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Doctors for America Physician Survey
June 17-18, 2009

In preparation for the White House Health Care Stakeholder Discussion with Physicians on June 18, 2009, Doctors for America conducted a survey of physicians across the country. In the 24-hours leading up to the forum, we received these comments from physicians across America on the topic of discussion: **How can we use prevention and wellness initiatives to cut health care costs and improve individuals' health?**

Name	Location	Comments
Carolyn V Brown, MD MPH	Douglas, AK	Health Care Reform 1. Universal Health Care must be well defined, portable and available to every American. 2. The "package" of health care must be clearly defined and must include preventive, acute clinical (episodic), mental health, wellness, vision, dental, hospital, rehabilitative, and end of life respite care. Each of these must have clear definitions, be open to all, and have no pre-existing or "cherry picking" components. 3. A single payer system is the most cost effective plan for payment. If income taxes must be raised to bring this to pass – so be it. 4. Insurance companies as we know them now must morph into something else. For those who want more and different health care than is in the established package of care, private insurance companies can provide that. It is reprehensible that insurance companies maintain the current overhead and exorbitant pay out salaries to their corporate officers. This is particular so if taxes are raised to care for other portions of insurance. 5. Establishment of pharmaceutical formularies must be put in place – based on the best evidence of effectiveness. If people want different medicine, they can purchase it or have "boutique" insurance that will pay for this. 6. Health care providers' compensation and salaries must be adjusted so that primary care and preventive medicine is more adequately compensated. High technology medicine will have to decrease the incredible amount of money that comes and goes to those in high-tech fields. 7. Tort reform must become consistent across the country. Oversight for health care practitioners must become consistent across the country. 8. There must be oversight for the "widgets, gadgets, and gadgets" that the medical industrial complex throws at Americans. 9. Hospitals must be brought to accountability for medical errors, lack of quality care, refusal for care of patients, "dumping", inefficiency and waste. 10. Training and education for health care providers must be increased with high incentives and encouragement for these people to participate in primary and preventive health care rather than the "high ticket" surgical and technology specialties. That's for starters... carolyn V Brown MD MPH June 2009
Ernie Meloche, MD	Ketchikan, AK	I propose three simple ideas to solve the health care crisis: 1. use the buying power of all governments within the USA to insist that there be a single premium for a single coverage for all, the same coverage offered President Obama and his family, with NO denial for pre-existing illness and NO change in rate for anyone with pre-existing illness. 2. Establish a permanent fund with an UNTOUCHABLE principal as a capital foundation, derived from those things which increase our health care costs (tobacco sales, alcohol sales, gun sales, car sales) and those who profit from health care (insurance, drug sales, equipment sales) and those whose

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		criminal activity increases health care costs (drug arrests, fines, drunk drivers, etctera) - they would establish a principal that would ALWAYS grow, giving the USA a capital fund to invest and make interest on. That interest would then be used to purchase the Obama Policy for all citizens unable to purchase their own policy, thus moving ever closer to a fully insured nation. 3. Increase the workforce available to deliver health care and increase the available sites for health care delivery, while increasing the quality and efficiency of health care in currently owned governmental health care facilities like the VA, Military Health care, prisons and the Indian Health care service by establishing a UNIFICATION of these services, no longer denying care between them, and recruiting citizens to become doctors, nurses, pharmacists, and any health care related job by joining this Unified Medical Service Corp. Make it the best, like the Marines, teach and deliver the best health care in the world. Thus a citizen could go from unemployed to a health care professional though service to their country and we could use this force to truly \\\"wage peace\\\" throughout the world. Three ideas of mine which, implemented together deliver the highest quality care in the world, increase the work force to deliver that care, decrease the number of unininsured to zero eventually, and eliminates the abomination of denial of health care coverage because of illness. They are worth consideration and I\\\'ve been trying to get these ideas to Obama since last year. I would appreciate your help in getting him to hear them. Note that, once established, once EVERYONE is insured, the permanent fund would be a resource to decrease the cost of the premium we all pay. Also, those serving the country would AUTOMATICALLY be covered through the Obama Coverage because the government is obligated to provide health care coverage to those who serve. Thus, in a single action health care is equalized nationwide and with the permanent fund we build national capital to stabilize the economy derived mostly from the source of illness within our nation. Thanks for trying. If you need further details of my three ideas I can forward them to you anytime. Ernie Meloche, MD, FACEP ernieme2@att.net ernie.meloche@gmail.com 907-247-6058
George Brown, M D	Douglas, AK	Hold Town Meetings with parents, patients, health care providers, adolescents, college students, town officials and legislators to discuss the following: 1 - What is the difference between health care and access to health care? 2 - What are the major health care needs in your town? 3 - What can families and patients do to meet these needs, both in life style changes and better teamwork with their health care providers? 4 - What are the major obstacles to equality in access to health care?
Thomas Ellison, MD, PhD	Birmingham, AL	We utilize programs that are intergenerational, that begin with 5th graders as youth community advocates and youth Medical Reserve Corps Members, these combine screenings with follow-up and education for the entire family. We also use Mobile Medical Units, HOSA, and Senior Sites for Treatment, Trainings and Fitness Demonstration and guidance. Churches and Neighborhood Sites host Free Community Clinics, with refer to traditional clinics, hospitals, and Physicians Offices. We screen in excess of 850 people week, and are able to identify issues at an early stage.

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Hosea McAdoo, M.D.	Sherwood, AR	I entered the practice of medicine before Medicare, have practiced under Medicare, under private pay, under health insurers and have cared for those with none of the above. Of the above groups Medicare is the easiest with which to deal. They pay promptly, have more stable rules and once you learn their system takes less time with hassles. They pay nearly as well as private insurers who often base their payments on Medicare. The office cost is less and payment delay is shorter. There is less wasted time. I have also been a cancer patient under Medicare. I was seen promptly, got all the needed tests, drugs and treatment. The only paperwork has been showing my cards and receiving a statement. Except for drugs, another separate problem, I have spent no money for my care. My physicians do not seem to resent Medicare. If one is an oncologist or general internist you surely know that most of your patients will be Medicare and I don't see many starving oncologists. I am completely satisfied with Medicare. I hear all the fuss over electronic records. I agree there would be much help and some duplication of care reduced but this is not where medicine is in trouble. Also while I have no love for malpractice attorneys, this also is not the problem. They make the practice of medicine difficult and waste time but solving this problem is estimated to reduce costs only around one percent The real problem is that most of those who make our decisions have access to good care, are wealthy and have little concern for those without insurance. They either don't care that there is much suffering or they feel that the poor should just work as hard as our leaders. The same leaders born on third base and think they just hit a triple. Civilization means caring for one another, the Republican philosophy of ' "get mine, the hell with you" is un-American, un-Christian and unacceptable. These people are the first to cry foul if they feel slighted in any way but have no empathy at all. The AMA has been in the news lately as being synonymous with physicians. This is untrue. Only half of the delegates at the speech are in active practice and more than half of all physicians do not belong and many of those who do, belong for the educational and insurance benefits. More than half of physicians support Single Payer; most nurses support single payer and most Americans support Single Payer. Single Payer could give access to all and with a single paying pool versus the present 1300 companies markedly reduce costs as well as saving 30% of the overhead waste and saving physician and hospital billing costs. As a physician having a patient in need is difficult. Even if you give your care free, where is the patient going to get imaging, lab, medicine, hospital or other specialist care? Emergency care may be available but it surely would cost less and reduce suffering if prevented by outpatient care. I spent much time in Canada and it truly galls me to hear the lies about Canadian Single Payer. Is not perfect but surely beats the USA hands down. We have the potential for excellent care but with the cost and rationed access we place far down on the WHO listing, lower that 30 and just above Cuba. This should be something Congress is ashamed of but I guess money can make shame melt away along with responsibility, morality and a caring brotherly love. From what I see from my perspective I am becoming ashamed to be an American, one of the most despised countries in the world. My disappointment includes Congress and the White House.
Jim Dudley, O.D.	Eureka Springs, AR	1. Some kind of capitation for patient care. 2. some kind of limits on medical malpractice. 3. single payer option like Medicare

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Janet Shalwitz, MD	Phoenix, AZ	As a physician and patient with a chronic condition I can't think of too many things that are more important than a system that prioritizes well funded primary care as the center piece of health care. And, the primary care needs to be organized so that patients have easy access to primary care teams (medical provider, behavioral health, case management/patient advocacy assistance, nutrition and PT services)that have dedicated time for quality care and proper follow-up as well as good access to and coordination with specialty care. Right now, too many people have to rely on themselves to make make critical decisions about their health AND they really don't have a clue about the steps to take to address their health concerns. As a result, care is uncoordinated, duplicative, not to mention dangerous!
Susan Wilder, MD	Scottsdale, AZ	Prevention and wellness are critical and span education, workplace, community service, and medical arenas. The PROVEN most cost-effective delivery system is for EVERY patient to have a stable CONTINUOUS relationship with a primary care PHYSICIAN in a PATIENT-CENTERED MEDICAL HOME. (NPs are capable of working within a medical home and performing many key tasks but their skill levels - equivalent to a first year medical resident in training - are insufficient to handle the increased case complexity/pharmaceutical complexity/psychosocial complexity we see in the average population). Managed care erodes continuity by tying providers to plans and results in patients hopping from provider to provider based as their plans change. Continuity for patients and their families SAVES money and improves outcomes. Lack of integrated electronic medical records and a standard format personal health record that can virtually blend into any EHR (we have a tower of Babel out here) further destroys comprehensive preventive care delivery. Fragmentation of services by limited work-place screening and wellness services creates problems both by insufficient and unnecessary testing. Many patients think that because their workplace lab screen and ultrasound was fine, they need no other care resulting in big gaping holes in preventive coverage and comprehensive care. We further see tremendous costs generated by tail-chasing for follow-up on clinically irrelevant incidentalomas generated by well-intended but inappropriate medical screening. My suggestions: 1) Deregulate primary care by making primary care services a defined benefit and letting providers balance bill. We will go from "Bell telephone" to a more robust free market by incenting innovation, service, technology and competition which the current "one size fits all" payment scheme. Fixed payments limit market flexibility and result economically to erode supply and quality. Truly patient-centered care requires that the PATIENT be the PAYER and the ARBITER OF QUALITY - not Medicare or other payers. Build a floor but PLEASE don't impose a ceiling. 2) Encourage every citizen to establish a care in a primary care medical home. Assure that workplace, school, and community wellness programs work in concert with, not against or around, medical homes. 3) Focus IT funding on improved patient centered records that overlay and interface virtually with any EHR or on data hubs at least for lab and radiology results. Incenting more providers to jump into the costly tower of Babel is NOT cost-effective nor will it be fruitful.

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Matthew Haden, MD, MPH	Phoenix, AZ	Consider model programs of mid-level providers or RNs running health maintenance/prev med programs & chronic disease mgmt. These are algorithm-driven or checklist patient encounters that do not require the expertise or expense of a physician. This would free up primary care physicians to spend adequate time with patients who need it, and reduce referrals and hospitalizations. It would reduce simultaneous under- & overuse of medical services, re-align pt needs with appropriate providers, improve access, and improve physician satisfaction. I am confident there would be better clinical outcomes as well. It would also help to change laws to make it easier for doctors to practice medicine across states. With new technology, it is entirely possible to evaluate and treat many medical problems without examining patients, or at least initiate their evaluation and help guide their entry into the medical system. We could increase access to care in rural and underserved areas this way by paying doctors for telemedicine appointments via webcam, telephone, email, instant messaging etc. Laws are currently too restrictive for the modern practice of medicine.
Hella Nordberg, MD	Tucson, AZ	The obesity epidemic is a huge problem for health care costs. Major prevention efforts should be focusing on nutrition education and regulation. Also, having insurance incentives for getting preventative care done (lower premiums for example for people up to date with recommended screenings and normal weights). I totally think we should have a "junk food tax" (just like we have an alcohol and tobacco tax) to help pay for health care coverage. 10 cents on every hamburger, fries, and soda would bring in a lot of money to pay for preventative/primary care for everyone. Support training and retaining PCPs.
Maureen Oskandy, M.D.	Tucson, AZ	It's too early in the a.m. to put my thoughts into grammatically correct sentences! Here are the points: 1. Offer incentives to medical students who go into primary care residencies. Something similar to NHSC scholarships for those who go to underserved areas (I was one of those recipients and served in IHS). Financial incentives are very powerful with docs just out of training. 2. We need to find a way to get patients to utilize primary care docs appropriately. Those patients (and there are a lot of them) who use the ER for non-emergent care or who self-refer to specialists for problems that their family physician could handle are draining the system and are NOT getting prevention-oriented care. 3. We need to ensure that those who are providing primary care really are qualified to do so. Family practice already has a recertification process in place, and this has a strong focus on prevention/wellness. I see GYN FP's, for example, ordering glucose tolerance tests to screen for diabetes! Perhaps there should be a standardized testing process for all of those who say they provide primary care to make sure they really know the basics. Patients would have to go to a "certified primary care provider" for most of their care (enforced by their insurance companies--similar to gatekeeper concept). 4. Financial incentives and disincentives for healthy vs. unhealthy behaviors on part of patients. E.g. much lower insurance premiums for those who do not smoke and are normal BMI, maybe some type of bonus to patients who can demonstrate they have lost weight, stopped smoking, etc. 5. Focus more time in medical school training students in prevention and wellness care. Medical education seems to be stuck in a rut--it's time to revise those curricula!

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Laurie Menk Otto, ND	Tucson, AZ	Please include naturopathic physicians in your discussions about health care reform efforts. Naturopaths are licensed, medically trained physicians that specialize in facilitating the body's natural healing mechanisms, and preventing disease. Though we prescribe pharmaceuticals, we are not reliant on them. We are trained in many other modalities to help patients improve their state of health, restore functional balance, and treat disease. Inclusion of naturopathic physicians will increase health care choice for consumers, and help to reduce the overwhelming cost of health care.
Marilyn Heins, AQB, MD	Tucson, AZ	UNIVERSAL, UNIVERSAL, UNIVERSAL PUBLIC OPTION, PUBLIC OPTION, PUBLIC OPTION
Jennifer Linder, M.D.	Paradise Valley, AZ	Tort reform, malpractice and liability must be addressed. I have practiced in 5 states. As a result in differences in the probability of being sued in California versus Arizona, Missouri and Pennsylvania I have had huge differences in the cost of malpractice insurance. I have personal friends in OB/GYN and Neurosurgery that have left states or left private medicine due to the high cost of malpractice and the cost of the tail when left a practice. In addition the high cost of medical care is too frequently a direct result of increased testing that is done to protect physicians from a medical liability standpoint. We must have tort reform to decrease the cost of health care. Additionally Americans must become more comfortable with end of life care. More hospices should be used to increase quality of life at the end of life. Not only due patients and family members have a better understanding and less fear of end of life but there also resulting decrease in the overuse of ICUs and ERs at the end of life. I believe I read that as much as 80% of health care dollars are spent in the last 3 months of life. Many European countries have better perceptive on this. Obesity must not be defined as a disability or physicians may become less comfortable talking about the importance of weight loss. We need healthy food and more education regarding diet in the schools.
Linda Lundergan, MD, MPH	Tucson, AZ	1. Offer patients incentives (in healthcare costs) for wellness behaviors (smoking cessation, weight loss, etc.) 2. Increase emphasis on the Primary care model such as is used in most other high performing countries - most studies have shown that patients get better preventive screening if they have a regular PCP. PCP's could be incentivized as is currently being done by Pay for Performance plans. The Medical Home model may be a good concept. 3. Employer centered wellness programs have been productive - both for producing improved parameters (better HgbA1C control, weight loss, smoking cessation, etc.) and lower costs. 4. Establish a minimum benefit "set" and require that all are covered by it. If there is a basic set of insurance benefits that all citizens are required to have, then insurance companies will be more aggressive with prevention that might not pay off for several years. As it is now, the ins. company knows that it will probably be insuring a certain person only a short length of time so that they won't reap the benefits of a preventive measure (such as HPV vaccine, or statins before heart disease has developed) so they do not emphasize these measures. If all insurance companies will benefit from prevention, the insurance company will be much more likely to encourage these interventions. Thank you for the opportunity to give input.
Syed Azam, MD	Vail, AZ	

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Alice Chen, MD	Los Angeles, CA	Prevention and wellness initiatives must involve shared responsibility between physicians and patients. This means the concrete, short-term incentives (i.e., the reward that is more tangible than better long-term health) must be aligned to encourage that.
Casey KirkHart, DO	Culver City, CA	Atul Gawande's article in the New Yorker brings light the dark secret of medicine - with rare exception, ask 10 doctors how to do something and you get 20 answers. Medicine is not a perfect science, and medical investigation has a price. Costs grow further when doctors put profit before patient. An effective, low-cost wellness program must have at least these 3 components: 1. Universal access - EVERYONE should have access to at least a primary care provider 2. Team-oriented care - physicians are not the end-all, be-all of medical care. It should integrate health educators, nutrition experts and specialists. 3. Be outcomes-oriented. Reimbursement should reflect that doctors' actions contribute toward better health outcomes. HIT would enable better measures of best practices. Finally, the AMA is NOT the voice of physicians. IN fact, the AMA represents so few physicians BECAUSE it has rejected physicians' views that all Americans deserve quality health care. Historically, the AMA has opposed all attempts to do that.
Piper Calasanti-Ayuste, M.D.	Los Angeles, CA	As you know, recent studies were released which possibly suggested that preventative medicine practices may not be as cost effective as once thought. However, as a pediatrician, I feel that such studies are skewed as they do not focus on the role of prevention in younger patients (children, teens, etc.). More money should be allocated toward primary prevention in this population, as I feel this is where the benefits are more likely to be realized. In addition, physicians should be better reimbursed for devoting themselves to the rather consuming albeit noble, art of prevention and anticipatory guidance.
Peggy Weintrub, MD	San Francisco, CA	I'm behind this reform but I have one major concern as a hospital based university physician. there has been a lot about reducing reimbursement to hospitals in the press being part of the plan. in California, we have many unfunded mandates (some by the state legislature) that are very costly and are already constantly making cuts in beneficial programs. I am very concerned about cuts to reimbursement for inpatients as in this very sick tertiary care population, the expenses are enormous.
JUDITH WOFSY, MD	Albany, CA	financial support for approaches other than individual face to face visits with doctor for management of chronic diseases with the goal of improving outcomes and avoiding complications.
David Rosenthal, MD	Sausalito, CA	We need to financially incentivize health and wellness - this is the true motivator in many people's lives - the nudge to health. Taxes on unhealthy food and beverage items are one way (Lifestyle taxes). Use these collected taxes to provide subsidies for gym memberships, fresh fruit and vegetables, and actual rebates for gym usage. Using Safeway as the model, any proposals that use financial incentives are bound to be more significant in behavioral change that is sustained.

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Name	Location	Comments
John Lipson, MD	Martinez, CA	If young physicians can pay off our heavy debt burdens in a reasonable time, make a decent living, and focuses on patients, remaining a primary care physician will be extremely rewarding and be a life-long service big numbers of people will provide to this country. Pay physicians for their time, not their procedures: spending 15 minutes on a skin biopsy (for example) should be compensated the same as 15 minutes of office counseling a depressed patient. Reimburse cost of equipment and supplies, but TIME--not procedures--should be how doctors are paid. Then, preventive health rise and overall costs fall, and primary care will be much more attractive and keep doctors practicing. STREAMLINE record keeping, whether electronic or paper, as it is ridiculously burdensome and redundant to the point of absurdity. One final thought: ensure that reasonable referrals would be made available should it be necessary (even if expensive), in the proper course of a workup, to persuade those who fear "government bureaucrats" (but not insurance bureaucrats, for some reason).
Scott Nass, MPA	Los Angeles, CA	Single payer now! We can settle for nothing less. Single payer will ensure a focus on prevention and wellness initiatives AND dramatically cut health care costs. No other alternative promises to be as simple and complete a fix for our broken system. Physicians and patients want and deserve single-payer healthcare; why are we not advocating for what we know to be in everyone's best interest (except for drug companies, HMOs, and private insurers)? Why are we cowing to pressure to settle for a public option when our ethical code REQUIRES us to fight for what is right? Real reform can be accomplished only through comprehensive single-payer healthcare.
Hal Grotke, MD	Samoa, CA	
Varsha Puri, DO	Los Angeles, CA	My name is Varsha Puri, I am a Pediatrician practicing in Community Clinics in California. Prevention and wellness initiatives most definitely need to be the focus of reform, a shift from our current treatment based incentives. Medicare/Medi-cal has many inefficiencies. 1. Certain plans may refer themselves directly to a specialist. Every patient should have a primary care provider referral prior to seeing a specialist. 2. Patients are allowed to jump providers. While many patients see no providers, others are going to multiple different sites, getting conflicting advice with minimal follow-through. Every patient should be assigned a primary physician. 3. The quality of health in the low-income groups needs to be mandatorily increased. Low reimbursement provides breeding ground for low quality, high-volume practices. I have seen PAs treating patients the same as doctors and doctors seeing upwards 50-60 patients (pediatric)/ day. Care, especially, preventative care is compromised. 4. Medical/Medicare sets the trend for insurance companies. While important medicines are often denied, other unnecessarily expensive medicines are mandated. At one point, I could no longer prescribe Albuterol and was only permitted to prescribe Xoponex. Every Medical/Medicare patient is permitted unlimited amounts of Tylenol and Motrin. 6. Financial incentive should be provided for each child getting their annual wellness exam. Perhaps more in our high risk populations, like Adolescents. The reimbursement is low, while their problems & preventative care is much more significant. Often times they are covered for a physical exam only 2 years. Meanwhile, they are one of the most vulnerable and neglected populations (early smoking, early drug use, teenage

Name	Location	Comments
		pregnancy, HIV, depression & school failure). 5. Lastly, absolutely everyone, especially our children, need to be insured, for it is through diagnosing obesity, learning disorders, malnutrition, asthma, etc early that we can treat and increase the health of our children. Not only is it an ethical imperative, it is the strongest investment into decreased costs of treating diabetes, school-failure, repeated asthma exacerbations & hospitalizations, heart disease, obesity, teenage pregnancy, etc in our futures. For these are some of the primary etiologies of the exponentially increasing medical burden along with decreased productivity in general that our society is bearing. Thank you for allowing me to provide my feedback.
Alice Chen, MD	Los Angeles, CA	An ounce of prevention, a pound of cure. You pay for what you get.
Mika Godzich,	Martinez, CA	As a recent graduate from medical school who has chosen to work in primary care I would like to communicate to you how often we put figurative expensive band aids on gaping, festering wounds that were started years before, when no insurance company would cover the needed preventive care that would have stopped those wounds from developing into the disabling, painful, expensive wounds that we end up seeing. Also, we need to teach doctors in training to look for opportunities to educate and empower our patients so that preventive measures can be used by patients to stave off disease. Today's physicians are trained to study pathology and act on advanced disease - that's what is described as "sexy" to medical students. Preventive medicine is perceived as boring and unfulfilling and truthfully it is unrewarding from a financial standpoint - we need to stop reimbursing physicians only for procedures performed - there is no financial incentive to provide preventive care. Because there is no research money in it either, few academic physicians study preventive medicine and it is perceived by physicians in training as not as intellectually stimulating as cutting edge specialty care. This perception in turn influences medical students' choice of career and plays a large role in the dearth of primary care physicians available to care for patients. We need to encourage research in primary care, promote preventive medicine as a career choice, increase reimbursements to primary care physicians, and the ensuing increase in number of available primary care physicians will have a huge impact on decreasing the price of health care and improving the overall wellness of the population.
Sheldon Salins, dmd	San Francisco, CA	Just simply education the public, most importantly the children about the importance of oral health can have a drastic effect on the number of carious lesions in the mouth. If the number of caries incidence is markedly reduced, this will have profound effects on the number of insurance claims and out-of-pocket expenses for dental restorations. I do not think the American Dental Association places enough emphasis on education on the correct techniques of oral hygiene outside the dental office.
Jonas Green, MD. MPH	Santa Monica, CA	Save tens or hundreds of millions of dollars and improve health with the following: Millions of Americans have lost access to necessary but often inexpensive medications during the past year due to job loss and therefore loss of health insurance. They often therefore end up having preventable hospitalizations. The administration should champion two measures on this front: 1) No fault extension of prescription refills for select medications for chronic conditions including: hypertension, asthma, COPD, diabetes, and

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		congestive heart failure. 2)Universal pharmaceutical insurance coverage for all inexpensive generic medications (i.e. the $4 prescriptions now available at Target, Walmart, etc).
Jorge Fernandez, MD	Los Angeles, CA	1. Innovative advertisements and webcasts in multiple languages to promote healthy eating, daily exercise, and nutrition. These should be featured in hospital and emergency department waiting rooms 2. Increase public health research funding. 3. Increase incentives (e.g. tax credits/student loan reimbursements) to primary care physicians who see a certain percentage of Medicaid or unreimbursed patients. 4. Increase public school programs that promote exercise and healthy living. 5. Increase funding and promotion of palliative care programs to the lay population (including foreign-born nationals), to prevent wasteful and unethical end of life care. 6. Provide incentives or mandates that promote collaborative, cost saving, health care models like Kaiser or the Mayo Clinic. 7. End the corporate practice of medicine and the culture of for profit HMOs/PPOs. Profits made from health care should be recycled into the system, to use on preventative and wellness research and spending. 8. Increase wellness and prevention training in US medical and osteopathic schools.
Elaine Chu, MD	La Canada Flintridge, CA	1. have to make primary care stronger so we can keep pt healthy, we can advocate for our pts in this complex system, so people can have a home base to their care 2. primary care doctors can act as the pre authorizing for all referral and procedures (? gate keeper) since we know our pt better than any admin in an insurance company, since we do not have financial interest in whether the procedure happens or not. We know our pts and act on their best interest. This would reduce unnecessary procedure, reduce cost and cut paper work of trying to get pre auth from an insurance co that has no idea about medical judgment , no idea about the pt 3. Unbelievable that insurance co can hire people in 3rd world countries to hassle us well educated, hard working doctors about the money they owe us. What a waste of resources for doctors and a win fall for insurance companies 4. there should be a time limit that the doctor must be paid by...submitted, the insurance co need to pay up in 2 weeks. if there is a delay on ins co, dr should be paid current interest rate for that delay. pt have paid high premiums w the expectation that when they see their dr, the insurance co will pay the dr. Not delay payment so the insurance co. essentially gets a "loan" from us struggling primary care dr, who would make more being a UPS driver (and they get benefits which we in solo practice do not). 5. dr should be allowed to organize or unionize so we can fairly negotiate with ins co 6. reimbursement needs to be transparent 7. limits on malpractice 8. pay primary care dr more and specialist less if you value prevention over procedures. 9. pay us fairly - tie medical raises to inflation 10. ins have shot themselves in the foot. it is time for them to go

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Gary Seto, MD	South Pasadena, CA	1. I support the public insurance option 2. Need to increase payment for primary care physicians so that we don't need to churn patients in order to make ends meet. 3. Stop basing payment only by visits, pay for coordinating care per patient whether it is by phone, Internet, etc. 4. If doctors aren't forced to see so many patients, then they can spend more time together. More time together helps foster the doctor-patient relationship, which improves compliance, trust and reduces unnecessary testing and treatment. This lowers cost and improves health. 5. If primary care doctors can be relieved of hamster wheel type medicine and have their income more in line with other physician specialists, they will be more satisfied, and medical students will be more attracted to becoming primary care doctors. The more primary care doctors there are, the more prevention and health care savings there will be. 6. Need to decrease administrative costs/burden for primary care physicians. Thank you.
Jennifer Stella,	San Francisco, CA	Prevention and spending on public health improves country health. Group effect, similar to vaccinations, means better health for everyone when everyone is protected. Prevention isn't just cancer; it means extending health care to all so that everyone can access primary care for wellness checks from birth on up. Chronic disease burden in this country, including hypertension, hyperlipidemia, and diabetes, is disproportionately experienced by those of lower socioeconomic status. Health care and access to excellent, highest standard medical treatment and prevention services is a human right, not a privilege.
S. balasubramaniam, M.D	Anaheim, CA	Minutes of Doctors for America Community meeting On Sunday June 7th 2007 At Anaheim Hills, CA The meeting was called to Order by Dr. S. Balasubramaniam M.D. Eighteen were present and each one went on to introduce themselves. They were of different specialties, all Board certified and consisted of Cardiologists, Pediatricians , Internists (some in general practice), Surgeons, Obstetrician & Gynecologists, Medical Oncologists, & Rheumatologist. One was employed at Kaiser and one was an academician in the public sector. All the others are in private practice. The average number of years in practice after residency was 30 years the senior most being 37 years and the junior being 26 years. In the group were the Past Presidents of Orange County Medical Association and the Riverside Medical Association Dr. Balasubramaniam presented the Mission and FAQ of the Doctors for America Dr. Balasubramaniam presented the current status of health care in the country and the problems (Power Point) namely:- • Characteristics of the Uninsured since 1987 and 45 million in 2007 by Age, Race,& Income • Household Health Spending as a Percentage of Personal Income in the United States, 1987-2003 • Current Level of Consumer Financial Risk • Health Care Spending as a Percentage of Income by Income Level, 2006 • International Comparisons of Chronically Ill Patients' Experiences with Care • National Health Expenditures—Actual and Projected, 1965—2017 • Breakdown of Health Care Spending, 2006 by Personal, Federal, State and Private Insurance funds • Details of Public Sources of Health Care Spending, 2006 • Personal Health Care Expenditures, by Type of Expenditure, 2006 • Use of Selected Health Care Procedures by Patients Age 50 and Older, 1970-2004 • The Five Big Health-Care Dilemmas Time Magazine An interactive discussion then followed on the three current health reform proposals:- 1. Baucus Plan – " Health Reform 2009" 2. Kennedy Plan – "American Health Choices Act" 3. President Obama's – "Health Budget Proposal." Recommendations of the group are:- 1. Control Health

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		Insurance Premiums costs by requiring that the companies spend at a minimum 85 % of their income on health care related costs (Physicians, hospitals etc). Currently the health insurance companies on an average make a 30% profit. This must be curtailed to not more than 15%. This follows the recommendation of California Medical Association. 2. Levy a small co-pay to all Medi-Cal (Medicaid) patients to reduce overutilization of E.D , doctors office visits, extended care etc. 3. Follow strictly, enrollment criteria laid down by Medi-Cal (Medicaid) like income verification etc.. 4. Convert Medical Insurance Companies into Mutual Insurance companies wherein all share holders are premium paying individuals 5. Reduce Lab tests, radiology (non emergency) and drug costs by levying a small co pay from Medicare and Medi-Cal (Medicaid) recipients or adopt Kaiser plan of co-pay for each visit. 6. Improve Tort reform by creating a special panel of Judges familiar with malpractice cases. These judges should be only ones to adjudicate these cases. 7. Create a Council of Medical Experts (MD's) to screen all malpractice lawsuits and determine the existence of medical malpractice, prior to any legal procedures 8. Prohibit attorney compensation as a percentage of medical malpractice award.(English Model) 9. Strict review of End of Life Medicare costs. 10. Separate Physicians fees from other items in Medicare Part B (like drug and lab costs) spending. 11. Curtail unnecessary expenses in the "Beginning of Life' situations like excessive charges by non MD's in care of disabled children , "Octomum" etc. 12. Reimburse and encourage specialist to assume the role of primary care physicians in chronic conditions such as renal failure on dialysis. 13. Require that all Medi-Cal (Medicaid) and Medicare recipients to participate in preventive community education programs when diagnosed with any one of the following:- Obesity, smoking, hypertension diabetes, failing which their benefits will be lost. 14. Reimbursement for procedures to be risk based as determined by mortality and morbidity of the specific procedure. 15. Establish a tax credit for physicians who render treatment for patients without insurance. 16. Eliminate reimbursements to Non M. D's rendering direct patient care. 17. Reduce drug costs by allowing drugs to be imported from manufactures from other countries who are willing to follow strict production criteria. Issues raised by Doctors for America 1. Change RBRVS to compensate primary care more The group unanimously agreed to accept the proposal if the Primary care physician spent adequate time in diagnosing and treatment and did not act as 'triage officer" and refer the patients to the specialists. 2. Single payment for all services related to a treatment or condition The group unanimously voted AGAINST this proposal, citing a number of logistic issues, creating unnecessary "middleman" into the equation with no real cost savings. On the other hand this proposal will increase reimbursement to entities like the hospitals. 3. Align payments with value not volume (Pay for performance, P4P This will call for developing performance measure similar to what the insurance companies have done. It will delay reimbursement and end once again decrease physician reimbursement. 4. Adopt the medical home model to promote coordinated care. The group supported this measure. 5. Fix the Sustainable Growth Rate (SGR) formula The group felt that the first step should be to create physician payment as a separate line item from the total Medicare part B expenses. This step would reveal that Medicare reimbursement to physician has been far less than the cost increase in part A and Non physician

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		expenses in part B. No decision should be taken until the true facts are revealed. Prepared by Dr. S. Balasubramaniam M.D Chief Physician Dept. of Health Services L.A. County LAC + USC Healthcare Network 213 744 3515 (office) 714 713 4770 (cell) ..
Seymour Grossman, M. D.	Berkeley, CA	I would like to build on the president's eagerness to support systems like Geisenger, Mayo, and Kaiser Permanente, which have highly developed ways of implementing prevention and wellness. The common thread in these systems is SALARIED DOCTORS. As long as fee-for-service incentives run our medical care, we will continue to over-test and do unnecessary procedures at the expense of concentrating on preventive programs
Laura Nicholson, MD/PhD	San Diego, CA	Probably said many times, but good disease prevention keeps pts from entering the health care system only when disease is intolerable or end-stage (when it has become much more expensive to control). I also believe we will have to have honest discussions about expensive, extraordinary care for elderly patients with significant co morbidities or even terminal diagnoses. As a hospitalist in Southern CA, I\'m consistently asked and expected to provide expensive, advanced care to patients who are fairly clearly terminal within a year (due to advanced heart failure, cancer, etc.). It\'s becoming a joke, the tens of thousands we spend right before people pass away; and we know we are doing it. We are afraid to say no, because the patient is regarded as a CONSUMER of heath care, ordering up futile treatments as if ordering in a restaurant rather than a hospital.
Marie Johantgen, MD	Santa Rosa, CA	By providing basic health coverage for all we can educate, prevent and intervene earlier in the disease process and decrease costs and morbidity/mortality.
Michael Treece, MD	San Francisco, CA	The first thing we need to do is to break the stranglehold of insurance companies on health care in the US. They are a destructive, rapacious bunch, and they have caused a great deal of suffering. We need single payer now!
Crystal Terry, MD	Berkeley, CA	Incentivize preventative and wellness care, just as you would any behavior that you are trying to promote. Make it inexpensive or "free", wrap it in a package with other services that are in demand (dental, pregnancy test, etc) and reward patients who practice wellness and get good benefits from it (lower premiums later on with a track record of wellness practices)
David Cantor, MD	Los Angeles, CA	health is not a commodity or an article of trade. Shoes are a commodity. The more shoes we sell the more money we make. there lay the flaw of placing health at the level of a product. Health Insurers make money by the opposite model the less service they provide the more money they make
Li-hsia Wang, MD	Berkeley, CA	Support primary care and a medical home--management of chronic conditions and disease prevention is best done by primary care providers--it\'s been shown that outcomes are better than with specialists. Single payer insurance will give the best opportunity for strengthening primary care.

