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PRESENTATION

Marc Naughton *- Cerner Corporation - EVP & CFO*

Good morning. Let's get started. First, I'd like to welcome everyone to Orlando, often referred to as home of the happiest place on earth. It is certainly quite a change from last year's venue of New Orleans, which might more accurately be called the dirtiest place on earth. But I hate to -- I have learned I do need to be a little bit more careful about the comments I make on venues.

My comments about Harrah's Casino as our -- the HIMSS in Vegas got me banned from that establishment for life. Of course that is a little like being refused a travel visa to Afghanistan. So I'm not too worried.

We had our client event at the Orlando equivalent of a Cuban restaurant last night; it was a great chance to see our clients and prospects. But I would describe the chain restaurant decor as Walt Disney meets Fidel Castro, so it was a little bit fake.

And after looking at my notes for this intro this morning I would warn you that mojitos only make you think you are funny, they don't actually make you funny.

So this year I am staying and we are having our event at the beautiful Hyatt Regency Orlando, which is a step -- a significant step up from my normal travel hotel in New York which most of you know is at the low end of the spectrum.

Just to compare. At the Hyatt there is a huge lobby with marble, smiling desk associate cheerfully asking me how many nights am I going to stay. In New York the desk clerk slides open the bulletproof window and asks how many hours I want to stay.

At the Hyatt the Environmental Systems can keep my room at a temperature within one half of a degree. In New York the system has two settings, summer and winter. So a little different.

At the Hyatt there are nightlights under the bedside table and the bathroom cabinet that come on when you put your feet on the floor. So that is very cool. In New York there are random poundings on my door at night that make sure that my feet get on the floor in the middle of the night.

And finally, at the Hyatt they have four outstanding restaurants and a very excellent room service offering. In New York we get free breakfast with the best fake eggs in the city. So, pretty big difference.

I would comment though as a travel tip that hotels that have room service that use room service carts in the hallway at night make a great place for a free late-night snack, so --.

I do want to thank our events team for giving me the chance to stay at a hotel this nice. I also want to thank them for not telling me how much my room costs. So with that let me get on with the agenda today.

First of all I will talk a little bit about the financial overview. We will go to Zane Burke who will talk to us about the marketplace. For revenue cycle we have Rick Heise, our revenue cycle leader, and Bill Wing, EVP and Chief Operating Officer of Adventist Health.

On the Population Health topic we have Matthew Swindells, our Senior Vice President of Population Health, and two of our esteemed colleagues from Advocate, our significant partner in that space.

Intermountain Healthcare strategic partnership discussion, Jeff Townsend and Bert Zimmerli will be presenting that. And then Neal will join us for Chairman's comments and we'll have Q&A after that. so with that let me get started. Here is our Safe Harbor statement.

Proceeding, Cerner at a glance, just as a side, Allan Kells spent many late nights updating our slides so they look modern. So I will give Allan the shout out for that.

Clearly a lot of you in this room are very familiar with the Cerner story, so I am not going to spend a whole lot of time going through this in order to get to the business model slide, which I think is really what everybody is most interested in.

But we have 14,000 associates, we actually also have 14,000 client facilities, significant earnings and operating earnings, revenue and earnings growth over the last 10 years, finished the year at $2.9 billion of revenue, 13% 10-year CAGR, strong 25% operating earnings CAGR.

So doing very well from a financial standpoint. We are investing heavily in the future of Cerner from an R&D component, we at the end of the year hit $3.8 billion of cumulative R&D spend. We have a 3,000 person IP organization and 1,800 clinicians within that 3,000.

So a lot of the people that are building our software actually have used or been in an environment that would use that software. So significant differentiation from our competitors.

The financial highlights most of you heard us on our last conference call talking about the success we had. Bookings were up 20% for the year, revenue was up 9% impacted by lower technology resale that we discussed on the call. Operating margin is up 25% and EPS up 18%. So good strong performance on the income statement side.

The balance sheet remains very strong with $1.4 billion of cash and investments, that basically is flat year over year. We have been investing, as I said, in R&D, so putting cash into that. We have also been investing in some facilities built out in order to house our associates.

I think as we look forward to cash flow and our cash deployment. You will see us continue to make investments in R&D and slightly less in infrastructure. You will see us in 2014 continue a stock repurchase program as we did in 2013, and we will certainly look for small strategic acquisitions that can get us quicker into a marketplace or provide a technology we can incorporate in the [Millennium] and that would be our expectation going forward.

Relative to cash flow, we certainly expect to see a significant increase in cash flow from 2013 to 2014.

This is the business model slide. For a change I might not actually have to explain every piece of it as our old model was. Trying to go to the spreadsheet approach, all the data that was in that is still on this, but I think it is a much easier way to look at it.

So you have got the revenue column that takes the six main areas or lines of business that we often talk about, provides the revenue number, provides the contribution amount and then the contribution margin segregated by the items on our -- the elements of our income statement which is system sales and support maintenance and services. So total revenue and then R&D and SG&A are below.

So let me just kind of take you through what the evolution year over year on this was. And once again, these are all available online and there should be Wi-Fi available in the building if you want to see it closer.

So revenue, on the license software side revenue was up 12%. Interestingly, I don't know if people are focused on that, about 20% of our software is coming from a SaaS business or approach, so power works and other elements that are a repetitive source of software where we are hosting, we have all the benefits of a SaaS business of one place to do all the upgrades for all of that client base, etc.

So an interesting tidbit that might not be well known, 13% CAGR, so our growth in 2013 was very kind of comparable to what we've seen in the prior years. Technology resale revenue was down significantly as we have talked with technology resale of low margin hardware being the biggest impact.

The interesting thing of having selling less of that low-margin software is that our contribution margin from that business increased 500 basis points from 13% to 18% and the total margin dollars actually from that business were only down $5 million year over year.

Subscriptions and transactions, revenue was up 19% on strong growth in subscriptions, so recurring sales -- content and transaction revenue, contribution margin was up 200 basis points on expense leverage so good performance in that space.

Professional services, obviously we are really active, really busy working with our clients, getting things implemented, doing consulting work. That revenue was up 24% year over year, contribution margin increasing 100 basis points. So strong leverage not only in our traditional but also that includes the increase in revenue you what I've seen from our works businesses.

Managed services revenue was up 15%, contribution margin up slightly on fixed cost leverage. And then support and maintenance grew 10%, contribution margin stayed steady at a pretty healthy 75%, it creates approximately $500 million of recurring margin which is more than we actually are investing on an annual basis in R&D. So we are at a point where support certainly funds some of that activity.

R&D and SG&A remain about the same percent of revenue but declined as a percent of dollars of gross margin. So that is the business model slide; hopefully the new format will make it a little bit easier to digest.

Relative to what the mix of our business is, as you saw that in a spreadsheet format, the revenue mix from a pie chart shows what percent those each contributed of revenue. Licensed software is 14% of revenue. We are still a software Company, software still triggers the vast majority of all of the rest of our businesses.

But from a visibility standpoint the fact that the recurring and highly visible elements of our business, those that are in backlog, those that recur over time, 73% of our revenue is coming from those sources. So even as we have grown revenue significantly over the years our visibility to that revenue is actually increased as well. So it is a nice top-line view of being able to have a mix that allows us to support growth but also allows us to support higher visibility.

Operating margins continue to grow; they have grown from -- since 2003 from 9% to 25%. That was a focus of ours and we continue to deliver on that. Going forward we continue to believe the business is capable of providing about 100 basis points a year of additional growth on that line.

Talked about the R&D investments continuing to increase; 2013 we were over $400 million. 2014 as we continue to fund those projects and as they wind down we will actually have even a higher level of gross capital -- gross R&D. These graphs are on the same scale so when you look at our capital expenditures you will see that while we do spend money on CapEx it is a lower dollar number than we are investing back in the business on the R&D line so that is a pretty key element of the Cerner strategy.

This slide shows you on the right-hand side three alternatives for a 2020 view of the Company. So the goal here is to show top-line growth at a 10%, 11%, 13% and 14% CAGR would look like and would require us to create kind of on the new business side.

So each of these elements of the graph represent either an existing business we expect to grow such as global or new businesses such as Pop Health, DeviceWorks, revenue cycle and IT works that are relatively small today but we expect to grow to $500 million businesses and in some cases more than that.

The core element of our business we hit and the 11% scenario we keep relatively flat because we continue to see our clients looking to get more business. We continue to expect there to be demand over the next three to five years of core EMR solutions. And our average client has about 16 of our solutions versus the 50 that we offer.

So there is a lot of opportunities to sell back in the base. So the gap in between we think is pretty reasonable if you draw a line across that from the left to the right, we think that growth is a pretty reasonable target for us to achieve. Once again, this isn't guidance, but it is a view that we think shows why we indicate we believe we can grow the top-line double digit over that timeframe.

This is a slide that basically recaps the guidance we provided on our last conference call. There isn't -- we don't do interim guidance so that is the last guidance we have. I won't read all the numbers because they are available on the slide for you to look at. But with that I would like to turn the podium over to Zane Burke, President of Cerner Corporation.

Zane Burke - *Cerner Corporation - President*

Good morning. Thanks, Marc, for the introduction. I'm going to spend a few minutes talking about some of the 2013 highlights and then focusing on marketplace trends overall. So as we shared on our conference call, bookings grew 20% over a very tough comparable from the prior year.

I think one of the interesting points to note here are a couple items, one that new business portion of this we crossed the $1 billion mark in 2013. And we had heavy emphasis on the physician market space so we had over 40% growth on both bookings and revenue in the physician market space.

Having a number of competitive displacements that occurred and we have gone to over 60,000 physicians using the Cerner solution and the ambulatory setting, which is very impressive in that sense. The strong ITWorks and RevWorks offerings, which you will see highlighted in some of my marketplace trends as we look forward; we expect that to continue to grow. And we had great growth in both of those marketplaces for last year.

And then I want to focus on some operational success of CommonWell and some things that we saw happen there in that space. So a year ago we announced CommonWell, which to remind you is the industry consortium of -- started with five partners, it has grown to nine partners. So yesterday we announced the inclusion of CBS as well as HMS, MEDHOST. So they became the eighth and ninth partners of CommonWell.

Also we have delivered on the four pilots and so they are alive and operating and you can go by and see them on the floor of the CommonWell booth, which had very deep traffic yesterday and so they are doing a live presentation at the CommonWell booth of the national patient identifier strategy that we are doing there.

Back onto the competitive side of things. While we have taken about $10 billion of bookings out of our pipeline over the last four years, you actually can see that our pipeline has more than doubled over that same time period. So we've had great growth in the pipeline so the future looks very strong.

