The Aspen Institute

Spotlight Health 2018

Spotlight Health Opening and Welcome

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Speakers:

Bertha Coombs

Larry Merlo

Bernard J. Tyson

Peggy Clark: Welcome, everyone. Please take your seats. We're about ready to start the program.

What a great group under the tent, here today. Thank you so much all of you for coming. I'm Peggy Clark and I'm Co-Director along with Ruth Katz, in the front. Ruth would you stand up, of Spotlight Health. And Executive Director of Aspen Global Innovators Group, here, and I'm really thrilled you are all here. We have a great gathering. We have, in fact, two former Secretaries of Health and Human Services, honorable Kathleen Sebelius and Tommy Thompson. I think they're in the house. Are you in the house? Along with so many others, this is really such a great group. And to kick off today's program, I am especially thrilled to introduce someone who spent four years himself at HHS under Donna Shalala. One when she was Secretary during the Clinton administration, and he's our new President and CEO of the Aspen Institute, Dan Porterfield.

So, Dan has done many, many things in his life. He was formerly a Senior Vice President and English professor at Georgetown University, and most recently, the President of Franklin and Marshall College where he really upended our whole notion of higher education and how to make it accessible to everyone.

So, that's Dan's professional resume and Dan, I'm going to give you a little bit of your own medicine. Just to start us off, as everyone knows, here at Spotlight Health and at Aspen, we like everyone to relax, take your shoes off. I want to just tell you a little bit about a quote from Dan's commencement speech that he just gave at Franklin and Marshall. Here's what he said. This is back to you Dan. "You all have professional resumes, but try making a life resume, too. Just one page that speaks to who you truly are and what you deeply value. I'd recommend four sections, each headed by a question. When did I grow? When did I help someone else? When did I deal well with fear or pain? When did I feel joy or love? All you need to do is create the experiences that fill in those sections. Just create and note your growth. Just help people. Just acknowledge pain and put it to some good use. Just savor the feelings of joy and love." Keep creating these experiences, Dan. Keep making this meaning and you'll find another section starts to appear. Maybe at the bottom of the life resume, rather than at the top. That section emerging out of your actions and explorations will be called 'purpose', and years later perhaps that section will start to appear at the top.

I speak for every person at the Aspen Institute to say that we are overjoyed and over the moon and honored to welcome you to this chapter in the purpose of your life. Dan Porterfield.

Dan Porterfield: Thank you, Peggy, for that lovely introduction. At least the first part. The second part ... and for your leadership with Ruth Katz, with Katie Drasser, your teams, for organizing an extraordinary series of discussions aimed at framing problems and finding solutions. A number of our interns are here now. So, I'll give the interns a little bit of secret advice. That is when you start a new job, and you get

those first speaking opportunities, take the risk of saying what you mean. That's what I'm going to try to do today. Say what you mean.

The conference organizers have brought in people from all over the world to talk about medical breakthroughs, unpack scientific advances, and examine the transformational promise and risk of technology. One theme you'll hear often over the next through days, is disruption, for good and for ill. There's an enormous amount of change taking place right now, all across the world. From how we provide healthcare in the US and fight cancer in Africa, to how we harness the power of design thinking and implement strategies to reduce the cost of medicine. We will take you to the cutting edge of genetics. Produce novel ways to prevent chronic disease and share insights about the microbiome. And we'll talk about the visionaries and venture capitals think we can go next.

I love this array of things. I love the array of backgrounds that we represent. I love the cross-cultural, multi-disciplinary, evidence-based, results-oriented methodologies that we employ. It's especially important that we work in a non-partisan, open-minded way, gathering perspectives inclusively, willing to entertain ideas that may not appeal to us, always asking critically if we've drawn enough voices to the table and done so respectfully.

I suspect among us here, there are a few core convictions that we share. One, for example, is that advances, and access, and excellence in healthcare offer people of our planet greater quality of life than ever before. Thus we must keep questioning, keep learning, keep researching, keep discovering, keep sharing the tools and treatments that can enable greater human flourishing. Second conviction, is that it's a lot smarter for any society to prevent illnesses than to resort only to treating to them, and that also it's a lot smarter to empower people to take care of themselves rather than scrambling around trying to save them and stop the spread of further harm in desperate moments after a preventable calamity. A third conviction is that in every country and culture, successful health systems and strategies will benefit everything else, from job quality to learning outcomes, from innovation to gender equity, from family stability, to job creation, from local empowerment to national security. It's deeply interdependent when our health systems work and when the meltdown. One more conviction. Surely we all share the belief that it matters to involve people in their own healthcare decisions, to give great weight to the choices people make about their lives, to treat cultures as a collection of assets and capabilities and wisdoms, to respect and engage cultural values, and to always bring an ethical sensibility to our conversations about who gets healthcare and what it is that they get.

Those are four convictions. I bet the conviction upon which all those other convictions rest, I suspect, I hope, is that we all believe, fundamentally, in the dignity and value of each and every human being. All humans are equal. No one is more human than anyone else. We all deserve the opportunity to develop our talents, to express our faiths, to care for our children and our elders, and

flourish. I would argue that the greatest gift we have for the work, that here we call promoting healthcare equity, is our capacity to respect the dignity of all people, and from that essential power that we have, as human beings, then to develop the interest and empathy to accompany one another, to try to see with each other's eyes, to bear each other's burdens, to celebrate each other's joys. Which also means that we have to say no when one group is being stigmatized or scapegoated or labeled as less than human.

I'm a parent. My wife, Karen, is here. Our daughters, Caroline and Sarah, are over there. Perhaps drawn here against their will. This is a paradox. We love our children the most, but we are called to love each other the same. This is a paradox. For me the answer is not to crumble beneath that contradiction, but to try to create the conditions where everybody else's children can live their best lives, just like Karen and I want our children to be able to live to their fullest. This means it's our work to help others build strong communities and good societies, because we believe in each person's human dignity and know the capacity of others to love their families precisely because the intensity with which we love our own. Because we believe in human dignity, I believe that we should try to avoid picking sides too quickly, or seizing upon a ready opportunity to score political points. Because we believe in human dignity, we should go the extra mile to avoid prejudging other's views, or sizing up people fast so we can shut them down and take away their seat from the table, and negate the experiences they would have shared there.

