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Series: Timely Topics of Interest

Session: The Future of Healthcare is Now

Presenter: Robert Jesse

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Robert Jesse: The goal is not to embrace technology, the goal is actually to change healthcare from being about encounters, face to face encounters in an office to being about sustained relationships. All of the technology that you can lump under this collective of collective – of connected health is intended to do that. I think if we get too invested in any given technology, we actually lose opportunity.

The technology is changing rapidly. But one thing that is clear is that the smartphone in some iteration beginning to what it is today and well into the future will be the instrument of healthcare into the future. Then finally another topic I will talk about is commoditization. Everybody keeps saying consumer behavior will change healthcare. I do not think so.

Consumer behavior is giving people what we should have been giving them all along. Every other industry does it. But in fact, commoditization meaning when I talk about a commodity, I mean something that is widely available and affordable. More recently, I have added a caveat to that which is that the person who is making the selection also is the one who is paying. Because that is not true in current days.

A good example, you can think of something like a flu shot where it has become so ubiquitous, it is out of the visibility of the healthcare systems. Yet at the same time, we judge healthcare systems on their immunization rates. It is just so much easier for patients to get it done at like Costco versus making an appointment. Then there are a lot of other things that are going to be coming that way. We will talk a little bit about that. What does that mean really? Well, let us talk about UnitedHealthcare and others.

A series of videos I could show. But you can go and in your leisure on YouTube watch, and just search out UnitedHealthcare commercials. You have seen them all on TV. There is one of the first ones that came out of the guy riding around on a motorcycle. A bunch of numbers swirling around; and most of them have that theme going through. They talk about health and numbers. Essentially what United is saying is that they can manage population health in particular but also individual's health better because they have the data and the ability to look across it.

In fact, the thing that struck me when I was watching these is the almost universal absence of reference to a healthcare provider. The one in the motorcycle, you will never once hear mention the physician or a nurse. But what you will hear is thank God, I was prescribed one drug one place, and then another place. But thankfully my insurance company caught it and notified my pharmacist. Otherwise, it could have been a disaster; and no mention of the doctor, and no mention of the nurse.

There is another one of a guy who is a coach on a little league who gets cancer. The comment in there is our doctor was great, but my insurance company gave me a real specialist, a specialty training nurse who knew all about this and helped me make decisions. I think more and more the engagement of patients directly in their care for information is going to be one of the real drivers of things moving forward. But going back to my original \_\_\_\_\_ [00:03:17] predicate for that is actually patients both owning and understanding their health information.

We can take a look at this. Those are some of the comments that were in there. But remember, United is an insurance company. But next is Walgreens. Walgreens has a number of interesting commercials. You have probably seen many of them. But you can also pull them up on YouTube. But essentially Walgreens as a company is moving. It is repositioning itself from being a retail pharmacy to being a healthcare provider. There is probably no simpler way to say it than that. They are converting their stores at a measured pace from being a place that you get prescriptions and sundries to health centers. Not unlike CVS, probably known for the Minute Clinic is doing.

But if you think about it, it is a pretty big step. Now what they have done a lot more quietly is they are running ACOs going back into 2013. They had first announced an ACO in the Pennsylvania and New Jersey area. But also, in the Florida, and in Texas, and Arizona. They are also providing occupational health for companies like BMW and their factory down in South Carolina. That includes primary care for employees, dependents, and their retirees. Not to be singular in this, CVS is doing it. Rite-Aid is doing it. They are a national retail pharmacies, so interesting.

Then Target is in the fray with CVS. Everybody was waiting to see what Target was going to do. They surprised everybody essentially by merging their health operations with CVS. They will be a store in a store. The Target will have CVS Minute Clinics, and CVS pharmacies rather than Target trying to get into that, which was really kind of interesting when that popped out. Then, of course, not to be left out is Wal-Mart.

As you know, Wal-Mart is the largest retailer, although I think that is probably a bit of a misnomer there. It is probably not a retailer at all. They are a transaction management group. But they have said that they will have primary care in all of their stores within five to seven years. You hear different terminology around that. Some say in all of their rural locations in five to seven years. But it is very clear that Walmart is pretty adept at doing these things. They have eye clinics. They have all sorts of other things at the front of the stores.

Primary care is going to be part of that. Wal-Mart they say is the world's largest retailer. United wants to be your primary care provider. Walgreens wants to be your primary care provider. Walmart wants to be your primary care provider. Why is a large insurance company and your health insurance company, retail pharmacies in the big box; and retailer all trying to get into the same space?

There are some pretty obvious answers. I am not certain that driving front end sales is really why they are doing it. I suppose you can – somebody will buy some sunscreen and some candy while they are waiting to be seen. But I think there is a big difference here. Now, the one thing they can provide is convenience. CVS, I think has somewhere around 7,500 retail locations. Walgreens is a bit bigger with little over 8,000. Four hundred of them today are health centers.

Of course, Walmart is worldwide and are known for really how they manage logistics and supply chain management. But maybe one of the things they really want is access to health information. Then I may be being a little bit of a skeptic. But if you look at the top five capitalized companies in the U.S. today, two of them really do not have a product of when…. Well, that is not entirely true. They \_\_\_\_\_ [00:07:28] the product is you. But that is Facebook and Google, right. They make money by selling you to other people meaning advertisers.

But there is this whole big chunk of view that they cannot legitimately advertise too, because they do not have access to that information, which is your health information. But if you have a covered relationship with somebody, I suppose that you cannot. We are looking at access to fundamentally with 17 or 18 percent of the GDP, which is somewhere in the range of today, I do not know four trillion dollars or three \_\_\_\_\_ [00:08:11] trillion dollars, or somewhere around there. It is a big market they are trying to open. Also big data is big money. Interestingly, if you steal healthcare data, it is worth a whole lot more than stealing credit card data.

There is a reference on the bottom there, if you are interested. But it just kind of a little proof of principle that having access to health data is pretty important. If you do not believe it, set up a dummy account on YouTube. I am sorry, on Gmail or Yahoo!, and go shopping for EPTs, pregnancy tests. See how long before you start seeing all sorts of ads being pushed to you for everything from diapers to baby furniture and the like. Pretty clearly, people are watching this thing.

Now it gets interesting. This is the first video I want you to watch. It is loaded up in here. It should be in the chat session right at the very top, okay. I am going to start it. I am assuming that you all are starting it as well. Then it got moved to – yeah. It is right at the very top. It is the one that says Lisa \_\_\_\_\_ [00:09:32]. Click that and let us watch that video.

Unidentified Female: \_\_\_\_\_ [00:09:54].

