AARP

Lowering Costs and Improving Care in Medicare: Promising Approaches

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Patricia Smith,
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Nicholas Wolter, MD,
CEO,
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[00:00:12] SUSAN REINHARD: Good morning. Good morning to all of you. This is such a spectacular view, for those of you that can see it. There are some who are listening to this via the Web and some who will see it on the archives. I wish we could turn the cameras around so you can see the beautiful view of the Capitol.

But it's also a very rainy day so we're really appreciative of all of you taking your time out on this morning to join us. There's lots going on around town and we appreciate your spending your time with us this morning. So let me just welcome all of you and thank you for joining us to this AARP Solutions forum. We titled it "Promising Approaches to Improving Care and Lowering Costs in Medicare." And you'll hear more about what that's going to entail in a few minutes.

Let me just introduce myself briefly before I set a context and introduce the others on the panel [00:01:00] and give you a little bit of the housekeeping details.

My name is Susan Reinhard. I don't know everyone in this room. It's always nice to meet other people that you don't know. So I am a senior vice president at AARP. It's my real delight to be able to direct the AARP Public Policy Institute, which is the focal point for policy analysis and research at the state, national and even international levels with our colleagues in the AARP International.

I also serve as chief strategist for the Center to Champion Nursing in America, which is a resource center for 51 states and D.C. right now, trying to make sure that America has the nurses it needs now and in the future. I always like to put that out there. And it is related to health care.

I'm going to be co-moderating the solutions forum with Dr. Larry Atkins. I'm going to introduce him in a moment. But first I want to acknowledge colleagues in this room who have worked, really I can say, tirelessly, battling many different barriers to making sure we could [00:02:00] get this show on the road and have you here.

First is Dr. Lina Walker. I wish you would stand, Lina. Dr. Walker. She is – (applause) – yes. She's the director of health policy for the Public Policy Institute. She led this effort, but she of course wants me to acknowledge our collaborators in the state and national group. Ariel Gonzalez is somewhere in the room.

[00:02:21] ARIEL GONZALEZ: I'm over here.

[00:02:22] MS. REINHARD: There he is. Thank you, Ariel. (Applause.) Yeah. And also Maggie Randolph, who did a lot of the logistics.

So I did want to mention that Dr. Walker is an economist and expert in health care and economic security. So she is one of those boundary-spanning leaders, and we're very fortunate to have her on our team.

And I also want to thank Rick Deutsch, who is also in the room, back there. Rick Deutsch is the Public Policy Institute's director of communication. And he's making sure this forum is being streamed live on the Web. It's also going to be archived and available for viewing on Thursday at [00:03:00] www.aarp.org/ppi. And of course he wants me, because of all that, to say it's on the record – make sure everyone knows this is on the record.

A little bit of housekeeping. As soon as we started you saw we closed this door. So if you need to leave, you need to use that door. And the restrooms are behind us, past the elevators.

So let me just set a little context and then I'm going to introduce the panelists. Those of you who may have looked at the New York Times this morning might have seen that this topic of cost is of course huge and being discussed all over the capital as well as in the states. But what was stated today is, between 2009 and 2011 the total health care spending grew at the lowest annual pace in the last five decades.

So that sounds like good news. It's complicated. I think we might get into a little bit of that. I think Larry is going to be addressing it. But it's an incredibly timely time for us to be having this conversation. We know that Medicare [00:04:00] is a big part of the health care system, clearly, but we also know that to get to quality of care and lowering cost, Medicare cannot do this alone. You really have to have the private sector.

And so that's what we're really trying to focus on today, how Medicare can learn from the private sector and how the private sector might learn from what's going on in Medicare as well, really looking on the ground perspective, so to speak, about how to improve quality of care and reduce costs.

So we're going to be hearing from these panelists in a few moments about emerging models of care; innovative use of technology; approaches to encourage broader and better, safer care that uses transparency and provider accountability and other means to ensure that people receive the care they need and no more than they need.

I want to mention the packet. In the packet there are examples of promising practices that several of the speakers have provided to us. You'll also see more detailed bios than I'm going to be able to provide in the time that is give to me. [00:05:00] And they're of course very distinguished bios, so please take a look at them. And there are index cards available for you to write your questions. So pull them out and write questions as we go along because there will be lots of time for that opportunity for you to participate.

So one more thing before I introduce – for those of you who are tweeting about this event, please use the hashtag medicareforum with no spaces. So that's medicareforum, no spaces. And we encourage you to tweet, of course.

So let me introduce the speakers and tell you how this is going to go. Larry will be moderating the first panel. Each panelist will have five minutes to introduce key points from their perspective. And then the first panel, Larry will make sure that they have about 15 minutes to talk to each other. Then he's going to turn it over to me, and I'll have the other panel, actually on my right, talking and each giving five minutes, and then having 15 minutes to talk amongst themselves.

Then we're going to have them really talk amongst themselves for about 15 minutes. And then we will moderate questions and receive some input from you. [00:06:00]

So let me start by introducing Dr. Lawrence Atkins, who is president of the National Academy of Social Insurance here in Washington, D.C. As a health policy consultant, he's well known on the Hill. He's well known across the country. So we're delighted that he could be with us today. He recently retired from Merck & Co. And we were talking about how I'm a Jersey girl so Merck is a big

deal to me, to be sitting next to someone who is an executive director of U.S. public policy. Larry is a veteran of more than 30 years of health and social policy analysis, policy development and legislative representation at the local, state and federal levels.

Just a few more highlights: He was founder and president of Health Policy Analysts and the executive director of the Corporate Health Care Coalition of Fortune 200 companies, served on two quadrennial Social Security advisory commissions, and served on the U.S. Senate's Special Committee on Aging as professional staff, deputy staff director and Republican staff director for Chairman John Heinz. So you can see why we asked him to join us to co-moderate this panel. [00:07:00]

And let me start over here with Dr. Wolter, who is the CEO of Billings Clinic. He wins the prize, I think, for the longest trip, and we appreciate that he was able to change his plans to be with us. Billings Clinic is a fully integrated health care system in South Central Montana. Many of you have seen and heard about the work that he has been leading for quite some time. Billings Clinic includes a 240-physician multispecialty group practice, a 270-bed acute care hospital, multiple regional clinics, and a long-term care facility.

So when we talk about an integrated system, he really does have it all to pull together. He also manages eight critical access hospitals and has focused their core strategy on improvements and outstanding performance in the area of patient safety, quality of service and value to patients and their families.

Just a few more things about him to show you why we asked him to join us today: He is a former member of the board of directors at the American Hospital Association and he served two terms as a commissioner [00:08:00] on the Medicare Payment Advisory Commission, fondly known of course as MedPAC to all of us here. And he's a frequent speaker on health care delivery of payment reform.

Michael James is with us as well. For the past 19 years Michael James has been president and CEO of Genesys, which is a physician-hospital joint venture that specializes in managed care products for commercial Medicare and Medicaid patients. This collaboration includes 160 primary care physicians, 400 specialist physicians, a 410-bed hospital, and a full continuum of care.

He is president and CEO of Genesys Integrated Group Practice, a primary care specialist group practice with 90 physicians, and he is president and CEO of Providers Management. He is leading Genesys through participation with the CMS Centers for Innovation, and he's one – this whole group is part of only 32 pioneer ACOs in the United States. So we have a lot to learn from Michael as well.

I don't know that Tricia is with us, so –

[00:08:58] MS. : She's on her way.

[00:08:59] MS. REINHARD: She's on her way, so we'll just wait to introduce Tricia when she comes.

Now let me turn here. Jennifer Huff is the director of Advancing Policy at the Pacific Group on Health, and the director for the Consumer-Purchaser Disclosure Project. That project is a group of leading employer, consumer and labor organizations improving health care quality and affordability by

advancing public reporting of provider performance information so it can be used for, of course, improvement, consumer choice and payment.

She brings over 18 years of experience working in the arena of health care performance and measurement to the project. She was a health economist Genentech, a program officer at the California Health Care Foundation, and director of client services at the Picker Institute. So she brings a lot to her current position with all those different perspectives over the years.

Lisa McGiffert directs Consumer Union's Safe Patient Project. Consumer Union – I'm pretty sure you know this, but just to make it clear – this is the advocacy [00:10:00] arm of Consumer Reports. She leads this campaign on state and national levels to make information available to consumers about medical harm, focusing on health-acquired infections, medical device safety, medical errors and physician accountability.

This has been going on for 10 years. The campaign initiated state laws to publish hospital infection rates and raise public awareness about the problem. And today more than half of the states and Medicare requires such reporting. So it's been a huge achievement personally and for the organization. The campaign's collaboration with individuals who have personal experience with medical harm has developed into a national consumer activist network to make health care safety, so she often represents consumers on panels such as this.

And certainly not least, Leah Binder, who is president and CEO of the Leapfrog Group. This is a national nonprofit organization representing employers and other purchasers of health benefits, advancing safety and quality in American hospitals. [00:11:00] She has been there for five years, and during that time has launched the Hospital Safety Score. And that, with Leapfrog's hospitals survey, addresses key health policy issues like early elective deliveries and hospital infections.

She sits on numerous boards and councils as a regular contributor to Forbes.com and the Wall Street Journal online forum. And for four years she's appeared on the Modern Health Care's list of the hundred most influential people in health care. So I'm proud to know her too.

And then you will hear from Debra Whitman, who's right here in the front row – wave to everybody – who is AARP's executive vice president of policy, strategy and international affairs. She's been here a year. We just celebrated her anniversary. She's an authority on aging issues, with extensive experience in national policy making, domestic and international research, and the political process.

She oversees AARP's Public Policy Institute, the Office of Policy Integration, and the Office of International Affairs, as well as the Office of Academic Affairs. [00:12:00] She works closely with the board of AARP and the National Policy Council of AARP to develop the organization's priorities, which is to make life better for older Americans.

She is an economist herself, a former staff director for the U.S. Senate Special Committee on Aging where she worked to increase retirement security, preserve a strong system of Social Security, lower the cost of health care, protect vulnerable seniors and safeguard consumers. She has sought bipartisan, fact-based solutions to these and other challenges facing older Americans, which is why she was recruited to come here to serve in her current position.

So with that I'm going to turn this over to Larry, who –

[00:12:38] LAWRENCE ATKINS: Do you want to introduce Tricia?

[00:12:40] MS. REINHARD: Oh, you're here. OK. Sorry. Thanks for pointing it out.

We're sorry you were in traffic in the rain.

[00:12:46] PATRICIA SMITH: You know, it is what it is.

[00:12:49] MS. REINHARD: It is what it is.

[00:12:50] MS. SMITH: I'm glad to be here.

[00:12:51] MS. REINHARD: Well, you're safe and sound, so thanks for being here.

This is Tricia Smith – Patricia Smith. We call her Tricia. I think you prefer that.

[00:12:56] MS. SMITH: Yes.

[00:12:57] MS. REINHARD: She is president and CEO of the Alliance of Community Health Plans, which is a national leadership organization here in D.C. that brings together high-quality, innovative health plans and provider groups. In this role she works closely with this organization's 22 member organizations nationwide to promote learning, innovation in public policy solutions to improve health, health care, affordability and consumer experience.

She has experience working as the director of the Medicare Advantage Group at the Centers for Medicare and Medicaid Services, and she previously served as the vice president of AHIP, the American Health Insurance Plans, and senior vice president for policy at that organization.

And I'm happy to say that Tricia led federal affairs lobbying efforts at AARP for several years, so welcome home.

[00:13:42] MS. SMITH: Several years. (Laughter.)

[00:13:43] MS. REINHARD: Several years. So welcome. Thank you for noting that.

And, Larry, I'll turn it over to you.

[00:13:48] MR. ATKINS: Thank you, Susan.

I wanted to start out this morning and just make a few observations. You know, we're talking this morning about improving the quality of care and lowering costs, health care costs generally in the system [00:14:00] but with a focus on Medicare. And I think Susan made an important point, which is you can't address Medicare in isolation. Obviously the forces that drive the Medicare program drive health care spending just generally, and so we are looking at how do you get learning to go back and forth between Medicare and the private sector?

But I think it's important to start with a recognition and an acknowledgement that we have a significant financing problem in the Medicare program. You know, I'm encouraged – and I think a lot of policy experts are encouraged – by the recent trends in health care spending, you know, that, you know, at least suggest that there could be a permanent change in the health care cost curve going forward.

But if you take that into account and you project out the growth in the program, it's important to note that for example CBO now projects that health care spending over the next 10 years, and Medicare spending in particular, [00:15:00] will grow – Medicare per capita health costs will grow at about GDP plus about a half a percent or less. So it's pretty close to the GDP growth rate, per capital GDP growth rate for the next 10 years, which is a phenomenal situation. We haven't been anywhere close to that for a very long time.

But when you look at that, you have to bear in mind that that's a real growth rate in health care spending, somewhere in the order of about 4 percent a year, so that when you add that to the growth in beneficiaries, the growth in health care spending in Medicare, even under very optimistic projections, and the growth in beneficiaries, we'll double the size of the Medicare program in 10 years.

