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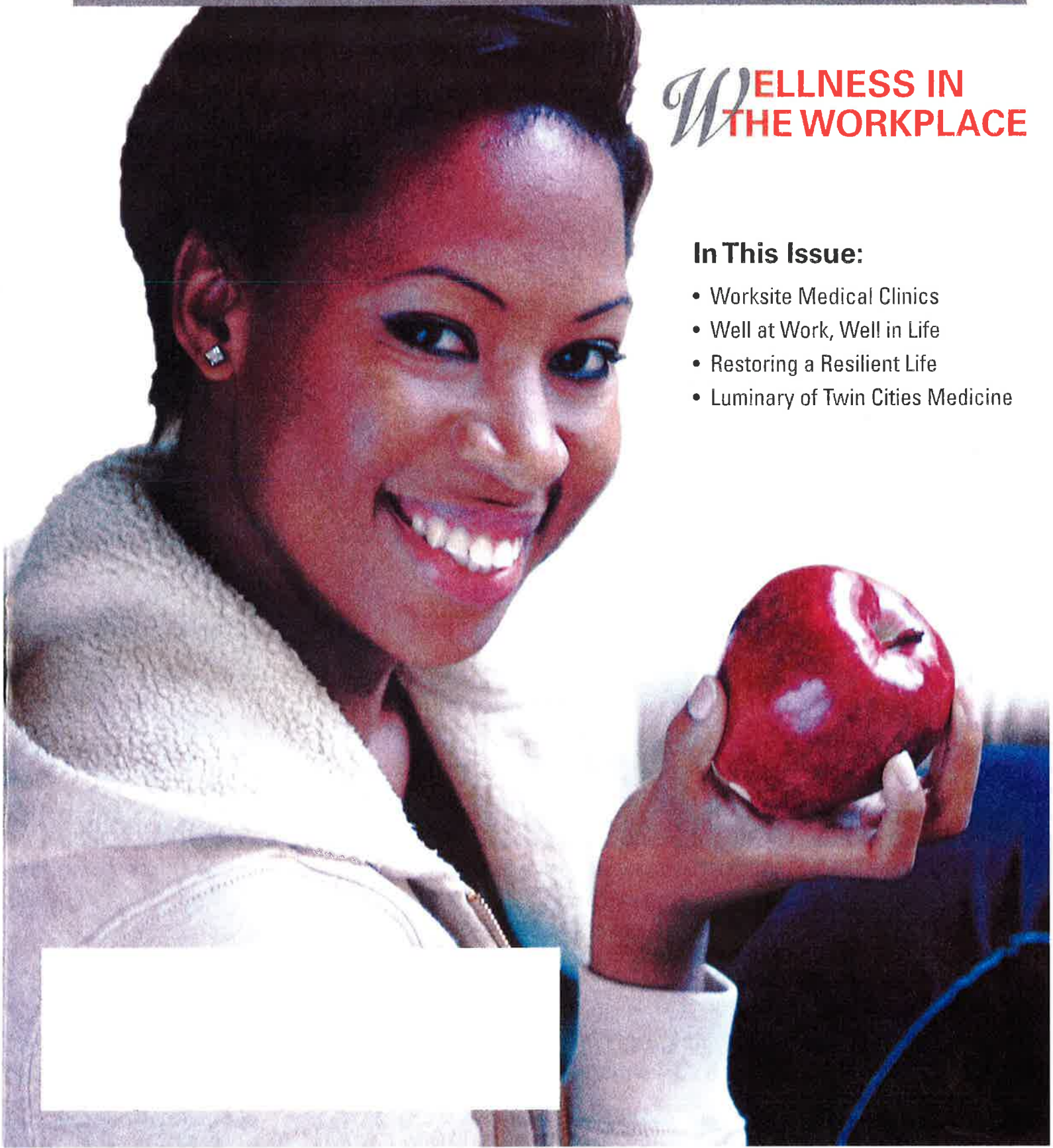

WELLNESS IN THE WORKPLACE

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On the cover: Employers and employees are adopting a workplace culture of health and wellness. Articles begin on page 8.