Robert Jesse: Okay. Hopefully you all are able to watch that. I will give you another minute or so, or a couple of seconds to finish it up, if you have not. I think the lesson here and this is really important to my mind is in reality healthcare is mostly in information and business. I have seen different estimates. But it is probably somewhere between 80, 85, and 90 percent of what we do is really the processing of information rather than the performance procedures of the laying on of hands. Remember it because the majority of healthcare occurs in the outpatient setting.

This is, I think in some respects a testament to the power of the connected health movement. But healthcare is an information business. The amount of information is increasing. The information we have is getting increasingly complicated; think genomics. But the bottom line is most patients cannot access this information. Even when they can, in the form that we have it, they cannot understand it. This is actually what is called information asymmetry. We have access to and an understanding of information that others do not. That is basically what healthcare thrives on.

Essentially people come to us because they have to and not because they necessarily want to. Because we do have access to that information. Healthcare also functions on the transaction, right. Again, people have to come to us. Why? Because we have the same color of prescription pad. In many cases, patients know exactly or they think they know exactly what they need. In many case, they are correct. But the only reason they are coming to us is because they have to get a prescription.

If you think about it, there has been a whole host of industries who have functioned in this mode, information and symmetry enforced transactions who are one by one dropping. The first one to go was the travel agents. Because they could see the flights and the seats on the planes. You could not, so you have to go through a travel agent or go to the city counter for an airline \_\_\_\_\_ [00:14:06] to book a flight. When they moved all of that to the web, heck, you can even check in yourself now online. Did that put all of the travel agents out of business? No, but the ones who were there, people are willing to pay for them for their time and expertise and particularly when they are booking large or complicated itineraries.

Buying a car, car dealers do not make money selling cars anymore because everybody knows what they cost. They can go in and they start their negotiation from a very different point. The car industry now is really making money based on service. They try and make the selling a great process and trying to make you think you can get a great deal so you will come to them for service.

The biggest one and I think the paradigm we should all really be watching is the stock broker industry. People made a lot of money on the churn. They wanted you to buy or sell stocks. They did not really care whether they were going up or going down. Because every time you bought and every time you sold, they made money on that transaction. They made a commission. With ETrade, you do not have to do that anymore. The stockbrokers did not all go out of business, but certainly the sweatshops mostly have. They reconfigured themselves through wealth managers. Just as we are going to have to reconfigure ourselves to health managers, rather than serving transactions.

The one to watch because it is evolving now is real estate. Between Zillow, and Redfin, and Trulia, the realtors are really getting into a squeeze. They basically owned this published book called the MLS, the Mobile Listing Service book, which had every house that was available. Nobody else could see it. Now you can see everything on the web as well as all of the cost comparators. People are moving in a very different directions with them. A lot of them are beginning to drop their commissions because of that very fact.

The other reality is that healthcare systems have to reconfigure their informatics capability and do not have to go through transformation. This is what is what I was talking about in terms of being transactional. Healthcare was still a clipboard operation for the most part. The VA pays people to come in and hopefully \_\_\_\_\_ [00:16:34] and not for much longer. Or we are done with it. But we come and open up our computers and open up their laptops; and take information from our computer, and type them in their laptop.

A couple of months from now, they tell us what we did a couple of months ago. We need this. Our monitor has always been that if you need information to manage the patient or the system, it should be acquired through the workflow process and not as a secondary operation. It needs to be visible across the systems. As I said in the beginning, this current EHR construct is not sufficient to meet this model. Rather than develop new EHRs, we really need to be developing the models that move data, and that harmonize data; and construct it in a fashion that gives us a very good picture about how both we patients and the healthcare systems.

Currently, the healthcare, the progress note is, essentially, it is a medical and legal document. Even if you look in VistA, most progress notes have become almost intelligible because they pull so much data and profit into one note. You have to wade through page, and pages, and pages to find the couple of lines that are actually new information that has been put in by an individual. But I think on the other hand, if – what if instead of the provider signing the note, the patient signs the note? Then that not would have to be understandable. It would be a documented communication rather than a CYA type of thing.

Other dynamics are changing. We talk about engagement. We keep saying, we need to engage patients. Well, I think the reverse is really happening. Patients are thinking they are going to engage us. Eric Topol put out a book last year I guess called "The Patient Will See You Now." This is more and more where things are going to be going. We focus on preventive health and on chronic disease management that patient centered; and in the VA, we say patient driven outcomes. So do our patients, but at the same time, they are demanding of us more convenient, local, and timely care. People do not like to wait time between lines and no one knowing is the breeding ground for uncertainty; which ends up in fear and distrust.

They want to know more about the complete opportunities. That includes complementary and alternative medicine. It always amazes me. When you went to a bookstore, and when you could still go to a bookstore, and look for medical books. You would find sort of one little row that had things like the PDR, or the Merck Manual, and a couple of other medical, real medical types of textbooks; then rows, and rows, and rows of stuff on complementary and alternative medicine. Every year, there would be a couple in the top ten, and remember the Melatonin Miracle, and things along those lines. Patients are really interested in this. In fact, it is not because – well, maybe it is because they do not trust us. But, I think they just want to know more.

Those options seem much more understandable to them at times. Because they are not very good frankly at explaining what we are talking about. This movement is really catching on. I think you need to pay attention to PatientsLikeMe and some of those types of websites. But also, PCORI the Patient-Centered Outcomes Research Institute, which was funded through the Affordable Care Act is really trying to change the whole research agenda towards finding the answers to questions that patients have rather than finding answers to questions that researchers have. Because we have not been very good at that. The other thing is how do we make this information readily available? Thing is the real transaction piece.

Then it gets even more interesting than that. This is the next video to watch. It is going to be in the thing when it is labeled ZocDoc. If you go ahead and click on that. We will watch that. We will come back.

Unidentified Female: Dr. Jesse, I am actually going to try the \_\_\_\_\_ [00:20:58] audio from my end here.

Robert Jesse: I am sorry, what? Hold on. You are what?

Unidentified Female: I am going to try to run the audio from my end, here.

Robert Jesse: Okay.

Unidentified Female: …. May help you feel better faster by booking doctor or dentist appointments through ZocDoc, the website that makes finding doctors and getting an appointment quicker and easier than ever before. ZocDoc lets you find doctors and make appointments right from your computer 24/7. Just enter the type of doctor you want to see, your zip code, and insurance, and \_\_\_\_\_ [00:21:31] a list of doctors and \_\_\_\_\_ [00:21:33] open appointments.

You can also read reviews by real patients who have seen a doctor to make sure you are picking the right doctor for you. Choose the more convenient time and click to book it right on the spot. You will have peace of mind knowing the doctor's office is notified the instant you make your appointment. Plus you receive appointment reminders by e-mail or text. \_\_\_\_\_ [00:21:54] ZocDoc makes finding an open appointment much easier than booking by phone. The patients who use ZocDoc typically see a doctor within 24 hours. We even advise you when it is time for your next checkup. It is so easy, you might find yourself feeling better in no time. ZocDoc, get well sooner.