And then CBO of course takes it out 75 years, which is highly speculative, [00:16:00] and says that basically if it continues in the path that it's on, Medicare spending will be 13 percent of GDP in 75 years, which would account for 70 percent of a federal budget if the federal budget were to be the same proportion of GDP that it has been in recent years.

So, you know, I think it's important to bear in mind that even with very optimistic projections about what can happen with health care costs, there is a lot more that needs to be done. And granted, a lot of the growth in the program is going to be attributable to just the growth in the number of beneficiaries, and it's important that we – you know, we acknowledge that we have a growth in the number of beneficiaries and accept that fact and don't try to penalize beneficiaries for the fact that we have more of them.

But we also need a very substantial and convincing change in the dynamic [00:17:00] of health care costs systemwide in this country that we haven't achieved yet. So I'll say then, you know, second, that there is a lot of transformation going on in health care delivery today, and payment, you know, innovation as well, and going on in the private sector and going on really regardless of what is and is not done in federal legislation. And we'll hear about a lot of that today.

Some of it has been stimulated in the last couple of years by the roadmap that was created in the Affordable Care Act, and organizations – and we were talking earlier before the start about, you know, as soon as – well, even it was before the Affordable Care Act was passed. As soon as the accountable care organizations became kind of the fad of the moment, everybody in the country was an accountable care organization, if they could just figure out what that meant.

But I think it's indicative of the fact that the private sector is moving quickly [00:18:00] to anticipate a lot of the changes that were suggested in the Affordable Care Act, and it will develop in the system over time. So the market is already moving in that direction and I think that's somewhat in line with the – you know, the fact that in Washington Congress legislates most successfully what has already happened in the real world. (Laughter.)

And then, third, I think there's a concept that is now emerging in a lot of conversations going on around Medicare reform, and I think one of the things that's kind of interesting about this last year is we have more comprehensive proposals for Medicare reform on the table at the moment than I think we have organizations in Washington that do Medicare reform. (Laughter.) So you can take your choice, or you can kind of look at all of them and kind of absorb, where are they all really heading?

And what I think is interesting about them is that there's a remarkable similarity [00:19:00] in what people are putting on the table as a way to try to address a lot of these issues in the Medicare program going forward. And I think it's fair to say that the two kind of extreme options, one of which is to do nothing and assume that the program will kind of bail out of its problem because of the change in the trajectory on health care costs, or at the other extreme to completely change the structure of Medicare and cap federal expenditures for Medicare and then hope somebody else is going to pay for all of this.

I think those extremes are rejected by most of the – most of the political – not all. There's a portion of the right-hand side of the Congress up there that's still on it. But I think that what is interesting is that what is emerging now is what I would call a third way. It's kind of a way to transform the Medicare program without really changing or restructuring the system but building on a lot of what was done in the [00:20:00] Affordable Care Act and then accelerating that and building it out to create a situation, an incentive structure that will migrate both patients and providers to more integrated delivery systems, better coordinated care, and more accountability for care and for outcomes and for patient health – or for population health.

But it also recognizes that a good portion of the system will remain in what we know of as the fee-for-service payment model for some time. And therefore, a lot of these proposals are looking at how do you build mechanisms into that structure that will have the impact that we want to have on outcomes and quality? And I think it gets us to the point at the end that, you know, fee-for-service payment itself may not be the issue. It really is more [00:21:00] the systems in which providers operate and the incentive structures that are built into those systems, and the emphasis that – you know, the improvement of care coordination and accountability for outcomes that in the end may trump really what efforts to just change payment and the way payment is made.

So there's a lot of innovation going on already in the near term to change incentives and performance in traditional Medicare that would significantly impact health care costs and outcomes for this population. And I think we can anticipate we'll have a diverse system with a lot of integrated delivery systems and a lot of systems that maybe aren't as integrated but – and a lot of different ways of paying, but at the end hopefully all aligned to get better outcomes for patients at a lower cost.

And so we have a fabulous panel – two panels this morning to talk about a lot of this, but our first panel to focus on innovative care models and to talk about how [00:22:00] some of those could offer solutions for managing Medicare populations more effectively in the future.

[00:22:06] MS. REINHARD: So we'll start with Nicholas?

[00:22:07] MR. ATKINS: Yeah.

[00:22:08] MS. REINHARD: OK.

[00:22:10] DR. NICHOLAS WOLTER: Thank you very much. And it's a pleasure to be here and to see some colleagues that I've worked with over the years.

I would just start by saying that you heard a little bit about the Billings Clinic. We are a highly integrated health care organization in a more remote part of the country. We do deliver care out about 250 miles. And on the hospital side of our business, more than half of our revenues would be coming related to care of patients who come from long distances away. And as you might imagine, that does make accountability and coordinating care for that reasonably large population of ours more difficult than if they were all being cared for in a much more constrained geography. Nevertheless, there are ways to do that.

We really started on our quality and safety [00:23:00] journey around 2000. We've taken the Institute of Medicine reports very seriously, and some of the recommendations in "Crossing the Quality Chasm," and in their most recent publication this past fall really do lay out a roadmap in terms of how health care organizations can leverage tools that can really make health care safer and at the same time try to add value through how cost is approached.

And we really have taken that very seriously. For example, our electronic health record is the same one in the clinic, in the hospital, in nine critical access hospitals, and in five remote clinics, so that patients in our care, even though they may not reside in Billings, the access to their information is really quite seamless. That makes a huge difference in terms of how one tackles quality and safety.

The other thing I wanted to emphasize in these [00:24:00] remarks is the importance of culture and how one has to stay on that and be persistent and constant about how one tackles that. And there are many things I could cover in this regard, but we have made it our primary mission and vision to be best in nation at quality, safety, service and value.

And that is reinforced across our organization in many, many ways. We do believe in the integration of the care model – physicians and nurses and hospital all feeling like they're part of that same culture. And this is not an easy task, even when one has the right structural setup, which we've had for 20 years now. And I think it's even more difficult when one looks at some of the accountable care models where payments may incentivize cooperative care but that cultural effort can be more difficult because people don't feel that they're part of the same thing.

We recently completed our fourth, [00:25:00] over about the last six or seven years, Pascal Metrics survey of our staff. And that's clinic and hospital staff. So these are questions that look at the culture of teamwork and the culture of safety, things like do nursing units feel that they can raise questions when they see problems? Can they speak to physicians? Can they speak to each other? How does administration respond?

We had some 75 of our departments with over a 90-percent response rate in these surveys. And when one ranks the questions, if you're at above 80 percent you likely are going to see much better outcomes. If you're below 60 percent in a given unit, that does identify potential areas of focus, which can be improved. And the studies that have linked the culture of teamwork and safety to actual results are really quite amazing. This makes a difference. And it's not just about payment policy. [00:26:00]

In the packet there is a handout that we've prepared. And I thank my staff for doing that. It covers in more detail many of the efforts we've been involved in now over the last 10 years, whether

it's core measures or value-based purchasing, and now the new efforts in readmissions and hospital-acquired conditions – Leapfrog, NCQA, et cetera.

We have really tried to use the thinking of outstanding groups like this to influence what we put into practice. And just to echo the comments that were just made, it's going to be very hard for us to deal with the payment trajectory, even though it may be better in United States health care, unless the underlying health care delivery system has a way to lead that. And I think that in our work at the Billings Clinic, we've decided who we want to be like when we grow up – (laughter) – and that's Mayo Clinic, Geisinger, Denver Health, [00:27:00] Virginia Mason.

And there are characteristics shared by these organizations, to name a few, that care about the right thing and are willing to be honest with themselves about what they're not doing well and what they may be able to improve if they put the right systems in place to make quality and safety and value better.

And to echo another thing that Larry says, I think these organizations have been doing these things for some decades, independent of the underlying payment system. And I think that as I look at the underlying payment system we're working with, it is still reasonably broken. The ACO models are not likely to stand the test of a decade or longer. Once you share in those savings, what's the next step? The underlying fee-for-service system – again to echo Larry – is going to be with us for a long time, particularly in my part of the world.

And physician payment is really, unfortunately, in very [00:28:00] bad shape in the underlying fee-for-service system. And hospital payment on the DRG site is also reasonably screwed up in that there is incredible profitability in about six things, and then in much of the rest of the hospital system you can barely break even, or you lose significant amounts of money, which is why we don't see geriatric towers and mental health towers being built across the United States.

But for the organizations that are truly integrated, who care about the right thing for patients across silos and over time, they look at their revenues as a revenue stream that allows them to then make allocations to the care that patients need. And I think that as we try to continue to evolve the payment system to at least be more rational, we need to keep that in mind. And yet many of our recommendations continue to focus on unit pricing and silos of care rather than something that would really allow organizations who are more interested in the big picture [00:29:00] to operate effectively.

I've been impressed with some of the recent publications on the need for improvements in the health care delivery system, comments by Pronovost and Atul Gawande in his article "The Checklist," where, you know, we really need to look at health care in terms of there is, relatively speaking, a science of health care delivery. It's not as though we don't know what can be done in a health care delivery organization that can improve the odds of high-quality safety and the delivery of value. And yet we tend to focus, as I've mentioned, on unit pricing rather than looking at how do organizations need to evolve so that they really can deliver great value.

In another article that was published in the New England Journal several years ago, I think Karen Davis, Don Berwick – and I'm forgetting the other author – [00:30:00] they sort of looked at four levels of things that have to happen in our health care system.

You know, one has to do with individual excellence and a triple aim in trying to deliver that patient experience of care appropriately. The other has to do with microsystems of care, and that's what I just mentioned. How does each unit in your organization perform? Because oftentimes, in any one patient encounter, it's really about the care in a surgical center unit or an internal medicine practice.

And then the third level would be the organization as a whole. How do we set up health care delivery for those of us on the private side where we feel some responsibility to look at patient care across silo and overtime rather than just our individual encounter? [00:30:51]

And I like to say, having trained as a pulmonary critical care doctor – physician medical training kind of positions us to think of ourselves as fighter pilots. The care of the patient's up to us, and that's how medical school has generally taught medical students.

But really, now we've shifted. And I think the paradigm is more like being an astronaut, where you can't complete the mission with all those people in Houston, and that's why these culture surveys and how we look at team care is becoming so important if we're going to deliver value. And that's really critical, and I can't emphasize enough the whole leadership and culture issue and how the best organizations will continue on that pathway in some ways, in spite of a payment system that's not terribly supportive. Having said that, as you can tell, I'd like to see our payment system evolve into one that's more rational. [00:31:50]

I think there are some very promising things on the horizon. If we could improve the underlying fee-for-service systems in ways that would still create some linkages between physicians and the hospital, that could be very important. I'm not a fan of recent recommendations that would eliminate hospital-based physician reimbursement, because although there have been abuses, if that were tightened and improved, it could create a much longer-lasting integration of care and approaches to value than ACOs are likely to do.

Bundling is very promising. We're doing a hip and knee bundling project, and in our initial analysis of the data, we're about $600 for the episode of care involving care 60 days post-discharge. But In one area – (SNIF ?) utilization, we're $2,000 off the benchmark, and just having that knowledge makes a huge difference in terms of how one really can deliver care differently. [00:32:51]

Of course, as I mentioned, capitation down the road can be very, very useful as well, but that's going to be, I think, growing in areas where the population supports it. And then lastly, I'll just reiterate again – this issue of the science of health care delivery and how we look at how leaders need to foster cultures that really integrates care across silos and overtime, that can be done in any payment model. It needs a lot more emphasis, and that's what Billings Clinic has been really dedicated to. A number of the things we've worked on in terms of specific innovations around patient care are in the handout, and I'd be happy to take questions from any of you if you have more specific questions about any of those initiatives. And again, thank you for inviting me today.

(Applause.)

[00:33:50] MICHAEL JAMES: Genesis PHO is really a partnership of this collaboration of different business units, unlike Billings (sp), which is more encycled (ph) to an integrated system. So as we go through and do the process, we always have to bring the culture of separate business units

together. We started that process by looking at patients and their primary care physicians. About 10 years ago, we got involved in the patient-centered medical home project, and we looked at that process. And fundamentally, we came to a conclusion that every patient should have the right to have a primary care physician of their choosing. And when they develop that relationship, then they should be able to work with a team that primary care works with to help improve their health.

Now, unfortunately, in most places in the United States, there's simply not enough primary care physicians to make that true. Fortunately, in our system, as you heard in the intro, we have 160 primary care physicians, and we serve about 250,000 patients. So it is true for us; we can do this, and we do do it.

[00:34:57] So there are 250,000 patients; 140,000 patients have selected to be in a primary medical home, and so they communicate differently – electronically; they're hooked up. It's a much more fluid conversation with the process.