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Richard Loftus, M.D.	San Francisco, CA	PAY PRIMARY CARE! PAY PRIMARY CARE! PAY PRIMARY CARE! I'm so tired of all the lip service: "Tsk tsk, the ongoing crisis in primary care, such a shame." And then all this ^&%*& BS about "the medical home." ANOTHER buzzword? I just got over the stupid "gatekeeper" buzzword from 15 years ago. NO MORE BUZZWORDS! Primary care practitioners can produce BETTER CARE FOR LESS MONEY but we need non-starvation wages to do it! I'm a young doc in my own practice 2 years and I've watched 18 (!) fellow primary care providers go out of practice in my community that time, most due to BANKRUPTCY! Meanwhile, thanks to modernizing a Boomer-led paper practice into a high IT practice with e-scripts, e-mailing, "virtual visits" and chronic disease management with a proud low rate of hospitalizations, my total debt since graduating med school has TRIPLED and I have not been able to PAY MYSELF SINCE FEBRUARY! And my story among young primary care internists and family physicians is NOT unique. Many of us are working 85 hour weeks to pay our staff, but not ourselves. MORE PAY FOR PRIMARY CARE! If you cut us, even a little, we'll all go out of business. I, for one, will simply declare personal bankruptcy and leave the country. I appreciate the need to cut costs, but you'll accomplish this better by shunting some of that money to primaries instead of more expensive subspecialists and often-needless expensive procedures.
Michael Stein, M.D.	Walnut Creek, CA	Americans must be allowed equal access to health care. You cannot talk about prevention and wellness initiatives if someone can't afford to have their blood pressure or cholesterol checked; if the cost of a Pap smear or an EKG is prohibitive; if dietary and nutrition counseling is unaffordable. Access to health care should be a right, not a privilege. The only way this can happen is to have a publicly funded, tax supported program.
Jennifer Chen, MD, MPH	Los Angeles, CA	In many ways, we know how to prevent many chronic diseases -- healthy diet and regular exercise. But carrying that out on a regular basis is currently very tough; only about 25% of U.S. adults eat 5 servings of fruits and vegetables daily and get adequate exercise. Certainly we need to continue getting the message about diet and exercise out there, but I think the research and initiatives need to focus beyond simple public service announcements to innovative ways to get people to translate that message into action. Improving the built environment to emphasize walking vs. driving, healthy food choices will help. Changing the reimbursement system (capitation) so doctors can creatively structure their appointments, i.e. scheduling all their diabetic patients for the same half day where they get nutrition lectures, cooking demonstrations, exercise instruction and can share personal strategies for healthy living while they are in the waiting room. Another strategy that may not be commonly thought of as prevention but is a form of secondary prevention is looking at reforming the reimbursement system/incentive system so that hospitals get paid for quality, i.e. not paying for repeat hospitalizations from line infections, surgical site infections, and other nosocomial problems.

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Robert Vinetz, MD	Los Angeles, CA	As a pediatrician and director of the Pediatric Asthma Disease Management Program of our 6-clinic safety-net community health center organization in inner-city Los Angeles here are a few of my thoughts and suggestions: 1. Funding prevention: Create a policy with a formula such that X-percent of the dollars spent on treatment of chronic diseases are directed to prevention of that disease (research on primary, clinical or translational community-based prevention...or implementation of proven effective prevention programs). 2. Patient education on prevention: Primary care physicians have inadequate time, personnel, reimbursement and other resources to do point-of-care patient education on prevention for both chronic and acute diseases. In large part this is because of the current insurance structure (mostly HMO/managed care), inadequate payment mechanisms and high volume of patients needed for practice survival. However this is also because of the relative absence of research on and effective models for preventive patient education in the primary care setting. Centers should be created and funded to do clinical and translational research on effective prevention education of patients in the primary care setting…and then funding streams must be created to implement prevention education as a standard part of primary care. One of the novel things we are doing is training and utilizing lay people (community health workers/“promotoras de salud”) in the office to educate children with asthma and their parents on asthma prevention and control. They teach what asthma is, how to recognize its early warning signs, how to correctly use the medicines and asthma devices and, with home visits, how to reduce asthma triggers in the home. We hope to implement group asthma visits and other cutting-edge patient education activities. 3. Finally, I am convinced, after over 35 years of practice including 3 years in public health, that the only way that our nation can pay for prevention and for universal healthcare is through a well-planned “Medicare for Kids/Medicare for All” single-payer insurance system. The fact that Americans deeply distrust, are fearful of and furious with the health insurance companies and big pharma, I strongly believe that such legislation IS POLITICALLY POSSIBLE, if the public is mobilized by grass roots efforts and by political leadership that has the conviction and courage to really fight for the health and interests of the people of our nation and fight against the health insurance and big pharma lobbies that put their own financial well being far ahead of well being of the children and adults of our nation. The politicians who do so, and explain themselves openly and forcefully, can and will win the trust, admiration and votes of their constituents. The “public option” approach being rather tepidly promoted by President Obama offers some advantages over the current system, but it still will leave most Americans and our healthcare system having to pay, unnecessarily, some 30-plus cents of every healthcare dollar for advertising, administrative overhead and profit expenses imposed on us by the for-profit health care industry. What a terrible waste when, for Medicare (even with its imperfections…which can be improved) the advertising cost is virtually nothing, the administrative overhead is less than 3 percent and the profit is zero. Tell the White House that they MUST fight, with every tool at their disposal, for Medicare for Kids/Medicare for All…or, at the very least, Medicare for Kids plus a “public option” for all adults.

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Sharad Kohli, MD	Emeryville, CA	We need to overhaul medical schools to focus more on prevention and wellness. This way we will have our future physicians coming out prepared to keep our society healthy instead of just managing illness. We need to provide more of a curriculum emphasizing nutrition and the importance of lifestyle changes. We then need to allow future physicians to come out and practice what they have learned. Physicians need to have the time to meet a patient, get to know them and learn their story, and then provide them education in a manner that might be effective for them. If the reimbursement system is not changed to emphasize preventive visits, this will not happen. Also, we should really look at nationally recognizing Naturopathic Doctors, who have completed accredited medical schools with exactly the emphasis on prevention and wellness that will help cut costs and significantly improve the health of the country. If allopathic medical schools are resistant to change, why not have two medical education systems, one providing doctors that can be primary care providers and focus on prevention while the other provides doctors that can take care of patients when they become very ill.
Jessica Woan, BA	San Francisco, CA	Mental health services. Please see the Global Burden of Disease Report, and the Lancet six-article series (especially number one) that was published in late 2007. I can't say how essential having psychiatrists re-defined as primary health care are to the well-being of Americans. Suicide is the 8th leading cause of death to American men, the 3rd leading cause of death in 15-24 year olds, and 2nd leading cause of death in young women 15-24. We do not have statistics on attempted suicide, but the lifetime risk for developing depression is 25%. That is one out of every four people you know! Where are the dollars for research and prevention? Millions are spent looking for medications, developing new invasive interventions to address MI and stroke and cancer, but we've forgotten we are healers, not mechanics. And the impact of mood disorders on those with preventable chronic diseases is immeasurable. If someone is dysthymic, it is less likely that person is going to take measures to eat healthy, get exercise, come to the doctor for wellness checks, or take blood pressure medications. There needs to be a reason to be well, and mental health is the under-recognized link in preventive health. Altering our thought habits through talk-based therapies, relying on medications only where appropriate, but creating a culture that teaches children and adults how to manage stress, anxiety, frustration constructively will nurture a society of wellness for minimal cost. I'm especially an advocate of teaching stress management in young children and young adults. These are life skills that are not taught at schools. When life skills are taught and practiced, they are impossible to forget. A pill is easy to forget to take, but when a person has cultivated a mind-set where they want to take care of themselves, they might then just take the pill. Another important place of intervention is training primary care providers on integrating basic psychotherapeutic skills into their every day interactions with patients. A doctor can easily say, "You need to lose weight, eat healthier, and exercise." We've heard that a million times. But doctors aren't trained to MOTIVATE people to do that. Psychotherapeutic skills at the bedside would be invaluable and cost-effective ways to intervene. Outcomes research would need to take place to identify best strategies. Taking care of mental health illnesses will have a large impact on the economy as well. People will be physically healthier, cognitively healthier, better able to cope with stressors. The benefits of investing

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		in the mental health of our children and youth, our parents and grandparents, are immeasurable. How many heart attacks, strokes, homicides, "unintentional injuries," could we prevent if people had the INTERNAL resources to better take care of themselves? How much more dignified would death be after terminal illness, or quality of life improved in chronic illness if we had the INTERNAL resources to do so? Family and friends are essential, but developing self-capacity to deal with life is essential to health. The WHO defines health as a state of Health of complete physical, mental and social well-being and not merely the absence of disease or infirmity. We have skewed this definition in terms of real dollars towards physical health. Let us integrate mental and social well-being with real dollars as well. There is no health without mental health. There is no health without physical health. They go hand in hand. I truly believe mental health and global mental health will be the next AIDS epidemic. (It exists, but is not recognized). And then, let's cultivate a culture of wellness...and not just for those who can afford it.
Wendy Shearn, MD, MPH	Belvedere Tiburon, CA	Kaiser Northern California should be the model for the country. If we could copy what we do, quality would go up and costs would go down. We have it down. Evidence based measures are used to follow quality indicators and patients are the beneficiaries.
Bonnie Balzer, M.D., Ph.D.	Saratoga, CA	I do not think government involvement will improve health. How can you possibly advance this ridiculous agenda when the government has ruined Medicare and Social Security.
John Goldenring, MD,MPH, JD	San Diego, CA	Let me speak as an expert for an underserved population: the Frogotten Agegroup- 18-25. Young brains do not mature fully, particularly as to judgement untilage 25. Yet we set them free withno safety net (outside College Healthcenters) at age 18 based on a legal fictio,not on science) atage 18!(The Founding Fathers knewbetter without or fancy PET scans - the Constitution says no Cngressional serviceuntil age 26!) This agegroup is the least insured, has more accidents; more drug, alcohol and cigarette use; more STDs; more abortions unwanted pregnancies; more violent deaths; is the agegroup where HIVis most acquired; the agegroup where obesity and sedentary lifestyle is cemented. Far worse than teens. BUt we think they are "healthy young adults" - ignore them in research, do not reach out to them with health care access and education. If we want to attack all these big issues previously listed, we must find ways to reach out to the FOrgotten Agegroup. thefailure to do this costs us billions longterm in both healthand social dollars! John Goldnering, MD,MPH, JD, FAAP,FSAM, FCLM Adolescent Medicine specialist, MEdical Director and Counsel at Law. San Diego, CA
Flavio Casoy, MD	San Francisco, CA	Tell them we are working intensely on the ground to build support for a robust public option.
Lisa Santora, MD, MPH	Redondo Beach, CA	Thank you for your efforts to bring the true voices of physicians to DC. I am a family physician/preventive medicine specialist who trained in county hospitals. For the majority of my career I have provided primary care to the underserved at FQHCs. I have seen first hand the physical, emotional, and financial costs of our failure to prevent and support self-management of chronic diseases in all populations (but especially the un/underinsured). Last year, I made a career transition and became the chief medical officer of Beach Cities Health District (BCHD). BCHD has begun outcomes-based research to prove our hypothesis that

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		"if every community had a community-based public agency dedicated to primary and secondary prevention we could decrease the impact of chronic disease." Here is the abridged executive summary of the report we presented to the office of Rep. Jane Harman. Please contact me if you have any questions. Thank you again for all of your work Beach Cities Health District A National Model for Community Wellness Centers www.bchd.org Executive Summary For more than 50 years, Beach Cities Health District (BCHD) has served the health care needs of beach cities residents in Los Angeles, California. BCHD was created in 1955 when beach cities residents passed a bond measure to establish a special health care district in the South Bay. After four decades of operating South Bay Hospital, BCHD responded to the evolution of the local heath care industry and changed its mandate from meeting the sick care needs of a community to providing preventive health care services. BCHD has now been operating as a primary prevention agency for more than a decade. We provide innovative and evidence-based prevention programs and services to 125,000 residents across the lifespan. BCHD empowers residents to make healthy lifestyle decisions by equipping them with information, motivation, and skills in prevention and self-management. BCHD also supports local health promotion and disease prevention actions through our partnerships with city government, school districts, local businesses, non-profit organizations, and community groups. BCHD further extends its reach in the community through the efforts of more than 800 volunteers. BCHD is a public agency that focuses on primary prevention. BCHD has a hybrid-funding model that leverages a property tax increment of $2.3 million into more than $10 million in preventive services for beach cities residents. Prevention is a critical component for health care reform. Our country cannot support the burden of chronic diseases. Promoting healthy lifestyle behaviors, through education, evidence-based prevention programs and public policy, is essential to reducing the burden of chronic diseases. BCHD addresses behavioral change on all levels of the social environment – individual, interpersonal, organizational, community, public policy – across the lifespans. BCHD is positioned to serve as a national model for community wellness centers that promote health and prevent disease.
Betty Fletcher, MD	Playa Del Rey, CA	
Bonnie MacEvoy MD MPH, MD MPH	Arcata, CA	We MUST take the profit out of medicine. It is greed rather than patient care that is driving the costs up. Also, we must incentivize patients to stay well. It is their job, not the doctors to keep well. **Devise a public health care that anyone may use as a safety net. It will not provide bells and whistles; only birth control/pregnancy/child health care (up to 18 years of age), antibiotics, analgesia for terminal care, emergency surgery, and basic generic medications. NO TRANSPLANTATIONS, BYPASS SURGERY, VASCULAR SURGERY, OR OTHER EXPENSIVE PROCEDURES THAT RESULT FROM SELF ABUSE (smoking, obesity, alcohol). **surcharge to patient of $1 per pound over ideal weight per month. **no care for risky lifestyle (drinking and driving, drug abuse, motorcycle without helmet, sky-diving) **private insurance for those who are working and/or can afford to purchase it. **Not unlike travel insurance, if someone wants to bungee-jump, insurance must be purchased. **doctors somehow paid by the hour, not by the invasiveness or procedure. I see so many patients who get UNNECESSARY SURGERY. The records are falsified as to indications and findings, which is so easy

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		to do. **Extra insurance may be purchased from private companies, just like travel insurance, to cover risky behaviors. We will not change patient behavior until we make it cost money to be sick. It is immoral to have to enter into a business relationship with a patient. Consider making a priest, fireman, or policeman work "on commission". It is a BAD SYSTEM. We cannot offer all things to all people. Right now, the system is bankrupting because those who abuse themselves use most of the health care. Those who take care of themselves are punished by having to pay for the physiological deadbeats. Doctors are struggling to be business experts and play politics against hardball MBA CEOs. So-called "non-profit" hospitals are driving other hospitals out of business, while they pad their pockets and lock up the patient care in communities. Religious dogma has no place in health care. EQUALIZE THE PLAYING FIELD. We have to stop marketing health care, drugs, and procedures in the denial of our mortality. We do not die gracefully, and we all seem to die pumped with drugs and covered with sutures. It is a badly broken system. We are asking, "would you like your poison now, or after dinner?" The question is, "why poison? We cannot ask how to fix the current approach to medicine, but rather come up with a better one. MEDICAL CARE CANNOT BE FOR PROFIT. PATIENTS CANNOT ABUSE THEMSELVES WITH ABANDON AND NOT EXPERIENCE CONSEQUENCES. WE HAVE TO STOP PRETENDING TO BE SAVIORS AND BECOME PARTNERS IN HEALTH WITH OUR PATIENTS. THERE MUST BE EXPECTATIONS THAT EACH PERSON MAKE AN EFFORT TO STAY WELL. WE CANNOT AFFORD TO GIVE ALL THINGS TO ALL PEOPLE. The bells and whistles ought to be luxury items. WE CANNOT CONTINUE TO PROVIDE PROCEDURES THAT HAVE NOT BEEN SHOWN TO HAVE OUTCOMES WITH EVIDENCE-BASED IMPROVEMENTS. Health care is spiraling out of control, and has become a gravy train for too many, with the patients as pawns. The average patient is on a long list of medications that he does not know why he is taking, many that conflict with each other, and that require so much time from the patients daily life. No prescription ought to be filled without a review of the ENTIRE list. I could go on for hours, obviously. I am a highly paid anesthesiologist, and work with highly paid surgeons. I see so many people that have lists of medications, years of self-abuse, and no incentive or interventions to change. There is no time like now to make change. Obama has a mandate. The system is badly broken. Patient behavior is out of the loop. Those with the most to lose have the money to manipulate the change and ideas. I have been a patient and a provider in socialized systems and they work well. As a poor patient, I was in a room with 9 other women, and IT WAS FINE. I survived, I got excellent care, and had everything I needed to get well. I didn't choose my doctor, but they were all scrutinized. As a pregnant patient, I got good care and had a wonderful baby. As a physician, I was paid well enough, and took care of whoever came to the best of my ability, and diverted those who could get by with less. My payment was not linked to how much I did TO people, but how well I did FOR them (if I didn't do well, I would lose my job). Please - give back responsibility to the patient. No coverage for risky life-styles (obesity, smoking, drinking, drugs) Take away the fee-for-service incentive to do more expensive procedures at the drop of a hat. Stop paying for the high-end fancy medical procedures, especially before they are shown to make a difference. Stop paying for the excessive prescribing of expensive, non-generic pills. SCRAP THE CURRENT FOR-PROFIT SYSTEM AND GIVE

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		RESPONSIBILITY TO THE PATIENTS.
Alan Newman, MD	San Francisco, CA	I am certainly in favor of wellness and prevention initiatives. I think the President needs to hear from us that NO VIABLE HEALTH CARE REFORM WILL WORK WITHOUT REGULATION OF THE HEALTH INSURANCE INDUSTRY. The administrative costs that the arcane and inefficient managed care system imposes on physicians offices has led to physician burnout, the rise of \"concierge\" medicine, and financial pressures on physicians that may lead some to see too many patients, order too many tests, etc. Because the insurance companies set their own rules for claims processing, they benefit from making the system incredibly complicated, from denying care (even when they know they are wrong), from errors they make in their own favor, from their own inefficient workforce. Physicians are NOT solely responsible for the rise in health care costs. A second important fact: health care costs are going to rise consistently due to new technologies and treatments. Any cost analyses must take this into account. I do think it is important to be sure that research monies are spent on high priority projects, but we must be very careful that innovation and discoveries that may save lives is not stifled in the interest of cost containment. Also we must not condemn patientents with rare diseases from benefiting from medical research just because their disease is uncommon and \"low priority\" I am staunchly in favor of the public health plan option.
Anna Kirby, MD	San Diego, CA	Contraceptive services and cervical cancer screening are extremely effective at preventing unwanted pregnancy and disease, both of which are devastating and expensive.
Brecken Armstrong, MD	El Segundo, CA	Tort Reform is one of the most important ways of balancing the healthcare budget. A tremendous part of the cost of healthcare is associated with malpractice insurance and defensive medicine. Please encourage President Obama to include tort reform in his healthcare plans.
James Montoya, MD	Sacramento, CA	1)TORT reform NOW. Fear of lawsuits and defensive medicine cause Drs to spend inordinate amounts on unecessary tests. Savings will help pay for the program 2) REPEAL or PROVIDE FUNDING FOR THE UNFUNDED MANDATE known as EMTALA. STOP the indentured servitude of EMERGENCY physicians, our nation's de facto providers of health insurance for all. 3) MORE HOSPITAL BEDS, MORE NURSES, MORE PHYSICIANS. Without these, access to care for all will be inadequate.
DENARD FOBBS, MD	Fresno, CA	COMMUNITY BASED EDUCATION & INTERVENTION PROGRAMS HAVE PROVEN TO BE DRAMATICALLY SUCCESSFUL IN FRESNO, CA. MY WIFE'S ORGANIZATION FACILITATED A HEART DISEASE EDUCATION AND INTERVENTION PROGRAM LAST YEAR WITH DRAMATIC RESULTS. THEY PARTNERED WITH A LOCAL CARDIOLOGIST, JOHN NELSON, MD. SOME OF MY PATIENTS PARTICIPATED AND I AM AMAZED AT THEIR MAINTAINED WEIGHT-LOSS AND HEALTHY LIFESTYLE. EDUCATE A MAN AND YOU EDUCATE AN INDIVIDUAL. EDUCATE A WOMAN AND

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		YOU EDUCATE A FAMILY.
Kea Bunting, MD	Menlo Park, CA	One of the largest problems I see as a physician is an overwhelming lack of education on the part of patients, and especially parents. I also feel as a primary care provider that the most helpful thing I offer is education. Doing this in a 15 minute appointment is impossible, but what is required to stay afloat. Our system has to change, to make primary care/prevention the number one priority, or things will continue to get worse until our system collapses...which seems to be impending.
Francine Yep, MD	Oakland, CA	1. All infants and children should be able to get their shots. There are PPO's who will not pay for childhood vaccines now! 2. Smoking cessation programs, nicotine replacement methods, medications like Buproprion and Chantix should be covered benefits. Motivated smokers who want to stop smoking should be helped. Having to pay $100 a month to STOP smoking is a real disincentive. Think of the savings when we prevent heart attacks and strokes! 3. All diabetes and heart disease patients should have access to health education on exercise and nutrition. We have Medicare and privately insured patients who must pay $1000 to attend a diabetes education program. They can't afford it. This should be a covered benefit.
Anniken Hansen, MD	Martinez, CA	The most important thing is for everyone to have coverage so that they can access preventative health care. Public health initiatives could also help greatly. Encouraging healthy eating- possibly a snack tax, versus regulation on advertisements for very unhealthy food (fast food, sodas etc). Encouragement of more physical activity- more parks, more free recreational programs. Help with drug abuse- prevention programs and treatment programs. Weightloss programs included in health care coverage. Thanks!
Joseph Levitt, M.D., M.S.	San Francisco, CA	Please stress to the administration that the AMA does not represent the mainstream of doctors. Conscientious physician strongly support substantial health care reform that includes a public option, both for the health of our patients and our nation as a whole.
Sharon Durousseau, MD, MPH	Oakland, CA	We need to change the culture of how patient access care and think about their health as well how doctor delivery. We need to promote primary care and pay primary care docs for the work they do. Specialist make a third to twice as much and many studies indicate that overuse of specialty care leads to higher cost without better outcomes. If primary care doctors were more supported in taking care of the whole patient we can avoid duplication, reduce overuse of tests and provide better counseling in prevention. but we cant if we are seeing a patient in 10-15 min increments and if the patient belives they need to see a specialist or have a test to get good care. More linking of patients to a pcp and providing them a medical home will allow patients to have the conversation with someone they know and trust to make better overall decisions so their health will improve. Plus we need to make sure primary care docs are paid well enough (not excessively) to encourage medical students to go into primary care. If you cant afford to buy a home as in states like California or New York, you cant pay for your loans and you cant provide a good life style for your family...why be a primary care doctor, why not just be a plumber or realtor or a ER nurse...they all can make more than a

Name	Location	Comments
		family practice doctor or pediatrician... despite our 8+ years of additinoal education. thanks
Neil Patel, MD	Fountain Valley, CA	Ensuring access to primary preventive care will prevent hospitalizations when the problem(s) are out of control and therefore will cost much more to manage, and in the end, the health issue is much better treated by prevention than attempting to reverse a pathology once it has developed. Also, I would HIGHLY encourage tort-reform as much of the cost of medicine is driven by the practice of defensive medicine. While it is easy to instruct physicians to stop practicing in this way, unfortunately, we are forced to practice defensively when our entire livelihoods are threatened each and every day by the fear of having a frivolous lawsuit filed against us. There absolutely needs to be a cap on damages or a no-fault compensation system set up for medical malpractice claims. Without this, attempting to make healthcare more cost-effective is a quixotic task.
thomas barber, MD	Orinda, CA	First we need to make all preventive health as inexpensive as possible for patients. There really are only 10 major preventive health tests that have been proven to reduce morbidity.mortality - mamograms, HgB A1c measurement, colonoscopies, HTN measurement, etc lets establish a national board of preventive health measures that would define those tests that an individual with certain diagnoses should have at governemnt expense. In exchange for government paying for these tests the providers would be required to update a national website that would track all preventive health measures. The patient could sign on at any time, see peventive health measures, and see any measures that he/she should be doing at this point in time. so : 1. govenrment paid preventive health measures like mammograms, immunizations 2. MD and public health panel to decide which preventive measures are most effective and should be paid for by the government 3. A government website that would contain secure information for providers and patients on what preventive measures are due for each patient. Also would be available for print out at provider's offices for those without interenet access.
Neal Rojas, MD, MPH	Palo Alto, CA	I am a Developmental-Behavioral Pediatrican working in the San Francisco Bay Area. I diagnose and treat children and adolescents with Autism, Learning Disorders, ADHD, and a variety of other ailments. My biggest concern for improving prevention and wellness campaigns for children involves reinvigorating physical and social education in our schools. Recent studies are now showing the obvious decline in not just physical health of children but emotional and academic performance associated with decreased physical education (including decreased time at recess). My training as a developmental-behavioral pediatrician tells me that children learn much more than good exercise and eating habits through PE and recess. They also learn to problem solve in social settings, to get along and work with others as a team, and to tolerate differences better. Increased physical education among children will have a lasting benefit, not only on cardiovascular health but mental health and overall learning capacity.

Name	Location	Comments
		Cost saving benefits will likely be immediate with decreased utilization of child health services as children feel and act healthier. A more educated and healthy workforce will insure lasting fiscal impact not only on reducing care costs but improving productivity.
Tonya Chaffee, MD,MPH	San Francisco, CA	I am a pediatrician and adolescent medicine specialist (fyi, an adolescent medicine specialist completes 3 extra years of training after completing a 3-4year primary care residency). IN my over 10 years of practice, I cannot write enough about how adolescents in our country have the WORST health outcomes of any industrialized (and many 3rd world) countries. This is primarily due to poor access to care, lack of training of providers, complete lack of coordination of care due to adolescents and young adults not seeking care (or believing they do not need care because they are not "sick"). We need a paradigm shift and place an emphasis on prevention, not only in childhood but throughout adolescence and into early adulthood. Please help support training in adolescent medicine, streamline care for this underserved aged population to confront unwanted pregnancies (US has the highest rates), sexually transmitted diseases (US has the highest rates), obesity, drug abuse (US has the highest rates) and the variety of mental health illnesses that often present in adolescence. There are very cheap, effective models in other countries, and even our own country, Kaiser Permanente is one example (and I don't work for them!) We need to invest in early life, not the end of life! Thanks for reading my comments!
Jeffrey Pierce, MD	Santa Rosa, CA	I am a family physician in California, working in a variety of settings, from teaching resident physicians, seeing patients in a clinic setting, to working in emergency rooms and admitting patients to the hospital. Based on my experiences, both locally and internationally, I strongly believe in and support the use of prevention and wellness initiatives as the most cost effective way to maintain physical, mental, and social health. Our country's dependence on a disease model of health care has led to unacceptable costs and unimpressive health outcomes when compared to the rest of the developed world. Now is the time for bringing about real change. We are ready for it and welcome it.
Bruce Heller, MD	Sausalito, CA	I am a family physician and see patients for primary care. I have special training in lifestyle management and behavioral change. These are considered first line therapy for many chronic, debilitating and costly diseases such as diabetes mellitus, heart disease and some cancers. Because counseling for behavioral change is not typically reimbursed by insurance, most doctors are not trained to provide this type of care effectively. Society ends up paying higher costs later as unhealthy behaviors continue and disease progresses. I would like to see health care reform include fair compensation for counseling and behavior modification therapies. These have been proven to be effective and cost-saving interventions. I also support a single payer plan that will solve many of our health care problems: it reduces wasteful spending on insurance company administration, it will contain spending on defensive medicine, and it will provide universal coverage for the millions of Americans who are un- or under-insured.

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Name	Location	Comments
Joan Chapman,	Vallejo, CA	Imagine you you are forced to instantly trust someone you have NEVER met with your life? This is the state of health care in America. It is well known that people put off going to the doctor because it is invariably a negative experience once preventive measures have been overlooked. How can we deny that these initiatives are important?
Natasha Marston, MD	Santa Monica, CA	Diet and exercise!!! Diet and exercise!!! Diet and exercise!!!!The typical American lifestyle is killing us. We have to focus on the food we are putting into our bodies and our activity level if we are going to alter the course we are on which is an epidemic of obesity, diabetes, hypertension, heart disease, liver disease, renal failure, etc. etc. I think the place to focus is with our children and their parents. We have got to teach our children how to eat sanely and how to integrate activity into their daily lives. We need to teach them about the consequences of an unhealthy lifestyle. We need to also have more intensive education programs available for every child at very high risk already exhibiting obesity and all the related problems. If we don't do something to curb the rate of diabetes and obesity then we are out of luck because we will not be able to absorb the costs to society, families, or the health care system. In addition, one area that we need to put more focus on is end of life issues. The fact that we spend so much money on the last few months of life can be changed and at the same time we can have patients and families who are much more satisfied with their experiences. We need to start talking to patients and doctors more about communicating about end of life wishes way before the time actually comes. I consider this a prevention issue. The prevention of futile, risky, and painful care at the end of life.
Carol Archie, MD	Los Angeles, CA	While listening to news coverage of Healthcare reform heard a US Republican Senitor tell the story of a Canadian woman (by name) who had an unfortunately long wait for an elective but needed procedure in order to scare the public. I know that DFA members could easily counter such stories with specific examples for any senator's home state! HOw powerful would that be! He cares so much about a Canadian while the same or worse is happening to his own constituents.Let us all submit stories and sort them by congressional district and states and BLAST them if any others try the same thing.
Art Levit, MD	Oakland, CA	Here are a couple of ideas that come immediately to mind. Use screening approaches according to proven schedules. Do NOT screen inappropriately. It is not unusual to see recommendations in the lay press that go beyond USPHS guidelines and scientific research. Unfortunately, caregivers do not always educate patients who request unnecessary testing. There can be a conflict of interest for physicians, provider-owned clinical laboratories and imaging facilities in ordering of tests not supported by evidence-based medicine. Reimburse only for indicated screening tests. Obtain data on caregivers' patient population with respect to specific guidelines, such as lipid levels, last mammogram, BMI, tobacco use, most recent cervical screen, immunization status, etc. Offer financial incentives to caregivers whose patient populations show improvements and/or meet overall optimum values in areas such as these. (This requires FIRST that the caregiver keeps detailed electronic records on the health of his/her patients. This is a vital need for the whole country.)