Robert Jesse: Okay. I could hear that fine. Maybe that is a better solution. To me ZocDoc is really transformational. When I started asking people a couple of years ago had they ever heard of it, nobody had ever heard it. Today, if you go in a room and ask people who has heard of it, and who has used it, you will get a good number of hands going up. The proportion of the audience is kind of driven a lot by the younger side than particularly the millennials who when they want something, they want it right away. They are of the Amazon Prime generation. If they want to see something, just go on, and go to ZocDoc. That is a little bit different.

But ZocDoc is interesting because it has ratings of the physicians. It has testimonials. It has all of these other things. When you really think about it, it is open table for doctors’ visits. This is the type of thing where consumer behavior is driving change. But it is not driving change through the fundamental delivery model itself. It is just driving change to meet more of the consumer demands.

\_\_\_\_\_ [00:23:37]. We are on the big screen here. I mean, I think if you have not seen it, it is just ZocDoc dot com. You can go and look at it. You can put in what you want to see somebody for a type of doctor you would want to see. They do not charge anything at the front end, if you just want to go and explore it.

There is also a thing. They did not show the video for this. But there is a thing called InstyMeds. Basically, it is a medication dispensing machine that initially, they are putting in some of these walk-in clinics or urgent care centers. But more and more, the goal is actually to have them in the grocery stores and other places that you can go to.

The way it works is your doctor gives you a prescription. But they log it in through InstyMeds. It gives you a code number. You just go to a machine, and punch in the code, and put in your credit card or cash. It drops your medication down. It saves you from running around going to pharmacies and the like. Or after hours when most of the pharmacies are closed, you can still get your medicines and medications dispensed.

I always kind of noodled the idea that we could have one of these in Post Offices. Because we are federal and Post Offices are federal. They are secure. It would be a way to get a medications to Veterans. On the other hand, partnerships with CVS and Walgreens would do the same thing, I suppose.

Then labs will be next. This is cunning. Mary, I saw your thing in there. I am not going to show the video. But there are a couple of interesting things to be aware of. The first is that the FDA has actually waived a requirement that physicians order your labs. You can go and order labs yourself through a company like WellnessFX. There are a bunch of them out there now. They will tell you where to go to get your blood drawn. Then, they will manage the test, I guess.

Interesting is they are really not trying to sell the lab tests as much as they are trying to sell you their services and helping to understand, and manage that information over time. The kind of thoughts that they have as well as you are high cholesterol. You want to take a lifestyle modification as your primary means of reducing your cholesterol before going on the drug. Well, then this kind of gives you the option to check those parameters of cholesterol as frequently as you want. Interestingly, the first question when I show this and people usually ask is well, would my insurance company cover it?

But I think rapidly, the labs are in fact becoming commodities. That in many cases, what you would pay for it yourself may be actually less than what you would be paying on a copay against your insurance. That becomes really transformational. There is a company called Theranos, which is really interesting. This is Elizabeth Holmes, who is the founder of that and is the first self-made woman billionaire under the age of 30. What Theranos does is they can do about 100 tests on that amount of blood essentially from a finger stick. It is a very interesting technology.

But the comment here is they were testing themselves in the Bay Area. Their first sort of real implementation was with Walgreens out in Phoenix. Theranos becomes part of the Wellness Centers at the Walgreens stores. Literally you can get labs drawn on a finger stick. But what is really important here is not actually the running of the test. The disruptive model that they have is essentially saying we are not going to make our money in running the test. We are going to make our money in managing the information of that test. In fact, if you talk to systems engineers, they talk about a thing called traveled risk; which is what happens to something in the space between wanting to know it, about it, or having it where something needs to be done; and then knowing or getting it done?

In that space as it goes from one place to another over time, you have what is called traveled risk, which is not just that you move the risk. You amplify it. Think about most primary care offices if they need blood work done, they are either going to draw it themselves; then they are stick in a little note box kind of thing outside the back door. Somebody from Roche or one of the other labs is going to come around and pick it up at the end of the day.

They will run it maybe overnight and maybe the next day. Then somewhere they will somehow, they will get the information back over to your primary care doc. But if the person who ordered it went out on vacation; and somebody is just slipping the slips in the charts. There is a huge opportunity for things to get missed. Again, there are a number of websites on this. Now, in interest and in full disclosure, they just recently got kind of hammered by the FDA who was questioning the validity and the voracity of some of their tests.

If you go onto the Theranos website; I was looking to see if there is any sort of updated thing that we are short. There is actually one now which has got a big disclaimer from Walgreens saying that they are not doing anything with them. Now, I have been saying that they may be out of business before they are in business because of things like this. It turns out when you do a lab test, you have got two things. One is the test itself. The other is the detector.

The whole Theranos model is built on a system called microfluidics, which is what most EPT tests and all of the home based are done, Glucometers, for instance. Well, it turns out that the screen on your smartphone is a really good detector. Especially the later iterations where they have real high resolution. This is obviously from Germany. But they are developing films that you can put on – that you can lay on top of your cell or smartphone screen. Then the smartphone becomes the reader and the processor, storer, or purveyor, distributor of that information. \_\_\_\_\_ [00:30:20] a picture of the same thing. More and more, that is going to be interesting. Then talk about the consumerization; I am not going to show this video. But it is a great video.

A lot of people – this, it became a little bit of a darling. But it is a Breathalyzer that you plug into your iPhone. It got a lot of attention because it was on Shark Tank. They got funded by one of the sharks. But it is pretty interesting with the thought that went into it. For instance, if you blow into it, and your blood alcohol is greater than 0.8, the first question it asks you is do you want me to call a cab? It is taking information, linking it into a system to mitigate risk. It is pretty clever when you actually think about it. More and more, we are going to be seeing lab tests, specific lab tests like this; it is a lab test – moving into the consumer space. The adoption will be because it helps people doing things differently.

Another topic moving into is the simple fact that patients actually can and do talk. We are told as providers that everything that we do; we write. The directive of the patient has to be written at the fifth grade level. I have a little bit of an objection of that. I think that is the wrong answer. I think it has to be written to a level that patients can understand. That might have nothing to do with the amount of education they have had. It is the language that we use. PatientsLikeMe, it is an interesting organization. It was founded by a couple of brothers and a friend from MIT whose older brother had been diagnosed with ALS.