Our win rate has more than doubled against all competitors and has more than tripled against our primary competitor in this space. And again, we've doubled the bookings on new business side in terms of sheer dollar volume.

So we've seen a lot of progress on the competitive side, so the investments that Marc highlighted from a research and development perspective are paying off, and our future vision elements are paying off in terms of the new business elements of this.

I would like to spend a few minutes on some marketplace trends and look -- basically the agenda has been somewhat laid out this way as well. And so, I'm going to highlight the first four of these and how they dramatically impact what is going on from a marketplace perspective and then we're going to want our clients to kind of highlight some of the elements that they are doing around revenue cycle and population health.

But suffice to say that IT is a huge driver in each one of these elements as it relates to impacts on our clients and the fact we believe Cerner is best positioned to capture that additional spend in IT and most clients are actually looking to double down on their IT investments as they prepare for the future.

I will show you a few of those items. And the reasons for that, it's continuing to rain measures and mandates. And we discussed this with you a number of times where the number of measures and mandates and the decreases in impact on their top-line for our clients is very significant.

And the driving they have got to go drive costs out of their organizations and they've got to ensure the revenue on the top-line for both the reimbursement perspective of readmissions, value-based payments, taking additional risk all require heavier use of IT systems.

As you look at consolidation, it is another significant trend in the market place that we have highlighted and it has been very successful for Cerner. So this is a 2013 view of acquisitions and the impact on the core EMR marketplace and what is occurring. And so, what you will see here is 61% of the acquisitions were done by Cerner primary EMR organizations.

What that means is as we look forward that gives us very good opportunity to sell into that base to help them standardize across the organizations and help be part of their consolidation strategies and part of their M&A activity. And I have highlighted a couple other competitors just to see on a relative basis what that impact looks like. And so, this is something we track very closely.

It is also critical to note that Cerner is the primary core EMR in 17 of the top 30 systems in the US. It is probably not something that most people are familiar with, but when you look at the top 30 organizations in terms of revenue Cerner is the primary EMR in those organizations. And those are likely to be the winners as we look forward and they're consolidating in many ways.

So there is a lot of ways and which this happens, so it is both the geographical consolidation as well as the vertical integration as they go after home care hospice, skilled nursing facilities, rehab, behavioral health and some of those other areas they look to elevate that and we have the full solution offering and can be the partner across those.

We are also the most open and interoperable, which creates another dynamic by which our clients are excited about because not all of the time, as much as I want it to be a Cerner world everywhere and have them buy everything from Cerner, it is just not a rational thought. And people have to justify those investments accordingly and there is just only so much change they can take. So our open and interoperable platform is very important as we move forward and it creates competitive advantage for us.

I want to highlight a little bit of what we see from a marketplace on the core EMR space as well as the Pop Health adoption curve. So if you look back over time, many suppliers benefited from the meaningful use era. And so I commented previously that the meaningful use is not a driver in our bookings as we look forward.

The driver in our core EMR bookings are clients that are looking for foundational plumbing to move forward for a different era. So they're preparing for a different era and they are getting their house in order in terms to prepare for that different era. And increasingly it is down to two suppliers. And so, increasingly it is becoming more of a duopoly as we look forward.

And we believe Cerner is well-positioned and our win rates continue to improve and have, as I discussed earlier, puts us in the best position as we move forward. And so, that also is critical as it relates to the Pop Health side of this.

So we believe our market share is very important as it gives us a little bit of an advantage in the incumbent perspective and use our footprint in a different way as it relates to the Population Health side of this. I want to share with you the first time I've really shared kind of this level of detail of what are my teams go after from a great perspective.

So if you go to 2014 perspective this is how we are organizing thinking about the business. So growth within our client base as we talked about costs are key, quality is key for our clients, those are huge initiatives for them. That really drives a lot of our businesses, things like ITWorks where the measures and mandates continue to pile up.

How do clients get more done with less? That is frankly what has to happen in this world. So how do they get more done with less? We could be part of that answer key as it relates to the ITWorks and the RevWorks aspects of this.

How do we use our scale to benefit our clients in a different way? And so that is part of what we are looking to do. We've already talked about the footprint success; we've got to continue that. The investments that we've made in the past few years and the investments we're continue to make will help our competitive advantage and continue to increase that win rate as we move forward.

The continuum of care -- so if you get the opportunity to walk the floor you will see something that looks a lot different for Cerner. It is that full continuum of care on both an integrated basis, so we're fully integrated across the continuum of -- whether it is behavioral health, whether it is ambulatory surgery centers, home care, extended care, those pieces or -- and we're fully interoperable. So two items that are incredibly important.

And then as we look forward our focus around the Population Health solutions. And so that is a net lift for us as we begin to sell the Smart Registries and some of the new PHM tools around that. Our global execution and growth has really been -- we are starting to see in the pipeline. So if we went back into that pipeline and looked actually at that pipeline slide you would see the global growth looks very significant as we move forward.

Our global growth historically we have about a 21% CAGR if you go back to 2004 and look to where we are today. And so, we continue to see good growth, we added Brazil in 2013 as a principal country we have entered and we have the, as we have previously discussed, our Einstein win against our primary competitor in that marketplace sets us up extremely well in that growing market and one of the fastest growing markets in the world economy.

As far as breadth and depth we have no match as it relates to the rest of the globe and our entries and our clients, more importantly, are having a lot of success, not just measured by the HIMSS levels that our clients have seen in the HIMSS level 6 and 7, but in terms of what they are doing to utilize our systems.

So overall looking very positive and feeling really good about 2014 and beyond. And with that I am going to invite Rick and Bill.

Rick Heise - *Cerner Corporation - SVP, Revenue Cycle*

Okay, good morning, I am Rick Heise, I have executive responsibilities ay Cerner for our revenue cycle and revenue management businesses and I'm also pleased to have Bill Wing with us here today, he is the Executive Vice President and Chief Operating Officer for Adventist Health, a very important strategic partner of ours on a variety of levels. But Bill is going to highlight a few things around our revenue cycle and revenue management relationship.

Bill's responsibilities as Chief Operating Officer are really to help with the leadership -- his leadership team setting the strategy but also executing the strategy across a couple of key principles in a very aggressive five year plan.

Those principles you will hear Bill talk about around value-based performance, care coordination and care and change management and also smart growth. It's an organization that is looking to grow and so Bill is going to take you through that journey after I give you just a couple of opening comments about how we are doing specifically inside of our revenue cycle business.

As Zane said, we are really enjoying the investments we have been making in this business, 51% revenue grow year-over-year with really strong contributions across all three major parts of our revenue cycle and revenue management business. Our software business, the implementation services and then our RevWorks business, which is our business outsourcing for revenue management services and I will take you through that in just a minute.

Part of our approach is not just to do and focus on traditional revenue cycle, but it is also to take advantage of a lot of the clinical automation that is playing out in the marketplace over the last five to seven years, either through meaningful use initiatives or other foundational initiatives that clients are having in automating their clinical practices and making revenue cycle a byproduct of that.

A lot of our clients in the marketplace today in healthcare spend anywhere from 2.5% to 7% of their own money chasing their own money in the revenue cycle practice. It is a very complex, complicated part of healthcare and part of what we are doing is simplifying that through leveraging automation and taking cost out in areas otherwise where you would otherwise need labor and employees.

We also have had a significant year in 2013 and well in 2014 as well around just our footprint. We have grown from a patient accounting and practice management perspective to having over 900 live sites, about 150 hospitals and 800 clinics as we ended 2013.

From a marketplace, the demand -- and Zane touched on this briefly, we are in the perfect position with the way we have built out our platforms and our technologies. We're a single platform that covers all venues, but also with both clinical and financial solutions. And that is how the marketplace is buying and we are in a perfect spot for satisfying that demand.

From a [1910] perspective, obviously the market is very focused on that. The good news for us is that we are not seeing diminished focus on buying process as it relates to that occurring on October 1 of this year. So while there will be some delays in terms of just people wanting to implement during that timeframe, the buying process has not been interrupted.

Just a minute on our RevWorks business, this is terminology we introduced last year, but RevWorks is our business outsourcing solutions for revenue cycle and there's really a couple of approaches there I wanted to share with you. More than anything at its core is our ability to help align with our clients to manage revenue cycle operations.

We do that a couple of different ways. First way is through a central business office organization where we can provide services to help clients transition off of old platforms onto new platforms. Or just provide some AR liquidation services, all the way to and what Bill will describe a little bit in our relationship is to a full outsourced model where we will go ahead and re-badge and like our ITWorks business and take over and shared responsibility for running the full revenue cycle operation of our clients and their health systems.

Our approach is really a couple of things. One, this allows us to align differently with our clients. The reason that is important is that we are not going to be stuck in this fee-for-service world for too much longer.

It is going to be there for a while, but the transition that is happening to get to more risk-based reimbursement taking on models of accountable care, looking at models around bundles which are pretty prevalent in the marketplace today. This allows Cerner to spend time shoulder to shoulder with our clients and continue to learn to automate as the industry transitions from that fee-for-service to a set of risk-based models.

So outcomes that we expect obviously clearly top-line growth. You can see from the chart on the right we are now at a point of managing and sharing the management of revenue cycle responsibility for over $4.3 billion of net revenues with our clients. We expect that trend to continue in 2014 and beyond as a major growth area for Cerner.

So let me pause there and I will have Bill Wing come up, again Bill is Executive Vice President and Chief Operating Officer for Adventist Health. Thanks, Bill.

Bill Wing - *Adventist Health - EVP & COO*

Well, good morning, it is great to be with you. So I have a couple of disclaimers before I start. First of all, I am on West Coast time so I hope you'll forgive me for that. I just looked at my watch and it is 7 AM and I actually thought I was doing this at 6 AM, so this is great.

Two, I am a recovering CFO. And I was pleased to see that Marc had opportunity to go before me and I just want to assure you that I won't use much humor as part of my presentation today. Thank you, Marc. About the same as you, yes.

So who we are. Talk a little bit about Adventist Health, Adventist Health is located on the West Coast. We currently operate in four states, California, Oregon, Washington and Hawaii. The system is truly an integrated delivery system and evolving much more in that direction.

Currently own and operate 19 hospitals, the majority of those in the state of California representing 2,700 beds and a complement of physicians who are either medical staff members or tightly aligned to us in some form of business arrangement representing about 4,500 physicians.

For those that are tightly aligned with us, we have 180 ambulatory clinics. What is unique I think about Adventist Health is really the diversity that we have inside of our portfolio. We are at the very probably most urban settings of downtown East LA.