Name	Location	Comments
Steven Smith, MD	Soulsbyville, CA	Clean out the FDA! It has been corrupted by Big Pharma. Stop all drug rep contact with doctors. If a medicine works, it sells itself. Punish drug and device manufacturers severely for publication bias and other tricks designed to fool doctors regarding medication efficacy. Stop extending patent durations... Pharma has so many tricks for extending patents, costing taxpayers billions. Decrease payments for dermatology and most surgical subspecialties. Provide a STANDARD medical documentation format for all Americans, with ONLINE ACCESS to all providers. Change billing requirements so that payment does not rely so heavily on documentation. The necessary correllary is limiting lawsuits based on documentation. Let us do what is necessary to treat patients rather than waste time safeguarding ourselves against lawyers. And yes: Tort reform. Lawsuits don't prevent patient harm, they merely punish it. Only stricter training and continuing education requirements for providers can achieve the goal of better patient care. An agreeable alternative is to limit lawyer compensation, with the difference going to fund physician training programs and other programs to decrease harm to patients. Keep up the good fight. Sincerely. Steve
patrick mauer, MD	Los Angeles, CA	Incentive pay 1)for meeting preventive care guidlines rather than productivity 2)Monitoring chronic illnesses 3) Living wills completion
Lisa Solinas, M.D.	Ojai, CA	Incentives for doctors and patients to get and stay healthy. Disincentives for non-compliance with healthy lifestye changes. I know that this doesn't address the above topic but I think you should use this oppotunity to organize a "quarter-million doctor" march on Washington in support of President Obabma's plan.
Jeannette Aldous, MD	San Diego, CA	While I believe strongly in focusing on prevention and wellness, I think too often we think we can prevent our way out of the current crisis. prevention and wellness will just be a drop in the bucket, we need to control costs and create a system where primary care is the foundation. The VA is an excellent example: they have created a very efficient, low-cost, high-quality system by combining wellness programs, health promotion, prevention programs (smoking cesation etc.), primary care and excellent specialty care when needed. all at a fraction of the cost of other systems. The VA is a true "medical home" that can be a model for all the issues in the current debate (prevention, cost control, quality. plus a great computer system!).
Panna Lossy, MD	Cotati, CA	We need to encourage doctors to choose primary care by increasing payments and offering loan repayment. We will have a big workforce shortage unless serious steps are taken to put primary care doctors on a par with specialists. However, we will never get costs down if we don't directly deal with the source of our high costs - profits from insurance companies, duplication and adminsitrative waste and overuse of technology. We need a robust public option that builds on and improves MediCare. We need to consolidate health plans not spawn new ones.
andrea vannatta,	Santa Monica, CA	By educating our patients and providing tools, such as vaccinations and physical activity strategies, as well as encouraging healthy diets, and recognizing early signs of disease, such as increased BMI or mild hypertension, we can save not only hundreds of thousands of dollars in Emergency room visits, but also empower the people to take hold of their health - ultimately, their lives - and be more productive and fulfilled individuals. People are motivated by positive reinforcement - and for many, the first piece of the chain must come from a trusted source, such as a physician. We can show people we care by inquiring

Name	Location	Comments
		about their lives and about potential threats before those threats/diseases are even realized. And the knowledge people gain from listening and interacting with a compassionate healer can trickle down to friends, children, family members in multiple ways - sharing that knowledge, as well as sharing the openness and patience, which will reduce stress and also improve health. There is a huge link there, and everyone needs to start acknowledging that.
stephen hansen, MD	San Luis Obispo, CA	Ban tobacco,eventually--it's doable, and political support is right among the populace. Then ban high-fructose corn syrup. Pay for weight-reduction surgery. Tax large food purchases, i.e. Costco 12-pack pork chops,etc.--turn the tables on the super-sizers. Link personal risk to out-of-pocket cost liability for overweight, and raise consciousness on this issue. Most BMI 25-29 people are not convinced of their risk--saturate the paid media with the adult&pediatric overeating/under-exercising pandemic story. Pay docs for primary care prevention which is cost-effective. Realize that the pay-off in prevention is not always in dollars, but rather in less frailty,etc. Walkable towns.
Sue kIM, MD	Palo Alto, CA	Expand "school nurse" system to incorporate doctors in training in administering immunizations, caring for children w/acute issues (uri, etc.), and teaching wellness classes (incorporate into curriculum) on subjects such as nutrition, colds and common illnesses children encounter, healthy lifestyles, etc.
susan Van Scoyk, MD	Denver, CO	I am a psychiatrist and ever since I can remember studies have shown that if people receive psychiatric/supportive care, their use of medical clinic visits decrease and their perception of their overall health improves. I think we need to make this type of preventive care accessable to all.
Roger Cambor, MD	Boulder, CO	Mental health and substance use problems carry a tremendous cost in our society in terms. Prevention efforts can target populations at risk as early as elementary school age children to identify individuals with a risk factors for current or future depression, trauma, behavioral disorders and substance use disorders. Individuals at risk by virtue of family/genetic influences could be followed by primary care physicians and targeted for early intervention if symptomatic. Individuals who are showing symptoms can be identified and referred for treatment at an early stage of problem development, when the intervention may have a greater likelihood of reducing future morbidity and health care service utilization. This type of intervention would involve widespread screening of school aged children, using standardized instruments assessing depression, anxiety, sleep patterns, exposure to trauma and use of substances, as well as education of teachers and primary care physicians and pediatricians regarding identification, treatment and referral procedures for pediatric and adolescent mental health problems. Wellness initiatives essentially deal with lifestyle. Although this can ultimately be a far more cost-effective approach to health care, it will require that medicine make a shift away from an emphasis on technology-driven procedures to a more relationship-based model, which emphasizes time spent in cultivating and optimizing the relationship between doctor and patients; the outcome of a successful doctor-patient relationship is health over the lifetime. In order to promote health on a widespread scale, medicine must make the understanding of health as much of a priority as the understanding of illness. Health is more than the absence of illness. Most doctors understand this, but doing it differently would require a radical change of

Name	Location	Comments
		medical culture, which would have to start at medical schools and within professional organizations. Medicine in its current form is profoundly ineffectual in dealing with lifestyle issues. Although a fair amount of information is available, doctors are very often unsuccessful in promoting lifestyle changes among patients in the absence of a crisis. Most doctors do not have the time or requisite skills to understand the lives and lifestyles of their patients. The impact of psychological, emotional, behavioral and substance use factors are frequently misunderstood, underestimated or ignored by doctors, unless the patient is in crisis because of such issues. Most physicians do not possess a deep understanding of their patients as people, hence do not understand stresses, motivations, conflicts and decision-making. The question of how to help people change unhealthy habits is complex, and worth of study in itself. Success involves more than exposing the patient to factual information. Habits themselves are complex and always serve psychological functions which may not always be apparent to patient or physician. It takes time to understand a person well enough to discern the true psychological function of a habit, which often involves belief systems, a view of the world and oneself, conscious and unconscious motivations, and importantly, anxiety. Medical education in its current form is dualistic and fails to convey to medical students and young physicians the necessity of a sophisticated social, psychological and emotional understanding of patients. This is especially true regarding the issue of lifestyle habits and their modification. To change the situation will require changing the culture of medical education in a fundamental way, such that doctors view themselves and are viewed by patients as professionals of health, not pathology, treating persons, not disorders. Much research on the topic of prevention and wellness needs to be done in order to develop the best methods for screening at risk populations and maximizing the impact of the doctor-patient relationship on lifestyle and habits. Long term studies of large populations are needed to determine the lifestyle habits that will provide an individual with optimal health throughout the lifespan. More studies of diet, exercise, relaxation, workplace and environmental factors are needed. Such studies do not require medications necessarily and are labor intensive. Studies like this are of no interest to pharmaceutical companies, hence a separate government-funded entity devoted to research of this nature should be created so that an evolving database of information can inform patient and physician decision making.
Oswaldo Grenardo, MD, MBA, MS	Aurora, CO	I think the more we spend on prevention, the more we will spend in general without getting that investment back. The real equation is how much hand holding and the costs of doing so do we need to do to get someone to eat healthy and exercise that will then give us positive outcomes thus defraying the costs of the chronic diseases we battle every day. I don't think this equation will ever balance. Thus I don't believe paying for wellness initiatives and prevention programs will give us the cost containment we need. I think these are necessary parts of our system that need to be enhanced but the savings/containment will come from other areas. I'm all for universal health care but I also think the costs will skyrocket out of control. Congrats on going to the White House and I hope you represent us well.

Name	Location	Comments
Irene Aguilar, MD	Denver, CO	Dear Mr. Brooks, I appreciate your insight into the health care system. As a primary care provider and president of a grassroots organization working to ensure quality, affordable, Health Care for All Colorado, I too want the health care system fixed. However, I refuse to bankrupt the nation when it is possible to provide comprehensive health care to everyone AND reduce expenditures by utilizing single payer financing. I am NOT talking about government run medicine - the entire entity could be outside the control of Congress. The reasons that the free market does not work in health care are multiple. First, people will only choose to buy what they think they need. Most 24 year olds correctly guess that they will not be diagnosed with Hodgkins Disease and thus do not choose to purchase health insurance coverage. Yet once diagnosed our society expects them to be treated and cured regardless of their ability to pay. And no one will allow them to purchase insurance. Second, Americans are not given the ability to cost compare. What does it cost to suture a laceration on your leg? Well, that depends - did you go to a clinic or a hospital? Which one in which city? Do you have insurance? Did you go to the location where your insurer has negotiated a discounted rate? Do you have a copay or a high deductible? Does your insurer discounted rate apply to your large deductible? While you were bleeding did you take the time to go online and see where you could get the best price? The best care? Do you count the cost of your insurance and the cost to your employer for your insurance in your calculation of the cost of this care? The AMA, which represents only 25% of physicians, will not support a public option. They are concerned that the "government" will control their choices and income. That same control exists right now in medicine, but it is held by private insurers. In the case of for-profit insurers the entity exerting the control is legally bound to make a profit for their shareholders. Not to ensure the health of the population. This results in negotiated prices for care and, according to a study published online May 14 in Health Affairs the average physician spends 43 minutes per work day dealing with health plan administrative requirements. The costs average $68,274 per physician per year. And hours of frustration. I would encourage those involved in reforming the health care system to spend a day working in an urgent care center. This would exponentially increase their knowledge of what the real issues are in health care financing and reform. Irene Aguilar, MD President Health Care for All Colorado www.healthcareforallcolorado.org
Joseph Kay, MD	Golden, CO	We can not have any preventative care without some form of universal coverage. We can not make the poorest fo the poor pay for health care coverage. We need different tiers of coverage, with the highest tier being purchased by those who can afford it. AT MINIMUM, ADULTS BORN WITH CHRONIC MEDICAL CONDITIONS NEED LIFE LONG HEALTH CARE COVERAGE. I TRIAL OF HOW TO DO THAT COULD BE A PLATFORM FOR EXPERIMENTING WITH A LARGER NUMBER IN THE FUTURE
Danielle Loeb, MD	Denver, CO	As a primary care physician, I find that if I am able to spend more time speaking with patients and reviewing their records, I tend or order less tests. The more I can get to know my patient and think through their problems, the less costly their healthcare becomes. Time spent with patients on chronic medical problems needs to be incentivised. The current system's focus on proceedures definitely encourages physicians to do first and think later as opposed to thinking through issues completely and only ordering necessary tests.

Name	Location	Comments
Douglas Cave,	Fort Collins, CO	Please simply ask the question: What good is it to see the doctor if one cannot eat?
Deborah Proctor, MD	New Haven, CT	Colon cancer screening with colonoscopies has been shown (USPSTF, ACS) to decrease the risk of developing colon cancer. This must be offered to all patients at an affordable rate. Specifically, there should be no deductible that the patient has to pay out of pocket in order to have this procedure done.
Robert Chessin, MD	Fairfield, CT	I am a primary care pediatrician. It is very important that primary care physicians have a significant increase in health care reimbursements. Medicaid rates are unacceptable, and Medicare rates only discourage participation. Any new system should be oriented to cognitive, not procedural reimbursements. Coordination of care and medical home reimbursements need to be recognized as well. If we get paid in the future worse than what the HMO's pay now, we might as well pack it in.
Cyrus Kapadia, M.D., F.A.C.P., A.G.a.F.	Guilford, CT	President Obama must gradually bring the American public to the realization that none of us can live forever. We, the Medical Profession, have conveyed to the Public that we can cure everything in everybody, and no body is wiling to die! Billions upon billions of dollars are spent at the end of life when there is no real expectancy of survival. So much could be done to allow people to die with dignity, often in their own homes, if home end of life services were available instead of long ICU stays, a great deal of money would be saved and people would die with dignity. THERE IS ALSO AN OVERWHELMING NEED FOR TORT REFORM. Without it nothing will be resolved. Thank you.
Yaron Gesthalter, MD	New Haven, CT	I think there is room for more personal responsibility to be placed on the patient in the medicaid arena, hopefully allowing increasing benefits for more people with a goal of increasing the amount of people with a minimal health coverage if not more.
Suzanne Lagarde, MD	Hamden, CT	In the GI world, screening colonoscopy tops our prevention strategies. I just performed 110 screening colonoscopies on uninsured CT residents ages 50-64 who have never had one. Two colon cancers, approximately 40% with adenomas. Similar data were just presented at GI meetings in Chicago. Maimonides in NY did 288 screening colonoscopies in uninsured residents and found 5 colon cancers. In almost all cases, cancer found at earlier stage---less morbidity, mortality and LESS COST.
Julie Rosenbaum, MD	Fairfield, CT	Give us more time to teach and talk, understand how to help a patient eat better, take their medicines better. Pay for nutritional counseling instead of so many questionably effective angioplasties for stable angina. Provide resources for case management to make the phone calls and keep contact to help a patient through the process of quitting smoking. Provide resources for proven pharmacist resources to help with education of patients and review of medication lists for interactions. It has been shown to reduce side effects, help adherence, and improve outcomes. Help develop a personal online medical record that patients can access from any computer. Reimburse better for group visits for common illnesses to improve education, such as diabetes group visits and classes. Relieve us primary care physicians of the burden of insurance forms, paperwork, and documentation that overwhelms our time and energy and takes us away from ensuring that patients understand what they need to do to make themselves healthier. IT TAKES MORE TIME THAN WE HAVE!
Andrew	Norwalk, CT	Tort Reform

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Name	Location	Comments
Seevaratnam, MD		
Charles Glass, M.D.	Guilford, CT	Two thoughts. One, get rid of the insurance companies. They do nothing to advance health care, only to interfere in the patient-doctor relationship and drive up costs. Two, why should I, as an Internist, not be compensated for keeping my patients healthy? I trained in a vigorous academic program and put that knowledge to use every day, but somehow my skills are less valuable than specialists doing procedures? That's not right and we will never solve the shortage of PCP's unless we compensate them more and specialists less.
Douglas Davis, M.D., Ph.D.	East Haven, CT	Whatever healthcare plan this administration puts forth, it is essential that it includes (1) guaranteed universal coverage (by whatever combination of private vs public subsidization is needed to do so); (2) a shift in focus towards preventative health measures; (3) low cost or no cost primary care for all patients (with incentives, e.g., tax rebates, designed to encourage basic health maintenance, screening and follow up); (4) a shift in resources and compensation to primary care physicians and their practices; and (5) a standardized, government secured, nation-wide EMR database and a "free" database client (comparable to the EMR client used in the VA system) that is available to all physicians but which also is open to third party developers of EMR clients (i.e., for hospitals and practices who want more bells and whistles from their EMR clients). We waste so much money on health care in this country because we don't push simple preventative measures or make the relatively minimal payout up front for good quality primary care. When patient's sit at home because they're worried about how much a doctor's visit and the follow up is going to cost, small problems become big, expensive problems quickly. Cost should never enter a patient's mind when it comes to deciding whether or not to seek medical attention or healthcare maintenance. If anything, the government's role should be to make basic primary care and emergency care available to everyone and to reward those who utilize the system responsibly (i.e., who get screening and make it to the appropriate check ups). The government can facilitate the creation of a secure, nation-wide EMR and communications system that will cut out the waste and save all the redundant man hours that are spent reacquiring health care data every time a patient visits a new physician or hospital. The government can help reduce all the bureaucratic red-tape (e.g., HIPPA needs major common sense reform) and paperwork that pushes physicians out of the areas of medicine where this is most burdensome, namely, primary care and general internal medicine. The Emergency Department should not be the gateway to our healthcare system. And hospitals should be for treating patients with medical and surgical problems, not social ones. How much money could we save, if the typical “social admit” for substance abuse, indigence, psych issue, etc would be admitted directly to a lower cost social work/rehab/psych facility where they would actually receive better care for their issues, rather than admitting them to a $2000 a night hospital bed. Whatever plan is devised, there has to be a fundamental shift in the way this country thinks about and prioritizes health care and in the procedures, resources and institutions that deliver it. It should be the priority of this administration to persuade the electorate of this and to generate the public insight and political will to accomplish this from the ground up.

Name	Location	Comments
Neena Qasba, Third year Medical Student	Farmington, CT	Firstly, the AMA does not speak for me and never has. It is despicable that these physicians have taken an oath to serve humanity unconditionally and yet at every point in history have blocked and subverted any efforts for universal health care. They are a disgrace to the medical profession. I hope that President Obama will continue rallying the medical profession outside the AMA. I personally invite him to University of Connecticut where medical students have been especially active in our state legislature and health care debate. As a medical and public health student, I have seen the health care system fail from a prevention and treatment standpoints. I agree that public option is the right way to go. However, we need to address several key points missing from the health care debate: 1) Patient's responsibility. make health insurance give patient's incentives (reduced premiums, discounts, etc) to be in charge of their own health- compliance with meds, weight loss, smoking cessation, gym membership, local farmer's markets, biking to work, etc. INCENTIVIZE good health outcomes and health habits. of course there are medically complicated cases where this can not apply, but we are facing a Metabolic Syndrome epidemic so we need to get patients active in their own health, not just doctors. 2) Medical Malpractice- it must change. As a future Ob/gyn, hopefully, I am scared, very scared about the prospects of working incredible hours just to cover costs of malpractice. TORT LAW REFORM is a must to ensure quality health care (reduce over-testing), and allow growth in high-risk professions such as Obstetrics and Gynecology. 3. MEDICAL STUDENT DEBT!!! I am so shocked that this issue has not been in the debate. We are one of the only countries in the world where Medical Students graduate with $200,000+ in debt. You want to increase Primary Care Physicians, you need to address medical student debt. If you ask any medical student in my class with debt like this, they will say the reason they will not do Primary Care is because of the bills they have to pay. Reimbursement should be addressed, but you need to address supply-side economics to encourage that the best and brightest students pursue primary care fields. National Health Service Corp chooses 60 applicants a year. This is insufficient to address the primary care physician shortage. An expansion of a program like NHSC must be done through private-public partnerships to recruit more students into primary care fields. Thank you for your time in reading these comments.
james boyer, M.D.	Hamden, CT	universal vaccination for hepatitis A and B; safe use of medications; Moderate use of alchohol; student education in healthy life style, diet etc.
Ninani Kombo, M.D.	New Haven, CT	Public announcements about the most common preventable and treatable diseases (hypertension, diabetes) should be everywhere: radio stations, tv stations, billboards, EVERYWHERE! I believe this can inform people more and have them test more often. Free health screening fares should be set up everywhere. If we encourage medical students and physicians to donate a few hours of their time quarterly to participate in these health screenings they can work. Support systems for patients. Physicians practices, insurance companies, and hospitals (health care centers can set up support groups and buddy systems for patients so that they motivate and encourage one another to keep up with treatment/weight loss programs etc. Nutrition consultants. I realize that people don't know how to eat healthy and are sometimes worried that healthy food is expensive. Nutrition consultants could work with patients and meet them every 2-3 months and encourage them to make small changes each time. I have many

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		more ideas, however I will stop right here! thank you, Ninani
Danielle Alexander,	Washington, DC	Improving quality and reducing costs: Claims versus evidence Prepared by Kip Sullivan, June 1, 2008, on behalf of the Greater Minnesota Health Care Coalition and Physicians for a National Health Program, Minnesota Chapter This handout compares claims commonly made about the American health care crisis with evidence from the peer-reviewed literature about those claims. It states the claim in question, contrasts that claim with a summary of what the research says about the claim, and then offers illustrative quotes from the research. Nearly all the evidence presented here is from papers published in peer-reviewed journals. Page 6 presents evidence indicating two-thirds of Americans support a single-payer system. Claim: Overuse of health care explains why US per capita health costs are double those of the rest of the industrialized world. The evidence: Underuse is four times worse than overuse in the US. Rationing is far worse in the US than in other industrialized nations. “[W]e found greater problems with underuse (46.3% of participants did not receive recommended care …) than with overuse (11.3% of participants received care that was not recommended and was potentially harmful…).” Elizabeth A. McGlynn et al., “The quality of health care delivered to adults in the United States,” New England Journal of Medicine 2003;348:2635-2645. “Did not visit a doctor when sick [in the past year]:” 4% of Canadians said yes to this question versus 25% of Americans. Cathy Schoen et al., “Toward higher performance health system: Adults’ health care experiences in seven countries, 2007,” Health Affairs Web Exclusives 2007:W717-W734, Exhibit 2. Claim: Doctors provide the right care only half the time. The evidence: Patients get the care they need half the time (see the citation to McGlynn et al. above). The role doctors play in this problem versus the role of other factors (including high prices, the nurse shortage, insufficient emergency room facilities, patient illiteracy, patient preferences, and lack of transportation, day care, and health insurance) has not been established. Claim: Health Savings Accounts will cut costs without damaging quality of care. The evidence: HSAs can lower costs for employers with healthy work forces, but they cannot lower costs for the health care system as a whole; high deductibles damage quality. “Our simulations show that the MSA [Medical Savings Account, the 1990s version of the Health Savings Account] approach is not likely to produce the reduction in health care use that its advocates foresee” (p. 1671). “[N]ot all nonelderly Americans would choose MSAs; taking [that] into account, health spending would change by +1% to -2%” (p. 1666). Emmett B. Keeler et al. “Can Medical Savings Accounts for the nonelderly reduce health care costs?” Journal of the American Medical Association 1996;275:1666-1671. “Increased cost sharing is associated with lower rates of drug treatment, worse adherence among existing users, and more frequent discontinuation of therapy….. For some chronic conditions, higher cost sharing [for drugs] is associated with increased use of medical services….” Dana P. Goldman et al., “Prescription drug cost sharing: Associations with medication

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		and medical utilization and spending and health," Journal of the American Medical Association 2007;298:61-69, 61. Claim: "Teams" are better than doctors working alone or in small groups, even in outpatient settings. The evidence: Skilled teamwork is necessary in the obvious settings (ERs, ORs, and ICUs), but research does not support the claim that "teams" improve care outside those settings, and there is no evidence that "teams" lower net costs. "The … literature on health care teams …. has failed to demonstrate conclusively that the use of teams will enhance patient or organizational outcomes…." Louise Lemieux-Charles and Wendy L. McGuire, "What do we know about health care team effectiveness? A review of the literature," Medical Care Research and Review 2006;63:263-300, 263-264. "In outpatient settings, there is limited evidence that the use of teams results in superior quality of care…. [E]vidence suggests that patients often do not experience primary care teams as coherent or as an asset to their care [citations omitted]" (p. 20). "[T]his study challenges the idea that using bounded teams to support PCP [primary care physician] practices will result in superior primary care experiences relative to using clinicians not formally associated with a PCP's practice"(p. 24). Hector P. Rodriguez et al., "Multidisciplinary primary care teams: Effects on the quality of clinician-patient interactions and organizations features of care," Medical Care 2007;45:19-27. Claim: Report cards and "paying for performance" (P4P) based on "grades" on report cards improves provider performance, improves health, and saves money. The evidence: Report cards can damage patients and cause the equivalent of "teaching to the test"; there is no evidence that report cards and P4P save money. "Despite … extensive adoption of quality measurement and reporting, little research examines the effect of public reporting on the delivery of health care, and even less examines how report cards may improve care. … [T]he potential … negative consequences of public reporting are largely unexplored." Rachel M. Werner and David A. Asch, "The unintended consequences of publicly reporting quality information," Journal of the American Medical Association 2005;293:1239-44, 39. "Performance-based contracting gave providers of substance abuse treatment financial incentives to treat less severe OSA [Office of Substance Abuse] clients in order to improve their performance outcomes. Fewer OSA clients with the greatest severity were treated in outpatient programs with the implementation of PBC [performance-based contracting]." Yujing Shen, "Selection incentives in a performance-based contracting system," Health Services Research 2003;38:535-552, 535. "[O]ur results show that report cards [on heart surgeons] led to increased expenditures for both healthy and sick patients, marginal health benefits for healthy patients, and major adverse health consequences for sicker patients. Thus, we conclude that report cards reduced our measure of welfare over the time period of our study" (p. 577). "[M]andatory reporting mechanisms inevitably give providers the incentive to decline to treat more difficult and complicated patients" (p. 581). David Dranove et al., "Is more information better? The effects of 'report cards' on health care providers," Journal of Political Economy 2003;111:555-588. "Although a majority of payers have instituted pay-for-performance programs (Rosenthal et al. 2006), it is too early to tell whether P4P programs, currently based largely on process measures, are improving quality and/or reducing costs." Sean Nicholson et al., "Getting real performance out of pay-for-performance," Milbank Quarterly 2008;86:435-457,

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		435. “We evaluated the impact on quality of all P4P program introduced into physician group contracts during 2001-2003 by the five major commercial health plans operating in Massachusetts. Overall, P4P contracts were not associated with greater improvement in quality compared to a rising secular trend.” Steven D. Pearson et al., “The impact of pay-for-performance on health care quality in Massachusetts, 2001-2003,” Health Affairs 2008;27:1167-1176, 1167. Claim: Clinical prevention services and disease management improve health and save money. The evidence: Effective clinical preventive services and disease management improve health, but as a general rule they raise rather than lower costs. There are exceptions to this rule (e.g., pneumonia shots and disease management of congestive heart failure), but they are exceptions, not the rule. Note carefully what is being said here: Preventive and disease management services, like all other forms of effective medicine, should be provided first and foremost to improve health, not to save money. “Although some preventive services do save money, the vast majority reviewed in the health economics literature do not” Joshua T. Cohen et al., “Does preventive care save money? Health economics and the presidential candidates,” New England Journal of Medicine 2008;358:661-663. “It’s a nice thing to think, and it seems like it should be true, but I don’t know of any evidence that preventive care actually saves money.” Jonathan Gruber, economist at the Massachusetts Institute of Technology, quoted in David Leonhardt, “Free lunch on health? Think again,” New York Times, August 8, 2007, C2. ____ ______ Example of the problem: Flu vaccinations for seniors cost more than they save “The observed hospitalization rates for unvaccinated and for vaccinated participants [65 and older] were, on average, 0.7% and 0.6% per season….” (Kristin L. Nichol et al., “Effectiveness of influenza vaccine in community-dwelling elderly,” New England Journal of Medicine 2007;357:1373-1381) Cost per flu patient 65 and older for inpatient care = $8,300 Cost per flu patient 65 and older for outpatient care = $200 Total cost = $8,500 If none of the seniors were vaccinated, 280,000 (.007 x 40 million) would be hospitalized for flu at total cost of $2.38 billion. If all were vaccinated, 240,000 (.006 x 40 million) would be hospitalized for flu at total cost of $2.04 billion, or savings of $340,000. But vaccinating 40 million seniors costs $1 billion: 40 million seniors x $25 per vaccination = $1 billion. Total cost of flu program is $1 billion minus $340 million = $660 million. Sources: Flu shots were $23 and nasal spray was $30.00 for state employees in 2004 (http://www.doer.state.mn.us/ei-sehpp/flu/Flu.htm). $25 is mid-range. Hospital and outpatient costs from Michael Masiocek et al., Influenza Immunization for Adults 50 Years and Older: Technical Report Prepared for the National Commission on Prevention Priorities, May 11, 2006, Partnership for Prevention, Table 2, p. 15, http://www.prevent.org/images/stories/clinicalprevention/influenza.pdf, accessed February 17, 2008. ____ ____________________ Another example of the problem: Reducing obesity and smoking does not save money at the system level “Preventing obesity and smoking can save lives, but it doesn’t save money, researchers reported Monday. It costs more to care for healthy people who live years longer, according to a

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		Dutch study.… In a paper published online Monday in the Public Library of Science Medicine journal, Dutch researchers found that … the thin and healthy group cost the most, about $417,000, from age 20 on. The cost of care for obese people was $371,000, and for smokers, about $326,000." "Obese people, smokers cost the health system less than healthy do, study finds," Minneapolis Star Tribune February 5, 2008, A10. ____ _____________________ "[T]he results of our review suggest that … support for population-based disease management is more an article of faith than a reasoned conclusion grounded on well-researched facts. ... Most of the evidence on disease management programs to date is derived from small high-intensity programs focusing on high-risk patients that are typically run as part of a demonstration project by the providers at a single site. This evidence suggests that those programs typically lead to better processes of care, but the evidence for improved long-term health outcomes and cost savings is inconclusive. ... [T]he vendor-run assessments typically do not meet the requirements of peer-reviewed research ...." Soeren Mattke et al., "Evidence for the effect of disease management: Is $1 billion a year a good investment?" American Journal of Managed Care 2007;13:670-676. "On the basis of its examination of peer-reviewed studies of disease management programs…, CBO [the Congressional Budget Office] finds that to date there is insufficient evidence to conclude that disease management programs can generally reduce the overall cost of health care services…. The few studies reporting cost savings generally do not account for all health care costs, including the cost of the intervention itself." Congressional Budget Office, An Analysis of the Literature on Disease Management Programs, October 13, 2004, http://www.cbo.gov/showdoc.cfm?index=5909&sequence=0, accessed September 25, 2005. Claim: Electronic medical records (EMRs) improve care and save money. The evidence: EMRs have mixed effects on quality; universal adoption of EMRs will probably raise total spending. "Evidence from the literature on health IT does not … uniformly support the possibility of … savings." Congressional Budget Office, Evidence on the Benefits and Costs of Health Information Technology, May 2008, 10. "With the exception of pharmacy settings, there is little consistent evidence that IT [information technology] systems save time for providers. In some instances, the literature suggests the reverse." Medicare Payment Advisory Commission, Report to Congress: New Approaches in Medicare, June 2004, 163. "The … use of the EMR made … monitoring of preventive health and chronic illness unwieldy and offered little or no improvement when compared with paper charts." Jesse C. Crosson et al., "Implementing an electronic medical record in a family medicine practice: Communication, decision making, and conflict," Annals of Family Medicine 2005;3;307-311. "[P]atients with diabetes in practices that did not have an EMR were significantly more likely to have received care that met the guidelines for processes of care, treatment, and intermediate outcomes. For intermediate outcomes, the odds of patients in non-EMR-using practices meeting all 3 targets was 2.68 times the odds of patients in EMR-using practices." Jesse C. Crosson et al., "Electronic medical records and diabetes quality of care: Results from a sample of family medicine practices," Annals of Family Medicine 2007;5:209-215,

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		http://www. annfammed.org/cgi/content/full/5/3/209. "I]f inaccessible [paper] records are responsible for costly retesting, reductions should be readily achievable. This was not the case at Kaiser Permanente, where 'use of clinical laboratory and radiology services did not change conclusively' over a two year transition to EHR [citation omitted]." Jaan Siderov, "It ain't necessarily so: The electronic health record and the unlikely prospect of reducing health care costs," Health Affairs 2006;25:1079-1085. "We found that a widely used CPOE [computerized physician order entry] system facilitated 22 types of medication error risks. Examples include fragmented CPOE displays that prevent a coherent view of patients' medications, pharmacy inventory displays mistaken for dosage guidelines, … and inflexible ordering formats generating wrong orders." Ross Koppel et al., "Role of computerized physician order entry systems in facilitating medication errors," Journal of the American Medical Association 2005;293:1197-1203. "[M]ortality rate [at a children's hospital in Pittsburg] significantly increased from 2.80% … before CPOE implementation to 6.57% … after CPOE implementation." Yong Y. Han et al., "Unexpected increased mortality after implementation of a commercially sold computerized physician order entry system," Pediatrics 2005;116:1506-1512, 1506. "To achieve an NHIN (national health information network) would cost $156 billion in capital investment over 5 years and $48 billion in annual operating costs. … $156 billion is equivalent to 2% of annual health care spending for 5 years." Rainu Kaushal et al., "The costs of a National Health Information Network," Annals of Internal Medicine 2005;143:165-173, 165. Evidence: Majority favor single-payer: citizen juries Single-payer Managed care MSAs No. of national citizen jury (of 24) who supported 17 5 na No. of Minnesota citizen jury (of 14) who supported 8.5 3.5 0* * One citizen voted for a hybrid of single-payer and managed care. There were two abstentions. Sources: national citizen jury results reported in: Patrick Howe, "'Citizens Jury' supports Wellstone's health care proposal over Clinton plan," Star Tribune, October 15, 1993, 10A; Jefferson Center, Citizens Jury Update, December 1993; and Barry M. Casper, Lost in Washington: Finding the Way Back to Democracy in America, University of Massachusetts Press, Amherst, MA, 2000, 235; Minnesota citizen jury results reported in Glenn Howatt, "Canadian-style care starting to look more attractive to panelists," Minneapolis Star Tribune, October 9, 1996, A15. Evidence: Majority favor single-payer: polls For single-payer Opposed to single-payer Harvard University poll (1988) 61% 37% Wall Street Journal-NBC poll (1991) 69% 20% CBS-New York Times poll (1993) 59% not asked NEJM poll (med school faclty/studnts) ('99) 57% not asked ABC News poll (2003) 62% not asked* Arch Int Med poll (doctors) (2004) 64% not asked Minnesota Med (Minnesota doctors) (2007) 64% not asked AP-Yahoo poll (2007) 65% not asked** *The ABC News poll asked: "[Do you support] a universal health insurance program, in which everyone is covered under a program like Medicare that's run by the government and financed by taxpayers?" ** The AP-Yahoo poll asked whether respondents agreed: "The United States should adopt a universal health insurance program in which everyone is covered under a program like Medicare that is run by the government and financed by taxpayers." Sources: Robert J. Blendon, "Three systems: A comparative survey," Health Management Quarterly 1989;11(1):2-10, Exhibit 5, 5 (Harvard poll); Wall Street Journal, June 28, 1991, A4 (Wall Street Journal-NBC poll); American Health Line April 19, 1993

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		(CBS-New York Times poll); Steven R. Simon et al., "Views of managed care: A survey of students, residents, faculty, and deans of medical schools in the United States," New England Journal of Medicine 1999;340:928-936, 929 (medical school poll); Will Lester, "Poll: Public supports health care for all," Washington Post, October 19, 2003, http://www.pnhp.org/news/2003/october/public_now_supports_.php, accessed May 6, 2004 (ABC News poll); Danny McCormick et al., "Single-payer national health insurance: Physicians' views," Archives of Internal Medicine 2004;164:300-304 (doctors poll); Joel Albers et al, "Single-payer, health savings accounts, or managed care? Minnesota physicians' perspectives," Minnesota Medicine, February 2007:36-40 (Minnesota doctors poll); http://news.yahoo.com/page/election-2008-political-pulse-voter-worries (page 15) (AP-Yahoo poll). ***
Andrew Gordon, Ph.D. , M.D. Class of 2010	Washington, DC	I would strongly emphasize to President Obama to focus HARD on gradually raising the age of Medicare eligibility. This is a win-win proposition as life expectancy is longer and as such Americans should also be expected to work a couiple of years longer and retire later. This promotes a healthier and more responsible lifestyle, enables Americans to take advantage of private insurance for longer and also decrease the burden on the Medicare system. This should be an essential part of any health care reform package.
Kathleen Mayor-Lynn, MD	Gainesville, FL	With the two largest contributors to preventable morbidity being obesity and cigarette smoking, we need to come up with ways to decrease these two conditions. Tax incentives for use of gym membership/health clubs is one - some health insurance companies already offer discounts on membership fees at health clubs at sign-up, but a way to track actual use of the club to lead to tax incentives would be an option. Implementing taxes geared specifically for health care spending on cigarettes and fast food to help offset the health care costs associated with the associated complications. Unfortunately, it is difficult for some families to cook healthy meals because of time and money issues and seems cheaper for them to go to a fast food place for a 99 cent burger and fries than to make healthier choices. We need campaigns to educate the public on the complications of obesity including increased rates of birth defects, stillbirths, complications of labor and delivery, increased need for cesarean section and significantly increased risks for surgery - including prolonged cases, increased blood loss, increased infection rates, increased DVT, etc as well as the non-obstetric related complications and premature death. Beyond that we need campaigns to educate the public on ways to prevent obesity and improve general health and empower them to take responsibilty for their own health. We need to show that cooking a healthy meal for a family of 4 is actually cheaper than a fast food meal for 4. This needs to start in schools, if children are encouraging a more healthy lifestyle, I think a lot of parents would be more likely to follow through with those things.
Glenda Hutson, m.d	Miami, FL	As a physican I think its important to place more emphasis on prevention and wellness. as this will decrease long term illnesses which is what place a great drain on our health care system. such as dialysis cardiac caths admissions for heart failure. Too much is placed on the amount of patients seen not on the quality or preventive service given.