Again, where does this commitment to openness come from. We tolerate, or include, or embrace, or protect views we may not agree with, partly out of practical problem solving, partly out of enlightened self-interest, partly perhaps out of a sense of a social contract, but fundamentally because respecting the dignity of others means we must give them their due. Quite often our own hearts and minds grow when we do that, even when it takes a strong spine to put up with ideas we wish we didn't have to hear. Which brings me to this. Thank you for listening, because out of a love for humans and humanity we work, and being here, the most inviting, inclusive, non-partisan leaders and organizations that we can be, and here I'm talking about your organizations and mine, the Aspen Institute. We've positioned ourselves, because we make that commitment to openness. As necessary, and probably rarely, and always with thought to speak aloud when we see at the actions of others the denial of human beings' dignity and ability to flourish.

For that reason, as a healthcare advocate and as a human being, I believe, for example, that cigarettes should not be marketed to children. I believe that sex should not happen without consent. I believe that guns should be kept out of our schools. I believe, with Pope Francis and First Lady Laura Bush, that the children at any border should not be taken from their parents and placed in 95 degree heat cages with captors mocking their wails. It's precisely because we admit that we do not have a monopoly on truth. It's precisely because with humility we protect the greatest range of thought and ideas. It's precisely

because we actively seek out contrary views and protect speaker's rights, that we can then look without blinking into the face of an atrocity and say, "No, not here, not to humans, never again." But it's our commitment to the biggest possible table for discussion that allows us that, to have that clarity of thought when it's needed. But our core commitment is to openness, to ideas and viewpoints, and inclusiveness of all type, and then every now and then, occasionally we simply have to say, "This is not consistent with the human dignity that we uphold."

One reason why the Spotlight Health is so fertile for growing partnerships and solving problems, is that when we talk about health here, we think in very broad terms. Those levers create a lot of common ground, in which both audience members and speakers can meet. Together with you, I look forward to a great deal in the coming days. Thank you so much for being a part of Spotlight Heath. Thank you very much.

And now I'm thrilled to welcome to the stage, Margaret Low, the President of Atlantic Live. Our media partner for Spotlight Health and so many other big projects. Thank you so much.

Margaret Low: Thank you so much, Dan. It's really wonderful to be here with you on your first Aspen Ideas Adventure at the helm of the institute. My Atlantic colleagues and I love our collaboration with the Institute on Spotlight Health. This is one of the most extraordinary gatherings. You've come from across the country and from around the world, from Ecuador, Japan, Kenya, Mexico, Nepal, Peru, Rwanda. The list goes on. Hundreds of leading thinkers and practitioners drawn together to grapple with some of the most pressing issues in health today.

On the shuttle last night, from the airport to town, I met a physician who was just arriving from Philadelphia. We launched immediately into conversation. We talked about how excited we were to be at this conference together. Then, in the middle of our conversation, she looked at me and she said, "Are you a derm?" And I said, "Am I a derm?" I said, "Do you mean 'am I a dermatologist'?" As it happens, there are two health conferences here in Aspen this week. Just in case you missed it, or if you're looking for a little corporeal diversion, there is a cosmetic boot camp taking place at the St. Regis, where attendees will be learning the latest on Botox, fillers, and tucks.

I think it's fair to say that it's a little less weighty than our focus here on the Aspen campus, but who's to judge. As for us, we will confine ourselves to the, shall we say, real cutting edge of medicine and science, the mental health impact of gun violence, breakthroughs in cancer treatment, opioids, doctor burn out, and more. How lucky we are to have these critical conversations here in Aspen, where the fresh mountain air provides a sense of well-being, clears and sharpens the mind. John Muir, the environmental philosopher and the founder of this here club, who wrote a great deal for The Atlantic more than a century ago, believed deeply in the restorative power of nature, and is known for saying,

"The mountains are calling and I must go." We're so glad you heard that call and that you are here. I will leave you with this, a Spotlight limerick. Elk, black bears, mountains and moose. Here we come to cut minds loose. Of matters of consequence, health, heart, and science. All with POM wonderful juice.

With that, it gives me enormous pleasure to introduce my friend, and one of the masterminds of this gathering, Peggy Clark, Co-Director of Spotlight Health. Peggy.

Peggy Clark: Great. Hello everyone. I'm delighted to welcome you inside our tent as we being Spotlight Health 2018. I invite you, as others have, to sort of drop your shoulders down a little bit, take your shoes off, breathe in the mountain air, smile at the person next to you, and say yes to an experience that promises to open your mind, your heart, and your spirit over the next three days.

Isn't true, as Dan noted, that we all could use a little bit of hope these days. When you consider the health issues that we're all confronting, as private or public health professionals, in our personal lives, or as part of our collective family of 7.6 billion people, it's no wonder that we all may feel a little bit daunted. Access to healthcare is still dramatically and dangerously uneven among us, depending on where we live, what we can afford, our age, our race, and our gender. Children under five are still at greater risk of dying if they were born to households, or in rural areas, or to mothers who are denied education. Cancer, heart disease, HIV/AIDS, still plague us along with diabetes and mental illness. The specter of Ebola and Zika still loom very large, even while we need to prepare ourselves for that next disease X, which is an unidentified virus that's looming in the unknown.

In the face of these realities, we can all feel overwhelmed and lose sight of the personal impact that each of us many be having. We just can't see it. Doubt and inertia can creep into our minds at night, robbing us of the sheer will need to keep up our good work. For the next three days, and hopefully beyond, Spotlight Health offers you an antidote to the feeling of hopelessness. We offer you an experience of hope. We imagine a world where good health is accessible and affordable for all, especially the most vulnerable. We believe that we really can bring about this lasting effect. How? By bringing together the experts we know are capable of achieving it. The people sitting right next to you, in front of you, and behind you, right here, right now. Creating that future requires all of us to call forth the better angels of our nature. It begins with valuing science and empirical evidence, but there is no algorithm to rely on when things get really hard. We have to talk to each other.

At Spotlight Health, you'll hear the gnarliest healthcare issues talked about. You'll be enlightened by new challenges you've never heard of, like permafrost and what's underneath there, or genomics or many of the things we'll hear today. You'll be inspired by re imagined solutions from surprising sources. But most importantly, you'll witness the integrated kinship of a broad cross-section

of experts extending far beyond medicine, who will bring about the changes in health that we want to see in the world. You'll hear from community health workers, ministers of health, members of Congress, environmentalists, feminists, journalists, scientists, and venture capitalists. We're all here together, and we're so pleased that once again, after a very rigorous process of nomination and sponsorship, and the generous good will of our partners, we have a hundred scholars representing 30 countries from all facets of health and economy, who are joining us here. They all have the chance to join with us, connect with us, and learn about the work of others.