I like to define the market of that particular facility is really almost a one mile radius representing almost 1 million lives in that population of one mile. To some of the most rural settings in both California, Oregon and Washington. We operate 50 rural health centers across those three states; probably the largest rural health presence at least on the West Coast is not even nationally.

As part of our physician alignment, we do have 550 physician providers who are either contracted exclusively or also employed depending on which state that we are referring to. And we believe that going forward they are absolutely key partner as we really look at our strategy which I will cover here in a few minutes.

From a workforce perspective about 29,000 when you include our employees, our volunteers and our physician partners. And when you look at the numbers, really we have about 4 million individual encounters a year and really covers the gamut of ambulatory acute and post-acute services. You can see some of the statistics reflected there.

But I want to talk about is the future and really the changing landscape that is before us. And one of the things is -- I've got to kind of step back and share with you a little bit about our relationship maybe with Cerner.

We have been aligned with Cerner, and I probably don't have the exact date, but late 1990s, so 15-year relationship. From a clinical perspective we are all Cerner both on the post-acute, acute and ambulatory side even though we do have a few elements that we continue to roll out in that regard.

But one of the important things as we kind of look at the changing landscape is really this slide here. And healthcare is on this journey from volume to value. This is a slide where really Adventist Health and Cerner align from a vision perspective from where is the industry going.

At the bottom left you can see it is kind of the traditional fee-for-service environment. Kind of upper left-hand quadrant the population care. Bottom right-hand bundles and kind of new business or reimbursement models.

But really in the upper right-hand corner is this kind of transition to Population Health. When you think about Adventist Health, we live in an environment on the West Coast that probably has been early adopters around managed-care trends. And if I walked you through each of our markets, which I think are fairly diverse, you would see a variety of models playing out.

What was important for us is to have this alignment around vision with Cerner because it was key and instrumental as we kind of made the decision around our clinically driven revenue cycle process and bringing both the clinical and the financial platform together.

With Adventist Health I would say we're our early on this journey. You're going to get to hear a little bit I think from Advocate next. And around their journey and they are a lot more progressed in a lot of ways than we are. We have about 100,000 lives at risk today across Adventist Health, represents about 10% of our net revenue. I don't know where that ends, but we know that we are on this journey of moving from that bottom left-hand corner to the upper right-hand corner.

Now along this journey though there are a lot of challenges. And this slide here is really to depict what I kind of call our margin walk. As we look out over the next five years and all of the changing landscape around healthcare, this is what we believe the impact is to our margin over that period of time, going from a positive 4%-plus to as much as a negative 20% if all of these things played out as anticipated.

And the real question is how do kind of walk out of that? And we believe there are a number of key things specifically around this transition of volume to value that are instrumental, including the revenue cycle aspect which I will talk about here.

And so, as we kind of looked at our journey and our strategy and we really kind of set a five-year horizon, one of the things that -- or three things that evolved were really around smart growth, because we believe that we are going to have to continue to evolve and reshape who Adventist Health is.

Two is around care transformation and really kind of creating the alignment and integration that is necessary to make that journey from volume to value.

And then third is really around value-based performance. And for us we have kind of defined that as that around a number of focused areas we want to be top quartile if not top decile performance in those respective areas.

One of those areas is really around revenue cycle. And as we kind of looked at that we thought there were at least three significant swings that we needed to make as Adventist Health, one was around standardization.

So it historically I would say that we have been more of a federated model as a health system. And we are moving towards much tighter operating model. I always kind of test the barometer inside around where we think we are on that journey and I would say we are probably not even at the midpoint.

But around that is standardization which is kind of that first swing and that is how do you take across these 180 clinics, 14 different post-acute care settings, 19 hospitals, how do we create standardization or may I say [systemness] in order to really drive out this level of performance of top quartile if not decile. So that is the first swing.

The second swing was around modernization. So we are running on a platform on the revenue cycle side that is 30 plus years old. We have spent most of the last decade really focused on the clinical side of the equation and here we are really talking about modernizing our revenue cycle platform and creating the integration of both the clinical and the financial with Cerner.

And this third swing as around consolidation. And this word always kind of perks people's ears up at least internally when we talk about consolidation. I use the term kind of loosely; there are lots of ways to consolidate. One is just from a governance perspective, one you can virtualize, you can regionalize, you can centralize, all forms of consolidation and that is in the play as it relates to how do we actually effectively run revenue cycle.

So with these three swings we are really impacting what I consider to be three significant metrics and I add a fourth. One is improve our yield. And we believe that we have significant opportunities, especially in this transition period, to ensure that we are collecting every dollar that is appropriate.

Two is reduce our cost, our total cost to collect is what I call that. Because I think there is opportunity and a lot of friction and waste and inefficiency in that space. Third is accelerate our cash.

And lastly but not last is really to ensure as we do this the standardization, the modernization, the consolidation, we do that with an aligned and engaged workforce.

And so this is where we have partnered with Cerner, I think it is a very unique relationship. One of the interesting things as I kind of open the door to my office I actually have Cerner associates that are embedded within Adventist Health just down the hall. I think in total there are 200 Cerner associates aligned with Adventist Health in a shared vision around really achieving the results in this level of integration that I have articulated.

So what does it look like the kind of current state future state. Across the Adventist Health we hadn't really kind of put our arms around what is our total cost to collect. And for us that starts with scheduling to registration to peer management, the health information management and patient financial services all and was about a $200-million-plus spend to collect our $2.8 billion in net revenue.

From a headcount Perspective, almost just north of 2500 and you can see that is over 10% of our total employee base. Given the fact that we are running on a 30-year plus platform, a number of kind of bolt-on technologies that really enable us to collect the revenue that is due and you can see we have 15 plus of those.

And you can see some of the other statistics; I will focus on the cost to collect as one metric, that 4.9%. Now that is a mix of three different lines of business, ambulatory, acute and post-acute with a journey to the right there of achieving top quartile or just north of 2.78% is the range that we want to get into.

And as we kind of stepped back and said if we're going to take this journey we felt like we needed a partner. And this was the opportunity where Cerner and Adventist Health really aligned what has been driving performance if not top quartile or better performance around a tightly integrated platform as well as a really co-sourced team of individuals allowing us, I believe, if we're going to take the cost out of the equation to innovate really at the edge which is where I think the next level of innovations is necessary.

So what does this journey look like and I spent too much time on this slide just to say a couple of things one is that it is a multi-year journey. This relationship is a 10-year relationship even though we only have five out here on this particular slide. One of the drivers as we kind of looked at our timeline was really to get in front of ICD-10 which we all know is kind of coming down the pike here in 2014.

In order to really affect change on the backside of ICD-10 and I would concur with the statements that Rick made earlier in that I think that there is still a significant amount of industry that are running on legacy revenue cycle platforms and I think that this will accelerate as we come out the other side of ICD-10 as it relates to really creating clinical and financial integration.

I will also say that I don't think our journey really kind of ends or starts and ends with revenue cycle. Adventist Health and Cerner are already looking at other ways where we can actually create value together. One of those initiatives is really focused on something that we are calling a value creation office.

It is really intended to go after, in my mind, if $200 million plus is coming from revenue cycle and I still have a $400 million need to make from a journey perspective I want Cerner aligned with that from a data perspective, how do we leverage the clinical platform, the revenue cycle platform, how do we take the analytics from that and really drive performance across the rest of the organization.

So we are looking at through the value creation office to continue to extend the journey that we have already started on the revenue cycle side. So I will pause and turn it over to our friends at Advocate.

Matthew Swindells - *Cerner Corporation - SVP, Population Health & Global Strategy*

Thanks, Bill, that is really exciting stuff. Let me introduce myself, if you remember me from spending up here this time last year, I am Matthew Swindells and I lead Cerner's Population Health activities and also our global strategy. I am very excited to be here again with our colleagues from Advocate Health Care and Advocate Physician Partners to talk about what we have done in the last year.

But the single most important thing we have done in the last year is I've moved my family from London to Kansas City. And certainly my daughters have very much enjoyed their first experience with a Midwest winter.

So I have with me Mike Englehart, President of Advocate Physician Partners and Dr. Rishi Sikka, Senior Vice President for Clinical transformation at Advocate Health Care. You know Advocate as a leading health system based in Chicago, you know them as industry leaders in clinical integration and one of the most advanced ACO's in the country. While they were here with us last year and I introduced them as valued partners on this journey.

I am pleased now to be able to say that they are value partners and really good friends, good friends with Cerner and I think good friends of me and the team. It has been a real joy to work with them.

When we stood here last year we talked about the launch of our partnership through innovation and also how we were going to develop together the next generation of the Population Health platform and move the industry on the management of populations. And I am really, really pleased to say that I can come back here now and tell you that during the year we brought our healthy intent platform live.

We now take data from multiple data sources, 62 data sources I think now from Advocate of which one is Cerner Millennium and the others are other data sources. We are mapping and standardizing that data to create a single linked view. We have created a programmable engine that runs in real-time to allow you to drive change across the health system and push activity back into the workflow.

We have created a platform that is now with Advocate managing a population of 735,000 people, taking in -- has taken in since it went live 153 million lab results, generating automatically 13 registries and over 4,000 scorecards. So we have created that programmable real-time platform to fit across a help system.

And we have gone live with our Smart Registry solution supporting and helping Advocate to advance their clinical integration and drive improvements in quality, improvements in Population Health and drive down the cost of managing healthcare.

We have also launched, as we said we would, our first readmissions algorithm predictive modeling which is now an industry leading model. And we are linking together the other solutions that we have across the continuum from hospitals to clinics to long-term care and into the home to create a single view across the health system.

So we've done a great deal in the last year and you can see that list there in green. But part of what we're doing with the healthy intent platform is creating the basis on which the next innovations are going to come, the way in which we cycle through new innovations.

So over the next six to 24 months we will be creating a set of solutions, including those in the blue column here, including new analytics and business intelligence, the ability to care coordinate across multiple settings, the ability to manage -- extend our contract management so that it extends beyond the hospital and across the whole of a population and to run the clinical programs across it.

So Mike will talk about how they are using this technology to change and drive forward their organization, Rishi is going to talk about some of the innovations.

And I just wanted to end by saying this feels like a new partnership for us, this feels like a new way of working with organizations where we are helping them improve within their hospital, we are genuinely innovating across the whole system and we are helping to drive forward the way in which the wider health system and the physician partnership works.

So it is a tremendously exciting time for Cerner, it is an exciting time for us, and I am delighted to welcome Mike Englehart to the stage.