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Hallegere murthy, M.D.	Miami, FL	Hi Nikil Thank you for your efforts, I heard the president\\\'s speech given at AMA meeting in Chicago. All the meassures to cut down the costs were addressed except the issue of cutting down the investigations for legal defense, which amounts to 20-25 % of the medical bills. Example- one pt I treated for prostatitis 3 times in the office setting cost $200 to $300/ visit. I was out of town and pt had the same prostatitis on the w/e, so went to the ER with fever. He had cbc, chem profile, blood culture, CT scan of the abdomen, pelvis, ecg, IV fluids and finally sent home after 12 hrs on cipro, total bill was $12800.00. All of that has to be done to protect onself to rule out any & all possible factors for the symptoms. So it is important to devolp a plan at the federal level to protect the physicians for not doing these defensive investigations. It is also important to prevent frivulos mal- practice law suits and cap the awards. Thank you again for the efforts, wish you all best of luck.
Nat Wisser, PHD	Estero, FL	My 60 years in Health care has made me conclude that the single payer system is what we need. I can give a 100 reasons for this.
Gerald Stein, MD	Gainesville, FL	Nothing less than a government sponsored health plan is essential for reforming our out of control health expenditures. In addition please work toward a single payer national health plan as the final component to make our industries competative.
Deborah Weyer, MD, MBA, BSBA	Keystone Heights, FL	I am a pediatrician who sees primarily medicaid insured children. Most of my patients' parents are uninsured. It is quite common for bacterial illnesses such as strep to be passed back and forth between family members. Treating the child is a temporary fix as the parent is still contagious. My parents tell me they have no money to go to the doctor and will typically end up at the emergency room when they become too ill to function. This is one concrete example of the need for health care access to everyone. From a purely cost-savings standpoint, a parent's visit to a primary care physician can avoid multiple illnesses and courses of antibiotics for their children as well as a costly ER visit. One should also consider quality of life and productivity for these children and their family. I could go on and on with other examples such as diabetes and heart disease prevention through proper counseling and support (a child eats what his/her family eats), asthma management (if untreated, asthma can result in costly ER visits as well as increase a child's danger of death and morbidity, and a host of other diseases.
seema chaudhary, MD	Safety Harbor, FL	1. Some thing HAS to be done for the medical malpractice for doctors to practice real medicine.when obama can ask the doctors to help then why can't he ask his colleagues(lawyers) to help as well. He is playing double standards here. 2. A simpler and faster way for the reimbursements so that doctors can spend more time with patients than haggling with insurance companies. 3. Reward the primary care doctors who do most of the work and are most underpayed.Their reimbursements have to be better so that their future is better and that is the only way medical students would opt for primary care. they can make up all the money they own in debt just in a year or so if they choose higher payed specialities than getting getting it pardoned to choose primary care fields. show them the better future with primary care and they will automatically choose primary care,The most needed speciality for a better economy which can sustain.
rohit suri, MD	Safety Harbor, FL	We have to work towards the Insurance companies paying more for the Prreventive Care, espeacially Obesity, as it is the mother of most of the serious Illnesses afflicting US, and also to pay for the coordination of Care among the

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		Physicians. The most critical part still remains the Malpractice Reforms, unless that is reformes all the effforts will not yield much.
john masson, MD	Safety Harbor, FL	I listened to the president's address to the AMA and frankly i was disturbed by the president's comments. Tort reform is an absolute imperative if we physicians are to help curtail costs. We need to be able to able to practice medicine in a way that allows us to use good judgement, and the education we all spent years acquiring. The presidents is not for caps on pain and suffering. The other comment that alarmed me is the one about medicine being a business and not a calling. It is a calling and it is also a business. I pay 401K, health insurance, and salaries to 19 employees and my salary has remained the same. The president needs to undertand that physicians are ready to help him with reforming the health system because we understand that the system needs to be overhauled, and soon. Pretending that medicine is not a business is naive and frankly caters to peoples ideas that good healthcare is a right regardless of personal behavior, ie.smoking obesity risky behaviors. Iam a fervent supporter of this president and campaigned and voted for him.
Janice Stone, D.C., B.S.	Fort Lauderdale, FL	I think individuals should be given the choice to see the alternative practitioner of their choice instead of or in addition to their traditional physician. All forms of health care are valid and important and patients deserve the right to choose without recrimination!
Jeff Berman, MD	Boca Raton, FL	1)Easy access to Flu/pneumonia injections with very low or no cost. It is still expensive for the mass population to get these shots
J. Paul Newell, B.A., M.D., C.C.F.P. (Can)	Cartersville, GA	Given: 1. the reality that only about 3% of the health care expenditures of the Federal government are spent on prevention and health promotion; and 2. that the impact of health promotion has long-ago been proven, it may be that the most important thing you can do is work to convince the White House that it needs to put its full and unwavering support behind some reallocation of health care dollars to dollars focused on the creation of health. You can't buy health from your physician. JPNewell
Leslie Gise, MD	Kula, HI	A single payer system makes it much easier to do prevention and wellness. I am a psychiatrist. Our patients die 25 years earler than other people. The VA is socialized medicine and single payer. Their psychiatric patients death rates are the same as the general populaton. They do prevention and wellness and have the best electronic medical record. We should all use it, all use the same one! Check out pnhp.org and let me know what you think. Its the most fiscally conservative reform and the only way to get affordable quality health care for all.
Alvin Fuse, MD	Honolulu, HI	A single payer system will have the largest impact on prevention. When patients become Medicare age (a single payer system) a recent publication found an improvement in outcomes managing and working with chronic diseases.
david derauf,	Honolulu, HI	Prevention and wellness are all finr and well but the evidence is clear: of you want to improve population health than it is the SOCIAL DETERMINANTS of health, mostly affected by braod social policy, that needs increased attention!
Laurie Steelsmith, N.D., L..Ac.	Honolulu, HI	Include licensed naturopathic doctors in your health care plan. Naturopathic doctors are the best trained natural health practitioners offering their patients natural, non-toxic alternatives to drug therapies. They work with their patients to create lifestyle changes that ultimately work with preventing disease and treating the underlying cause of disease. Naturopathic doctors can help make America

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		richer by lowering health care costs, and healthier by working one-on-one with patients to create optimal health and wellness.
Renee Latimer, BSN, MSN, APRN	Kaneohe, HI	I am a Psychiatric Advanced Practice Registered Nurse who believes in treating the entire person rather than just one system. I work with patients with the most serious of mental illnesses: schizophrenia and very severe mood disorders. Most of these patients live sedentary lifestyles, eat high fat, overly processed diets and smoke cigarettes. They suffer from multiple co-morbidities such as diabetes, heart disease, and asthma. Many of them wait until these conditions are life-threatening before seeking costly, inconvenient treatment. When they do seek treatment it is from the most costly provider - the ER. Prevention and wellness programs such as affordable options for physical activity, healthy, local food options and pharmacological support for smoking cessation provide the earliest amd most affordable intervention to high risk populations.
J Gardner, B.A.,M.D.,MS BME	Buffalo, IA	We need a public plan to cover the 10-20% of our population with multiple chronic conditions that consume the majority of our health care dollars. We have car insurance for accidents. It does not cover maintenance,oilchanges,etc. The insurance concept is not appropriate for this population.
Rebecca Wiese, MD	Davenport, IA	I am a family doc, with >20 years experience in community health centers; I have worked in the private sector as well. I have found that the most effective method for helping my patients and my professional colleagues get a more realistic perspective on health care costs and needs and responsibilities is when I talk about my experiences in Tanzania or Guatemala. That dose of reality puts a new perspective on life in a way nothing else can. So, talk about the rest of the world, and maybe my colleagues and patients can be convinced to work together for the good of all.
John Macatee, D.O.	Iowa City, IA	I am completely convinced that good, timely preventative health care that emphazises healthy lifestyles (including diet, nutrition, and regular exercise)is essential for ideal health and reduced health care costs. I support a well-planned, sensibly run, cost effective health care system that provides good health care emphasizing preventative health care for everyone in the U.S. Ideally this system will include a public health care insurance program (in addition to existing private health care insurance programs) that pools all participants and negotiates all costs to deliver the best health care at the lowest cost. Good, sensible preventative health care will always provide better health care at lower cost. For example, early screening for and treatment of diabetes will provide better outcomes at a lower cost because diabetes is more effectively treated early in its progression with less cost. Even more important is to help everyone develop healthy lifestyles so adults and especially children eat sensibly (i.e. minimal junk food, excessive sugar, fat, etc.)and exercise regularly to prevent the development of childhood and adult obesity. This would of course minimize the incidence of diabetes. "Prevention is the best cure." Every dollar spent sensibly for prevention is will save many more dollars in later unnecessary costs of evaluation and treatment. I am an osteopathic physician specializing in osteopathic manipulative medicine and nutritional medicine. My practice of 18 years is completely aboout providing good, sensible, cost-effective preventative health care. The present U.S. health care system is extremely flawed, inefficient, and overexpensive yet it

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		does not provide good, affordable health care to at least 50 million people in the U.S. We desperately need a good, sensible, well-run, cost-efective universal health care system. Our present system often rewards and overpays insurance companies, physicans, hospital/health care centers, and pharmaceutical companies for providing less effective health care that costs too much. For example, there are thousands of insurance companies, each with their own redundant administrative costs and overpaid CEO's. Many communities as McClellen, TX have too many doctors ordering too many tests and doing too many costly interventions including overtreatment by too many specialists and surgeons without more effective and cheaper preventative health care. Waste and inefficiency is rampant in our present health care system. There are frequently too many providers or services in some area that compete to provide even more services as CT scans that provide billable income, often to the physicians that own those services as CT scanners. Many other areas as Amerian Indian reservations and inner cities have a pitiful lack of good health care services which provide good preventative health care to everyone whenever needed. It's always more expensive and less effective to treat anyone after their medical condition has been neglected or poorly treated for a long time. It's much more expensive and less effective to provide medical care in an emergency room if that care could have been provided much earlier and more effectively by a good primary care provider emphasizing preventative care. Pharmaceutical companies, insurance companies, hospitals/clinics, and physicians are often allowed to charge too much money for what they provide. A prime example is the Medicare Reform Bill passed several years ago after it was railroaded through congress with insufficient discussion, debate, and transparency> It effectively prohibits Medicare from negotiating for the best costs for drugs and insurance coverage for millions of Medicare recipients for years to come. It is a good example of why we "pay more for less" in our present health care system that cintinues to favor many special interests instead of the common good, the good of all. I wish President Obama great luck and success in fixing our broken health care system and making it really as good as it could be if we all work together instead of against each other. We need to find common ground that best benefits us all in the most cost-effective way. John Macatee, D.O.
Chris Schuster,	Iowa City, IA	1) Everyone needs access to health care. 2) Marriage equality (same sex marriage) is a health care priority, as it has been linked to a decrease in HIV. 3) Fighting HIV and other STIs should become a greater priority.
eric hanks, DC	Burlington, IA	freedom of choice and the public option must remain on the table. also, allowing patinet to choose provider and to pay providers of all types of degree (MD DC DO) equally for the same service. End the hig deductables and high copays that are crippling patients ability to get even minimal care.
Barbara Daugharty, md	Coeur D Alene, ID	We absolutely need a onepayor system...other plans will not work. One option would to be to allow everyone to buy into Medicare or Medicaid for a nominal amount...i.e. 40 Dollars a month....
David Eisenberg, MD	Chicago, IL	Cover comprehensive reproductive health care including family planning. "For every $1 spent, $4.02 is saved" in publicly funded family planning programs. Source: Frost JJ, Finer LB, Tapales A. The impact of publicly funded family planning clinic services on unintended pregnancies and government cost savings. J Health Care Poor Underserved. Aug 2008;19(3):778-796.

Name	Location	Comments
Kohar Jones, MD	Chicago, IL	--Improved access to mental health/addiction treatments --Increase payments to primary care physicians to attract the necessary workforce --Support guidance/resources programs, with confidential consultation on personal issues; legal information and resources; information, referrals and resources for work-life needs; and financial information, resources and tools to address the social determinants of health and prevent health crises.
Paul Jones, MD, MAT	Chicago, IL	Low-income and especially ethnically and linguistic minority children with serious chronic physical illness (diabetes, asthma, cystic fibrosis, epilepsy, neurodevelopmental illness, HIV/AIDS) represent an extremely vulnerable population whose needs are absolutely not met by the current system. These children and families require ongoing, coordinated and truly comprehensive medical, psychiatric, developmental, educational, housing, economic, and parenting support and services, but rarely get them. In addition, children with mental health needs generally, particularly those who may not yet have frank mental illness but who are at high risk by virtue of genetics and family and living conditions, are also in extremely high need of early, preventive and comprehensive intervention. Early Head Start addresses some of these needs but not comprehensively, and it reaches only a fraction of those who need it. Mechanisms to fund and provide COORDINATED comprehensive FAMILY CENTERED biopsychosocial preventive and intervention services to the above populations sorely need to be a part of the reformed system. I would be delighted to converse with anyone interested and to get more involved regarding the above issues. I have just moved (today!) to DC for job at Georgetown and NIH. Please feel free to contact me at 773 573 6516. Good luck in the meeting tomorrow. Paul M. Jones, MD MAT
Natasha Diaz, MD	Forest Park, IL	Thank you for soliciting the opinions of your members. I appreciate the opportunity to share my views. Overall, to cut costs and improve access to care, I favor a single payer system. However, I will support any reform that focuses on improving access to care for the uninsured population. There are three things that are imperative to improve health and cut costs. These include changing the medical education system to place more value on primary care, improving community outreach, and providing incentives for quality care. 1. Medical schools must value primary care and encourage bright students to go into this field. There needs to be a paradigm shift in teaching institutions to value the expertise of family practice as a specialty. Family practioners offer a unique ability to care for a broadly defined population including pregnant women, children, and adults with chronic disease. The specialty is very adaptable and that is helpful for volume in both the inpatient and outpatient setting. This allows families to one-stop shop if you will. The practioner, social worker, nutritionist can focus on the family instead of the individual. If the future of medicine is to focus on prevention, then a larger number of Family Practice physicians must be available and it must be an attractive choice for graduating medical students. 2. Community outreach is a vital part of prevention. First, each community needs an epidemiological evaluation to determine the unique population health concerns. Once they are identified, an appropriate prevention plan can be initiated in the community setting. Examples of outreach include education on diet and cholesterol, school programs for teens on safe sex. Finally, if we want to address infant mortality rates in some of the communities in this country we need to

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		create outreach programs for prental care and approriate drug rehab programs for pregnant women. I would also like to add that group visits for patients with similar conditions (ie centering pregnancy groups, diabetes group visits, etc) has proven useful to improve patient awareness and involvement in their care which in turn leads to better outcomes. 3. Finally, there must be incentives to provide quality of care, not just quantity. Measuring appropriate care is difficult, but there are some clear evidence based practices that can be tracked. These could be things like performing screening tests (ie mammograms), using appropriate tools for patients with chronic disease (ie. checking HbA1C in diabetic patients). Currently, Harmony HMO (part of Medicaid in IL) provides bonuses for meeting best practice guidelines. I do want to caution however that the option of Harmony HMO has created longer waits for referals and tests within this network when compared to the straight public aid option. This is often frustrating for both providers and patients. We prefer a more open network so that patients can get appropriate care in a timely fashion. Again, I appreciate all of your efforts in compiling this information for presentation in such short time.
Risha Raven, MD	Polo, IL	If basic preventive care (annual adult and indicated child checks) were covered 100%, and referrals for health initiatives and basic medications were covered... millions could be saved.
Sarah-Anne Schumann, MD	Chicago, IL	Free summer camp for all kids; I am a family doctor in a community health center on the South Side of Chicago and most of the kids I see have no summer plans other than watching tv and snacking; we need to get kids active in the summer - swimming, playing outside, doing sports, gardening and eating healthy foods; expanding summer camp so that every child in America can attend free of charge would greatly improve the health of the country; it would also provide summer jobs for teenagers who could be counselors and keep kids off the streets and promote safety (i would even argue that some sort of sumemer program should be mandatory. . .)
Robert Goldberg, M.D.	Chicago, IL	Dear Ms. Nancy-Ann DeParle, I am an orthopedic surgeon practicing in Chicago. I'm quite worried about the viability of current healthcare reform proposals. There are many groups applying pressure. But, the one which I believe is most important is not well represented: physicians. Without the full cooperation of doctors, any healthcare reform legislation will be DOA. At minimum, physicians need 1) national malpractice tort reform and 2) fee for service reimbursement stability. Defensive medicine behaviors by physicians, nurses and hospital administrators are real and very costly. Physicians, especially surgeons and medicine subspecialists, believe any government healthcare plan will decrease reimbursement rates. Doctors feel caught between the crushing effects over their rising financial overhead (including high malpractice insurance rates) and decreasing reimbursement rates for their services. Without national tort reform and guarantees about fee for service reimbursement stability, I fear that any healthcare reform proposal will be rejected and nationally boycotted by the majority of physicians, especially surgeons and medical subspecialists. The Whitehouse Healthcare Reform Team needs more dialogue with these physicians. Respectfully, Robert Goldberg, M.D. Chicago

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Name	Location	Comments
Prabha Dosi, MD	Freeport, IL	Preventive care, on going nursing help to encourage continuation of care and change in living style to avoid complication and maintain good health is the basic minimum any body and everybody should be able to access at minimal cost or free for infirm and low socio-economic class. To save money education to people with health power of attorney should be done early and involved with the physicians in providing the care elderly has decided after discussion. So that when they are brought to emergency rooms , the current unnecessary expensive, futile end of the life care can be converted to the sensible dignified care and comfort. Each elderly should be assigned a personal case worker who will make sure that all POA and DNR as well as contact numbers are readily available, may be a elecronic info card like credit card. This will allow proper allocation of the resources to those in real need at minimal cost. A parallel public insurance source is a must to put end to the absurd and dangerous games insurance companies play.
John Brna, MD	Northbrook, IL	If ERs and specialists are to order less tests to hold down costs then tort reform to stop defensive medicine is important
neeru jayanthi, m.d.	Chicago, IL	I think it is a great idea to focus on prevention and wellness. Are Medicare and other payors going to reimburse appropriately for this now. Are procedures/surgeries going to be reimbursed less to make up this difference and inequities. I agree that cost cutting maneuvers are important, but how can the government prevent decreasing reimbursement from private insurance. We are generally helpless with this. Also with public insurance option, how is this going to be funded and reimbursed and at what rate. I work in academic center where we already see all the state medicaid, etc. Private groups will continue to decine low paying insurances. The state medicaid program in Illinois is many millions behind in payments already, will public insurance option also have those same problems. PLEASE protect academic universities. Medical student education and resident training are so important, and it is these settings that need a "bail out". Private hospitals manage to find the "best payors" and make millions in our area, while academic health centers struggle and barely able to keep doors open. I like many of President Obama's ideas, but we need specific solutions to some of above potential problems. Lastly, it goes without saying that malpractice premiums MUST be improved. Medical advisory boards should throw out frivolous lawsuits, and some system to limit/cap lawsuits that destroys self-insured health systems is necessary! good luck!!
Parag Shah, MD	Chicago, IL	1) If the president wants the support of doctors for his reform plan, he need not look only to the AMA (as it seems he is already doing). Doctors think differently by demographic, specialty, etc. 2) In the pediatric literature various models of delivery such as incorporating a care coordinator have been studied on the basis of their cost-effectiveness and results have been favorable for reduction of overall health expenditures for the child, but not necessarily for the practice. Overall cost reductions occur mainly by decrease in intensity of service needed, such as a child avoiding an inpatient stay or an ER visit. Various programs, U Special Kids in Minnesota, and Section on Special Needs in Milwaukee employ non-physicians to do care coordination and have demonstrated cost savings (published data). However, the programs support the extra costs of care coordinators through outside funding. While the child incurs a lower overall cost, practices increase their costs. Motives should be aligned between hospitals and

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		practices so that cost increases for the practice can be offset by cost savings for the overall health system.
Rohan Shah, Doctor of Medicine	Chicago, IL	Create incentives for people that go see their doctors, including eye and dental care as well. Furthermore, do not focus on decreasing compensation for physicians so that physicians will have an incentive to spend more time with patients and on preventative measures. Govt and private insurance plans should both provide incentives to cover such visits for both patient and physicians.
Kevin Moore, D.C.	Mount Prospect, IL	I believe a healthcare system that rewards doctors and facilities that keep people healthy and moving would not only reduce costs but also improve the quality of life for the populace. Type 2 diabetes, Obesity, cardiovascular health, chronic and acute pain syndromes all drain the system of funds that could be used to combat illnesses and disorders that are less preventable. Low back pain costs over 10 billion dollars to treat. 8% of cases utilize 80% of the money. Targeting these cases earlier and getting them the proper treatment(rehabiltation, chiropractic, strengthening) earlier instead of after surgery can cut alarge slice out of the amount paid for treatment of chronic and failed backs.
Jane Lau, MD	Indianapolis, IN	Universal coverage is the starting point. As long as people have only catastrophic coverage, high deductibles, or no coverage, they will only seek care when they have a significant problem. Once people feel they have ready access to care at an affordable cost, then it will take some significant education campaigns and an increase of primary care providers to shift to a preventive health paradigm. Over the course of a lifetime, however, prevention of disease is certainly going to be cheaper than treatment of a condition once it's established.
Emily Walvoord, MD	Indianapolis, IN	I care for children with diabetes. Uninsured and underinsured children get good coverage now under Medicaid. However, once they become adults and no longer have access to affordable health care, they are no longer able to appropriately care for their diabetes. This results in horrible long-term complications including renal failure and dialysis- which is THEN paid for by Medicare/Disability. We need a rational approach to HEALTH by providing healthcare throughout our citizens lives, not just in childhood and then not again as adults, once they have developed life-threatening and costly complications which could have been prevented. In the end, providing healthcare throughout life will SAVE MONEY and result in a better quality of life and increased productiveness of our citizens.
Harvey Thalblum, MD	Overland Park, KS	Stress the necessity of a public option. There is no meaningful health reform without it. It must not be compromised.
Donald Walker, M.D.	Overland Park, KS	Huh? Please advocate for a viable, real, public option, if not single payor.
Carla Aamodt, MD	Mission, KS	I am a primary care internist, and formally taught at the University of Kansas Medical Center and George Washington University. I was continually disappointed with the number of residents and students who opted for sub-specialty medicine outside of primary care internal medicine. When asked why they did this, they discussed the poor reimbursement for primary care. We need

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		to spend more money for top-notch primary care doctors who need to be able to take the time with their patients to give them quality health care that will utilize expensive sub-specialists less.
Sharon Lee, MD	Kansas City, KS	It will only work if there is a means of payment for wellness. That means people who do not have insurance MUST have access to insurance coverage and the cheapest, most effective method of covering EVERYONE is with a single payer system (ie expanded Medicare.)
isabella b. nyan, md	Louisville, KY	We want one-payer system and malpractice cap
Robert Toon, MD	Mount Sterling, KY	Medical malpractice will decrease with a single payer plan. Fewer ladies will die of cervical cancer in Eastern Kentucky because they can get Pap smears. Doctors will be able to practice in underserviced rural areas. I've been there. I've served in Europe. I trained in Canada and the US. I know a single payer plan works.
Dave Bart, MPH	New Orleans, LA	1) a Federal Board of Health, like what Tom Daschle and Ezekiel Emmanuel described, would allow public health programs to operate insulated from political gamesmanship
mohammad suleman, md	Kenner, LA	Please do something about liability insurance .Any heathcare reform will be incomplete without ensuring reducing tha cost of practicing medicine. One of thr big items of expense is malpractice insurance premiums. Please make a no fault insurance and compensate the patients who get affected.Cut the midle man out we spend 70% in lawyers ffes and patients only get 20-30%.
Asaf Bitton, MD	Brookline, MA	We need to support the Rockefeller proposal to have MedPAC decide on Medicare fee schedules, sent to congress for an up/down only vote. This is the most meaningful payment reform mechanism currently under consideration.
Lydia Siegel, MD, MPH	Jamaica Plain, MA	I'm a dedicated primary care doctor. I love my patients. But as one student just said, when she and her classmates visit subspecialty offices, they see happy subspecialists with 30 min to devote to 1 problem (heart disease, lymphoma or rheumatoid arthritis) in a follow-up visit, or a full hour for a new patient visit. And even cheerfully whistling between visits. Then they visit a general internist/primary care physician, who is juggling 7 problems or more, including all the complex drug interactions, trying to make sure the patient understands his/her medical problems, earn his/her trust and maintain it, all in 15 minutes. 30 if it's a new visit. And without real time to build trust, patients won't have any faith they are dealing with a good doctor. So internists are harried, trying to be careful, give patients the good care they deserve, not interrupt, hear patients' issues, discuss things in depth, do careful exams, all in 15 minutes, over and over, 30 times per day. It's a losing proposition, all for the lowest reimbursement. Then do battle with insurance companies over tiny medication changes or wheelchair approvals. Then stay late into the night doing unpaid additional paperwork or answering emails or phone calls that there is no one else to do. Now, this is for the privilege and honor of being someone's personal physician. To me, it's still worth it. My patients mean the world to me. But once I have kids and have to pick them up? I'll have to leave, the work will pile up, and this will no longer be possible. Care has to be restructured so that it can be done with the constraints of a reasonable workday, not one that runs until 10pm and that pays per pitiful 15-minute interval or not at all. This is insulting to patients, to expect that they can get what they want and need in 15 minutes, and impossible for us to do in

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		this little time. I try to give patients what they deserve, but I run late, which is isn't fair to the next ones. But I get results when patients understand what to do with their medications and their lives - their A1Cs go down. Their blood pressure improves. They get fewer migraines. They actually go get their colonoscopies. I can prevent bad outcomes if I have enough time with my patients. But the health care system yells loud and clear that it doesn't value my time, so it gives me nothing in time or money. This has to change, or we'll continue to get what we pay for - nothing.
Nancy Keating, MD, MPH	Newton Center, MA	you guys are doing an amazing job! Certainly let them know that the AMA doesn't represent most docs, even their members. As you have demonstrated, many docs support a private plan. Big key is also need for practice reform (and associated payment reform) to control costs. congratulations!
Peter Cohen, MD	Chestnut Hill, MA	INSIST UPON A PUBLIC OPTION--single payer is the most cost-effective; fee-for-service can never provide the necessary incentives to emphasize prevention and wellness because these are not procedure based. PCPs need to be better paid; procedure based specialists are going to have to give up some of their ill-gotten gains.
Sean Palfrey, MD	Cambridge, MA	1) Establish national universal vaccination funding and distribution for all children regardless of insurance - Vaccines have proven to be the most cost-effective preventive measures since clean water. 2) Acknowledge EPSDT and Bright Futures as the other universal foundations of pediatric care for all children in the country. As screening tools and preventive interventions, they are key to successful child health. 3) Base all child health care in medical homes, with resources to provide effective coordination of care for those children with complex needs. Sean
Frank Speizer, MD	Boston, MA	We need to learn from some of the successes in the past. For example, the people of Australia have been taught to wear hats. This has clearly reduced the risk of skin cancer. How did this come about? Who provided the message and how was it successful? With the right investment in screening we can totally prevent colon cancer. This would require getting the procedure out of the hands of high priced gastroenterologists and into the hands of well trained nurse practitioners (along with public education about the procedures). Better dealing with obesity with exercise and diet, would reduce the incidence of diabetes. All this would require better organization and reward for a wide variety of issues related to PREVENTION, not the least of which is paying for it rather than paying for on piece meal treatment.
Katharine Treadway, MD	Weston, MA	Obviously preventive care reduces incidence of disease - the best way to achieve this is to increase the number of primary care doctors. Barbara Starfield's data suggests that in any region the ONLY density of doctor that reduces mortality in a given region is the density of primary care doctors. As the density increases mortality is lowered, quality improves and costs go down. In addition we need to reform payment structures so docs are not incented to do more tests. We need to erase the enormous disparity in payment between doctors in different specialties which causes students with a high debt burden to pick the most lucrative specialties thus driving up costs and decreasing attention to preventive measures. LAStly, we need massive public education and infrastructure change that encourages people to exercise - most people are completely car dependent and we need to make alternative transportation - foot and bike more feasible.

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Name	Location	Comments
Enrico Cagliero, MD	Boston, MA	As a diabetes specialist with a research interest in chronic disease management applications, I want to be sure that there is a link between performance and payments (a similar apporach in the UK, with incentives for GP to achieve targets for their diabetic patients has improved diabetes care in that country), and that frequent communications with patients (essential for good management of difficult and time consuming diabetic patients), either electronic or by phone, are not penalized as they are in the current system where there is no reimbursement for such contacts. Moreover a public insurance system is essential, as currently planned in the health care reform.
Alan Sugar, MD	Sandwich, MA	avoid duplicate testing when specialists are consulted by having records and labs readily available in a standardized electronic medical record system
Naomi Dworkin, MD	Belmont, MA	Please continue to support the public plan option, but please try to explain to the public why this is so important and how it fits in with the private plan offerings.
Nandini Sengupta, MBBS, MD, MPH	Lexington, MA	I am a pediatrician in a community health center in Boston. Our greatest unmet (and unreimbursed) needs are access to mental health counseling, psychiatric care -- both ambulatory and inpatient, case managment serices for health needs for families with major psychosocial needs, such as teen moms with minimal support, etc. Mental health services are extremely limited with both private insurances as well as Medicaid, and for the uninsured there are no options except in extreme and acute situations. Preventive care and case managment of the sort I have described are outside the purview of traditional health care coverage, and are very difficult to access. Programs that exist are fragmented and limited in scope.
HARDY KORNFELD, MD	Wayland, MA	America needs a national health insurance program to remain economically competitive in the world. If private programs can compete, so much the better. But artificially supporting private programs because of their support for various politician\\\\\\\'s election campaigns would be corporporate welfare at its worst.
gerald sitomer, MD	Brewster, MA	Start all discussions with attention to the absolute need for reform in order to prevent financial disaster. Then review the various ways that reform has been accomplished in other countries, (see"Sick Around The World", by J. Palfreman and T. R.Reid.
Edward Rao, MD	Quincy, MA	Number 1....Liability insurance/malpractice reform....this will help to prevent unnecessary testing and defensive medicine that is not validated by evidence. Number 2....Start a national education program regarding diet / exercise / smoking. Lady Byrd Johnson did something like this back in the 1960's. It had to do with beautifying America. Individuals were discouraged from throwing trash out of their car windows....within a few years, the highways and byways were much cleaner. A more drastic incentive would be to tie the health insurance premium to specific quality indicators like smoking, BMI. Consumers are very price savvy.....they will drive an extra 2 miles to buy gasoline that is 5 cents cheaper. It they have to pay %5 more for their premium than the person in the next cubicle, believe me, they will think about losing weight. Third, encourage the President to speak , at some point in the next 8 years about the cost of end of life care. This is a huge drain on our resources. I have seen the socialized medicine systems at work in Germany and France, and there is much that we can learn directly from them: Why re-invent the wheel. My friends in Germany that are practicing are doing quite well financially. Lastly, I think we should move towards legalizing drugs....This is something that obviously cannot be taken up now. The

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		Taliban thrives because of poppy production. I agree with the idea of pulling the rug out from under the feet of the international drug cartels by legalizing the distribution of these drugs; this would lower the price , and at the same time would stigmatize the individuals who are attending the public clinics for their addictions. With public clinics, drug addicts would not be commiting petty crimes to feed their habits, such as breaking into my house in the suburbs. I could go on....but I think I have made my main points. Thanks for this opportunity. E.K. Rao
Paul Vernaglia, MD	Winchester, MA	I actually prefer a well run, politically isolated, properly funded, single payer government system like England and Canada. However, as we have seen with Medicare here and in both England and Canada politics trumps their advantages. Each political action group pushes its financial interest. Politicians give in. Also whenever the proper and appropriate costs conflict with government financial problems, the week (those with fewer well-funded lobyists)loose out. In particular the sustainable cost protocol in Medicare is a disaster for patient access and physican solvency. Therefore a private option is essential to keep government honest.
ronald mccaffrey, md	Boston, MA	we have no system for primary, non-urgent care. Instead, what we have is a series of expensive, hospital-based, Emergency Rooms, which dispense care, both urgent care, and non-urgent primary care. We need a system of primary care centers, open on a 24/7 basis, to whcih the non-urgent primary care that is now being done in expensive Emergency Rooms can be shifted. Such a system could result in dramatic savings.
Mark Friedberg, MD	Boston, MA	Short and sweet: 1. Cover everybody. It doesn't matter how, really. Go with the politically possible. You can always tinker with the details later. 2. Don't over-specify reforms to the health delivery system (i.e., payment policies, provider regulation, ACOs, etc) in the legislative language. Congress is a lousy place to make detailed policy. Instead, the ideal legislation should put in place the mechanisms that will--in the near future--allow the policy details to be set in a relatively politically insulated environment. Empowering bodies like MedPAC and agencies like the AHRQ to do the detailed decisionmaking is the best way to go. In other words, create a "medical Fed."
Craig Szela, ba	Boston, MA	Support primary care in a sustaining and meaningful way, recognizing that pay differentials more than debt push medical students away from primary care.
Danielle Murstein, MD, MD	Newton Center, MA	We need to eliminate wasteful spending due to: 1) Redundancy in ordering labs and medical tests due to not having access to documentation of recent tests. Also the ordering of excessive MRI's and other costly tests (too many machines to pay off and maintain may contribute to this). 2) Time wasted on complex paperwork--standardize the forms needed to speed things up. Computerize the system. 3) Time spent away from patients due to micromanagement by insurance companies, decreasing the number of patients that can be seen and increasing the cost of seeing each patient. 4) Astronomic insurance costs due to lack of true competition, which a government sponsored health option would help to provide. I am for 100% coverage for people. The French have one of the best health care systems, the highest level of satisfaction, etc. and they spend much less than we do on health care. Even when one is charged as a "non-citizen" the rates are dramatically lower than the US (speaking from personal experience)and the care is excellent.

