



NEIAHU Newsletter

February 2007

Volume 5-Issue 2

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In This Issue

[Four Big Trends](#)

[Become a Leader](#)

[Meet your Board](#)

[What a concept: The patient as a Health Care Consumer - Article from The Vancouver Sun](#)

[Calendar of Events](#)

Quick Links

[NAHU](#)

[NAHU Region 3](#)

[NorthEast Indiana AHU](#)

[Indianapolis AHU](#)

Dear Barbara,

To change the way your name appears above, click on the "update profile/email" link at the bottom of this email.

Don't miss this Month's Meeting!

February 21, 2008

Noon at the Summit Club

25th Floor - National City Bank Building

110 West Berry Street - Fort Wayne, IN

Speakers:

Phil Wenino & Denny Wright

Program:

Capitol Conference Re-Cap and Up-Date

Lunch:

Members

\$15.00

Non-Members

\$25.00

Please RSVP to Rita Musser

rita.musser@verizon.net

by February 14th, 2008.

Did you know that you can use your NAHU Bucks to pay

[Greater Northern AHU](#)
[South Central Indiana AHU](#)

Four Big Trends

by Brian Klepper

Several events and trends emerged over the last year that will reverberate throughout the **health care marketplace** in 2008 and going forward. While none of these dominated the trade press like some other issues--**electronic and personal health records, RHIOs, the evolving labor shortage, pay-for-performance reimbursement**--these manifestations of change are occurring in the marketplace as well as through policy, and are moving **health care** forward in fundamentally positive and far-reaching ways.

Health 2.0

The most significant, in terms of its capacity to change how health care works in the long-term, is the **Health 2.0 movement**, which **Matthew Holt** and **Indu Sabaiya** have played a central role in facilitating and explaining. In some ways, **Health 2.0** is simply a continuation of what has come before: companies creating new value through information and connecting with customers over the Web. Health 2.0 takes this approach into every area of **health care data**, often driven by companies outside of or at the margins of health care, who have no financial stake in perpetuating inappropriateness and waste, and who see an opportunity to make money by rationalizing the system.

We've already seen big, established IT companies like Microsoft and Google announce some forays into this space, as

for your lunch? Present unsigned bucks when you arrive, must be current.

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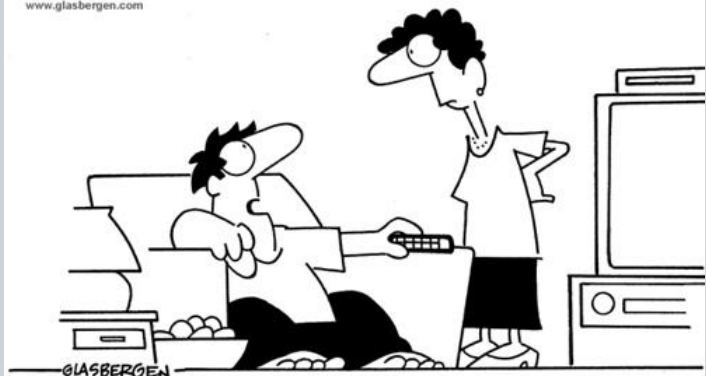
well as a slew of startups, most of whom have staked out interesting niches. But there are other players who haven't made themselves known yet: **health IT companies** who are positioned to aggregate **data** and feed it back to their clients; companies who already have established health care data streams and have large repositories; analytics firms; organizations from financial services and other areas that see an opportunity to leverage their own data strengths and expand into **health care**; and established **health care** organizations that, as the competitive market intensifies in **health care**, will use their strength to enter the **data space** and use it to advantage.

In the process, the **health care data** will move beyond simple **transparency**--public availability of **pricing and performance information**, which is often inscrutable for many groups, especially consumers, and difficult to make sense of. The creation of easy-to-use **data-driven decision assistance tools** that can help **consumers, clinicians, designers and purchasers** of all kinds will change everything.

My bet is that **business** and the **health care sector**, more than **consumers**, will first fully take advantage of the offerings that will gradually come online, and use this new information to make better **clinical decisions**, better **purchasing decisions** and to understand their own **performance** relative to the market. Ultimately, as **payment is tied to results**, this information will constitute **incentives for performance and disincentives for waste**.

Consumer Checkbook v HHS

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www.glasbergen.com



"Exercising builds muscle. Muscle makes you want to show off your body. To show off your body, you need a tan. Tanning turns your skin to leather. Cows are made of leather. Cows are fat. Therefore, exercising makes you fat!"

What a concept: The patient as a Health Care Consumer

Barbara Yaffe, Vancouver Sun

Published: Tuesday, January 22, 2008

Imagine if the balance of power within Canada's health care system swung from provider to the patient.

