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ACCELERATING HEALTH CARE INNOVATION TO achieve SYSTEM-WIDE IMPACT

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PANEL 2: FEDERAL LEADERSHIP FOR SYSTEM-WIDE IMPACT

JEFF KANG
Chief Medical Officer
CIGNA Corporation

FARZAD MOSTASHARI
Deputy National Coordinator for Programs and Policy
Office of the National Coordinator for Health
Information Technology
U.S. Department of Health and Human Services

DANA SAFRAN
Senior Vice President, Performance Measurement and Improvement
Blue Cross Blue Shield of Massachusetts

RICHARD GILFILLAN
Acting Director
Center for Medicare and Medicaid Innovation

JASON HWANG
Executive Director of Healthcare
Innosight Institute

Closing Remarks:

MARK MCCLELLAN
Director, Engelberg Center for Health Care Reform
Leonard D. Schaeffer Chair in Health Policy Studies
The Brookings Institution

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P R O C E E D I N G S

What we want to turn to in this next panel is a little bit more detailed discussion of the role of federal leadership and the role of HHS to help support this kind of broad implementation and improvement in our healthcare systems.

So there's more – earlier today we talked about pilots that can support efficient and effective rapid cycle learning. Now, how does that fit into the broader context of policy levers available to HHS? And to kick off this discussion, we're fortunate to have Doctor Jeff Kang here with us today.

Jeff is Chief Medical Officer for the CIGNA Corporation. He also has a tremendous amount of experience at the federal level. He was part of the Healthcare Reform Effort under the Clinton Administration and was the Chief Medical Officer of CMS from 1995 onward for a number of years, thinking before it was called CMS. So Jeff thanks for being here with us today to kick off this discussion.

And then as we did for the first panel, we're going to have a number of reactors from some different perspectives here to talk about the implications for innovation from a variety of perspectives as well. Dana Safran is the Vice President for Performance Measurement and Improvement at Blue Cross Blue Shield of Massachusetts.

Jason Hwang is the Director of the Healthcare Innosight Institute and the coauthor with Clayton Christianson of a very prominently noticed book on the innovators prescription, or how to get more rapid innovation in healthcare.

And Doctor Farzad Mostashari is the Deputy National Coordinator for Health Information Technology at HHS. We were also scheduled to have Carolyn Clancy with us today. Unfortunately, Carolyn could not be here but we're very pleased to have Doctor John White.

John is the Health IT Director at the Agency for Healthcare Research and Quality and John has been integrally and extensively involved in the development of that national quality strategy that you heard referenced earlier in this session. So a great panel and Jeff let me turn it over to you to kick it off.

MR. KANG: Thanks Mark. I'm going to be fairly quick. Let's see here. So my job here is to just summarize some of the thinking from the first panel from the second panel, I guess, last July.

A couple of things where we are looking for federal leadership. One is just in the area of measurement and you heard Doctor Berwick talk about that. And then the second I'll talk about is around information.

In the area of measurement there is no question – everyone pretty much agrees with these two principles. One is a consistent single to the entire healthcare delivery system. So that's a reference to the extent that, as payers, if Medicaid, Medicare, and commercial payers all agree to the same metrics for success then regardless of who's paying the bills the delivery system will have – be a consistent signal from all – from everyone. And I think that everyone is in agreement that that is a very important thing that we need federal leadership in.

I think though the devil really is in the details of how to get to this and I actually think that the Feds will have to exert a lot of leadership here. I like the way that Doctor Berwick framed the initial, if you want a design with the end in mind, as the first panel suggested, let's start with the Triple Aim and I think that's a very good framework to do that.

I do think though that that's not historically how we've thought about measurement. In the past we've thought about measurement as agreeing to measure what we can measure. That's kind of – the consensus process creates that, versus really starting with the end in mind and then trying to create the measurements and what we should be measuring. So it's not what we can measure, but it's what we should measure.

