futures. Many of us in this room don't have a positive vision of aging. Many of us in this room don't really believe Dr. Jim Fries compression of morbidity hypothesis, that we can postpone illness and disability until the very end of life and live a very full life. We don't believe that, we haven't been educated about that. It hasn't been bought yet, even by us. But the boomers are beginning to say, "that's the package I want." And that's what you heard here, it's that package and we're not delivering that package.

I think stories are the extraordinary thing that's been woven throughout the last day and a half. The power of stories, the power of children to communicate. Our panel touched on those things. We have to find ways to tell positive stories about aging. We have a great opportunity in our fields to help boomers to crystallize a positive vision.

Karen Kaplan

Thank you. Now I'd like to go back to Suzanne Mintz to talk about caregiving. We've touched on that

issue especially in the context of not wanting to be dependent on our children.

Suzanne Mintz, MS: President & Co-Founder, National Family Caregivers Association

(presentation slides are available for downloading from www.wrgh.org)

Family caregivers 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. Some of it just might be helping Mom with the groceries, or managing finances, but for over half of us, caregiving on average takes up more than 20 hours a week, the equivalent of a half time job.

Family caregivers are prone to depression at much higher rates than the general population. It affects as much as 59% of people who are dealing with folks with Alzheimer's or cognitive problems. I've personally suffered from clinical depression four times. If you haven't experienced it, trust me, you don't want to. Depression is an overwhelming illness that destroys your ability to cope with life.

Family caregivers also are suffering on the physical level. Our immune systems are impacted. A study that came out last week and even made the Today Show looked at parents of children with special needs--a young population. They showed that, because of the stress of caregiving, people in the study were aging up to 10 years faster at the cellular level than typical Americans in their age group who were not under such severe stress.

I think because Americans are so afraid of aging, there is the potential to use the chronological age / biological age comparisons as a way of turning on light-bulbs, the realization *"I'm only 40 but, my God, I've got the body of a 55 year old!"* I think the 'scare factor' can actually be very powerful.

One of the aspects of caregiving that affects its overall impact is the duration. I don't know if there are studies that prove this or not, but intuitively I think we'd all agree that the longer one is a family caregiver, the more likely they are to develop physical, emotional, and financial problems.

The term 'burden' is often used in relationship to family caregiving, but I am not sure it is the right term. It seems to imply that burden derives from being a family caregiver, but I believe the burden is an effect caused by the lack of appropriate supports in our healthcare and social service systems.

There's not a family in America that isn't going to be impacted by family caregiving, because either you have been a family caregiver, you are currently a family caregiver, you will be a family caregiver, or you'll be the person needing care. No matter how healthy we stay in our senior years, sooner or later, unless we just have a heart attack and drop dead, we are going to have a chronic illness and are going to need some level of care.

So we do need to be looking ahead. One of the problems is that family caregiving is invisible. It happens in bedrooms and bathrooms. The rest of the world does not see what goes on and can't imagine how difficult it can be to get somebody out of bed and dressed and all the other things you've got to do to accomplish the basic activities of life that healthy people take for granted. This trip for me is both a business trip and a respite because while I'm here, I don't have to do all those things for my husband, and as much as I love him, I don't missing doing them.

Family caregivers don't self-identify. People don't see that, given what's going on in medical science, caring is not what God and Moses talked about when they were up there on Mt. Sinai. People never

lived as long as they are living now. People died of infectious diseases. In 1900 the average age of death was 47. Today it's approximately 77. So we are experiencing something that the world has never seen before. It's not surprising therefore that we don't know how to deal with it and that we don't have programs and services in place to deal with it.

The challenge, of course, is now that our eyes are opening, what are we going to do about it – and how quickly. If your parents are still young by today's standards you haven't dealt with caregiving yet. Your parents are experiencing the bounty that has come with extended and healthier life. But sooner or later, the golden years, the things that AARP pitches and all the ads depict, are going to turn into the rust years. And that's when caregiving comes into play.

We were talking about stories before. We have a project called the National Family Caregivers Story Project. It's a web-based initiative on our site, *www.thefamilycaregiver.org*. It is an opportunity for family caregivers to tell their stories and list their needs and concerns. The stories are all the same, and the stories are all different. One of the things that comes up a lot is the need for 'some time for myself'. One woman wanted to be able to go to church twice a month. That should not be somebody's wish. Regarding the bigger issues, one of the things people talk about is access to good quality, affordable home care. The workforce shortage is a huge, huge issue. It could get to the point where it's not going to matter how much money you have, there won't be any people to hire to give you a respite or provide personal care help on a regular basis.

Most everybody here probably gets paid vacation, except those of you who are self-employed and you give yourself a vacation. Family caregivers don't think to give themselves a vacation. They haven't made the switch from thinking of family caregiving as solely a familial responsibility to thinking of it as also a service they are providing for the public good, as a job that requires skills and compensation, not necessarily a salary.

If you think about it, nobody in their right mind would ever hire a family caregiver. What society has done is caused family caregivers to become health care workers. We have not given families any training; we do not give them support. We don't give them any compensation for the costs incurred and the income or savings lost. We don't do anything to mentor family caregivers, and we don't give them breaks. But we are taking these people and putting them in charge of our most vulnerable population. This does not make sense.

The health care system is actually living on the backs of family caregivers. A study was done to try and show the economic impact of family caregiving. An extremely conservative estimate of $257 billion a year in 2000 was developed. That is twice what we pay out in formal home care and nursing home services combined, and is comparable to all Medicare spending in 2002. So that gives you some sense of the impact of what families do.

One provocative question has to do with this issue of living so long, living past the point of having quality of life. Looking at it from the perspective of all the resources that we are going to use up, we should ask ourselves, *"if we really love our kids, do we want to do that?"*

I'm a Trekkie, and the Next Generation series of Star Trek had an episode once that I'll never forget. The crew of the Enterprise visited a planet on which when you reached a certain age, you were euthanized, or you killed yourself, and it was a celebration of the ending of your life. Of course the people on the Enterprise thought this was horrendous and tried to talk a person from this planet out of it by raising issues about all the things he could still contribute. The character has a conversation

with his daughter who asks him to remember how awful everything was before this policy was instituted, how there were no resources for the younger population. So to reiterate my provocative question, what do we want to leave our children? And when is quantity far less important than quality when it comes to evaluating our lives? So that's a thought.

I want to mention one more thing in closing. NFCA recently embarked on a public education campaign using social marketing principles to help family caregivers self-identify and reach out for help. One of the key messages of the campaign that came out of our earlier research is this – "If you are caring for a loved one, you may be the person more at risk". It strikes me that this gets back to the whole idea of thinking about the role of the 'influencer' in bringing about change. If you want more information about the campaign send me an email and I'll get you a press kit. If you want to check out the campaign website its URL is *www.familycareigving101.org*.

Karen Kaplan

Thank you, Suzanne. We now want to hear from you. What is your reaction to what you've heard? How can we sustain this? How can we do the visioning that we need to do? How can we unmask the power of 76 million people to build the right kind of structure for an aging population? What is each of us going to contribute to it? And what are the next steps?

Session VI Discussion

Health is wealth

A physician bemoaned the fact that *"Every month I receive 10 journals about how to take care of my assets, my 401K's, how to invest. I wish we had journals that said 'health is an asset. Here is how you can take care of that asset,' just as you would wealth."* Studies have shown that if you use it as an asset, your health is just as valuable as your wealth.

"Suzanne [Mintz] talked about Real Age. The head of our Anesthesia Department, Dr. Ryosan, wrote that book. One of the reasons he was on Oprah 3 or 4 times is he told her instead of being 45 she's 39. If we can convince people they could get their biological age down, maybe their chronological age wouldn't mean as much to them."

Another participant reminisced about an experience in college. *"I had a social work project in a retirement home. One of the things I did was to set up a checker tournament. Many of the people were too busy with activities to participate. But of those who did, two 92 year olds played for the championship. They couldn't hear each other but they were very, very good."*

He went on to say that, on the other hand, he recalled a 62 year old who left his company after 35 years and passed away within 2 months. All he could think of to do was go hunting and fishing for the rest of his life. Another 35-year employee passed away 3 weeks before her 65th birthday. *"And I'm thinking of others who similarly lost their purpose in life. We need to change our attitude about work in the United States. Despite all the hours we put in, for many of us it's TGIF, Thank Goodness It's Friday. Work can and should be fulfilling. For many it is, but it's not cool to acknowledge that."*

This participant strongly supported the idea of a vision and mission statement for life. *"It can help reaffirm that life doesn't stop at 62 or 65, and we should continue to maximize our life experiences and opportunities,"* he concluded.

A clinical cardiologist said he was faced every day with patients rolling into the hospital, totally unprepared for the idea that they'd ever get sick. And old people who have lived alone in the countryside, and suddenly they're not going to be able to do it, and they don't know what they're going to do. *"We have to be straight forward with people,"* he urged, *"that they need to invest in their health to preserve their wealth, and it makes a huge difference."*

He said they were working on a decision support tool to show people the impact of controlling their cholesterol, versus the impact of having by-pass surgery or a home defibrillator. *"Even the guys who advocate for defibrillators in public places say it'll save around 2,000 lives a year. There are a million deaths a year!"*

He'd like to test out whether a web-accessed decision support tool that people can play with, just as they do with retirement accounts, could impress on them how much small changes can matter. *"We can either drain our resources on daily medications, or we can say, there are certain things we can't do. There are trade-offs. It's invest or spend. Are we going to spend our health stock now, or are we going to invest in health and therefore have more disposable 'income' later. 80% of my practice now is obesity, and I hate it. I don't hate the patients, but I see these people trapped in their own bodies and they can't get out, they can't move from the chair to the exam table, and it's just so unfortunate,"* he concluded sadly.

A new paradigm for aging

A participant from the UK said, *"I was very struck by what Ted [Borgstadt] said about how lifestyle change is possibly the best single investment you could make in terms of your future."* He said a business contact of his was going to take early retirement and tour all the Greek Ruins. That was when he suddenly realized that for the first time ever there are a lot of people going to be getting older at the same time, which provides enormous opportunity to create something new.

"We really have to get away from talking about burdens of older people, and focus on them as an incredible asset, in terms of wisdom and experience and ability," he suggested. He pointed out that caregiving is not an isolated experience in every country. In the Mediterranean, South American, and Japanese cultures, there's much more of a mix between older and younger people. There is much more of a sense of family in a wider community. *"I think there are some models there that we should look to import."*

A European participant pointed out that there's a lot of talk about aging, not surprisingly, in Europe. There are some interesting, cutting edge, workplace initiatives dealing with aging in Europe, especially in Scandinavia. 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 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. Research has shown they are pretty accurate with these predictions or estimates.

There's a lot of talk about raising the retirement age in a number of European countries because there's not enough employees anymore. *"We have high unemployment rate now and I think this trend is really going to get more pronounced. We're going to be looking for qualified workers, and developing some interesting initiatives to try and match the abilities of a worker, especially with the 'workability' index, to the actual job."* He noted that it is extremely difficult to fire anyone in European countries, and employers need the expertise of each employee because it is harder and harder to find them. So it's important to

work very hard to keep each employee and maintain his or her productivity. *"I don't know how well these strategies would work in the US,"* he added.

On the subject of models, a hospital association executive noted that in South Florida there are some really wonderful models that are relevant to where the country is going to be, in terms of aging and ethnic diversity. She said that they have 20 years of experience with Medicare managed care and know what works well and what doesn't. Similarly, they have been involved on long-term care planning for some time. *"The health care system needs to deliver services to people along a continuum, from the well, to the worried well, the chronically ill, the acutely ill, and the terminally ill. There is clearly no one perfect way to do it, but there are certainly examples, and we'd love to share those with you,"* she offered.

"Another point is we need to redefine the concept of 'family planning' in a whole different context now. I'm 56 and I'm trying to get my children to think of that. There are some marvelous programs and samples of what I call 'intergenerational opportunities.' What you do is provide opportunities for 80 year olds and 10 year olds to work on the same project together, whether that's making things out of pipe cleaners, or cleaning up a house for a senior who is living alone. If a 10 year old Boy Scout helps an 80 year old lady clean her house, at the end of the day, he will have a better concept of what it's like to be 80. It's how better race relations were built in the 60's and it's how intergenerational education can be done in the 2000's and 2010's," she opined.

Gobble agreed that there are some wonderful, successful models around the country, and there are large community interventions, such as the MN example that Tom [Kottke] talked about, that show populations changing.

He pointed out that using the metaphor, *'the pig in the python,'* 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. If we restructure Medicare to really promote prevention and ensure the incentives for providers are aligned, we will get the other kinds of services needed to redistribute care.

"However, the larger issue here is what we call 'Health by Design.' March 17-19, 2005 we're having a conference at Ball State in Muncie, IN. We'll not be talking about health care, but rather, how do you design for health? How do you create structure in communities that promotes health and well-being? And that's part of what the boomers are going to demand, to live in communities that allow them to live full, empowered lives. Currently America isn't doing that. By being involved, by being active, they'll change the community and make it healthier. They'll demand community resources be redistributed. And how are communities going to respond? We will all be challenged," he concluded.

Will the services and providers be there?

In considering new ways to assess the need for services, a participant drew a parallel to the model of delivering disaster services, where there is damage assessment, then triage of multiple services from a convenient central location, like a school gym, utilizing the most cost-effective provider. The system can first be accessed through an 800 number or a website and provides a sort of 'wrap-around' of services that might be needed by different victims. She explained, *"I started making a list of what the wrap-around 'gym' might look like, for people in a contemplative stage on aging: housing options; medical care, outpatient, inpatient and pharmaceuticals; money and financial planning; transportation; spiritual options; and caregiving."*

Another participant expressed concern about the availability of the right types of providers in the right place to care for the needs of the boomers. First, he highlighted the increasing number of singles in the

population, couples without children, which will test the family care model that was described. Second, as part of the demographic change, there is an increasing desire for independent living in retirement age, leading to a shift, to rural living where cost of living is lower. But, because of income issues, physicians are not going to those areas in numbers to support the needs of the increasing retiree population. *"How do you get providers into places like Spearfish, SD, Spokane, WA and similar areas?"* he asked. *"How do you tailor Medicare? It's not just care, it's location."*

He went on to say that, even if you believe the premise that providers will follow the money, the reality is, the money is not there. Based on the American Medical Association, the ideal ratio of Medicare patients to regular patients is about 15% Medicare. He told the group that in some communities, that ratio is now 40% and in 6 years will be 60%. Those hospitals and providers that are now experiencing a 40% rate are just barely able to stay profitable. They're now fighting to survive because, at the rates they're getting under the current structure, they can't attract physicians. *"I agree if the money were there, providers would be, but there is also the issue of lag time, and you've already got a population that's in need. When looking at Medicare restructuring, we have to look at reimbursement rates in rural areas versus urban areas, and incentive programs to bring foreign physicians in,"* he concluded.

How do we reach people?

Even with all the prevention, aging is inevitable. One participant said, *"In thinking about messages that could accelerate the needed planning, I heard a couple of interesting phrases, like 'family planning,' and 'life mission.'"* He asked the panel to offer their different perspectives on the kind of messages that would really spark action.

In Kaplan's view, the message is that, as boomers, we are going to create the services that we are going to use when the inevitable comes. *"So we need to think about what we want and how we want it."*

"Unfortunately we're going to 'want it' too late and not have time to prepare," Borgstadt said. *"We need to begin the discussion now, begin the visioning, the family planning. And it needs to be at a level that is understandable to the average American today, the Motorola worker, the Walmart check out person."*

Allen commented, *"As I've said, even knowing it's coming, I'm not thinking about all the things that we're talking about here that we need to be thinking about. I hate to keep beating the military drum, but the military requires a soldier who's 18 years old and going off to fight a battle where they may die to ensure his will is in order, finances reviewed, health records up to date. And they make it very convenient—one stop shopping. Perhaps if we just made it more convenient, because right now time is a real limiting factor for most people. Maybe a big corporation could institute something like that. Maybe the government could spur that."*

Gobble pointed out that health care is different from some of the issues we've been talking about, which really relate to 'life care.' *"I think boomers are really beginning to be more holistic. We have this multi-channel, multi-dimensional concern and we've also been a very spoiled, catered-to generation. That's going to drive the kinds of messages we're going to respond to. It's not only a capitalistic opportunity, but it's a health care opportunity, if you can meet what the boomer perceives as his or her needs, which in essence will be almost everything."*

Mintz highlighted one of the messages from her organization's campaign which is that doing your hardest and doing your best are two different things. She noted the studies by the Employees Benefit Research Institute that show that most people are not going to have enough money. *"So talk of retirement at age 62 or 65 doesn't make a lot of sense,"* she concluded.