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Name	Location	Comments
Ronald Pye, MD	Newbury, MA	Prevention and Wellness Programs Support for: • Childhood immunization programs • Automobile injury prevention programs • Unintentional childhood injury prevention programs • Violence prevention programs • School based programs that provide: o nutrition education o physical activity o other school based activities that promote student wellness Electronic Medical Records Use of electronic medical records to: • monitor childhood immunizations • calculate BMI values and identify children at risk for overweight and obesity • provide "red flags" and reminders for preventive interventions • generate appointment cards as reminders to patients • facilitate physician self-monitoring • use data for quality improvement processes Physician Reimbursement Reimbursement incentives for wellness and prevention interventions rather than reimbursement for treatment of sickness. Resource Reference Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities http://healthyamericans.org/reports/prevention08/ Physician Representation A majority of physicians are not members of the AMA. AMA does not represent the majority of physicians.
Luis Fernandez-Herlihy, MD	West Newton, MA	This article in the Boston Globe is exactly my position. I\'m afraid that if we settle for anything less now, such as what the administration seems to be aiming for (everyone covered plus private-public options), we\'ll never get what I consider the best solution, single payer: A singular solution for healthcare By Judy Norsigian and Jennifer Potter June 15, 2009. A single-payer healthcare system would more effectively control costs than any other plan that Congress is considering as it moves toward a reform bill. And by controlling costs, existing resources could be allocated more equitably, especially for the benefit of women. First, single-payer plans eliminate the $300 billion to $400 billion that insurance companies spend annually in administrative overhead and waste. Second, single-payer plans are best positioned to take on the enormous challenge of reducing or eliminating the financial incentives that have led to so much overtreatment and undertreatment. Maternity care illustrates this phenomenon: We spend far more per capita than any other industrialized country and yet do worse on most birth outcome measures than most of these other countries. So-called best practices - medical practices already demonstrated to improve outcomes - are well described in the medical literature, but they are not widely implemented, even though doing so would lower costs and improve the health of mothers and babies. For example, nearly one-third of all US women deliver their babies by caesarean section, a rate that is far higher than medically necessary. One of the reasons is that most obstetricians and hospitals are paid far more for a surgical delivery than for a vaginal birth. Such incentives not only raise costs, but ironically often produce worse health outcomes. By reducing the ability of for-profit companies to siphon off huge sums of money for private gain, a single payer system is better able to expand best practices. Why? Because the motivations to over-treat those who are well-insured and to undertreat those with limited or no insurance coverage will no longer be built into the medical care system. Women in particular have much to gain from single-payer healthcare. Our country has an excess of medical specialists, and is in desperate need of more primary caregivers - such as general internists, family practice physicians, nurse practitioners, and licensed midwives - who are often more aptly trained than specialists to provide the comprehensive services women need. A

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		single payer plan would eliminate the financial incentives that have been obstacles to training more primary care professionals. It would also eliminate the need for so many medical malpractice lawsuits, as people would not have to worry about paying for medical care whenever they experienced bad outcomes. The only national plan for healthcare reform that explicitly includes women\'s reproductive health services, including abortion, is one sponsored by Representative Barbara Lee, a California Democrat. Other sponsors of single-payer plans are also amenable to including women\'s reproductive health services. Coverage with a single-payer plan is independent from employment. Because women are more likely to be self-employed, to work part time, and to move in and out of employment outside the home, they are now more likely either to lack coverage through work or to lose insurance when changing jobs. Medical debt is an enormous concern for many women, and single-payer plans effectively address the cost issues that send women into debt and even bankruptcy. A 2009 Commonwealth Fund study found that 45 percent of women accrued medical debt or reported problems with medical bills in 2007 compared with 36 percent of men. Under Rep. John Conyers\' single-payer bill, a family of four making the median income of $56,200 would pay about $2,700 in payroll tax for all health care costs - with no deductibles or copays or concerns about catastrophic costs. Since a single-payer plan may be the only approach that will successfully contain costs, it was a good sign that Congress finally held hearings on a single-payer system last week. Although many progressive members of Congress now support a proposal that includes a \"public insurance option\" as an alternative to private insurance industry plans, numerous critiques demonstrate how this approach could fail. Unless designed to mirror the effective Medicare system - by automatically enrolling the majority of the population and using Medicare\'s cost control levers - the public option will not be affordable for all. When polled, a majority of physicians as well as the public support a single-payer plan. For example, a 2007 AP-Yahoo poll asked respondents whether they agreed with this statement: \"The United States should adopt a universal health insurance program in which everyone is covered under a program like Medicare that is run by the government and financed by taxpayers.\" A whopping 65 percent said yes to that question. By political standards, this is a landslide. It is time for Congress to pay attention to the voters, not the well-funded lobbyists. Judy Norsigian is executive director of Our Bodies Ourselves. Jennifer Potter, MD, is director of the Women\'s Health Center at Beth Israel Deaconess Medical Center and director of women\'s health at Fenway Health. © Copyright 2009 Globe Newspaper Company.
Jordan Tishler, MD	Jamaica Plain, MA	My thoughts, unfashionable as they may be, are based on being a practicing physician (in the VA ED) and a small business owner (non medical). I believe health and wellness initiative are largely a waste of time. With the exception of diabetes care (not primary prevention) and HTN (again not primary prevention) there is NO evidence that true primary prevention is effective, let alone cost effective. In reality the cost of health care is driven by provision in costly settings like the ED for non-emergencies, over-use of high tech diagnostics and treatment, and most of all, the manner of insurance provision and the wasted efforts involved in getting paid. Streamlining payment, reducing malpractice insurance, reinforcing PCP centered care, reduction of sub-specialty services,

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		these would go a long way. Furthermore, health insurance tied to your employer is a bad idea. It misaligns the insurers priorities with the employer rather than the patient. It puts an unfair burden on the employer as well. It makes it difficult for a patient to switch insurers if they do not like their current one. The relationship between patient and insurer must be direct and foster options for patients. I could go on, but am running out of time, and space. Please feel free to contact me.
Shilpa Hattangadi, MD	Boston, MA	I think doctors tend to see firsthand how much prevention, anticipatory guidance, education, and early intervention can prevent costly and dangerous complications in the future, from everything from exercise and weight loss programs reducing heart disease to breast cancer caught early, to screening CBCs in children catching hematologic disease. We need to have foresight as a country, considering how spending a small amount now on education and prevention can truly prevent worse outcomes and more expense later on. Often, preventative measures also take a few years to see savings, so we need to be cognizant of this - there is data for such outcomes research in the literature.
Erica Mintzer, MD	Cambridge, MA	I am a new intern in a family medicine residency, committed to providing high quality primary care that is not based on ability to pay. The best healthcare system that can help me achieve my goals is a single payer national health insurance system. A single payer system would help us save in administrative costs, provide universal access, reduce spending on unnecessary tests and procedures, and allow us to focus on health prevention and wellness.
Andrea Bauer, MD	Brookline, MA	A key part of prevention and wellness is to have primary care physicians available. One main reason medical school graduates avoid primary care and internal medicine careers is that their medical school debt is so high, malpractice insurance so expensive, and reimbursement for seeing patient so low, that they will never be able to make a decent living. That being said, there are bigger and better ways to achieve cost savings than wellness initiatives: 1. Reform medical liability. Doctors order unnecessary tests, images, consultations, and even hospital admissions out of fear of liability. 2. Eliminate for-profit insurance. They are beholden to their shareholders (as any good corporation should be) and not to patients. 3. Eliminate direct-to-consumer marketing of drugs and devices. When patients show up to the doctor's office demanding the latest drug they saw on TV when a generic medication could work just as well, money is wasted needlessly. Think big and hopefully we can finally fix this!
Jeff Kullgren, MD, MPH	Roslindale, MA	Health reform offers an important opportunity to reorient our health care system to focus more effectively on prevention and wellness. Recent evidence from studies by Kevin Volpp at the University of Pennsylvania, and the experience of large employers like Safeway and General Electric, suggests that applying principles from the field of behavioral economics holds high promise for encouraging healthy lifestyle choices. The majority of work in this young but emerging field has investigated the efficacy of financial incentives for smoking cessation and weight loss. Much more work is needed to determine how broadly applicable these policy tools are, and how they can best be structured to maximize their cost-effectiveness. Tangible ways in which these initiatives could best be incorporated into health reform would be creating demonstration projects within Medicare and Medicaid to more broadly test the effectiveness of

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		financial incentives to reduce smoking, lose weight, and increase physical activity. In the private sector, while employer interest in wellness programs and financial incentives for healthy behaviors is high and increasing, many of these efforts are being initiated without the evaluation needed to describe and learn from their effects. Increased funding from the NIH, AHRQ, and the CDC would help greatly to speed the evaluation of these programs and determine how they can best be incorporated into health insurance plans and workplace initiatives. While prevention and wellness initiatives are critical to improving the public's health and ultimately reducing or at least slowing the growth of the nation's burden of chronic illness, it is worth noting that prevention usually costs more money than it saves, and while important for improving the health of our patients should not be relied upon to fund any substantial proportion of the overall costs of health reform. Carefully framing how the outcomes of these initiatives will be judged is important; if they are deemed successful only if they reduce costs then they are unlikely to ultimately be considered effective. Finally, it is critical to the political sustainability of efforts to refocus our health care system on prevention and wellness that they be crafted in a bipartisan manner so that a broad majority of lawmakers has a stake in their success. Along those lines, both physicians and lawmakers must be willing to fully consider and if needed compromise on controversial health reform details – such as creating a health insurance exchange that does not include a public plan option and eliminating the federal tax exemption on health insurance benefits – if they would allow health reform to be funded in a deficit-neutral fashion that engenders far-reaching political support.
Patricia Kauffman, A.B., M.D.	Chestnut Hill, MA	1. Every primary care practice should have a psychiatrist involved for screening and evaluation, as so many primary care complaints have a psychiatric component . As a psychiatrist with Consultation-Liaison experience, I consulted to a primary care clinic at Stanford Medical Center. I was part of the team and would hear residents' presentation of cases, along with the Primary Care attending. We averted many medical work-ups working as a team: e.g. in my interview with a patient she revealed that she had not taken her medication because she could not afford to pay for both home heating fuel and her medication. She had to make a choice and chose heat over meds. Of note, she did NOT reveal this to her PCP in his visit with her, but did to me in a psychiatric screening evaluation. She felt too ashamed and depressed to let her PCP know of her dilemma. He was about to do further medical testing, assuming that she was taking her meds., which she was not. 2. Having medical insurance tied to an employer deters people from using their mental health coverage, or complaining about their mental health benefits. Because of the stigma associated with psychiatric problems, employees don't want their employers to know that they are using mental health benefits. If there is a problem, they are afraid to complain about the choice of plan that their employer offers for mental health. This problem supports the need for a non-employer based choice of insurance.

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Arun Mohan, MD, MBA	Cambridge, MA	We need a system that rewards all doctors - not just specialists - for doing what's in a patient's best interest. At the same time, to make prevention and wellness work, we need a system that is patient-centered and empowers patients to be equal participants in their care. An important illustration of the latter is our approach to health information technology. I'm a big believer in HIT and I think it offers great promise to patients. However, without further intervention from policy makers, many of these tools will remain unavailable to patients. Doctors may adopt electronic health records, but those health records will be just as inaccessible to patients as today. As a result, Americans will miss out on a powerful way to improve their own health. Research shows that what we do for ourselves - stopping smoking, losing weight and making better daily decisions - are better than any pill a doctor can prescribe. So why shouldn't any effort to expand health information technology be focused on accomplishing these goals? Why shouldn't we demand a system that gives patients equal access to the data and the tools to use it? Wouldn't that be preferred by patients and save money? From where I stand, building a patient-centered health care system is the real promise of health information technology and using technology to engage patients where the real return on investment will come from. From where we stand, building a patient-centered health care system is the real promise of health information technology and activating patients is where the real return on investment will come from. That means instead of giving doctors billions to adopt records they don't want, we might be better off encouraging doctors to adopt just the parts of the record that will be useful to patients -- problem lists, labs, medications and imaging results. It also means that perhaps some of those billions ought to be directed at helping patients adopt technology they clearly want.
Heather Sankey, MD	West Springfield, MA	I agree that prevention is key. I think we need to educate more midwives, nurse practitioners, PA's, and nurse anesthetists to work with physicians. We also need to set up some preventative programs (like immunization) that run through protocol and nurses created by but not involving physicians. Don't forget ob/gyn for prenatal care AND contraception/family planning. Again, doesn't always require physicians but access is really important.
Pamela Lindor, MD	Uxbridge, MA	Prevention and wellness are the cornerstones of primary care. ALL AMERICANs need to be granted their BASIC RIGHT to primary care. If all receive good, accessible, primary care as a basic right, Americans will be healthier and health care "costs" will be reduced. We are all paying for the poor design of the system we have, and we are ALL suffering. Doctors are discouraged and overwhelmed, leaving medicine in droves. Their will be a shortage of primary care doctors if the system does not change. Many, many patients use health care resources inappropriately BECAUSE they are uninsured.......we can fix this. Please, listen to the patients and the doctors, not the insurance companies and employers.
Lucette Nadle, DO	Southborough, MA	Get rid of artificial additives to foods, encourage organic local farming, multiple initiatives (long list if you want) to improve nutrition by improving diet will decrease chronic inflammatory conditions. Shorten the work week and workday to allow for exercise, rest, food prep, family/friend time, adequate sleep. Change healthcare delivery systems so doctors can spend time educating patients regarding lifestyle changes, reward employers for providing healthy work conditions (food, rest, fresh air, good water, community work, exercise).

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		Separate health insurance from work - employers should not choose an individual's health insurance plan. Have insurance cover healthcare now considered complementary or alternative which often promote lower cost, lower technology, safer approaches to health care, but often require more face-to-face time between provider and patient.
Alfred Garfall, MD	Brookline, MA	Thank you for representing our views. I am about to finish my internship in internal medicine, and even after the long hours I remain stunned by the burden imposed on our system - and the suffering imposed on our patients - by entirely preventable disease. It remains difficult in our system to maintain a long-term, continuous relationship with a single primary care physician, who could take responsibility for implementing effective prevention. Losing or changing jobs often means changing physicians, and the lack of portable medical records makes longitudinally tracking health maintenance practices difficult. Any prevention initiative must focus on strengthening the primary care relationship, and making this relationship less contingent on arbitrary factors like employment. Finally, it means rewarding effective primary care physicians the way we currently reward specialists that perform high-volume procedures.
Garry Choy, MD MS	Boston, MA	Increase funding for research and implementation of electronic order entry + decision support (reduce inappropriate or ineffective procedures, imaging tests, and errors)
Nancy Briggs, MD, MPH, FACEP	California, MD	Community needs assessments conducted by public health agencies can provide data on appropriate prevention and wellness strategies. Health care providers can develop initiatives based on these community priorities. In addition, electronic medical records should provide data at a community level to assess progress toward prevention and wellness goals.
Alejandro Necochea, MD, MPH	Baltimore, MD	Prevention and wellness don't happen in a bubble, in isolation. It entails behavior changes (both among providers and patients). Therefore, strategies must happen in the context of systems that reward more integrated, coordinated systems. I.e. clinics won't expand disease management programs with reminder systems for patients if they don't see the benefit from it (no reward for better outcomes) and if they are not given the tools/support to set up those programs. There are many demonstration projects out there that have shown that prevention and wellness programs in the context of this type of integrated systems does save money by preventing readmissions and ER visits. There are other benefits from this type of smart, coordinated system, including reducing waste (duplication) and inefficiency. One big barrier to disseminating these types of programs is having control over all the pieces of the system (drug/device/procedure costs, hospital and doctor payments, ability to insure people, etc). If you start increasing payments for preventive care you must be able to control costs somewhere else--you can't just rely on the future gains from preventive care alone.

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Anna Reed, MD	Baltimore, MD	I work in the pediatric ER and see how education could help families from coming in every single day. They are terrified of things like fever, "prolonged cough", "prolonged runny nose" (both of which have been lasting just 3-4 days), vomiting and so on and so forth. They almost never call the pediatrician before using the ER as primary care(one of the reasons for this is that phone consultations are not billable and therefore, physicians do not invest a lot of time on this as they will not be reimbursed - perhaps we should make this billable and people can have more access to their doctors therefore using places like the ER less) and they have never previously been educated about the above topics to know that they are not emergencies. Until they ARE educated, they will use the ER as a primary care facility, demanding unnecesary tests which if they are denied, take the patient to another ER, incuring huge health care costs. (Also, a lack of physician access to electronic medical records does cause TONS on redundant testing and has enormous costs). Additionally, I see many teenage girls with STDs or unplanned pregnancy who seem to have no idea the long-term dangers and lifestyle implications of their decisions and have no understanding of their own bodies. I feel prevention and wellness initiatives have to start with education of parents and children, of teachers, of everyone. In schools, in pediatricians' offices, anywhere we need to have a massive educational campaign. We have to educate and help people avoid incuring costs, and we have to help them take responsibility for this. We have to all be accountable.
Kathleen Parr, MD	Ellicott City, MD	Two most important issues to control costs. 1) Tort reform. Physicians order many tests because they are trying to prevent a law suit. There may be a low probablilty of the test yielding worthwhile results and evidence based medicine does not support the ordering of the test in that situation. But because there is a small chance the test might give useful results and the physician is afraid of being sued if he/she misses something, the test gets ordered and costs rise. Most physicians worry everyday about being sued and that fear effects everything they do, in both positive and negative ways, but mostly negative. 2) Lack of quality primary care for the uninsured means that when patients present they are sicker and more complicated. Therefore the cost to treat them is much, much more. Health care coverage that gives access to quality primary care is paramount.
J Michael Niehoff, MD	Forest Hill, MD	I support the concept of encouraging each patient/family to have a medical home- the qualifications of the medical home would be that it is accessible, comprehensive and offer continuity of care. These characteristics are described in the work of Dr Barbara Starfield of Johns Hopkins University and are found in all high quality, economically efficient health systems though the world. I am in agreement with the proposals for health reform that the AAFP (American Academy of Family Practice) is supporting right now on Capital Hill. Thank you for noting my views. John Michael Niehoff, MD, FAAFP, CAQSM Family Medicine Franklin Square Hospital 9000 Franklin Square Dr Baltimore, Md. 21237 michael.niehoff@medstar.net phone 443-777-2008 fax 443-777-203
Robert Lawrence, MD	Baltimore, MD	Insurers, whether private or public, should reimburse for clinical preventive services that are based on evidence-based decision rules, such as those developed by the US Preventive Services Task Force.
Zaneb Beams, M.D.	Ellicott City, MD	I want to help more children and their families eat better, exercise more, and live healthier lives. I ask Senator Harkin to ensure that the legislation supports Primary Care physicians- by allowing them more time for education, and more

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		financial and structural support for this kind of Preventive Health Care?
Joseph Marine, MD	Cockeysville, MD	1. Stop profiteering of insurance companies, which divert $100\\\'s of billions of dollars out of the health care system and add no value to it. 2. Use the savings to ensure universal access to health care and strengthen the primary care system. Increase reimbursement for evaluation and management services. 3. Real malpractice reform, including regulation of attorney fees and caps on non-economic damages, is essential to striking the \\"grand bargain\\\" that will be needed to get major reform through and reduce costs of defensive medicine. 4. If the public wants to have a public insurance plan as an alternative to private insurance, then they should have it, but physicians should not be compelled to participate. 5. If the SGR formula is going to continue, it should apply equally to all providers (hospitals, home health agencies, pharma) and not just outpatient services (aka physicians). SGR skews funding toward inpatient care and away from outpatient care - the exact opposite of what the federal gov\\\'t should be doing. 6. Allow federal gov\\\'t to negotiate lower drug prices through a national formulary. 7. Pay Medicare Advantage plan on par with traditional Medicare, rather than the guaranteed 15% margin that was written into the original law (by insurance lobbyists).
John Beauregard, MS, MD	Potomac, MD	Anesthesiologists can not survive at Medicare rates. The rates are ONE THIRD of insurance rates. Manditory participation at that rate will force me to stop practicing. I will lose my house.
Matthew Mintz, MD	Potomac, MD	I think we need to be careful when discussing prevention and cost, because this can be a losing argument. For example, if you have initiatives to stop smoking (which almost everyone would agree is valuable), you will likely prevent lung cancer deaths and some cardiovascular disease. However, people will live longer, get other cancers and other expensive diseases like high blood pressure and diabetes, and this will cost more. In addition, you will lose tax revenue from cigarette sales, so the smoking cessation interventions may actually turn into a huge net loss. Put another way, keeping people alive often costs more money than it saves. The way that I would look at this is in a two phased approach. First, disease prevention will likely not save money until many years down the road and will likely have significant initial costs. However, promoting good health in our country is the right thing to do and down the road will lead to enormous savings. In the short term, we need to focus on preventing the complications of disease. For example, we need to prevent heart attack and strokes in people who are known to be at risk. We know how to accomplish this, but our fragmented system of care does not allow us to meet this potential. By focusing on both prevention of disease and prevention of disease complications, we will net both long term and short term gains that should substantially decrease costs both now and in the future.

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paul thesiger, MD	Chevy Chase, MD	The most important issue is malpractice reform, in my view. Defensive medicine drives unneccessary testing and costs like no other factor. Malpractice ins companies are a legal racket where premiums are not based on your safety record but rather your specialty.med mal should evolve to arbitration boards in every case excluding death outcome. This could all but eliminate malpractice liability needs and take overhead costs way down for docs who could then pass on savings to patients.
Lee Goodman, MD	Baltimore, MD	Several thoughts: --Don't get caught up in the panacea of "wellness and prevention". These things sound great, and no one will argue that they are worthwhile initiatives, but there are lots of illnesses that simply can't be prevented. Sure, everyone should stop smoking and get in shape, and check their blood pressures, but that won't address the major issues. Instead, they are catch phrases that delude health care reformers to think that they're accomplishing something. --You can only expect docs to work so hard. I'm already working extraordinarily efficiently...I simply can't do more cases each day. I'm reading about 150-200 x-rays/CT scans per day, and I'm taking advantage of every efficiency enhancement available. I'm putting in 10-12 hour days regularly. What I'm saying is that you can't automatically assume that enhancements in efficency will make docs' lives easier. That's old news...most of us are already pretty efficient. --The administration's claim that lost revenues will be made up in increased volumes is bizarre logic. Just what we all want to do...do twice the amount of work at halp the pay just to maintain our salaries. And in many cases, docs simply can't do more work. --Malpractice reform must be an integral part of reform. A layman can't understand the anguish that a doc goes through when he's the subject of a malpractice case. When one is sued, it takes an enormous emotional toll. I've been sued 4 times in my 30 year career...never successfully...but it's an awful experience. Frankly, sometimes docs screw up, but most of us are trying our hardest. --At the same time, don't assume that the threat of malpractice suits is the main impetus for overutilizing mediacal care and testing. The real reason is that docs are so swamped that it's easier to order tests than to think first. For instance, if a patient arrives in an ER with ankle trauma, it's easier for the triage nurse or doc to order an x-ray FIRST, before the patient is seen by a physician than it is to evaluate the patient first. While you might say that "who cares...it's only an ankle x-ray", the same logic applies to virtually everything in medicine. If you have low back pain and you call your general practitioner, instead of treating you with motrin, it's easier for him to tell you to get an MRI, and THEN call him in a few days. He's not concerned with malpractice issues...he's just trying to get through the day. --These are just a few of my thoughts. Please understand that I'm a strong supporter of the President, I'm a lifelong Democrat, I'm a prior presidnet of my state specialty organization, I've been on the staffs of both Hopkins and the U of Maryland, I'm the Q/A officer of one of the largest radiology organization in the country, and I'm still reasonably well respected. I just don't want the Administration to be deluded that all we have to do is encourage people to lead healthier lifestyles and our problems will go away.

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Joanne Wu, ND, MSOM	Takoma Park, MD	Good day and thank you for the invitation to comment. I believe our current health care crisis can be addressed not only via health delivery systems but by incorporating naturopathic medicine into our national health care system. Naturopathic physicians represent the medical specialty that is trained in BOTH conventional and 'alternative' or complementary medicine. We are trained in such topics as cardiology, gynecology, oncology, and pharmacology; and we are trained to order appropriate lab tests and imaging. The current perceived shortage of primary care physicians could be alleviated by the cadre of naturopathic physicians who are trained in just that - primary, preventative care. We number in the thousands and could provide needed assistance if State and Federal statute simply allow us to practice to the full scope of our training. (For instance, if the Federal Indian Health Care Improvement Act could pass with inclusion of 'naturopathic medicine,' then our ready and willing graduates could assist some of our nation's neediest populations.) In addition to providing more docs on the ground, naturopathic physicians represent a shift in our entire way of thinking about health. What is broken about the health care system is not just delivery. What is broken is its perspective. The current conventional model focuses on disease management, and it treats the patient as a passive entity. It acts as Superman and tells us that we cannot manage on our own, but rather that we need some kind of intervention (such as pharmaceutical or surgical) to manage both acute and chronic disease. Although Superman may be needed in an emergency, he cannot carry all of us through the rest of our lives. And that is the kernel of the health care crisis: chronic disease cannot be effectively managed with purely interventionist measures. As an example of how naturopathic medicine can work, a pilot program using this system with the Vermont Auto Dealers' Association has shown a 9-to-1 return on investment. Incidence of chronic conditions were reduced (ex: HTN reduced by 36% in the first year; program has continued since 2005). Specific examples of how naturopathic medicine can be included at the national level are: - As mentioned above, including 'naturopathic medicine,' in and passing the Indian Health Care Improvement Act Reauthorization. - Expanding Congressional health care offerings and existing Department of Defense pilot programs to include naturopathic medicine (and also acupuncture). - Housing an Office of Integrative Health within Congress, as presented to Senator Mikulski of Maryland in March of 2009. Once again, thank you for this opportunity. I wish you well in the meeting with Nancy-Ann DeParle.
Beth Rockcress, MD	Bangor, ME	More pay for primary care physicians - that's where the specialists get their referrals from anyway. The primary care docs are already doing the largest volume of work in medicine right now.
Jason Dugal,	Saco, ME	The only way to positively affect wellness initiatives is by offering incentive. Significant tax write off or lower premiums for regular doctor/ office visits, improving health, lowering weight and BP and cholesterol. If people can get a break for making healthy choices, many will make healthy choices. Documented involvement in an exercise fundraiser walk, run or whatever... completing a marathon or other competition... meeting certain goals outlined and approved by your physician. These are all things that can happen easily on a large scale with the right incentives to both the individual the patient and the doctor/ allied health professional.

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Jean Antonucci, MD	Farmington, ME	I feel obligated to express my opinions on health care reform. I am a solo family physician working in rural Maine .I am part of a nationwide collaborative of physicians dedicated to providing great care to their patients (www.impcenter.com). I have worked working on the front lines of health care for the past 21 years, and I have dedicated my last 4 years to trying to understand how to provide superior care to my patients. I am independent, I have no axes to grind, and I represent no interests except those of my patients. There is no question we need reform. The health care system is disintegrating and taking a lot of wonderful patients and doctors with it. Patients are literally dying from both not having access to good primary care and from the poor quality care they receive once they get through the door. Doctors are imprisoned by mounds of administrative minutia which strip away their freedom to practice medicine individualized to the patient's wants and needs (patient-centered collaborative care) and which serve as a wedge between them and their patients. Study after study has shown that the stronger the relationship between a doctor and his patient, the greater the quality and the lower the costs, but our system is set up not to enhance but to destroy this cornerstone of medicine. Unless the reform ideas being proposed address this fundamental flaw in our system, they are doomed to increase healthcare costs while remaining unable to enhance quality. Indeed, it is the failure of the doctor-patient relationship over the past twenty years which has been the true reason behind the cost escalation and the quality chasm. Doctors are paid for quantity. The faster we push our patients through, the more money we make. The problem is that the faster we push our patients through, the less we know each one and the less we know each one, the more we rely on testing and specialty referrals to augment our clinical judgment. Over the past 20 years, reimbursement has not kept up with overhead costs and so doctors have had to see more and more patients a day. The number of tests being done has exploded with the resultant explosion of costs. Insurance companies, seeing this trend, have tried to put roadblocks up to halt testing and referrals, but all this does is increase the administrative costs of the office forcing the doctors to see even more patients per day. Harried doctors become burned out and begin to lack empathy leading to worsening quality and increased liability. Medical students see the trend of increasing workload, flat salary, and miserable physicians and have begun to avoid choosing primary care as a life choice. All this is occurring at the exact time the population is aging, which puts the country on the precipice of a complete meltdown of the medical system. Clearly, the toxic reimbursement system needs to be fundamentally changed such that policies are adopted which enhance the relationship between doctors and patients. Preserving the current insurance companies as they are now is inappropriate Fearing that insurance companies as they exist now will not survive is bizarre. We cannot afford to have insurance companies ,as they are now, continue on. One solution would be to offer doctors the ability to opt out of the current nightmare payment scheme into a new system where the physician gets a dollar a day for every patient who chooses him/her as their primary care doctor. That reimbursement is then adjusted up or down quarterly based on the patient's experience of care. Questions surrounding access, efficiency (waiting time), continuity, information exchange, and coordination can all be easily attained through a simple survey like How's Your Health

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		(www.howsyourhealth.com). I use this tool and I can prove I keep patients out of the ER. MAine medicaid knows I do and has called me about it. By doing this, doctors will be encouraged to provide the best service to their patient, and the resulting happier, healthier patients will be much less likely to go to the ER or have to get admitted to the hospital. Doctors, vying for high satisfaction grades, will quickly adopt quality initiatives like secure e-mail, online appointments, etc. Primary Care salaries will become much closer to that of the specialists- which may drop Specialists salaries are inflated and the political will to deal with this is being addressed see the orthopedic run patientsatcenter.org , More importantly as the relationship with their patients strengthen, overall medical costs will decrease, physicians will have higher job satisfaction, and medical students will flock to primary care. Truly this becomes a win-win situation for everyone. I know this solution does not involve covering the uninsured or forcing the implementation of new tools or cool (expensive) technology, but that is why it will work. Covering the masses is a laudable goal, but doing this prior to fixing primary care is the equivalent of giving everyone a car and not building any roads. Turning to computers and electronic medical systems to try and make a medical office a “medical home” is similar to thinking that adding the internet or a flat screen TV to a house will make it a home. It is the relationships, not the furniture, which makes a house a home. Similarly, to encourage the development of medical homes, we have to start by encouraging the development of strong relationships and only then worry about where the furniture (computers, integrated systems, etc) should go. I appreciate you taking the time to read this letter, and I hope it resonates with you. I fear the potential harm to my patients and my country if we decide to do what might be politically easy instead of what is right. I remain willing to discuss any part of this in more depth if you desire and I can forward many good studies supporting everything I have stated. Providing high quality, cost effective care is possible in today’s environment—I do it every day. But, in order to encourage quality care to become mainstream, we have to change the way doctors are paid. If that cannot be accomplished, nothing else will matter. Sincerely, Jean Antonucci MD --
Bhimsen Rao, MD	Bloomfield Hills, MI	First thing we need to get the insurance companies to cover the prventive care visits to the primary care Docs. We also need to improve access to care and make it affordable to all We should stop paying the specialists like opthalmologists an exorbitant amount of money for cataracts and divert that money to primary care and preventive care. Good luck and keep me posted Bhimsen
Marguerite Shearer, MD	Dexter, MI	Ezekial Emanuel's book, Healthcare Guaranteed, incorporates all necessary aspects of meaningful and successful health care reform. As a retired family physician and HMO medical director,I agree with the author that incremental reform will not work.
Roger Albin, MD	Ann Arbor, MI	We need major reform of our so-called health care system. The minimum reform needed should include a substantial public insurance option and an overhaul of the reimbursement system to emphasize preventative care and move the economic incentives away from procedures and tests.

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Paul Lazar, MD	Flint, MI	As a family doctor I have worked hard at prevention with my patients every day. I know I am most succesful when the following conditions apply: 1) Patients are hearing the same thing I am saying on TV, radio, and in other media. Also the kids are learning it in school. The message has to be congruent and consistent. 2) There is a stick of some sort to go with the carrot of wellness. I get a couple smokers to stop smoking every time the cigarette tax goes up. Same would be true with alcohol. 3) There is easy access to resources to support behavior change. No good telling people to exercise when the only place they have to do it is a street full of gang bangers with guns. We used to have public swimming pools. Why not again. It is infrastructure as an investment.
Erawati Bawle, MD	Troy, MI	It is important to increase primary physician's reimbursement, so enough time can be spent to promote wellness and prevention. Perhaps there could be additionsal incentives which lead to less specialty care and better coordination of care. There is no incentive for the primary doctor to go the extra mile to avoid unnecessary specialty consults. We need to really create a medical home for each citizen. Only monetary incentives will achieve this goal, talk does not do it. I am a pediatric specialist and I am advocating more for the primary care doctor.
Denise Flinn, MD	Ann Arbor, MI	Hello, there. Thanks for the opportunity to share my thoughts with this group. I agree that focusing on preventive health should be an integral part of any major health care reform. I also wanted to point out another type of "preventive health" that is not rewarded under our current system. As a geriatrician, I often spend 30 minutes (and let's face it, sometimes 60 minutes!) talking with a patient and/or family member about medications, screening for depression/dementia, doing a good foot exam or gait testing. These interventions can often prevent adverse outcomes such as a medication error or interaction, foot ulcer, untreated depression or dementia, or falls. Since doctors are rewarded for what they DO (procedures) rather than what they SAY or recommend (office visits, counseling) in our current system, there is little to no incentive for myself (or any general internist, for that matter) to spend the face-to-face time needed to care for many of our complex, frail patients. In addition, I sometimes spend just as much time in between visits coordinating care, talking with family members via phone or email, consulting via phone or face-to-face with other specialists caring for the pt. This is often time very well spent, again "preventive" medicine that can keep a patient at home instead of in the ER, or help a family member cope with their loved one's advancing dementia. However, because this occurs outside the context of an "return ofice visit," I am not compensated for this time. Largely due to our current reimbursement structure, few medical students are choosing to practice primary care, esp. geriatrics. Instead, more and more of them are opting for procedure-based specialities such as dermatology, anesthesiology, cardiology or gastroenterology. So, just as our baby boomers enter their golden years, there will be fewer and fewer MDs to care for them. I believe one major change would go a long way in alleviating this problem: Reimburse doctors for office visits and counseling at a rate that more accurately reflects the true value of these interactions. There are some relatively straightforward office visits that take 10-15 minutes. But if, like myself, you work exclusively with patients over 65, these visits are the exception rather than the rule. Bearing in mind that because there are so few geriatricians, most of our older population will be cared for by primary care MDs (family practice or internal medicine), this change would benefit those

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		already overloaded practioners as well. A busy primary care doc usually sees ~25-30 pts in an 8 hour day, making it quite a challenge to adequately address all of the issues for a complicated, older patient. In addition, I think the reimbursement structure should more accurately reflect the nature of primary care today. Rather than acute episodes of illness that resolve (URI, UTI), most patients are presenting with multiple chronic diseases (HTN, CHF, DM) --and in my practice, geriatric syndromes (dementia, falls, depression)-- that require coordinated management over time and often necessitate frequent interactions between visits. As the discussion moves forward on health care reform, I believe these are important issues to consider. Thanks for your time.
Alex Townsend, D.O.	Lansing, MI	The government must stay out of the practice of medicine. Enforce the regulations that impact those entities that feed off and diminish the practice of medicine. Change the emphasis to the funding of prevention & wellness--thru out the entire medical, insurance and Pharma systems.
Amy Beeman, DO	Onekama, MI	Offer doctors the ability to opt out of the current nightmare payment scheme into a new system where the physician gets a dollar a day for every patient who chooses him/her as their primary care doctor. That reimbursement is then adjusted up or down quarterly based on the patient's experience of care. Questions surrounding access, efficiency (waiting time), continuity, information exchange, and coordination can all be easily attained through a simple survey like How's Your Health (www.howsyourhealth.com). By doing this, doctors will be encouraged to provide the best service to their patient, and the resulting happier, healthier patients are much less likely to go to the ER or have to get admitted to the hospital. Doctors, vying for high satisfaction grades, will quickly adopt quality initiatives like secure e-mail, online appointments, etc. Primary Care salaries will become much closer to that of the specialists, but more importantly as the relationship with their patients strengthen, overall medical costs will decrease, physicians will have higher job satisfaction, and medical students will flock to primary care. Truly this becomes a win-win situation for everyone.
Maren Olson, MD, MPH	Saint Paul, MN	As a pediatrician, I am especially concerned about the needs of children as we engage in health care reform. We must not forget them in our conversations and planning, even though they aren't able to vote or lobby for themselves. For children, good access to health care means receiving pediatric-specific services, having enough pediatricians and pediatric specialists nearby, and paying pediatric providers enough to accept patients from both public and private insurance plans. Please bring these concerns to the attention of the White House. Also, we need to ensure that health care reform results in all Americans having access to quality health care, including preventative care services. Simply adding coverage for a portion of the 46 million people lacking insurance is not adequate--everyone needs to good access to high quality care.
James Kemp, MD	Saint Louis, MO	Make affordable exercise programs available that are based at work. It is a win-win arrangement for companies and their employees
Stephen Griffith, MD	Kansas City, MO	Any initiative that increases the number of docs entering into a career in primary care will result in improved prevention and wellness services and decrease costs while improving health nationally. Either limit then number of specialty slots or increase financial incentives for the docs entering primary care.