Mike Englehart - *Advocate Physician Partners - President*

So again, my name is Mike Englehart, I am the President of Advocate Physician Partners. It is good to be back with you again this year. Just a quick overview of Advocate Health Care and APP.

Advocate Health Care is the largest healthcare provider in the State of Illinois, we are just shy of $5 billion and we are AA rated. We have 12 acute-care hospitals. We grew up as a hospital company and through this presentation you will hear both myself and Dr. Sikka talk about how we are transitioning and trying to be more of a Population Health Company, frankly.

We have 250 sites of care, so we are pretty much dotted across all of the Chicagoland market and have a decent presence in Central Illinois. The right side is Advocate Physician Partners. We have over 4,500 physicians that we go to market with, we contract with.

Ten years ago we had an interesting conversation with the FTC. I wouldn't recommend that to anybody. But it was arguably the most challenging thing we've ever done and the best thing we ever did, because a byproduct of that was we became a kind of the standard for clinical integration. We were able to explain how coming together with physicians and hospitals to try and improve care for a community was the right thing to do.

For the last seven years we have produced a value report. We were producing a value report when it wasn't cool and it wasn't the thing to say on to every different PowerPoint presentation. Because of that we have had a great deal of transparency with our physicians, 65% of our physicians are still independent.

In the Chicagoland market most of the physicians are from very small practices, two to five physicians. So because of what we have been able to do for our physicians, they trust us, we measure quality, value and we've made this journey together. When we were looking at whether or not to step into the pioneer or the MSSP program with CMS we decided that Medicare insured savings program made perfect sense for us.

Before that though we have a very interesting relationship with Blue Cross Blue Shield whereby we went to market together and did our own ACL and we are now finishing up the fourth year of that relationship and it's been a unique journey.

So between the two, last year we had the dubious honor by Modern Healthcare to be identified as the largest ACO in the country. And so we really have moved in to a Population Health value model.

I was talking to Bert before this and is presentation I think will touch upon this as well. Every market is different, but the reality is most healthcare systems spend time in each one of these domains.

So we are trying to speak to our physicians and our hospital presidents about we are moving towards value and we're going to take on risk, but at the end of the day they still need to make sure that they can put the lights on and drive the value and hit their bottom line. But our model continues to move toward the right.

For the longest time we were doing pay for performance. We have skipped over bundling, it hasn't really hit in the Chicagoland market, but we are taking on risk and ultimately the goal for most organizations is to get up to first dollar risk. If you can manage it that is the play.

Underneath it there is a lot of transformation that needs to take place. Bill's comments were absolutely accurate. We are focused and by the end of this year 50% of all of our primary physicians will be in patient centered medical homes.

So it's one thing, we mandated for them to get out in EMR, but doctors will take a paper process and bring it into an electronic world, but if you reengineer you can move them towards a value model. We have obviously stepped into ACOs, but underneath all of this is arguably a transformation of help with healthcare systems view themselves.

The consumer is going to drive more, we have got to be value added, we have got to have a lifelong relationship with them and we are looking at different ways in which we interact. And every market is different.

I would take a step back and simply say that for us to -- on an annual basis to be able to manage our CI program we had a disease registry. It started as paper, moved its way to a paper/electronic format and a year ago when we were down in New Orleans we said, mission-critical we will roll out with Cerner a disease registry.

In order for that to work we had to build up a healthy intent platform; Dr. Sikka will speak to the power of it. But Advocate is quite complex. While we are heavily focused on Cerner, through acquisitions and mergers we have the alphabet soup of EMRs. And at the appropriate time we will make transitions over into the Cerner world, but ultimately to be effective and take on risk and manage lives we need to aggregate all of this information.

We also clear claims. And so now we have the marriage of both clinical and financial information. And that is what is so powerful about the healthy intent platform, that we were able to aggregate all of this information -- Matthew talked about 62 different data points. You start to get a real picture of what is going on with your population when you aggregate all of this information.

So our registry, I talked about this before. By the end of this year it is possible that our disease registries will have over 700,000 patients that we will be managing through the registry. That means that our physicians are responsible for these lives.

In the past we still worked in silos. But now if a cardiologist, an epidemiologist and a primary care all have a patient that they are responsible for, regardless of the EMR, we can share information. We think this is powerful. This is how you manage a population.

Scorecards, we are going to show you both ultimately physicians are motivated on how they compare to their peers. And we can do this because we have been working with them for 10 plus years and they understand it is about transparency and driving value.

Programmability, every year we get a curveball turn to us by a payer. And while we try to standardize as much as possible, we need to be able to tweak our model. And what we love about the disease registry is we are able to change it.

Analytics, while we don't think a physician needs to spend all of his or her time in this, someone whether it is Advocate, the physician office they need to take a look and think differently about how they care for their patients. And we will show you a couple of screen prints of how they are going to be able to see their world in a different way.

Medications, there is a lot of slippage here. We are big fans of the CommonWell initiative because we think that whether it is CVS, Walgreens, Walmart -- everyone needs to share information. If we are really going to bend the curve on cost, that information is powerful and if it is aggregated and we can see whether or not Mr. Englehart has not filled his order an intervention could take place.

We are excited about what that potentially means because those are wasteful dollars as far as emergency room visits. And so, we are interested in being able to aggregate all this information again on the healthy intent platform.

This is an example of what a registry looks like now as a byproduct of our very close partnership with Cerner. We sat down and had over 10 physicians and 20 office managers help us to develop this. It has got to be intuitive. It's got to be at a first glance what does this look like.

So you can see in the upper left-hand corner the name of the physician and then it is laid out -- communication, your quality score and all the different initiatives that are underway. What we find interesting is this would be the snapshot; this is where a doctor would come in and see what is going on.

The next slide talks about the registry. Physicians respectfully give me what I need to focus on, that was the number one concern of our physicians. Give me the biggest opportunity and I will work my way back. As you can see in the upper left-hand quadrant this is a diabetic patient, foot exams, if you clicked on this you would see the list of all the patients.

So a physician will look at it, the office manager, whether it is an employed physician or it is an independent physician, instead of saying, I have got open five, this is an opportunity to go out and actually call the patient forward rather for them waiting to come forward to us. This allows them to also see how they are doing as far as a score is concerned.

This is extremely powerful. As we change, whether we like it or not, the payers will push more risk upon us, this will allow us to start to better understand who the patients are and how we are going to activate the patients. Where is the biggest risk in our portfolio and what are we going to need to focus on on a go forward basis.

This is an example of the registry. What we're most excited about this is the programmability. Literally our team to go in and stand up and change the way a report looks. It's written in such a way that it will also allow us to go to the next phase and that is care management.

So last year we talked about the smart registry, this next year we will partner with Cerner and stand up a brand-new care management system that we think is very provider centric and take full advantage of all of the technology and the data that is flowing through the healthy intent.

We have employed and put out into the marketplace over 100 care managers. And so, we have used some predictive analysis and it has been helpful, but this will absolutely help us to identify patients that fall through the cracks. And so by doing so we will be able to take on more risk and be able to be more effective for our patients to intervene and partner with our physicians.

At this point I will turn it over to Dr. Sikka. I would just add as Dr. Sikka walks up, his team is developing the incubator for all of this new technology and the goal here is anything that is developed from his team at Sterner we actually implement.

Rishi Sikka - *Advocate Health - SVP, Clinical Transformation*

Great, thank you, Mike, and good morning. It is really a pleasure to be here again with you and share with you our journey as part of the Advocate Cerner collaborative. And that collaborative is our strategic partnership with Cerner around Big Data and Population Health analytics.

So I am going to take the next couple of minutes and sort of frame it in two or three big parts. The first is really just talk to you about what we set out to do, what we have accomplished and what the impact of that work has been in a very real basis on our day in and day out clinical care and Population Health work.

Then I will give you a little bit, a glimpse, of not just the coming months and years actually, but what we really see as the vision for the future in population health, big data and analytics. Now if you think about our strategic partnership, you can sort of think about it in three parts.

And the first part has really been about the construction and the data platform and we talked a bit about that last year. Really challenging and difficult and very proud to say successful work of building that healthy intent platform taking 63 different sources of data, internal, external from the data, creating true longitudinal patient histories that really give us our first holistic blends of what is going on in the population and that has been the foundation for all of the work that you see here.

On top of that while we have been building that platform of data we've actually been starting to work on the advanced analytics and the predictive model. But it is important to realize this is not an academic exercise.

Every model we build, every analytic has to be deployed into workflow and have an impact on patients; it has to have an impact on individual so we can bend the cost curve. This is a very important strategic imperative for us, this is not just about innovation, it is about innovation and impact at the same time.

So a little bit about what that innovation and impact has been in a very concrete way over the past 18 to 24 months. One of the first models that we developed was an all cause readmission model, a model that helps predict which patients are going to be readmitted to the hospital within 30 days.

I'm very proud to say that our model actually performs 20% better -- 20% from a statistical standpoint better than any other published model or to our knowledge actually any other commercially available model that is out there.

Now the nice thing is this that this isn't just a model that is relevant to Advocate, it is a model that actually works and has statistical validity and a broader context too. The reason is because of you look at those slides that Mike showed earlier about who Advocate is, we're really kind of like a snapshot of everything that is there in healthcare, right?

We have got urban teaching hospitals, we have got suburban hospitals, we have critical access teaching, rural -- we really have the entire spectrum there. So our predictive model not only works just for us but actually for other organizations.

And true to the spirit of this partnership, this model is being commercialized, sold and deployed at over 120 other non-Advocate Cerner facilities across the country. That is really the hallmark, everything we do has to have impact and real-world applicability.

The second model we are working on that we are really excited about and we think it's the first of its kind is what we call the transition of care model. We believe it is the first model that can predict where a patient should be discharged to. The first model that can tell you should you discharge or, to use a more appropriate nomenclature, the best place to transition a patient from the hospital.

Should they be transitioned to home? Should they be transitioned to home with home care? Should they be transitioned to a skilled nursing facility? And to statistically predict where is that best place. We have a dire need for that.

We have talked with other leading health systems and we know they have a need for that too. And to our knowledge no one else has developed this type of model.

Just to give you a sense of what the impact of this -- now we've just finished developing the model; we hope to get this deployed in the latter half of this year. If this model is deployed, and even if we conservatively follow its recommendations, that would have an over $200 million total cost of care impact on our attributable patients. Real word impact of all the work that we're doing.

Similarly we've developed a model that helps predict which patients are going to revisit the ER within 30 days. So the patient goes home from the ER, who is going to get readmitted or who is going to come back to the ER in 30 days? Who do you need to intervene on, follow up on, call, ensure that they are connected into the system?