Then, when the institute of health came along and said the triple aim was – and talked about, really, you should not just work on the quality of that patient, but the population diseases in your area you need to focus on and also do it in a cost-efficient manner. Then we started looking at our population, and every geographic's going to be a little different, but in (Justice ?) County, where I'm from, diabetes is one of our number one predominant processes. We have a large minority population, and it is a real struggle working with diabetics to try to get them to understand that the vast majority of diabetics are diabetics because of lifestyle, not because of genetics. So you could really work with a diabetic and help them get much healthier and potentially take them right off of all their insulin just by lifestyle changes.

[00:36:03] So we started working with that process on a population base. We set that up, and so then we started working on group practice visits and bringing diabetic patients together to understand that they weren't alone and how – the works of that process.

The next natural progression for us was to look at the pioneer ACO, because it really is taking that medical home concept, only making it a medical community by integrating the hospital and all the specialist physicians and the teams. I will tell you the strength of the pioneer ACO is – it does break down the culture of physicians. I like the fighter pilot comment, but sort of – a physician tends to think of themselves as an acute care provider on an episode, and not relating to the patient's whole life, where in the primary medical home, we're trying to relate to the whole life. And so getting the specialist physicians to start to think that way and work on care – seemed very good for us.

[00:37:00] And I would tell you, in the pioneer ACO or the shared savings model, the weakness in the program is the cultural of changing patients. They want to care about their health, and the fundamental principle in the process is, there's no change to beneficiaries' benefits, selection of physicians at point of care. So when you're saying, we'll bring you into a team and deal with your disease, halfway through that treatment protocol, patients say, well, I may be going to Billings Clinic, and yet, their treatment protocol's all halfway through in one process. And so I think that process of that silo of getting the patients more engaged with their health care, educating the patients on their health care – and I would even advocate what we've learned in the commercial market as we do Medicare advantage, Medicaid, commercial, and we do – also do the uninsured – (inaudible) – we need product in their market for that – is, if you will take for people who will engage in healthy lifestyles – or, stop doing unhealthy lifestyles is a better way to say it – reduce their copays.

[00:38:10] Make them pay less so they don't have any kind of economic barrier to actually provide quality health care. So, like in the pioneer ACO, when the Accountable Care Act came out, physicals, which, in every product I deal with on risk – and we have 72,000 full-risk lives – physicals have no co-pay except in Medicare. So you cannot get a Medicare patient to come in until the part B copay is gone – do a physical. Typically, the first three, four, five months of a year. That doesn't make any sense. And in fact, that's one of the things we would change if we go to full-risk in our third or fourth year is, we will make physicals have no copay. Other crazy things – you can't put a patient into a nursing home without a three-day stay in a hospital. What sense is that in Medicare?

[00:39:08] So there's lots of odd rules in the billing systems that aren't necessarily just reimbursement rules but rules that actually prevent people from getting quality care and taking the care themselves. And we're working to try and solve those problems. I do think the answer is in fee-for-service. I would suggest an answer that could evolve over time is that if we could have actually agreed upon evidence-based medicine, or just a top-300 diagnosis and say, if you will stay on that evidence-based measurement for the type of the disease over a six-month period, we'll pay you an 80 percent fee, yet at the end, if you stay there, we'll give you a 40 percent or a 20 percent bonus. If you don't follow the track, we won't pay you the end fee.

[00:39:52] So the divergence in care – because we see this and we measure it all the time – so many providers treat the same patients with the same diseases remarkably different, and not always the right way. And we could really get that and come down, and that would actually take care of some of the litigation in medicine, too, which is also a hamper, because too many doctors do things defensively, and not because of just proactive quality. (Applause.)

[00:40:31] PATRICIA SMITH: Thank you and good morning. Apologies, again, for being late, but really glad to be here on this panel. And I think we've set the stage very well for a conversation about payment. And so what I'm going to try to do is cut to the chase a little bit after I tell you a bit about who the alliance of community health plans is.

So I represent a group of 22 organizations from around the country that are health plans that are community-based, not for profit. They are – they ensure roughly 17 million people in all lines of business. So Medicare, Medicaid, as well as the commercial market. In addition to that, we have some insurance in the self-insured marketplace – so through the ASO administrative services contracts where we're providing with – where larger employers are self-ensuring.

These are organizations that have the very highest ratings in health care quality, and Nick (sp), as you said, you know, they've been in their communities for a long time. The average length in our communities is 37 years. Been in the Medicare program since the 1980s, for the most part. Been in Medicare Plus Choice and then Medicare Advantage almost since the inceptions of those programs.

[00:41:50] So lots of experience there, but also a huge emphasis on quality. These are organizations that created some of the original measures that are still used in health care today, and those measures are ones that are really important to consumers. They're clinical quality, they're access, they're satisfaction. So they go the spectrum of things that you want to be measuring. Interestingly enough, those are only applied in the Medicare advantage marketplace. They are not yet applied fully in the fee-for-service marketplace. So I think there's one thing that you want to think

about, and my guess is that there are a few folks on the other panel that will address some of those issues.

So as we step back and think about this – and you're looking at organizations that range from Geisinger to Tufts Health Plan up in Boston to Health Partners in Minnesota to Group Health in Seattle to Kaiser Permanente to Presbyterian to New West Health Plan, which is part of the system underneath – or in and around Billings Clinic. All of those are health plans that are members of ACHP. And they join the organization and are looking at how they can share best practices across all of those lines of business to promote better quality, to promote better outcomes in terms of cost, to promote better outcomes for consumers, and to figure out how to do that, which is really the toughest question.

[00:43:19] I would zero in initially on the payment issue, and I think that it's timely that Congress is considering that very actively. You know, maybe it's a blessing along with the curse of the SGR problem is that we do have a fire sale on the SGR – fixing the SGR right now, and that's a useful thing. And it's also, I think, propelled us into a discussion about, how do you actually move the fee-for-service system to one that represents or shows characteristics that are the positive characteristics of more system-oriented, more organized care?

And that's really the challenge, the crux. And some of the tools for doing that are actually fairly readily apparent. In particular, I would point to measurement and measuring the right things. I think you don't – you can't have a hundred measures. You do need to think very parsimoniously about what measures ought to be used, and they really should drill down into clinical care those areas that drive the greatest cost in our systems and those areas that matters the most for consumers.

[00:44:30] So you're probably looking at chronic conditions, and you're probably – you're definitely looking at things that consider, are patients actually getting the care that they need? It drives you into some level of thinking about diversity, but you really need to focus in on, what's going to be delivering high-quality care. And then you need to think about, how are the systems underneath that really driving those measures forward.

And that's where process measures – there's a big debate in Washington about whether process versus outcomes measures really matter. Well, if you know what the outcome is that you want, but you don't know how you're going to get there, you're going to have a real problem getting there. So I think both of those things matter, it's just where they fit in the system. So that's the – that's the place that I would start. I do believe that we've got to zero in on payment now. It's not an overnight shift. And one of the things that our plans have been able to do in the commercial market – we may receive a capitated payment – a budgeted payment from a provider, whether that be Medicare or an employer, but then we turn that payment around and we pay it to contracted providers – not owned or dedicated providers, but contracted providers, and we're asking those contracted providers to actually improve their care based on a payment structure.

[00:44:49] So the base of the payment might be, let's say, fee-for-service, and then the next layer on top of that is a set of quality measures. And the next layer on top of that is a set of access measures. So you're building your reimbursement away from fee-for-service and towards the outcomes that you want to achieve in the health care system. It's built on a thesis that the cost of health care, whether it's in the commercial or private or public markets, is unsustainable at this point. But it's also built on the thesis that if you try to change something overnight, it's unsustainable for consumers, that they need the comfort to be able to adjust to this. And it's also built on the thesis – and this is true

in all of their organizations – that building a very strong relationship between providers and systems – in our case – health plans, but systems, is critically important – having providers look at what it is that you want to do in order to shift to providing better care.

[00:46:54] Most fee-for-service providers that I've met would say that they're not terribly happy with the gerbil run that they're on, you know, in just sort of churning out patients. They would rather be part of a more organized way of delivering care. But for individual players to jump off of that is very difficult. So how do you begin to create the opportunity to do that? And I think part of that does come in the payment system. Part of that also comes in data and in helping and providing organizations with data and the tools to be able to access data so that they can understand what's going on in their populations – so looking across the community and recognizing – you know, most of the time, a health plan does not know immediately when somebody goes to the hospital. And then, you don't know when they're released. And so if we don't set up systems – and our organizations have done that – so that you're finding that go-in point, you're meeting with the patient during that – during the time that they're in. So you're figuring out what the best exit strategy is, and then you're meeting them with right after they're leaving so that you're setting up the best plans of care.

[00:48:04] That's why organizations like the ones in ACHP have dramatically lower readmissions rates of all causes within 30 days than the rest of the country does. So there's – there are a variety of tools that I think we've got that are readily available to us at this point that are incremental steps in the right direction, and part of what we have to do is – the discussion in Washington that begins to bring that together around some common themes. I think there's real promise out of the ACA and the – and the discussion and the dialogue that it has precipitated, you know. There are positives, there are negatives – there's challenges galore, but it has certainly made it possible for us to talk about some things that were pretty much off the table a few years ago.

[00:48:51] One other comment I guess I want to make is that when you're looking at how to shift the Medicare program and what might happen in the future, I think risk segmentation is a really important element in that. And that means, effectively, who do we spend most of our time looking at? How do we begin to tease apart the patient population and then deliver to them the care that they need? How do we set up the teams around individual players? Who is likely to be the expensive player, and how do you then begin to shift that direction so that they no longer are a diabetic patient that ends up as an ESRD patient but rather a diabetic patient that's well-managed? Those kinds of strategies are ones that employers in the commercial market have been demanding for over a decade, and they really do need to be brought more emphatically into the Medicare program as well.

So thanks. Look forward to questions.

(Applause.)

[00:49:57] MR. ATKINS: So I'm going to start it out – we have about 10 minutes for questions, because we're going to keep moving with the other panel. So – but I just want to start out with the first one. We've got just a conversation going, really, on the panel around some of this.

But a lot of what you talk about, you know, you've talked about taking place in organizations that are fairly well-organized, highly organized organizations, where the organizations themselves are taking risk and where they've developed, over some period of time, tools to do a lot of these things. And there is a culture change that's going on within the organization.

So when you step back from the organizations that are doing this very well in this country – and we have – we have a lot of good models of, you know, good care and lower costs and better outcomes – but how do we scale that up and, you know, in the United States, how do we get it to start to happen in organizations and communities where we don't have, you know, these kinds of well-developed organizations? [00:51:02] You know, what kinds of things can we expect we really can accomplish, and what are some of the challenges going to be?

[00:51:13] MR. JAMES: Well, you ask a great question because most providers are exactly what you are describing. It's not the large organizations that are such a minority; it's the individuals out there –

[00:51:23] MS. REINHARD: Could you just move your mic in a little?

[00:51:24] MR. JAMES: Sure. So really, the scaling up is to take, fundamentally, the infrastructure out of my organizations or Billings and make that available at a price that smaller organizations can afford, so that you can bring together 30 or 40, 50 providers, and they can afford the process. I can tell you our administration costs for running the Pioneer ACO runs about $2 ½ million a year, and if we weren't scaled as large as we were, we couldn't afford that kind to start. [00:51:58] And we have been doing this for 20 years, so I'm not even talking about our IS (ph) cost because that was already in place. So I think the scale of this is the issue, and how can you make that affordable and transportable.

[00:52:14] MS. SMITH: I'll make a couple of comments to that. I think, first of all, transparency matters. And then you ask the question, transparency around what? And it's transparency around that parsimonious set of measures that begins to show providers, who I have always believed and still believe that they want to provide the best care and take the best care of their patients that they possibly can.

And so at the point that you begin to collect information around metrics that matter to providers and that also matter to consumers and that ultimately matter to the larger system, even in a – even in a nonsystem environment, that those metrics are things that providers begin to care about, because they want to be performing in the top of their class. [00:53:02] They really do want to show that they are taking the best care of their patients possible.

And in a fee-for-service system, actually, you have the discomfort, which you might not have in a health plan, or in all health plans – you have the discomfort of knowing that somebody can always walk if they're not happy. And so transparency does – is a very, very important tool in that, and again, around a set of metrics that matters across the board but nonetheless can be used to drive performance.

Another thing that I think is absolutely the case and is relevant in today's SGR debate, and that is if you make the incentive strong enough, people follow it, and markets do work. And they – so if you're – if you're driving towards higher performance around those metrics, you can then begin to say, even in a massive fee-for-service system like – such as – such as Medicare, you can actually begin to drive performance in that direction as well.

[00:54:04] I think a third thing I would suggest here is that we should give Medicare Advantage the credit that it's due. It certainly did have rough days, and back in – back in the '90s, and probably

some very poor judgments were made at various points. But the program is now enrolling a huge percentage of Medicare beneficiaries each year, has about 30 percent of beneficiaries, has a lot of solutions in terms of allowing consumers the access and the choice that they need in the marketplace and at the same time is driven by sets of measures and performance standards that don't exist in the fee-for-service marketplace.