These guys are in Boston. Their father is a professor at MIT. They are very smart people. They had all of the smartest doctors in the world. The healthcare system could tell them all about the disease, pathophysiology, and current treatments, and all of these other things. What they could not tell them is what is going to happen next, and when, and what do I do when it happens? They only found that out from talking to other patients and families with the disease that were kind of progressing through it ahead of them.

They started up this website called PatientsLikeMe. Now, they have got hundreds of different communities. If you are not aware of them, it is definitely worth going to look at some of the stuff that they have out on the web. But, I am very enamored with them for the simple reason is they are probably teaching us more about health literacy than anything we have done before. In my conversations with them and looking at some of the stuff they put out, this is where I have come to the conclusion that sometimes the most illiterate person in the room is not the patient. It is us. Because we cannot speak in a language they understand.

Going back to my very original premise that healthcare fundamentally is an information business. Then, if you are going to be in that business, you have to make that information useful. If you cannot make it useful to the people that you are trying to serve or service, or your customers, although I hate that term, then you are going to be out of business. Learning how to talk to patients is probably best done by listening to how patients talk to each other.

What you are beginning to see with organizations like PatientsLikeMe. There is Audax Health. There are a whole bunch of them. When the web came out, a lot of the healthcare systems used the web essentially in lieu of a mailing. It is like our current model of electronic record, it is a digital version of a paper record. Well, the web was being used as a digital version of something that mail out.

But more and more, you are beginning to see people who understand how the web works. Leveraging what does work on the Internet as we work with the patients. For instance, crowd sourcing becomes really interesting. If you, any of you have kids who are in their 20s, they wake up in the morning and feel crappy. They are going to – everybody is going to know it. They are going to have 20 responses before 9 o'clock on everybody who had the same thing last week and what they got from their doctor. They are going to go into a situation expecting the same.

The whole idea of crowd sourcing is going to be I think really important. But we are going to kind of come back to that notion in a minute. But the bottom line is – and I think you really need to be aware and cognizant of is healthcare is really about stories. It is not about data. Talking to the Ted Net folks who have been trying to understand this. They say the most important and influencing is the significant healthcare decision is by your parents, or your kids. It is your best friend's friend. It is the one person that somebody knows who had that same thing. Wherever they were, it was either really good or a really bad manufactured decision more than anything else.

They say \_\_\_\_\_ [00:35:39] has been thoroughly befuddled by the fact that nobody bothers to go and look at Hospital Compare. It is still driven by anecdote. Again, it changes the whole dimension of connected health. Because now, there are a lot of people who can answer a question.

Lastly, we are about big data. As they say, we were having a hard enough time getting real data. There are actually people who are starting to look at patient's credit card data. Now, this is an article in Bloomberg last year. But they are literally mining it. Because they are looking at what people buy and eat. If you have got a diabetic who says I am watching my diet. But then you know that they are buying a couple of tubs of ice cream a week, well, you have got a very different story on your hands. You can have those conversations.

That comes back to what I said in the beginning about healthcare, the enriched information set is healthcare. It is going to be the big data of looking across multiple patient records. But the data that feeds that is going to be a lot of this small data about what are people eating? How much exercise are they really getting when you put Fitbits and Upbands on them? Not only that, who are their networks? Who do they talk to? How robust are they? How active are they during the day?

If you are looking at things like this, at some point somebody is going to ask the ethics question. It is well, if you are knowing this for healthcare reasons, should it not be protective under HIPAA, right? Those are for the ethicists to ponder. But I will throw that out.

The issue – the first slide was who will provide primary care in the future? I think the real question is what will primary care of the future be, right? Healthcare is an information business. We have got to get information that is transactional and coherent. We have got to manage it, what and the same way we would manage any business that had a product. It is about logistics and scale. That comes back to the involvement of people like Wal-Mart and what they can bring to the table. They just talk about data big and small. As information asymmetry is reduced; and more and more people are going to be looking for different ways for them to find out what that really means rather than trusting your doctor or your healthcare provider. The role of artificial intelligence really begins to shift out of the suit consumer demand. My sort of notion for this is looking at what is going on with Amazon. Amazon is a very different place today than it was even three years or five years ago in terms of the power of their recommendation engines. Just imagine, if you were able to take that and apply it to healthcare. It is a very different thing.

Managing data and the information exchange is really where the value proposition is in healthcare moving forward. Companies like Theranos are beginning to realize this. While consumer behavior is going to drive expectations, commoditization will accelerate the shift into individual control. If I saw Mary's comment about wanting to be able to check certain labs herself without having to go to a doctor. That is the forced transaction piece. The fact is you do not need to do that anymore. You can get your own labs done without a doctor's prescription. The question is are enough people who know that and willing to give up that control? Would your insurance company pay for it now the way they do then?

But if Theranos has its way, their prices will be so much less expensive. It is going to be cheaper for you to go to them directly rather than having your doctor do it. By the way, if you look at that wellness FX, there is a video. But the one thing they say is you own the information. Then you can choose with whom to share it. The first person that pops up, they were talking about cholesterol, I think. But the first person who's mention is your personal trainer.

Then the last person he mentioned is your doctor. Having now information that only you know, and it is not widely known to the rest to the healthcare system unless you want it to be. It is now really putting control into the hands of the patients. This is the last video to watch. This is called – or so the slide is the future of healthcare is now. This is about a thing called Scanadu, which is in the XPRIZE. If you go and click on that one and watch this. It is about a minute and a half. Are you going to try and run the sound?

Unidentified Female: I am going to try to, yeah.

Robert Jesse: Okay, good.

Unidentified Male: Technology has given us an unprecedented window into the human body. On a day to day basis, we are still in the dark about our own health. We are changing that. What is it instead of fearing the worst when you look at something out of the ordinary? You could identify the \_\_\_\_\_ [00:41:13] yourself. If getting the right diagnosis would save you worry, is it worth the \_\_\_\_\_ [00:41:20] and an unnecessary doctor's visit? \_\_\_\_\_ [00:41:25].

Instead of hearing about a viral outbreak of SIDs, imagine you got an alert that was tailored to your family's needs. It would also give you advice about what to do next. What if you had a way to identify what was wrong right away? \_\_\_\_\_ [00:41:49] a way to get all of the information you need to understand the situation. \_\_\_\_\_ [00:42:01] serious cases, you would know when and where to seek help. \_\_\_\_\_ [00:42:06] thing \_\_\_\_\_ [00:42:07]. We are building a way for people to check their bodies as often as they check their e-mails. It is all \_\_\_\_\_ [00:42:18]. It is only the beginning.