As two concrete examples, many commercial payers actually are indeed measuring the total cost of care as a measurement per individual or per capita. Now if you look at the national quality forum, for example, that is not a measurement for efficiency so that's one example.

A second is that it actually turns out many commercial payers are actually measuring for hospital care, complication or mortality rates at the admission level rather than process measures.

So I actually think that this is a – because that really, from a patient centered perspective, is a measurement you're most interested in. Am I going to come out alive from this cardiac admission or am I going to have complications?

So this is a great place I think where Doctor Berwick and CMS can really exercise federal leadership and think about a measurement system that measures what we should be, not what we can.

The other place where the panel really spent a fair amount of time where federal leadership could be used was in the issue of information. The – and you've already heard about this from the previous panel.

I thought where I might be most helpful is it turns out many payers, CIGNA included, actually have many of these accountable care organizations or gain sharing approaches running and I actually think that what would be helpful is in that context what sorts of things are the physicians or hospitals looking for from an information standpoint. What are we hearing?

And actually interestingly enough, some of us are doing these demonstrations where they were also participating in the Medicare PGP. So they had an experience with – in the Medicare pilots, what was it like versus in the commercial pilots. And it really does come down to information.

CMS actually provides the payment methodology but they haven't historically, unlike the commercial, or provided the claims information and a lot of the management reports. So a couple of concrete examples; gaps in care at the point of care.

CMS again doesn't supply that or any management reports. And I don't say this as critical but I just want to just give some sense of the importance of information as a critical enabler to these practices. And I actually think that it's a very strong federal leadership here is going to be important.

My last point here is one of the other things that commercial payers hear from physician practices in addition to the payment reform and that data and the information is actually they are very interested in incentive designs that incent consumers or patients or beneficiaries to do the right thing. Historically called value based incentive designs.

And I think that what's important here is comparative effectiveness research is really what's going to be the fuel to begin to think about how you can incent better care in a cost effective and high quality way. So I think that summarizes, Mark, the kind of – what our panel talked about. Thank you for the opportunity.

MR. MCCLELLAN: Okay; great. Jeff thanks for the opening comments and I don't want to open it up to a broader discussion with the panel. I think I'll start by alternating. Dana if you don't mind going first; Dana, and then Jason, and then John, and Farzad.

MS. SAFRAN: Sure thing. So I guess I'd love to pick up on the point that Jeff was making about the importance of sharing information in an ongoing way or be able to deliver on the promise of some of the innovation that Doctor Berwick was talking about and that Doctor Gilfillan spoke about too.

And so I'll speak to that from the perspective that Blue Cross of Massachusetts has from having introduced a model that involves payment reform into our network. That model is called the Alternative Quality Contract.

It's a model that we designed in 2007 with the really twin goals of accelerating progress toward improving quality and outcomes while at the same time significantly slowing the rate of growth in healthcare spending. And the model, while designed in 2007, first really became launched in 2009.

So I took some comfort in the fact that the PGP demos, which came so much earlier, have yet to produce evaluation. I actually can share a little bit about what we've seen produced so far, but bearing in mind that – that we're just really 22 months in at this point with the first organizations.

So for those unfamiliar, just to speak briefly, what the AQC model is, really there's four components that differentiate it from our traditional contracts. One is that it encompasses payment reform so we move from our future service model of paying for it and incentivizing care to a global budget.

Second is that there are very significant quality incentives built around a broad set of measures that include really three domains; clinical process, clinical outcomes, and patient care experiences in both the ambulatory and inpatient settings.

Third is that trends are negotiated in advance and over the five year contract period and are set to move toward general inflation. So rather than even the high rates of healthcare afflation that we've seen, that these are – are tied to CPI and moving toward CPI over time.

The fourth and maybe most relevant to the panel discussion we're here to have today is the ongoing data support – and support that we're providing to the organizations that come into this model.