[00:54:46] JENNIFER EAMES HUFF: Can I also add to that – is this on? From my position at the Pacific Business Group on Health, which has over 50 large self-insured employers in the program, and we spend about $6 billion just in California alone, in health care, one of the things that I think you're talking about that we're concerned with, because most of our employers are national, is the spread issue. [00:55:10] You know, they may have some really high-performing providers in their networks, but there's also a lot of other places where they're missing this.

One of the things that I think that can be done is for the places that don't have the infrastructure, there are many organizations out there that take that information and help spread it. So you may be using the transparency in the payment as an incentive to pay attention, but the organization still needs some support and someplace to continue the learning around it.

At PBGH, we first did an ACO in our commercial population with Boeing, and now we're spreading this to the Medicare population, and we're using the learnings that we've done there to work with 19 clinics in California in the Medicare population. [00:55:58] So it's taking what's been learned, not reinventing the wheel and providing some external support to the other organizations to help with the spread.

[00:56:10] DR. WOLTER: I was just going to add that I couldn't support more the comments that were just made about the transparency on measures and how that can drive things, and also payment policy.

And what – also add that there are some interesting organizations around the country that are doing great work, and they're about 120 physicians in size. There's an organization in Denver that will only do Medicare Advantage. They're partnering with two insurers. They've hired their own hospitalist for when those patients get hospitalized; those hospitals only see the patients of this particular group. The results, as I am hearing about them, are really quite outstanding. You know, one of the critical success factors there is the insurance partnership.

[00:56:58] And I think as we see insurance partnerships increase again – remember the early '90s, when you weren't an integrated system unless you had a health plan as part of your organization, because the access to data that most providers have is more fragmented than what they have if they're – if they're partnering with insurers.

And then I'd like to reiterate again, the single biggest lapse in current health care payment policy discussions is the urgent need to reform fee-for-service payment. It can be along the lines of what Michael just said. A number of us have good ideas. But fee for service is not only going to be around awhile, but most of the, quote, innovative payment models are being built on top of the underlying fee-for-service system, and yet this is not getting attention. And I think if we could look at innovative ways where fee for service could incent some of these coordination-of-care models, even if the structures might be different, we could see a lot of improvement.

[00:57:58] MS. REINHARD: Great. Thank you.

So we're going to turn to the second panel. And I love the fact that transparency has already come up, and we already had one of the panelists already addressing some of these topics. So we're going to talk about patient safety, accountability, transparency, and we're going to start with Jennifer.

[00:58:14] MS. HUFF: You ready for the second panel? (Laughter.)

[00:58:16] MS. REINHARD: Yes. Go, team!

[00:58:18] MS. HUFF: Great! Awesome. So I'll start off by saying thank you for asking me to be here. AARP is a very active participant in the Consumer-Purchaser Disclosure Project, and I'm always asking them to go to meetings – (chuckles) – or sign onto things. So it's nice to be able to do a little payback as well for that.

I will also say I've been working in patient safety since about 1999, similar to what was mentioned. It was the Institute of Medicine's report "To Err Is Human." I had been working in quality for quite a while. And once that report was published, every – I had to come up with a portfolio that specifically dealt with patient safety. [00:59:00] There was a lot of energy and a lot of momentum that that report generated. At the time, there were also a couple media reports on some pretty severe errors that had happened that related to death that created this sense of urgency that we need to do something about this. So it really catapulted a national focus on patient safety.

I will say that was 14 years ago, when you look at, you know, the timing around it. I think – one of my punch lines is one of the reasons there's been some sustainability around it is there have been payment programs and transparency programs that have been built around encouraging patient safety. If we haven't had things in the marketplace to continue the focus on this, I'm not sure it would have been as big of a report as it was, and maybe another one of those reports that, after a few months, just sits up on the shelf.

The other thing I'd say is recently the CDC has released some data on hospital reductions. [01:00:02] And it shows that there is improvement in infections that are going on in hospitals – health-care-acquired infections, health-care-acquired conditions, whatever you call them, they fall into the same bucket. And this includes central-line bloodstream infections, infections after surgery and infections related to urinary tract infections. However, it's estimated that still, we're getting about in the Medicare population 13,000 central-line bloodstream infections every year. And for each patient, that's an additional $26,000.

So while we've made some progress, we still have a ways to go. There has been a lot of innovation, but there is much more that still can be done. And I think from the groups that I represent, the consumer labor and purchasers, I think one of the things you'll commonly hear is the pace is too slow. When they talk about – 14 years ago is when we really had a big push around this, and we look at where we are now. [01:01:04] Yes indeed, there is improvement, but there is also a need to continue to have a pace that will actually move us much forward and much faster than we've currently been doing.

I think oftentimes you'll hear – I think one of the – well, I will say one of the things I agree totally with Tricia around the importance of measurement and the role that measurement plays in

bringing attention and focus and, in particular, I would say that public reporting of measures, of when you see public reporting, you see greater attention and greater intensity focused on improvement, and you see greater change. When we talk about measurement, we often hear, but the burden that it takes to collect the data, the burden around the changes to make improvement. And it's really, from a system's perspective, that you're hearing about this challenge around all the effort and the time it takes. [01:02:06] I think often that's lost in that conversation is the burden on patients. We don't hear about the burden on patients who are dealing with these infections, that spend a lot longer time in the hospital, that end up paying more, that affects their quality of life. We don't hear about the burden that's on patients when they don't have any information to make decisions about their health care. A lot of consumers, and even, I'd say, purchasers as well, are operating in the dark in terms of the quality. But we don't hear about that burden around making decisions. So I think that's an important piece in this discussion when we talk about measurement and moving it forward and some of the challenges.

I'll tie this a little bit, I think, to the new models of care that (senses ?) some of the focus of the panel discussion. [01:03:02] I think one of the cornerstones of improving patient safety is care coordination and care transitions. And we also see in a lot of the new models of care improving care coordination as a cornerstone to changing the delivery system. So I think there's a way in, which, with the emerging new models of care, there's another opportunity to keep the momentum on improving patient safety by the way care is delivered and focusing on how fragmented the system is. Pretense – it presents a really good opportunity for keeping this moving.

And then I would make the final comment around – let me see – around the piece around transparency of you need these two levers, both transparency and payment initiatives, to really keep the pace moving and keep focused in the direction. [01:04:02] I will also say that there is – there is a need, both in the private sector and in the public sector, to do joint work around this area so that we're actually providing similar signals and the same incentives, so we're not getting mixed signals or diffusing all the different areas that we're asking providers to work on, so there's an opportunity for the private sector and the public sector to better coordinate what areas they're working on and the different payment and transparency initiatives that they're doing.

[01:04:38] MS. REINHARD: Thank you, Jennifer. And thanks for bringing up public reporting because our next two panelists, I'm sure, will address it, starting with Lisa.

[01:04:45] LISA MCGIFFERT: Good morning, and – good morning, and it's good to be here. I reside in Austin, Texas, so it's always nice to come here and see rain. (Laughter.) Not much of that there.

[01:05:00] We started our work in patient safety at Consumers Union about 10 years ago, although I have been working on it at the state level prior to that. But during the course of this work, I think that the one message that we've heard repeatedly, constantly from people who have been touched by mental harm, loud and clear, is that there is not enough urgency to address this problem of preventing harm.

Well, there's definitely been a culture shift, and we've heard about some of that today. In the past 10 years – when we started in 2003 on our campaign to get hospital infections reported, you know, we faced a culture that basically accepted them as inevitable, they didn't think reporting was a good idea, it couldn't be done, it was – it was – there was sort of a hopeless attitude about it. [01:05:59]

And that, remarkably, I think has changed in the last 10 years. And that is a huge – a huge shift. And, of course, there has been a real uptick in activities.

But when you look at the resources that are devoted to the problem of medical harm, it's dwarfed by the scope of the numbers. So we're clearly not doing enough. Medical errors and infections make up the top 10 causes of death in America – probably top five, if you include everything. Yeah, we don't even document the occurrence or presence of an adverse event or infection on death certificates, which is the key element to identifying what are the major health problems in our country and how do we prevent them. So we don't even do the basics on that.

A bit – you know, a big part, as has been said, of raising the bar in preventing medical harm is transparency about when it is occurring. [01:07:05] And we believe that it's essential to be aware of the problem. That is the first step towards change. It produces some pressure internally within the health care provider community, and it also produces some pressure from the outside consumer community. And our work on transparency has been focused on that. And we depend on people like the people in this room to figure out how to do it, but we want to know what's happening and where the – what is the problem and what needs to be done.

We've heard it today, people quote still the IOM statistics from 1999 of 98,000 deaths, and even then that number was a little bit off because they did intend to include infections, and there were almost 99,000 deaths in infections at the same time. [01:07:59] But what we really should be looking are – there were three studies in 2010 and 2011 that all found independently the same statistics: The Office of Inspector General found that 27 percent of Medicare patients were harmed in the hospital. The New England Journal published an article – a study about – from North Carolina, and they found one in four hospital patients were harmed. And Health Affairs published a study using the IHI Global Trigger Tool, and they found one in three hospital patients are harmed. This is a very serious, serious problem, and we need to begin to treat it as such. We need to see high-profile campaigns. We need to see adequate resources to raise up the low performers and to train people in – help them understand what's going on and to educate the public about the problem.

So now we have – we do have a lot more information on patient safety than we have in the past, and that's really great, but what do we do with it? [01:09:03] That is the big question. It's kind of like the dog chases the car and the dog catches the car, and then what? And so, you know, there's been a lot of discussion about how consumers don't use this information. Judith Hibbard, who's a great thinker and writer about these issues, you know, basically said, you have to put it in context to – for consumers, or they're going to be clueless. You can't throw a bunch of numbers out there and a bunch of statistics. We need translators to turn the data into information for the public and for health care providers and for pairs. That is very – it is very critical, and it in order to do that, the underlying data that's collected by government – and we think government is the best collector because they're independent and they have the power to require information to be given – that that underlying data has to be public; it has to be available for these translators to take and use. [01:10:05]

That's what Consumer Reports is doing and other people are going to talk about what they're doing. But my employer is one of the big translators for information for consumers. And in recent years, we've taken the hospital infection information available in the states that created ratings with our traditional blobs – the red and black blobs that people know that we use for cars and toasters. But we've been translating that with health care information.

And recently we did a safety score, which is a composite score of many different measures that we have studied and analyzed and decided we think these create a safety score for the hospital because what consumers want, is they don't want to know what the central line associated infection rate is in this ICU, what this – colon surgery infections are over here. They want to see the whole picture. [01:11:08]

So while it's important to have those individual measures out there, someone needs to be translating and creating sort of a picture of the whole hospital. Most of the patient safety information we have about infections is focused on the ICU. And we need to get out of the ICU. Sixty percent of – (inaudible) – occur outside the ICU. We need to get out there in the whole hospital.

So – and it's OK to have many translators because there are many listeners. We translate for consumers. Someone else translates for business or employers. Hospital associations and plan associations transfer – translate for their population. That's OK. And it should be – you know, should be used. We need timely and validated data. [01:11:59]

And I'll say something kind of controversial on this. The regulators should be using this data. The overseers should be looking at the infection rate. The entities that license the hospitals should be watching those reports. They should target the hospitals that are having the most problem, go out and find out what the problem is, make them – you know, help them perform, identify those.

And you know, the federal programs that we have – and there are many of – many of them out there that are really trying to help hospitals learn. What are the right things to do to prevent infections and errors? We should be targeting the low performers not focusing on volunteers. The volunteers are going to be the ones that are not afraid to come forward. And some of them may need a lot of help, but a lot of the ones that need help are hiding and, you know, trying not to call attention to themselves. So that's a really important thing.

I want to say a couple of things about consumer engagement because it's critical and there's a lot of talk about how consumers can be engaged. [01:13:06] And we think – we think patients have a role in reporting also. We need to have a system – an organized, comprehensive system that allows patients to report harm because we know that what the hospitals report and what the patients report are going to be two different things. And together, we might be a full picture. But one or the other, we're not going to.

We think maybe a good solution would be to add some questions to the HCAHPS patient survey – patient experience survey. That simple questions, sort of broad questions about whether harm occurred, would be beneficial to giving patients some input. There's a lot of talk about patient-centered care. And one of the advocates we work with, Kathy Day from Maine, has a great quote that she – that I love, that says: No one but their patient gets to decide if they got patient-centered care. [01:14:00]

And so it's that personal. And if it's delivered to – in a patient-centered environment, that particular patient's going to be the deciders of what they – whether they got it. And that means that the health care workers, the nurses, the doctors have to listen to that patient. Just having discussions about patient-centered care reflects the absurdity of our system that is not set up, really, for patients.

It's set up for the system to work to well, what is convenient to the hospital, giving every – too many patients urinary catheters. That's not patient centered. That's convenience. That's so you don't have to walk everybody to the bathroom. Too many procedures that are unnecessary. That's not for the patients. That's for maybe some financial incentives in doing those procedures.