A human resources executive echoed her sentiment, pointing out that the average 401K balance today for 55 – 65 year olds is $50,000, and the average cost for retiree medical coverage between 55 – 65 is $15,000.00 a year. He added that the number of employers providing retirees medical coverage and the number of retirees covered is down dramatically, probably by half, in the last 15 years. *"So this is a huge issue,"* he stressed.

Another participant chimed in with the following thoughts. *"The rational person hypothesis has been kind of destroyed in the last 10 years in various research, so we really have to create structural changes and then using Prochaska's model, gradually bring people along to the inevitability of those structural changes. In some ways we really do have to do 'social engineering', the government can't avoid that. The financial realities related to the boomers are going to make the need to limit choices and modify behaviors inevitable. There is no way around it."*

A psychologist offered his thoughts on the concept of resilience, and the ability to teach people the skills they need to bounce back in the face of hardship, adversity, difficult times, drama, even significant life-stressors. *"The bounce back piece is also an inoculation. Research has found that people who are more resilient are people who have a spiritual connection and are connected to others. They have good support systems."*

Psychology has always focused on the negative. It's just now turning around to focus on positive behaviors and changing the vision to thinking about potential, versus deficits. *"In 2000 APA set up a section on positive psychology, but it's still so new, we're talking about a literal paradigm shift. It's a 'sea change' that hasn't washed across the masses yet,"* he added.

Morlocks and Eloi

Another participant tried to look at the situation of the relationship between the boomers and other generations using an interesting analogy.

"For those in the room who are familiar with HG Wells time machine, there were the Morlocks and the Eloi. I know that from what we heard yesterday, we are supposed to be focusing on the Eloi. But the Morlocks exist, or existed in the story. The point is, ultimately this is all about money, and there are two large factors that while negative need to be confronted head on. The first is the sufficiency of money in the system now to take care of the social needs that are emerging. The United States in its wisdom a long time ago decided to divide up that responsibility between the employer community and the public sector, and what's happening now is that the employer community is slowly and surely withdrawing. The consequence is obvious in the condition of state Medicaid solvency, resulting from large numbers of people being thrust into that system.

Many people lack an adequate retirement income, because they didn't or couldn't save enough, or because they now have this new burden of having to pay more for health care, whether it's as active employees or retired employees. And we've got this wonderful opportunity down the road of maybe privatizing social security. So there are forces that are saying to people, 'you have to become more financially disciplined, and begin to pay for things that for a long time were someone else's responsibility.' It's a serious problem, a serious shift. We don't talk about it, we kind of walk around it and say 'oh, we can teach people to be financially disciplined, it's easy.' Having tried to do it for 25 years, it's not easy.

The other thing, on the money side, is that a lot of this depends on looking at populations and looking for opportunities to improve health, which tends to lower consumption of resources so you, theoretically, free up resources for other people. Well there's been a fair amount of research that says there's not a whole lot of folks

out there that are really willing to give up their demands on the system for the sake of freeing up resources for someone else who is less fortunate. In other words, social responsibility in health care isn't very strong.

So I think these are two very important realities, like the Morlocks, and I don't think that despite our desire to be positive and tell positive stories and to offer hope, that we can ignore that the Morlocks exist. They are, it's out there, and we've got to confront it head on," he concluded.

A challenge to the Boomers

Another attendee seemed on a similar track. *"I sit squarely in Generation X. I'm not a boomer. And often when people ask me why it is I even work in health care, I tell them that I have a probably incurable condition, and it is a raging case of baby boomer envy. I think that as a generation, you guys are pretty incredible.*

"There is this phenomenon that happens in nuclear families when the kids realize that they outnumber the parents, and then they just take over. In my opinion, that happened at a national level with baby boomers and gave that generation a sort of dichotomy. On the one hand, they are very hopeful and powerful, and took on some of the most important big social issues that we ever faced. On the other hand, this generation, having the ability to get what it wanted, became spoiled and selfish.

The good news is that through most of the history of 'baby boomer-ism,' the two sides were balanced. In my opinion, that went away after the failure of health care reform in the 90s. That was the last big attempt to be socially conscious and now all that is left is the spoiled and selfish side. That is what I think.

What I know is that in a few short years the boomers will be an unstoppable political force on the planet. The ability to outvote any other segment of society will allow baby boomers to determine what's going to happen every place else on the globe, because they will effectively control the resources of the United States.

So here is my challenge. My challenge is for baby boomers to try one more time to remember that hopeful side and dig deep and try to take on the health care reform issue in one last big effort. I think you could do it. There are a lot of cool folks who would take over the leadership roles in AARP, maybe even create a secondary organization so that in 2 or 3 or 5 or 10 years from now, there's the necessary infrastructure and the right thinking and leadership to take one last shot at it.

Hopefully you guys will take on this challenge and remember the part of you, in my opinion, that creates the envy and not the part that creates the pain and suffering and makes me not want to be around boomers so much."

Discussion Wrap-Up

Ian Morrison

My personal plan is to have fun and work forever and then check out. It's the Eli Ginsburg model. We baby boomers do not have enough money. And the comments about us were, I think, dead on.

In 2008 or 2012 there will be a referendum on the financial security in the middle class baby boomers. They will finally wake up and realize the statistics that were cited earlier. The actuaries tell me that you will need $200,000 dollars in retirement just to pay for your unfunded medical liability, because Medicare and Medicaid pay only half of the cost of aging. So nobody, unless you're in the top 1% of income, can afford to retire. The other goal is, everybody should be in the top 1% of income, okay.

The observation I make on the compression of morbidity is we have an inability, not just in the US, to say 'no' to the medical intervention at the end. The technical term in health services is 'upward banding age-specific utilization.' And it's true in every country in the world. What that means in lay terms is we're doing more for the average 75 year old with disease X than 10 years ago. So while on the one hand, I think we all violently agree that we've got to compress morbidity, there is little evidence at the present that it causes us to do less when the morbidity happens. That is a gigantic question that speaks to rationing and all kinds of stuff that Americans don't want to go anywhere near.

I just did some numbers on the back of an envelope. We spend $15,000 per household on health care today. Conservative estimate, by 2020 we'll spend about $35,000. And if you assume the same distribution between business, government and households, which is a very difficult distribution to change, it means taxes are going go up enormously over the next 20 years. It means businesses' burdens are going to go up enormously over the next 20 years. And the burden on the household is going to double, unless we do something very radically different.

I think we've got to scare the hell out of the baby boomers and say, *"that's the reality you face. I don't care what your politics are, that's the reality you face as society."* It's got to come from one of those three buckets, and basically it's got to come from us chickens any way you cut it. But I don't think you should scare them without having a vision. That's why there are some good opportunities to present new models.

I really liked the congregate housing idea. I've always joked that if we don't do something different, we're all going to be sitting around in nursing homes, we baby boomers, singing *"I've got you, Babe"* to each other and it's going to be profoundly unpleasant. But congregate housing is kind of the Big Chill on steroids.

The other idea I'd leave you with, I think we've got to get very imaginative with workplace initiatives. We've got to talk about the fact that everybody's going to work forever.

My last comment is my personal peeve. I can take my social security money to Costa Rica, but I can't take my Medicare money. I think one of the opportunities is to export our problem somewhere else. I say that half-joking, full-serious and it sounds fundamentally un-American, but there are a lot of lower cost health care environments around the world where people could retire. If you take your $50,000 by-pass money to Costa Rica, you can live forever.

Session VII Integrating Mind and Body

Marcia Comstock

We've heard a lot over the course of the past 3 days about how health care is siloed and people are not looked at as individuals. In the last session we want to explore the concept of 'holistic' or 'integrative' medicine. What is it about treating patients more holistically, more as a person, not as a symptom or a disease, that tends to encourage more compliance with treatment? Russ Newman is going to start off, looking at it from the perspective of integrating mental and behavioral health, then Milt Hammerly and Sita Ananth will discuss the growing use and 'mainstreaming' of what is known as complementary and alternative medicine.

Russ Newman, PhD JD: Executive Director, Professional Practice, American Psychological Association

Thanks Marcia, and thank you (the audience) for still being here at this part of the conference to hear about mind/body integration. Perhaps that suggests something about your higher level of integration. I want to go back to where I let off with my comments yesterday because I think it is a fitting transition into this session. I have a few specific points to make before I set up the panelists to be able to talk about their parts of the program.

I **am** optimistic, and that's where I was in the session yesterday, in terms of what we have to build on in an effort to reform the health care system. I think 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. This optimism is, I think, a good thing. Research tells us that people who are optimistic are healthier people. It also tells us people who maintain an optimistic attitude live longer, so I'm going to keep that optimism. I hope all of you do as well.

But we didn't always have the ability to talk about lifestyle, behavior and health or mental health and health together. In fact, our society has done a lot over the years to separate those things, to actively and aggressively keep them separate. Mind and body have for the longest time been considered separate, at least in our western culture, although not necessarily in an eastern culture. In our health care system, we've actually built structures to keep mental health separate from physical health care. The most obvious, of course, is the creation of behavioral health carve outs. This 'system' takes the services to be provided for physical health and for behavioral health care, puts them literally in different locations, and creates a separate system for behavioral health services. In addition, gatekeepers are established to say whether you can access that behavioral health system or not. There is also a different financial system for behavioral health services; the dollars that go to mental health services are kept completely separate from the dollars that are being used for physical health care services on the med-surg side of healthcare.

A good example of this separation surfaced when we tried to do a demonstration project of collaborative care with psychologists and primary care physicians in rural areas about ten years ago. The project particularly focused on alcohol and substance abuse issues, although other mental health disorders such as anxiety and depression were involved as well. One of the things the participants told us was a big obstacle to collaborating was that they frequently served on very different provider panels with different behavioral health and health care companies. Specifically, this made it very difficult administratively for them to collaborate on services provided to individual patients. We have since been trying to do something to fix this problem, and we will talk about those activities in a minute.

In addition to the structural and financial separation that has been created, there has also been a stigma associated with mental health, and even with behavioral health, that has facilitated the separation from health care. Just think about what the connotation is if I were to say to Jon, *"Jon, I have questions about your mental health."* That is not something easily discussed. Behavioral health is, perhaps, a better frame, but even that has some stigma associated with it. Saying to Jon, *"I have questions about your behavior,"* also has some connotation that is less than helpful to our ability to bring behavior into the mix.

About five years ago, the American Psychological Association was beginning the development of a project called the Decade of Behavior, to follow the prior Decade of the Brain. As is often the case with these kinds of initiatives, we attempted to get a Presidential proclamation to support and accompany

the initiative. The Whitehouse, which was then the Clinton Whitehouse, declined to provide a proclamation regarding the Decade of Behavior. While we really don't know why they declined, we couldn't help but notice that it was just after the Monica Lewinski episode and we speculated that 'behavior' wasn't something the Whitehouse was much interested in calling attention to! The point is that even talking about behavior can create discomfort, although not nearly to the same extent as taking about mental health.

But we are making progress in trying to bring those things together, those two entities, those two systems, and those two worlds. One of the things we've done at the APA [American Psychological Association] is to work with the American Medical Association to create some new CPT codes, the Health and Behavior Treatment and Assessment codes. Previous to the newly developed codes, the CPT codes available to psychologists required that the patient have a mental health diagnosis in order for the services to be readily reimbursed. Some of the problems for which psychological services are useful are physical disorders, for which patients do not have mental health diagnoses. Perhaps somebody with cardiovascular disease is depressed, but that is not always the case and that is not always the target of the psychological intervention. The treatment is often times intended to help someone deal with their chronic physical illness or to help them manage their stress, which we know can exacerbate cardiovascular disease. So we created new CPT codes that enable the reimbursement and the delivery of psychological services to someone without a mental health diagnosis. A significant piece of progress with the new codes is that the dollars used to reimburse services with the new codes now come from the med-surg side of the system, not out of segregated mental health dollars. This is a good step towards integrating the psychological and the physical. We have a lot farther to go for sure, but it is a step forward.

We've also been engaged in building a number of demonstration projects in order to better integrate psychological and behavioral health services with physical health and primary care services. One project has integrated psychological services with the treatment of breast cancer and is intended to show that not only do you get better health outcomes, you actually get some health care cost savings as well.

It is interesting that frequently when we've tried to make the case for mental health services, the argument cannot be just, *"how does it help [somebody]?"* Rather, the argument has to be, *"will it save money?"* When we talk about the delivery of physical health services for the treatment of cancer, for example, we don't ask the question, *"how much money is this going to save?"* We simply ask, *"Is this going to be beneficial from a health outcome standpoint?"* In any event, we think there is good cause to say you can deliver mental health services and get a better health outcome AND cost savings as well. Because of the two different financial systems, however, it has been very difficult to actually document that in real hard dollars, as opposed to just actuarial projections. We have a lot of actuarial projections but when you've got two separate systems, you can not actually track the impact on the med-surg dollars of spending mental health dollars.

In addition to the integration of psychological services and treatment of breast cancer, we have done work with the integration of psychological services in the treatment of cardiovascular disease. We have also recently gotten some appropriations from Congress to do a demonstration project in Pennsylvania integrating psychological services with primary care for the elderly. We are also looking at some psychological services integration with the treatment of obesity. In each instance, the goal is to demonstrate better health outcomes, as well as health care cost savings.

In the public's mind, the recognition of the connection between the physical and psychological has also been increasing. If you saw the September 27 issue of Newsweek, on the mind-body connection, the

cover story and accompanying articles had all kinds of examples of the connections between the psychological and physical. 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 (or 'crashes' as the CDC says) and suicides. Depending upon which study you look at, some 60 - 90% of visits to medical doctors are considered to be for stress-related complaints. The aging study that Suzanne [Mintz] mentioned earlier -- the study looking at the effect of caring for a chronically ill child on the aging process -- is yet another clear connection between behavior and health. The increased of use of complementary and alternative medicine in the last 4-5 years, which I know Sita [Ananth] is going to talk to you much more about, has also facilitated the public's increased awareness of the connections between mind and body, behavior and health, mental health and physical health.

We recently did some public opinion surveying for a public education campaign that we are engaged in at the APA, and we found some interesting results. Some 97% of those surveyed said they 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. One of the things we also encountered as we tapped into public opinion, perception and attitude was a sense that while people were more than willing to spend money out of their own pocket for services when they were described as complementary and alternative, once you put these services into a mainstream health delivery system, there was a growing expectation that they would be paid for by a third-party payer. Once that expectation was created, people were reluctant to use the service if insurance did not pay for it. This is one of the challenges we will have to deal with. You will hear from Milt [Hammerly] some of the other challenges we have in trying to get the current health care delivery system to bring mind and body together.

Before I pass the baton, I want to address one more issue that is an extension of the mind/body concept into the workplace. People spend a lot of time in the workplace, and if we're going to deal with both the individual and the environment in which they function, the workplace is an important setting to think about. We've heard about programs during the course of this meeting that deal directly with health and safety issues in the workplace. Those are great, but there are a lot more things that can happen in the workplace to positively influence the environment and benefit employee health. My organization has developed a psychologically healthy workplace award program, where awards are given to companies that are doing things to create psychologically healthy workplaces. For example, among the things we know is that when employees feel like they have more say and more decision-making power in their workplace, they feel less stressed and are more productive. Programs that build employee involvement increase both employee well-being and an organization's productivity. We also have seen that programs intended to bring about employee growth and development also have positive effects on an organization's performance. Other areas that the research shows contribute to both employee well-being and an organization's productivity are recognition programs for employees and work-life balance programs.

While we know that each of these types programs individually has a positive effect on employees and organizations, we think the whole can be much greater than the sum of the parts. We intend with our psychologically healthy workplace awards program to collect data from companies who are doing things in all of those areas, and eventually have some good metrics. This will enable us to show just what happens to both employee well-being and organizational productivity when you create a more comprehensive psychologically healthy workplace.

I want to return to the connection of health and behavior, and to build on what we know about how to change behavior. We live in a culture that has been a 'just do it' culture. But we heard from Dr.