And so I'd like to think of – as having moved us from a kind of traditional pay for performance model where we provided reports and performance information once a year tied to a settlement check to something that is much more an ongoing flow of information from us to the organizations that come into this model really because we recognize the importance of that information to their ability to succeed under the model; both in their ability to succeed and achieving the quality and outcome incentives that we've put in front of them but also very importantly, their ability to succeed on the incentives to be careful stewards of healthcare resources that we've put in front of them.

More than anything we have recognized over this time period that that is transformational change; that is to say going from payment incentives, that our design to drive volume and complexity up to now payment incentives that are designed to produce better quality, better outcomes while slowing the rate of growth and spending.

That is really transformational change that these provider organizations need every bit of data and support that we can provide. So I guess that the couple of things that I'd say that we could align on in terms of federal and private efforts here and that Jeff has already, you know, nicely teed up is absolutely a core set of measures.

That's been essential for the organizations that have come into this, not only Massachusetts, is they know how they're going to be judged, not just what the measures are over

the five year period and that those measures won't change but also what the performance targets are.

Those are set in absolute terms, not in relative terms so we're not comparing them to the network average or to something that's going to move over time but rather in absolute terms setting out what is good performance, what is outstanding performance, and rewarding them across that whole continuum.

And one of the really wonderful and unexpected benefits of having done that is that it's created the opportunity for an even eagerness for collaboration among the organizations that have come into this because it's removed the element of competitive sport and pay for performance.

That is to say all of them can succeed because the targets are the same. And so there's actually an enormous amount of collaboration and cooperation among them in sharing thus practices as to how to get there.

But truthfully, they know a lot about these measures already and how to be successful on these measures more on the process measures than on the outcomes and patient experience, but nonetheless, all of these are measures that are familiar to them.

The part that's brand new and that really has required innovation on our part and that we would welcome the opportunity to sort of work together with CMS and share in providing kind of an all payer view, two providers, has to do with providing these organizations with information that allow them to act on – to identify and act on clinical waste in the system.

So keeping in mind again that the current incentives really have driven toward as much volume, as much complexity as possible, that's how you make money, to now a set of incentives that we've put out there to manage that money well; really begs for information to help with that challenge.

And so we've developed a methodology for providing information both about differences in costs for different sites of service, which probably isn't so much of an issue for CMS as it is for the private payers, but very importantly for providing data and support around issues of clinical waste and doing that in a way that's very clinically specific, as well as ways that deal with

broad topics like avoidable use of hospital resources, non urgent use of emergency departments, ambulatory sense of admissions.

And so joining together, I think, the reporting that we're already doing and bringing into that a view of the same metrics and the same information but broadened to incorporate Medicare, Medicaid, and other private payers as well, I think – I know would be welcome in our market from the providers who are now already functioning this way and who, having had some months of experience with this and some success, are now I think pretty eager to do this as a way of practice for their whole book of business. So hopefully that's a good introduction –

MR. MCCLELLAN: And at this stage Medicare being part of that effort. There's enough clarity among multiple private payers and so forth that you can see a path forward together around common metrics and the like?

MS. SAFRAN: I would say we absolutely see a path toward common metrics, and you know, of all things I think we have broadest agreement, both in our market and nationally and in some of the work that Brookings and Dartmouth are leading, about a common core set of metrics on the quality and outcomes side as a really good place to start. So absolutely; I think that that common metrics piece is something that we could start with today and move forward.

We have to build in though an approach that allows us to bring in new measures because all of us would agree that while we know the important domains of care and we have a good pool of measures to draw from for each of those domains, patient experience, clinical outcomes, et cetera, that there are, even with all of that, enormous gaps in very important areas of quality and safety and outcomes that we need to fill.

But the best way to fill them is to start with a common core and start to work the developmental measures along the pipeline into where we could actually have them as measures for accountability.

MR. MCCLELLAN: Great, okay.

MS. SAFRAN: Thanks.

MR. MCCLELLAN: Thanks; Jason.