We've engaged with a number of provider – doctor groups on the Choosing Wisely campaign. And I would encourage you all to look at that campaign. [01:15:00] It's remarkable. I don't even know how many of the physician groups, but they've each come up with five things that are done by their profession that shouldn't be done that – all the time, that shouldn't be done as much as they are being done, that doctors and patients should ask questions whenever they think about doing those things. And I think that's extremely valuable to patients and providers.

And then improving communication is really important. And that requires listening. It requires true informed consent. I think if we really had an informed consent system that was unbiased in this country that patients would be more prepared to make better decisions. And I'm not sure how to get there. I think maybe we need sort of a centralized place where it's unbiased information, where people can go and look up the risk factors and the alternatives for procedures that are being offered. [01:16:02]

And I think – you know, I think patients should be asked to participate in improving their safety, but it's kind of dicey. You have to figure out what does this patient want to do? What is this patient willing to do? I heard in a recent California meeting on hospital infections, at their advisory committee, someone was suggesting that perhaps it would be a good idea for patients to refuse the urinary catheter. At the time they're going to insert it, they would say: No, I don't think I want that.

Well, that might be a little bit too much to ask of a patient, but to inform them ahead of time to ask questions about whether the doctor of the hospital plans to use this, and have a discussion about it, can be done. Thank you.

[01:16:53] MS. REINHARD: Thank you, Lisa. (Applause.) [01:16:58] We appreciate your role as translator and the safety – the – Choosing Wisely is a campaign that AARP has been involved in. We know that Leah is another translator, and she'll talk about things she's doing. And AARP magazine has featured some of the work that you're doing as well. So, please, Lisa – I mean, Leah.

[01:17:16] LEAH BINDER: Thank you. First, let me reflect for a moment on the really good news that I think Susan mentioned first when we started the panel about health costs appearing to come down, or it may be slowing the trend in the growth of health costs, is a better way to put it.

When I first read the article in the Times this morning about that, I have to admit, I was a bit pessimistic because I thought, well, what the story really is that Medicare and Medicaid costs are probably slowing in their growth, but not the private sector, the – which is the group that I represent. Leapfrog's membership are purchasers of health benefits, large employers, some unions and also coalitions – like EBGH (ph) is a member of ours. [01:18:00]

And so we are concerned that even when Medicare costs may go down, other costs are then shifted on the backs of the private sector purchasers. This is a tradition in health care. So I was pessimistic, admittedly. And I looked at the story and I said, so, what did they say about overall health

costs? Well, the really good news is, overall health costs are also slowing – not as much, by the way, as Medicare, but they are slowing. So this is truly good news.

And it got me reflecting on what I think is a major changing happening in our health care system, and one for which transparency is critical. This change is controversial. It is not – it is parallel to but not necessarily directly related to the Affordable Care Act. And I think it has every bit as much of a consequence to American health care as the affordable health care – Affordable Care Act. [01:18:55]

And that is the shift by employers to high-deductible health plans, often coupled by health savings accounts, which are tax-protected accounts employees can use to pay out of their pocket for their health care. His has caused many employer – employees to suddenly be shopping for their health care. They are paying out of pocket, so suddenly they actually do care what the price is of the services they're getting and – as well as what the quality and value of that care is. They have a direct stake, skin in the game.

Now, again, there's controversy to this. There are pros and cons to this. But there's pros and cons to a rainstorm today. I'm not going argue about it; I'm going to get my umbrella out because this is happening. It is the fastest growing form of health coverage in the country – are high-deductible health plans. And I have yet to talk to a single employer who's not planning on shifting to a high-deductible health plan either, for all their employees or as a choice. Very large companies, like GE, have gone entirely high-deductible health plan. This is a major change. [01:20:00]

So what happens when this occurs is, first of all, most employers that I've talked to see an immediate reduction in their expenses. It cuts their costs. This is a big problem for employers. They need to have their costs cut. They cannot continue to see growth the way they've seen them in the past decade. The past decade, health costs for employers have gone up by a hundred percent. It's hard to think of any other item that any one of us purchases that costs twice as much as it did a decade ago, that we would be happy about that, unless we saw a massive increase in quality, which they're not seeing. So it definitely reduces their cost, but it also changes the culture. Again, suddenly employees are shopping.

And now we see two movements around transparency. One is a movement for price transparency, and we are seeing that led by my colleague at Catalyst for Payment Reform, Suzanne Delbanco, a real effort to have health plans publicly report to their members on the price of the services they can expect. [01:21:07]

And the other is what I would say is an acceleration of the movement toward quality transparency, and that's where leapfrog comes in. Leapfrog has been, for over a decade, publicly reporting on hospital performance, on quality outcomes, mortality rates, safety. Safety is our flagship.

And last year, we started a new program called the hospital safety score. And for those of you have a smartphone, you can right this minute for free download Hospital Safety Score on iPhone or Android, and that will give you letter grades rating the safety of over 2,600 general hospitals across the country – Billings is an A – thank you, good work – (laughter) – as are – a good number of hospitals are rated A, but a good number are not. We rate A, B, C, D and F, and some are in all categories. And so there – and there are – there's real variation within communities. [01:22:02]

The goal of the hospital safety score is to help employers continue their work in informing their employees about the choices that they have at the variation among hospitals and their safety. But the second goal is for consumers themselves, and here's where we get to the – get to the importance of transparency for consumers. Lisa and Jennifer have talked about people need this information to protect themselves. And when consumers start truly asking their doctors, how safe is that hospital and why did this – why you sending me to this hospital that got a C? What about the one down the street that got an A? Can I go there? When that conversation happens, we will see a change in safety that is driving a market for safety. And that's what's missing right now.

What I would say for Medicare – and obviously I work on the – although many of our members are public sector purchasers, so we actually are partly in the public sector, our focus is often on the private sector. [01:23:04] But what we need from Medicare is to truly partner with employers if we're going to jointly bring all of health care costs down as we're now seeing happen. And for that we need transparency from CMS, from Medicare. And Lisa has mentioned this, but I want to reiterate that we need for Medicare to publicly report the public data they have, and to do so in a way that's easy – easily accessible to consumers and easily accessible to all of us who work with this data. Right now, that is not happening the way it should. We get some data, but not enough. And it would not – it seems to me that if Medicare could commit to a full level of transparency, we could see a real acceleration in all of our efforts to improve health care, to engage consumers in protecting their lives and driving a market for the expansion and improvement of the best possible health care for everyone.

So with that, I'll conclude. Thank you.

[01:24:07] MS. REINHARD: OK. Thank you. So – (applause) – so just for a moment, I wondered if this panel, if you have any questions or comments to each other. You don't have to. I'm just giving you an opportunity. Otherwise I'm going to ask a question, which I hope will then lead us to the cross discussion that we want to generate.

I was very intrigued, Jennifer, by your pace of change. It's a term that I use often in long-term care, for example, in home and community based services. Let's pick up – pick it up here. Two percent a year is just not enough. And then you threw out an idea, I thought, which kind of ties into, I thought, around the fee-for-service comments that you were making too, and that's rehospitalization. It seems to be an instrument of change It's a policy change that I think you were getting to, that this could be used in a way that somehow could increase the focus on patient safety. [01:15:01] I want – I think that's what you're saying, along with care coordination. So could you elaborate on what you meant by that, or maybe I'm not capturing what you were saying.

[01:25:10] MS. HUFF: Sure. I think you're capturing the flavor of what I was saying. I think the connections I was making was between the new models of care which are changing the way they deliver care to focus – a big piece of that is to focus on care coordination and transitions and communications between providers to make sure the patient is getting seamless care. And I think – and patient safety, if you look at some of the issues or drivers or barriers to having good patient safety, it's care coordination and care transitions. So there's a commonality there. So if we start using the new models as another opportunity to continue the focus on patient safety and improving patient safety, that's an avenue for us to do so. And it has a myriad of other benefits as well.

[01:26:03] MS. REINHARD: So the new models, as you said, which partly come from ACA and partly from the private sector and other areas, but there's also the policy of payment – a payment policy around rehospitalization that seems it could be, or at least to put it on a table. Is that a trigger for

really focusing more on transparency, on patient safety, or is it only about length of stay and rehospitalization?

[01:26:28] MS. HUFF: Yeah. Well, I was just going to say, what you're touching upon is –it's actually going on right now in the Medicare and their fee-for-service program. They're starting to implement around rehospitalizations and health care-acquired conditions of what are the payment incentives around that. So there is some activity. It doesn't necessarily have to be through the models of care. It can also be specifically focused on the issue of rehospitalizations and looking at how that can drive down. And that in itself will also improve care coordination and cause better systems in the health care system.

[01:27:05] MS. MCGIFFERT: Can I comment on that?

[01:27:06] MS. REINHARD: Yes, please.

[01:27:07] MS. MCGIFFERT: I think one of the things that always has puzzled me is that you go into the hospital and you spend thousands and thousands of dollars, maybe 50,000 (dollars), maybe 100,000 (dollars) for a complicated procedures, and you walk out and you never – and that's it. And I think that what the readmission to the hospital payment structure has done is it's caused hospitals to take a look at what happens to these people when they leave and I'm going to get paid differently if I don't follow them and figure out how to make sure they do the follow-up appointments that if something happens that we can, you know, continue the care. And what I've noticed in the last six months or so – and I travel around the country a lot on local televisions and in local newspapers, there are all these profiles of these things hospitals are doing to help people who've left the hospital. [01:28:09] So there are lots – there's lots of activity and models out there of following those patients, and it's not frankly all that hard and it's sort of a no-brainer that it should have happened a long time ago, but the payment incentive is what made it happen.

[01:28:24] MS. REINHARD: OK. Anyone? Yes, Nicholas.

[01:28:31] DR. WOLTER: Well, I would just say that there's some interesting data out there. For example, if I'm remembering right, the cost variation around a hospitalization is bigger in the 60 days post-discharge than it is within the hospital stay if one looks at data about any surgery or condition in the hospital. So to really focus on this, one needs to look at larger bundles, which is also happening and which I think will be very positive over time. [01:28:56]

But Michael alluded to this. It – there's waste that we are all are trying to take out of our system, and we can redeploy those dollars to do some of these things. But at the Billings clinic, we've just hired five pharmacists to do Medicare medication reconciliation. We're increasing the approach to how social workers work in the medical home so that patients who get into the hospital can have much better coordination (and care ?) post-operatively.

The fee for service system doesn't cover any of that. And some of the new models, like ACO payment, are so focused really on unit price as the underneath mechanism that we're not really looking at more innovative ways to use the fee for service system to allow the infrastructure that can reduce overall costs.

When I was on MedPAC, there was a study of acute coronary episodes comparing Miami to Minneapolis. They were much more expensive in Miami than in Minneapolis; however, the unit prices, in some cases, were higher in Minneapolis. So we need to get ourselves into a framework that's looking at larger bundles of payment in order to really tackle this issue effectively.

[01:30:06] MS. REINHARD: Great.

(Cross talk.)

[01:30:08] MR. ATKINS: I'd like to follow up on that a little bit and explore this issue around price transparency and some of the barriers there are to really achieving price transparency in the first place, but secondly, you know, how much power there really is in price transparency. I mean, you know, one of the things that goes on in the marketplace in health care is tremendous market segmentation, so that – and consumers really don't see, and purchasers really don't see a lot of what's going on in the cost of care.

And then, you know, I thought the Steven Brule (ph) article, for all of its focus on chargemaster and criticism around we've known this for a long time, raises an interesting question around the segmentation of the market and the variation of prices that people pay. And so the question I have is really around does price – is price transparency really [01:31:00] achievable? And at the end of the day, is that really what we need?

I mean, your talk about the focus on unit prices may be missing the point if overall we're looking at what does it cost to treat an episode of care and being able to get the efficiency in the way that care is delivered as opposed to worrying about unit prices. So I just wanted to explore that a little bit and see, are we chasing the wrong thing here and are we ever going to really achieve the kind of market competition, price competition?

[01:31:26] MS. BINDER: Can I try that one?

[01:31:28] MS. REINHARD: Go ahead.

[01:31:29] MS. BINDER: So this is another one of my analogy about the rainstorm: Get out your umbrella. This isn't a question of whether price transparency is a good idea and maybe it's a bad idea and so we won't do it. Consumers are going to want it. They want to know how much things are going to cost them because they are going to be paying increasingly out of their own pocket. I don't think it's an option. I think we have to figure out how to make it work best. But I do think it is coming.

But I want to say, what's extremely important from the point of view of the health care [01:32:00] industry is that it be coupled with good-quality data. And employers know that as well, and that's a big priority for employers, is to be able to couple pricing data with quality data in a way that's accessible and understandable to consumers.

So here's why: A number of researchers, but including one in particular, Shoshanna Sofaer, have written about how consumers approach pricing and quality data and health care. And what she found in her study in Health Affairs was that if consumers are only given information about prices between three different services, they will choose the highest-priced service. And the reason is because most consumers assume high price equals high quality. And it's hard to actually convince them otherwise, she found in her study.