This is a model we've also finished developing, we hope to deploy in the latter half of this year. We would anticipate very conservatively that the total cost of care impact of this model would be $3 million per organization.

We also are working now on a model that predicts who is going to be admitted to the hospital from an ambulatory setting. And then I'll talk a little bit more about really what I think is groundbreaking and transformative work in Population Health analytics, an approach we call clustering.

Just to go step back for a second to readmissions, just to really give you a sense of how important and significant this breakthrough has been. We had a readmission model we were using about three or four years ago, largely home grown. It was a model that had about 15 variables. We tried to score it one today on a piece of paper with a patient.

This model is much more robust, it looks at about 35 variables, it is built into the cloud, it auto scores every hour and looks at -- and gives that score right there. No manual calculations, no paper, the score is right there ready for you and tells you what the prediction is for the patient being readmitted. And once again, 20% better than anything that is out there both published and in industry.

I've talked to a lot about what we've accomplished and what we set out in that impact. Let me talk about what we see as the future, and that is future around Population Health big data and Population Health analytics.

And this is a slide that is probably familiar to many of you because this is the way we think about Population Health today. It's the way even our organization has thought about Population Health, which is to take your population and to stratify them on a single dimension and usually cost.

And when you take the population you stratify it by cost you get a pyramid that looks like this, where there is a small proportion of the population at the top that drives a disproportionate share of the cost. And this is the way we have been thinking about Population Health and particularly focusing on that top part of the pyramid.

Now this is a great place to start and it's where our industry has started its thinking, but it is not going to get us to where we need to really bend the cost curve and really get to transformative Population Health Care.

The reason why this doesn't get us there is for a couple of reasons. First of all, you are really just looking at claims data and costs and you are not really looking at the whole clinical picture.

The second is when you are not looking at the whole clinical picture you are lumping folks into these big broad categories. And when you lump folks into big broad categories you lose the distinction. You don't know who really can be impacted, who can you intervene on, what interventions are best. You just kind of lump into big groups.

The third thing is that when you look at the pyramid you have a tendency and we have had that tendency to focus largely on the top, the high-cost patients. And you should focus on the high-cost patients, but it is not enough. Because if you just focus on the high-cost patients you are not going to move the average of the population.

Basically what you are doing is you are focusing on the tail and hoping the average will move. What you need is an approach that will allow you to focus appropriately on everybody in the pyramid. Give something for everybody so you can really bend the cost curve and move the average.

We call our novel approach to achieve this Population Health Clustering. Now before in Population Health 101 you were looking at our patients on a single axis of cost. We believe that the right approach is to look at patients and group them according to two or three dimensions and one of those could be cost.

In this example you are looking at patients that are clustered or grouped according to the dimensions of complexity and wellness. So you are no longer really looking at a pyramid, you are really looking at taking what we believe are at least six characteristics, looking at them in two or three dimensions and clustering the patient population.

Once you cluster the patient population there are tools that you overlay on the clusters that generate that real world meaningful impact. Tools like who can be impacted, and that is the example you see here, tools on medication adherence, tools on what are the appropriate interventions.

So you take this combination of two or three dimensions, overlay the tools and you really get a Population Health application. An application that goes beyond the pyramid, groups the patients, groups the population on an individual basis, acknowledges the distinction from them and shows you who you can intervene on, where and why.

Once again, this is not an academic exercise. What you are going to see over the coming year is that this is going to be visualized within the tools that we are building with Cerner. It is going to be summarized in a score. And it is going to lead to meaningful action that needs to be taken in the ambulatory setting primarily to help bend that cost curve.

We are very excited about this innovation, you can see just a glimpse of it here and the possibilities when you take that there are six dimensions, you can array them two or three different ways and there's a couple different applications, there are a lot of different solutions that we're going to be working on over the coming years. And we are very excited about that work.

I'm going to hand it over now to Bert Zimmerli and to Jeff Townsend.

Jeff Townsend - *Cerner Corporation - EVP & Chief of Staff*

We are going to -- Bert and I are going to do ours a little backwards. I think I'm making a huge mistake following Bert because I won't be nearly as interesting as he is going to be.

We are about 90 days into the formal part of our relationship or post-contract, but some of the journey started on the back end of this week with both organizations being incredibly tired and spending Thursday, Friday together on the way back to Utah. I now understand why you do that because I live in Utah and it is on the way.

So I think my quick summary of 90 days in Intermountain is an organization top to bottom that has a purpose, every one of their employees get it. And this morning we have started with a comedic CFO, we went to a recovering CFO and I'm now going to introduce Bert who I think is the CFO with a passion to make a difference. Bert Zimmerli.

Bert Zimmerli - *Intermountain Healthcare - CFO & EVP*

Well, that is a tough act to follow, you have got these big city, big state systems, Advocate and Adventist, you've got the public Company with 25% margins, 24 countries, you have got a recovering CFO and I am just an accountant from a small state in Utah. So this is pretty hard for me, I want you to know that.

It reminds me -- I grew up in Wisconsin, worked a long time in Houston and 10 years ago came to Utah, worked for Intermountain Healthcare. And one of the things at a conference like this or here in New York at the Citi conference or whatever, you don't know someone, a break the ice kind of thing is where are you from?

And when I first went to Texas, pretty naive, small-town boy and so I asked this older country guy, I said where are you from? He said, boy, never ask a man where he is from. Well, that didn't go too well. So I asked him why and he said, well, if he is from Texas he will have already told you, if he is not why would you want to embarrass him.

But I am not from Texas, I him from Utah. And I have to tell you being serious now the first couple of years when I got asked that question where are you from and I said, well, I am from Salt Lake City, I'm from Utah. But I grew up in Wisconsin and I lived in Houston a long time; I am not from there. Because there's a lot of misconceptions about Utah, a lot of misconceptions.

But I don't say that anymore, I've been there almost 11 years now. And I have learned a couple things -- one, Utah is a great place to live. Jeff, you are going to find that out, it's a tremendous amount of outside activity, great things as look at trying to inculcate a culture of wellness, we've got a great platform, a great state to do that in.

It is a great place to raise a family. It is a great place to do business. Utah is consistently ranked as first or second by Forbes and others as the best states to do business in anywhere in the country. And as you are going to hear from me, I absolutely believe it is the best place to get healthcare in the world.

And so I'm going to tell you a little bit about the Intermountain story and you might see we are in Booth 3903 by the way. We have had an exhibit the last two years. And last year it was interesting, I heard a couple questions repeatedly. We are there with a few of our partners that we work with. And people came and asked two things -- why are you here. You are a healthcare system, what are you doing here at this IT conference? And number two, what are you selling?

And it was really interesting because I think I'm going to talk a little about our partnership with Cerner and I think it is a good cultural fit, okay. But a little bit of the culture of the folks we had in the booth last year was when they got asked a question about what are you selling, it was almost like they were really embarrassed. And, oh, we're not selling anything.

And so we met as a group later and I said of course we're selling something, I mean you are all selling something, right, whether it is your family, your name, your reputation. So what are we selling at Intermountain? Why are we here? We are here to demonstrate -- if you look we have got an RV, that is a little different. So that demonstrates that healthcare, you have heard it from two presentations already, it's about mobility, it's about reaching out.

It is not about demanding everybody come to see us in our bricks and mortar building like healthcare has always been. So it is where things are going. We need to be able to provide healthcare where you are, how you want it, when you want it on your terms, not what is convenient to us and not what is convenient to the doctors, which is the way it has always been done.

So, yes, we are selling, I hope I can sell you that we as an industry, Advocate, Adventist, Intermountain, Cerner working together, we have to transform healthcare. Our United States economy depends on it. Healthcare costs too much, the quality is not good enough. And together we are going to do that.

So I'm going to quickly go through this, I'm not going to read the slides. Intermountain Healthcare is an integrated healthcare system, you know what that means. Probably the most important thing on this slide is look at the dates, we have been doing this a long time.

So work through what does it mean to have a health insurance company which is the largest health insurance company in Utah, almost 30 years now. An employed medical group for almost 25 years and then the clinical programs, the last thing you see on there, this is really unique. These are teams of physicians, nurses and data analysts working together to develop systems to truly improve healthcare. I will talk a little bit about that later.

Probably the most important thing though is Intermountain was formed in 1975. I like to say that it is the first organization I worked for; I am actually older than the organization. Now there is probably a couple of things going on there, but while we are a relatively young organization, we were given the charge to be a model healthcare system.

And if you think about that at the time, there were 15 fairly rundown hospitals, we are out in this remote state. Before Mitt Romney ran for president probably nobody knew where that was in New York. Be a model healthcare system, a pretty bold goal. And we are not there but we are working hard to get there. And so that really drives everybody on the Board and it drives all of us on the management side.

I appreciate what Jeff said about employees that get it, I absolutely believe that. We've got 35,000 employees and by and large they come to work every day and they try dang hard to do the right thing and it really shows.

So if we got asked the question, we're an integrated healthcare system so we've got hospitals, doctors, insurance companies. So what is your core business? Out of all of that what is your really core business? If my boss, [Charles Sorensen] who is a surgeon, was here he would say it is none of those three, we are not about running hospitals, we are not about running physician practices, we are not an insurance company.

We are about perfecting the clinical work process. And the best clinical care in the world doesn't mean anything if nobody can afford it. So it has got to be both those things together, high clinical care at an affordable sustainable cost.

Now kind of trying to articulate sort of who, what is Intermountain. Again, it all starts with quality at our organization. And we try to put that -- some of you may have heard of Dr. [Brent James] who teaches quality following the lean process, putting metrics around that. You've seen a lot of metrics and dashboards in the previous presentations. We absolutely believe on that.

But look at these areas, base it on evidence not intuition, not what I was taught in medical school 30 years ago, but base it on evidence. What is the evidence-based way to do what needs to be done? And then put a system around it to make sure you are doing it right every time and constantly improve it.

And we've tried to take that approach since I have been at Intermountain, say, hey, if that works on the clinical side, if we can put a system, if we can do this at 22 hospitals, 200 clinics, do it right every time, measure it and monitor it, we ought to be able to do that in every operational area, we ought to be able to do that in every financial area and we ought to be able to improve our governance processes. And we have done that.

So in every department of any size the expectation at Intermountain Healthcare, if you are a manager, is you have to know what is the best practice in your area. Whether you are in accounts payable or the neonatal ICU you have to know what is the best practice. And many times it will be in healthcare, sometimes some of these areas the best practice is not going to be in healthcare, it is going to be in some other industry.