Altogether, we're bound to get a renewed sense that it takes a diverse group of people working in solidarity to bring about real change. Things get started here. It's a hot house for achievers like all of you in this tent. New ideas get recognized, discussed, and then acted upon. It was actually here, a few years ago, when gun violence was first talked about as a public health epidemic. Last year, psychiatrist Dixon Chibanda of Zimbabwe, presented the idea of a friendship bench using trained grandmothers to bring mental health treatment to many instead of the few who could afford professionals. An idea that since been picked up in cities across the US and in countries across the world as a result of his being here. The University of Global Health Equity, a new type of university that extends medical education to those from low income backgrounds who will become the global leaders in health of tomorrow, was first presented here at an ideas incubator. This year, it graduated it's first class. The Chancellor's here today, where are you, Agnes? You're here somewhere.

So, what you'll find, for those who are new here, is much of this magic starts from a spontaneous introduction after a presentation, or a conversation along one of our beautiful Aspen paths. A light bulb goes off in an informal exchange or a new alliance is born. So, let me leave you with one thought. The idea of the healthy future and a better world is not waiting for us int he distance, it's not somewhere out there in the horizon, and it's not a place that we'll get to by just going along for the ride. It's a new way of thinking and a new way of behaving. We can get there with the active engagement, participation, and leadership from every single one of the incredible people who are inside this tent, today. So, we are delighted to welcome you Spotlight Health, you're gonna have a wonderful couple of days, and I'd like to kick off our program by introducing one of the remarkable people we have with us today, CNBC's resident expert on the business of healthcare, Bertha Coombs.

Bertha Coombs: Thank you so much. While we get acquainted here, I am so excited to be here. What an amazing crowd. So many people that I read about and admire and love to learn from, and we get to rub shoulders here in person. It's an interesting thing, my family came from Cuba, I was born there. My parents came in the mid 60s. I have this feeling that my father's parents were also immigrants, they went from Jamaica to Cuba. Something about their Jamaican side, in particular, they were awfully ornery. My dad could be kind of ornery, and I think in general, immigrants are that way because they kind of say, "You know what? I am gonna

leave what is safe. I am gonna leave what I know, because I think I could do better." They go with this hope and they sometimes take steps backwards. You might be a doctor, but you may not have the language skills, so you drive a cab until you can get yourself back into the profession of healthcare. It seems that when it comes to innovation and disruption, when I talk to folks in healthcare, they have that same kind of orneriness. We live in the best of times and the worst of times, in terms of what we can deliver. Yet we all feel like we really can do better, and we need to do better.

You are two leaders. Larry Merlo, the President and CEO of CVS Health, who is embarking on a real new and different path for your company. And Bernard Tyson, the Chairman and CEO of Kaiser Health, which is often held up as really what a lot of heath systems want to achieve in terms of population health and in terms of integrated care. Talk about, I'd love for each of you to talk about what you're ornery about. What is it that you feel we want to do to better and the way that you are approaching disruption in innovation?

Larry Merlo: Well, Bertha you answered a very important question, because when my colleagues turn around and say, "Larry, why are you so ornery?" And I'm going to say, "It's because we're in healthcare." Bertha, I think as we look at our healthcare system today, obviously it has challenges. Many people say the system's broken. We would sit here and say our healthcare system was created for episodic care and a fee for service environment, not one that is created to support and provide for the individual healthcare needs of consumers. Healthcare's grown to almost 3.6 trillion dollars. It's 18% of GDP. It's continuing to grow. We know more than half of all Americans suffer from one of more chronic diseases. The dollars that we're spending on that are not helping those individuals to achieve their best health. I can go on and on. You think about the size of this industry and the fact that everybody is frustrated and dissatisfied with the results that we're getting. I think that's a pretty good reason to be ornery, in terms of we've got to do something. The status quo is not sustainable as we think about the health of individuals, the health of communities, and the health of our country.

Bertha Coombs: Bernard, you're doing integrated care. You're kind of doing it right. Why are you still ornery?

I don't want to assume that you are, but I think it's part of the condition of healthcare.

Bernard Tyson: No, I mean ... no, I'm feeling great. I'm with the trees. I'm walking on thin air. I get to dream up here.

Bertha Coombs: Everyone remember to drink some water.

Bernard Tyson: It's all good. Yeah, please everyone drink water.

I think, picking up on what Larry's saying, I think that we have to come to the reality that in the 21st century, a sick care model is not the right answer. That we have to rethink the narrative, and it's about health and well-being, and to use my term inside of Kaiser Permanente, how do we maximize the healthy life years of individuals. I think that's the first part. Which suggests that we move away from a 'fix me' system to a 'whole health' system that is not bound by the lane that we are in now called healthcare, it looks at bring all aspects of health as an equal system.

Bertha Coombs: So it's not bound by the four walls. We're the many parts of a health system campus.

Bernard Tyson: Yeah. For our 12 and a half million members, for the ones that are living in communities in which they can't get fresh foods, we can benefit their health more with figuring out how to solve to that problem, and then helping them understand how to cook, how to exercise, building a more safe environment for them to play and to live and to, in essence, reduce the stress level, and to exist in a very competitive environment. We all live now, in the 21st century, in a whole different set of circumstances that we all face. From trying to figure out how to get through the day, to being a wire 24/7, to trying to figure out how to deal with multiple demands. We live an exciting life. It does something to the body, and the body needs to be in great shape to take it on.

How do we design a health system that focuses on prevention as the best medicine, which speaks to self-care, and then early detection, early diagnoses, early treatment. How do we deal with a system of coordination of care and services that deals with, what you just described, chronic care, and doing it in a way that is not episodic? We have models. Our physicians, at Kaiser Permanente, thinks that if one of our members comes in from a diabetic attack, that's a failure of our system, because we haven't figured it all out to keep that member as healthy as possible, with diabetes out living their life. That's, I think, the both exciting and daunting challenge that we have in front of us.

Bertha Coombs: One of the things that, I think, makes our system different, in a way, I often say to people, "No on in their right mind, would ever design a system like the US Health System in the way that it has evolved, because it just is not efficient." In a sense, in works in opposition to doing what you're trying to do at Kaiser and what you're trying to do with the merger with ETNA. What you're hoping to do in terms of this new model of a community-based, more affordable care. Our health-based system here is really based on opposition. Payers and providers. PBMS and drug makers. Everyone's sort of fighting to say, "I'm the one that's bringing the value. You're the one that's causing the problem." How do we solve that? Do we solve that just by in the sense we get married? And we all just because part of one family, inevitably integrate so we don't have to spar as much?