However, when she was able to couple that pricing data with quality data that was very simply depicted, [01:33:00] most of them went to about the medium-priced provider. But very few even then

were willing to say, well, I'll pick the lowest-priced, highest-quality provider, which they would perhaps do with other goods or services but they didn't do with that. But in any case, consumers need to have that information to couple it with the pricing. And then I think ultimately prices are going to become less insane in health care if there actually is this consumer oversight in the form of a market.

[01:33:33] MS. HUFF: Can I add to that?

So I think Leah is pointing to one important area of price transparency, which is at the individual consumer level. And when you have it at the individual consumer level, what's most important to them is what – the price cost to them, so taking into account their benefit design becomes really important. We've seen some of the health plans now do cost calculators where they make this information available to their members, where you can go online [01:34:00] look up the services that you may be getting and see the range of prices that are occurring for the providers in your area.

And there's been, I would say, from the few years back to where we are now, improvement in terms of how these cost calculators are providing information. I think there's still a ways to go. I think it's – explaining prices in health care to consumers is not a simple thing, and making sure we're capturing all of them is really challenging. So that needs some work, but that's at the individual consumer level.

I think if we're trying to move the market, the question remains, will there be enough organization around consumers to move the market? Will their decisions make changes in the marketplace? And I think what Leah is pointing to is it may not, not right away, given how they view price information. So the question really is, do we make it more publicly available at a more aggregate level as well so there are others [01:35:00] in the marketplace that can develop policy solutions for addressing some of the problems with it?

I think the other thing related to pricing transparency that we really need to look at is competition and competition in the marketplace, which drives what the prices are going to be in a lot of markets. And while I've been touting these new models of care and saying I think they're great to be moving in that direction, one of the cautions I have about them is they're causing providers to merge and come together and they're getting greater market power. So we're also seeing on the other end of while they may be providing better care, they now have the ability to ask for higher prices.

So we need some mechanisms in the market to monitor the prices to see where they're going, to see the changes that are going on, and being able to make some adjustments to that. I would say our current antitrust issues [01:36:00] is more of a reactionary – it's something that happens after the fact. We need something more proactive in terms of the monitoring. One of the things that we advocated for when CMS was doing its Medicare ACO pilots was that they collect information on the pricing and monitor that over time to see what will happen as these new organizations are developing.

[01:36:22] MS. REINHARD: Great.

[01:36:23] MS. MCGIFFERT: I just think that we, when we talk about price transparency and the cost and consumers bearing more of the cost, I'm just going to – I think we really have to think about how that has an impact on middle-income and low-income consumers who don't have a lot of expendable money to pay for these health care services.

You look at a – you know, a typical family of five, you know, with three kids, they don't have a lot of extra money hanging around after they pay the rent and pay for the food. So that's going to have to be part of [01:37:00] the picture and we have to, like, look at how that has an impact on that population.

[01:37:06] MS. REINHARD: Thank you.

[01:37:07] MS. SMITH: You know, I'd just make one comment, which I think picks up on a number of themes expressed here.

One is I think as we talk about accountability, whether it's accountable care organizations formally or just more broadly in the system, accountability has to happen on cost as well as on the other features of health care, such as health care delivery or access.

And so that drives us towards an understanding of how much should it cost you to deliver care in the health care system, and are you able to do that against a set of quality and performance metrics? So you're doing that in a budgeted environment, like most of us have to live in – you know, here's the amount of money that you have, patients to keep healthy in that context; how are you doing it and is the system actually setting up the metrics underneath [01:38:00] that?

So, Larry, I would say, looking at price per se may be chasing the wrong bear here. Looking at total cost of care and accountability around a budgeted system, and beginning to pull that out of the fee-for-service system, as we were talking about earlier – you know, the incremental steps there – I think those are the strategies that will actually begin to pay off.

[01:38:22] MR. JAMES: If I could make a comment on that, and just a divergence of opinion.

[01:38:27] MS. SMITH: Good.

[01:38:28] MR. JAMES: Pricing, as providers do it today, the uninsured pay substantially more for health care than the insured, and that can least afford it. So if you are being reimbursed Medicare $14,000, say, for a hip replacement and you charge $35,000 on your chargemaster and give a 20 percent discount for cash, that is just driving the system the wrong way. [01:39:00]

So I think there has to be some issues with prices. There has to be some fair disclosures with prices and some limitations. You shouldn't have a chargemaster that's 200 percent of Medicare. And there has to be some kind of a process here so that everybody can take advantage of a reasonable price, and then I would agree with you. Then for budget, most of my contracts are full cap.

[01:39:25] MS. SMITH: Yeah. I would not disagree with that at all. The fact that there are markets in this country where you cannot get a service for less than 150 (percent) or 200 percent of what Medicare will pay is not an acceptable environment. You know, that's just – you can't create an accountable situation there.

[01:39:43] MR. ATKINS: Right. But, Tricia, I think that takes us back to this question of accountability is critical but accountability to who, because once you get beyond Medicare and you get to the health care system as a whole, you know, we don't have broad accountability.

And so, you know, we've had this process in the past [01:40:00] where when Medicare cuts rates, then the cost gets shifted to other payers who don't have the market power that Medicare has. So what do we do to get overall accountability across the board?

[01:40:14] MS. SMITH: I wish there were an easy answer to that, Larry. I suspect you and I have been talking about that one for a lot of years. But just – you know, I'll just toss out a couple of ideas for people to shoot down or comment on.

You know, we're talking right now about two of the biggest hot potatoes in the health care marketplace right now. One is how do we pay physicians in the SGR? And two is geographic distribution of the Medicare dollars. It couldn't get nastier up there to try to take that on. But I do think that some of the things that we've learned, in part out of the MedPAC analysis and in part out of analyses of the commercial marketplace is that you do have to look at both of those things together, that the cost shift that Leah and others talked about is real.

If you looked at some of the most [01:41:00] expensive Medicare markets, you will discover that on the other side of that, the commercial market is not so expensive, and so that shift is in fact happening in particular marketplaces. And they reverse is true as well, so looking at both of those things matter.

But, Larry, I think the challenge is how many – practically speaking, how many bites at the apple can Congress take at one time? So longer term I think that geographic question has to be addressed, but shorter term, is it the thing you've got to do today, you know, along with the other shifts that we've talked about today? I'm not so sure.

[01:41:38] MS. REINHARD: Let me shift – oh, go ahead, Lisa. I'm sorry.

[01:41:41] MS. MCGIFFERT: Well, I think when you talk about price you have to also talk about quantity. And I think that there's – as I said in my remarks, we really need to have more conversation with the public about necessary and unnecessary care, [01:42:00] you know, and just sort of the system that we have that pushes people along, and it pushes them along at a time when they're most vulnerable. They're sick or their loved one's sick and it's hard to say, no, I don't need that, my husband doesn't need that stint right now today. I could go home and we could think about it. We could do some research and come back in 24 hours and figure out what needs to be done.

So, so much of what is happening is people feel pressured – you've got to do this now – when it's not always the case. I'm not saying don't pressure them when it is the case, but too often there are hundreds of examples that are in the general media about these issues. And we have to figure out how to create a system that makes that accountable, [01:43:00] and that's going to include – a lot of it's going to include educating the public about these things. That's why the Choosing Wisely campaign is so great. But, you know, we need to build on that and do a lot more to educate the public.

[01:43:14] MS. HUFF: Can I just add one other piece?

I think I'll add to the suggestion of having some limits on the percentage of the Medicare rate and the private sector marketplace. I think there are also a lot of other what I'd term anticompetitive contracting provisions that are in the private sector that serve as barriers to having better pricing information, so for an example like that, better pricing and better quality transparency information.

So there are providers that are using their market clout to have in their contracts with health plans that the health plan cannot use its data in public reporting initiatives, that the health plan cannot share information [01:44:00] on pricing. And given the domination that the provider has in the particular marketplace, it really leaves the health plans' hands tied.

What we've done in California is we've passed two laws that actually make gag clauses null and void. So we've removed the barrier that no longer can health plans say, I can't give you this information because of my provider contract. And what it does is it makes information on all providers available to consumers, because there's been a place which we don't talk about where we can't necessarily get information on all providers because of their market clout.

[01:44:40] MS. REINHARD: Yes, please.

[01:44:42] DR. WOLTER: I just wanted to re-emphasize something Lisa just said, which I think were contained in my earlier comments.

I do think unexplained variation is the next frontier in how we look at payment policy. I was on an AHA task force that looked at this, and we had a version of what Congress is dealing with because we had [01:45:00] people from all over the country who had better wage indexes or more GME or et cetera.

And at the end of the day, once all those things were taken into account, fully 55 percent of spending variation was felt to be unexplained, which likely is due to higher utilization rates, I think in many cases, and the Dartmouth Atlas work has certainly highlighted that. But how do we bring into payment policy something that creates transparency around the differences in utilization? That's not easy to do, but I think it is the next frontier and we need to do it.

[01:45:40] MS. REINHARD: Let me take another path here that really came up on both panels, I thought, and that was around culture change. And I think you brought it up, Nicholas, first and then it came up over on this side too.

So, you know, thinking about financial incentives and different things we've been talking about, but still at the end of the day [01:46:00] how do you get it done, or how do you provide leadership to make it happen, to use the evidence? I'm reminded this is the week of Florence Nightingale's birthday, and she was – her big thing was sanitation, getting people to wash hands and all those things – were still there, as she said. And so how, in the safety world, can we make it possible for nurses and for others to make sure everyone is washing their hands? That's been an issue, just cutting infections by very simple procedures.

And then, Nicholas, you were raising, you know, how do you get more teamwork together? How do you bring nurses, physicians, other health care professionals to see the world differently than the fighter pilot metaphor – which was terrific, thank you; I appreciated that too – into more of an astronaut model that you were describing?

[01:46:55] DR. WOLTER: Well, let me just say a couple things. The IHI has done some nice work in this arena [01:47:00] looking at how one really transforms, how organizations approach safety and quality and cost variation differently. And we have used that work inside the organization quite

extensively in terms of how we try to have physicians, nurses and other staff all really see what the big dots are that we're aiming for. It's been very useful.

I will also say that, you know, it's nice to be recognized by Leapfrog or Consumers Union or a number of other organizations that do various quality rankings, but we take those things with a strong grain of humility but we use them extensively internally to raise the bar on what we are hoping the leaders in our organization, both physicians and administrators, really focus on.

We've done a lot of work on leadership development at the Billings Clinic, both physician and non-physician, and those things take time. Jim Reinertsen once says [01:48:00] – once said that it can take three generations of administrative teams to get an organization into a place that really has a culture that can strongly address these issues in a very consistent way. And certainly it takes time. The three-year time frame of a Pioneer ACO will not get you to the culture – the long-term culture that will sustain improvement, but hopefully it's a great start.

And then I'll just mention a couple other things at our place that have made a big difference. And some of these are fairly recent. We only formed a board committee on quality and safety about three years ago, and we've been on this journey now for 15 years.

And so our board, that have oil executives and statewide bank presidents of national banking companies, et cetera, they have really embraced the quality and safety work. And they're pushing us in different ways, I think, even though I thought we were pushing ourselves pretty hard. We have patients come [01:49:00] and present to that group about harm that was done to one of their loved ones. So we're using stories. And the stories are more impactful in some ways than data percentages.

And then we did an interesting thing on methicillin-resistant staph aureus rates. We used some complexity theory principles and we really struggled reducing the incidence of those infections in our organization. And we actually brought staff together from various parts of the organization, whether it was nurses, physicians, housekeepers, et cetera. And they actually did acting. They role-played doctors and nurses.

And, you know, the science of how to reduce MRSA is somewhat understood, but the cultural practices, including hand-washing and how nurses feel empowered to ask doctors to take a time out or et cetera, those are difficult. But those role-playing exercises became very powerful in the organization. And ultimately, along [01:50:00] with applying some of the known scientific approaches to reducing those infections, we had about a 40-percent drop in MRSA rates.

[01:50:09] MS. REINHARD: Wow. Thank you.

Anyone else? Leah.

[01:50:13] MS. BINDER: I'm glad you brought up Florence Nightingale – and it is Nurses Week, actually – because actually what Leapfrog has really been looking closely at is the relationship between the strength of a nursing leadership and nursing workforce within a hospital and its safety record.

We do find significant correlation between the two just on the data that we've collected from hospitals, and as a result we begin, on the Leapfrog survey, asking hospitals to report whether they

have magnet status, which is an elite designation for excellence in nursing, and also for outcomes in safety, which do correlate for them as well.

But I think that when you talk about culture change within a hospital, I think that nursing is probably the number-one change that – or the number-one [01:51:00] most important factor to safety, because most of what hospitals do for the patient is provide nursing care. The nurses need to be empowered and not doing workarounds when there's a safety problem.

So I think that's a really important and key element. And in fact nurses have been leaders around patient safety for much longer than since the IOM report. I think the nursing model of care has put a priority on some of the things nowadays we're now seeing much more priority on, like infection prevention and hand-washing, et cetera. But I do think that's an important piece, and I know Billings is ahead on that, as well as other very – some excellent organizations that I've seen, like Virginia Mason.