Robert Jesse: Okay. I did not hear any sound coming out from your side. But I am going to presuming everybody has watched it. This to me is really interesting. Scanadu is but one of many monitoring companies, sensor based companies that are just proliferating out there. Topol in his book and his speaking’s talks about this destructive innovations. Healthcare is really about what does this bring to bear? The interesting thing here is not that you can monitor stuff. The question is what do you do with the information? Even in some of the AIDs innovation calls, we have had a lot of people respond with monitoring stuff. But in the end, it is not – it does not give you the information you can use. It is more data but not useful information. Then of course, the other challenge is how do we integrate in there?

Just a couple of other things to close. It is fascinating to me about the Internet within…. Barry Shortz – I had a book. He has got a bunch of YouTube videos as well that you can watch. But there is one nice minute and long, short one. I did not put it in here. But the whole notion is that of the paradox of choice. We have got so much now information at our hands. It is really bad. Now we start to look at \_\_\_\_\_ [00:44:06] reviews. Now, the problem is there is more reviews than we know what to do with. If we just type review for anything, you get hundreds of responses.

Now we actually have websites that Right. Essentially doing the equivalent of the meta-analysis of reviews. My Next and some others are like that. But it is a great story. This is a Wired article by a guy named Mat Honan who was kind of talking about this. But he put in reference, he needed to buy a grill. Of course, the first thing you do is talk to all of your friends who are grill masters. The problem was none of them can agree on what is the right thing. You keep going back and forth. You are reading all of the reviews. Everybody is contradictory. They have a little paragraph and thing that says, then one night after a few drinks, I dove back into my research. I woke up the next day to an e-mail from Amazon comparing my purchase of the \_\_\_\_\_ [00:44:55] element. No, Wire does not endorse consuming alcohol in excess. It is an excellent way to free yourself from tyranny of big decisions.

I just loved that term, the tyranny of good decisions. Because that is what we keep doing. Essentially, we create a paralysis. Think of that in the construct of what you know in healthcare. What you have to do with it. This is the patient. This is where the patients really struggle. My definition in the patient centered care is personalized certainty. What do patients want to know? They want to know what is going to happen to me. What is going to happen next? Our ability to translate complex information back to them in ways that they can understand will then lead to better decisions, and in turn lead to better health.

That is it in a nutshell. I mean, I think the real take home message is that this future is rapidly headed our way. More and more our role with patients is going to change because information asymmetry is going to go away. Even if prescriptive license does not, it is being diffused meaning we now have nurse practitioners who are really reconfiguring as doctors of nursing practice. There is going to be only in 20 some states they have full prescriptive license. You cannot get an undergraduate degree in pharmacy anymore. It is now a Pharm.D. They also are looking for prescriptive license. Frankly, if you look at most of the developed countries and undeveloped countries, they are – none have the real capture of the prescription pad like physicians do in this country. Clearly that is going to change. Anyway, so I will stop there. There is probably some questions in here. I will be glad to take them on in whatever time we have left.

Unidentified Female: Great, we do have a few questions here. We do not have a lot of time. We will jump right in. The first question here, a fantastic presentation. There are no government run travel agencies, car dealerships, or wealth management firms. If healthcare is going the way of these industries, what is the future of government run healthcare?

Robert Jesse: That is interesting. Well, two things, first is healthcare is healthcare. It does not matter who is paying for it. Although, healthcare is healthcare. It really matters who is paying for it. The argument is government healthcare different than non-government healthcare? Well, it new in the VA because we are not bound by a lot of what the private sector has to do in terms of how do you make money and be profitable, and be sustainable?

We actually are – government healthcare is in a better position to do the right thing. The biggest challenge is convincing everything that the right thing really is the right thing. I mean, it sounds like a pretty simple statement. But it is not so simple to do. A lot of times when the VA has been called on the carpet for not doing something, in fact, it turns out we were doing the right thing. We had good principles around the work that we did. More and more though, I think as it comes into the hands of patients, we are going to be everybody whether it is in government or not – is going to be accountable to the individual patient.

My concern, and this is not technically answering the question you are asking. But the big challenge is that a lot of real – a lot the work we do in quality for instance, it stopped being – it became a statistical function and stopped being about patients. How do we get patients back into the center of that equation? How do you make quality for an N of one? A lot of the answer to that is the focus now on patient safety and harm. Because from a patient perspective, it does not matter what the odds are. If it happens to them, it is real.

Again, whether it is done government or it is done in the private sector. Or, whether it is paid as a single payer or a paid through a competitive marketplace, the people that are going to survive are the ones who can do it best. Who can really move with this transformation into a much more information based healthcare system. Frankly, I think government is probably in a better position to move than others are.

Unidentified Female: Great, thank you. The next question here – who are the current leaders of direct to consumers health information?

Robert Jesse: Well, the current leaders are probably the pharma industry. I mean, they have been practicing at it for a long time. They know how to do it really well. Everybody is trying to figure this out. A big chunk of the PCORI money and a big chunk of our ARC money these days is going towards the patient engagement. How do you communicate research findings that would change how we practiced to both providers and to patients?

Certainly every time a new medicine comes out, particularly now that it is so hard for the old time detail rep to get in front of a clinician. They are going straight to the patients. They have got a lot of experience and decades of experience in doing this. I would say that they are… I mean, another comment about that is to me it is just unfathomable, our relationship with pharma and the device industry. If you look at any industry in the world and certainly in this country who has been on the brink of disaster and has recovered, the one thing that I think a commonality in the recovery is that they have moved from their suppliers to being – from being suppliers to being strategic partners. Even look at a Wal-Mart where every one of their Wal-Mart's major vendors has offices in Bentonville. In healthcare, we do not trust our suppliers. They are untrusted adversaries. I do not know how you can really function the business like that. If I were smart, I could probably figure out a way to put a dollar sign on it. But, I think one of the predicates we need for healthcare reform is to fix that dynamic.

The only way I can see to do it is to actually have a shared accountability for outcomes, and particularly patient based outcomes. If you think about it, why do I buy a statin to get somebody's cholesterol? Now, why not I buy the – why do I not license out the outcome? You have got a drug that says you can do this. Well, we will pay you this amount of money per patient per month kind of the way we do everything else per patient per month on a capitated system. We expect the outcomes and basically let everybody play.

Then you call them out. Because the ones who cannot do it, either the drugs do not work the way they claim or, they are not providing the secondary damage. We are starting out to see some changes like this particularly in the device industry where the reps have gone from being selling to actually being true tech support. In fact, we are credentialing them and privileging them in some places. They get badged and they wear – they can have computer access and all of those types of things. But yeah, from engaging patients right now, I would say it is pharma. But everybody, we all need to learn a whole more about that.

Unidentified Female: Great, thank you, the next question. How can the VA create an environment for Veterans like me so the health literacy of the Veterans can improve and the communication with their clinicians also improve?