That would be quite a paradigm shift. Right now governments make all the rules and doctors make all the medical decisions. The patient is not so much a consumer as a humble and relatively powerless supplicant.

Personally, I've never thought to ask for electronic access to my medical records.

Never dreamed of exercising power under a patient's bill of rights.

Never imagined a situation in which I might bypass my GP to directly access care from a specialist.

Good thing too, because Canada's medicare system does not feature any of the above.

A study released Monday, comparing health care in 29 European Union countries plus Canada, reveals we perform poorly, particularly when it comes to patients' rights and accessibility.

In fact, we placed 23rd, of 30, on the first "Euro-Canada Health Consumer Index."

Since 2005 the index has provided an annual report card for medical systems on the other side of the pond. The project is the work of an independent think-tank, the Health Consumer Powerhouse, based in Brussels and Stockholm.

Last year the Winnipeg Frontier Centre for Public Policy joined the exercise, to provide Canadians with perspective on how

Last August 22, the consumer advocacy organization **Consumers' Checkbook** won a Freedom of Information lawsuit against the **US Department of Health and Human Services**, which demanded that **CMS** be **required to release Medicare physician data** for 4 states and DC. Interestingly, **HHS** had argued that **physicians** are entitled to a **right of privacy**, a particularly curious position, given the generally progressive stance on **health care pricing/performance transparency** that **CMS** has taken under this Administration's tenure and keeping in mind the fact that **physicians** paid by **Medicare** are vendors taking public dollars. On October 19th, **HHS** filed an appeal, indicating that they would fight to keep the data secret. The case is still unresolved. Even so, **Checkbook** has filed suit for the release of **Medicare physician data** in all other states.

As I noted in writing about this previously, the **AMA's** fingerprints seemed to be all over this, but I had no direct knowledge that this was so. Then, a December 10th **American Medical News** article reported, "The Association is pleased that **HHS** is taking its advice, said **AMA** Board of Trustees Chair Edward L. Langston, MD." I'll bet they are.

The **Checkbook case** is a watershed moment in **physician transparency**. Until now, despite all the calls from supposed "market-advocates" for informed **consumerism in health care**, the public has had no way to really tell how a **doctor** compares to his/her peers in terms of resource consumption or results. If the **data** were released so it could be evaluated, that information could become available and one important part of **health care** could begin to work like a competitive market. Whatever the outcome of this case, kudos to

medicare compares to the European systems.

The report expresses hope that, with comparative data in hand, Canadians will start demanding more of their health scheme.

The Frontier Centre asserts it's more logical to compare Canada's system to those in the EU than to U.S. health care because the latter is a private sector, service-oriented model. The findings, however, do not make for happy tidings.

The 41-page report

(www.troymedia.com/reports/health_consumer_indexEMB.pdf) concludes Canada "spends more money to achieve worse results than any other country."

Canada spent \$160 billion -- nearly \$5,000 per person -- last year on health care, 71 per cent of which derived from public sources. This reflects higher per capita spending than all 29 countries except Norway, Switzerland and Luxembourg.

Declares the report: "When adjusted for bang for the buck, [Canada] is 30th of 30 in the index."

Researchers considered five barometers: Patient rights; waiting times; health outcomes; access to drugs, and generosity of the systems as reflected by kidney transplants, early childhood vaccinations and state-sponsored dental care. Canada scored 550 of a possible 1,000, compared to top-ranking Austria, with 806 points. Others in the top five: Netherlands, Switzerland, Germany and France.

Accordingly, the report recommends smarter spending for Canada, rather than more money. "Much more can be done with the money being spent."

The index found that Canada does reasonably well in terms of all-important health outcomes, for example, heart attack survival. But we score badly -- on a par with Poland -- on consumer friendliness. That is, Canada tends to be "disdainful of the rights of health care consumers."

Canada, says the report, "suffers from what seems to be an expert-driven attitude to health care."

The report notes disapprovingly that self-referral to specialists isn't permitted. Medical records, not yet in electronic form, remain the property of doctors.

Canada lacks a patient charter of rights. And patients aren't involved in health care policy-making, a top-down affair coordinated by Ottawa and provinces.

Rather than thinking of health care as a rationed set of public goods, it ought to be considered more as consumer-related services.

The report's authors are on to something here. Last week, CBC TV reported the Ontario College of Physicians and Surgeons is concerned about a new trend -- doctors taking it upon themselves to screen for patients, turning away people who might present too big a load!

Consumers' Checkbook for taking the initiative and, in the process, betraying the lie of those who call for consumerism but want to hold back the information that are necessary to make markets work, all so they protect their advantages.

Stopping the Payments for Hospitals' Mistakes

August must have been a big month, because that was also when **CMS** threw down the gauntlet and announced that, starting October 1, 2008, it would no longer pay for **preventable errors**. Until this change, **hospitals** were **paid for the mistake** and for the care of rectifying it, a no-lose proposition.