And so the expectation is you will know that and the expectation is you will have a written plan for how you get to there in the next five years. Now we don't always accomplish it, but that is the goal. And fundamentally at the end of the day it is about doing the right thing.

So Intermountain if you go back to its roots actually before it was formed in 1975, there was a physician, Dr. [Homer Warner] at what was then our flagship hospital that actually believed you could take computers and of course computers then were almost as big as this room, probably didn't have the power that we now have in our iPhone, but that you could use information to improve care and set about to do that.

We have got up until very recently, still do, Axa, homegrown systems, electronic data warehouse with coded data for the last 30 years and that has been absolutely critical to our success. So as a legacy of really in-house development, using that to improve care and innovation.

And so our decision to go with Cerner, big, big deal in our organization, not one we took lightly because it is fundamental to the culture of innovation within the organization.

So move quickly to how we have done first from a cost standpoint. You can see that a recent Wall Street Journal article on a cost per capita basis Utah is the lowest, these are Utah numbers now, not Intermountain Healthcare, but we are about 55% of healthcare in Utah so we have a pretty big impact on these numbers. You can see we are the lowest in the country.

If you look now at quality of care, various indicators here, you can see compared to the US average, again these are state numbers, we are either number one or number two and on that readmission number you see there Intermountain is actually number one again these are state numbers and other Intermountain Medical Center, our flagship hospital for cardiovascular procedures, number one hospital in the world.

So you might say, well, what is the opportunity to get better? Well, it is significant, it is significant. So what you've got here, these are the four largest counties kind of all surrounding Salt Lake City. A number of fairly common procedures. And this is the county variation in those four counties.

Red means the utilization is statistically higher on a demographic adjusted basis, green means it is significantly lower. So if Dr. Brent James were here he would tell you that variation is the enemy of quality improvement.

So we look at this kind of stuff every day and this is what our vision in working with Cerner, we have to have these clinical processes embedded in our system so when the physician is at the point of care we absolutely know the protocol so we can drive out unnecessary variation.

You've seen clinical, you have seen cost numbers. Financially I don't have a lot of numbers for you, but we are the highest rated healthcare system in the world, for-profit or not-for-profit, AA1 from Moody's. We are the only Moody's rated AA1 organization and then AA+ from Standard & Poor's.

And that is all nice, but I think what is nicer is actually some of the comments that you will read in their publications. And obviously you have to have decent financial numbers, you have to be consistent and that sort of thing to get these numbers both on the income statement and the balance sheet.

But they both make great comments about the operational way we approach it and our Board of trustees and then you can see from Standard & Poor's really the same type of comment. Sp it really all gets down to this be a model healthcare system, what is the tone at the top of the organization and it is really strong.

And I am proud that in addition to the financial indicators the rating agencies recognize this. And I think that is really what gets us from the AA to the AA+, frankly. You can have great financial numbers and still not have the plus.

So how have we done it? Put together five principles that I think have served us well these last 10 years, I think will continue to serve us well, I will go through them quickly.

We are not-for-profit [50123] organization, but that should never mean that we are not as efficient. And I've been at this business long enough to know when Columbia HCA got going, their message was the nonprofits are dumb, fat and happy. And we are either going to buy you or we're going to bury you. So a lot of the nonprofits got about trying to change that.

And then that quickly changed. All of a sudden it was pushed back mostly around billing practices. And so, we learned to operate like a business and then we got criticized for operating too much like a business. So what does this mean? We have to be efficient. Have to be efficient, there is no excuse not to be efficient, we should never hide behind a mission and not be efficient. But we need to operate like a business but we shouldn't feel like a business.

So next three, I have grouped these together, I have touched on these really already a little bit, but maybe just to comment on that one in the middle, again as we look at best practices, I have talked about other industries. We have done some tremendous things with the supply chain in our organization, looking at Dell, Walmart and others from a distribution where the best practices really are.

And we started to look at other countries. Now we've looked at India and the first reaction of people when you say that is, they have a different rule of law, they don't have all the legal liability issues we have in the United States so we can't do that. Well, yes, that is true. But there is plenty we can learn from other countries and so we are just kind of on the cusp of doing that but we love to work with others to learn what we can from other countries.

And then finally this always do the right thing which I happen to believe that not every time, but usually is the right business decision in the long-term. So where we are going, there's really not time to do this.

We chose not to do the Pioneer ACO or to be an ACO per se. The concept we work under is what we call a shared accountability organization. And we think the patient, the member, the community has to have skin in the game to really make this thing work.

So that means we have to have engaged communities, we have to have engaged patients as we put all this together. And that box on aligned incentives, I can't over emphasize how important that is. Whether it is working with physicians or employers or others we have to get the incentives aligned in this organization.

Just another I guess reflection on relatively short term, but have done a lot quickly relationship with Cerner I feel like we absolutely have our incentives aligned for the future and for the right reasons. So kind of looking forward to as we think about being the best.

Some of you will remember Wayne Gretzky, the US could've used him even though he is from Canada here recently. But you know what Wayne Gretzky, he was asked about what makes him great. And he said a lot of people skate to where the puck is, I skate to where the puck is going to be.

And again really kind of in a nutshell as we looked at how did we come together, why did we come together with Cerner. And a year ago as I was standing here I wouldn't necessarily have thought that was going to happen. But really we think this is about really where the puck is going.

And I was pleased to hear the other speakers as well. This industry is changing, some are changing faster than others but this industry is changing and frankly if we don't change we are going to be obsolete pretty fast. And so we really looked at a couple of different things.

We laid this out in the first meeting that I know I had had with Neal and Don and said here is about 10 things we have got to focus on. These three were on that list but there were others. And we came together very quickly on a vision for what the future had to be, and just to comment on that service oriented architecture, it is kind of who Intermountain has been.

And as I look at the future and I know there are some vendors out there that don't believe in this, but to me it is nuts that our healthcare system -- to think that my iPhone can't speak to your Droid, that we couldn't send emails back and forth, I think that is nuts in our industry. And I think as a community we shouldn't allow that, we should demand where we have interoperability and this service oriented architecture.

And maybe a last comment on the partnering, as we got serious about putting this together back in July/August, on the Intermountain side we were advised by our supply-chain guys who, like I said, have done a great job.

And by our legal folks, we signed a letter of intent. And they both said, oh, don't do that, don't do that. Supply-chain guys said it would take all of our leverage way when we negotiate the contract. You know, these contracts are big. And the legal guys said, that is nonbinding, don't waste your time if it is nonbinding.

And we said, no, we are going to sign this letter of intent, it is going to have all the right things in it, it is going to talk about where we are going. And once we sign it and once we announce it it is binding, it is binding.

And the other thing they told us is so that happen in about September, we set a goal of having a contract done by Thanksgiving. And everybody told us, no, you can't do that these contracts are too complicated. And Jeff Townsend was on the phone we were in a room at about 10:30 on the Wednesday night before Thanksgiving we signed the contract.

So again, we are very focused on what we're doing, we know we can't do this alone. I think it is really a thrill, frankly, to hear from Adventist and Advocate and from others who are in this because we have to do this together.

So, we are all in with Cerner. And while it is early, admittedly, we are very encouraged by what we've seen. We have got Jeff wearing blue jeans. And I think he has actually told me he is going to come up here and tell a bunch of jokes that are funnier than Marc already did. So that is going to be good.

So I want to close with one story and be a little serious here. So, and I think this actually fits the leadership and culture alignment I have talked about. So this is a story, on this systemness and all of that.

Two years ago we had 14 disparate foundations, so the fundraising type of organization they were tied back to these hospitals that before we were ever a system and they just never have gone away, so they're inefficient, very political, as you can imagine. So we set about, we're going to roll those all into one foundation, we're going to operate on best practices, we are going to keep the local touch, but we are going to increase our goal.

So we did that, worked through it and we are on our journey now of that. But that has been done for a year. So we had a first meeting of this new foundation Board. Now most of these people had no formal tie to Intermountain before. And the Board Chair went around the room and he asked each person why did they agree to do this?

And he came to a lady, [Diane Stewart], a philanthropist in the community and he said, as only this person could do, he said, Diane, you have got all kinds of other things you could have done with your time -- and you agreed to serve on this Board, and by what you know I'm going to come asking you for a lot of money. So why did you agree to do it?

She said two things. The number one, well, Kim, you asked me and I've seen what you have done in the community over 30 years and I respect that. So that is one. You asked me. Number two she said a number of years ago one of our sons was in a terrible accident in Southern Utah and was taken to one of our rural hospitals and then was life flighted to our Children's Hospital in Salt Lake City.

And she said your physicians, your employees, your hospitals, they saved my son's life, no question about that. So she said the second reason is it is personal, it is personal.

So I would like to tell you for me, people have told me all my life don't take things personal in business, and a lot of times that is good advice, it really is. But this is personal for me. And I hope it is personal for all of us. I know it is personal for Neal. He could be doing a lot of other things at this stage in life, right.

And -- but it is really about making our healthcare system, and it is not so much a healthcare system anymore as it is a health system as we really get out there and transform healthcare. So I hope we all take it personal and come by our booth, we will show you what we are doing to transform healthcare. Thank you very much.

Jeff Townsend - *Cerner Corporation - EVP & Chief of Staff*

So I warned you that is going to be as good as it gets. There is no way to match that. Yes, yes, there is a story there. Okay. So I'm going to -- this is the part of the session where nothing will fit into a spreadsheet.

I'm going to give you a glimpse of how we are thinking about the future and more specifically some of the innovations we are doing at Intermountain, some of which you can -- some of the really cool ones you can actually see in both booths and there is transactions flying back and forth between the booths, video and a level of openness.

So this is -- I think one of my early quotes was I think a byproduct of the partnership is we will accelerate clinical computing by at least a decade. So if you watch the snail's pace of standards and interoperability and who is in club A and who is an club B and no, we, our club is better, it's just -- there is nonsense.

We have got to get to the work. Move the information, drive the cost down, improve the quality and create a platform for innovation. So this is four of the pillars, there are several things beyond this, but these are the four that I've pulled out that are kind of anchor points that match Bert's slides as well. And the journey is really to become a learning system.

And part of what excited me around the relationship is, Bert mentioned them briefly, those clinical programs. So you have clinicians getting together around a grander purpose of how do we get better, how do we use data to get better. So quality is in the culture of that organization. They are the closest thing I have seen to IOM's report of what is a learning healthcare system.

So the opportunity to go put a digital backbone into that cultural fabric will be an incredible accelerant. So as I go into the open space and this has been a project over the last six to eight weeks, the basic premise here is that the productivity of innovation in healthcare IT needs to increase significantly.