Robert Jesse: I do not think it is the question of how. It is easy to do. The question is do we have the will to do it? Then can we get through the contracting process and make it happen. Now patients like me – it might have finished. It might still be going on – have a pilot going on out at San Francisco with I think the Parkinson’s group. But it is one of the neuro degenerative diseases. It would be interesting to see what would happen there. Frankly, the VA has been in a conversation with them for a couple of years. But DoD, was talking to them too about building a whole independent website called lawyers like me. Since we know that the DoD, is much more at depth at contracting then we are – we were kind of taking a seat to see what would happen there; and maybe be able to jump onto the back of a different contract.

But I think it can easily be done. It is just a matter of do we have the will to do it? Somebody, the willingness to champion it. Then it is probably not something you can sole source. You have got to write some specs and put it out. But we need to do this. We need to do it, I think, pretty quickly and to do it well. For all we are talking about in MyVA about patient engagement, and staff engagement, these are the things I think that are right on the top of the list.

Unidentified Female: Great.

Robert Jesse: \_\_\_\_\_ [00:55:20].

Unidentified Female: The next question here. You made a comment about patients signing their own progress notes. Is there a role for healthcare providers who own medical records? Should that shift back to patients?

Robert Jesse: Well, that is what I said. I personally think patients – everybody who enters data is going to keep track of their own stuff that they put in. A hospital is not going to seed over all of the records from a patient visit to the patient. But they should transmit everything that they have to a patient's record somewhere. If that patient leaves the hospital and a week later goes to an urgent care center, that urgent care center should likewise send the data to that patient's independent, the record that the patient owns. Obviously, they are going to keep track of their own thing and as will the doctors' offices and everybody else. But, if we are really going to make difference with electronic health records, the one thing that has to happen is everything for each one individual goes to one place.

There are a couple of simple examples when you think about it. My son was going to post graduate school. Of course, he calls the night before school was supposed to start saying I cannot start in the morning if I do not have proof of immunization. Of course, this is a typical boy thing. Well, who has that? Right, the pediatrician that he saw has probably long ago purged the records. Because they had not been seen there in five years. They usually purge their records after five or seven years.

The only person who actually has that record is Dr. Mom. The only reason she has it because she had to do it when he was an undergraduate, and knew where it was. But just kind of think about it. How many times have you gone to the doctor and said when was your last tetanus shot? Well, geez, I have no idea. It was the other day; which like the kids would tell my wife, the other day means anywhere from yesterday to the day I was born. Because we really have a hard time keeping track of time in between those times.

I think the patients need to own it. I do not think we have ever been there. The closest thing we have is military guys who know that you get a hold of your records. You copy everything. You keep a copy of everything. Because the services were notoriously good at losing things, and particularly when you have got disabilities and things happen to you in the service. If all of this went to one place, we would have a very different story. There are enough translation engines and normalization engines these days that you can reconstruct data from multiple sources into a common patient.

In fact, the EHMP people can do this today, I think. Yeah, this is what needs to happen. It has never happened before. Harlan Krumholz up at Yale has tried to build a community wide test of this up in the \_\_\_\_\_ [00:58:30] area. He was trying to get the VA involved. Of course, we will spend years with lawyers and everybody else arguing about what we can do. It is what we tried to do with Bieler. But the problem with Bieler becomes sort of effervescent. It lets you look at stuff. But then it does not get incorporated or sustained in any way. It is not integrated. But this is where we need to be going. I hope that answered the question.

Unidentified Female: Yeah. Now, they may send in a clarifying question.

Robert Jesse: Yeah.

Unidentified Female: We are past the top of the hour, Dr. Jesse. I am not sure how much time you have for questions?

Robert Jesse: I am okay, if people want to stay on.

Unidentified Female: Okay. Yeah we do definitely have a few still here. I will just keep going. Let me know when you need to wrap up. The next question, have you thought about using VHA innovation to add with the implementation of some of these topics? I wonder how many employees have their finger on the pulse in this manner. Could we not use the future of technology's laboratory as a test bed with some of the companies?

Robert Jesse: Yes. I think – but I think this is a really fruitful area. Because we actually have data that goes back so long. It is important. In part, some of the work that VINCI did was to create the sandboxes and allow that to happen. We are working with the Watson team for instance to revoke \_\_\_\_\_ [00:59:55] dynamic contract. In fact, I am going up to – at the end of week on Friday with Dr. Shulkin to go to the Watson Center to see exactly what they are doing. But we need to make it a whole lot easier to do. Particularly in the world of like the big data because there are so many people who are entering into that market today from both the kind of the assimilation side but also to the processing side.

We need to be able to open that door up. Because what we have to my mind, the cumulative VA records of all of our patients literally is a national treasure. It is not reproducible anywhere. We ought to be using that to really develop these things. We do through the innovations program have some ongoing projects that are kind of coming to fruition. One of which is with a monitoring company. It is kind of struggling to get from the proof of principle into a more robust testing case. But this is a company where the focus is not on the monitoring. The focus is on the processing of the data.

Because in generating a lot more data points is not going to be productive unless we can actually do something with them. Knowledge is information put to productive use, right. They come out of the signal to noise space. Specifically, it is a group that had designed the protocol that monitored jet engines and flight time to predict when they will fail. Well, you can use that same sort of logic models to look at patients and try and predict when they are going to have problems. The problem is the changes are very clear. But they are buried in so much noise that you have got to have ways to find them.

This is a whole different set of sciences. There are some other types of things that have come through that project. A lot of the apps and IT suggestions that have been very productive as well. But I think every healthcare system worth its salt, it needs to have an innovations program. My fear is that for most people, innovations really ends up being just basic process improvement. I think there is a real difference between re–engineering and reimagining how we do things. The worst thing you can do is to re-engineer a non-value-added process. Because you just end up with a really well engineered non-value-added process. What are the game changers?

This Scanadu \_\_\_\_\_ [01:02:54], that is kind of interesting. The simple fact is that there is an outbreak of – their example is there is an outbreak of whooping cough. Well, it actually looks back and everybody's records of the families and see who is ready for a booster shot, right? It says go and get it done; and then come schedule the appointments. These are pretty interesting things. But I think we do have an innovations program both in the VA and in VHA. Chuck Brown, and Patrick Littlefield are running this. But when the money gets tight, kind of those are the places it gets pulled from. My fear is we sort of lose our will to be able to explore a lot of these other options.

Unidentified Female: Great, thank you, the next question. As patients are empowered with more decision making, what are the mechanisms that will constrain costs? Will it be through copayment or other financial levers? If so, will the VA be able to use those levers in the same way? Or is the assumption that greater choice might increase utilization is incorrect?