Prochaska, 'just doing it' doesn't always get it done. Not everybody can 'just do it', and those who can't often get left by the wayside. If the connection between health and behavior holds the key to fixing what ails our health care system, we need to address both the necessary behaviors and how to help people accomplish behavior change to be successful. I think you will hear in what Sita and Milt discuss some lessons about how 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. Thank you.

Milt Hammerly, MD: Director, Integrative Medicine, Catholic Health Initiatives

(presentation slides are available for downloading from www.wrgh.org)

I'd like to echo some themes that have been talked about over the last couple of days and reinforce what Russ [Newman] has mentioned. One brief theme is again the irrationality of the current system and lack of sustainability. I'll use a brief illustration borrowed from Jamie Orlikoff. He says that given demographic and economic trends that Medicare is unsustainable. We've all heard this before. He says that 4 changes need to occur by 2012 - 2015 for Medicare to be sustainable. The first one is that premiums need to go up. That's necessary but not sufficient. The second one is that benefits need to go down. Those two are both necessary but not sufficient. The third one is there needs to be means testing, so only the people that have low financial means will qualify, and there will be fewer qualifying. All three are necessary but not sufficient. The final one is the age of eligibility needs to go up to 92! Now obviously that politically is a time bomb. So the reason he uses this illustration is to say, as a call to wake up, that we really need to do something different.

One of the articles on your table talks about the role of CAM (complementary alternative medicine) and preventive medicine. On the 6th page of that article, (page 128,) there's an S shaped curve, the classic S shaped curve. On the steep part of the curve are the lifestyle interventions, the mind/body interventions, the behavioral interventions, diet, exercise, stress reduction, etc. These interventions have a large return on investment, in the classic "health as an asset" illustration. On the flat upper part of the curve, the professional interventions, the high-tech aggressive interventions yield a smaller return on investment. We're investing far more resources there than on the steep part of the curve, where we get more return on investment. That's a more rational model, but we're not allocating resources in that way. The answer is not more money; we're spending more than anyone else. The answer is spending it differently.

Catholic Health Initiatives (CHI,) the organization I work with, was aware of the trends. Sita [Ananth] will talk more about the growing use of CAM. The American Medical Association, the county medical societies, the state medical societies, were all saying doctors need to ask their patients about this. They're using these different therapies, the unconventional, complementary, alternative, whatever you want to call them. One of the big ones is the use of supplements: vitamins, herbs and so on. The estimates are that based on the concurrent use of supplements and medicines there are 50 million Americans having potential interactions between them—dangerous interactions sometimes. So from a kind of fear or worry perspective, we're being told, incorporate questions about CAM in the history and talk to patients.

As a result of the trends and the alarms being raised in the medical community, CHI started to look at how we can do this, and we crafted a person-centered care model. It's not about the therapy; it's about person-centered care. The person-centered philosophy is that we want to provide comprehensive body/mind/spirit care. When we look at people that way, we provide comprehensive care that allows us to personalize it more. It's comprehensive in scope, personalized by design. We realized that if we are

actually going to do that, we have to collaborate, we have to work together, because no one can do all those things and do them well. So the driving philosophy again is holistic, a comprehensive, personalized, collaborative philosophy. Then there's the person-centered use of therapies, the person-centered evaluation, the person-centered use of science—it's all person-centered.

The distinction I think is going to be worth making is that initially we talked about patient-centered care, but we shifted it to person-centered care. I included in the other handout some definitions for you to compare and contrast, patients are defined simply by their relationship with us. If we asked any room of people, who are you? How do they answer that question? They say I'm a dad, a doctor, a mom, a brother and whatever, by their work, by their relationships. "Patient" would be maybe 18th or somewhere down the line. That is not how they define themselves. So in interacting and treating people, it's a much richer relationship in which we recognize values, preferences, their beliefs, their connections, all those things which help us think of them as persons as opposed to patients.

So that's one aspect. The other tie in is in terms of the different categories of complementary therapies. Mind/body medicine is clearly one of those. Behavioral medicine is often put in that category. Some people will debate that. One person who debates that is Dr. Herbert Benson. He's published a lot, he's widely known in that field, and he actually says that mind/body medicine is no longer complementary because the evidence is so strong, the data so robust, that we can no longer call it complementary or alternative. It's conventional. The problem with that is even though there's solid evidence these therapies aren't routinely incorporated. So from a functional perspective, it's still complementary/alternative because it's not routinely incorporated even though there's no concern about side affects and interactions as there are with other therapies.

The other point to emphasize, going back to the initial article, is the concept that, CAM practitioners, and we'll talk much more about the trends, spend more time with patients, or the persons they treat and interact with, and they do tend to have a more holistic philosophy. They tend to look at people more comprehensively. At the very core of their approach is behavioral lifestyle intervention. We've heard from Dr. Prochaska and others that most physicians don't believe patients can make the necessary changes. They don't have the confidence or the commitment or the belief that that's going to work. So it's actually a very good fit—CAM practitioners on a regular basis talk about these things. They have more time and they're also less expensive. A pretty simple business principle is don't pay someone who's more qualified or expensive to do a job that someone less qualified or less expensive can do. So in terms of an entry point into the health care system and an interface with the health care system, perhaps we need to rethink.

The last thing I'd like to mention is a couple of metaphors. First the three-legged stool metaphor, which Herbert Benson talks about as conventional medicine, self-care, and mind/body medicine. I would actually say that the three legs are professional care, and mind/body medicine can be either professional or self-care, then self-care, and then the third, I think, that has emerged from our discussions, is coaching. So we've got the things we can do for ourselves or our families can do for us; things the professionals can do for us; and coaching support to know when to do what, and to actually help us do it. The things that support the stool, the ground that it sits on, are the coalitions, the collaborations, the infrastructure, and what's on top of the stool is the person and his or her needs.

The parallel metaphor--you know there's always a danger of mixing metaphors--is the pyramid (you've got the illustration on a handout) and at the top of the pyramid is the person. If person-centered care is the organizing principle of the new health care system, and we look at the "STEEEP" criteria of the IOM (safe, timely, effective, efficient, equitable, person-centered), all of the principles fall under person-

centered. And if in fact we're going to design health care as person-centered, then we need to meet all the person's needs--body, mind and spirit. From a Maslow's hierarchy perspective, the purpose of health care is not health in and of itself, but it's actualization. And I think really that's ultimately what we're trying to support.

Sita Ananth, MHA: Project Director for Complementary and Alternative Medicine, Health Forum

Thanks so much for having us here and giving us a chance to champion our cause. CAM (complementary and alternative medicine), in our experience, lives a 'parallel life' in healthcare and is quite separate from the traditional medical care system, so what I'd like to do in the next 5 minutes is just give you an overview of the trends that we're seeing in consumer utilization; hospital services; and insurance coverage and then lay out six issues that I think are opportunities and challenges that we can use in the venue.

Consumers in the United States are seeking out CAM in unprecedented numbers. In May of this year, the CDC conducted a very extensive survey and found that 42% of Americans are using some form of alternative modality, and this ranges anywhere from vitamin therapy to acupuncture to relaxation techniques. And this is a 25% increase from 1997 when Dr. David Eisenberg at Harvard wrote the seminal report in the New England Journal of Medicine. In 1997 the number of visits to CAM practitioners was 629 million visits, which was 60% greater than all primary care visits combined. That is a huge number that no one is even talking about. Five years ago, we at Health Forum conducted a series of focus groups. We went all over the nation and to communities with different socioeconomic and racial backgrounds, and even in the most disadvantaged communities, people were telling us that they would like to have the choice of seeing alternative medicine practitioners and using those services.

On the hospital side, the number of hospitals that offer complementary services has doubled from 8% of hospitals in 1998 to 16% in 2003. In 2003, I conducted a survey of AHA's 500 member hospitals. We queried them about the reasons for offering these services; the types of services offered, reimbursement, etc. The primary reason for offering these services was to respond to the communities that they serve and to differentiate themselves in the market. In terms of insurers, between 2000 and 2003, Ken Pelletier at Stanford University conducted a survey of some insurers, and asking them what their coverage of alternative medicine services was. He found that some of them were covering acupuncture, chiropractic and biofeedback, which tend to be most common. Again they said that the motivator was employee and employer demand.

So now that we have a sense of the landscape, I'm going to talk about 6 important issues in CAM that can impact the work we are doing here in this meeting.

The research has shown us that between 30 to 70 % of patients with chronic illnesses utilize CAM, in addition to their conventional medicine. So again, we have a wonderful opportunity for us to bring these 2 groups together, so that the CAM providers are not just one more unnecessary player in this disjointed process. The conditions for which the CAM therapies are being sought are cardiovascular disease, arthritis, AIDS, HIV, cancer, and chronic pain.

The second point is payment and reimbursement. Again in the 1997 Harvard study, they estimated that Americans spent 13 billion dollars out of pocket for visits to CAM providers. Once it's outside of the system, people tend to be much more willing to spend their own money. In addition they spend 26 billion for supplements and mega-vitamins. Of the hospitals surveyed, we found that the majority of

hospital-based CAM services are paid for out-of-pocket by the patient. So even though there is some insurance coverage, it just doesn't seem to match what's being offered in the hospitals. This creates a huge dichotomy between the elite and people with disposable income who are able to access these services, and a vast majority of uninsured and indigent patients who have absolutely no access to these services and could very well use them. There are a few stellar examples, wonderful community-based programs but they're really not enough. And as Ron [Bachman] talked about yesterday, consumer-driven healthcare I think will have a huge impact on people's ability to choose the type of health care they want.

The third issue, which I think is really important, is patient safety. Another Harvard study reported that 70% of patients who use complementary medicine are not telling their physicians about it, because they feel ridiculed, or they simply think the doctor doesn't know enough about it to offer good advice or decision support. So they're not telling them and this could become a huge patient safety issue with drug interactions, which then leads to liability for providers.

The fourth point is education, and what is happening in clinical education. At last count, 60 or 65 medical schools are offering an elective in CAM, which is extremely popular. The only problem is these universities are designing the programs however they want, there's no standardization, there are no minimum curriculum requirements, so students are coming out with different levels of knowledge base. At the CME level there are a few fellowship programs. Dr Andrew Weil has a program at the University of Arizona, and there are a couple of programs in New York. But they're still under-funded and it's hard to get access to those programs. From the CAM provider side, there's a real need for education as well, because when they start coming into the mainstream, working in hospitals and clinics, these people are generally very independent, not used to working in a structured environment. Teaching them how to work with hospital professionals, with physicians is really important.

The fifth point is patient satisfaction, and there has been some research, but it isn't very well documented. I found some research that was done in the state of Washington. This is a unique state because in 1995 they passed a mandate that every licensed provider had to be covered by health plans, which that meant that massage, acupuncture, and naturopathy had to be offered by every health plan in the state. This was a wonderful opportunity to collect data on patient satisfaction. About 1100 health plan members were surveyed and the results found that 56% of users of massage, acupuncture and naturopathy were very satisfied, 92% were satisfied with the care, 76% said they would come back, and then another 61% said it had reduced their use of prescription drugs. In 1998 there was a study conducted by the University of Maryland to find out why patients use alternative medicine, and the most influential factor in that decision was the perceived efficacy and belief that CAM actually promoted health rather than a focus on illness. I think this was a very interesting perception issue. As Milt [Hammerly] said, generally these types of modalities tend to focus on the whole person and tend to be more customized to the individual rather than therapy based.

Finally, I think we have a huge opportunity with kids. 50% of kids in their teens are using some type of alternative medicine and this of course is no surprise because their parents are using it.

So in closing I'd just like to say that the CAM practitioners that are out in the community are a huge untapped resource, and they would be willing partners and we should really try to include them as we talk about these issues. As Milt said, patients spend a lot of time with these folks and we have a wonderful opportunity to really collaborate and bring them into this conversation of personal health improvement.

Session VII Discussion

The discussion began with a question relative to the emphasis placed by CAM providers on self-care and empowerment.

Hammerly indicated that in his practice he often sees patients with a diagnosis of cancer or some serious illness who have seen several physicians, all of whom have recommended conventional treatments. Although these patients tell him they have asked about other options, generally the physicians are not supportive of the use of CAM approaches. *"Invariably they've gotten talked down to and told not to waste their money and their time,"* he said. *"So they come to me expecting me to tell them, 'do all those things.' But I tell them while these things help reduce the side affects and may help you tolerate the treatments better, you still need [conventional treatment.] 95% of the time those people who had rejected conventional treatments will now accept them. So by not invalidating their belief system, you can actually enhance compliance dramatically."*

In response to a question regarding CAM research, Ananth stated that there is quite a lot of research on CAM modalities. The NIH has the National Center for Complementary Alternative Medicine, which is funded at about $120 million a year. They do clinical trials involving various interventions and conditions, for example, acupuncture for back pain, gingko biloba for certain conditions, ginseng for others. Unfortunately, there isn't any research on how these modalities are best applied in healthcare delivery, and how conventional and CAM practitioners could work together in multi-disciplinary teams. *"So that's something we are really struggling with and trying to figure out,"* she said. *"Who we can lobby and who we can talk to about doing research on the delivery side? There's plenty of clinical evidence that shows efficacy in isolation…. However, on the actual delivery of care, there's really no good evidence if combining therapies and integration of conventional and complementary medicine works well. How does it really improve outcomes?"*

Hammerly agreed. *"The research design is largely reductionistic and isolates interventions. For the most part, it doesn't use an integrated model. In terms of the isolated use of a specific intervention, there is increasing evidence for particular therapies—some more than others, such as mind/body evidence. But there are limited resources and there are therapies for which we don't currently, and I wonder if we ever will, have randomized, placebo-controlled clinical trials. There are some therapies that are not amenable to that kind of research. Does that mean because they can't fit in that research model that they can't be validated? Those kinds of questions are being asked in research communities. The other question worth asking, I think, is: what is the role of science in deciding which therapies do we choose?"*

He went on to use the example of a patient with chronic pain who has seen a pain specialist, and has had virtually every kind of conventional therapy, including medications, a TENS unit, physical therapy, nerve blocks and ablations. Yet, the patient is still disabled, still dysfunctional. *"The patient says, 'I talked to a friend and she said maybe I should try magnets and therapeutic touch and acupuncture.' The doctor responds, 'Well there are no randomized, placebo-controlled trials, therefore I can't recommend you try that.' In essence, without even realizing it, the doctor is saying, 'My science is more important than your suffering.' Ethically I don't think that's a valid position to take,"* Hammerly said. He agrees that if there is a concern about the safety of the therapy, it is legitimate to discourage use. However, if the worst that can happen is the patient does not get better and has to try something else, the lack of randomized, controlled trials should not be a barrier.

Picking up on the issue of evidence-based practice, a physician executive noted that there is no consensus on the definition of evidence-based practice. Not everyone limits it to randomized, controlled

trials, which don't include effectiveness and efficacy studies. *"The Institute of Medicine talks about evidence as being part research, part clinical experience, part patient value, choices, demographics—and all of those things have got to be considered in order to provide evidence-based practice. One of the problems, if you use a narrow definition, is that you eliminate any emerging practices or treatments that might eventually have some demonstrated effectiveness or efficacy,"* he stated.

Another physician suggested that in considering person-oriented or population-oriented care, we need to redefine effectiveness research because it remains technology-based or intervention-based. There is a lot of frustration associated with the translation of research into practice, but sometimes the research is simply irrelevant. He pointed out that, *"The treatment that is supported by randomized control trials may only be able to be delivered to 0.05 % of the population, whereas another treatment that's supported by other kinds of evidence may be able to be delivered to 20% of the patient population."*

A nursing executive appreciated the focus on the person, rather than on programs and providers, in this session and the one on the boomers. *"We have to look at it from the economics, the society, but we're all here about the person."*

A hospital executive asked Newmann about the future of reimbursement for behavioral and mental health services. *"Is there any enlightenment down the road?"* she asked.

Newmann responded: *"An initial step was taken in '96 which created parity for annual and lifetime dollar limits. Payers however found loopholes around that. So the proposal that sits with Congress now is one to create parity for other things, like hospital days, deductibles, co-pays, out of pocket maxes. There can be limits, but there not limits that are different from physical health coverage."* He pointed out that there is a lot of bipartisan support in both houses of Congress, but the leadership has not let it come to the floor. The employer community has opposed it as a mandate, although it doesn't require that mental health services be provided. *"It's still going to be an uphill battle,"* he said. He acknowledged that his organization's emphasis has been on individual treatment, but they would like to see appropriate reimbursement for group-related treatments, to the extent that they are both effective and cost-effective.