You walk that floor over there and the booths that I'm most excited about, I think it is somewhat by luck. They happen to be in the back corner across the aisle from Cerner's booth and they are the size of this podium. And they have one person standing in front of them. And it is the start-up area.

So this is where an incredible idea has been created by a small number of people, but for them to ever get that idea into the bigger marketplace they have got insurmountable hurdles to get through. And it is things that Cerner is never going to work on. We are never going to go make our life's work to crave the most beautiful growth chart for pediatrics ever built. Okay. But there is a small group that believes in that and has actually done it in this case.

So this is the architectural picture. If you are looking really in either the Intermountain booth or ours it's called SMART on FHIR will be the little tagline above it. But basically what we have done, Advocate stood up here last year and then kind of confirmed the advancements this year.

We have done a lot of the interoperability on the back end to take large data sets from lots of the disparaged systems that use multiple nomenclatures and try to bring that altogether in a higher value container. That begins to open up big data, which receives kind of flashing at you what you can do in that space.

That doesn't matter nearly as much, there are dozens -- it's not 100 booths over there that have a warehouse with a little graph that gives you an incredible insight into something. If you can get that insight back into the workflow when the physician is making that decision on what I call at the moment of relevance, then you are doing it retrospectively in committee meetings and saying here is how we are scoring, here is how we are doing.

So broadly what this work has done is taking existing standards, we are not creating anything new, we are trying to accelerate the adoption of what is out there by doing real work versus spending 90% of our time in committee arguing about the real work.

So in short order I think there is half a dozen applications, two or three of them are not Intermountain and they are not Cerner. So we are able to go find organizations that have an existing web-based app that did this moment of relevance type function, plugged them in and interact with in this case multiple EMRs underneath.

In the Intermountain booth you will actually see I think of the growth chart spans both their existing HELP II system and Cerner's Millennium system to create a continuous story for that kit, pulling both from history and then showing that we will have a way forward.

So this is a little more technical but this is what we think opens up the ability to take your little component and get it to show up right inside the workflow. And this is an example of one, I tried to get the picture that was, given you guys just had breakfast, that was -- you could make it through. There are some incredibly ugly ones on there.

But so this is an organization called VisualDx is the name of their solution. And so, this plug in you are seeing power chart as the broader frame, the little blue line there is where that plug-in was activated.

So it isn't just I can now link to a bunch of places, this is I can apply Smart in the workflow that says for this patient, their condition and their needs these are the tools that need to be pushed at you. Don't show me a growth chart for somebody that is 60 years old. Remove that clutter.

So the ability to apply clinical decision support in context -- in this case this one uses conditions and medications. And based on that combination it's showing you images of rashes or skin conditions that have a cause and effect relationship that you cannot only diagnose the problem better but you can interact with the patient in an educational way.

So that intelligence throughout that workflow, we think that is a game changer that you can now go through that floor and stitch together high end high-value decision-support components, where those organizations today, the interface work inside of IT far exceeds the cost of the gadget. They can't get off the ground. In this space you can actually get things to market faster, we think.

So part two, so around these clinical programs Intermountain has developed a collaborative effort inside these clinical programs to pull together multiple reference sources, multiple experiences and eventually it gets down to what some will refer to as precision medicine.

So if you are highly contextual, I know the patient, I know the role, the venue and I know the decision you are about to make. Can I increase the accuracy of that decision, its appropriateness to deliver high-quality low-cost and better outcomes?

So they have a library of these and, more important, they have an engine that produces them in a real world setting, not in a think tank. And they turn on these monthly. So this is kind of a continuous improvement, continuous quality type environment that if we match it with digitizing of this evidence we can continually improve those scores across the organization. And that is what I get excited about it, is built in their culture, they are good to go there.

So this is an eye chart but it gives you kind of a feel for that is now a combination of content, decision-support apps and you probably have on here as well, training. So how do you build training and adoption and measurement into that same lifecycle? So we put out the new thing here is who is following, he here is who isn't. What did that do to the outcomes, how do you drive that through?

So we think we can get a library to market relatively quickly and this work is being done against that open platform, so this is not being created -- endgame is native inside the Millennium EMR. Endgame is that these are smart plug-ins that can be applied across the community.

So step three is they have an existing investment/vision around something they call the transformation lap. Bert would say it is closer to investment because there is a lot of money being spent there, so it is not a vision. And some of that you can see in their van.

On the left-hand side we have gotten up over the years and talked to you about CareAware. And the ability to have plug and play around devices. So we kind of get this open pattern of how do you accelerate the industry and move things quicker, but on the left hand side it is mostly a remove the pain points to collect data more quickly and interoperate or interact with those medical devices.

Big benefit in that space. You can do the pump programming and there is no errors from CPOE down to the pump being told what to do. the big benefit is on the right-hand side where we call it orchestrating the activity management and measurement.

A simple example is today we can get vitals off of a device whether it is wearable or whether it is something bolted to the wall, so continuously streaming vitals. We have the IV plugged in, but the physician has placed an order that says give this medication until the heart rate gets into this zone.

And once it gets into that zone then taper back the medication. And they will clinically write orders in that way. So we call those outcome based orders. I have an expectation of the impact of this decision, I want it to continue until the criteria is met.

On the right-hand side the ability to orchestrate that order without human interaction is very plausible. So you can write that conditional order, the medication is being given, you are monitoring the vitals as soon as it hits the range you notify the caregivers that you did it but you don't have to wait for them to be doing rounds or alarms to go off, you have removed all delay.

The other thing that is happening on that right hand side is all of the activities are measurable. So you have loaded the environment whether it is inpatient, ambulatory or home, it is loaded with sensors. I know when things were done, who did them, how they did them, so the ability to manage these activities and measure those activities is painless.

So last step is I use the term activity-based EMR so kind of under that broader activity-based costing model the core component here is to dissect all the activities of medicine into Legos so that you can build those and snap those together.

And Bert mentioned Dr. James, he has done a lot of work in this space that has put containers around a few thousand nursing procedures, 800 different risk for algorithms or scoring, things that trigger actions to occur.

So we think going back to open, if we've solved the nomenclature, the ability to group things together into components that the option to now snap together workflows and drive that change into the clinical process rapidly, knowing cost, measures and outcomes at the same time is very, very practical.

So the example I have up here, we are 90 days in, we've identified 267 healthcare roles at Intermountain that we're going to automate. It will cost us 207, there's about 350 major workflows, about 100 of those are highly collaborative multi-roll workflows. So you now link all of those to content to clinical decisions to the CPM's that I showed, so on the left-hand side that nurses gathering vitals manually.

And you can see that flow diagram down there, and that last number five, the big circle is a multistep process. There is multiple vitals to gather, it takes time and you only do it once per -- once every so many or hours, once per shift. On the right-hand side they are wearing a device that continuously feeds vital sign information. It happens to be a Sotera device called ViSi Mobile.

There is now no human interaction on the left, your ability to decision support and provide safer, smarter healthcare is constant. Where on the left-hand side if you look at costing or the costing problem as a pure effort based model you will miss this.

You will miss the fact that you can actually change outcomes, so outcomes have to be applied to the costing equation, it can't just be this was how many hours were consumed. And they get that there. So this is how those four go together.

So last slide, we actually have a demo of this but we knew we would run out of time. If you put all those together, today's EMR, so kind of this let's get to where the puck is going, at the end of the day it is an administrative system that incrementally became clinical. It is still heavily based in how do I chart, and how do I put in what is necessary to get paid in the fee-for-service world.

If you put those four pillars together that I just walked through you now -- the term I use is you are now interacting with a clinical companion. They know who I am, they know the patient, they know the disease, they know the best clinical evidence. My navigation bar on the left is contextual, it shows me the next thing I need to go work on, the next thing I need to do.

The interactive risk scoring, which Rishi flashed some of those risk sketches. Here is the score, here is the breadcrumbs on how the score was produced and if you want to change that risk these are the actions you can take.

The medical record is going to be loaded with a ton of information, the interoperable back end is working, more information is flying back-and-forth it is too much for the clinician. You do not have time to read the whole thing. So how do you get the moment relevant information face up. Only show me the labs that are relevant for this contextual decision. Don't show me everything. So that is on the right-hand side.

And then as I interact with the system it is pushing for recommended actions, recommended problems based on that clinical evidence. So it is smart. So there is nothing in there that looks like charting now. It is a game changer. So I am going to end with that and turn it over to Neal.

Neal Patterson - *Cerner Corporation - Chairman & CEO*

Thanks, Jeff. So do you know why, so when Lear designed the first business jet do you know why or how they decided how much fuel to put on the jet? It was a function of biology and bladder size. So we are probably reaching the end of what the size of how long you can be in the air without some sort of break. Particularly given the amount of coffee and fluids out there.

Rev -- I am actually reminded by the way I will be the worst speaker, many of you have heard me so you get -- I start with a lot of thoughts and I never finished very many.

But I was reminded of the closes -- the old movie Close Encounters where there is the core scene was basically that we were being invaded by aliens, they were going to land and there were people from all over the world basically feeling that and had envisioned it and they were all coming together because there was something that was going to change and it was very important.

So I mean the -- for you to get to hear three very important clients basically telling their story and building their -- talking about what they are doing to create their future, it has the elements of we are all working on a bit of different parts of it, but it is the same vision, it is the same impulse.

Cost and care fundamentally have to be reengineered and substantially reduced. Quality is for here ever going to be measured and in many cases those measurements are going to be integrated into the payment systems.

And fundamentally what many of you viewed as the hospital, the doctor's office which evolved into today relatively impressive organizations around health systems, those systems are basically -- positioned themselves to be more at risk for the health in a population.

And fundamentally I think they have the huge edge if you were at the Derby, the horse at the end of the decade what part of our society is really going to be in a position to assume risk and manage risk? It is going to be the coherent health systems, the basic invested wise in this era.

So we are, 2014, so I guess the increment is one year. But this decade is big. But it is a bit chaotic right now but it was an unbelievable, beautiful symmetry to what Bill got up and talked about what he was doing and it is -- he had his clay model -- everybody was kind of building those clay models of what -- who was coming.

So and then what Michael basically took on -- talked about taking on the FTC because they said it was against the law to actually work with doctors to try to organize care in a community. So, and then Rishi got up and basically talked about the unbelievable -- probably the biggest of all levers.

So if you want to change something, we really need to change healthcare -- so if you wanted to change anything the best -- the single most important thing to do to create change in the future is to predict the future. So I know what is going to happen and it isn't what I want to happen, I now have the opportunity.