Virginia Mason actually built a floor – several of their floors are built around nursing workflow. So by architecturally as well as protocols, clinical protocols, they made is so that nurses spend [01:52:00] much more of their time directly with patients. And that has, for them, shown enormous results. We see a great improvement – at least from the data that we collect, improvement in their quality and safety.

So I think that that's an element of the picture of safety, and it's an area where I know we need lots of support, both at the public – from the public sector as well as the private sector.

[01:52:23] MS. REINHARD: Thank you.

Lisa?

[01:52:25] MS. MCGIFFERT: I'll just throw a few ideas out there. And I think certainly the CEO and upper management need to be strongly involved in changing the culture, and it has to be sort of a top-down message to everyone in the hospital or health care system. And that involves putting resources towards it. You aren't going to get much of a change if you don't have adequate nursing staff.

The other thing that I think changes culture is to talk about dignity and respect. [01:53:00] And I think that there's – a lot of that is lacking in the health care system, not just from the health care workers and doctors to the patients, but also between the people who work there. I think I've heard some of the most – the worst stories about dysfunctional workplaces in the health care system that I've ever heard. And so dignity and respect can really make a difference there.

And then the other thing that I heard once was at a conference about MRSA, and it was full of hospital representatives and they were overwhelmed with this problem. And one of the early innovators from Pennsylvania got up and said, you know, you just have to start somewhere. And it's kind of what you all have been talking about, and on the other panel, is don't be overwhelmed. Start with one thing. Build on that, then build on that and build on that. It takes time [01:54:00] but once you get all the pieces together it will start working.

[01:54:06] MS. REINHARD: Thank you.

Jennifer?

[01:54:08] MS. HUFF: I'll just underscore something Nicholas said, and that was he was mentioning the inclusion of business on some of his boards and some of the leadership roles that take place. And I think that's really important to have others outside of health care that have investment in health care participating in the decision-making process and I think reminding the executives about particular issues that are important to them.

I'd also expand it to also including consumers as well, not just business. I think that's a great place of having more consumers participate and help support the patient-centered care model by having that voice and perspective in leadership roles.

I think with it, though, it's important to take on the responsibility of supporting these folks and serving in these roles, [01:55:00] not just throwing them in it. We have to remember this is not a usual environment to many folks outside of health care, so their transition to it and their ability to really participate also depends on the organization being able to support them in that process.

[01:55:17] MS. REINHARD: Yes?

[01:55:19] MR. JAMES: There are so many cultural changes going on in health care it's hard to identify a few. Let me just try to go through a few that we're doing.

First, the Pioneer ACO, you have to have consumers on your board and a patient advocate. And our patient advocate is a leader of our volunteer association, and so we use them constantly as groups. So when we have a good idea, we think, at the board, we go back to a group of patients of 50, 60, go down and say we're thinking about doing this; what does that make sense to you? So it's a culture of engaging the patients in the process and also a culture of providers seeing health care from the patients' point of view.

And then between our specialists and hospitals we use a code management company for most of our major [01:56:00] departments where physicians and administrators sit down and really run the department, do historically what just administration did by itself. And then between our primaries and our specialists what we found is in our primaries we had a huge deviation in training depending on where they did their residency programs.

So we're going through every subspecialty group, and the specialists are teaching the primaries the basic specialty care that they could actually do in the primary office so the specialists don't have to do it in their office. And they come across some very interesting things, like pharmaceuticals are very expensive for us and we take risks for all of our pharmaceuticals, so we really look for generics.

But the truth of the matter is there's a number of pharmaceuticals that the specialists understand the primaries don't understand, that if they use those they will avoid hospitalization. So sometimes pharmaceutical costs go up a little bit. It cuts the whole spend down – as Pat was saying earlier – all the way back down.

So it's a combination of I think bringing everybody together, [01:57:00] but it is one step at a time going through all the system.

[01:57:05] MS. REINHARD: Thank you.

Yes?

[01:57:05] MS. SMITH: You know, I'll make one other comment that relies on all of these, and that is that I think the culture – the discussion of how Medicare can influence culture, you know, is just such an enormous leap that most people give up and go home. But that said, I do think that there is a lot of merit out of some of the conversation that we've heard this morning where communities, systems, organizations that care about getting to better outcomes for patients and for the system, that picking up on what they can do matters.

And so how does that translate into Medicare? Well if in fact you do begin to put out there some metrics for performance – you don't have to say how every community has to get there. You can leave some of that to learning collaboratives. And I think it was the other panel that really began to talk about [01:58:00] the significance of learning collaboratives.

But the ability for providers, or providers and other stakeholders – whether that be employers, plans, even the federal government but all of the players – to begin to look at how do we get to the big dot, how do we get to the things that we need to accomplish, I think that needs to be done at much more of a community level.

Some of the places in the country that have done it most successfully have done it built on community-based systems. I think throwing a "here's the federal government solution" at every community probably isn't going to work. But setting the big dots out there for performance – and that would be, frankly, across all three elements of the triple aim – and then moving towards those at community-based ways probably is something that will work.

[01:58:57] MS. REINHARD: A lot of local work.

[01:58:58] MS. SMITH: A lot of local work.

[01:1:58:59] MS. REINHARD: We're going to open this up to questions [01:59:00] from you. I know Lina has been collecting cards. There's also roving mics, I believe. So why don't I take – if there's specific questions right away – or will we just talk off the cards then? Anyone have an immediate question? Yes, Jeri Smoaka (ph).

[01:59:19] Q: Yes, I'd like to ask Mr. James, when you were talking about the patient being one of the weaknesses in the system and – oh, sorry – the patient being one of the weaknesses in the system, and I'm curious if you can – and you said out of the 250,000 patients that your group serves, 140,000 of them have elected to be part of a medical home. What can you tell us, if anything, about who those patients are who elect that as opposed to the ones who don't?

[01:59:50] MR. JAMES: It's after usually a conversation with the physician – and sometimes you use a nurse educator – to talk about what really is quality [01:20:00] health care versus voluminous health care.

Some patients believe, if I'm feeling bad and I go to a doctor, the doctor does not give me a script or do some kind of study for me, then that's a bad doctor. And the truth of matter is, if the

doctor's cognitive skills are high enough to really understand what's wrong with you, and you have something that will self-correct, that you don't need an antibiotic for, that's a better health care. Well, we're finding that penetrates about 60 to 65 percent of our patients. But still there is 40, 45 percent that think more is better. OK, my back hurts, I need an MRI. No, we don't want to radiate you. Let's just feel your back and see what's wrong with it, you know? And there is – and there is that.

Now, I would tell you, again, I grew up at a – the home of General Motors, with really high health benefits, huge amounts of health care overuse for years and years and years. [02:01:01] I think we're starting to change that culture. I think we're educating more people. If you'd asked me five years ago, that'd have been, like, 30 percent that said I want to be involved – (inaudible).

Now, we still treat the other patients, but it's a different kind of treatment, different kind of conversation. Instead of us saying, OK, you know, you had pneumonia last year; what are we going to do together to stop pneumonia this year? Let's get the vaccine. Let's talk about your breathing, what's your respiration going on? So it's a combination of engagement, and just not everybody's ready to be engaged yet.

[02:01:33] MS. MCGIFFERT: Can I – can I ask you a follow-up on that?

[02:01:35] MR. JAMES: Sure.

[02:01:35] MS. MCGIFFERT: Do you ever bring those – some of those 60 percenters together with some of the 40 percenters to have conversations? That might be interesting.

[02:01:44] MR. JAMES: We are doing that now in the seniors in our ACO because on the ACO, you – obviously, you have – you know financial risk for all 17,000 assigned to us, and the ones that are not really joining – (inaudible) – we're bringing them together in focus groups and have them talk, because it is right, the stories do work; it's those personal stories of why this was a better project for me.

[02:02:04] MS. : Absolutely. (Nice ?).

[02:02:06] MS. HUFF: Can I just add a piece of what we're doing for the PBGH ACO-type programs, the intensive outpatient care program. When patients are enrolled to participate in that, they're given Judy Hibbard's patient activation measure, and so the providers are using this to understand how activated their patients are. And then they tailor their level of communication and engagement with the patients based on where the patient is at, so that's sort of another mechanism for doing that.

[02:02:38] MS. REINHARD: So Larry has been collecting the questions.

[02:02:41] MR. ATKINS: Yeah, we have questions. OK. So I'll throw out one out here, and that has to do with bundling payments and the approach to trying to improve coordination to bundling payments. But the issue is, I mean, how do you fit – how do you fit bundling payments into, you know, the delivery system itself and the kind of lack of integration and the – and the fee-for-service structure delivery system? [02:03:06] And where do you – how do you assign accountability in that process for actually having impact at the end of the day? So a lot of these bundles would cross, you know, silos in the – in the delivery system, so –

[02:03:21] DR. WOLTER: Well, you know, we live in a community the size of which it's easy to have conversations with the other caregivers in the post-acute part of the bundle, and so we believe that we'll have cooperative approaches to how we look at that. But we also have an increasing amount of ability to influence how that payment would work. For example, I mentioned in the hip-and-knee bundled information we looked at, we were utilizing sniff (ph) care at higher rates then benchmarks we saw in our own sniff (ph). And so I think that's a huge opportunity to try to drive us to a better value equation. [02:03:58] And then we're also starting with a local post-acute care provider that we work closely with, both home care and hospice care; we're starting up in the next couple months. And so we'll have that, so to speak, within the system as a – as a way to really address that coordination.

[02:04:19] MR. JAMES: We work with bundled payments through the co-management companies, the specialist and the hospital coming together. And it was an interesting output of bringing them to make that decision, as we do bundle hips and knees too. But if there are complications, both providers pay equally in the complication, not just the hospital. So it's a bundle payment but also a bundle outcome process. And that is starting to work very well, and our complication rates are going way down.

[02:04:52] MS. REINHARD: So – question, go ahead.

[02:04:53] MS. SMITH: Well, I just going to comment that I think, Larry, we need to tease apart your question because the way Nick and Billings Clinic and a system in a community can answer that question or an ACO can answer that question is probably – you're going to have to take another step because you can answer that question of Medicare's payment to a fee-for-service provider. [02:05:15] And I guess I'm not – I'm not sure I can have the perfect answer, but the way in which you look at the flow of dollars from Medicare to fee-for-service payers, how they might be able to bundle what their expectations are – and, you know, we've – that's what the system has begun to do in ACOs and in Medicare Advantage. In the – in the footloose and fancy-free total fee-for-service market, it's a, I think, harder question.

[02:05:45] MR. ATKINS: Yeah. And who in the – in the fee-for-service market then ultimately holds that accountability? Is it the hospital?

[02:05:51] MS. SMITH: Well, I think – I – what would you say there, gentlemen? I – you know, I don't – I – the question is, accountability for what service? [02:06:00] Is this for readmission or an admission or for – you know, sort of what set of circumstances are we looking at? Because there is accountability at, say, a patient-centered medical home level in terms of the ability to keep people out of the hospital when they have ambulatory care, sensitive conditions, conditions for which you should never have to be admitted to the hospital, sort of like another readmissions kind of area – is there a way that we can begin to look at groupings like that. But I – you know, the ultimate accountability, I think, really depends on what your – what services, what conditions, what circumstances you're looking at.

[02:06:39] MR. JAMES: Yeah. I would agree. I – if it's an integrated delivery system where they own all the components, clearly, the hospitals lead in that process. But I would suggest in the future insurance companies might be dispensers of bundles where they will actually cap it and subcap it out because they have so many contract already with the providers, and they could handle that because

I think insurance companies' role in the future are going to diminish substantially, so they need to create a different kind of business, and that would be one that they could go to.

[02:07:12] MS. HUFF: Can I ask a follow-up question related to this? And it's some commonalities of the bundled payment system along with ACOs and medical homes is to break down the silos across providers, create more payment incentives for care coordination.

My question, though, and one thing I struggle with is – and bundled payment, it's usually for a particular service or a bundle of services. It's not as global as a medical home for say. And one of the things, at least from a purchaser perspective, is we wonder if this starts becoming a shell game of it looks like it's becoming a better payment, it looks – you know, it looks like better quality, it looks more affordable, but there is some place else in the system that it's getting past you, and there is compensation for it. [02:08:04] So I've – is it one or the other or both of – in terms of how do we deal with this and the – and the health care system around sort of bringing providers together?

[02:08:15] MS. SMITH: You know, one of the things that we've – our plans have begun to do – and NQF has recently approved a total cost-of-care measure. And there are lots of different ways that are beginning to develop around that. But it's – Jennifer, it's exactly to your point, that this shouldn't be about pushing the balloon down here and it pops up over there, that you really do need to begin to pull all the pieces into it. So I think that the science on this has a long way to go. But looking at the question of how do you begin to capture total cost of care and make sure that that's coming down a patient, you know, there are a lot of building blocks in that that we don't yet have in the – in the unfettered fee-for-service system, that we don't yet have in place. We don't have assignment of a patient to a system or to particular physician necessarily. [02:09:03] And so how do you track total cost of care for a particular patient? But the fact that NQF has in fact looked at that and approved a measure and is looking more down that road I think is a good sign.