Robert Jesse: Yeah. That is an interesting notion. I do not think. I think it is not an issue of greater utilization or less utilization. I think it is a question of appropriate utilization. If you really want to drive reduction in costs…. This is sort of dangerous territory to be treading around in. But we in the VA…. The VA put down in the 2013 strategic plans that were going to provide personalized proactive patient driven care. That proactive piece was essentially we need to move away from finding the U.S. healthcare model of find it faster and fix it better; which is what we do.

I mean, as a cardiologist, this is what I do. To much more of in a preventive mode; and actually preventive cardiology is one of the most successful fields in terms of preventing subsequent onset of significant disease. You just need to look at the MI population health and MI rates over the past 50 years. See how they have come down because we have changed diet and got people to quit smoking, and all of these other things. The first, that the so equipoise here is what is right; which we do not really even know. But the other thing is that the more that the costs go into the hands of the consumer, and the more judicious they become.

The challenge in the VA is well, it is a challenge everywhere, or rather than specific to the VA. But my sense is whenever we think of that notion of what is value. Can we stop driving the healthcare system on performance and start driving it on value? Do that from the perspective that meet everybody's needs? That is where we need to get to. Now, the problem is…. It is an interesting statement because there are a lot of health economist folks. I am sure that are on the line. For those who do not know, the value in healthcare is defined as quality over cost. The problem is that quality is in the eyes of the beholder. It has multiple domains.

Cost and particularly in single payer systems like the VA; but even for your fee-for-service insured, the cost is not always in dollars. Or it is not – it is tangentially in dollars. But if you think about for a service connected Veteran who does not have to pay anything, there is still the whole notion of transactional costs. What did it take to get what I needed? If you want to talk anything about the current stuff that we are in the middle of, that is what we are driving. A lot of the people just did not get what they needed. They are bitter because of the amount of energy they expended to try and get it was disproportionate, right. In those opportunity costs, there's transactional costs. There are time based costs.

That very simple flat equation of values, and quality over cost really becomes probably even four dimensional, if you put time on top of it. But really trying to figure out how to build that construct in a way that it can – it meets every perspective is in fact, how we are going to get where we really need to be. It is a challenge because nobody wants to take it on. The language is confusing because when you talk to value open, and just at the HHS level, to them, it means values based purchasing; which means you get the most for your money in the short-term and not in the long-term.

It is interesting, there is a Harvard Business Review article about a company in the full disclosure. It is my brother's. But they pay their executives. The executive bonuses are paid something like seven years after the earn year. Essentially, they are trying to create a system of management in the companies where you get rewarded for how the company performs in the future, not how it performed last year. Because it is real easy to make it look good and drive stock price up; and then cash out and \_\_\_\_\_ [01:09:22] things collapse. If you look at real leadership in healthcare, it is not about how the organization performed under you. It is how the organization performed two, three, five, or ten years after you are gone. Because you have actually built that capability.

I think to answer the kind of questions that are you asking is a real challenge. Because it is not going to be driven by dollars. It is going to be driven by value. We just do not know how to express that yet or get the right data. But more and more as we go to patient reported outcomes and understand what is important to patients, then that is what is going to change the dynamic, right.

You have got to show particularly in government side. We have got to show that we are of value or we are not going to exist. Right now, the field we are playing on, there are a lot of people that are trying to say well, this is not really value-added stuff. We ought to just get it in a different way. I do not believe that for a minute. Because I think we provided a much better value and healthcare experience than anybody else does. But we do not have a very good way to express it.

Unidentified Female: Great, thank you. The next question here – in your role as chief academic officer, how would VA prepare in our next generation of healthcare providers for the changes you described?

Robert Jesse: That is a great question. The one thing about this office is they sort of have this core function of we basically pay for residence at GME, medical residence. I keep telling people that we do not own them. They are more like timeshares. We reimburse the program for the time they spend at the VA. But there is also sort of a really brilliant sort of innovations program of our own that funds a lot of other projects and programs. There are some really just incredible things going on in the world of nursing. Residency programs for nurse practitioners like similar to the kinds of residencies that our house staff do.

But I think the most important one to answering that particular question is the Centers of Excellence for Primary Care Education where they really are based on training a cohort. There originally were five. We just expanded it to seven around interprofessional and team based care. Because that is where the future really is. For the most part, we are still training people to practice in the old fashioned way. Then they get out. Then they have got to come and learn how to practice. We have got to get beyond that and change the whole dynamic of the training programs.

More and more I think some of the things we really need to be looking at is training and communication skills. There was this little I do want to say cultish thing because it is still around and pretty interesting. But the whole idea of emotional intelligence. How can you relate to patients? I mean, there is a very innovative little healthcare system called Iora Health; which was put together to take care of how to work casino workers in Atlantic City. The union was responsible for healthcare. They did not have a lot of money. They had to do something. Iora Health is really built on a lot of really proactive preventative care.

It can save a lot of money. That is tact that they have taken. They use a large number of health coaches rather than a large number of doctors and nurses. For every physician and nurse, they might be supported by five or seven health coaches. I asked them who did you use as a health coach. Do you like hire like nurses that do want to be on wards anymore? He is like no, dummy. The answer was pretty, essentially pretty – it is baffling. He said look you can take the smartest doctor. The role of the health coaches to engage patients. Right, that is what you hire them for. I mean, you can take the smartest doctor or nurse in the world, and if they are not inherently engaging people, you cannot make that way.

But you can take somebody who is an engaging person. You can teach them everything they need to know to help somebody manage their diabetes, or hypertension, or just lipedema in about a week. It is a pretty – I mean, it is a really important statement. The simple fact is the best outcome you can agree with the patient is by actually getting them engaged in the process of taking care of themselves. You need engaging people to do that. These I think are the biggest challenges that we are going to face in moving this forward. How do we begin to train people? Maybe it needs to start at not hiring the people. Of not hiring – not limiting med school admission to people who with 4 – O's in the sciences; As in organic chemistry. But actually really looking for much more of a skill set in an information world that becomes of value.

Because frankly, we are training people on a model where the expectation is you can know everything you need to know. That may have been true even 20 years ago. It is not true today. I think one of the strong – the technical skills of a physician in the future is going to library science and knowing where to get information. The real training is got to be about the emotional intelligence of communicating information to patients, of putting in constructs to them – of helping patients come to decisions that they can make because they are informed. A lot of times patients do not like to be told well, you decide what you want because they feel so inadequate in terms of knowing enough to make the right decision. It is not that they are indecisive. It is that they are just ill informed.

These are the training skills that we need to be working on. But we are starting to do that through the Center for Primary Care Education and through kind of how we are training both pre and post baccalaureate nurses. How we are engaging multiple or specialties in the teams early in their training and not just waiting until after everybody has done their training and now are working. Frankly, I think – again and one of the things we are looking at is what do we do in the first two years that when we hire our physicians and nurses to come on board? In fact, many industries, most industries invest a lot of money in new hires in the first two to three years even having a pretty high attrition rate; but to get a competent workforce.