Larry Merlo: Bertha, listen. I admire what Bernard has done at Kaiser, because I think he has created the framework for a solution in that he is centering healthcare around the patient. I think the challenge that we have today as you look at healthcare, it's a series of transaction. Who's connecting the dots across those transactions, versus the opportunity to provide care management to patients, consumers, individuals. Those words are all starting to get blurred now. I think that's the direction that we need to go. We need to take healthcare to where the people are, to the communities in which the live and work. It's the opposite today.

Bertha Coombs: So, in our system, we all think that it happens through competition. If you succeed in setting up, what is essentially a different kind of model of, almost primary care in the retail setting in most every neighborhood where there's a CVS, and there are a lot of neighborhoods where there are CVSs, you're coming to mine, thank you very much, does that then threaten the hospital? Does that then threaten the physicians office? The AMA just came out in opposition to your merger feeling that it threatens them a bit.

Bernard Tyson: Let's have two mics on that.

Larry Merlo: Let me go back to ... Bernard talked about that patient with diabetes. If we play that out here for a minute, because I'm sure everybody here knows someone.

Bertha Coombs: Or hypertension?

Larry Merlo: That patient is probably going to the physician three, four times a year. They leave the docs office with a care plan and if they're a patient with diabetes, it's medication, it's diet, exercise, and nutrition. And here's where the system breaks down, because no one knows what's happening in terms of is that patient following that care plan in between visits. The fact that we're in communities all across the country, we believe that we can fill that void. We can be a compliment to the work of the physician, the work of that patient's medical care team, to keep them adherent to that care plan. Because the studies are out there, and there are folks here in the audience that have written them that have quantified the fact that there are significant numbers of patients with chronic disease that are not following that care plan. It's costing our healthcare system billions of dollars every year in avoidable and unnecessary costs. At the same time, we're not helping those individuals achieve their best help.

I don't see this community-based model as a replacement for hospitals or physicians, I see it as complement to the work that they do. Because of the voids that we see going on all around us in healthcare today.

Bernard Tyson: I would second that. I think that one of the things that we have to be careful about. First of all, in my narrative of re-crafting how we think about health and healthcare, in no way do I want to diminish the great work that's been going on in the healthcare industry. As I'm talking to you right now, I promise you with my own statistics, my doctors and nurses, the most wonderful people, they're

operating on a patient right now and they've got the chest open, and they're going to do this great heart surgery. That patient is gonna be up in the next couple of hours, walking around. In our system, because of all the wrap-around services, they'll probably be going home in the next couple od days, starting a brand new life. Right? So, to that patient, they're going, "This is a great healthcare system."

To the innocent one, who many pass out in the streets, that now in the healthcare industry, we can diagnose you immediately, and figure out what to do about you. We're living in a day and age where we have figured out how to cure a certain illness. So, great progress, but that's a very expensive system, and it's focused on sick care and fixing. What we're describing here is a whole new ecosystem of health where it comes together as a whole system, as opposed to, is siloed now in each part of the industry. We have a real opportunity to innovate and redesign the whole healthcare landscape.

Bertha Coombs: Yet, that's an expensive proposition to. So, if you're not relying just on the gazillion dollar MRI machine, or the latest technology to solve problems, it really comes down to people. You take that data and now you have to make it actionable. We are in an era in this country, where the hunt for talent is really very competitive, so as you build out your community-based, retail health system, as you build out and do more social determinant of health programs, you need people to go out there and interact. Where are you gonna find the talent?

Larry Merlo: Well, Bertha, I don't think there's a company out there that doesn't have this as one of their key priorities. How do you attract, inspire, and retain that top talent? Listen, we all have a number of programs that ... whether it's training programs. I think one of the dynamics that we're beginning to see, especially in this mil lineal generation, is we think about what we were focused on when we were out looking for that first job, or perhaps that second job. In today, I see many, many more people who want to understand the purpose of the company, the purpose of the organization. What's the mission? They want to be inspired by that, and they want to make sure that their work has a contributing factor to whatever that happens to be. I think for reasons that we're talking about, we can deliver on that part of the inspiration.

I think our particular case, we have a set of diverse assets where we can create unique development programs to help people grow in their roles and achieve their professional aspirations. At the same time, I do think that innovation around attracting talent is going to need to be different. We've piloted a program we've started a few years ago, where we actually had created an apprenticeship program for pharmacy technicians. It's now across 12 states. We have about 5,000 of our colleagues enrolled in that program. It's been absolutely a home run. I think we need to think more like that, in terms of all the other opportunities that can apply in a similar fashion. We would have never thought about that four or five years ago.

Bernard Tyson: I agree. We have training programs and things that we invest in around our people. We're opening up a medical school in 2020, in Pasadena, and we're on a mission now to really, through our Permanente Medical Groups, teach future physicians about team-based care, stress management, all the things that we practice inside of Kaiser Permanente, so we want to make a bigger contribution to medical education. We also have a challenge, and it's an opportunity, we have 220,000 employees. Some of our issues are around, as we introduce more technology into healthcare, how do we bring the work force along? And how do we make sure, at least in Kaiser Permanente, everyone is clear that our technology strategy is not a replacement strategy of the human touch, it's an extension of that? It helps to enable them. But how do we continue to build the skill sets in our organization? And to make sure that people obviously feel empowered towards the destiny that we're creating together, as opposed to a victim of something that's being dictated to them?

Bertha Coombs: Where do you feel we are? We were talking earlier how some of this disruption and innovation, is it about that big bang, is it about the big home run, but hitting those singles and ground balls, just to keep the metaphor in baseball, what inning do you feel you're in?

Bernard Tyson: The third inning, the first quarter, the third tee.

Larry Merlo: I'll tell you what, you're ahead of where we are, so that makes us the bottom of the first, I guess.

Bernard Tyson: I think, I think ...

Bertha Coombs: So, tell me what it looks like when you get to the seventh inning stretch.

Bernard Tyson: That the whole health system is not community based and technology connects everything and-

Bertha Coombs: So the whole health system being Kaiser Permanente, or Kaiser Permanente being able to talk with CVS's health system, or talk with Geisinger

Bernard Tyson: Oh yeah, that's big piece of it, the whole interoperability is critically important. The walk from paper-based to electronic health records, and etc, is a challenge, but I would also tell you though, once that platform is built, there are so many things you can do differently. Now, we use the metaphor inside of Kaiser Permanente, because it's our reality now, is that care can be anywhere. So the idea that we have historically in the industry designed a health system, quite frankly, with the hospital being the centerpiece, and everybody had to come in and then you have medical office buildings, et cetera. But what we did was we trained our patients, generally, that you had to come to us for everything.