Name	Location	Comments
Megan Sarnecki, M.D.	Missoula, MT	Public health level: subsidize fresh fruits and vegetables! Americans are dying and disabling themsleves in shocking numbers from their inactivity. Incentives to move! Some employers pay thier emplyees to exercise - up to three hours per week (forest service in Montana)they can put it on their time sheet. Other employers have bonuses for people who walk or bike to work. Some health plans will pay for your gym membership (as long as you use it - they track how often you go). Don't forget mental health and wellness - it affects people's ability to make changes in all other areas of their lives. Cover mental health fully!
Shane Boosey, MD	Chapel Hill, NC	Please include information on mental health screenings, especially for children and adolescents. Also, include mental health awareness and monitoring for schools.
Alison Stuebe, MD, MSc	Chapel Hill, NC	Breastfeeding is a major predictor of health outcomes for mothers and infants, but the quality of care delivered to nursing mothers and infants is poor. A recent CDC survey found that maternity hospitals routinely engage in practices that are known to interfere with breastfeeding. As a result, breastfeeding rates fall far short of Healthy People 2010 goals. Policies to improve breastfeeding care could substantially impact health care costs. Mothers who do not breastfeed face increased risks of breast and ovarian cancer, as well as diabetes and cardiovascular disease. Infants who are not breastfed face increased risks of ear infections, respiratory illness, gastroenteritis, asthma, type I diabetes, sudden infant death syndrome and leukemia. Policies to improve breastfeeding initiation and duration could include incentives for hospitals to implement the Baby Friendly Hospital Initiative, a set of evidence-based practices that improves breastfeeding intensity and duration; requirements for training in basic lactation management for physicians and physician extenders who care for infants and/or reproductive-aged women; insurance coverage for lactation management and support; reduction or elimination of marketing of infant formula; and incentives for workplaces to adopt policies that support continued breastfeeding, such as flex-time, working at home, and babies in the workplace. For a summary of the importance of breastfeeding in health care reform, see http://www.usbreastfeeding.org/LinkClick.aspx?link=Publications%2fHealth-Care-Reform-One-Page-USBC.pdf&tabid=36&mid=378
Phillip Stover, MD	Louisburg, NC	Do not compromise on the public option!!!
charles scott, md	Burlington, NC	I think we need a public option. I want us to put in place realistic means to pay for universal health care. We need to have malpractice reform. I have been victimized by an unwarented suit which I won, but it has made me more inclined to order tests etc. to cover myself. There will have to be some sort of committee to evaluate the efficacy of certain treatments and whether the system will pay for them--- chiopractic for example.
John Haresch, MD	Kitty Hawk, NC	Let's be honest. Spending more money on more screenings and more physicals is not going to save a dime. What will save money? Having an effective primary care system, with every person having a single doctor who knows them, who can offer a range of services, and who can spend time with them. This will save money over the current system of rushing people on to their next test or specialist. Supporting effective primary care with better payment and less busy work will improve health and save money. Studies are clear on this point. The only other thing that will save money is rationing. And we will have to do that,

Name	Location	Comments
		too. Let's do it rationally.
John Page, MD	Durham, NC	Three words: Obesity, alcohol and smoking.
Lea Watson, MD,MPH	Chapel Hill, NC	Correcting the pay for primary care and psychiatry and placing value on the "thinking" (prevention/wellness)encounters equal to the "procedural" encounters will go far to align incentives.
Priya Rajan,	Charlotte, NC	Access to adequate early prenatal care for all women will help those who are higher risk get appropriate management. This would be a more effective use of societal dollars than pushing the limits of viability or allowing expectant mothers to request interventions that have very low likelihoods of improving outcomes, which result in huge financial and social costs to the system.
Eric Lewis, MD	Chapel Hill, NC	I think part of the discussion should be concerning prevention and wellness issues and their fit into a single payer government funded healthcare system. Private insurers have done a miserable job at prevention as witnessed by the obesity in our society. One of the major health achievements was government based - anti-smoking which HHS took up back in the 60's. At least only 20% of Americans now smoke.
Gary Greenberg, MD MPH FACP FACOEM	Durham, NC	1) Healthcare reform needs a mechanism to provide evidence-based criticism on the explosion of popular, expensive but marginally useful tests & treatments. The structure should include advocates from all parties, but the methodology needs to be rigorous and skeptical. E.Emanuel\'s panel was a correct version. 2) The 240B program provides federally required discounts on pharmaceuticals, as provided to FQHC\'s. This is a good idea, but not far enough. Other purchases (eg resp.ther & DME) should also be included. Even more importantly, other authorized purchasing sites like (true) charity facilities like Free Clinics.
karl stevenson, MD	Durham, NC	The only way to cut costs is to be sure that NOONE is benefiting by making financial decisions that deprive patients and of timely and effective treatment. This is the only way to be sure that the current cost effectively represemts the true cost of treatment. Only when we know the true cost of treating those who are ill can we figure out the best and most efffective forms of treatment and stop paying for what is not necessary.
Kim Eng Koo, MD	Rocky Mount, NC	I feel it is important for the president to realise that healthcare reforem will not happen unless he attacks the problem from 3 angles. 1. the overall cost of care, test, hosp. stays etc. 2.reduce liability insurance for all, doctors, PAs, nurses and hospitals, to a reasonable level, including judgements. 3. curbing the insurance companies. He must deal with them. This include both the liability insurance companies and the third party payors. Probably best resolution is a government general health insuranc available for all. I am disappointed by what I read so far on his proposal. I feel he need to talk not only to doctors, but nurses, hospital administratora and the legal profesiion. The lawyers are driving up healthcare costs too. Sorry, I cannot make it tomorrow, but wopuld love to hear from you all.

Name	Location	Comments
Wayne Hale, MD MS	Greensboro, NC	Obesity should be disincentivized by increasing contributions to health care coverage incrementally with increasing BMI. This money could be put into a fund with positive incentives for those who lose weight. Prevention tests should be defined by the evidence for efficacy only with this being the basis for retesting rather than political influence from those who gain from more frequent testing.
Ellen Blair, MD	Apex, NC	I support the 4 top priorities in ACP's health care reform agenda: ensure all Americans have access to affordable coverage; re-align incentives to support effective, efficient, patient-centered, coordinated care; make primary care payments competitive with other specialties; establish a national workforce policy to ensure sufficient numbers of primary care and other physicians. Also, I would like to see a cap on "pain & suffering" malpractice payments. But MOST IMPORTANTLY (since it is UNlikely congress will support all of these), the "public plan" should be "a public option without conditions or triggers -- one that gives the public insurer bargaining leverage over drug companies, and pushes insurers to do what they've promised to do" (quoting Robert Reich). The drug companies and insurance industry MUST be forced into efficiency and cost-containment. LET'S GET IT DONE NOW! (TY for taking our voices to the Obama administration).
Elizabeth Peverall, MD	Burnsville, NC	THE ONLY WAY IS A SINGLE PAYER NATIONAL HEALTH CARE PLAN.
Perry Dryor,	Valparaiso, NE	
Barry Smith, MD	Lebanon, NH	I appreciate your efforts. I am concerned that we will solve parts of the problem without addressing the issues that could really improve outcomes while actually reducing cost. My comments below were sent to Rep Peter Welch who I know. In my clinical years and in my current patient safety work I have of course been influenced by the Dartmouth Quality approaches which you are all hearing about these days. I believe that the system must change-payment incentives, liability issues etc. However I also feel that it is the attitude and approach of health care providers including MDs, nurses and administrators that will the hardest to change even if we are able to fix the liability and financial incentive issues. There needs to be a plan and a uniform approach that is not just a series of state by state battles. We also need to reach a time when medical students do not graduate with debts so high that the debt level effects their career choice and their practice location decisions. Last but not least we need to be committed to mentoring young MDs into the real world of practice since they are so over supervised in today's residency programs. Regionalization of care will be inevitable, but there will be huge turf battles along the way. The Obama administration needs to change the Democrat's attitudes with regard to tort reform. In almost all fields of medicine we are wasting 10-20% of health care dollars on defensive medicine based on fear. This money could provide basic health care for most of the uninsured. Barry Smith Barry D. Smith, MD Professor of Obstetrics and Gynecology, Emeritus Chairman Emeritus Dartmouth Hitchcock Medical Center One Medical Center Drive Lebanon NH 03756-0001 (603) 653-3296 direct line/voicemail (603) 653-3212 fax E-mail is the best way to reach me. 6/9/09 Peter, It was nice to see you at the Norwich Historical Society event. My late wife was very interested in seeing that project happen and I know she would be thrilled with how well it has progressed. I am writing to offer some information on health care for the childbearing age population and newborn

Name	Location	Comments
		care. Since stepping down as Chair and then returning to work part time I have been working on patient safety and quality improvement in Obstetrics. This of course connects with the health of newborns and NICU care. We have developed an Obstetrics Patient Safety web site at Dartmouth and have expanded the project to many NH and VT hospitals. Currently we have about 1300 people in the region participating in a Web based educational course on Electronic Fetal Monitoring, and our two state quality improvement network, NNEPQIN, Northern New England Perinatal Quality Improvement Network, is a collaboration of most VT and NH Hospitals which has produced some excellent projects and improved outcomes. This is a jointly led effort from Dartmouth and UVM that I worked to organize several years ago. I have attempted to share this work with others through ACOG since I also volunteer as the Chair of the District l (New England and Eastern Canada) OB Patient Safety and Quality Improvement Committee. There is much to be done that could lead to better Obstetric outcomes while reducing costs. It is my hope that the current health care effort you are participating in will push many of the issues I feel would help: 1. We need insurance coverage for all pregnant women so that they will get the best prenatal and intrapartum care. A good investment of money that would save money down the line. 2. We need standardization of care which will only come through improved data collection and use of that data to change behaviors of patients and health care providers. The HCA system has done some excellent work with results that could be attained elsewhere. I was a task force member and then a participant at the Maternity Symposium in DC in early April. It was clear that many in the field who care about these issues need to work with you and your colleagues to improve the system. The current data collection and EMRs that don't speak with one another impede the best care and the best data collection we need in order to obtain better results and lower costs. Unfortunately many of the HIPPA privacy laws also in my view impede these efforts as well. 3. I know that you are familiar with the Dartmouth Atlas based on Medicare data. With Medicaid now paying for 43% of deliveries in the US I believe that a Dartmouth like atlas for Maternity and newborn care would help greatly. You may have read how pilot studies that have restricted elective inductions of labor prior to 39 weeks of pregnancy have been shown to improve outcomes, reduce Cesarean section rates and reduce NICU admissions by close to 50%. This could and should happen everywhere. 4. Rural Obstetrics services at smaller hospitals are a major concern in our region as well as many other areas of the country. It is very difficult to run small delivery services safely, to recruit new MDs, Nurse Midwives and nurses to these hospitals and then to serve rural populations who are often under insured. Regionalization of care will need to be a major issue for discussion. 5. Last but not least the practice of Obstetrics is very adversely affected and financially burdened by the current medical liability climate. Bad and expensive medical decisions are made based on fear of litigation. We need to change that. I recently heard an excellent presentation by a NY MD on a no fault system that would save money, improve care and also rapidly reward those families who need financial help after a mal-occurrence. Most bad outcomes in Obstetrics are not related to negligence but are rather no ones fault. The current tort system is the only avenue that needy families have today and this system only adds costs that do not benefit the family or the child. I would be happy to

Name	Location	Comments
		expand on any of this with you. You might enjoy looking at the Dartmouth Safety web site and the NNEPQIN web sites. http://www.nnepqin.org/ http://www.dhmc.org/webpage.cfm?site_id=2&org_id=872&gsec_id=0&sec_id=0&item_id=44599 I enjoyed looking at the energy references in your web site. Gro-Solar is installing solar panels on my house today and my son earns his living in wind energy working on his own in California after working for several years for NRG in Hinesburg. They started him into a wonderful career, and he still collaborates with NRG on projects around the world. Sincerely, Barry Smith
Lalitha Hansch, MD	Bridgewater, NJ	1. Pay for the time it takes to counsel patients on prevention and wellness. Value it, decrease the emphasis on paying to fix problems once they occur. 2. Cover preventive services like nutritionists, supervised exercise programs for a period of time. 3. Provide financial incentives to quit smoking, such as reduced premiums or health savings account credit. 4. Re-evaluate the effectiveness of screening measures in prevention. 5. Cover prevention in Medicare!! 6. Cover relaxation technique training (such as meditation), counselling, and exercises that relax (tai chi, qi gong, yoga) to help treat anxiety and stress disorders rather than just give medication. Maybe incentivize employers to provide classes in the work place. This is a huge problem in the American society and costs the society a lot of money (medication, lost time at work, illness, etc) 7. Improve the nutritional content of food by shifting the farm subsidies to allow for a more balanced inexpensive food supply.
Anita Vaughn, MD	Plainfield, NJ	By paying for Physicians to practice prevention and wellness initiatives more African-American and other patients of Color as well as others could decrease weight through improved diet and excercise to improve or prevent DM, Hypertension, Dyslipidemia and CV risk and cancer vs treating these diseases. Community education, outreach and Adherence of needed Behavioral change regarding Prevention and Wellness through individual, family, group sessions would be more effective for long term results.
Cynthia Reichman, MD	Moorestown, NJ	Healthcare is a human right, not a privilege for those who can afford it. I strongly believe that the best solution to the health care crisis is a single payer plan. However, knowing that single payer is politically impossible at this time, the next best solution is to include a public plan option in the reform legislation. Please do not cave into the demands of the AMA, the insurance industry, and the Republican opposition. A public plan option is absolutely necessary in order to begin to rectify the inequalities that exist in health care today.
Estelle Williams, MD	Montclair, NJ	In order to cut medical costs, doctors need student loan relief for medical education. There also must be tort reform. The practice of defensive medicine is expensive but will not end without protection for the doctors. Clearly when there is gross negligence - e.g. the wrong limb amputated - the patient should be able to sue. However, it's the smaller suits (thousands of examples) with large payouts. When we hear these cases, it is human nature to do whatever we can to protect ourselves - and we order more tests. In the emergency department, we don't get more money for more testing, but we do it to protect ourselves and our families. The emergency departments of the nation need a bailout! We are overwhelmed and understaffed. Please see the cover article of Time magazine Sept 10, 2001.

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Name	Location	Comments
Frances Wu, MD	Warren, NJ	There should be a program or programs which can hold a small amount of the patient's cash and then give it back to them as a quarterly reward for maintaining their own health--by exercising regularly, or getting vaccinations, or staying off cigarettes or eating vegetables or being compliant with their necessary medications. This checklist could be maintained on some kind of automated online registry or by the honor system or by a community support group, or the local pharmacists, or the "medical home".
Rajni Bhardwaj, DO	Stratford, NJ	Reimburse primary care better so that students will have incentives to go into primary care! Also put more funding into alternative medicine research.
Shena Vander Ploeg, Biochemistry & Naturopathic Doctorate	Oak Ridge, NJ	Since the top ten to twelve most prevalent health conditions in the U.S. are by and large preventable, i think it is time to seriously consider investing in educating people about their health and encouraging healthy lifestyle decisions, to promote wellness. Helping people understand how their body works and getting them to a point where they feel great is ideal, because that will motivate them to stay healthy. It is important to address the psychological, physiological, and emotional factors that contribute to wellness/health and disease states. Prevention and Wellness should include: counseling, advising, teaching, treating the whole patient (not just the symptoms they manifest), and working with the patient to customize their health care. It is important to remember that everyone has their own variables involved so it will be different for each and every person. I think things like accupuncture, massage, therapeutic manipulation, hydrotherapy, gym memberships, and physiotherapy should all be included in the wellness plan... since the body will not be healthy if the mind is not well. WELLNESS is the result of a well-rounded lifestyle, a healthy mind, body, and spirit are necessary to achieve states of wellness. I think that here in the U.S. we need to have stricter standards on food regulation- such as: organically grown products, harmful chemicals in food, pesticides, and genetically modified foods. Since we are what we eat... a good place to begin to encouraging the health of this nation would be through improved education on nutrition. (since 40% or more of American are obese- putting them at risk for many other disease states). Empower the patient with the tools they need to live a sustainable and healthy life- with lower risk of the preventable conditions and diseases that plague this society. Some simple things such as decreased consumption of processed foods/fast foods; adequate exercise; and a balanced diet would significantly improve many common conditions i.e.: obesity, type two diabetes, heart disease, depression etc..
Dora Wang, M.D.	Albuquerque, NM	Please listen to the leadership of Doctors for America, an important alternative and I believe, a more genuine and inclusive voice for physicians than the AMA. The AMA took important leadership on behalf of patients in the early 1900's. However, they have been working against health care reform since the Nixon years, and have been steadily losing clout among physicians. To me, Doctors for America seems more aligned with reforming health care in the best interest of all patients, more in line with the core mission of doctors--which is to serve in the best interest of patients.

Name	Location	Comments
Neil A. Holtzman, M.D., M.P.H.	Las Cruces, NM	Prevention and wellness initiatives will cut costs only if we have more primary care providers--those who give continuing care to their patients and coordinate their care with other providers. Primary care provides know their patients best and can tailor prevention and wellness initiatives to their individual needs. There is a drastic shortage of primary care physicians, as well as other primary care providers. The shortage of primary care providers will also drive up the cost of providing health insurance to everyone. The shortage leads uninsured and underinsured to use expensive Emergency Room visits or delay in seeking care, which can make people sicker. At the other extreme, the shortage drives people to specialists who are much more expensive than primary care physicians and may not be appropriate to a patient's problems. An increase in primary care providers is the key to increasing prevention and wellness initiatives, reducing costs, and providing ongoing care for people when they are sick as well as healthy.
Donna Tully, PA	Albuquerque , NM	One main concern I have is how to provide healthcare for the additional 45+million adults and children currently uninsured: what plans are being made to increase the number of medical students and allied health personnel? I also suggest adding funding to NHService Corps to make medical education affordable to more MD and PA students.
elaine bradshaw, md	Santa Fe, NM	#1 Please increase availability of primary care clinics and pay for them if you want to keep people from waiting for care until they're way-past unwell and then going to the emergency room for what should have been primary care months (or years) ago. #2 Deal with the obesity epidemic- NOW. I'm a pediatrician, and seeing obese 4 year olds with acanthosis nigricans (no joke) is crazy. Our country's life expectancy is going to decrease, and our health care costs are going to go up, if we don't deal with this ASAP. Please, more free public phys ed/sports programs, and get the school lunch program out from under commodity agriculture (USDA) and under an agency that works for health (DOH or whomever). Can you believe my children's public school cafeteria serves frito pie for lunch once a week (for non-southwesterners, this is a pile of fritos, covered in beef chili, cheese, and lettuce- if you're lucky). #3 Please fix reimbursement so that time spent doing prevention is valued and reimbursed as much as doing procedures. I spend a half hour working to prevent obesity, smoking, infectious disease, etc, and if I didn't, and instead did cardiac caths or lung biopsies, I'd be making a pile more money- and costing the system a pile more money. #4 I, despite generally good health, have been "Sick Around the World" (to use the title of the PBS documentary)- and got easier to access, equally good, and lower cost urgent health care in the Philipines, Sweden, and France. They may not quite have the cutting edge, high tech diagnostic and therapeutic modalities we do (which can, of course, have value in their own rights), but at least one can get prompt, decent everyday care that doesn't run you into the poorhouse #4 Last, but certainly not least, I know big tobacco and big pharma are forces to contend with in society and on the hill, but if we can reign in their influences and costs to the system, we will have gone a LONG way toward prevention and making our system work better. Thanks for the opportunity to give input on issues I've been confronting and pondering for almost 20 years now. Reform, please!!!

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Name	Location	Comments
Neal Devitt, M.D.	Santa Fe, NM	The most important indicator of good health is good education. It is one of the most important influences on socioeconomic status as well. We can do little as physicians to compensate for the detriments of poor education and resultant poor health. By then the horse is out of the barn. The classic mechanisms of preventive medical care are important but secondary. We need to support initiatives to improve education.
Richard Todd, MD	Albuquerque, NM	Specialists in onc, cards, ortho, anesthesia, optho, derm, rads, and GI are ridiculously overpaid. I see my colleagues taking trips to egypt and china. My wife and I are both primary care docs -- she's in peds, i'm in internal medicine. We drive from Albuquerque to disney land because the plane tickets are too expensive for us. The overpaid specialists all park porsches and BMWs in the hospital. We drive a couple of old Hondas. Please fix this. Specialists will scream. Too bad. They all say they have to have enormous salaries or people won't do the extra training. Except that nobody pays endo, ID, or geriatrics any more money than me, and they have extra training. I'm tired of being paid by running patients through as fast as I can. I make less money if I slow down and do a good job that keeps patients out of the hospital. I would love to talk to someone who can make a difference.
Miriam Komaromy, MD	Albuquerque, NM	If we really want to acheive a healthier population than the bulk of our efforts should be on maintaining health and preventing illness. Childhood interventions should be prioritized over those in adults, but both are important. It would be helpful to develop a cost-benefit ranking and risk/benefit rankings for all kinds of medical interventions, so that they could be compared directly. Incentives could be provided to patients and providers to promote an emphasis on the best interventions, and make more low-yield interventions less accessible and more costly.l
Mike Irwin, M.D.	Reno, NV	Please keep the public plan!!
Henry McCurtis,	New York, NY	We must continue to push for a public/private hybrid plan that can evolve into a single payor system with centrally regulated quality and cost standards that preserves choice, cuts cost, sustains quality and comprehensiveness with parity
Raphael Pristoop, MD	Brooklyn, NY	I am a physician in an inner city Brooklyn hospital. I am on the front lines of people without adequate access to health care. Daily I care for patients who are uninsured and present suffering from advanced diseases which could have easily been prevented had they had better access to heath care coverage. Even some of the patients with insurance can't get the care they need because private insurance companies reject necessary therapeutics. This country needs a government run public insurance option. The government is responsible for the safety of its citizens. Heath care should be available for all citizens not just privileged ones. Honestly the best prevention is giving people health insurance. If they don't have health insurance they will be deterred from participating in prevention and wellness initiatives. If you can prevent a disease early on from progressing to a more severe outcome with worse consequences billions could be saved.

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Name	Location	Comments
Tina Dobsevage, MD	New York, NY	We need Medicare for all, expanded to preventive care. I agree with Atul Gawande that we have to reward care that results in better outcomes. This will not be accomplished uniquely by changing the source of funding. To reward Mayo Clinic type systems, we may need something like NHS in the UK. However, I believe we can achieve better care for all when patients don't have to choose between medicine and food. Universal coverage with a public single payer plan is a start. Currently in New York, the most completely insured patients are insured by Medicare with Medicaid as the supplemental insurance. These patients have vastly more services covered than the patients insured with commercial plans. In addition, coordination of care through a medical home model will reduce quantity of services provided and improve clinical outcomes.
karis cho, md	Long Island City, NY	1. Primary care needs to be reimbursed well for preventative and wellness counseling. Procedures are what get reimbursed. 2. Counseling and prevention takes time with patients...not the 10 minute visits allotted by many HMOs and private practices. I find it outrageous that I get more time with my dentist/hair stylist/ etc than a doctor, when there's so much more at stake. 3. Torte reform is integral to cutting costs. While prevention is the ideal, the reality is still that doctors will order some unnecessary tests so as to "CYA"...(cover your ass). I don't have too many patients who come in because they are well . Most people see a doctor because they're sick or worried about something. 4. Big picture issue: we're going to need more med students going into primary care in order for there to be any implementation of preventative care. I graduated from med school 5 yrs ago and hardly anyone from my class went into primary care. Why would they when you get paid less for more work than the specialties. - need incentives to vaccinate. Some clinics lose money in order to vaccinate. It's not just the cost of vaccines, it's the time it takes for support staff to give the shots. So far, most colleagues I know are still doing out of the ethical principle but don't know how long that will last. - need evidence based national guidelines for all doctors to adhere to...there are too many different guidelines. For ex. Pap smear guidelines differ between ACOG and USPSTF, but if in fact pap smears aren't needed every year, we would be cutting down costs. Ex 2. Most guidelines say screening colonoscopy q10 yrs after age 50 in avg risk person, but the specialists we refer to here in NYC say repeat in 5 yrs. There's too much variability in practice. Yet of course, if there happens to be an advanced colon ca in 10 yrs when the specialist recommended 5 yrs, you have no. Case in court.
Perry Pong, MD	New York, NY	Reward physicians for being judicious and cost effective for certain illnesses like back pain; pay more for preventive counseling given and less for procedures like physical therapy. Pay for mental health counseling since many multivisits for healthcare are for somatic manifestations of psychiatric illness. Use quality assurance payments to reward good practices. Where does the money come from - specialists and procedure-based specialties; from uniform national board guidelines for whether procedures are called for and payed for; from uniform billing and referral systems to eliminate extra bureaucracy; from eliminating Medicare advantage plans; to changing Medicare D plans to a single formulary to take advantage of government purchasing.

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Name	Location	Comments
Katherine Ellington, MD	Saint Albans, NY	Prevention and wellness initiatives need happen in local settings in the doctor's office and clinics. If more Americans are going to have access to health care then it must start with Adult Well visits that start with physical exams, but have follow-up that includes educational sessions and in some cases these should be mandatory for managing diabetes, hypertension, and hyperlipidemia. Yes, mandatory educational group sessions offered by nurse practitioners. For those who are obese and lack physical activity both educational and active sessions should be offered. So instead only having a yearly check up folks would be having Adult Well visits where age appropriate health and medical advice is discussed in group settings. Those who make all the session should see a reduce copayments and other incentives and those who choose not to participate should pay out of pocket into a health care fund. Some educational sessions could also be completed and offered online and then the Adult Well visits would take less time as the "informed patient" is empowered.
Sharlene Kinney, MD	Berkshire, NY	All insurers (including Medicare) should be required to cover an annual preventive health exam. Also, primary care physicians need to be paid more, reflecting what our services (including coordination of care) are REALLY WORTH to the health care system. If this is not done, a massive shortage of primary care physicians will result, resulting in increased expenditures as patients get more and more of their care from specialist physicians.
Alexandra Cornell, MD	New York, NY	The AMA does NOT speak for me. Comprehensive health reform is a moral imperative. It has to be reform that actually accomplishes something, not reform compromised by insurance/HMO lobbyists. In my opinion, single payor is the solution, but I will support a more modest proposal that offers adequate coverage for those in our society who are most in need of it. In terms of how we can use prevention and wellness initiatives to improve health...it would be a great start to just get kids to come in for regular check-ups, both well-child visits and follow-up appointments for chronic health issues. I have many patients who cannot afford a co-pay, so forego the care they need. I have patients with asthma and Cystic Fibrosis who do not take their medications as prescribed because they cannot afford them. If they did, they would avoid hospitalizations and ER visits. This would decrease health care costs by default, although prescription medication costs would rise comparatively.
Siatta Dunbar,	New York, NY	- need to increase incentives/tuition reimbursements to encourage more med students to go into family practice, ob/gyn, and other primary care fields - care needs to be administered in a cooperative/comprehensive manner (ie have facilities that offer mental health services, medical services, and nutrition counseling under one roof) - physicians need to actively participate in the wellness/health of their patients (how can a physician tell patients to stop smoking, eat properly, lose weight and we are ourselves aren't practicing those same habits) - target the younger generation through community initiatives/outreach that educate them on healthy lifestyles, managing stress, the risks of smoking, STI's, etc as it relates to the overall notion of a public plan i have the following comments: - the public plan should be on an elective basis - the public plan must be available nationwide in order to control costs and truly be able to compete with private insurance plans - the public plan must be available at its outset rather than taking months/years to "get off the ground" - the public plan must be publicly run so that it is transparent and able to be held

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		accountable for its successes and failures - the public plan must be electronic to cut down on patient errors and save the costs of billing THANK YOU FOR THE IMPORTANT WORK THAT YOU ARE DOING!!!
REBECCA LEE, MD	East Elmhurst, NY	cost cutting can be achieved by encouraging preventive care. Both doctors and patients must be given access and incentive for good preventive care practices. This would involve pediatricians or an assistant seeing to it that the children are eating well, exercising,taught and fully explained the consequences of smoking and drinking and using drugs. There should be more opportunity for group exercise that is fully available and advertized in each community. Alternative medicine and preventive medicine should be required classes in each medical school and part of the board exam. Healthy living and life styles should be heavily promoted by the government,community and places of worship. People will do what is popular. A healthier population with less heart disease and cancer will be the result. I also know that if abortion is outlawed you will have less people with PTSD,depression,suicide,low self esteem,alcoholism and drug abuse,lowered fertility rates etc. All this will add up to less drugs used , less time spent in hospitals and less surgery,less x-rays, and cost savings increased.
Javeed Sukhera, MD	Rochester, NY	Ensure that behavioral health is well funded. Reimburse providers for providing education/counseling regarding chronic illness. Pay primary care practitioners and mental health providers more and tertiary care procedure-based specialists less.
Constantine Farmakidis, MD	Rochester, NY	There is no question that broad access to primary care and prevention services would make a big difference in the illnesses that I treat. I see lots of patients with stroke, in whom earlier detection of high blood pressure, good follow up and access to basic meds would have made a tremendous difference. Instead, too often we have patients that arrive in the ICU devastatd from a large brain bleed or a low blood supply or ischemic stroke. We try clot blusters, we do an extraordinary amount of costly and sometimes dangerous testing, and we are developing even more expensive but still not clearly known to be effective catheter based procedures. Too often, when I look at my patients, I feel that we have failed them even before they get sick. When they arrive critically ill, it feels like we are doing too much, that does too little and arrives too late. This is a system that we can improve on. I have not doubt. Lets all work together to broaden access to basic preventive care. Lets also make sure that treatments that work become available, but treatments that do not work based on good comparative effectiveness research, are scaled back. I think it will also be important to make an effort to somehow contain liability. In such a difficult legal environment practicing cost effective medicine is not so much dangerous for the patients, as it is dangerous for the physicians. We shared sacrifice, by physicians, lawyers, insurers, and also to an extent by patients, we can make a better system. In my humble opinion, we have no other choice.