[02:09:17] MS. MCGIFFERT: And I think the other challenge as these new systems are emerging, how do you – from the consumer perspective, how do you have enough information to compare that system with the existing system, you know, or other systems in place? And I think, you know, we have some concerns that we might not get as much quality information broken down in the – in the ACO-type model as we can get in the other model, and maybe this measure was looking at that, I don't know, but we need to be sure that we don't lose the details about what's happening in there, not – you know, not just for, you know, accountability, but also for consumers. [02:10:06] If – you know, if this is really a great way to deliver services and deliver health care that's different than what we've had, then we need to have some evidence and show some comparisons about how it's great, why it's great; you know, how are the outcomes differently and how does it feel to me as a consumer? It's kind of like bringing the people from – in different models together to talk. We have to be able to compare them in some way.

[02:10:30] MR. JAMES: I would agree. And there's a reason the (pioneering seal ?) is called a pioneer, is we are in (the completion ?) of our first year. We have 33 quality measures that are measured and they're very – you know, very public. It's on patient experience, quality outcomes and on population care.

I think the data will build in time. All the shared-savings models are going to the same quality. So, today I believe there's over 300 groups in the country participating with CMS, and it's the broadest quality-data reporting we've ever had to do with any (payer ?). And the dashboard that we have to fill

out for CMS has 132 components into it. So, we're measuring at a level that is much, much higher than we've historically done, and that needs to get out in the public's eye. And I – and I think we – I already said this is publishable and we're ready to publish, so.

[02:11:29] MS. SMITH: You know, to that point, Lisa, we've got – we've got measures in ACOs now. We have measures in Medicare Advantage. We don't have measures in fee-for-service. And so the comparability doesn't – the ability to compare doesn't even exist. So, I think that as – part of Medicare payment reform, you have to go down that path one way or another. And there are different angles to do it.

[02:11:57] MS. MCGIFFERT: Yeah, and certainly in – generally in the United States, we don't have much information about physician care at all – zero, really. We don't have any information about performance of physicians and we need more of that.

[02:12:11] MS. REINHARD: Right, well, we have some. We have cardiac surgery rates in different states, but it's definitely –

[02:12:15] MS. MCGIFFERT: Pretty spotty.

[02:12:18] MS. REINHARD: Let me – we have lots of questions and not a lot of time, so I'm trying to combine a few things and maybe we can just go through a couple. One is around HIT and patient engagement. It came up – successful ways to engage patients, but the potential of HIT, health HIT, and also difficult-to-reach populations – perhaps rural areas. Any comments?

[02:12:41] MS. BINDER: So, a couple things about HIT. One is that we need to make best use of the emerging electronic medical records to report on quality directly. We have many problems with the reporting measures, and EMRs could help with that.

The second thing is that we really need to think differently about a medical record. And I would like to see opportunities for consumers not only to view their own medical records in real time, but we'd like to see models where they can actually add to their own medical record so they begin to understand that this – they own this. We think that would go a long way to preventing some of the errors that happen and really engaging consumers – (off mic).

And finally, Leapfrog monitors, the use of computerized position order entry, which reduces medication errors somewhere a little like 75 percent when it's introduced. And we also help hospitals test their systems to see if they're actually working. And that's – therein lies the rub. And this is very important:

[02:13:43] You can adopt health information technology of some sort. In this case, CPOE, when we look at it. But you have to monitor it. It's not – it's never plug-and-play. And what we find in the conversations around HIT is the issue of how you monitor and test the systems over time to make sure they're safe for patients is left off. We'll get to that later. We went live; we're done.

And what Leapfrog has found in our testing is that, in fact, about a third of the orders entered through CPOE systems tested through Leapfrog do not alert providers to the adverse events that would result from some of the orders. So, there's problems, so I just think it's really important as we look at

HIT that we have a sophisticated conversation of what that really means as we introduce it into health systems.

[02:14:30] MS. REINHARD: Thank you.

Lisa?

[02:14:33] MS. MCGIFFERT: And, just, it's really important for patients to own their medical record. I think that they have to contribute to it and they have to have complete access to it. Really, the patient is the only one that really cares to have that throughout their life.

I was recently in a meeting where we were talking about medical devices. And an issue came up that, well, after a certain number of years – it depends on your state – it might be seven years; it might be 10 years – the physicians don't have to keep the records anymore. And if you have a medical device in your body and it lasts for longer than a couple of years, hopefully, you need to have records about that. You're the one that has an interest in maintaining that and keeping a record of, what was that procedure I had 15 years ago, and could there have been something that happened in that hospital – in that surgery that might be affecting something that's going on with me today?

Those are – those are the – you know, the patients really need to have that kind of access, and I think electronic medical records gives us the opportunity to have that in an integrated manner sometime in the future; hopefully not too far off.

[02:15:47] MR. JAMES: I'm all in favor of patients having access to medical records. I think it's a great process. I am concerned that the medical records, or the way they're written, are not understandable by the patients. So, when we talk about health information exchange, it's the "information" part of that, that I would like to see improved. So, when you create a – the way we do it, is it goes into a data warehouse, and the way the providers pull the information out is based on who they are. And you can be better in pulling information out of a data warehouse for patients in a much more common language so they can understand it.

They can also, like – which you were talking about, Lisa – if for a procedure we can give them all the technical information so they can store it and take it with them if they need it, but the truth of the matter is, is the information informative to the patient or it's just a lot of data they don't understand? And I think as providers we have to think about that harder.

[02:16:48] MS. SMITH: There are a couple of other reasons, I think, that we look at the rich possibilities of HIT for consumer as well as system facilitation. And on the consumer side, one example – and, you know, this is really very forward-thinking, but one of the organizations that I work with in the Minneapolis market has created the first online clinic. Literally, you can today go online or to the telephone and dial into a particular organization and for about 40 circumstances you can give them – answer a series of questions. And so this is a very limited set of things. It's urinary tract infections or pink eye; very – things that are pretty identifiable.

[02:17:40] And then if they decide that through this series of questions that you have pink eye for – you might be ensured for it; or $40, if you're not insured for it. And that's what you get. You get a diagnosis, you get a prescription; you're done. And what they're finding is enormous convenience factor for mothers of school kids who run into whatever, you know; or it's the ear infection of the 3-

year-old again, and you know exactly what it is. And it's working beautifully, but if there's a referral that's necessary, then they say you really need – do need to go someplace else. And if that individual is uninsured, then they guide them through the processes of where you might be able to find that in the community. So, that's one example.

Another place where I think IT has been incredibly valuable is if you have individuals insured by different players across the marketplace, and then you create a hub-and-spokes information resource across the community so that every player in that marketplace can access individual information. And it's not – it's not necessarily dumping all that private information into a single source. It really is hub and spokes. But if a patient from over here ends up in a hospital over here, you can find out an awful lot about their circumstances quickly in that kind of community.

[02:19:07] MS. REINHARD: Great. As Larry gets ready to ask the last question, I'm going to ask Deb Whitman if she could come up and join us. can she – can she scoot around? Is there enough room?

OK, Larry.

[02:19:20] MR. ATKINS: So, OK, this is quick one. This is a five-minute question, so – (laughter) – for 10 points each and a chance to win the car.

So, the – one of the interesting challenges is around medication adherence and finding things that actually work in medication adherence. And fairly recently, CBO announced that they are now ready to score medication adherence as actually saving money in the Medicare program, which is interesting because, you know, there's still, I think, a lot of speculation around both the – you know, what programs really work to reduce medication – to improve medication adherence and then, when you improve medication adherence, what impact that really has on health care costs.

So, I'm interested in what programs you all are doing around medication adherence that you feel are really effective now and might fall in this category of something that CBO would say, yeah, that's great, that's going to really help reduce Medicare costs. do you have things now that are?

[02:20:30] MR. JAMES: Well, the only thing we're doing is education with the patients; making sure that this is not a script that the doctor goes through and explains exactly what the script will do, when they should start feeling better, why they should finish the script out and the process. But we have unsuccessfully tried with our local Rite Aids and Walgreen's to have them – because we send everything electronic to them – to have them electronically come back and say it's filled. I think if we could do that, we would have much, much better compliance on adherence. But we have not been able to accomplish that.

[02:21:02] MS. SMITH: This is a perfect example where HIT can be better used, and you do need that capability, but in more systems-driven organizations, the ability to track claims or to track whether or not a prescription was fulfilled – was filled is the first step down that path.

And then for individuals who are very expensive patients, what we've had success with doing is the kinds of things like calls. It's patient-centered medical homework. It's basically going back to that patient on a very routine basis. That tends to pay off because then you're checking in with that patient

not only on pharmacy but also on a whole range of things to monitor that. So, those are the places where we see it, Larry, as beginning to show results.

[02:21:50] MR. ATKINS: Do you think the high-touch strategies, which can be very expensive, do pay off?

[02:21:55] MS. SMITH: They absolutely do pay off in certain populations. So, if you use your data capability to figure out which patients you are going to be monitoring and using high-touch on, then it absolutely pays off with those populations. So, it's not – it's not a universal. You know, the discussion – does everybody need a medical home? Well, they probably need something. They need a relationship. But the intensity of that really does vary.

[02:22:22] MR. ATKINS: Yeah, so the cost savings really depend on your capacity to target effectively.

[02:22:26] MS. SMITH: I think that's probably true.

[02:22:28] MS. EAMES HUFF: I'll just – I'll just add a piece of this. I totally agree that technology is really important. A way of understanding of whether or not it's working is to ask the patients. I think we can bring this back – do the patients know whether or not they knew how to take their medication? And there are measures out there; there's something called the Care Transitions Measures, which measures the patient's understanding of if they knew how to take their medication when they left the hospital, so that's a way of informing the system in terms of how well we're doing.

[02:23:01] MS. REINHARD: We're the family caregiver. (Chuckles.)

Deb?

[02:23:05] DEBRA WHITMAN: I just really wanted to thank the speakers. As it is clear, we brought in the best in the business. These are the people that are working day to day to make our health system better. And so I appreciate them taking the time, speaking with us, speaking with you all.

I also really want to thank my team: Susan Reinhard, particularly; Lina Walker, Rick Deutsch; and the broader AARP team both in government affairs and communications that helped to pull today together.

We know change is happening in Medicare and even in the broader health system. The news reports today showing cost growths slowing down are coming, and they are making a big impact. But I think, as Larry said, a lot more still needs to be done to change the overall dynamics in health costs growth.

[02:24:01] And what you heard today is the shared goal of the Triple Aim, and for those of us that are not articulate as much in the health-speak, that's really about making better care for individuals, better health for populations and communities, and health care that is also affordable. And all of the speakers touched on those goals.

And while it's going to be challenging to address the Triple Aim, we need to have creative, cost-effective and innovative solutions. And I don't know if people were keeping score like I did, but there was a long list of solutions that were provided today by our speakers, and I thought I would just go over a few of them because it actually is quite a long list.

So, we heard that we should improve the measurement of quality. We should have translators to make sure that those measures are understandable to patients and individuals. People like Lisa and organizations like AARP can play a role in that.

[02:25:08] We need to have payment reform that's focused on incentives to both improve quality and also care coordination.

We should expand the use of medical homes, particularly using a primary care as the foundation, and Michael talked about how they do that at their business.

I couldn't leave this talk if I didn't talk about the need for culture change within nursing to empower the nursing leadership.

We also need to improve patient education and engagement. We talked at the end about owning your own medical record although making sure that it's understandable to patients.

We need to make sure that care is coordinated and transitions happen seamlessly.

We need transparency both of medical errors; we need transparencies in price. But not just price; the associated quality of the services as well.

[02:26:07] We need to proactively have protections to ensure that there's competition within the health-care marketplace, particularly as we create more ACOs and other organizations that reduce competition.

Oh, and we also need better health information technology.

So, that's a pretty long list by some of the nation's experts. And I would say here in the shadow of the U.S. Capitol that we actually – this is the right place to be talking about that list.

As Tricia mentioned, there's a fire sale on the sustainable growth rate this year, so Congress is actually looking at ways to permanently change the way physicians are paid for. And we hope that at the same time they're looking at ways to advance the quality of our health care system because we know if we look at Medicare, we can also improve the broader health system as a whole.

[02:27:08] The other thing you should notice about each of these solutions is that they are not a silver bullet; that each one plays on the roles of consumers, of insurers, of purchasers – both private and public – clinicians and the government. And all of those have a huge role if we want to transform our health care system.

So, I'm really proud to be a part of AARP and the public policy – my team at the public policy institution to sponsor these types of forums because we believe that sharing ideas, airing our

differences and identifying common ground is a real proactive way to achieve our goal and achieve our solutions.

So, thank you for your time today. (Applause.)

(END)