Now with technology and everything, we're demonstrating that no, you don't have to come in for everything. I'm connected. I can email what you need. I can-

Bertha Coombs: You do more than half of your interactions digitally.

Bernard Tyson: Yeah.

Bertha Coombs: Because frankly a lot of us are too busy to have to even call. I've become like the kids. Text me.

Bernard Tyson: Yeah. It's a way to empower the person, the consumer, it's a different kind of relationship. But it's based on a relationship with your provider.

Now, as I say that, there's a lot of re engineering that has to go on behind the scenes, because a day in the life of a physician, for example, is very different today than it was 25 or 30 years ago. How do we reorganize and rethink, for example, so what is productivity means now? How do we think about access now?

Bertha Coombs: And combat burn out as we're-

Bernard Tyson: How do we deal with burn out?

Bertha Coombs: Dealing with more and more responsibilities? My mom's geriatrician, God bless her, she is not a direct primary care, she is not in a concierge practice, but she spends time with her patients and she will text you and call you back.

Bernard Tyson: Yeah.

Bertha Coombs: Not everybody has time or really finds a way to do that.

Larry Merlo: Bertha, I see this dynamic. You're hearing people. You'll begin to talk about consumerism in healthcare. A couple years ago, we started talking about the retailization of healthcare. Why did we use that term? Each and every one of us here makes ... we're consumers of something. Whatever that happens to be at the moment, you're making your own value proposition about where you choose to go. It may be based on convenience, price, service. You're defining your value proposition.

Bertha Coombs: At that particular point in time, but that can change.

Larry Merlo: Your right, but the question that we have to ask ourselves is do we have that in healthcare today? Because you see benefit designs, plan designs pushing more decision making and accountability to, let's call that consumer of healthcare, but yet the tools to support that thought process, are they there? I think, all too often there're not.

Bertha Coombs: Sometimes they are, and there're so many of them you don't know how to navigate. Again, they're all there, your large employee has put them all

together, but they don't necessarily coordinate with one another. They have their little lane that they're very good at, but they don't always coordinate.

Bernard Tyson: That's why I'm saying we're in the third, now fourth inning.

Larry Merlo: I'm now in the top of the second.

Bernard Tyson: Yeah. Because, we start with an integrated model. And we start with the end-to-end responsibility. If you look at the industry that is still, basically on a fee for service chassis, I would argue that that incense the wrong behavior sometimes. Not bad people, it's just the incentives are aligned where I have to produce a certain amount of volume to get a certain amount of payback. Our model says I'm gonna pay you to take full responsibility working with individuals in population to produce these outcomes and these results. I think that there are a lot of challenges now, and how we continue to transform that to become even more relevant to someone living in the 21st century. So, for me, it is a combination of how do we continue to perfect medical excellence, but also how do we look at all the wrap around services that we should be engaged in and involved in on behalf of our member and communities in which we exist.

A medical record of the future, or medical information of the future will not just have my blood pressure and all those wonderful things, it would talk about what my social network looks like, it will talk about what my eating possibilities are or challenges are, it will talk about my stress levels at a different level, and quite frankly, I will have much more wrapped around me with sensors that gives me a chance to better understand my body and what I can do to take more responsibility for my health, and by the way make it all cool.

Bertha Coombs: Making it all cool. Speaking of cool, I want to open it up in the last few minutes we have to the audience. I'm sure folks have some great questions they want to ask. Gentleman here in the shirt, I think we have a microphone for you.

Steven: Steven Sommer from Denver, Colorado. Larry, I'd like to ask you whether you have any plans, now that you've bought insurance company, to move away from the fee for service model and move more toward what Kaiser has, since you identified some of the problems with fee for service medicine, you're combining drug company with CVS with an insurance company? Does that give you the opportunity to go in a different direction?

Larry Merlo: I think that this combination absolutely gives us the opportunities for new plan designs. Incentivize the right behavior, in terms of some of the things that Bernard was just alluding to. That's something that we're anxious to get started to work on.

Bertha Coombs: How about back in the corner? Sorry to make you run.

Amy Lynn: Hi. My name is Amy Lynn from Washington, D.C. I work in global health, and it's a really interesting discussion. I wanted to pick up on that last comment on 'lets' make it cool', I think a lot of what we struggle with in global health is how do we encourage our target communities to pick up on the interventions or the practices that we think are important. How do you think about using marketing practices or retail strategies, or others to cut through the noise of the everyday and empower consumers with the information they need and only that information, and make it attractive for them to act on it?

Bernard Tyson: I think that's a big part of our challenge in the healthcare industry, as we're continuing to transform and to figure out how to reach populations and individuals in very different ways. We're doing, for example, we're committed to de stigmatizing mental illnesses in this country. We have arrangements with unbelievable people who have been willing to work with us from sports stars, Steph Curry, who's been doing some media work with us. We kicked off our campaign with Kendrick Lamar, who brought a wonderful song about I Love Myself, and we have figured out how to put that into our first campaign to target children to say if you are having something that is going on, find your words. I think we have to look at modern tools and techniques that gets the attention of very busy people who are listening to a lot of noise every single day. We have to step out of our internal stats that we love to talk about. No one understands HEDIS, except for us, right? So, we gotta figure out how to make all of that relevant and cool to the 21st century.

I think it's very exciting, by the way.

Bertha Coombs: Got time for one more. The woman in the coral.

Stella: So, thank you. My name is Stella. I'm from Kenya. It's interesting to listen to this discussion about how you're moving away from out of pocket payment model of financing healthcare system, yet from where I come from, like in Kenya, for example, is that we are trying to kill the community health model system and moving towards more of, in terms of financing, we're either having insurance-based, we're either also having the out of pocket. This is just actually being driven by the market forces, and being driven by privatization of healthcare. How then, do we as [inaudible 00:52:17] discussing about global solution, and actually touches across the globe, and how do we carry some of this lessons and ensure that even as your investors are coming within developing countries, that the same models are actually being adopted instead of pushing towards a market driven forces of healthcare systems?

Bertha Coombs: That is a panel in itself.

Bernard Tyson: Yeah. That's a great question. I ... I'll start.

Larry Merlo: Go ahead.

I'm thinking about my answer to that.