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Joshua Allen-Dicker, MD, MPH	Great Neck, NY	As the founder of the Facebook group "Health Professionals Against the AMA's Stance on Public Insurance" (which, since its founding last week, has grown to have over 230 members), I believe that these goals can best be met through the institution of a public health insurance plan. A central health insurance option will allow the government to promulgate health reforms easily. Such reforms should focus on complying with the "Rules for Redesign" in the IOM's "Crossing the Quality Chasm" Report. Continuous healing relationships can be promoted first by increasing the amount of primary care physicians (increasing reimbursement rates), then providing incentives for doctors to work in multiphysician practices, provide options for patients to access care after-hours, etc; in the case of single-physician practices, Health IT can be used to provide networks of physicians who work together to provide continuous care. Patients need to be empowered--they must be provided freely with information about their health and prevention of disease, but they must also bear increased responsibilities to care for themselves. Evidence-based decision making must be promoted, both through the establishment of a government body to develop cost-effectiveness data on clinical decisionmaking/drugs/devices and through incentives to ensure implementation of proper protocols. Mandatory transparency reporting initiatives for hospitals with federal analysis and commentary will provide knowledge for consumers and incentives for improvements. Strict federal determination of need procedures could help prevent inefficient resource allocation and allow health system surpluses to be invested in cost saving measures. Please feel free to contact me with any questions you may have at joshua.ad@gmail.com. Regards, Joshua Allen-Dicker
Celia Quinn, MD, MPH	New York, NY	I am a Pediatrician and see countless examples each day of how timely, preventive care can promote wellness and child development. Children who miss health care maintenance visits because of lack of insurance, underinsurance, or lapses in insurance coverage can suffer the consequences of missed medical problems that later limit their ability to achieve their full potential. For example, a child with speech delay could have an easily correctable hearing problem, which, if not addressed early, could learn to a lifetime deficit in learning and communication, not to mention thousands of dollars in special ed instruction, speech therapy, and treatment for behavior disorders. While restructuring our broken health care system, please remember that children have unique needs and that prevention is more than vaccines- skilled Pediatricians help each child develop to their own full potential.
Clinton Sewell, MD	Cambria Heights, NY	The execution of any prevention and wellness initiative will require highly motivated physicians to achieve any degree of success. Indeed, the success of the healthcare reform and universal healthcare initiatives that have been advanced share this same requirement. Physician-actualization and satisfaction must therefore be assured as a pre-requisite for successful healthcare reform. Adequate compensation and patient care decision making autonomy are the linchpins of physician satisfaction, and must be assured if the increased demands by a system of universal healthcare are to be met. Physicians must therefore organize as integrated multidisciplinary groups that serve target communities to achieve these objectives. Such corporate organizations of physicians will create the operational framework that will best achieve the desired outcomes from initiatives such as prevention and wellness. These organizations are not likely to

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		occur spontaneously. The Obama administration should therefore actively promote their development. **THIS IS OF UTMOST IMPORTANCE. PLEASE, DO NOT FORGET TO MENTION THIS!
Raj Gupta, MD	Somers, NY	1. Fedrally mandated minimum standarads for preventive services for all insurances. (exmainations, mammograms, pap smears, Blood pressure and diabetic screenings, vaccinations etc) 2. Imposition of increased premiums for those who choose to have unhealthy life style (smoking, Obesity etc), premium reduction for participation in regular exercise programs. This should not be provider depandant
Charles Lee, MD	Brooklyn, NY	I am a community psychiatrist in New York. I am not part of the AMA, which represents some, but not all, physicians in this country. I believe that their opposition to considering a public insurance program is based on financial interest (and fear), not the interests of patients or the general health of this country. A couple of thoughts: -more money needs to go to primary care. a lot more. i'm not a primary care physician, and i'm saying this. primary care physicians are the ones who juggle the multiple medical problems of patients, and their time is sorely limited. more students would go into primary care if they knew they had adequate time to work with complex patients and would be reimbursed fairly. -less money needs to go to specialty care. there is way too much of it. specialists only want to deal with their area of specialty. how many times has a patient brought up an additional issue, and the specialist responds, "Talk to your primary care physician about that." The problem: there's no primary physician to talk to because there aren't enough of them, or they don't have the time. -re-hospitalization rates are high not necessarily because hospitals are doing a bad job, but because the linkage to follow-up is often so poor. that follow-up is supposed to be a primary care physician. we already know the shortage of PCPs. but it's often difficult to make an appointment with what few there are, even if you're already an established patient. and if a patient was hospitalized, chances are they had multiple complex issues that require more time than the typical 15 minute primary care visit. -medical school tuition is too high, and taking huge loans only persuades students to go into lucrative specialties. loan forgiveness for working in primary care--regardless of location, not just underserved areas--would be a start. -the system of private payer insurance completely distorts decision making, such as medication prescriptions and lab tests. -insurance should not be based on employment. people change jobs all the time (and from an economics point of view, a fluid labor market is a good thing), and every time they do, they have to go through a change in insurance, which is not only an administrative waste, but also a potential barrier to working with the same physician they are used to. also, some people stay at jobs simply for the benefits, and from an economics perspective, that isn't good either. -also, as we are seeing in these tough economic times, employer-based insurance doesn't work so well if there is a lot of unemployment. when people are losing their jobs and are under considerable stress to take care of themselves

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		and their families, the last thing they need is having to worry about their insurance. cobra is a terrible system, both bureaucratic and incredibly expensive.
laurie goldstein md, MD	New York, NY	they must be funded...ie well-person visits, pap smears, mammograms, screening colonoscopies, eye exams, dental exams,mental health exams must be covered by all insurance policies.. ..NO QUESTIONS ASKED... Right now, honestly, I have to make up diagnoses to get my patients their reimbursements (I am fee for service) since routine, preventive care is NOT covered. Also, there is no way to lower costs, and decrease the overtreatment of patients and overuse of diagnostic testing if we don\'t change the tort laws and the malpractice situation. It\'s all well and good for the Obama administration (whom I support) to appeal to the medical profession to stop all this overuse and overtreatment...but it will NEVER stop if doctors can easily be sued for not doing \"just that one other test.\" At this point in time, most doctors will do whatever it takes to avoid a lawsuit, or the risk of one, and that fact is making it very difficult to practice sound and cost-effective medicine. It is also greatly affecting the way residents are trained, and the newer generations of doctors are really losing out. In my field, they are learning how to do cesarean sections unless the baby is literally falling out. They are no longer being trained to do real obstetrics, and will be lost in any situation where an operating room is not immediately available. In essence, we are rapidly losing the art of obstetrics, and the ability to have our graduates be able to work outside of the first world. Unfortunately, I am not optimistic about our country\'s ability to stand up to the insurance lobby and/or the tort lawyers, and as a result, I think we are going to see a serious decline in the quality of american medical care in the future.
jacob steinberg, md	New York, NY	colleagues, great luck. be familiar with IHI & don berwick in boston - OVERUTILIZATION of medicine is dangerous 100,000+ lives lost ayear, millions of injuries. need to direct our funds to PREVENTATIVE care including behavioral/mental health services. great luck & stop all the excess procedures & unnecessary hospitalizations - they kill. best jj steinberg
John Weiser, MD	New York, NY	One day, I had a cancellation and had a few extra minutes to talk to a patient in my family practice. She was a woman in her mid-50s, a librarian, never married - a solitary type. I had been telling her for close to a year that she needed to take blood pressure medication but she wouldn't do so consistently. I used the extra few minutes we had together to try to understand why. I asked her what it meant about someone if they took medication every day and she answered, "old". When I asked her what it meant to be old, she said, "invisible". She didn't start taking her medication regularly that day, but we did open a dialogue. Over time, with increased understanding of her particular needs, I was able to help her to accept treatment. This wouldn't have happened without the extra few minutes that I used to try to understand her. I would still be seeing her for 10 minute visits, making the same pronouncements with little effect. Health behaviors change after a gradual process of becoming ready to change. In primary care,

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		there are huge opportunities to improve long term outcomes but we need resources - time with patients and staff support - to do that. I would be happy if we could get even half the financial support that surgeons and other specialists do for doing their important work.
Susan Rubin, MD, MPH	New York, NY	cover comprehensive reproductive health care including all forms of contraception as well as abortion, prenatal care and support for adoption. Please do not leave out a public option to any health care reform package.
Harold Appel, MD	New York, NY	The best way to cut costs is to be sure everyone has access to quality care so that they will be less likely to use the ER for primary care. Single payer is the only plan that make sense that will achieve this goal. Taking the profit and bureaucratic waste that the private insurers create out of the system will easily pay for universal coverage.
Jordan Nestor,	New York, NY	
Stephen Bauer, M.D.	New York, NY	The best way to promote wellness is by insuring all Americans are provided with adequate health care insurance. This will end the practice of using emergency rooms as family physicians, or waiting to seek care in emergency rooms until symptoms become unbearable --both of which are costly as well as inhumane. The best path to this objective is well-formulated public medical insurance.
William Gilmer, MD	New York, NY	My thoughts: Thank you for your efforts on this problem. In terms of reducing the costs secondary to unnecessary tests: often mentioned is the fear of lawsuits, but there is another factor which I haven't heard as much in the debate. And, it is this: In Ophthalmology, a proper history & exam (including dilation) pays very little so there is a large economic incentive to reduce time spent on a proper examination (including excluding a dilated exam - the gold standard) and instead have unnecessary tests performed by techs, etc to make the office visit valuable and to pay enough to run a business. If the proposed reforms include a system whereby doctors are paid a much higher, and appropriate, fee for doing proper histories and physical examinations, then I believe we might see a reduction in the strong economic incentive to order tests which may be of limited value or need; I can only imagine the combined cost in dollars of all these tests performed across the country - which might be reduced significantly if we could just pay a doctor an appropriate fee for doing what he/she was trained to do. Unfortunately, this would require the counter-intuitive notion of paying doctors much more money to actually decrease the cost of health care, which might be politically untenable, not to mention the discord it would cause among the industries which are a part of such ancillary testing. The second point I would like make is this: I am a supporter of President Obama's and of health care reform. But, if he is asking us all to help, sacrifice, etc then it would be helpful to hear him make stronger comments about the legal community. His AMA speech left one wanting. Like the president, I also fully support legal remedies for malpractice. But, that doesn't mean there can't be a reasonable cap on rewards. Kenneth Feinberg was charged with determining the value for compensation for victims of 9/11. In a similar way, determining reasonable caps for malpractice would be

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		hard and complicated, but it doesn't mean it cannot be done in a fair way. Finally, there has been much discussion regarding Medicare payments for doctors. It seems the stakeholders in this debate include doctors, lawyers, device makers, pharma, the insurance industry, hospitals, among others. President Obama often says he doesn't "begrudge" someone making a profit. I think this is right; device makers, pharma, HMOs etc should make a profit to drive their industries, but haven't those profits become too extraodinary and don't they drive many of the distorted facets of our health care system? Could there be a balance? Thank you again for your work. Sincerely, William Gilmer, MD
Judit Gordon-Lendvay, MD	Hartsdale, NY	High quality and readily available psychiatric care benefits many, not only the patient, because of the nature of these conditions. At the same time such care is seldom available in the current health care system. While symptom reduction can be achieved with short term therapies in patients without personality disorders, deeper levels of change can be achieved in personality disorders with long term intensive therapy. Focus on evidence based medicine misses the sad fact that funding of long-term studies is woefully minimal. However, such studies are available in European literature. These patients end up on a large number of medications at huge costs and little effectiveness. They often go from crisis to crisis, hospital to ER, etc. While at hospitals, the time pressure allows for the most superficial observation by overworked staff, little time of communication and integration of data. At the same time, in psychiatry, diagnosis depends on careful observation and a lot of collateral as well as longitudinal information. There is a great discrepancy between the care those can get, who have the means - they can see a psychiatrist who will take the necessary time (almost never one 45 minute session) to arrive at a diagnosis, is either well trained both in therapy and medications, and is able to treat the whole person- or has good communication with a well-trained therapist and has the luxury of only collaborating with those whose clinical skills he/she feels comfortable with. Those who need to use their insurance most often receive short-term treatments for long -term problems, and even this treatment is suboptimal because the medicating physician(often primary care MD who typically under-medicates; a very busy psychiatrist who sees about 40 patients per day, or NP who has superficial understanding of neuroscience) and the therapist do not communicate. In the meanwhile our understanding of the brain increases exponentially; there are well studied, manualized therapies available - little of which is translated into patient care. MDs are not invested in learning therapy with the low reimbursement rates that do not reflect the many years of training; and the severely limited numbers of sessions available. Proper mental health is cost-effective in the long run. It is not for the "worried well" - anyone who has ever been to therapy knows that it is a painful, difficult process, not something one would "abuse". The main cost is labor - no need for expensive diagnostic procedures etc. It is the labor that has been greatly devalued and that contributes to the discrepancy between available knowledge and its harnessing in patient care. We place too much emphasis on technology and too little on brain power.
Karinn Glover, MD, MPH	White Plains, NY	Pay MD's to keep pt's well by supporting preventive care, head start and patient education initiatives. Support programs that support programs for vulnerable mothers. Send nurses and social workers and childcare folks to educate new

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		mothers with their babies. Taking care of these mothers and you take care of generations of the population.
Alexander Pitts-Kiefer, M.D.	New York, NY	I am a 3rd year medical student who will graduate with over $200,000 in educational debt. I whole-heartedly support the need for healthcare reform. I could even support a government-run healthcare system such as the UK's NHS. However, I am concerned that the financial burden of attaining a medical degree is not part of this conversation. Although I lack specific statistics, the cost of a medical degree in the US is significantly higher than in any other industrialized country, where medical education is heavily subsidized. The effects of this disparity are inextricably intertwined with any meaningful attempt at reform, but yet, it has not been addressed by policy experts.
Elizabeth Jenny-Avital, MD	New York, NY	The funding of health care as piecemeal fee for service encounters is in itself a public health problem. The delivery of fragmented health care generates revenues irrespective of the need for services and irrespective of outcome. Fragmented health services generates revenues for providers and even generates academic research--but such fragmented health care does not benefit the intended recipient. On some level I think specialists and organizations which reap huge revenue from specialist services have to be accountable to document need and outcome for specialist services. Thus no patient should have a procedure in isolation without a quality history, physical, and trial of medications. That our system reimburses for procedures without any requirement that the attendant care was provided encourages indiscrimate use of procedures which do little benefit. Even if proceduralists are not deliberately doing unnecessary procedures, the fact that their responsibility for patient well being is so divorced from their care necessarily obscures the uselessness of much of what is done. Patients clamor for more services and specialists and institutions compete to provide those services--but the value of the procedures is overestimated and is not commensurate with the profit they generate. An astute diagnosis helps patients, spares them unnecessary complications and generates too little revenue to be valued. Americans need to understand that the goods and services of the health care industry are not equivalent to health care. Further, health care cannot be fragmented from socail infrastructure. Without clean air and water, safe food, education, housing, safe work places, justice--there can be no real equitable health care system.
Barbara Gatton, MD	New York, NY	We need a strong pubic plan as part of the healthcare reform initiative. We will never end healthcare disparities without that aspect of reform. I work in a NYC Emergency Department. Many people call to make appointments with private doctors, but can't get in. It is a myth that we don't have waits to see doctors in the U.S. We cannot leave this to private insurance companies. There is no financial incentive for them to promote health or to pay for prevention. It is not socialism to have governmental regulation of essential services. No one complains that it is socialist to have public police and fire departments. Some things are too important to let profit drive them. We need to value human life. We need to take care of our neighbors. We must have healthcare for everyone. We cannot have working people loosing their homes or declaring bankruptcy over medical bills. We need everyone in this country to have a medical home. I see patients who have strokes because they couldn't afford their blood pressure

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		medicine. It is tragic and preventable. It would save the government money to have that person working and paying taxes rather than lying in a nursing home. I urge Mr. Obama to continue to support a strong public health plan and we will help him by telling our legislators that we expect them to vote for it.
Linda Gross, M.D.	Beachwood, OH	1. All pts with chronic illnesses, which include many psychiatric ones, should be entitled to unlimited sessions, so that they can be treated well and hospitalization, which is much more expensive, can be averted; patients' quality of life can be improved this way. 2 Doctors must be paid for time collaborating with other caregivers, whether it be in a phone call over, say, 10 minutes, or a team meeting, so that tests aren't repeated and everyone puts their heads together. Like in the recent New Yorker article. 3 Doctors must retain some autonomy and decision-making authority! Appealing decisions made by a bureaucrat or nurse end up usually being approved on the second round of hassling, but considerable time is wasted by having to appeal refusals. 4 Patients should be able to choose their doctors and have continuity over time. 5 Doctors should be paid for their time, not for procedures!!! Pediatricians and child psychiatrists, for example, shouldn't earn a pittance compared to surgeons, as their work is equally as valuable.
Mary Murphy, MD	Strongsville, OH	To change the behavior of large numbers of people we need to set up the environment to encourage health.examples-Encourage breastfeeding by having more hospitals commit to the "Babyfriendly" Hospital initiative, more sidewalks to encourage walking, and healthier foods in schools(instead of pizza and cheese sticks)
Jophn Bloom, MD	Dayton, OH	As a Pediatrician I am well aware of prevention and well ness. However, I believe that Medical schools should put more emphasis on this aspect of Medicine which I do not believe is occuring now.
Heather Finlay-Morreale,	Cincinnati, OH	More assistance to help low income folks, not on Medicare, Medicaid, get cancer screening like mammograms and colonoscopies (ie vans) and then have a public insurance plan that picks up people with pre-existing cancer or pre-cancerous lesions. Early detection is best and cheaper overall.
Thomas Hirt, MD	Dayton, OH	One idea is what a lot of companies are trying - to give a discount on healthcare premiums for exercise time. If we can provide discounts for non-smokers, for active people, for people who get regular checkups and vaccines, that would help with primary prevention. For people with HTN or diabetes, or another chronic disease, providing a financial incentive for regular follow-up visits, for taking meds, for getting A1C's checked, etc. People respond to money/financial incentives. If a premium or copay is discounted, people will go and get things done. I personally think the #1 way to reduce healthcare costs is to get the population in better shape.

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M Burgett, MD	Wooster, OH	I am a primary care pediatrician, one year out of residency and currently loving my job. Despite complaints about the income of some doctors, I recognize that my income is still way above the majority of Americans. I have four thoughts when it comes to health care reform: 1. I absolutely agree that we need cost containment and more evidence based medicine. My only concern is that it is already very complicated to figure out which studies and therapies are covered by which insurance program, and which ones require preauthorization. My fear is that "cost-containment" could mean an even more complicated system than we already have. On the other hand, there are some great resources for evidence based medicine. For example, the AAP has published guidelines for how to best treat an ear infection. The first step is to treat with amoxicillin, an inexpensive antibiotic. Unfortunately, some doctors will still treat with more expensive, broad-spectrum antibiotics. Simple, evidence-based guidelines are helpful. 2. As a member of the American Academy of Pediatrics, I think they have wonderful ideas for evidence based medicine and good public health policies. I highly recommend looking to them for ideas. One huge issue is insurance companies' reimbursement of vaccinations. Some doctors won't provide immunizations anymore because it is costing them too much. 3. Primary care, when done well, works! Yesterday, I saw a patient who perfectly illustrated this issue. A few months ago, I met a teenage who was on at least 10 medications, and who was being treated with psychotropic medications for bipolar (on the waiting list for a psychiatrist), synthroid for hypothyroidism (on a waiting list for an endocrinologist), and on at least 6 medications for chronic abdominal pain (managed by a gastroenterologist), The pt had missed at least 100 days of school in the past year. She had multiple endoscopies and colonoscopies, and was seeing the gastroenterologist at least monthly. Recently, I checked her thyroid hormone levels, and they were sky-high. When I stopped her synthroid (for hypothyroidism), her mental health and GI problems improved within days. The GI doctor is a good and smart doctor, but sometimes it takes looking at the big picture to figure things out. The good news is that this pt is now telling me she feels 'awesome'. The bad news is that I should have figured this out one month ago, before she attempted suicide. When it comes to complicated pts like her, we need to be compensated for spending a long time trying to figure out each of these issues. When I saw this pt on my schedule, I would make sure I had 30min (rather than my usual 15min). However, she really needed a solid 60min several times in a row. That kind of time could help prevent the expensive referrals and studies she had. 4. The cost of medical education is very expensive. The average medical school debt is up to $150k, which is what I owed when I finished at a state medical school. If we really need more primary care doctors, then we should provide more loan repayment for doctors. Friends who owed more than $250k had to choose specialties that provided better pay (radiology, dermatology, anesthesia, etc). Lastly -- please keep up the good work on reform. Please don't buy into the fear-mongering that says good people won't go into medicine if they don't get paid better. There are huge numbers of talented, enthusiastic, and compassionate pre-meds who would love to have the med school slot of someone who is only there for the money. Having graduated in 2005, I don't buy the notion that people go in to medicine for money. My class was full of people who loved science, health, healing, curing, and serving.

Name	Location	Comments
Ryan Buchholz, MD	Cincinnati, OH	Please continue with the dual aims of cutting out-of-control costs, with cost-effectiveness research, and affordable coverage for all patients. Please do not assume that the AMA speaks for all physicians. Keep reading Atul Gawande's work. I have worked at Cincinnati Children's Hospital for the past 5 years and will be moving to DC to work in Upper Cardozo Health Center in Columbia Heights on the frontlines with patients who have no insurance. I thank you for keeping the patients first! Sincere regards, Ryan Buchholz, MD
Julia Mortlock, future ND, LAc	Portland, OR	We need to focus on prevention...and true prevention of chronic disease. This involves teaching patients about healthy lifestyles and applying good preventative healthcare. If we can focus on prevention, the costs will go down.
Usha Honeyman, ND, DC	Corvallis, OR	Include CAM fully in every health care plan. There is no question that patients are healthier, happier, need fewer surgeries and hospitalizations when they are taught good information about how food, herbs, supplements, and lifestyle changes benefit them. Physician means teacher; please let us do a good job of teaching patients how to be healthy. Include naturopathic physicians and chiropractors fully to do what we are licensed to do.
Jenny Fisher, naturopathic doctorate	Portland, OR	Prevention and wellness initiatives will work to cut health care costs and improve individual health if patient's are seen before they are sick. The current health care model doesn't pay physicians for well patients or prevention visits as insurance coding is based off of a disease based paying system. The solution that I have to offer is through like minded physicians who practice through a prevention model. I would like to take this opportunity to bring up the discussion of Naturopathic medicine. Naturopathic medicine offers an alternative to the current health care system because the guiding philosophy for this field is prevention and stopping the progressing pathologies that lead to disease. Naturopathic medicine forms a bridge between eastern and western forms of medicine as the physicians receive a rigorous education that the federal government has viewed to be comparable to conventional medical schools. The education covers the basic sciences and includes a thorough education in treatments ranging from pharmaceuticals and other conventional treatments to botanicals, nutrition, hydrotherapy, and more eastern treatments. This wide range of treatments allows Naturopathic physicians to individualize treatment plans for patients at various levels of pathology. Currently, there are five federally accredited naturopathic medical schools in the United States. Students graduating from these schools are licensed primary care physicians. Despite the fact that Naturopathic medical schools are federally accredited as medical schools, they are only licensed in roughly 1/3 of the states due to various reasons for opposition from the AMA. Naturopathic medicine and other lines of medical providers all have a place within healthcare. The future of medicine is within integration between various practitioners. Together, physicians from different medical backgrounds can fill the gaps that are created by each profession, uniting healthcare and maximizing wellness initiatives for the public. But in order to reach a state of integration, naturopathic medicine and other areas of medicine need to be accepted and fully licensed throughout the states.
John W. Schulte, MD	Salem, OR	A vigrous PE program in the schools would be agood place to start.
Joseph Eusterman	Wilsonville, OR	Take care of people, not insurance companies. Single buyer, single payer-American people!

Name	Location	Comments
MD, BA<BS<MD< in>		
Peter Mahr, MD	Portland, OR	Adopt single payer national health insurance NOW!!!!!!!!
Suniti Kumar, MD	Portland, OR	Routine vaccinations should be free for all people. This includes the flu shot. We should tax junk food, sodas, and juices which have any added sweeteners. WIC should not give out juice, as this contributes to the obesity epidemic. We should provide birth control free of cost. Ideally, this would include vasectomy and tubal ligation. Prenatal care should also be free. These would be good starts for my patients.
Honora Englander, MD	Portland, OR	The AMA does not represent the majority of physician's views about healthcare reform. Physicians want a system that supports primary and preventive care through a strong public option. I support a single payor system.
Kelley Shackleton, M.D.	Portland, OR	Address the elephant in the room. There will not be healthcare reform until the insurance companies are regulated and restricted. Consider CUTTING OUT the middle man and eliminating the insurance companies as they are now, which is outdated, and what Nixon originally put into place. NO MORE HMO's! You can't reform and lower the costs while the fat insurance cats have their chubby toes in our business!
Frank McCullar MD, MD	Portland, OR	We need Single Payer Health Care.
Sara Knuth, BBA, seeking ND	Portland, OR	I would just request that Naturopathic Physicians be included in the conversation of Healthcare reform. Naturopathic medicine is an effective consumer choice for chronic disease prevention and management. A licensed naturopathic physician attends a four-year U.S. Department of Education approved graduate level naturopathic medical school and is educated in all of the same basic and clinical sciences as an M.D. but also studies holistic and nontoxic approaches to therapy with a strong emphasis on disease prevention and optimizing wellness. Naturopathic physicians are trained in the basic medical sciences and conventional diagnostics, and are also trained in therapeutic nutrition, botanical medicine, homeopathy, natural childbirth, classical Chinese medicine, hydrotherapy, naturopathic manipulative therapy, pharmacology and minor surgery. Naturopathic doctors are positioned to practice preventive health care, engaging patients in health promotion and in treating those with chronic disease to manage the entirety of their health. Current conventional definitions of wellness include disease screening, vaccinations and other prevention strategies such as drug therapy, which fail to empower the patient or enable patient choice to engage in health promotion and disease prevention behaviors. However, naturopathic physicians have practiced expertise in individualizing health promotion and fostering patients’ adherence to lifestyle-based health promotion behaviors.
Lauren Ward, BS	Portland, OR	Naturopathic medicine is focused on preventive care and natural healing techniques. This type of care is less expensive than any other type of health care, and eliminates some of the burden from the current system by keeping people healthy. We need to license all states in the USA for Naturopathic Medicine, and start getting the word out there; that there are other options. If MD's, DO's and

Name	Location	Comments
		ND's all worked together we could provide the optimum care for America. This means we must all be on a level playing field to start. We all have adequate training and can offer unique perspectives in health care.
Mark Davis,	Portland, OR	As a naturopathic medical student at the National College of Natural Medicine, I want to make my voice heard on the value of naturopathic physicians as primary care providers. Our focus is on prevention and wellness, and that's where our expertise lies. As Atul Gawande's excellent article in this month's New Yorker describes, the single most effective way to increase quality of patient care and decrease costs is to build a culture of medicine that supports collaboration and focuses on patient care over profit. Here in Oregon, where NDs have been licensed primary care providers for more than 80 years, MDs, DOs, NDs, NPs, PAs and other health professionals enjoy working collaboratively to provide wellness and preventative care services for their patients. I would be delighted to see, and I'm sure the nation would benefit greatly from, federal initiatives which include support for and compensation of NDs on a federal level.
Tineke Malus, B.S., N.D.(2010)	Portland, OR	Funding research into long-term preventative medicine will facilitate policy based on sound thinking. The NCCAM for example is focused on clinical interventions that are much cheaper to implement. Giving patients the choice in practitioner (DO, DC, NP, PA, ND) will bring primary care back to the forefront of medicine, where it belongs. Alternative and Integrative care needs to be made available to all Americans, not just the wealthy and educated class.
Carol Blenning, MD	Portland, OR	Most prevention and wellness education comes from primary care providers. We need many more, and fewer specialists. Students need incentives to choose primary care (loan forgiveness, better pay). We'll also need a lot more clinics (esp FQHCs) to address the increase in demand once everyone has coverage (preferably through a single payer system).
Kristen McElveen, ND	Fairview, OR	Naturopathic medicine is the leader in preventative health and in many states where we are licensed, we are primary care providers for many, including the under-insured. It is imperative that we get naturopathic medicine licensed in all states to help promote wellness and work together with allopathic medical providers to help aid this healthcare crisis and still provide the utmost care to all Americans.
Meghan Larivee, N.D. ,M.S.O.M ., LAc	Portland, OR	utilize the expertise and skills of naturopathic physicians those trained as primary care physicians with complete clinical training and medical education from an accredited medical school (NCNM, Bastyr University, Southwest College of Natural Medicine, and University of Bridgeport) Utilize Chinese medicine too. Both forms of so-called "natural" medicine approach care with a holistic philosophy and address the underlying cause of an illness and symptoms with and effort to support optimal physiology and therefore truly PREVENT chronic disease. this approach to health care enlists the patient- it focuses on teaching an individual healthy habits and how to stay and be healthy in order to prevent chronic illness.
Kristin Odegaard,	Portland, OR	As a naturopathic medical student, this hits home for me and drives my passion further into my path of study. By making complementary and alternative care more accessible to Americans. These include, but are not limited to naturopathic medicine, acupuncture, osteopathy, chiropractic, nutrition, the list goes on. Obesity is one underlying culprit for many of the diseased affecting the nation.

Name	Location	Comments
		What's worse is that it is preventable. Individuals that are put on copious amounts of prescription drugs without having the foundation of healthy living habits get placed into a vicious cycle. Preventative measures would be a minimal initial investment, yet the savings in the reduction of more invasive would make it well worth the initial effort.
Scott Casey, ND	Portland, OR	Chronic disease is bankrupting our health care system. The best way to decrease chronic disease rates is by preventing them. Any health care measure that is not solidly based around prevention is simply a disease care measure. Caring for disease is costly while preventing disease is inexpensive and improves the quality of life that individuals can enjoy. I believe that most health care concerns present in the world today can be treated with simple lifestyle interventions. Doctors must develop trusting relationships with their patients and physicians that go out of their way to develop these relationships must be promoted.
Aimee Bonneval, Bachelor of Science, biology	Portland, OR	By motivating people to take care of themselves, we can cut the price of healthcare. Exercising and eating healthier foods are the solutions to many health problems such as diabetes and heart disease. Also, living a healthier lifestyle, like not smoking, can help by not activating specific genes that are linked to cancer!
Jolene Hedges, ND, 2012	Portland, OR	It has been my experience that health is easier to maintain than to regain. I think it is important that as a nation we embrace the concept of preventative medicine as a means to cut health care costs, decrease the disenfranchised state in which our current system has left us, and move forward with a healthier America. Currently, to my knowledge, this country holds 60 million medically disenfranchised individuals. While many factors play a role, the lack of primary care physicians available to the public is a key issue. As a medical student, I see this as a prime opportunity for naturopathic physicians to be utilized in restoring this nation to a state of health. Naturopathic doctors, who practice as licensed primary care physicians in many states, regard preventative medicine as the ultimate goal in health care. Our focus is on the education and promotion of lifestyles that are conducive to healthy living, increasing both the quality and quantity of life. I ask that as you look to the future of health care that you consider the national licensure of naturopathic doctors as a means of developing the primary care workforce.
Myra Long,	Portland, OR	Federal licensing of naturopathic doctors can help preventative healthcare grow exponentially. Naturopathic doctors not only are trained in modern medicine, but they are also trained to utilize the healing power of nature - a very cost effective alternative to palliative healthcare.
Sarah Walker, BS, almost ND	Portland, OR	The principle and modalities of Naturopathic medicine inherently cut health care costs in the long-run. Using modalities such as herbal remedies, homeopathy, and physical manipulation take a small initial investment and save enormously as an investment in the overall health of an individual. The side effects of the more natural modalities are virtually imperceptible in comparison to pharmaceuticals and drug-drug interactions are minimized as well, not to mention that they foster health and healing over further deterioration. It must also be taken into consideration how patents are driving up health costs. The increasing number of patents being doled out and the binding nature of these agreements is sending us into dangerous territory. Although, there use is in spurring on researchers, their pay off is mounting towards a debilitating level. Natural remedies using

Name	Location	Comments
		whole plants, homeopathic remedies, and natural manipulations are minimally bound by patents. Thus both research on and the use of such modalities are more cost effective.
Eliana kozin, MD	Portland, OR	public health care screening programs are large initiatives in public health in other countries run at a national level which can improve an individuals' health care who would otherwise not get care. this is other countries includes mammography which goes into the community. also multiple diabetics cannot afford adequate treatment and focusing in prevention in this group can improve health and prevent dialysis, surgeries, etc which cost millions.
Mary Morrison, MD, MS	Wynnewood, PA	Dear President Obama, I strongly endorse the need for health care reform in 2009 that includes a public option. I am a Distinguished Fellow of the American Psychiatric Association and a Fellow of the American College of Physicians. The AMA does not speak for me. We need universal coverage with affordable individual mandates. We need mental health parity for the disabling mental health illnesses that are currently poorly covered. We are behind you and doctors want a system that reflects the needs of patients and true American compassionate and competent values.
Christopher Hughes, MD	Canonsburg, PA	Theodore Roosevelt gave a famous speech at the Sorbonne in PAris called, "The Man in the Arena. I think these two parts are especially appropriate in our current discussion on health care reform. "It is a mistake for any nation to merely copy another; but it is even a greater mistake, it is a proof of weakness in any nation, not to be anxious to learn from one another and willing and able to adapt that learning to the new national conditions and make it fruitful and productive therein." And, "The poorest way to face life is to face it with a sneer. There are many men who feel a kind of twister pride in cynicism; there are many who confine themselves to criticism of the way others do what they themselves dare not even attempt. There is no more unhealthy being, no man less worthy of respect, than he who either really holds, or feigns to hold, an attitude of sneering disbelief toward all that is great and lofty, whether in achievement or in that noble effort which, even if it fails, comes to second achievement." This is always how I see those opposing progress who seem to sneer at the idea of universal health care. To quote JFK, "We choose to go to the moon. We choose to go to the moon in this decade and do the other things, not because they are easy, but because they are hard, because that goal will serve to organize and measure the best of our energies and skills, because that challenge is one that we are willing to accept, one we are unwilling to postpone, and one which we intend to win, and the others, too." Let's be THAT America again!
mandy garber, md	Pittsburgh, PA	We need a universally accessible EMR that would reduce the # of unnecessarily repeated diagnostic studies and consultations. PLEASE!!!
Jennifer Holst, MD	Pittsburgh, PA	Pay for diabetes education and nutrition education for those with diaebtes, and those at risk for diabetes (i.e metabolic syndrome).

Name	Location	Comments
Eric Holmboe, MD	Philadelphia, PA	1) We must have a public option as part of healthcare reform - hard to see how reform works without it. 2) Strongly support the push for measurement, but also want to broaden the meaning of measurement so as not to be overly focused on current performance measures. Issues such as diagnostic error, communication, etc. are also critical to healthcare quality - they need more attention 3) While I realize this is a "small" component of a very complex problem, I strongly believe substantial attention is needed on medical education. We are simply not training the medical workforce we need for the 21st century, and it is not just about physicians. I'd really like to see a task force of some sort take on this issue in a meaningful and comprehensive way - left to the myriad of existing organizations, I worry there will not be a coherent policy moving forward to support President Obama's reform agenda. The focus of the discussion relates directly to the issue.
Tiffany Farchione, MD	Pittsburgh, PA	Thank you for all of your hard work on health reform! The AMA does *not* represent me on this matter. Please do not forget about those with mental illness in the push for health reform. Now that parity has finally passed, I would hate to see it fall by the wayside in the new system.
Geoffrery Ruben, MD, MMM	Washington, PA	I believe there needs to be discussion of adopting a version of the German health care system to the United States. I believe more each day that this may offer a compromise to bridge the political divide between the supporters and opponents of a public plan along side the private plans. Such a system should be less costly than the projected expense of the public plan. I would be more than happy to be involved in helping to explore this option. Sincerely, Geoffrey L. Ruben, MD, MMM, FAAP, FACEP Clinical Assistant Professor of Emergency Medicine, West Virginia Uiversity School of Medicine
Derrick Mobley, MD	Philadelphia, PA	Increase or begin reimbursement for these services in private and public insurance domains.
Leigh Winston, MD	Pittsburgh, PA	Prevention and wellness initiatives are a drop in the bucket...we need to address insurance company profiteering. With a national health insurance program, we could bring administrative costs down to a level where tweaking prevention would have some meaning. (see PNHP.org for details)
Darren Linkin, MD, MSCE	Philadelphia, PA	1) get everyone covered / in the system..whatever the system is. And covered means adequately covered. 2) Standardize good care more, cut out excessive (and sometimes harmful) and undercare, move towards universal medical record. This also means penalizing/finding bad care more (e.g., more pro-active state or other licensing investigations) and supporting those injured by care more (current malpractice suing effectively does neither for most cases). 3) Fed gov't must fund more health services, clinical, and translational research. (note: i'm a clinical researcher). We can't get things funded these days unless there is an interesting biological mechanism involved. This is often not inline with research to help prevent treat and cure disease. 4) Pay doctors/ healthcare systems to a) help people stay well, and b) make people better. Current payment systems pay doctors to "do things" to people. Or essentially by throughput so we're paying more at the end of the day to those doing short procedures/visits and less to those doing longer visits when needed and preventative care. We won't fund hospitals in NYC to keep diabetics well, but then will pay a surgeon and hospital thousands of dollars to amputate their leg when the preventable severe infection happens. This is a fundamental problem.