Health Care as a Bowl of Cherries...

Ken Paulus' excellent article on "Cherry-pick(ing) the best ideas for health care" is a must read for all thoughtful analysts of the current state of medicine in Minnesota, and I thank Mr. Paulus for sharing his vision (*Star Tribune,* April 11, 2011).

Cherry-picking is defined by Wikipedia as "the act of pointing at individual cases or data that seem to confirm a particular position, while ignoring a significant portion of related cases or data that may contradict that position." I am not suggesting that Mr. Paulus ignored other components of this most critical issue, but that his hospital and clinic network experience might have precluded him from seeing other important subsets of health care. We are, after all, products of our own experiences. And our experience is the view from below: small providers serving and supplying large metropolitan, even state-wide health care systems. Since an "extreme makeover" is not a current reality, I would like to offer the following proposals for contemplation by the body politic and the powers that be...

1. **Accountable Care Organizations**–Encourage the formation of ACOs that promote team-based care under risk–bearing contracting. ACOs are organizations that will bring together and integrate doctors, clinics, hospitals and ancillary providers to share resources, with the duo expectations of improving the quality of care, while at the same time decreasing the cost of that care.
2. **Mobile Medicine**–Hospitals have historically been at the epicenter of the medical mission. We have evolved, however, from "Bricks and Mortar" to "Bricks and Clicks," and now to "Bricks and Wheels." Mobile Medicine is the logical outgrowth of the current health care delivery system. It features lower cost, better patient safety, no transportation hassles, improved security for the frail elderly, an on-premise review of the patient's living environment and lower malpractice expense. Examples include in-home physician visits, portable x-ray, rehabilitation services, laboratory processing, oxygen supply, etc.
3. **Consolidation and Its Impact on Competition**–Christine Varney, the assistant attorney general in charge of the Department of Justice's Anti-Trust Division has stated that "Unfettered competition among hospitals is vital to insuring that patients receive high-quality, low-cost health care." With integration acceleration, how do we insure competitive pricing and open bidding in an already oligopoly marketplace? As Milton Friedman once stated: "The greatest enemies of the free market system are university professors and corporate CEOs." Is it prudent public policy, for example, to have large health care systems owning or partnering in ownership of health plans, which contract with their respective facilities to provide health care services?
4. **Non-Compensated Care**–KSTP-TV reported that the national average for charitable care is about 6 percent for non-profit hospitals vs. 2 percent for Minnesota's Hospitals. Minnesota has 98 non-profit hospitals. What would be the financial impact of them providing non-compensated care at 6 percent or paying property taxes in lieu of non-compensated care?
5. **Benefits Managers**–How could Employer/Employee Benefits Managers across the State, acting as a collective body, reduce health and dependent care costs? Could they develop a generic tool kit, whose utilization could improve the health status of all Minnesotans, while reducing the cost of the delivery of this vital resource?
6. **Price Transparency**–How do we achieve true price comparisons through the posting of not billed charges, but actual payments from third party payers? How do we distinguish between the advertised price and the actual paid price? What is charged is not generally what is paid, unless one is a non-participating facility or provider. The federal government does a better job legislating prices than does the private sector. According to David Blitzer, Medicare per capita growth costs in 2010 were 3.27 percent vs. 7.5 percent for commercial plans—how is this possible?
7. **The Role of Vendors**–Suppliers can be and want to become partners, not just contributors of goods and services. They can contribute through GPO's, analytics and strategic sourcing. Vendors and health care providers have the same goals: satisfied customers in an expanding marketplace. Both sides are better together.

I am offering a medical reformation starter kit and thoughts on health care for the new millennium in an effort to build upon those of Mr. Paulus; because I know that health care reform is a journey, not a destination. I also know that what Winston Churchill once stated is true: "You shape your houses and then they shape you." ✦

By Peter R. Bartling
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