Bernard Tyson: I think that we will not really, and I will put Kaiser Permanente in there as well, the total transformation of healthcare, until we have also redesigned the economics of healthcare. The idea that we can stand up and say truthfully that we have the most efficient, effective healthcare system on earth and we think the next set of solutions is how to add to that, I think that we would be kidding ourselves, both as a health system and as a country. I think that part of our work ultimately is in the empowerment of the people who are actually paying us for the things that we do, but done in a way that the incentives are aligned for the right behaviors and outcomes that we need to do. The fact that we haven't even figured out how to really tell you how much we're charging as an industry for what you are actually paying for, is a great example of how far behind we are as an industry. There's no such thing as we cannot do it, in fact, we're going to prove it one day at Kaiser Permanente, that really puts it in the same terms as a true consumer going in for anything else. That's unstacking a lot of things in the industry to better understand that.

I think the second thing is that, there is a big difference between access to coverage and affordability of access of coverage and access to care, and the affordability of access to care. We deal in this country where people are trying hard, paying money to afford access to coverage, but then when they need to interact with the care system, they discover there's a big gap in the affordability of how do I now get the care. Until we solve those two things, we a long ways from transforming healthcare in this great country.

Larry Merlo: Bernard, you said that very well by the way, but-

Bernard Tyson: Bring it home. Bring it home.

Larry Merlo: I'm gonna-

Bertha Coombs: He's waving you in.

Larry Merlo: I'm gonna give you an example, because in our shop, we just had a discussion about, what is transparency and how do we make transparency actionable. I'll give you an example of something that we're in the process of rolling out, because there's been so much rhetoric and discussion about drug pricing, but yet think about that physician. When he or she is writing that prescription, that doc has no idea the out of pocket cost of that medication for their patient. So, we're in the process of embedding that patient's plan design in the patient's CHR. When the physician goes and puts that prescription in, assuming they're prescribing it electronically, and today about 80% of all scripts are prescribed electronically, he or she will be able to see the patient's out of pocket costs and up to five alternatives and the costs associated with each. One of the things that we're seeing is physicians are switching to a lower cost alternative 30% of the

time with an average savings to the patient of $70. I think, Bernard, that's a great example of what you're talking about.

Bernard Tyson: Yeah, absolutely.

Bertha Coombs: We could go on here for hours. We didn't even get to my pet peeve, and I won't give you my rant on billing. It's not just you can't tell me how much it costs, why does it take seven different times to bill afterwards, but ...

Bernard Tyson: Next year.

Bertha Coombs: I will spare you. I will spare you. That is my personal rant and one of the things that I think really bogs everything down. Thank you so much for your thoughts. I think you've given us a lot.

Bernard Tyson: Thank you.

Bertha Coombs: You've given us a lot to think about over the next few days. Thank you.

Peggy Clark: Thank you so much, Bernard, Larry, Bertha. That was fantastic. Thank you so much. So now it's time to officially open Spotlight Health. To do that, we have our own special opening ceremony. We traditionally ask 10 inspiring participants to light the torch for us with 10 brave, overlooked ideas to ignite your imaginations. So, let's hear from there now. Ladies and gentlemen, 10 brave new ideas.

Devita

Devita Davison: Yes, yes, yes, yes, yes. Well, good evening everyone. My name is Devita Davison and I am from FoodLab, Detroit, and I have a big idea. We all know too well the visible forms of racism in our society. We know the inequities in opportunities and income. We even know how police violence plays out in communities of color. That's why we know the names of Mike Brown, Tamir Rice, Freddy Gray, Sandra Bland, but what we don't know, is that we don't know the names of millions of African Americans who are killed every year due to an invisible form of racism. Do you all know that the deadliest weapon that is used against the poor and people of color, the deadliest weapons that keeps them poor, that keeps them sick, that keeps them obese, that keeps them addicted to a sugary, salty, and starchy diet? The deadliest is our food system.

So, my big idea is to build a brand new food system. But here's the deal. In order to build a new food system, one that feeds us all, and one that does not perpetuate systemic racism against millions of people, we have to start by listening to the voices of those who are most deeply impacted by our toxic food system. So, here's my big idea. In a huge collaborative partnership, armed with the survival strategies of our ancestors, things like collectivism and a commitment to social change, I see farmers, I see chefs, I see restaurateurs, I

see food entrepreneurs, food justice activists, food sovereignty organizers, all coming together to design and launch my big idea, which is the Dream Café. I envision this Dream Café as being our laboratory of how we practice food production and food service in a way that is truly cooperative, collaborative, and yes, equitable.

My big idea is that this Dream Café, over the next 12 months pops up in cities like my hometown, Detroit, Philadelphia, Baltimore, Atlanta, and yes, Puerto Rico. The Dream Café is a place, not only that serves delicious and healthy, locally-sourced breakfasts, lunch, and dinners, but the Dream Café is a space where we come together to learn, where we come together to exchange knowledge, where we come together and teach. We teach the community and we teach food workers who want to learn how to use the power of food. Food that can help heal us, that can help empower us, and that help transform our communities. That's my big idea, guys. Thank you very much.

Robert Green: How would you like to follow that? I can't touch the spirit of that, but that was magnificent. I will take you from that global vision of nurture to the nature of genomics. I'm Robert Green. I'm a medical doctor who specializes in genetics. I see patients, and I'm also a researcher in genetics at Brigham and Women's Hospital in the Broad Institute in Harvard Medical School. I want to talk to you today about a provocative idea, which is this. Let's throw out the construct of dominant, recessive, and x-linked heritability. Now, at first you can say, "Wait a minute. That's the backbone of genetics." Well, we inherited that from peas from fruit flies, and when we looked at human disease through the lens of that construct, we did find conditions that fulfilled that construct, and we called them our first genetic conditions. But the more we learn, the more we realize those constructs are completely inadequate. Those constructs do not help us when we're trying to explain genetic conditions to patients, to society, and to ourselves.

In my research lab, we're doing something a little counterintuitive. Instead of sequencing genetic conditions, we're sequencing healthy or apparently healthy people, like most of you. We're sequencing healthy adults, and we're sequencing very provocatively healthy newborns. What we're finding is really exciting. A tremendous amount of genetic diversity and genetic breakage that's there, but not expressed, or at least not expressed until later.

So, here's my proposition. What if, instead of that construct, we had something, I'm sure there's some company working on this, but, what if we had instead a kind of molecular dashboard, which we started the day you were born with sequencing and other molecular information inputs, and then we updated it with the downstream molecular outcomes with gene expression, with protein amalgamation, with organ function? What if this became part, just one part, of that matrix of prevention that we're all hoping to glean. I will say that we're starting clinic of preventive genomics in Boston. While you're health insurance won't pay for it, maybe Larry will, all you Kaiser folks, if you want to explore, be

one of the first explorers and getting your own genome sequenced and trying this idea, please give me a shout. Thank you very much.