A physician executive expressed surprise that the integration of complementary alternative modalities with mental health and general medical care has not been tested more actively in prepaid group practices or in government-run facilities, like the Department of Defense, or in community health centers, *"where the funding mechanisms of American medicine, that guarantee fragmentation, are not as much at play. That's often the way we've learned how to apply things in our fragmented model. It was tested at the VA or the Air Force or these kinds of facilities."*

He went on to ask if there was any definitive movement to seek funding for integrative demonstration models to prove effectiveness, and specifically asking if there was evidence from England or other pre-paid government systems.

A participant pointed to a demo with integration of psychological services and breast cancer treatment in Blue Cross/ Blue Shield of Massachusetts HMO. *"Even then it took us forever to get the financing mechanisms in place so that the data was able to be captured both on the clinical side and on the psychological side. The difficulty was the company kept reorganizing every 6 months and we ran into all kinds of logistical problems."* He went on to say that it is an ongoing service now in the Department of Defense at Walter Reed Army Medical Center. Further, 78% of all VA hospitals offer complementary medicine.

Ananth cited Kaiser in Northern California as the ideal system where incentives are aligned as everyone is on salary. The problem is that the complementary medicine that's offered is on a very limited basis, as part of the care for chronic pain. It is not a separate benefit. Also, patients have to failed more invasive treatment before they can have acupuncture or other modalities. This approach is relatively recent, in the last 3-4 years. They have a department of research, but have not yet collected any meaningful data on outcomes or cost savings.

Hammerly offered one example, Alternative Medicine, Inc. in Illinois. Dr. Sarnot, an ophthalmologist by training, set the program up. *"It's a controversial model,"* Hammerly said. Dr. Sarnot proposed the primary care provider, or entry point into the healthcare system, be the chiropractor, because they are more holistic and less expensive. *"When I first heard about this,"* Hammerly admitted, *"I thought 'oh, bad idea because they're not trained in triage, something's going to fall through the cracks, people are going to have complications and bad outcomes.' But Dr. Sarnot was astute and provided additional training to the chiropractors to fulfill that role, as well as medical oversight."* Dr. Sarnot worked with a patient population through Blue Cross/Blue Shield of Illinois. Three years of tracking shows consistently good outcomes, including 50-60% reduction in hospitalization, 50-60% reduction in medication use. Not surprisingly, the result has been a dramatic reduction in costs. *"This is an integrative model that has turned things upside-down, by starting with CAM, not holding CAM until everything else has failed,"* Hammerly emphasized. Dr Sarnot attributes much of the savings to early and frequent use of behavioral health interventions, as the chiropractors made a lot of referrals, which resulted in early identification of depression and behavioral issues. Hammerly referred the group to the website for more information, *www.alternativemedicineinc.com*.

A British attendee stated that, although he does not have any data readily available on the use of CAM in the UK, *"there has been a lot of piloting going on for about 4-5 years. The new UK head of public health put alternative medicine very high on the list of priorities. That makes me think it's working."*

Referring to the figure cited that 70% of patients don't tell their doctors that they're taking some sort of supplemental alternative medicine, a patient spoke up: *"Through my illness I've probably done over 2 dozen types of alternative complementary medicine. And I've had the experience of sitting with my doctor who's the chairman [of the department].....and a personal friend, who's saying, 'are you taking any supplements?' And I looked at him and said 'no'? Well I was. I was just lying right to his face, because I knew what his opinion was about these things....It seems to me we'd have to affect both sides of the equation, because it's a huge safety problem, but in terms of patient-physician shared decision-making, it's a huge disconnect."*

He thinks on the physician's side, it is sometimes a matter of going against a belief system; other times it is a matter of not knowing. There does not seem to be any way in training or practice for physicians to be kept current with information on these modalities. On the patient side, he feels it is curious that, *"I have spent thousands of dollars on complementary integrative medicine, but I get so upset when I have to pay that $15 co-pay!"* He points out that it is a struggle to get patients to do anything preventive, even if it's paid for, but we've got millions of people paying out-of-pocket to do alternative medicine. *"Can we try and understand those behaviors? Why am I doing this? I know for me, it's because I feel like I'm doing something, rather than being passive. We can take some lessons from that as we try and move the message out to people to take care of their health."* He concluded by wondering if in China people get acupuncture and then have to pay extra for Western medicine!

Ananth responded that in India traditional Western medicine is one of the norms. *"People who do acupuncture are sort of viewed as being out there."* With regard to paying for a treatment and its impact

on compliance, she stated, *"Personally I think if you're seeking it out, and feel you're getting value, once you've paid the money you're more likely to comply."*

In terms of discussing interactions with other therapies, the AMA, state and county medical societies are all saying that physicians have to ask the question. But Hammerly noted that even when the question is asked, physicians aren't always getting the true answer. *"Sometimes it's how you ask the question,"* he said. *"If you ask, 'you're not using any of those bogus therapies, are you?' it will be perceived as judgmental. I routinely get patients that are doing things that I actually get upset about. But I'm able to bite my tongue, and to mask my face, for the value of the relationship. If they perceive that judgmental aspect, it undermines the relationship, it undermines compliance, it undermines the ability to help them make good choices."*

On the issue of willingness to pay, Hammerly opined, *"Choice and control enhances willpower, enhances confidence and improves outcomes."* While practitioners bemoan the fact that insurance doesn't pay for everything, his view is *"Be careful what you wish for."* He admitted not knowing if it had been confirmed by research, but his experience and others' observations suggest that sometimes reimbursement changes outcomes in a negative way!

A hospice representative broadened the discussion, by offering another perspective. *"About 12 years ago I heard Leland Kiser talk about the future of health care…He said the future model of health care will be what we commonly see as the hospice model or palliative care model, because it is inter-disciplinary, not multi-disciplinary. It is mind, body, and spirit. It is person centered. It is about choices. The unit of care is the patient, family and the loved ones in that person's circle. …It's just interesting that that's a lot of what we're talking about here today."*

She suggested that perhaps the real opportunity is to think about patterns of things that are effective, rather than pure research. She cited work by Dr. Ginny Nelson in the nursing school at the University of Colorado on a variety of alternative interventions that demonstrates that they are helpful in palliation and end of life care. *"This is with a pretty captive audience, one that is typically dealing with a very complicated illness and a lot of complicated symptoms. And I'm talking about relief from suffering and pain, nausea, confusion, constipation, agitation, ability to eat, ability to sleep, ability to converse, ability to resolve. So we have seen incredibly powerful things happening with all elements of touch, music, art, animals, all of those things. As far as I'm concerned, it is really not to be argued."*

Another attendee was moved to respond to her comment. He pointed out *"we spend all of our waking hours in health care talking about what doesn't work. And you have just described something that does work in health care at a very critical time…I wonder if there isn't something very important to be said about our focusing on that and what we do with the publications that result from this event. Because it is a very important message and that message is not being transmitted very well.*

A hospital association executive pointed out that many parts of the country are now seeing a shortage of traditional practitioners that spans most health professionals and allied health professionals. She suggested that if we start to embrace some alternative providers, it might provide some solutions, as it is much less expensive to train these types of providers. In addition, one of the attractions of CAM in multi-cultural communities is that these alternatives are less costly, and the informal health advisors that families use are generally supportive of herbal and other remedies. As a precaution against 'quackery' she suggested that we do what we can to ensure there is adequate oversight and appropriate scope of practice laws for CAM providers.

Ananth responded by pointing out that chiropractors and acupuncturists are licensed in all or most

states, in fact acupuncturists can write prescriptions. Their licenses' scope of practice allow them to be considered family care/primary care providers, and this is recognized by state workers' compensation.

A representative of the arts spoke up, saying that supporters of the use of the arts and humanities in health care run up against the same skeptics as CAM advocates when it comes to research. He argues that there already is a good deal of research showing how use of the arts *"can lower your blood pressure, reduce the amount of medication you need, get you out of the hospital sooner. But, of course, in some cases a pill can do the same things, and with the changing economics of health care, hospital stays are already reduced!"*

His view is we really need to pay attention to is what hospital CEOs think. *"They ask us, 'Can you make the hospital more competitive? Can you help us get good press? Can you enhance our community relations? Can you help reduce staff turnover?' I would really pay attention to what rings the bells for health care executives."*

Picking up on the issue of staff turnover, Hammerly offered that initially through a grant, CHI did track and demonstrate a 27% reduction in nursing turnover at one of their facilities where they were providing music therapy, aromatherapy, massage, and therapeutic touch for staff, patients and family. "When they demonstrated to the CFO that there was a return on investment, he said, *"they funded it through the regular budget. And in this particular, market they are not charging a dime to the patients for those services.*

He added that there are several Planetree affiliated hospitals around the country whose philosophy is to provide *"patient-centered care in healing environments." They are tracking not only patient satisfaction but also employee satisfaction. Hammerly concluded, "There is all kinds of data out there. That is the sort of research going on."*

A dentist said he hesitated to be negative, *"but I am thinking about going back to Oregon and having the task of going down to the legislators and the governor's office and asking them to maintain some semblance of an oral health benefit, just the essentials."* Dentistry is in "competition" with mental health, home health care, and complementary alternative modalities. He pointed out that payers *"don't want to hear about what works, what's effective, what's in the best interest. They believe all of us. But what are we going to pay for?"* He expressed concern that the discussion in this meeting seems in conflict with the previous Foundation meeting on economic value. *"I'm wondering if we shouldn't get together and propose to leadership that these are the essential benefits of an integrated [benefit] package that we can all agree on. Because it's all important and we're the choir here and we've got to take this message somewhere else. We can't even agree among ourselves when it comes to limited dollars."*

Close

Ian Morrison

Again, in the spirit of what may we do? Here's a few suggestions.

The world of consumer directed healthcare or high deductible plans is a world in which consumers have access to dollars to spend. The really interesting thing about complimentary and alternative medicine is that when push comes to shove, more people spend more money out of their pocket on that than they do on physicians.

One thing the Foundation might do is use its influence on what's included in the bucket of allowable expenses that would be coming out of the spending accounts. That is a huge debate that is not yet resolved. Are you putting in a preventative service? What's good in what bucket of designer directed health care? You have influence and ideas and background on that. That's something very concrete that you could engage policy makers in.

The second is to encourage the design and implementation of holistic research trials that can really test the benefit of various CAM modalities, as opposed to NIH carving it out and testing one thing against another.

The third is a broader set of issues in shared decision making, which relates to discussions in the meeting, and how we integrate that.

The fourth relates to the question about environments where behavioral health and CAM have been effectively integrated with mainstream healthcare. The former Medical Director at a large insurer said "50% of back surgeries in America are for unhappiness." There is some money in the chronic care experiments at CMS and I think that one of the things we should be thinking about is how to evaluate the integration of mental health and alternative medicine into the management of chronic care in demonstration projects. The Foundation should be advising CMS to keep their eyes open to those kinds of alternatives.

I just want to say that this has been a terrific meeting and I've learned a hell of a lot about areas that I thought I knew something about and didn't, and those that I didn't know anything about and now I know a lot. I'll be an expert.

Marcia Comstock

This is really an important topic if we're going to consider working on a campaign to change behavior. We've got to understand what people value, and there is obviously a lot here that people value.

We will move directly from here to the room next door for a brief informal meeting with Marsha Vanderford of CDC. I think that what Marsha shared with us about where CDC is going and the opportunities that exist both from a business perspective and a partnering perspective could certainly help us to move some of these great ideas forward.

In closing I just want to thank all of you. You've been a terrific participatory audience. You've been very respectful of one another in your comments. You've been very helpful in bringing clarity, staying on point, and making sure that the objectives we set out for the conference were met. Over the coming weeks we will be working to develop the report and to identify actionable next steps. You will be hearing from us!

Appendix A

Promoting and Enabling Healthy Choices: Linking the Desire for Health with the Decisions & Tools that Support Health

Key Points

Setting the stage

- There are four issues/trends that should frame the discussion: (1) demographics, specifically the aging of America; (2) this alarming obesity trend, which is a global phenomenon; (3) the potential to have available scientific interventions--technological solutions--that are both expensive and effective; (4) a tsunami of chronic care needs, a wave of diabetes and depression.

- We're trying to solve these problems in a pluralistic, dysfunctional healthcare delivery system where no one talks to one another.

- Almost 35 percent of the population are obese or severely obese, and those numbers have almost doubled in the last 25 years.

- Obesity is expensive. It explains almost as much of the healthcare cost increases as tobacco, and leads to a huge increase in risk of death from many causes.

- The increase in proportion of spending on obese people relative to normal weight people accounts for about 27 percent of the rise in inflation adjusted per capita spending.

- We're eating more. We're also eating out more. There's been a profound shift in Americans' eating habits. In 1970, a third of the food budget was consumed outside the home. By the late 90's it rose to almost half, and I guess now, the number is well over fifty percent outside the home. Everything is being super-sized.

- We're not just talking about obesity, we are talking about taking responsibility as a society and as individuals for wellness and health promotion.

- The problem is that we are 'medicalizing' many of these conditions and making costs associated with them even more extreme.

- If we don't deal with prevention, we can do all the 'consumer-deflection' we want and we'll still face enormous catastrophic costs which can't be managed unless we do something about the demand side.

- Generally speaking, high deductible plans tend to lead to lack of compliance on certain issues, but these issues ameliorate considerably if you put the first dollar coverage in place for preventive services.

- The public thinks health care providers should play a big role in fighting the obesity epidemic, but they also see a very significant role for government, for schools, and for employers.

- The public supports more public space for exercise, government-funded campaigns about the health risks of obesity, eating right and exercising, and requirements for restaurants to provide nutritional information. There is less support for taxing junk food and less interest in limiting advertising.

- In Harvard polling, the public was split, with 50 percent saying obesity is a private issue that should be dealt with in terms of personal responsibility, and 50 percent saying it's a public issue that requires public policy intervention.

Session I: The power and nuance of social marketing

- Critical success factors for social marketing campaigns include strong leadership; funding and technical capability; identification and targeting of key audiences; and relevant messages tailored for diverse populations.

- The message needs to be consistently delivered effectively, using a variety of media and tactics to reinforce and leave a lasting impression.

- The message needs to be aligned with cultural values, social circumstances and financial incentives.

- Humanize issues; use stories.

- To leverage resources, it is necessary to create partnerships, alliances, and collaborations.

- It takes 7 to 10 years to fundamentally change culture, so a public education campaign of 6 months to 2 years is rarely long enough to affect the needed cultural change.

- "I equals E": what is someone's expenditure is somebody else's income. Changes in the status quo result in winners and losers.

- Health is an unstoppable political force if we can get everybody (doctors, hospitals, health plans, employers, etc.) on the same page.

- Marketing campaigns need to be aimed at the whole population, such that the fraction of the population for whom we want behavior to change are getting some social pressure from those who are not engaged in the undesirable behavior.

- Obesity is the natural response of our human physiology to the environment that we have created through technology. Strong biological incentives tell us to eat and to rest whenever possible.

- We have been focusing on one macro nutrient at a time. But there's too much of everything.

- There are no external incentives for doing the 'right thing'. It's got to come from within the individual right now.

- Marketing takes advantage of overt or latent desires of consumers. The benefits exchange needs to be very simple, very clear, very tangible, and immediate, because our society runs on instant gratification.

- We know how to target and segment the audience, how to tailor the message, and how to get it on the radar screen. For healthy eating and active living we need to get clear on the benefits exchange that's tangible today.

- Losing weight and keeping it off is a profoundly difficult thing to do. Preventing weight gain in the first place is most important in our society today.

- We need to tap into 'higher order' human needs, by leveraging the early adopters and the strong desire to belong.

- To make meaningful progress at changing these unhealthy behaviors, we need to move some of our social cultural values, e.g., unbridled consumerism, in a different direction and take advantage of existing strongly held social values.

- The purpose of the CDC National Center for Health Marketing is to ensure that interventions, communication, information, and programs are based not only on sound and objective science, but also on continuous customer input.