I think we need to be doing that as well in the first couple of years, and not hope people work out; and could figure out the way we do it in the VA. But in fact, we spend a lot of time and effort to make sure that they can. If we say we are going to practice team based care, and somebody cannot function within a team, that they are a lone wolf. It does not mean they are not a good clinician. It just means that they cannot practice the type of medicine that we believe we want to be part of our delivery model.

We are doing that. It is not wholesale. But we are looking at a bunch of different models as they are looking successful or standing them out. It is pretty promising. Then, it is quite interesting. I certainly would encourage people to have ideas that we think need to be changed. Well, if it is about education, let us know. We need to open up the innovations program so people can come forward with ideas like that too, and run through there. Anyway, I hope that answers it.

Unidentified Female: Great, thank you. The next question here. How about patients who do not make appropriate decisions? For example, those who choose to seek help only when they are very sick or do not want to see a doctor because they cannot afford the copay and the meds that may be prescribed. Will these patients drive up rates for hospital admission?

Robert Jesse: Well, we know that they do. But the question is where do you draw the bounds between patient autonomy and making them have to do something? If patients are well informed, and we do not make it difficult to do, they as a rule will do the right thing. But not everybody will always do the right thing. There is George Halvorson, who was the CEO of the KP, Kaiser Permanente. I will give a slide, at a talk \_\_\_\_\_ [01:19:11] medicine. The title slide was making the right thing easy to do. The first slide was to figure out the right thing. The second slide was make it easy to do, right. We have got to cut down the barriers. A lot of the arguments for single payer or re-changing the financial structures of how things get paid is that people should not have to suffer or get lesser quality care because they cannot afford something. If it is that important, we need to figure out how it gets done.

Part of the Affordable Care Act was the legislation that says you cannot charge copays for preventative and screening types of things, right. You want people to undergo all of those. But there are always going to be people who do not want to. There are always going to be people who show up when they are sick rather than before they get sick. But interestingly, even when that happens, they still expect the appropriate care and to not be judged. I think one of the real important things for good providers is that you are not judgmental. It if this happens – it happened. But how do we make it easy…?

Unidentified Female: Dr. Jesse, are you still there?

Robert Jesse: …We work at it. If you believe as I said that healthcare is an information business, then people understand better; then they are more likely to do the right thing.

Unidentified Female: Okay. Great, thank you. I just want to double check on time. I have 2:26 right now. If you have time for more questions or should we wrap things up for today?

Robert Jesse: No. I think I am actually good. Let me just check quickly. Hold on one second.

Unidentified Female: Take a look at your calendar.

Robert Jesse: Yeah. I am pretty sure that I am fine. I think I had locked or blocked out a couple of hours.

Unidentified Female: Okay.

Robert Jesse: Let us just put this up. Well, I am good until 2:30. I guess I have got another call at 2:30. We have got about ten or a couple of minutes.

Unidentified Female: Okay.

Robert Jesse: One more slide….

Unidentified Female: The question I have here. What is your take on fiscal transparency with connected health? The patient knowledge of the cost of care prior to choosing a provider not hidden under the health insurance payment process?

Robert Jesse: I am not sure. Read that and say that again. I am not sure I understood it.

Unidentified Female: Your take on the fiscal transparency with connected health. The patient knowledge of the cost of care prior to choosing a provider.

Robert Jesse: I am not sure if that one question or two. I think one of the big issues and this comes back to the whole thing of information asymmetry. I mean, heck, we cannot even tell people what it costs because we do not know most of the time. But I think a system our size ought to have a chief transparency officer to make sure that we can be as open, and straightforward, and absolutely clear about everything as possible. In terms of patients making decisions based on cost, this is going to happen through, as things as I said become a commodity. When you were paying for it…. When you as the decision maker are paying for it, and you have the choice, and you are going to weigh the Cadillac versus the…. Well, I had better not say anything because of what. You are going to weigh a high priced option versus a low priced option; and which is the best value in every sense of that word. But if you cannot tell the price, you have got a big problem, right.

This is actually the big issue for insurance plans now where if you are within the plan you have one of price. If you are outside of the plan, you have another. People find out well, which hospital is in the plan? They go there. Then it turns out they get this huge bill because the DD group that practices at that hospital not in plan; or the anesthesia group that practices at a hospital is not in plan. They are having these huge cost overruns. We need to get to the point that we can tell people what it is going to cost. There is a big movement about cost transparency, getting hospitals that \_\_\_\_\_ [01:24:43] you are seeing HHS and CMS published the cost registers. But they are so confusing that we can figure them out anyway. In fact, many years ago, I was on a panel that did Blue Cross in Virginia when they were still Blue Cross in Virginia.

We had a HMO plan. They basically said here is the way it works. There is X amount of \_\_\_\_\_ [01:25:02] per member per month for hospitals. The X amount for member per month per doctors. The announcement that is going to doctors is never going to go up. It might go down. But if you can help us save money in the hospital side, we will do the cost sharing with you. We said, okay, well fine. Just tell us what it costs to get things done at certain places? They said we cannot do that because all of our contracts are negotiated. They are confidential. We can at best give you sort of like a restaurant, a one dollar, or two dollars, or three dollars, or four dollars. Even when physicians cannot make a decision on behalf of their patients based on costs, we got a real problem. That level of transparency, it needs to come to the system. Then we will figure it out. The good news is that VA because for most people, cost is not a factor. They can actually make a decision based not on costs but on what they think is the best thing for them.

All righty, well thank you everybody for hanging in there. Then I am sorry, I have to leave now. I do have another call I got to be on. But I hope this all helped. I can answer, if people have questions afterwards, you can \_\_\_\_\_ [01:26:16] to me. I will try and answer them.

Unidentified Female: I will be running them through \_\_\_\_\_ [01:26:19] first. It will definitely be passed on to you. I know I want to thank you for the time you put into the session. We are getting a lot of feedback from the audience. Thank you for a wonderful session. To the audience, I am going to close the session out in a moment. When I do, you will be prompted with a feedback form. Please take a few moments to fill that out. We really do read through all of your feedback.

Also, I have a slide on the screen right now for VA Pulse. We already have a good discussion going on out there about today's session. Please come and join us. We should be able to get some good things talked about out there. Thank you everyone for joining us for today's HSR&D Cyberseminar. We look forward to seeing you at a future session. Thank you.

Robert Jesse: Thank you all, bye-bye.

Unidentified Female: Bye.

[END OF TAPE]