Shada Alsalamah: I'm very short. My name is Shada Alsalamah. I am a faculty member at King Saud University, visit scholar at the Media Lab, at MIT, and also Vice President for the mHealth solutions at AnmarIT.

What is the biggest problem and the most important problem in healthcare today? That was the question I asked my grandmother. She answered, "I want my doctors to care about me as much as they care about the disease they're trying to treat, but how can they do that without knowing all about her." Three years ago, she passed away. After she had a stroke, and the ambulance crew did not even know which hospital to take her to. This is why 84% of Saudis, they avoid ambulances. Whereas globally, it is only 5% avoidance.

My idea is to use OPAL, which stands for open algorithms. In a smart blockchain system that can help us to know more, without having to share data, but rather sharing only safe answers. OPAL would have allowed the hospitals to share more broadly so the ambulance crew could find the nearest, most equipped hospital to my grandmother's home, in order to treat her in time. Not only that, OPAL could also call the ambulance after detecting the symptoms of a stroke. OPAl might even monitor her medication to predict a recurrence prior to the stroke even happening. OPAL would have allowed her other doctors to know more about her conditions to care more.

My idea is OPAL, the combination of open algorithms and blockchain for a true patient centered care. I am sure my grandmother would have loved it. Thank you.

Kierán Suckling: Hello. My name's Kierán Suckling and I'm the Executive Director of Center for Biological Diversity. But tonight, if I don't fall off the stage, I'm FrostPaw, the Center's climate mascot. The reason I'm FrostPaw tonight is somebody in the room [inaudible 01:07:07]. Humans evolved about 220,000 years ago, and all the millennia since then, when we've come together to talk about important things to make decisions, somebody there would have been dressed as a bear, or a headdress, maybe they would have brought real feathers, maybe it would have been [inaudible 01:07:43]. That's because back then, just as it's true today, plants and animals were critical parts of the community. If you're going to think about what's good for the community, you have to have everyone in the community there in some way. That's what they did, in fact, if you didn't, then you weren't really having a community discussion. The decisions they made could not really be trusted to be for the good of the community. I think that they could not be trusted to really be self-aware.

Now, in the last, we've kind of fallen away from that. Not entirely. [inaudible 01:08:41]. And I got invited here, which is an indication that it's not gone away. The consequence of that, [inaudible 01:08:53], that our sense of community is

much smaller, or meetings are much smaller, what we talk about is smaller, what we think about is smaller. I think it makes us less aware. That's where we are.

Now, we've come to relearn, here recently that the human body is itself a multi species community. Some 90% of all the cells in your body, belong to other species and without them you would die, but probably more importantly from a healthcare perspective, if we disrupt that community, your physical health, and even your mental health will suffer. So, medicine now has come to really think about the microbiome and the importance of that. Now, we're a little less further along in understanding the ecological community, or what I like to call the community of earthlings. That's the community that includes Aspen trees, and butterflies, trout, raven, and in some places, polar bears. My thought is we will never, ever have true community health until we start to relive and relearn a larger sense of community. And until we re-love a larger community, that perhaps meets outside in a tent instead of a building, we are not gonna have a healthcare system that works for society, that works for individuals, or that works for all the plants and animals that we are in community with, whether we know that or not. Thank you.

Agnes Igoye: How does one follow a bear? My name is Agnes Igoye. I come from Uganda. I ran after human traffickers and I founded the Dream Revival Center to rehabilitate survivors. So, this is my idea. Who is the fit to help us put an end to human trafficking? Is it the doctors? Is it the lawyers? Is it the politicians? Who is the best fit? Yes, all of the above are good collaborators, but who am I missing? Survivors.

What if we empowered survivors to disrupt human trafficking networks? 40 million people are enslaved today, and we are not putting the best people to use to help us crack down on human traffickers. How do I know this? I flee from the Lord's Resistance Army and they targeted me for sexual exploitation. I was displaced, but I worked my way through and when beyond just being given basic needs, to learn skills, because you know what? Survivors have skills. They can make the best investigators. They can make the best intelligence officials because they have lived it and they know better. So, let's move beyond the basic needs approach in supporting survivors, and give them the real skills needed to disrupt networks. I did that, and oh boy I give them help, helpless nights.

Yes, again, let's move beyond the basic needs and support survivors to get the needed skills to crack down on human traffickers. Thank you.

Jack Andraka: Hi everyone. My name's Keller. I'm the founder of Zipline, and my work brings me to a lot of health centers all over the world. Which is how the majority of humans on the planet experience healthcare. If you've visited any one of the millions of health centers on the planet, you know that they're typically staffed by maybe a nurse, or a nurse practitioner. Stock outs are a huge problem,

sometimes they range between 20 and 30% of products are stocked out at any given time. Expirations are very common. Generally, there aren't enough health facilities or nurse to support the patients that depend on these centers.

A couple months ago, I got to go to the Mayo Clinic for the first time, and I was totally blown away. When I was there it seemed like the best hospital in the world. You have access to the best doctors, the best diagnostics, the best treatments, all of the newest things that medicine has to offer.

My big idea is that in the next 10 years, disruptive technology is going to make it possible to make every clinic on the planet into the Mayo Clinic. I think that when you look at disruptive technology like telepresence, I read the other day that more than half of all patient visits at Kaiser Permanente happened over a smart phone. Well, guess what? Smart phones are becoming ubiquitous in the developing world, especially in Africa. 4G networks are rolling out across countries. Rwanda is gonna have national 4G coverage by the end of 2019. Autonomous aircraft are gonna make it possible to totally change the way supply chains work. Zipline delivers 25 % of the national blood supply of Rwanda using autonomous aircraft, today. Once it becomes possible to transform the way supply chains work, that's gonna make it possible to bring new kinds of medicine into these markets. Medicine like crispr therapies or immuno therapies, cancer therapies that have short shelf lives and are cold chain dependent, and can be very, very different to handle from a supply chain perspective, we can now bring those directly to every human on the planet.

I think it's very easy to look back 50 years from today and think about the things that we did 50 years ago that were barbaric, but if we look 50 years from today and ask, what about 50 will people 50 years from now think as barbaric, it's that people's access to healthcare depends on the GPS coordinates of where you live. Every human on the planet deserves access to healthcare and we can turn every clinic into the Mayo Clinic. Thanks.