So Rishi basically is describing how that is basically going. We are making investments in it, how quickly we are progressing on that and then the unbelievable -- there will be hundreds and hundreds of different models as we progress through what is important to our health and what is important to the quality of care and what is important to the cost of care in our society.

So and then third is -- and then the serendipity -- I'm also reminded about the serendipity of all of this. Okay, so literally, hey, we were going to pretty much going to make it -- this time last year we probably knew we were going to make a change in direction in how we are going to do IT, and we're actually going to go commercial. He didn't say it real loud, but he said, hey, I don't think I would envision I would be here, okay.

And so, and last year was his first year in the booth over there and so I went over there on a Friday afternoon and he is in that booth Friday afternoon kind of the last day of HIMSS, okay, and I am going there is -- this is all special. And how ever that worked -- I can't tell you precisely how it all works, but we are all on a journey.

My very -- and it is a bit odd for me to have client. I mean this is -- we are a public company so we are going to communicate to the shareholders and this is one way we do it. But to have clients here is a little bit like taking your parents to the prom. And my mother would have told you that Neal was -- she worried a lot about Neal. And the prom was probably one night she should worry.

But we are very transparent, have been, we are with our clients, we are with you all. We are on a journey, it is a very important journey in our opinion. And it is -- there is -- Jeff's bold statement that basically over the next -- we will get over a 10 year -- we will get a decade worth done in the next couple years.

So -- and it will be open, it will be collaborative, it will -- we will solve national problems that really aren't to our benefit to solve and somebody else should have solved them but they won't. And we love the fourth floor of small teams focusing on really brilliant things that will actually change quality and cost.

So you all get lots of opportunities to ask questions, you are going to get some here. But I am going to -- you aren't going to have a lot of time. My experience here is you really want to talk to our clients, so, not us -- you get -- but, questions. Mr. Hill.

QUESTIONS AND ANSWERS

Unidentified Audience Member

Mr. Patterson, last year at this time you talked about how Cerner's ability to achieve its manifest destiny was going to be --

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Neal Patterson - *Cerner Corporation - Chairman & CEO*

We probably ought to back off a little bit on that.

Unidentified Audience Member

Those might not have been your words. If Cerner's ability to achieve its end market goals in those 2020 expectations were going to be tied to the pace of change in the reimbursement environment, healthcare and the pace of change the provider organizations bear risk. Is that going as you have planned and has foreseen and maybe talk about the variance versus your expectations?

Neal Patterson - *Cerner Corporation - Chairman & CEO*

Okay, now, you can adjust me if I really -- what I would have said then or certainly would say now, we lack a trigger point, okay, from the reimbursement side. I mean fee-for-service is still very prominent and drives much behavior, it changes a little bit by region, Advocate is, you know, there ought

to be a parking lot at CMS, they ought to have a private parking space at CMS and they ought to have a monument somewhere because they have thought that.

But we still have a fee-for-service. So when the trigger does get pulled and it is fundamentally -- I assume it will be CMS basically -- and in the Accountable Care Act they basically have 20 different business models in the legislation all at the Fiat of the Secretary of Health can pull the trigger and change here is how I pay for Medicare tomorrow. Okay?

So once that happens the relevance of what you just heard our take costs out, basically organize physicians that are including ones that don't work for you, that aren't on your payroll, use the data to change the ability to say what will happen in the future and be able to close loop that back in the care process.

And then take these huge investments that a lot of people -- some people may know a lot but Intermountain has made I think the most clear and drives the variance completely out of healthcare, build a costing system that for the first -- so once fee-for-service -- once there is a trigger point on fee-for-service all of this becomes incredibly relevant.

And the people that were basically buying EMRs based on beauty contests of how the physicians viewed it and the ability to be able to document and code just get a fee-for-service payment, okay, are going to be behind. So I have always done I felt like that we don't have that we haven't had the trigger and I can't say when that trigger will happen. But I think it has to happen and I believe it will happen in this decade.

We will probably have to get through -- because when you have to do that kind of stuff you have to compile politics and all of that so election cycles and who has got the guts to do it and -- but I think it is all set up. We are -- we are definitely on that path. We believe that it will happen, we could be wrong. But the beauty of life is you don't actually know.

Unidentified Audience Member

Maybe a follow-up to George's question and revisiting a controversial statement you made many years ago since I know you like to make them so I will bring it back up. This is that -- I think it was maybe 2004 or 2003, your slides about the robber barons on the highway with the insurance companies.

With the changes you are seeing out there in healthcare what is going on to change the plans? As you think, revisit that idea we fast forward five years, seven years, 10 years do you foresee a world where they really are starting to be dis-intermediated and between you guys and the Advocate and the Intermountain, etc., you're playing a bigger role and that pure administrative networking idea becomes less and less relevant and less and less important?

Neal Patterson - *Cerner Corporation - Chairman & CEO*

Yes, I mean -- I am sticking with my quote, man. And so, I think we need to eliminate insurance companies as they exist today. There is too much value, there is too much friction, they add friction, they're providing very little value.

What did you just see here? The real change in the health the real change in the quality of the care is done at this level, this level is not ever going to go away. And they are all preparing, and, my God, Advocate again they should have parking spaces in every government -- they are taking huge risks, okay.

And thankfully Bert got the risk for about half of the state, and Bill is bold enough to go into California with a strategy to take risk. What is the old middle going to be doing? And then you add onto it the exchanges, yes, health.gov didn't particularly come flying out, but I think it is brilliant to be connecting the consumer directly to economic decisions in healthcare and then so you've got the public exchanges.

And then frankly the entrepreneurs of the world are over organizing private exchanges that are going to be then collaborated with health systems that are going to do private networks to sell -- to get to a coherent coordinated care model.

So -- now I know some -- I know that -- and you know and I feel a little bit bad saying all this because a couple of them are friends. But I don't like their position -- this doesn't ever go away. As a society I mean this is too big to fail in the financial world. This is too important to fail.

We will not face a society, regardless of what the cost is, let our healthcare system fail, there may be -- there will be failure inside it but we cannot. So we are be squeezing value as a society out of how healthcare works and the payment system, the fee-for-service payment system is the most arcane ridiculous system and it basically -- there needs to be a replacement.

We are going to start with a transaction. I mean so if I am paying for healthcare I only want to know three things. I want the price I want a good price, okay, so I need to know what you are going to charge me. I want to know was it medically necessary, was this really appropriate? What are you thinking when you ordered this, what are you thinking -- and is it medically appropriate for my condition?

And thirdly, are you doing a really good job? I want to be dealing with one of the best in the world and I want you to prove your quality. So I want price, appropriateness and quality in a transaction.

Claims have to be -- claims are gone, I mean they have to -- they are going to leave because they don't -- they basically have just a pad and they have done in 25 years tried to put a little bit of indicators in there. So we -- there is another layer that is going to grow up. And I am excited about that layer, but it is going to grow from what you just heard today. Sorry about the church like sermon. Mark, what do you want to do?

Unidentified Audience Member

Thank you. Neal, I wanted to get your perspective on how you view the business model for Population Health. Particularly as your clients are starting to take risk do you anticipate from Cerner potentially having to take risk? And I was hoping to get the comments from the clients as well in terms of how they want to pay for Population Health.

Neal Patterson - *Cerner Corporation - Chairman & CEO*

How they went to pay for Pop -- you can get a mic, give that to Mike or Rishi. And --.

Mike Englehart - *Advocate Physician Partners - President*

I think everyone will come to this game from a different point of view. I think for the smaller entities that have no Population Health strategy they need a partner, Cerner would appear to me to be ready to step in and potentially have a plug-and-play solution and potentially get down that road. There are other healthcare systems that feel like we have been on this journey for a while.

So if you were to walk over into the HIMSS conference you'd probably be accosted by no less than 10 different vendors saying we would like to do something with you and will take a portion of the risk. The question is, who is going to add value? Where are you on the overall spectrum of capability and who are your strategic partners?

Right now as it stands with ACOs, there is a decent upside but it is when you get the full risk, that first dollar where there is true upside opportunity, really shared savings as I'm taking a dollar and I'm basically getting $0.50 back. That is not a good play for any healthcare system.

But if you are taking first dollar risk and you are a midsize organization and you are late to the game Cerner could come in behind and stand up several solutions and I would suppose -- I don't want to put it in Neal's mouth -- but ultimately take on some level of risk, that's hence the reason why they are doing the revenue cycle work and other things. They are trying to be a long-term partner.

Neal Patterson - *Cerner Corporation - Chairman & CEO*

Bert you -- I don't know you've got a comment or Bill?

Bert Zimmerli - *Intermountain Healthcare - CFO & EVP*

I mean I can go quick. Our strategy (technical difficulty) so we within the next two years we want to have it (technical difficulty) what you don't want is your physicians aren't going to practice medicine (technical difficulty) so you want every patient (technical difficulty) so we want to get that line, you have got actuarial experience, expertise, you have got to be big enough to do that. But hospitals you go back 20 years ago (technical difficulty) don't want to call it that anymore but I think that is going to drive more consolidation, insurance tends to be a state-by-state product, that may lead to within state utilization. But the people I hear, my counterparts, everyone says they want to get to that. And I don't (technical difficulty).

Neal Patterson - *Cerner Corporation - Chairman & CEO*

Bill, you got thoughts?

Bill Wing - *Adventist Health - EVP & COO*

I think the question was around how we are going to pay for it? We believe that there is (technical difficulty) I think part of it is redistributing what is being spent, driving out the waste, (technical difficulty) when you think about what the insurance Company is keeping and what it cost us to collect our funds, roughly we are spending $0.25 of every healthcare dollar just on the administrative side of the equation.

I think we have got to eliminate that and redistribute to these value driven opportunities and I am really excited about what Advocate and Intermountain are doing to collect I think that is the key to transforming and managing the risk, not just taking the risk.

Neal Patterson - *Cerner Corporation - Chairman & CEO*

So I will just add my little piece here and we will land from this. So the -- every era in Cerner, we are always viewed as this and I think we articulate a vision of the future reasonably well. But people really always -- it's kind of like, to this very day your parents are still your parents -- your view of people doesn't change quickly.

So we are viewed one way and internally we probably view ourselves a little bit differently. But we are focused on present and we're focused on the future, we are entrepreneurs. So when $0.25 of $1 is being spent and getting people paid and they don't even -- and the transaction doesn't really include quality and appropriateness, I'm an entrepreneur, there is a huge amount of value to be created there.

I don't know exactly what that means at the end. But, say, hey, thank you very much. I hope this was useful. Thank you very much for Adventist, Advocate, Intermountain -- this was very costly for them to stop and come and share. So thank you very much.