Name	Location	Comments
Gene Bishop, MD	Philadelphia, PA	I don't think these will cut costs. I believe firmly we need single payer, or the closest we can get to it. We need to cut costs by improving primary care infrastructure.
Diane Hawk, ND, PhD	York, PA	License naturopathic doctors in all states. Preventive medicine and wellness are cornerstones of their training. More americans want natural health care alternatives available to them. Rather than letting insurance companies dictate what the standard of care should be, doctors should be given the freedom of treating their patients as individual and determining what the best approach is for each individual. Lifestyle changes like diet and exercise should be first line approaches for many diseases like diabetes and high cholesterol rather than pharmaceuticals. If doctors aren't trained to work with clients in this manor they should refer them out to naturopathic doctors or dieticians.
S.R. Keister, M.D. (Retired)	Erie, PA	Of course the REASONABLE way to improve health care and control costs is single payer per HR 676 or the Sander\'s bill in the Senate. This all rests on the 25 year study done by Physicians For A National Health Program. (Please remember that the Democratic leadership has no spine and that several med-western senators have been bought off. See:http://theragblog.blogspot.com/search?g=%22By+Dr.%22+R+Keister.
Kalonda Bradshaw, MD	Pittsburgh, PA	Developing a single-party payer system via national health care reform will allow for more Americans to benefit from prevention and wellness initiatives which will ultimately decrease health care costs and improve health. If individuals have insurance coverage they will more easily be able to access preventitive care, rather than waiting until medical conditions are urgent/emergent.
Jeannette South-Paul, MD	Pittsburgh, PA	As we consider reforming our health care non-system, it is clear that there will be a revision of the metrics previously used to measure performance. In addition to monitoring what is easy to measure - hospital admissions, complications, length of stay, A1C, cost and number of medications prescribed,etc, let's refocus our assessment on patient-centered metrics. Let's monitor length of time patient has been in a physician's care (one potential measure of satisfaction on part of both pt and doc), communication between physician and patient outside of visit - eg phone calls, home visits (something FPs and other pri care docs have been doing for years for little recognition or reimbursement), and patient satisfaction assessments. Many of us care for patients with multiple co-morbidities whose BP or A1C are not at target, but we do not fire them from our practices. We work with them thru their depression, personality disorders, SES challenges, and encounters with the criminal justice system and continue to help them come nearer to reaching goal. New systems that penalize docs whose patients have high A1Cs, etc, could well result in physicians being less likely to care for those with the greatest needs!
Antonette Frasch, MD	Devon, PA	Reform malpractice in this country. I am saddened to say that in only 2 years practicing after training, I have felt forced to order those extra tests, with malpractice in mind, despite wanting to limits costs for pts and the system.
Gabriel Silverman, MS	Pittsburgh, PA	It will be much easier to roll out prevention and wellness initiatives and structure payments to increase their use in the context of a single-payer, national health program. In the absence of such a unified system that is accountable for and affected financially by the public's long-term health, we absolutely must have a real public option -- a single, federally administered insurance option, providing uniform benefits across the US. The public plan must be allowed to set premiums

Name	Location	Comments
		and payment structure in negotiations with stakeholders, independent of other insurance plans, but subject to all federal insurance requirements; this will maximize its ability to promote prevention and wellness initiatives. It must be enacted concurrently with other significant expansions of coverage, not subject to triggers.
Soma Ilangovan, M.D	Southampton, PA	Malpractice exempted wellness centers run by para medicals under doctors supervision.Game and entertainment oriented education of prevention,exercise,nutrition and basic screening for Diabetes,Hypertension,addiction and mental health.Health and counseling in an enjoyable relaxed playful setting for kids and youth.
Faraz Ahmad, MD	Philadelphia, PA	First of all, I wanted to how great I think this organization is, and I'd be happy to help out in any way that I can. I am a new medicine intern at UPenn, and I think we, as physicians, we need to push for more research on what prevention and wellness initiatives actually work. A lot of the focus from Congress and the White House has been on increasing funding for comparative effectiveness research. Though that is important, as Dr. Atul Gawande argues most recently in the New Yorker, health systems research is equally important. There are health systems and insurers who are "positive deviants," ie provide high-quality, low cost preventative services, and we need to identify them, study them, and then disseminate the knowledge. If we are going to create a new national institute on comparative or cost effectiveness, we should include a division focusing on health systems. Though I am about to start internship, I am passionate about health policy, quality, and disparities, and I would love to help out in any way that I could. Good luck!
Nicholas Hoeh, MD	Philadelphia, PA	I am in favour of health care reform in the USA. I have been forced to work overseas in order to practice good quality medicine. There are countless others like me who want to come home again.
Toni Ramirez, BA	Providence, RI	Establishing medical homes that encompass a team of physicians, nutritionists, physical fitness experts, and education. Community health workers that understand the culture of the particular community need to become a part of the healthcare team! A community member who is educated and trained can relate to patients and educate communities in an effective and collaborative way! Medical school curricula should emphasize such wellness initiatives, engaged in research that looks at effective lifestyle change and maintenance. Lifestyle changes can have enormous impacts on healthcare yet there are the most difficult challenge to physicians and their patients. This needs to be a critical component of medical education.
Julie Meyers, MD	Pawtucket, RI	Immunizations, including flu vaccines (our patients call us for advice when there's a flu pandemic), nutrition/excercise campaigns to emphasize wellness and obesity prevention (5-2-1 campaign an example), working with adolescent girls on calcium intake to ensure good bone health growing older, contraception to teens to prevent unwanted pregnancies, oral health discussion from birth (not enough pediatric dentists in the country/family dentists not comfortable with kids < 3 so pediatricians pick up the slack), mental health screens and treatment (not enough child psychiatrists so pediatricians pick up the slack).

Name	Location	Comments
David Keller, MD	Pawtucket, RI	First, fully fund and provide universal immunization per CDC guidelines for all children and adolescents across America. Cost savings will accrue from decrease in hospitalization due to rotovirus and continued reductions in invasive bacterial diseases. Second, screen children in the first 3 years of life for developmental delay and behavioral disturbances, AND fund early intervention programs. Savings will accrue in decreased spending in of special education Third, match school lunch, SNAP and WIC guidelines with our obesity prevention message. High-fructose containing beverages have no place at the table. Fourth, mandate payment for pediatricians to screen mothers for post-partum depression. Maternal mood does affect child development. Fifth, incorporate early caries prevention into infant care. (ie fund dental screening and topical fluoride treatment in doctors offices) Finally, all of these initiatives should be part of the comprehensive care provided in a child's medical home.
Ellen Gurney, MD	Rumford, RI	It may be too late to send this but my off the top response is that WITHOUT insurance prevention and wellness is off the table. Discussing these initiatives should not be the motivator for providing insurance. The decrease in stress from knowing one is covered by insurance in and of itself is a prevention. The hows and whats of prevention and wellness initiatives can come later. How many babies have I seen this year who have lost their state insurance courtesy of Governor Carcieri in RI?? LOTS. Any one of these children could have developed fatal meningitis or whooping cough because the parents were too scared to come in for care not realizing that the immunizations would be provided at low cost. If we really want to talk prevention why is this country not addressing the long term health disabilities arising from bullying and sexual abuse. Dont get side tracked from the issue of universal coverage WHICH IS THE RIGHT THING TO DO by having to prove before the fact that prevention will be discussed. That is a distractor.
Peter Klatsky, MD, MPH	Providence, RI	1. End redundent state licensing of Physicians. It adds tremendous beaurocracy and does not make anyone safe. Providers should be licensed at the federal level and with the guidance of professional organizations. This would also help prevent "renegade" or negligent physicians from switching states when they lose their license in one place. They implemented the Natl Provider ID for this reason, but could simplify by federalizing credentialing. Doctors would like it because they would have more mobility to practice in different places if they needed to move.
Sarah Bagley, MD	Providence, RI	I of course believe that it is important, and not negotiable that we find a way to provide a way to provide access to health care for all individuals in the US. I have wished however, that during this discussion about access to health insurance that we have not had a more broad conversation about what it will mean to achieve health for all individuals. I do not believe that is a goal that can be accomplished by individual health insurance plans. Instead, we need a plan for prevention and public health that is based on building healthy communities where it is easy for individuals to make healthier choices. That means more sidewalks, playgrounds, access to health food etc. I think that President Obama was incorrect the other day when he said that people do what their doctors tell them to do....The patients I serve do not have a living wage, live in poor communities rife with crime, are surrounded by fast food and often do not do what is best for their health, no matter what I say. We will never be able to achieve health for individuals in the US if we do not address these difficult but critical issues.

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Name	Location	Comments
Veronica Mallett, MD	Germantown , TN	Please do not abandon a public option no matter how much heat. The only way to control cost is to form a large enough block that pharmaceutical and device companies will negotiate. In addition the only other way is to do something about spirally malpractice costs. We already have a three tiered system, those with commercial insurance, those with Medicare or medicaid, and those with no insurance. Covering the hard working people with no insurance should be our goal. I work in a safety net hospital with thirty eight percent self pay. We would take cost without any profit just to keep our doors open. Last we need to move to a more standardized cost effective approah. Doctors won't do it on their own. Be brave be boldbe radical
Heather Andrews, MD	Nashville, TN	Use CPRS EMR (already owned by the gov) linked throughout the country as our only emr, so we have access to all pts data and meds. Link all computers in all pharmacies too. Increase emphasis on diet, exercise, patient education, weight loss, smoking. Continue to encourage banning of smoking in public places, banning of trans fats, and banning of hugh fructose corn syrup! Processed food should be very highly taxes by the government. Encourage subsidy of gym memberships. Make it mandatory for all people/patients to get their baseline primary care checkups so we can catch and treat their htn, dm, obesity, unhealthy lifestyle better and earlier before it progresses to real and expensive and debilitating disease. We have got to focus on health! Diet and exercise are key. (ps. I am a Hospitalist, and see people miss their window of opportunity to prevent, treat and instead end up in the hospital with debilitating illness- it is their fault in many cases as much as the system's, b/c they don't go to the doctor in many cases even if they're insured and have decent prescription coverage). Incorporating mind-body and holistic medicine into our system for help in stress reduction would help the overall health of our country too.
Robert Luedecke, MD	San Antonio, TX	1) Offer cash incentives or some prize to obese patients to attend healthy eating seminars 2) Create social events and other positive reinforcement focused around increased activity and healthy eating. 3) Create advertising to make it cool to eat healthy and get more exercise. 4) Create free consulting to encourage healthy eating and healthy weights. 5) Create advertising campaigns to help draw attention to all the reasons people overeat and what others have done to overcome their problems. 6) Establish free wellness clinics to consult with each individual patient and touch on common problem areas and find what the patient would like to work to improve in themselves. 7) Create very fun websites to try to entice children in their early years of using the computer to learn more about healthy habits while playing a game. 8) Have easy access in public places to free information about birth control and preventing unwanted pregnancies even in parts of the country where voters may not want to have these programs so as to not deny anyone the help they need to control their own destiny.. 9) Have ethnic based programs to combat common health misperceptions in ethnic communities (ex: fat babies are healthy).
Steven Solis, MD	Amarillo, TX	Quality Prevention starts with reimbursing primary care physicians enough that medical students will consider going into those fields as opposed to procedure based specialties like surgery. More family and internal medicine physicians will mean more effective management of chronic disease which will keep patients out of the hospital and drive costs down.

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Name	Location	Comments
David Grant, MD	San Antonio, TX	Another way to cut health care costs is to talk people out of futile care. Hospice programs are pretty good at this, if an eligible patient is referred to hospice IN TIME. But it takes time -- a complete switch to a palliative approach requires acceptance on the part of the patient, her doctors, her family, and any other people in her 'circle of support', including friends and even home health aides.
Tiffany Powell, MD,MPH	Dallas, TX	Please don't give up the fight to cover as many people as possible - Look at the health care plan in Howard Co Maryland as a potential framework for how more people can be insured and preventive care can be emphasized
James Alexander, MD	Cleburne, TX	Prevention and wellness initiatives are the highest leverage tools for good health and cost effectiveness that we have. The problem is that these initiatives cost real money in real time, and the effects may not be fully apparent for years. This is where a "public option" for national health insurance can help since good programs in the "public option" will force private insurers to compete and pay for the prevention today that will be cost effective in the future. Private insurers are many times unwilling to spend money today that will cut into their reserves for the sake of possible gains in the future since the patient may be a member of a competing plan at that time and the cost benefit at that time belongs to a competing plan - an admitted short-sighted view, but a realistic situation. Medicare continues to have a very good set of proven preventive medicine measures that are covered and if utilized fully would improve health and can ultimately lead to healthier, more productive patients. This is where a "public option" like Medicare can stand out as a force to require private plans to fund and emphasize prevention and wellness if they are going to compete.
David Black, MD	Livingston, TX	President Elect Barack Obama Who I am: 60 year old retired internist, who practiced for 25 years in Texas, (many years in small Texas town with many poor, Medicare, Medicaid patients). Left the U.S. 9 years ago to work for no remuneration whatever here with the Honduran poor. License still maintained in good standing in Texas and in Pennsylvania. Became a Democrat after working with these people. I am not wealthy. Reason: Unbearable hassle with 3rd party payers, including insurance company processors of Medicare/Medicaid claims. My conclusion: Americans don't really want health care. It is near impossible for anybody, including the rich, to receive medical care. Unbearable host of bureaucratic "hoops" which make delivering care to anybody miserable. I used to say, "I'd rather practice medicine for nothing, than to go through this." And, I finally acted on that statement. Present position: I work 100% with the very poor here on the North Coast of Honduras in the La Ceiba area. I have been here for 8 years. For only the 3rd time in my life, do I thoroughly enjoy seeing sick people. Many obstacles here, but they are "real," not bureaucracy generated. Yes, I do know that Honduras is poor, because its people accept/revel in corruption, and that it is not, in general, a very nice place to live. Recommendations for the United States: 1. Single payer system as in Canada and the United Kingdom. 2. Single set of reimbursement criterion in all of U.S. (Currently, even with Medicare, criteria differ widely, and criteria are not available to public or to medical providers; criteria change without notice. Provider is assumed to be guilty of fraud.) 3. Pay more for primary care office visits. Don't pay so little that the doctor can provide only 10 minutes of attention to patient's history. That's impossible, not difficult. a) 90% of diagnoses made by history alone b) Fewer tests required if have time to take a good history 4. NO self referral to specialists

Name	Location	Comments
		by patients. a) Tremendous duplication of laboratory tests, etc. b) Primary care doctor can provide test results, etc, to be sent to specialist, thus avoiding duplication. c) Designated areas/facilities for: 1) Well baby checks 2) Minor pediatric / adult illnesses. 3) If patient goes to incorrect area, patient can be directed to appropriate area. 4) Result: Maintenance for folks with chronic problems will not be interrupted, and they will be much less chaotic. If it's flu season, don't see anybody who HAS the flu in this area. 5. Allocate professional health care personnel as in U.S. Public Health Service a) Not every doctor has a right to be trained as a specialist. 1) Only a fixed number of slots each year. 2) Doctors are assigned where needed b) Geographic Maldistribution CAN be solved 1) Instead of sending single Family Practitioner, send 3. MUST have more than two, since two doctors cannot practice good medicine with so much night call. 2) Example of variant of this practice is United Parcel Service. Their personnel cannot transfer from one city to another and maintain "rank." c) IF the "unforeseen" result of this is that fewer people go into medicine, "Thanks be to God." (I am not a saint, but I was not lured into medicine to "get rich.") 6. Established formulary supervised by local medical schools for medicines. a) Many of us trained at university hospitals which had a limited formulary. 1) Our patients STILL did well 2) Antibiotic use should be strictly controlled by university oversight. (Again, that is the milieu in which we doctors are trained. Actually works BETTER.) b) Will be many fewer "new drugs" which duplicate other similar drugs. So be it! 80% of my prescriptions were/are for meds that have been available for > 20 years. Ask the folks at Medical Letter at Yale University how many conclusions they reach about new drugs, with the following: "There is no evidence that this drug is of higher quality, and it costs more." 7. Better medical care is provided, in fact, when a doctor is able to "do the right thing," even if the patient wants something else. a) I was told in medical school that I would not be able to refuse to prescribe antibiotics for "colds" in private practice. That proved to be very true. b) It has never been possible, in ordinary societies, for everyone to "see the doctor." 1) Made my life boring. The only reason I saw these people was for the dollar. 2) Everybody should be "pre-seen" by an RN, nurse practitioner, or physician assistant, all well trained. 3) Much more effective to review a case than to be involved in deciding what laxative a person prefers. Most respectfully, David E. Black, MD See attached: "What I think I do here in Honduras." Programs Project Esperanza (Hope) Cuenca (watershed) of Rio Cangrejal (Crab River) south of La Ceiba Milk Program $135 buys 1 glass of milk for 15 children for 1 month Medical Medical Clinic serving the watershed Medical Contingency Fund Extraordinary medical services for very poor Facilitate Medical Surgical Evaluations Online medical treatment / diagnostic coordination Facilitate obtaining of finding needed surgeons, frequently North Americans Medical Support Services David E. Black, MD Helping Honduras Kids Red Cross Women's Shelter (La Ceiba) Finca del Niño Sonrisas de los Niños Un Mundo (El Pital) Community development worker Juan Paz Youth Clubs Medical logistical helper Coordinator / facilitator community activities Food Distribution of fortified rice (Kids Against Hunger) via Helping Honduras Kids Scholarship program Foundation for Helping People 3 University Students Transportation for 12 trade school students La Beca 1 University Student Community Library Sponsored by Los Libros, Inc. Attended by Peter Johnson Library services Individual and Group

Name	Location	Comments
		Tutoring English as a Second Language -- Planning Stages English as a Second Language for children and adults of the Cuenca Uniform Exchange Program Overall coordination by Anne Fowler of El Porvenir
L.E. Brumley, MD	Dallas, TX	We need to have more of an investment and incentive for medicaid providers, without enough providers it does not matter if every child has health insurance- they will all bottleneck at the few clinics and hospitals that see them. With loan repayment and higher reimbursement rates- it will encourage and attract physicians to take care of Medicaid and chip patients.
Angela Scheuerle, MD	Dallas, TX	If I could make one change in the current system it would be this: Require everyone over 18 on a government-sponsored insurance (Medicare, Medicaid, Tricare) to have an advanced directive. It doesn\'t matter what their care choice is: they could ask for continued aggressive treatment or for comfort care only. What matters is having the conversation with their families so that their wishes are known and understood by their surrogate decision makers. Most (in one study 80%) of people would choose not to continue aggressive therapies at the end of life. Most of the healthcare dollars are spent in the last 6 months of life. By limiting aggressive therapies in care of patients who don\'t want them anyway, there would be both a significant savings in health care spending AND promotion of patient autonomy and dignity. In addition to being in active medical practice, I am also a bioethicist and co-chair of the bioethics committee for a hospital in Dallas.
Tory Meyer, M.D.	Austin, TX	I think a basic premise of the plan has to be insurance coverage for all and especially children. As a surgeon for children, I have seen multiple instances where parents, scared of the cost or self pay care, delay bringing their child to the hospital and convert a simple problem (e.g. acute appendicitis) to a complex (and therefore more expensive) one (e.g. perforated appendicitis). President Obama should pounce on the recent American Insurance Association statement that they are willing to provide universal coverage regardless of previously existing conditions. I could see a system where each insurance company has to insure their quota of patients who fall into high risk groups and perhaps are given some government stipend to defray these costs but it means that everyone is covered. In order to promote wellness, a new system could be devised in which insurance payment rebates are given for quitting smoking, losing weight, maintaining good glucose controls (for diabetics), as we know the costs of these problems are high. This type of program could be expanded to promote increased physical activity and healthier eating as well.
Marilyn Wilking, MD	Houston, TX	We need to increase non-office based care such as: 1. Home visits by "Visiting Nurse/Health Care Worker" to young poor mothers. That intervention is one of the only ones that helps break the cycle of child abuse/foster care/family disruption and improved psychsocial functioning of children and parents. 2. School based health clinics for teens. 3. National mandate for daily aerobic exercise in all public schools. 4. After school supervision for older children (middle school+) that incorporates appropriate social activities. (A place to go, be

Name	Location	Comments
		and do rather than returning to an empty home with excess of TV and food.)
Winfred Parnell, MD	Dallas, TX	Please let to Whitehouse know that we support the public plan. The public plan was designed to help the 80% of the uninsured who are employed to have insurance. A side effect of the public plan would be competition for private insurers.
Louis Borgenicht, MD	Salt Lake City, UT	We need to enable patients and physicians to deal with uncertainty in a different manner. It is a source of anxiety for patients driving them to seek medical help. Physicians respond by doing tests and more tests in the search for answer.
James Ferguson,	Salt Lake City, UT	1. A single payer system for reimbursement is ultimately the only solution for the health care system reform. The alternative will eventually come to health care rationing. 2. Preventive care and a reorientation of the system towards health rather than diagnosing and treating illness 3. Only paying for treatments, for example medications, that are demonstrably superior to what is available at a lower price. My more radical suggestion: re-introduce mandatory physical exercise, nutrition education and lack of access to poor nutrition in schools.
Elizabeth Howell, MD	Salt Lake City, UT	Aggressively treat addiction to alcohol and other drugs, and proactively prevent abuse of drugs and alcohol. Without doing so, there is no way to afford health care reform, since these problems cost the U.S. nearly $500 billion per year.
Thomas Connally, MD, MACP	Arlington, VA	We need to strengthen our primary care network. The nations primary care doctors need to be rewarded for including evidence-based preventive care in their overall approach to their patients. Our schools and our media need to educate the public on working with their doctor to prevent our most prevalent disorders.
Christopher Lillis, MD	Fredericksbu rg, VA	Although single payor may be off the table politically in the current climate, we need to establish a strong public plan to cover those who are uninsured. Personally, I do not feel that for-profit insurance companies will EVER be the correct solution for patients. I am a member and advocate for the Physicians for a National Health Plan. Economics, Ethics and Evidence Based Medicine should be the only considerations when attempting to reform our system. Let's call out those Senators who are collecting millions in political contributions from health insurers and hospitals and make sure special interests do not get in the way of meaningful reform. I will never again renew my membership with the AMA.
Susan Miller, MD	Richmond, VA	You cannot expect the delivery system to decrese costs and increase quality when the financial system is broken and the administratve copmlexity is too great to make progress. I support HR676
Elizabeth Abell, MD	Newport News, VA	stop wasting money doing non-indicated tests or treatments: example treating for UTI when Ua either not done or contaminated or does not represent a UTI. There seems to be a breakdown between what we are taught in training and what ends up happening out in practice not just on this one issue or ID issues.
Nirjhor Bhowmik,	Richmond, VA	Please discuss a payment system that actually rewards doctors based on improvements in a patient's health. Right now we have "sick-care" where doctors are paid to fix problems after the patient is already sick. How about a system where doctors are also rewarded for preventing sickness. So, if a doctor and patient work together to lower the pt.'s cholesterol, A1C, blood pressure, etc., then the doctor should receive compensation for that work.

Name	Location	Comments
April Everett, md	Arlington, VA	Obesity and smoking, over the long term, cause a lot of disease. However, there is not much proven that a doctor can do about these things--it takes a societal shift. Where health initiatives can make a difference is secondary prevention-catching an illness in the early stages. Don't prevent a doc from doing a followup pap when the patient presents for something else by only reimbursing one problem at a time. Pay primary care docs more-there is evidence that the number of family physicians in an area is coorelated inversely with the rates of cervical cancer and skin cancer.
OWEN SPEER, OMS IV	Roanoke, VA	I hope we can build a system the encourages prevention and wellness. This needs to be based in the primary care physician's office, and strongly supported by the medical home concept. This should not be at the expense of the provider, but be more directly related to the benefits of the patient. So, better benefits should be available for those who care for themselves better. Providers should also have benefits available to them for the prvention and wellness work that they do. But, the system should not drop coverage of those who chose not to follow preventive measures. it is a difficult balance, but the leadership needs to come from physicians.
Abisola Ayodeji,	Richmond, VA	As a future doctor of America, I think one of the biggest issues medical students are having is the enormous cost of medical education. Paying back loans is a huge burden that we will have to undertake immediately after we graduate from medical school. Please ask how this administration can help with the loan deferrment period. Secondly, in order to have primary interventions be effective in urban/rural communities, there has to be an increase in doctors going into primary care. What incentives is this administration willing to put forward to future doctors of America that will allow students to pay off debt as well as serve the communities in most need of physicians. You guys are doing a wonderful job and I'm so honored to be part of this group. Good luck with tomorrow docs!!
Mary McMasters, MD	Lyndhurst, VA	TREAT ADDICTION!!! It is lethal, expensive and stigmatized.
Christine Staats, MD	Burlington, VT	Thank you so much for going for those of us who are busy trying to keep people living healthier lives. As PCPs we take every opportunity to address preventive medicine ie for those folks who ONLY come see us when they are really sick and not for well visits. If we were better compensated for addressing these issues at all appts, we would continue to improve the health and well being of all individuals. Also, any measures to help offset the cost of medical school will encourage folks to go back into Primary Care and not into more lucrative specialties. Thanks again!
Brooke Herndon, MD	Norwich, VT	It is clear that continuous care with a primary care provider who knows a patient personally is both more satisfying for patient and physician and most economically efficient. These non-specialty visits are low cost and allow for tailored decision making. Among the most important decisions made are those to pursue exercise, improved diet and other wellness strategies that cut down on use of other expensive services. We can do this if you will let us! As I have said for years, as soon as someone will pay me to actually take care of people rather than just sit in an exam room examining hearts and lungs that don't need examining just to meet billing requirements, we can provide great care at a very low cost. It would be an honor.

Name	Location	Comments
Raleigh Bowden, MD	Seattle, WA	We need to reimburse MDs for their time, not doing procedures We need coverage of some type for everyone, I vote for including a public insurance option. We need to help doctors transform to where they do not focus on how much money they make, but on the quality of the care they give
iris crawford, BSc, ND	Seattle, WA	Naturopathic medicine is the art and science of natural medicine that was originally developed over 100 years ago. The practice of naturopathy is based on thousands of years of knowledge of plant medicine combined with a unique philosophy of healing and modern, evidence-based natural therapeutics. At the forefront of modern medicine are the world's most highly trained practitioners of Natural therapies who also uphold the gold standards in medicine pertaining to diagnostics and responsible patient care. The pendulum has swung once again, I introduce to you the Modern Doctor: the Naturopathic Physician. I am a Naturopathic physician, a licensed, primary care doctor who specializes in natural medicine. I identify and correct the underlying causes of chronic disease. An ND is trained in general medicine similarly to the MD including the basic medical sciences, diagnostics, physical examination, and laboratory testing. In Washington, and in many of the 14 states where it is regulated, naturopathic medicine is complete primary care medicine requiring no other interventions except in the case a patient desires it or it is deemed medically necessary to refer to another specialist or in an emergency situation. We are now at a crossroads of tradition and convention. An overwhelming majority of people have used natural remedies, and recommended by whom? Magazine articles, their neighbor, or other helpful but unqualified health practitioners. The public demands and deserves true experts in health and disease to co-ordinate care and design treatment plans according to nationally accepted standards. The problem is conventional, allopathic practitioners are untrained in natural modalities and most are unaware of the Nutraceutical industry which encompasses professional, pharmaceutical grade (or higher quality) nutritional and botanical medicine companies. As we transition into this historical phenomenon of the modern doctor one must differentiate between two types of Naturopaths; those who studied at a school, college, or internet course that is not accredited by the Council on Naturopathic Medical Education (CNME) which do not include any medical training or clinical internship and those who studied at one of six CNME accredited Naturopathic Medical colleges in North America. These medical colleges or universities are nationally accredited and consist of four to six years of rigorous study in the classroom, preceptoring with other physicians, and hundreds of hours practicing in busy teaching clinics. Naturopathic medical curricula meet or exceed the standard (allopathic) medical curricula of all other highly respected medical colleges. Studies include the basic human sciences; anatomy, physiology, biochemistry, and pathology, as well as focused study in the "ologies"; neurology, urology, oncology, etc. Students are taught from the Merck Manual, the Bible of conventional medicine and learn pharmacology of prescription drugs, many of which are within the scope of practice of an ND and are prescribed by them if and when the case arises. In addition to all of this, naturopathic philosophy and history are taught, and the seemingly infinite number of natural modalities known. These include, but are by no means limited to; botanical medicine, homeopathy, nutritional medicine, hydrotherapy, exercise prescription, lifestyle counseling, health education, physical medicine

Name	Location	Comments
		(manual manipulation), dietary prescription, energy medicine, mind-body medicine, etc. Licensed Naturopaths sit for two sets of board exams to further ensure that they are indeed ready to begin the real world education of practicing as a doctor. Naturopaths are filling a crucial role in modern medicine and setting examples. Many Medical schools are now scrambling to open “natural medicine” branches in their medical programs such as the one at Harvard School of Medicine. With the initiation of the governmentally defined field of Complimentary and Alternative Medicine (CAM), a new integration of world medicine is being born. The U.S, it would seem, is finally breaking the convention of steadfast rigidity in what the American Medical Association has clung to as the definition of medicine. With the inclusion of healing in this definition and a deep understanding of these inherent physiological processes, we can develop a new understanding of how and why natural medicine works and what its crucial role is in improving the health of the American people. This is where we begin to heal the healthcare crisis in the US.
Cindy Toraya, MD and Masters	Tacoma, WA	By looking ahead instead of being reactionary. Prevention and wellness should be 100% covered by all insurances to motivate people to stay well and not wait until they are too sick and raise the level of care and cost needed to get them well. Cover counseling for example, instead of waiting for people to be so depressed they self-medicate with drugs and alcohol causing multiple medical issues for themselves, for example. So much to say... but the government is looking in the WRONG places to cut costs... the answer is NOT in cutting Dr's pay, cutting reimbursement and increasing red tape and administrators. They need to start from scratch and stop following the advice of those who are gaining from it, such as Medicare administration, insurance companies, and start backing the people on the front lines, like the quality doctors that will quickly start leaving medicine because of this broken system. Pay primary docs better so there doesn't become a shortage. Focus on more education and decreasing smoking, a cause for many of our most costly chronic diseases. Create motivators for people to stop smoking... financial motivators, such as major discounts in insurance costs, motivators for losing weight and exercising regularly. We know what works to keep people healthy... we have to work on getting it done and realizing it's important.
Peter Rowinsky, MD	Seattle, WA	Support states in funding vaccines for children.
Annie Murphy, MD, BSN MN MD	Bremerton, WA	Please don't take malpractice tort reform off the table. Fear of lawsuits is an important factor driving the ordering of tests and exams. The abdominal CT scans that are being done almost as a routine when a patient walks in the door of the ER with abdominal pain is one example. Not only is it wasteful but the mostly unnecessary radiation exposure is a seed of future problems. There are countless other examples of tests done to "CYA" when good clinical judgement would suggest otherwise.

Name	Location	Comments
Emerald Mansfield, Naturopathic Doctor	Bremerton, WA	How we can use prevention and wellness initiatives to cut health care costs and improve individuals' health? If we want the greatest return on our investment, education programs for our children is the best way to go. A crucially important issue is to remove influence of the USDA, meat, poultry, and dairy industries from nutrition programs in our public schools. I realize this is a dramatic change in the administration of the school lunch programs, but children obesity rates have been rising and their health has gotten worse because of school lunch programs being so high in fat from all the animal products. The nutrition our children are taught in public schools is scientifically proven to cause poor health and lead to diseases like obesity, diabetes, and heart disease - the epidemics of our modern age. Programs that create a diet high in fruits and vegetables, plentiful in whole grains, low in fat and animal products has improved student's grades, decreased behavioral problems, increased student's health, and gotten children involved in creating their own meals. I believe more curricular programs like this should be implemented nationwide if we truly want to decrease the government's spending on healthcare. Dr. Antonia Demas's nutritional curriculum "Food is Elementary," has demonstrates that children can learn to love food that is healthy for them and be excited about it. And their enthusiasm can spread to their parents. It has already been implemented in over 300 schools in our country with phenomenal results. For more information visit Dr. Dema's program's website: http://www.foodstudies.org/index.htm Additionally, if we are to implement a single payer health system, doctors should be paid on the basis of how healthy they make their patients. Payment should not be primarily based on how many tests, procedures, and medications a doctor can prescribe for a patient. Doctors thus will be paid primarily for keeping their patients healthier. The payment would be the most for perfectly health patients, less for patients with a few issues, even less with patients with multiple diseases. Doctors would not be allowed to refuse accepting a patient based on that patient being sick or having multiple diseases. However, additionally payment would be available to cover the necessary tests, procedures, and treatment, however profit off of these would be minimal and never be more profitable than a healthy patient. Implementing a payment system that pays for healthier patients would give doctors financial motivation to improve their patient's health. In a system like this doctors would practice and learn everything they could to help make their patients well instead of simply providing palliative care. Alternatively, or perhaps a starting point, doctors could be paid on minimum salary and get bonuses. Bonuses would be fore keeping or improving their patient's health. Of course the same limitation applies in that a doctor cannot refuse accepting a patient into his/her practice on the basis of having a disease. Bonuses would be for patients who implemented prevention measures in their life (quitting smoking, improving diet, exercising more, better lipid profiles). In this fashion it would be similar to the English model of payment. Prevention and wellness can mean many things. One way to prevent disease is by healthy lifestyle choices. I propose that we develop community health centers where people can come to free programs (government funded) to learn about how to incorporate healthier habits into their lives. Classes offered would include basic nutrition, cooking classes, how poor nutrition increases risk for a plethora of chronic diseases, and support groups for creating healthier lifestyles. These centers would be primarily run by people well versed in health

Name	Location	Comments
		promotion such as nutritionists, medical doctors who practice orthomolecular medicine, naturopathic physicians, and health enthusiasts with successful programs (with credentials or not). No one with ties to the pharmaceutical industry would be allowed to work in such facilities due to conflict of interest. Additionally, community members can volunteer to help run the program. Naturopathic doctors focus on prevention. They are well versed in these modalities that bring about these changes towards better health. The evidence of the benefits of diet, lifestyle changes, and vitamin supplements are increasingly shown to be effective in the prevention and treatment of diseases and elicit amazing biological changes. It would be wise to include naturopathic doctors in the new healthcare system.
Ian Gilson, MD	Milwaukee, WI	Only with a substantial allocation of funding to the advanced medical home in the public insurance option can real affordable access be achieved. That will put pressure on private insurers to do likewise.
Cindy Haq, MD	Madison, WI	An ounce of prevention is worth a pound of cure.
Helena Coke, MD	Milwaukee, WI	I believe a simplistic health care system is needed in this country where a patient in need of medical care should be able to receive adequate care without having to be faced with a large bill that he/she cannot pay. Those who are able to pay for their care, should pay, but those who do not have insurance and cannot pay the full cost should be subsidized. Preventive Medicine should be incorporated in health care.
Michael Miller, BS, MD	Madison, WI	Thank you for accompanying the President to Chicago on Monday to meet with us at the AMA House of Delegates. If we include all Americans as we must, and provide comprehensive/universal coverage, to remove 'pockets' of the uninsured, and end the practice of 'gotcha' and shifting risk, then the plan will be UNAFFORDABLE UNLESS we identify, intervene, and effectively treat alcohol, tobacco and other drug ADDICTION. Addiction treatment is a huge cost-saver. Addiction prevention can save even more. Why treat only the medical/surgical/psychiatric complications of addiction and leave the primary illness untreated as our current 'system' does today? Including addiction treatment at full parity is a way to IMPROVE THE HEALTH OF AMERICANS and to SAVE MONEY in our health care system. Thank you.