- CDC is looking to develop a more proactive, strategic approach to relationships and identify untapped opportunities for collaboration with both public and private sectors in order to enhance its response capacity and increase the power of prevention initiatives.

- Government should initiate the campaign and mobilize the resources that exist within the public and private sectors, identifying the unique capabilities of government agencies, state health departments, and private sector healthcare organizations and employers.

- Much of the marketing and messaging for better health is negative. We need to make the desired change to an acceptable alternative behavior not seem to be denial in the consumer's mind.

- We need to ascertain what combination of interventions will reach the greatest percentage and cause behavioral change.

- Sometimes concern over children can be a powerful motivator to move people, when there doesn't seem to be another incentive.

Session II: The role of the Internet, media and the arts in social change

- Health is a very complex issue, but you still need to clearly define the message that you want to get across.

- Talk to your audience about how they want to receive information. What is the language they want to use? What is the medium they prefer? Repeat the message again and again.

- Get particular communities to go out and communicate health messages through each other. Respect cultural differences

- Messages need to be human and visual because people relate to people, not to information and statistics.

- Make healthy behavior 'cool' by recognizing that young people want to look good. Sports might be another lever.

- People value authenticity and trust and generally want information in a clear and concise manner. Don't mix a social message with entertainment.

- If you make a mistake, correct it and move on.

- Today people are not getting information from the real world, but from sound bites, and they are beginning to believe that the media world is the real world.

- To get the media's attention when most health messages are not different, or bizarre, or new, remember that the media deals with '**A** person', not the statistics. Health education is not the same as health journalism.

- Find out what stories are being covered anyway and get the health messages into those stories.

- The arts represent a cost-effective medium to help health professionals deal with job-related stress and promote awareness and positive health messages.

- The arts can get a 'science' message across because the arts communicate full-spectrum with emotion and feeling.

- The arts represent an unattended opportunity to move people, because healing is not only about the medical process, it is a spiritual one.

- The arts can be an effective way to break down stereotypes.

- The benefits of long term investments in major cultural and social change accrue to the society at large, so the investment needs to come from the society as a whole.

Keynote: High Impact Tools for Health Promotion

- Over 50% of all health care costs are due to behaviors like smoking, alcohol abuse, unhealthy diet, sedentary lifestyles, and stress.

- Most primary care takes place at home, and the majority is behavioral. Physicians provide little information for patients to use at home to 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 have been action-oriented models. But change is a process that unfolds over time and it involves progress through a series of stages.

- If we are going to help people to progress, we need to give them feedback that they are not aware of in terms of their decision-making about their own behavior and their own health.

- The stage of readiness of an individual patient can be assessed in five easy questions so the behavioral medicine intervention can be matched to their stage. A realistic goal is to help them progress one stage in a brief interaction.

- Physicians do not as a rule practice behavioral medicine because they believe patients won't or can't change their behavior, they don't have time, there is no reimbursement, and they aren't trained.

- Although the results are significantly better with those that call for help, being proactive has more impact because we reach many more people.

- Treating multiple behaviors can be as effective as treating a single behavior and has a greater impact on health and health care costs.

- Programs are equally effective with minority populations and those with little education.

- To have an unprecedented impact on the major killers and cost drivers of our time, we need to change our paradigms: from individual patients to populations; from passive reactive to proactive; from office-based to home-based; from reliance on clinicians to adding computers; and from single behaviors to multiple behaviors.

Keynote: Capturing Growth at the Intersection

- Obesity is the largest issue the food industry will ever face, but the flip side, 'wellness', is probably the largest opportunity to add value. There is a business case for health and wellness.

- The marketing question is, how you provide different products for diverse groups with more convenience and a focus on the growing demand for 'wellness'?

- 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.

- Communication has to be consistent, simple, encouraging and absolutely unavoidable.

- Having powerhouse organizations (e.g., ACS, ADA, AHA) come together to create common standards in language would bring a lot of people in the food industry along.

- Pepsico would be open to the possibility of leading a demonstration project to develop a multi-factorial approach to shape all facets of the environment.

Session III: Public and private sector models from here and abroad

- Successful models for health promotion are based on a holistic approach, facilitating both individual responsibility and a supportive environment for change.

- Critical success factors include intellectual and institutional partnership; a clear, simple, targeted message; an inclusive approach appropriately tailored to target groups; and evaluation.

- There is a huge opportunity with corporations that have a big interest in health and wellness for their own employees.

- In addition to health, we need to consider education, recreation, safety, business, urban planning and transportation, which all impact our health.

- Most US programs lack a holistic approach, focusing strongly on individual responsibility for lifestyle changes, with much less attention paid to creating a supportive environment.
- There is no real 'high risk' population; most people are doing well in some areas and poorly in others.
- Successful programs go where people live and work and recognize that people need to be able to 'try' a new behavior and know they can 'retreat.'
- Cultural change to improve health is possible, and the best place to initiate such change is within the community starting with the behavior within a given culture most likely to improve.
- 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.
- Personal Health Coaches can develop intensive one-on-one relationships of trust and influence with participants, and the programs are 'scaleable' because outcomes data show that telephone contact is just as effective as face to face for promoting positive behavioral change.
- Lay health advisors are a great, although largely untapped, asset for promoting better health within communities.
- Every community is different, with unique needs and priorities for health promotion that should be heard and respected.
- Improving or maintaining health requires a commitment of time, which is in increasingly short supply for many Americans.
- Positive reinforcement and clear messages are more likely to promote healthy lifestyle changes than negative incentives.
- Health promotion programs can provide a significant return on investment, not only in terms of improved health outcomes, but also reduced health care expenses.

Session IV: Giving patients a voice

- Many patients/consumers (but not all) wish to – and do, to the extent possible – make decisions about their healthcare.
- Study results suggest that patients are most likely to influence and implement decisions relating to prevention and early treatment in contrast to late treatment in environments like hospitals.
- Patients are the most important source of continuity in their healthcare and thus their active involvement is crucial to ensuring its quality.
- Tools used to engage consumers/patients must be responsive to the entire array of people affected by the healthcare system and recognize disparities of disease, socioeconomic status, geography, and racial and ethnic background.
- Tools should be: (a) appropriate to specific cultures, languages, capacities, skills and health status, (b) relevant, (c) timely, (d) specific, measurable and appropriate to the behavior or goal desired, and

(e) supported by both positive and negative incentives.

- Consumer/patient engagement efforts should 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.

- A secure, centralized source of patient information is an essential tool for helping physicians provide efficient, quality care and consumers/patients track their progress and make crucial healthcare decisions.

- Tools and other interventions should be geared to improving patients' readiness to change.

- Multiple tools and exposures are necessary, because study results suggest that patients quickly forget much of the information provided during an encounter with their physician.

- Consumers/patients must be surrounded with help (e.g., web, phone, mail, print, community advisors, health coaches) to assist them in making healthcare decisions, particularly those involving behavioral change.

- Actions lists are effective tools for patients with chronic diseases.

- "Information therapy" integrates clinical care with condition and treatment specific information, involves the patient in "homework" and the healthcare professional in checking patient understanding of information they are getting.

- There are four generations of health plans that build upon one another and involve consumers/patients in different ways including (1) health plans focused on healthcare costs (e.g., savings accounts, high deductibles, (2) plans focused on behavioral change (e.g., free prescription drugs for being compliant), (3) plans focused on outcomes such as productivity, absenteeism, stabilizing those with chronic conditions and (4) plans based on an individual's specific characteristics.

- Potential barriers to engaging consumers actively in their health care include the explosion of complex information, lack of transparency regarding the cost and quality of available care, and perverse financial incentives.

- There is a chasm between the world of passionate, informed people who know what's really going on in healthcare and the 'real world' of the public. Little will happen until that chasm is bridged.

- Center for Medicare and Medicaid Services (CMS) is becoming more actively involved in personalizing services (e.g., personal healthcare records, quality comparison tools, personalized Medicare/Medicaid usage records including reminders for beneficiaries).

- Innovative channels for delivering health information need to be opened. Physicians should not be viewed as the only resource for patient education.

- To reach patients, we have to take the care to them, at a workplace, church, pharmacy, or community event.

- Information alone often is not sufficient to change people's behaviors. A more effective model would be to integrate the use of information with other tools to encourage positive behavioral change. Financial incentives may or may not have a role.

- Two specific changes in Medicare could drive tremendous savings: eliminate limits on the number of hospital days in Medicare Part A; provide HRAs to beneficiaries with money added based on compliance with recommended care.

- Key steps to reform the current system of health care, from an employer's perspective: 1) increase our focus on consumerism (use of personal health coaches, incentives to increase health screenings, health risk assessments, and disease management strategies;) 2)greater disclosure of health plan outcomes; 3) 'pay for performance'; 4) wellness promotion.

Session V: Shared decision-making

- The challenges for shared decision making are not difficult patients or difficult doctors but difficult relationships.

- Important elements of shared decision making include discussion of (1) the issues, (2) alternatives, (3) pros and cons, (4) any uncertainties, followed by (5) an attempt to assess the patient's understanding of the decision and its implications, and (6) some exploration of patient preferences.

- A study of 1000 patient encounters involving 3,000 decisions found only 9% of the decisions reflected a limited degree of shared decision-making and not one 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.

- Effective shared decision making requires trust, a clinician with good communication skills, time, incentives to practice good communication skills, commitment from patient and clinician to the value of shared decision making.

- In "lower-case decision making" (involving exercise, diet, smoking cessation) the doctor advises, the system reimburses, but the patient decides.

- The compliance rate of the typical physician in helping patients to adopt a healthier lifestyle is about the same as the compliance behavior of the patients themselves.

- The clinician needs three basic skills: (1) assessing the understanding of the patient before starting the lecture, (2) building rapport and adding consistent reflective listening skills, and (3) using empathetic communication, with a method tailored to the individual situation.

- Instead of seeing a physician-patient relationship, patients perceive a physician-consumer relationship.

- Physicians need to listen to patients and they should be included on organizational advisory boards and in strategic planning and decision-making processes.

- Access to information has changed the old physician-patient balance. There are a lot of smart patients now; they can give valuable feedback to health care organizations.

- It is very important that patients feel they have a part in making decisions.
- Patients assume their physician is competent so the attribute they value most highly is compassion and a sense of partnership.
- 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.
- 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).
- We have a fragmented health care system, so replicating the high tech tools that are being developed will require a national effort.
- 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 hinges on the doctor-patient relationship.
- People need more than facts about a disease or condition. Care coordinators working in the health care system can bridge into the area of social services.
- Policymakers need to have more understanding of real-life experiences behind policy recommendations.
- To get social change you need a Policy that can effect change, the Political will to adopt the change, and Public willingness to sustain that change over time.
- We should consider a campaign to create a shared vision of what the doctor-patient relationship should be.
- Doctors need to assess what the patient knows, needs to learn, and is likely to learn, cognitively and related to beliefs. Not all people from other cultures want or expect informed consent and mental health factors come into play in shared decision making.
- The medical school curriculum should include training in communication and as part of the national clinical skills exam for medical students, communication and counseling skills should be tested.
- The relationship between doctors and patients would be changed if there was a patient rating system.

Summation

- We know the problems and we know the solutions: a holistic approach; simple, clear, targeted messages and interventions, balanced with community-based, multi parameter, system wide tools for prevention.
- **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. There is a compelling business case for improving our food, although there are mixed motives there still.

- **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.

- There are several challenges that we have to address in our solutions: 1) Between scaleability and pluralism (we need scaleability and national standards, but Americans like pluralism, local community; 2) Between too little versus too much (we want a system that is incredibly personalized and customized, but we don't as a society want to pay for it); 3)Between time and money (in any structure this problem of not having enough time with care givers is a huge issue. We have to get creative about the complete and total redesign of the clinical encounter.)

Session VI: A conversation with Baby Boomers

- We are a society that is not prepared for longevity. We have neither the systems nor the services to take care of the coming wave of seniors, who will face an increasing symptom burden related to chronic illnesses and thus increasing disability in their later years.

- By 2011, the first edge of the baby boomer generation (those born between 1946 and 1964) will reach 65 and 76 million boomers will follow.

- The baby boomers, in general, tell us that aging is not for them. Their bodies might age, but they are healthy and they are never going to get old. Panelists and audience participants agreed that they are largely unwilling to think about the challenges (or opportunities) of aging and believe that a healthy life style now will obviate problems later.

- Nearly 80% of the boomer generation expects to "age in place" and continue working at some level.

- There are global concerns facing us as the population ages with their needs for significantly more and different health and social services, housing, and economic security being foremost among the challenges.

- Of all the primary challenges, economic security is the most serious.

- Panelists stressed that they represented only a fraction of the boomers --- those who had sufficient economic security to consider options such as retirement and congregate housing. The challenges facing those with more limited resources are much more daunting.

- Among the serious challenges is engaging baby boomers in healthy aging practices and in planning for the years of increasing disability.

- Health services (in contrast to medical services) and spirituality are key among current boomers' concerns and essential to healthy aging.

- Many of the boomers have already experienced the aging, dying process and death on one or both of their parents. They do not want their aging to resemble that of their parents.

- Quality of life concerns will be as important as quantity of life for our aging population.

- We have an opportunity to create the kind of environment in which we would like to live as seniors and the services we would like available.

- We should begin creating a vision for healthy aging and a vision of a policy and system environment within which healthy aging as well as increasing chronic illness can be accommodated effectively (e.g., create an extensive delphi process, convene local meetings)

- With the shift to rural environments where the cost of living is lower there is concern about the necessary types of providers being in the right place to care for the needs of the boomers.

- We could take a lesson from the military which ensures that a soldier's will is in order, finances regularly reviewed, and health records are up to date. And they make it very convenient—one stop shopping. Time is a real limiting factor for most people.

- The financial realities related to the Boomers are going to make the need to limit choices and modify behaviors inevitable. Using Prochaska's model we have to gradually bring people along to the inevitability of structural changes.

- Many people lack an adequate retirement income, and it is not easy to teach people to be financially disciplined. We need to improve population health and lower consumption of resources. But few people seem willing to lesson their demands on the system to free up resources for the less fortunate.

- Gen Xers see two sides to the boomers: on the one hand hopeful, powerful, and willing to take on big social issues. On the other hand, having the ability to get what it wanted, this generation became spoiled and selfish.

Session VII: Integrating mind and body

- 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.

- 97% of the public recognize the link between good psychological health and good physical health. 79% 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.

- 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.

- Generally physicians are not supportive of the use of CAM approaches. This attitude contributes to patients' lack of honesty regarding use of such modalities and an increased risk of interactions.

- A person-centered care model requires provision of holistic, comprehensive, personalized body/mind/spirit care, an approach that requires collaboration.

- 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.

- There has been a dramatic increase on the use of CAM by adults and teens and an increase in offerings by hospitals and coverage by health plans due to consumer demand.

- Current research isolates interventions and doesn't use an integrated model. There isn't any research on how these modalities are best applied in healthcare delivery, and how conventional and CAM practitioners could work together in multi-disciplinary teams.

- In considering person-oriented or population-oriented care, we need to redefine effectiveness research because it remains technology-based or intervention-based.

- The integration of CAM with mental health and general medical care could be most easily tested in prepaid group practices or in government-run facilities, where the funding is not so fragmented.

- It is ironic that it is a struggle to get patients to do anything preventive, even if it's paid for, but we've got millions of people paying out-of-pocket to do alternative medicine.

- Alternative providers might provide some solutions to the shortage of traditional providers, and they are less expensive to train and appreciated especially in multi-cultural communities.

- Dentistry, mental health, home health care, and complementary alternative modalities all 'compete' for coverage. Can we agree on the essential benefits of an integrated benefit package?

Appendix B

Distilling the Discussion
An Examination of the Meeting

By Karen Orloff Kaplan, MPH ScD

Recently, the President of The Commonwealth Fund, Karen Davis, noted that although "the United States spends [significantly] more than any other nation on healthcare…. it is increasingly clear that our money is not buying the best achievable care."[1] She went on to share the thought that transformational change is needed rather than radical restructuring of the healthcare system. The answers to the particular challenges associated with our system are targeted efforts that will add dramatically to the value of the healthcare services provided to the public. The Foundation for American Health Care Leadership's December meeting, *Promoting and Enabling Healthy Choices* dealt directly with one of these challenges – engaging individuals in preventing disease and assuming responsibility for healthy behaviors.