MR. HWANG: Thanks; I guess – I was asked to address, among other questions, first and foremost, is this report complete, what was missed, what are potential pitfalls that CMMI needs to watch out for and what can it help facilitate. You know, I have little doubt that with 10 billion dollars behind this institute that you're going to have a plethora of submissions of new innovative business models.

But I think really the – my biggest concern comes with the filtering and sorting process that comes after those submissions are received. There's a couple of things that I think really any investor has to face when it comes to choosing wisely; which innovations are going to succeed in the long term. And this applies to the D.C. community, it applies to corporate investments, and it applies to government agencies who wish to establish new innovations.

The first is a tendency to compare to the existing gold standard. And the belief that that gold standard is the only way to do things. And so that also establishes number two, rules of the game that are essentially stacked against disruptive innovations.

That is, innovations that try to do things a little bit differently. So that if you attempt to, for example, deliver the same outcome, the same clinical care using a nurse practitioner instead of a physician or if you try to deliver that care instead of within a hospital or a hospital affiliated institution, you try to deliver that in a retail clinic or in a home immediately there are outcries of concerns about safety or quality.

And so understanding really what outcomes try – allow us to move away from some of these rules that are stacked against disruptors, as well as understanding what should be the gold standard of clinical care I think is important.

Our healthcare system, despite its many faults, is capable of doing extraordinary things and trying to come up with a different way of doing things immediately I think evokes a lot of passionate debate.

So my brain thinks best in terms of analogies so I'm going to try to use two analogies from outside of healthcare to try to illustrate I think what often happens to innovations and what CMMI needs to try to prevent or help, you know, facilitate some of these innovations that are going to come in to overcome.

The first has to do with why haven't we seen the electric vehicle take off here in America? You know, there's been an extraordinary investment put into this. A lot of regulatory agencies, industry players, all very much involved trying to introduce an alternative fueled vehicle, especially the electric vehicle and yet only now are we just beginning to see hybrids get a foothold in the market.

And a large part of it has to do with the fact that the gold standard and the existing rules of the game in the automotive industry are really stacked against any different way of producing an automobile. It has to be able to reach highway speeds, it has to be able to drive long distances, it has to have certain safety precautions built in.

All of these things basically make it almost impossible to immediately put batteries in a car and have it meet those needs of the public, as well as regulatory agencies. And the disruptive approach, honestly, is not to create a car with a ton of batteries in it, but to figure out which consumer population is going to be most accepting of an electric powered vehicle.

And you only have to look overseas to China where you don't have a lot of people driving cars necessarily, there's more than there used to be, but certainly a lot more people there ride bicycles than here in America. And for them, a battery powered bicycle is a vast improvement over what they have already.

And that's actually where the electric vehicle is going to take stock. From there, battery technology improves. You'll get all of a sudden a battery powered golf cart driving the streets in China and then eventually they'll figure out a way to build good enough battery technology to power a car at close to highway speeds, at the distances you want – we want, and then it'll get imported to America.

So finding these – these non consuming populations, I think it's critical for understanding where innovations in healthcare, as well as really every industry, are going to come from.

But understanding, at least when it comes to CMMI, when it calls for new innovative approaches to healthcare, that there are certain rules and regulations that are going to

prevent I think adoption and spread of a lot of the innovations that actually might seem like good ideas.

The second has to do, again, with this idea of the gold standard. And in trying to come up with a good analogy for this, I referred back to the extensive research I did this past summer watching the World Cup on television trying to answer – trying to answer the question why is it that – is it that soccer is so popular overseas but not popular here.

And it's been pointed out that soccer is a game that can be played really by anybody; rich or poor, all you need is a field and a ball. And you contrast that with really what I consider to be a quintessential American sport because it's very popular in the States but virtually not recognized elsewhere and that's American football.

And it is very much a rich country sport. It requires a lot of technology, a lot of equipment. And the differences are vast and when you try to convince Americans that soccer is a beautiful sport and you compare it against the gold standard, well all of a sudden the contrasts stand out and there's no way for soccer to match that.