Toyin Ajayi: Hi there. My name's Toyin Ajayi. I'm a primary doctor and the co-founder and chief health officer of City Block Health. My big idea is this. In order for individuals and communities to live longer and healthier lives, the health system that cares for them has to adopt a whole new operating model. One in which trust is the leading performance indicator.

My perspective comes from the front lines of delivering care to people for whom the difference of trust and not, can be life and death. For people with chronic diseases, live in poverty, with mental illness, and substance use disorder, who struggle with the day to day barriers that our society sets up for healthy living. These are folks with whom the difference between trust and lack of truck could mean leaving in a hospital against medical advice instead of getting life-saving dialysis. It could mean having a baby at home under unsafe conditions, instead of accessing a hospital. It could me someone with mental

illness struggling and suffering at home until their symptoms become unbearable without asking for help.

In today's healthcare world, the prevailing paradigm measures success for health systems and for providers on the basis of visits completed, procedures performed, beds filled, medications dispensed. What's resulted is more healthcare but frequently poorer health, and particularly true for the most vulnerable amongst us. Those peoples whose bodies bear the scars of trust broken, not only in their private lives and and their personal lives, but in the very fabric of our society's institutionalized structures that diminish and disempower them. And also in health systems, that in their times of need, failed to listen to what really matters, did things to them and not with them, and they're so quick to sacrifice trust at the alter of higher revenues and quick throughput through their hospitals and clinics.

This world is changing, but not quickly enough. It's giving way to a paradigm in which health, and not simply healthcare, is the ultimate goal. So, as someone who is striving to build and to shape this promised land, I'm here to tell you that the currency in that new world is trust. In my world, health system executives are asking, "Do the patient's we hope to serve trust us? Are the systems that we build worthy of that trust? Have we built individual and collective relationships based on mutual respect, on dignity, and understanding, and honesty? Have we earned the right to guide and champion and accompany our patients through those different choices and journeys ahead of them?" My big idea is that we will learn to measure, and value, and to build trust. That health systems and providers will compete, they will be judged, they will be rewarded on the basis of the trust they engender with their patients and their communities, because without trust there's not health. So, welcome to this new world.

Jack Andraka: Hi. My name's Jack Andraka. I'm a global health researcher at Stanford and I combine big data, engineering, and anthropology to help support the local healthcare needs of these communities that I work with. My big idea is to question this kind of tendency that we have to associate science and democracy as natural bedfellows. Because when we think of science, we think of this very democratic exchange of ideas where the best rises to the top, but this really isn't the case. Some voices count far more than others, and some voices are heard at all. The silencing exists and operates along these exiting lines of inequality and works to hide these structural powers that decrease the health outcomes of patients around the world. The silencing is invisible silencing where science continues to portray itself as this neutral, objective object, when it's anything but. It becomes dangerous because the powerful truth-making ability of science in our society and global health discourse.

I see this danger every single day in my work in Sierra Leone and Tanzania, where my partners are silenced. Their narratives of unclean water and crushing poverty are silenced by walls of statistics and numbers, of these international monetary organizations and transnational mind conglomerates. This narrative of

'nothing to see' is despite this obviously effect of unclean water, of environmental contaminates, of crushing poverty, and negative health outcomes that these organizations create in these countries. this is silencing the narratives of my stake holders, who have found heavy metal levels in their water exceeding one hundred times the healthy amount. This is because science coagulates around real world power, the power over scientific discourse coagulates around real world power, like money, position, reputation. This needs to stop. This needs to changes. We need to realize that science in it's current form is neither democratic nor neutral, it's a highly political aristocracy where only some voices count. It's now up to us to stage a revolution as a community, such that everyone can have their voices count in global health. Thank you.

Jay Komarneni: I barely survived getting up those stairs, so hopefully ...

I'm Jay Komarneni, Founder and Chair of the Human Diagnosis Project, which exists to answer what we believe is the essential question of human health. When you, or someone you love, isn't well, what should be done? And in an interesting way, almost everyone in this room is answering that question in a different way, whether you work for a government or an insurance company or a search engine, or really any other organization that touches human health, we're all answering this question. I think we're doing this because most, if not all of us who are in this room, want to live in a world where the people we love have access to all of the resources that they need to achieve their hightest human potential.

Open knowledge projects guarantee that that's not just for the people in this room, and other people who are highly fortunate, but for everyone on this planet. Think about that next time ... there we go ... think about that next time that you use the internet, which was primarily built on open source code, or Wikipedia, an open content repository. It's almost impossible to imagine life without them, but the most important form of open knowledge is just now beginning. We can, for the first time in human history, network the minds of billions of people together into a collective super intelligence to solve many of human kinds most challenging problems. Open intelligence would differentiate itself from something like open content, because it would be much more like a two way conversation, as opposed to a book that you were reading. When you're sick, you don't want to just read an article to figure out what do you, you actually want to know what to do. When you're looking for a job, the same is true. When you're trying to figure out what's wrong with your computer, the same is true. The value of decision engines, and the value of intelligence to solve many of our problems is truly transformative.

Today, 10,000 healthcare professionals from 80 plus countries are already working together to build an open medical intelligence called The Human Diagnosis Project. The use cases which are emerging, are fascinating and unexpected. For one, we can now begin to use such a system to provide

personalized medical education to any health worker anywhere. We can also use such a system to dramatically reduce physician burn out, by actually automating many regulatory requirements such as CME, MOC, peer review, and many others, payment, billing, etc. Then, thirdly, we can actually use such a system in a value based healthcare world to actually enable payment based on the clinical nuance of an individual patient encounter, as opposed to merely using the code based system that we use today.

There are likely many more use cases for what I just described, which is what makes open ecosystem so powerful. They enable us to co-create the solutions to the most complex problems together. More than anything, we must ensure that human kinds most promising inventions, artificial intelligence, is available to all people, and ultimately able to help every single person on this planet. To do so, we need to nurture hundreds of open intelligence projects in all areas of human knowledge. In doing so, elevate well-being for all. Thank you.

Katie Drasser: Let's bring this home.

Hi all, I'm Katie Drasser. I'm Managing Director of the Aspen Global Innovators Group. I would follow those leaders and those ideas anywhere. So, let's give another round of applause for them.

Do you know what else is a good idea? Hiring wildly smart people who like to have fun towards something meaningful, and that is the Spotlight Health team. I want to give a huge shout out to the core team, that since this day last year has been working to make this happen. Natalie, Sola, Tracy, Deb, they're probably not here, because they're probably working, but huge shout out to them. This is hard work and we had fun doing it.