The meeting dealt with in this report was unique in several significant respects. First, it brought together a group of particularly knowledgeable and creative professionals whose careers – in one way or another – have been dedicated to maintaining or improving the health of all Americans. Second, those who met represented all of the groups with an interest in and responsibility for the public's health. Providers, payers, business, government, other public and private sector interests, consumers, educators, researchers, and media representatives were all at the table. Perhaps most important, each of those who met was passionately committed to the proposition that the health care challenges faced by this nation can only be solved by engaging all of the stakeholders – as individuals and as communities.

"Public engagement" (both individuals and communities) is viewed by many if not most individuals involved in healthcare provision or reform as the bottom line, the *sine quo non*, the absolutely essential ingredient for bringing about positive changes in the nation's health and healthcare system. "Public engagement" is a cry that has reverberated throughout public and private efforts at improving individuals' health behaviors for as along as any of us can remember. "Public engagement" is a source of vast amounts of discussion in books, classrooms, boardrooms and legislatures. Yet, insofar as health is concerned, the resources that the United States has poured into public engagement, particularly into social marketing, are hugely disproportionate to the limited results achieved. How come? And how can we shift that equation?

The answer to these questions was the subject under consideration at the *Promoting and Enabling Healthy Choices* meeting. A sort through the enormously rich presentations and discussions yields a high level of agreement about the environment in which public engagement must take place as well as the critical components of effective change efforts.

[1] Davis, K. Transformational Change: A Ten-Point Strategy to Achieve Better health Care for All. President's Message – 2004 Annual Report. The Commonwealth Fund, New York, 2005.

First – the environment. The most significant environmental challenge we face – one that will totally change the face of America – is the immense cohort of aging baby boomers. By 2011, the first edge of this generation (those born between 1946 and 1964) will reach 65 and 75 million boomers will follow. And technology will extend these seniors' lives.

However, as more of us live longer – particularly with our strikingly unhealthy behavior patterns, we will encounter life lived with an array of chronic illnesses. The symptom burden and expenses that accompany such ill health will soar as will our service needs, especially for caregiving. We are, nevertheless, a society that is unprepared for aging. We have neither the infrastructure, nor the services, personnel, experience and attitudes necessary to deal with the aging among us now, much less those arriving soon. Thus, public engagement is essential for building adequate structure and services. And change in health behaviors is essential if we are to stave off the disability and expenses that accompany chronic illness for as long as possible and rear future generations less likely to suffer as much.

The second significant environmental challenge we face is the existing morbidity and disability related to unhealthy behaviors. There is much discussion of the obesity epidemic and, in fact, 50 percent of healthcare costs today are related to smoking, alcohol abuse, unhealthy diet, sedentary lifestyles, stress, etc. Again, most experts agree that public engagement is essential if we are to ameliorate current ill health, promote improved health and prevent future illness.

As America ages, technology has entered its golden age and an expensive age it is! Primarily because of the costs involved, we are faced with a host of difficult decisions. Chief among the questions: who should have access to what technology under what circumstances and for how long? The experts speak about public engagement in terms of promoting good health and thus mitigating the need for expensive technologic interventions. However, there still is substantial debate about the cost/benefit ratios relating to prevention, health promotion and therapeutic technology. The research and our experience in these arenas are limited.

The final environmental challenge of note in this context is our healthcare system itself. Although there is considerable disagreement about how dysfunctional the system is, there is full concurrence that at least parts of it are broken. Public engagement regardless of whether we are talking about individuals or communities is much more difficult if we are expecting to sustain behavior change within a context that does not support such change either with policy or practices.

Our task is to meet these environmental challenges with change strategies that engage and sustain individuals and communities in healthier behaviors. A paradigm of effective change emerged as meeting participants worked together.

Promoting and Enabling Health Choices – Critical Components

The Ships: Leadership and Partnership
and the
The Four T's: Targeting, Tools, Testing and Time
and the
Wherewithal

The Ships: There are thought leaders in the healthcare arena who believe that strong, eloquent leadership is needed to help us, as a nation, reach consensus about a vision for healthy America towards which all the stakeholders can work. Although one might question whether such a diverse country can

reach this type of consensus, unquestionably, a public engagement campaign – whether local to a community or organization, state-wide or national will work only in the presence of robust leadership.

Leaders perform two vital functions. They articulate a compelling vision and promote refinement of that vision and agreement with it among the various stakeholders. Thus, identifying respected, trusted leaders with whom target populations will resonate is most critical to initiatives aimed at engaging people in changing their behavior.

The most influential leadership as well as the most vigorous engagement activities exist when the stakeholders form partnerships. Entities like the HHS Center for Disease Control (CDC) are developing specific programs to form partnerships with a variety of public and private groups to create stronger, more successful initiatives. Survey results suggest that the public agrees with this trend and thinks that healthcare providers, the government, schools and employers all have a role in dealing with problems like the obesity epidemic. Indeed, many believe that if the stakeholders form strong alliances around health promotion and prevention campaigns, they will become an unstoppable political force – a force for significantly improved public policy and healthcare financing and infrastructure.

Once we have identified leadership and stakeholder partnerships for engagement initiatives, the Four T's assume paramount importance. Regardless of the basic, underlying goal of an engagement effort, audiences must be segmented according to such factors as age, disease, geography, socioeconomic status and racial and ethnic background. Campaign activities should be targeted accordingly. This report contains multiple examples of successful campaigns that were appropriately targeted as well as efforts that failed because targeting did not take place.

Engagement efforts need to utilize appropriate tools – tools that help individuals change their health behaviors and tools that help sustain those changes. Among the most important tools we use are messages. Messages must be tailored to the specific audience receiving them. Thus, they must be age and culture relevant. They must be consistent and delivered frequently. Presenters advised repeatedly that messages should be "humanized." They must tell a story that is relevant to the receiver rather than simply presenting facts – regardless of how compelling those facts might be to us.

Messages can be designed to evoke specific emotional responses and to provide incentives for behavior change. Sometimes messages that speak to fear or greed work, and sometimes messages that speak to needs such as "belonging" work. Various generations of health plans involve varying types of incentives (particularly financial rewards). Additionally, multiple media – especially those taking advantage of technologic advances – should be used creatively to convey the same message so that the target audience is exposed frequently to them.

Again, the tools used to engage consumers must be responsive to the entire array of people affected by the healthcare system and should be specific to the cultures, languages, capacities, skills and health status of those receiving them. And finally, the target individual/audience needs to be surrounded by "tools" (i.e., help) such as web resources, phone assistance, mail, printed materials, community advisors, and health coaches.

How successful the engagement activity will be depends a great deal on the type and content of messages as well as the media through which they are delivered and the appropriateness with which they are targeted. How is appropriateness of message measured and how do we know how well a specific campaign has succeeded? The answer is testing.

Because there is no single "right" message, medium for delivering it, frequency for delivery, etc., it is essential that we ask the target audience about how they like to receive information and about how they responded to the messages in question. And, the messages must be evaluated against predetermined outcome criteria. Finally, combinations of interventions should be tested to determine which get the best results.

The final "T" is time. Time is a source of enormous stress in today's busy world. There never seems to be enough of it and, accustomed to instant gratification, very little patience with long waits exists. But behavioral changes and even more so, cultural changes take a long time – often years or even decades. Thus, it becomes important to "manage expectations." Offering individuals different types of assistance to sustain behavior over time and being realistic with funders and partners about the necessary length of a campaign is critical.

Obtaining behavioral change is both difficult and expensive. There are few shortcuts. As time and dollars will be spent in large quantities, is essential to have sufficient funds and expertise to conduct an effective campaign. Unrealistically low resource estimates will result in wasting the dollars and expertise invested in an unsuccessful initiative. Wherewithal matters – a great deal! So, too, does building on the experience and knowledge of experts in the field.

Stacking the Deck: Engaging individuals and communities in making healthy choices is difficult and complex. Thus, meeting participants generated suggestions for weighting efforts towards success. Among the most important of these suggestions was to utilize a robust model for understanding how change occurs overtime and the stages through which an individual travels to effect the change. Also important is the imperative that the healthcare community and its partners become proactive rather than reactive in its engagement efforts and that considerable energy go into creating an environment that will support the requisite behaviors. Finally, better training for physicians particularly related to encouraging partnerships – joint decision making – with their patients is crucial.

Discussion Implications – or "So What?" Sharing ideas, learning from one another and even disagreeing are components of a successful meeting. However, the ultimate success can be judged only by the actions that flow from the discussions. Participants generated a long list of "next steps" at the Promoting and Enabling Healthy Choices meeting. Some of the next steps are relatively simple and easy to implement (e.g., identify and review cutting edge programs). Some were complex and long range (e.g., changing Medicare). To bring about the transformational changes that Dr. Davis refers to in her report and to answer the ultimate meeting success criterion – "so what?" Foundation for American Health Care Leadership staff will facilitate taking the next steps. Hopefully, we all will be at the table.

Appendix C

Addressing the Health Challenges of our "Modern Environment"

Carol A. Staubach
Executive Director, Health Communities Initiative, Media, PA

It is hardly news to anyone involved in health care that the U.S. faces an impending epidemic of chronic disease, largely as the result of lifestyle habits that have spread among a broad segment of the American population. U.S. Health and Human Services Secretary Tommy Thompson has declared that overweight and obesity – and their link to chronic diseases – are among the most pressing health challenges we face today. "Our modern environment has allowed these conditions to increase at alarming rates and become a growing health problem for our nation," Secretary Thompson has said. "By confronting these conditions, we have tremendous opportunities to prevent the unnecessary disease and disability they portend for our future."

In economic terms, the burden of overweight in the U.S. is estimated at approximately $92 billion per year.[2] But the health burden – particularly in the area of chronic diseases – is almost incalculable. Adults who are considered obese are far more likely than adults with normal weight to be diagnosed with diabetes, high blood pressure, high cholesterol, asthma and arthritis, and to rate their health as fair or poor.

The problem of obesity is steadily growing worse, according to the Centers for Disease Control & Prevention (CDC). In 1991, only four states had obesity rates as high as 15%-19% of the population, and no states reported rates of 20% or higher. But just 12 years later, the number of states with obesity rates of 15%-19% had risen to fifteen. Even more alarming, 31 states reported obesity rates of 20%-24%, and four states had rates higher than 25 percent.[3] The prevalence of overweight has doubled among children and tripled among adolescents in a little over 20 years.[4]

Looking at Causes

As Secretary Thompson has pointed out, there are characteristics in our modern environment that contribute to the alarming growth in obesity rates in this country. A significant factor has been the dramatic change in the American diet. Most Americans now consume far too much of their nourishment from energy-dense foods, refined grains, added sugars and fats. At the same time, 75% of Americans do not eat enough fruit, and more than half do not eat enough vegetables.[5]

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2 Economic Analysis of Eating and Physical Activity: A Next Step for Research and Policy Change. J.O. Hill; J.F. Sallies; J.C. Peters. American Journal of Preventive Medicine, Oct. 2004, Supplement 3, 111.

3 Obesity and Trends; U.S. Obesity and Trends. CDC Nutrition and Physical Activity. http://www.cdc.gov/nccdphp/dnpa/obesity/trend/maps/

4 Making America Fit and Trim-Steps Big and Small, American Public Health Association, Volume 94(9), September 2004, 1478.

5 Obesity and the Food Environment; Dietary Energy Density and Diet Costs. A. Drewnowski, American Journal of Preventive Medicine, October, 2004, 27, Supplement 3, 154.

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Many Americans are experiencing a form of food poverty that results from lack of access to nutritious foods combined with over-consumption of foods that are not nutritious. Excess intake of the wrong foods is actually a form of malnutrition and an underlying cause for cardiovascular disease, diabetes, cancer, degenerative eye diseases, obesity and dental caries.[6] Studies have suggested that ongoing consumption of energy-dense foods impact metabolic rates, reduce satiety, and lead to overeating and weight gain.

While dietary changes have occurred among all populations, there are economic reasons that obesity is more common among lower-income groups. People living in poverty tend to choose processed food and "fast food" because it is cheaper than fresh food and often more accessible, particularly in poor, urban neighborhoods where fewer grocery stores and fresh produce markets exist. People with low incomes are least able to eat well.

Current dietary goals emphasize eating more fresh vegetable, fruits and legumes, and less animal fat, starchy foods, refined sugars and salt. Although health promotion creates some degree of awareness about appropriate choices, it is important to recognize that access to good, affordable food is a far greater determinant of what people eat than health education.

In addition to changes in dietary habits, there is the issue of exercise. Americans are less physically active in their normal, daily lives today than they were 30 years ago, which contributes substantially to the growing problem of obesity. Reasons for reduced physical activity include the automation and mechanization of our society, which have reduced the physical effort required for most jobs and housework. Leisure time is now dominated by activities that do not require physical exertion, including television viewing, use of computers, and spectator sports.[7] Walking and biking have become less common, and use of the automobile is the norm.

Social isolation and lack of community interaction are strongly associated with poorer health. Encouraging use of bikes, walking and mass transit can promote social interaction on the streets, combat sedentary lifestyles, and promote a sense of well-being.[8] However, making these kinds of choices is not easy in today's "built" environment, even when individuals are highly motivated.

It should be apparent that what seems to be a simple matter of reducing calories consumed and increasing calories burned is actually a complex social issue that requires multi-faceted solutions to reverse the trends. Behavioral change models applied to improving nutrition and physical activity have focused on methods for changing individual behavior. Education, skills training, counseling and support have resulted in some success. However, we must all recognize the need for broader social and environmental support to achieve the desired goals of reducing the prevalence of lifestyle diseases associated with overweight and obesity.

The environmental, physical and social circumstances surrounding individuals and communities are powerful predictors and influencers of health and healthy or unhealthy behavior. Unstable family structures, inadequate education during adolescence, unemployment and underemployment, and

6 Social Determinants of Health, The Solid Facts. Wilkinson, R, Editor. WHO Regional Office for Europe. Copenhagen, DNK. Second Edition, 2003.

7 The Economics of Physical Activity; Societal Trends and Rationale for Interventions. R. Sturm, American Journal of Preventive Medicine. October 2004, Issue 27; Supplement 3,126.

8 Social Determinants of Health, The Solid Facts. Wilkinson, R, Editor. WHO Regional Office for Europe. Copenhagen, DNK. Second Edition, 2003.

unsafe neighborhoods are all social determinants that affect health and behavior.[9]

Population-wide improvements in nutrition, physical activity, and obesity will require major environmental and policy change. The ecological model proposes that behavior change will be most effective when change efforts work on individuals, social environments, physical environments and policies.[10]

A National Framework

The federal government's statement of national health objectives, called *Healthy People 2010* (HP 2010), provides this type of framework and serves as a national and systematic model for communities to achieve lasting health improvements and disease prevention. Its two overarching goals – increased quality and years of healthy life, and the elimination of health disparities – recognize the environmental and social determinants of health that must be addressed. Two of the ten leading indicators used in *Healthy People 2010* are physical activity and overweight/obesity.[11]

HP 2010 addresses specific diseases and conditions through 28 health goals. Within each of the goals are different tasks that focus on healthcare delivery systems, environmental quality, and product safety, both medical and consumable. Health issues are addressed within the contexts of public health, health education, and school and employer organizations. Many of the goals focus on the lifestyles and daily habits of individuals. *Healthy People 2010* also offers support for the development of educational and community-based programs that provide high-quality, culturally sensitive initiatives to meet the health needs of individuals and provide easy access to health information. For example, one of the goals addresses the issue of health communication with regards to quality of information, health literacy, and satisfaction with the health care provider's communication skills.[12]

The challenge is to translate *Healthy People 2010* into an action plan that is accessible and usable on a national, state and community level. A new Department of Health and Human Services (HHS) prevention initiative called *Steps to a Healthier U.S.* is designed to make HP 2010 operational. *Steps* identifies and promotes programs and initiatives that encourage behavior changes and have prevention as a primary strategy. *Steps* also supports programs that identify state and federal policies that invest in prevention.

In addition, *Steps* encourages cooperation among policymakers and unites all HHS agencies, CDC, Centers for Medicare & Medicaid Services, Food and Drug Administration, and National Institutes of Health on behalf of prevention.[13] HHS has a large number of current initiatives and programs underway to address obesity and overweight, including education programs, communication and outreach, interventions for nutrition, physical activity and fitness, disease surveillance, research, clinical preventive

9 Social Determinants of Health, The Solid Facts. Wilkinson, R, Editor. WHO Regional Office for Europe. Copenhagen, DNK. Second Edition, 2003.