As **Medicare** goes, so goes the **commercial payers**, so this is momentous. Come October, **hospitals** will be on the financial hook for making sure they get it right the first time, a significant change from the past and potentially damaging when they fail, especially for organizations that have had average margins nationally of only five percent.

In a sense, this event is less important than the important **quality and safety work** underway at health systems around the country. (For a wonderful 5 minute articulation of the value of these efforts, see this short [interview](#) with Gary Kaplan MD, the CEO of Seattle's Virginia Mason Health System, recorded in April 2007.) But for those who are not yet focused on getting **quality** under control, **CMS'** action constitutes a major incentive.

Moving Toward A National Center for Comparative Effectiveness and National EBM Guidelines
American medicine is gradually,

Says the report: "Canada lacks a culture in which consumers have high expectations of health care services, and significant reform is unlikely without this."

Of course it's difficult to have high expectations when you get screened to access a doctor's patient roster, or after hours spent in an emergency room you step forward only to have a harried hospital nurse instruct you to get back to your seat and wait until you're called.

For all the billions taxpayers spend on health care, a little empowerment would be a fine thing.
byaffe@png.canwest.com

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Calendar of Events

March 2008

20-NEIAHU Board Meeting - 10:30am at the Summit Club
20-NEIAHU Monthly Meeting - Summit Club - 12:00 PM

Identity Theft 2 hr CE Credits

CE Presenter:

April 2008

17-NEIAHU Board Meeting - 10:30am at the Summit Club
17-NEIAHU Monthly Meeting - Summit Club - 12:00 PM

Speaker: Jack Fagan

Program:

Myths of a Single Payor Healthcare System

Sponsor:

CE Presenter:

Topic & Hrs:

May 2008

15-NEIAHU Board Meeting - 10:30am at the Summit Club
15-NEIAHU Monthly Meeting - Summit Club - 12:00 PM

Speaker:

Topic:

Sponsor:

CE Presenter:

Topic & Hrs:

grudgingly acknowledging that **using evidence to identify best practice**, and then applying that **best practice**, typically results in improved outcomes and reductions in variation. The refinement process is unending, of course, and the number of different **clinical** approaches that must be evaluated is vast.

In November 2006, economist and former HCFA Administrator Gail Wilensky published a *Health Affairs* paper that described the background and laid out the arguments for the establishment of a national agency that would sift available data to support **better clinical decision-making**. Another long-overdue idea that has private sector precedents in efforts like the **Blue Cross and Blue Shield Association's Technology Evaluation Center (TEC)**, the concept of a national **Comparative Effectiveness Center** is beginning to finally get traction.

In September, when **Senator Clinton** released her proposed **health plan**, a **Comparative Effectiveness Center** was featured prominently as a key element of required change. And more recently, in December, the **Congressional Budget Office** published a paper called "**Research on the Comparative Effectiveness of Medical Treatments**," that argues for the value of a governmental role in identifying **best practice**, the need for **tying identified best practice to financial incentives** in the marketplace, and the difficulties of creating these changes in a policy environment so highly susceptible to private interest influence.

The Long View

One of the most difficult of life's realities is the time required to effect desperately needed change. Each of the trends I've described above will take years to get

June 2008

19-NEIAHU Board Meeting - 10:30am at the Summit Club

19-NEIAHU Monthly Meeting - Summit Club - 12:00 PM

Speaker:

Topic:

Sponsor:

CE Presenter:

Topic & Hrs:

Sincerely,

Barbara Knox

NorthEast Indiana AHU Communications Chair

traction and actually change the ways that care manifests, but they're moving us in the right direction. Equally important, change is spreading to more areas and accelerating in **health care**, partially in response to the increasing pressure, but also simply because **technology** continues to enable approaches that the **marketplace** can leverage. To those of us consigned to take the long view, this is great news and important perspective while we're also focused on health care's persistent, moment-to-moment problems.

Become a Leader in the Industry and participate in the LPRT Program:

NAHU formed the Leading Producers Round Table in 1942 to recognize the successful underwriters of Accident & Health Insurance. Today, the LPRT committee is committed to making LPRT the premier program for top Health, Disability, Long-Term Care and Worksite Marketing Insurance producers, carrier reps, carrier management, and general agency/agency managers. Through the hard work of the LPRT committee members, LPRT will offer new membership benefits, exclusive LPRT events, and new categories and qualification requirements. Receive LPRT qualifier discounts and free webinars provided by NAHU. For more information regarding LPRT visit www.NAHU.org.

NOTE: *Copies of the NEIAHU By-Laws and Financial Reports, including the 2007-2008 Budget are available for review. Members may contact the Association Treasurer to request a copy.*

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