10 Economic Analysis of Eating and Physical Activity A Next Step for Research and Policy Change; J.O. Hill; J.F. Sallies; J.C. Peters. American Journal of Preventive Medicine, Oct. 2004, Supplement 3, 111.

11 Healthy People 2010; A Systematic Approach to Helping People, Volume I. http://www.healthypeople.gov/document/html/uih/uih_bw/uih_2.htm#goals

12 Healthy People 2010; A Systematic Approach to Helping People, Volume I. http://www.healthypeople.gov/document/html/uih/uih_bw/uih_2.htm#goals

13 Steps To A HealthierUS Initiative. http://www.healthierus.gov/steps/index.html.

services and therapeutics, and policy and web-based tools. Various populations are targeted at all ages, socioeconomic and geographic status.

As a natural progression from these initial efforts, The National Initiative to Improve Adolescent Health by the Year 2010 (NIIAH 2010) is the result of experts coming together to gain consensus on Healthy People 2010. It is an example of the cooperation between the Centers for Disease Control and Prevention's Division of Adolescents and School Health, and the Health Resources and Services Administration's Maternal and Child Health Bureau, Office of Adolescent Health.[14] Its purpose is to foster cooperation among different partners for attaining all 21 Critical Health Objectives for adolescents and young adults. In turn, the Coordinated School Health Program (CSHP) has adopted the same 21 Critical Objectives to build healthier futures through school health programs. Central to their program is nutrition and physical activity.

Programs that Make a Difference

How do these efforts translate into viable accessible programs that can be put into action at the community level? Moreover, how do communities come together to take action and harness the knowledge, programs and interventions already developed? The following examples illustrate the opportunities and the resources that are available to communities. The first example shows how programs are developed at a federal level and disseminated out to communities. The second shows how state agencies and organizations come together to create a viable structure to move communities ahead. Finally, the third example describes a community reacting to an event or situation who come together to make change at a grass roots level.

VERB-It's What You Do!

A CDC-sponsored national media campaign that is designed to change children's health behaviors, VERB is a great example of professionally designed offerings by the federal government that utilize behavioral models and social marketing theories. VERB was tested and implemented in nine cities that already had local organizations with the capacity to create a community-wide effort to improve physical activity with traditional interventions. VERB is currently expanding to other cities and conducting outcomes evaluation on the success and sustainability to change health behaviors. VERB also offers resources to organizations that are not directly connected with youth programs but that can influence the success of the programs at the advocacy and policy change level.

VERB's primary audience is "tweens" – that is, children ages nine to thirteen. The secondary audiences are parents, teachers, and youth program leaders. Its goal is to increase and maintain physical activity and reduce the incidence of obesity. VERB uses a multi-cultural social marketing framework that includes advertising and other marketing activities. Extensive research prior to program development identified youth attitudes, beliefs, and behaviors related to physical activity. Research was done among several cultural communities to ensure sensitivity and customization of material for the targeted venues.

The Four P's of commercial marketing were applied:

[14] Improving the Health of Adolescents & Young Adults: A Guide to States and Communities. National Adolescent Health and Information Center. http://www.cdc.gov/healthyyouth/nationalinitiative/guide.htm

Product: the desired behavior is physical activity; the package is VERB.

Price: the product benefits and costs of changing behavior

Place: where tweens can be physically active in a safe environment

Promotion: multiple venues that sell a lifestyle that consumers aspire to achieve and are targeted to specific audiences.

VERB-It's What You Do! was chosen as the brand name because it denotes action. The campaign inspires tweens to find their own "VERB" or physical activity. The campaign associates itself with the tweens' brand for having fun. Campaign ads are created and aired on children's TV channels such as Nickelodeon. VERB campaigns also include print advertising in popular youth publications such as Sports Illustrated for Kids and sponsorship of shows tweens watch. There are community-based promotions with fun themes, as well as participation in community events. VERB also collaborates with schools to distribute materials. Through its partnership with AOL, VERB has created a website: *www.VERBnow.com*. VERB now provides resources and information to make regular physical activity "cool" for tweens and a fun thing to do.

Organizations focused on healthy youth can take this "off the shelf" model and incorporate it into there own initiative and strategic plan. These types of resources can enhance limited local resources and talents and build community capacity for developing multi-faceted initiatives that are sustainable. Parents, partners, and professionals who serve tweens can take advantage of VERB's reach to tweens and the excitement the campaign is generating among this age group to get moving!

CANFIT and CPEHN

Sometimes it takes a champion to bring together leaders and passionate people in pursuit of a health goal. But sometimes there is a decision to bring already existing organizations together, as in the case of the California Adolescent Nutrition and Fitness Program (CANFit), and the California Pan-Ethnic Health Network (CPEHN), which came together in the spring of 2004 to improve programs designed to reduce the rates of obesity and diabetes among populations of color.

The statistics clearly indicate disparities among peoples of color with regard to obesity and overweight. More than one third of American Indian men and women and black women (38%) were obese in communities surveyed through the CDC, compared to approximately 20% obesity rate among all adults on the national level.[15] In women, overweight and obesity are higher among members of racial and ethnic minority populations than in non-Hispanic white women. Mexican-American men have a higher prevalence of overweight and obesity than non-Hispanic men, while non-Hispanic white men have a greater prevalence than non-Hispanic black men.[16]

Among women, higher obesity rates are associated with lower incomes, but the association between

15 REACH 2010 Surveillance for Health Status in Minority Communities --- United States, 2001—2002. Y. Liao; P. Tucker; C.A. Okoro.; W.H. Giles; A.H. Mokdad; V.B. Harris. Division of Adult and Community Health National Center for Chronic Disease Prevention and Health Promotion. MMWR. www.cdc.gov/mmwr/preview/mmwrhtml/ss5306al.html#5tab

16 Economic Analysis of Eating and Physical Activity A Next Step for Research and Policy Change; J.O. Hill; J. F. Sallies; J.C. Peters. American Journal of Preventive Medicine, Oct. 2004, Supplement 3, 111

obesity and socioeconomic status has been less consistent among men. The highest rates of obesity and type-2 diabetes are observed among groups with the highest poverty rates and the least education.[17] Interested in ensuring effective programs beyond behavioral interventions by impacting policy and the physical environment, ***CANFit and CPEHN*** conducted a series of meetings with policy experts and representatives from communities of color in California. Their goal was to understand the driving forces within the community, solicit their recommendations, and increase their involvement in state and local obesity and diabetes prevention policy efforts. The Advisory Committee, made up of policy makers, community leaders and experts in nutrition and fitness, delivered five Community Convenings, framed within the context of public policy change. Participants in the meetings represented African Americans, Cambodians, Chinese Americans, Caucasians, Filipinos, Hmong, Laotians, and Latinos.

The objectives were to:

Solicit input and buy-in from a broad cross-section of communities of color;
Secure community participation in the project;
Establish a statewide and local public policy agenda for healthy foods and physical activity environments;
Integrate representatives from communities of color and their public policy agenda into the work of the Strategic Alliance; and
Create presentation materials that describe obesity and diabetes prevention from communities of color perspective.

They addressed health disparities as well as identifying where communities were on the readiness to change continuum. Based on the identified barriers of transportation issues, community and individual disincentives, an honest assessment of their education system and resources for youth, and nutritional issues, the community identified these focused areas:

Increase access to healthy foods
Increase access to physical activity environments
Conduct advocacy work
Conduct community education and outreach
Focus on the healthcare industry for effective prevention programs
Develop strategies for reaching communities of color

While a new initiative, it demonstrates the value of utilizing formative research principles, grass roots involvement, and support from experts who not only have technical knowledge but also understand the principles of behavioral change models and the ecological model to make environmental and policy changes that sustain the changes.[18]

Yuma County On the Move

Communication strategies designed to get the word out provide a power opportunity for increasing the involvement of the community and moving closer to the goals of healthy weight and physical activity.

17 Economic Analysis of Eating and Physical Activity A Next Step for Research and Policy Change; J.O. Hill; J.F. Sallies; J.C. Peters. American Journal of Preventive Medicine, Oct. 2004, Supplement 3, 111.

18 Days of Dialogue: Obesity and Diabetes Prevention in Communities of Color; California Adolescence Nutrition and Fitness, July 2004.

The *Yuma County On the Move* initiative demonstrates the value of following established processes to implement a social marketing intervention to increase the physical activity of the residents.

In Yuma County, Arizona, residents leaped to action when the state of Arizona was rated nationally as having some of the least physically active groups. Located in the southwest corner of the state, Yuma has more than 121,000 residents, with 55% under 35 years of age and an ethnic distribution that is predominantly Hispanic (48.5%) and white (46.8%). Residents came together to tackle the problem and after reviewing background information on the lack of physical activity among their population, they felt a major deterrent to physical exercise was the perception that physical activity was regimented exercise. Their goal was to change the image of what constituted physical activity and create public awareness that simple routine daily activities can help an individual meet the U.S. recommendations of spending 30 minutes in moderately intense physical activity per day.[19]

With the assistance of the University of Arizona, the community group used a formative research process to gather additional data. Following accepted practices of social marketing, they identified their targeted population as adults, ages 30 to sixty-four. They assessed the community resources accessible to residents for improving physical activity. Because social marketing relies on a framework for social and behavioral change, they reviewed several behavioral change models and selected the Transtheoretical Model as their framework. Developed by Prochaska and DiClemente, the stages of change model consist of five stages of behavior change: pre-contemplation, contemplation, preparation, action, and maintenance. Their goal was to move their targeted audience from the pre-contemplation and contemplation stage to the preparation stage. They adopted the strategy of consciousness-raising, identified by Prochaska and DiClemente as a process individuals move through as they gain more personal insight and "prepare" to make a change in behaviors. Their goal was to educate the community on the benefits of physical activity, increase self-efficacy and remove the conceptual barriers to taking action (lack of motivation; lack of time; lack of knowledge of health benefits of physical activity; support and safety issues and hot weather).

Public service announcements (PSAs) focused on simple outdoor activities such as walking, washing cars, and playing in the rivers. Their theme was, "Think about it. It's our choice to be physically active." Local residents were featured in the PSAs, giving them a very personal feel. Comic strips were developed by Yuma's own high school students and integrated into public newspapers and company based newsletters. Posters available through the CDC were used in public locations, work sites, and schools.

Yuma on the Move was able to document success in reaching their targeted audience, both in age and stage of change. What surprised the group as they conducted post-project evaluations and self-reported behavioral change, was the number of residents who had moved from pre-contemplation to taking action. A significant number of residents reported an increase in leisure time activity.

Ongoing Challenges

Each of the examples cited above had its own particular impetus, but all have similar characteristics that include a process for bringing key stakeholders together to create a common vision and to gain consensus on issues to target, and the capacity to research within the community and outside the community by relying on residents who are "local" experts and knowledge experts in several disciplines.

19 Assessing The Effectiveness Of A Community-Based Media Campaign Targeting Physical Inactivity. R. Renger, V. Steinfelt, S. Lazarus. Family and Community Health. Gaithersburg: October, 2002. Volume 25, Issue 3,18.

In each of these examples, some group or individual who understands the power of building relationships and recruiting participants acts as a catalyst to drive a project or program development process. Small, grassroots movements come with a sense of community pride and the capacity to bring the community together and to raise awareness quickly on the specific issues.

On the other side are the challenges to community-based organizations. Often small in size and reliant upon a volunteer base, they struggle to maintain a focus on program development and implementation while dealing with the ongoing need to secure and maintain a volunteer base of operations and funding. As noted by many organizations, they often spend more time seeking funding, oftentimes in competition with a very large pool of needy organizations, which takes valuable time away from delivering programs and moving towards their goals.

There are daunting challenges at all levels in the effort to reverse the trends toward increasing overweight and obesity. The critical success factor in creating a healthy environment that encourages good eating habits and integrates physical activity back into daily life will be to make the connections and create the linkages at all levels – in government agencies, and in national and local organizations of all sizes--and to support each other's needs to ensure an effective delivery system that eliminates the barriers.

Appendix D

Foundation for
American Health Care Leadership℠
An affiliate of Wye River Group on Healthcare

Promoting and Enabling Healthy Choices: Linking the Desire for Health with the Decisions & Tools that Support Health

The Broadmoor
Colorado Springs, CO

December 6th-8th, 2004

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 inaugural meeting of the Foundation, 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. This meeting will focus on this 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.

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.

The meeting will consider the following questions:

- *What lessons can be learned from investments in multi-faceted public awareness/educational campaigns to create broad-based social and behavioral change? What are the critical success factors and impediments for influencing individual and group behavior?*

- *What measurable examples exist of local, national, and international initiatives (public and private) that*

have a lasting impact on social and cultural behaviors affecting health? Do these models have relevance for the improved financing and delivery of health care in the United States?

- *How robust are the current "tools" to support and enable consumer/patient involvement in healthcare decision-making? (e.g., transparent cost/quality information; financing mechanisms) and what are the barriers to their adoption?*

- *How do we develop viable business models that enable health care providers to engage with patients to support good healthcare decisions? How do we create business models for industry that incentivize the development of safer and more healthful products?*

- *How do we here in America strategically advance the shared objective of an informed, empowered, and healthy society and what are the concrete steps toward necessary change?*

As a result of this interactive retreat, we will develop a series of recommendations for action, explore possible allies and sources of funding for these activities, and identify the appropriate catalysts for advancing broad-based public strategies. Following the meeting, a report will be prepared that highlights concrete recommendations and practical next steps to improve existing efforts and launch new ones.

Agenda

Monday, 12/6/04

11:00am — **Registration Opens**
Robert Trent Jones Foyer

11:45pm-1:00pm — **Buffet Lunch**
Donald Ross Room

1:00pm-1:45pm — **Welcome & Meeting Overview**
Robert Trent Jones Room
Jon Comola, Marcia Comstock, *WRGH & FAHCL*

Setting the Stage
Ian Morrison, *Founding Partner, Strategic Health +-Initiatives*

1:45pm-3:00pm — **Session I: The power and nuance of social marketing: the "stickiness" factor**

Speakers
Kenneth Kizer, MD MPH, *President, National Quality Forum; former Director, California Department of Health Services*

John C. Peters, PhD, *Head, Nutrition Science Institute, and Associate Director, Snacks and Beverage Technology, The Procter & Gamble Company; CEO, Partnership to Promote Healthy Eating and Active Living*

Marsha L. Vanderford, PhD, *Acting Director of Health Communication, Centers for Disease Control and Prevention*

Speakers in this session will describe the critical success factors for high impact marketing, from various perspectives and tactical angles, including public health, consumer products, and use of the Internet. We will learn what strategies need to be considered both in broad social/behavioral campaigns and in targeted efforts, for example, to create youth engagement. How do we create the "stickiness" needed to motivate and sustain behavioral change?

2:30pm-3:00pm: **Open Discussion**

3:00pm-3:30pm **Break**
Robert Trent Jones Foyer

3:30pm-5:00pm **Session II: "Tell me a fact and I will learn, tell me a truth and I will believe. But tell me a story and it will live in my heart forever" The role of the Internet, media and the arts in social change**
Robert Trent Jones Room

Speakers
Tommy Hutchinson, *President of Kikass the brand name of youth charity K-Generation, registered in England and Wales*

Andrew Holtz, MPH, *Award-winning former CNN Medical Correspondent; Past P resident and Interim Executive Director of the Association of Health Care Journalists.*

Naj Wikoff, *President, Society for the Arts in Healthcare; Director, Healing and the Arts, C. Everett Koop Institute, Dartmouth Medical School*
(Participation sponsored by the National Endowment for the Arts.)

Art by definition reflects culture; if you want to influence culture, why not consider art? We are just beginning to explore the use of this powerful, multifaceted medium to teach and influence human behavior. We will hear from leaders working in traditional art mediums to those focused on the Internet and media. This session will advance ideas around the use of culturally connected entertainment mediums as high impact teaching tools.

4:15pm-5:30pm: **Open Discussion**

5:00pm-5:30pm **Professor Garfield!**
Reaching Kids through Edu-Tainment!

Speakers
Bob Levy, *Director of Education and On-Line Initiatives, PAWs, Inc.*

Larry Smith, PhD, *Associate Dean of Teachers' College; Professor of Elementary Education, Ball State University*

The Garfield comic strip is the most widely syndicated comic strip in the world, with a daily readership of more than 260 Million! This "special session" will demo the Professor Garfield Foundation web portal,

an exciting, unique and inspired educational Internet web portal for kids 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.

5:30pm-6:00pm **Keynote: "High Impact Tools for Health Promotion"**
James O. Prochaska, *PhD, Director of Cancer Prevention Research Consortium; Professor of Clinical and Health Psychology, University of Rhode Island*

6:00pm **Close of Day 1**

7:00pm-7:45pm **Reception**
Lake Terrace Dining Room

7:45pm-9:30pm **Dinner**
Fountain Room

Tuesday 12/7/04

8:00am-8:30am **Keynote: "Capturing Growth at the Intersection"**
Brock Leach, *SVP New Growth Platforms & Chief Innovation Officer; PepsiCo*

8:30am-10:15am **Session III: "You CAN get 'there' from 'here!' "Public and private sector models from here and abroad.**

Speakers
Wolf Kirsten, *CEO & President of International Health Consulting, Berlin, Germany, whose mission is to help international corporations, organizations and governments improve the quality of life of their respective population through innovative, culturally appropriate, and cost-effective health promotion programs.*

Thomas E. Kottke, MD, MSPH, *clinical cardiologist, epidemiologist, and health services researcher at Regions Hospital Heart Center in St. Paul and the HealthPartners Research Foundation in Minneapolis, Minnesota; developed and directed Cardiovision 2020 a project to make Olmsted County, Minnesota the healthiest county in the country.*

Panel Respondents
Laura Simonds, MS, M. Ed, *Executive Director, Partnership to Promote Healthy Eating and Active Living*

Ted Borgstadt, *Founder & CEO, TrestleTree*

Agnes Hinton, DrPH RD, *Professor, Center for Community Health; Co-Director, Center for Sustainable Health Outreach, University of Southern Mississippi*

We will hear from private and public sector leaders in the US and abroad who have successfully launched and operationalized models which have a positive impact on individual, organizational and

community health through a focus on health promotion and other preventive strategies. Whether inside corporate walls or within the environment of a community, the most positive change only occurs by design!

9:30am-10:15am: **Open discussion**

10:15am-10:45am **Break**
Robert Trent Jones Foyer

10:45am-12:30pm **Session IV: Giving patients a voice: What is the current status of the "tools" needed to support and enable consumer involvement in healthcare?**

Speaker
Jerry Reeves, MD, Chairman, Board of Directors, WorldDoc, Inc; President of Las Vegas Operations of the Hotel Employees and Restaurant Employees International Union Welfare Fund; former Corporate Senior Vice President and Chief Medical Officer of Humana Inc; former Chief of Clinical Medicine at USAF Headquarters in Europe

Panel Respondents
Ron Bachman, *Partner, PriceWaterhouseCoopers*

Wendy Selig, *Vice President, Legislative Affairs, American Cancer Society*

Clay Ackerly, *Special Assistant to the Administrator of the Centers for Medicare and Medicaid Services*

Ellen Severoni, *President, California Health Decisions*

We are witnessing a sea change in behavior on both sides of the doctor-patient relationship. In this session we will hear from leaders on the front lines working with consumers, business, doctors, health service delivery institutions, and public policy makers to enable the emerging market of information to create individual ownership of health and healthcare. What are the benefits and what are the risks, and how are consumers responding?

11:45am-12:30pm: **Open Discussion**

12:30pm-1:45pm **Lunch**
Robert Ross Room

1:45pm-3:15pm **Session V: "From the classroom to the clinic:" Shared decision-making**

Speaker
James Weinstein, DO, MS, *Professor and Chairman, Department of Orthopaedic Surgery, and Medical Director, Center for Shared Decision Making, Dartmouth-Hitchcock Medical Center; Senior Member, Center for the Evaluative Clinical Sciences, and Co-Director, Clinical Trials Center, Dartmouth Medical School*

Panel Respondents
J. Gregory Carroll, PhD, *Chief Executive Officer of the Bayer Institute for Health Care Communication; an educational psychologist with extensive experience in teaching interpersonal communication skills in the health professions.*

Andrew Robinson, JD, *Founder & CEO, Patient2Patient, LLC*

Dave Kendall, *Senior Fellow for Health Policy, Progressive Policy Institute*

Physician autonomy is an historical tenet of medical training. What was a great strength in yesterday's healthcare environment has become one of today's great weaknesses! 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. What can we expect to witness as this dramatic role redefinition unfolds? Several organizations are leading the way in the brave new world of "shared decision making".

2:45pm-3:15 **Open Discussion**

3:15pm-3:45pm **Break**
Robert Trent Jones Foyer

3:45pm-4:15pm **Summation of Discussion: Ian Morrison**
Robert Trent Jones Room

4:15pm-5:00pm **Roundtable discussion: How do we strategically advance the shared objective of an informed, empowered, and healthy society? What are the concrete steps toward necessary change?**

Facilitators: Jon Comola & Marcia Comstock

5:00pm-5:15pm **Implications for Moving Forward: Ian Morrison**

5:15pm **Close of Day 2**

Wednesday 12/8/04

8:30am-10:00am **Session VI: " 80 / 20 rules!" Anticipating social and cultural change necessary to support an aging society**

Moderator
Karen Kaplan, ScD, *Director, Special Initiatives, WRGH; Mt. Sinai School of Medicine*

Panelist Respondents
David Gobble, PhD, *Director, Fisher Center for Gerontology, Ball State University*

Suzanne Mintz, MS, *President & Co-Founder, National Family Caregivers Association*

Who says you can't teach an old(er!) dog new tricks? If 80 percent of healthcare dollars are spent on 20 percent of the population, our priority should be obvious! This session will look at the needs of the "pig in the python": those demanding baby boomers. How do we get them to financially plan now for their future health care needs? How do we incentivize communities to plan and promote "healthy aging?" What are the best models of care delivery/community housing to support complex needs cost-effectively? What are the appropriate "next steps" for public policy?

10:00am-10:15am **Break**
Robert Trent Jones Foyer

10:15am-11:45am **Session VII: "Integrating mind and body: engaging patients in their health & healthcare"**

Speaker
Russ Newman, PhD, JD, *Executive Director, Professional Practice, American Psychological Association*

Panelist Respondents
Sita Ananth, MHA, *Project Director for Complementary and Alternative Medicine, Health Forum*

Milt Hammerly, MD, *Director of Integrative Medicine and Medical Operations at Catholic Health Initiatives, Denver*

Mind-body approaches are beginning to find their way into mainstream healthcare, and even traditional practitioners are starting to incorporate these practices into a more holistic treatment approach. Yet consumers, for years, have "gotten it" and collectively paid considerable dollars out of their own pockets to get treatments typically labeled as "complementary and alternative medicine." Mainstream healthcare may have much to learn from these modalities about consumer satisfaction, a "healing" relationship and the importance of "low-tech", "high-touch" therapies. Much potential exists for increasing patient compliance, improving care and advancing prevention by adopting a more holistic approach to healthcare.

11:45am-12:00pm **Closing Remarks/Adjourn**

12:00pm-12:30pm **Informal meeting to discuss CDC Social Marketing Strategies**

Appendix E

Attendees

D. Clay Ackerly	Special Assistant to the Administrator of the Centers for Medicare and Medicaid Services
Gary Allen, DMD MS	Director of Clinical Support, Willamette Dental Management Corporation
Sita Ananth, MHA	Project Director for Complementary & Alternative Medicine, Health Forum
William "Reyn" Archer III, MD	US Director of Health Care Policy, Hill & Knowlton
Ron Bachman	Partner, PricewaterhouseCoopers
Martha M. Barton	President & CEO, Pikes Peak Hospice & Palliative Care and Pikes Peak Hospice Foundation; President, Board of Directors, Colorado Hospice Organization
Ted Borgstadt	Founder & CEO, TrestleTree, Inc.
J. Gregory Carroll, PhD	CEO, Bayer Institute for Health Care Communication
Jon Comola	CEO, Wye River Group on Healthcare
Marcia L. Comstock, MD MPH	COO, Wye River Group on Healthcare
Robert M. Dickler	Senior Vice President, Division of Health Care Affairs, Association of American Medical Colleges
Alissa Fox	Executive Director for Policy, Blue Cross Blue Shield Association
David Gobble, PhD	Director, Fisher Center for Gerontology, Ball State University
Pamela Hagan, MSN RN	Chief Programs Officer, American Nurses Association
Milt Hammerly, MD	Director of Integrative Medicine & Medical Operations, Catholic Health Initiatives
Cynthia K. Hansen, PhD	Clinical Psychologist; Federal Advocacy Coordinator, Oregon Psychological Association

Agnes Hinton, DrPH RD	Professor, Center for Community Health; Co-Director, Center for Sustainable Outreach, University of Southern Mississippi
Andrew Holtz, MPH	Past President and Interim Executive Director of the Association of Health Care Journalists; , former CNN Medical Correspondent
Terry Humo	Assistant Vice President & Attorney, Marsh
Tommy Hutchinson	President, Youth Charity K-Generation, Kikass, United Kingdom
Randall L. Johnson	Director, Human Resources Strategic Initiatives, Motorola
Karen Orloff Kaplan, MSW MPH	Director, Special Initiatives, WRGH; Former President & CEO, Last Acts Partnership
David B. Kendall	Senior Fellow for Health Policy, Progressive Policy Institute
Wolf Kirsten	President & CEO, International Health Consulting, Berlin, Germany
Kenneth W. Kizer, MD MPH	President & CEO, National Quality Forum
Thomas E. Kottke, MD MSPH	Senior Clinical Investigator, Regions Hospital and HealthPartners Research Foundation; Director, Cardiovision 2020
Amy Snow Landa	Communications Director, Wye River Group on Healthcare
Brock Leach	SVP, New Growth Platforms & Chief Innovation Officer; PepsiCo
Bob Levy	Director of Education & On-Line Initiatives, Professor Garfield Foundation
Juanita Lovett, PhD	Clinical Psychologist; Board of Directors, WRGH
Ed Martinez, MPH MPA	CEO, San Ysidro Health Center
Suzanne Mintz, MS	President & Co-founder, National Family Caregivers Association
Ian Morrison	Founding Partner, Strategic Health Initiatives
Russ Newman, JD PhD	Executive Director for Professional Practice, American Psychological Association
John C. Peters, PhD	Head, Nutrition Science Institute, The Procter & Gamble Company; CEO, Partnership to Promote Healthy Eating and Active Living.
Jim Phillips	President & CEO, Veritas Health Systems

James Prochaska, PhD	Director of Cancer Prevention Research Consortium; Professor of Clinical & Health Psychology, University of Rhode Island
Linda S. Quick	President, South Florida Hospital & Healthcare Association
Jerry Reeves, MD	Chairman, Board of Directors, WorldDoc, Inc; President, Las Vegas Operations, Hotel Employees & Restaurant Employees International Union Welfare Fund
Andrew Robinson, JD	Founder & Executive Director, Patient2Patient, LLC
Michael Rodgers	Vice President, Public Policy & Advocacy, Catholic Health Association of the United States
Elizabeth P. Scanlon	Health Policy Advisor, Majority Leader Bill Frist, M.D.
Timothy Schauer	Director, Government Relations, Hermann Memorial Healthcare System
Wendy Selig	Vice President of Legislative Affairs, American Cancer Society
Ellen Severoni	President & CEO, California Health Decisions
Michael Showalter	Vice President, Market Solutions, Definity Health
Laura Simonds, MS M.Ed	Executive Director, The Partnership to Promote Healthy Eating & Active Living
Larry Smith, PhD	Associate Dean of Teachers' College; Professor of Elementary Education, Ball State University
Herb Sohn, MD JD	Vice-Chair, Board of Trustees, Finch University of Health Sciences – Chicago Medical School; Strauss Surgical Group
Kelly Stanley	President, Ball Memorial Hospital Foundation; Board of Directors, US Chamber of Commerce
Carol Staubach	Executive Director, Healthy Communities Initiative, Media, PA
Pamela Austin Thompson, MS RN	CEO, American Organization of Nurse Executives
Tricia Trinité	Director, Prevention, Dissemination & Implementation, Agency for Healthcare Research & Quality
Marsha L. Vanderford	Acting Director for Health Communication, Centers for Disease Control & Prevention
Rick Wade	Senior Vice President, Strategic Communications, American Hospital Association

Mary Ann Wagner, R.Ph.	President, Pharmacy Care Alliance, NACDS
James Weinstein, DO MS	Professor & Chairman, Department of Orthopaedic Surgery, and Medical Director, Center for Shared Decision Making, Dartmouth-Hitchcock Medical Center; Senior Member, Center for the Evaluative Clinical Sciences, & Co-Director, Clinical Trials Center, Dartmouth Medical School
Ray Werntz, JD	Senior Consultant, HPN Worldwide; Former President, Consumer Health Education Council
James Whitfield	Senior Officer, Leader Engagement, Washington Health Foundation
Naj Wikoff	President, Society for the Arts in Healthcare; Director, Healing and the Arts, C. Everett Koop Institute, Dartmouth Medical School
Kim Wirthlin, MPH	Assistant Vice President for Government and Public Affairs, Health Sciences Center, University of Utah
Sandra Winfrey, CPA	Executive Officer, Albuquerque Area Indian Health Service
Donald Young, MD	Deputy Assistant Secretary for Health Policy, Office of the Assistant Secretary for Planning and Evaluation, US Department of Health and Human Services

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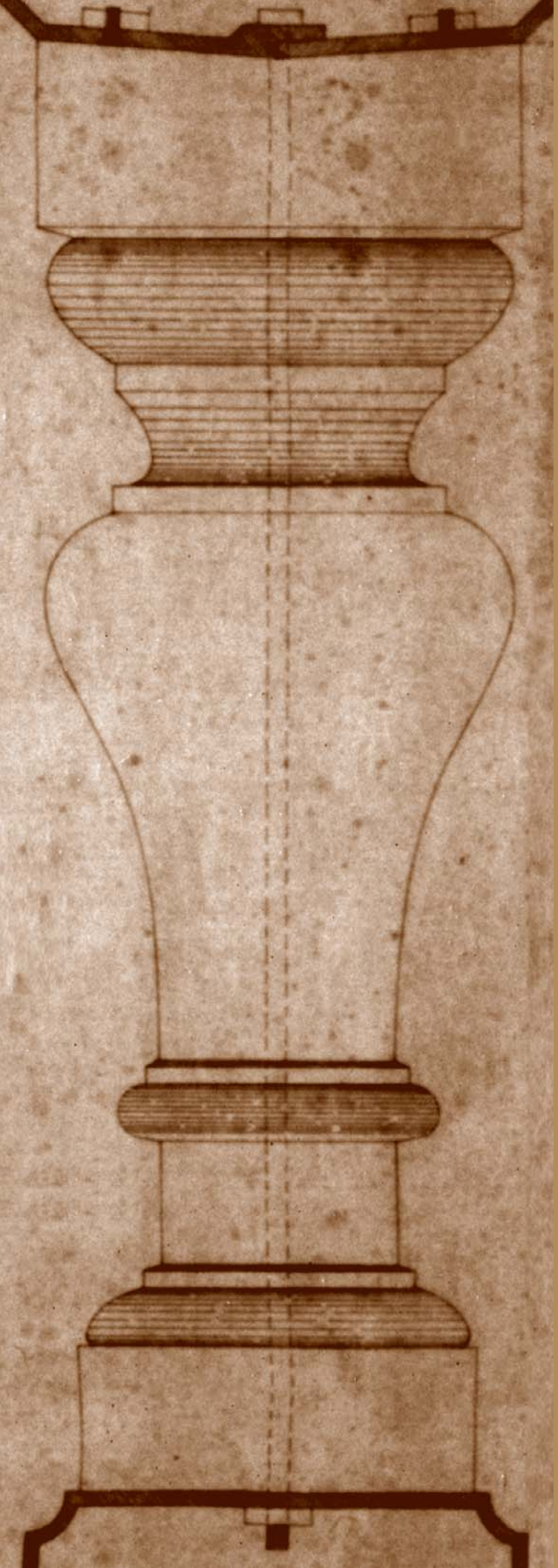

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