You know, you can't – you don't want people running around 90 to 120 minutes and for God's sake don't let it end up in a nil-nil tie, that's just not something Americans are going to accept. So trying to compete against the gold standard I think has made it extraordinarily difficult for even something like soccer to get adopted into America.

That's obviously a little bit of a facetious example but I think, again, it raises the question of what is going to be the gold standard comparison that we're going to have CMMI compare some of these innovations to.

Now, turning to healthcare, you know it's actually funny how often we find the status quo players resisting innovations time and time again. And we've seen this pattern arise any time there's a challenge; when, you know, there's ambulatory surgical clinics or specialty hospitals, retail clinics, if the venue is changing or the profession is changing, APRN's for example, as Polly mentioned earlier, you know, there have been extensive challenges, state by state battles to try to carve out changes to our delivery model.

And all of these rules – established rules of the game make it extremely difficult to innovate in creating a different type of delivery model. And when I talk to my physician colleagues who are often at the center of some of the opposition against these innovations, I have to remind them that, you know, when I was a primary care doctor my colleagues and I were doing – we were reading EKGs, we were reading chest x-rays, the gold standard would probably be a cardiologist or a radiologist interpreting those tests and yet we'd been doing those for decades of course.

Something more recent might be the treadmill stress test and I know a lot of cardiologists were concerned that somebody might die of a treadmill stress test if we were to do those in the primary care office as if it was any riskier. But then these are the same cardiologists, the same group of people who were doing interventional procedures that used to be the sole domain of cardiac surgeons. And meanwhile, you had interventional radiologists doing things that, you know, only surgeons could do before as well.

And so there's – there has been a constant shift in terms of what the professions have been allowed to do and yet when it comes to any – any changes in the scope of practice, we continue to fight these battles time and time again.

So when it comes to CMMI I think I would echo some of the things that came out in the Institute of Medicine and Robert Wood Johnson Foundation report on the future of nursing. These are the same things that are essential for insuring that disruptive innovations can be adopted in a widespread fashion.

And that is, first of all, for disruptions and new professionals delivering work in new ways, you need to make sure that they're paid the same for doing the same work.

Second of all, scope of practice laws, minimum education requirements for licensure and accreditation, we need to ensure that they're not preventing you from doing work that you're inherently capable of based on your training.

Third, certificate of need laws that prohibit institutions from being set up if there's already a player in town that can do it even though that old business model might do it at a significant cost with a high error rate, we need to overturn those when it's preventing a disruptive

innovation from entering that could perhaps do it at a higher quality, in a safer fashion, in a more convenient manner, and more affordably.

And so I think it – the guidelines that CMMI has released today is a start. Declaring, I think clearly articulated goals and allowing for flexibility to reach those goals is important but I think there are a lot of other facets in terms of selecting and disseminating the right innovations is also critical.

MR. MCCLELLAN: All right; great. And it sounds like from your examples those are really keeping this whole process focused on the results that you want to get and paying close attention to that, making sure that you actively are getting barriers of those results out of the way.

MR. HWANG: That's right. I think understanding which elements of the gold standard ought to be preserved but there are certain elements such as the credentials behind your name that perhaps aren't as meaningful for certain elements of care.

MR. MCCLELLAN: Okay; to be clear to everyone, Jason is an M.D. so – John.

MR. WHITE: Thank you, Mark. Carolyn sends her greetings and her appreciation for having us on the panel and regrets that she couldn't be here. You know, one of the – one of the fun things about my job is that a lot of people want to be like Carolyn Clancy but I get to be her every once in a while so that's a lot of fun.

We want to offer our compliments on a wonderful report. Thank you very much; a lot of insight and thought obviously went into it. I wanted to discuss with you today a few things that the questions and issues that the report tees up.

First is around the National Quality Strategy, which is really – we think it's a great opportunity to stand on the shoulders of giants because a lot of great work has gone ahead of this particular effort; looking at priorities and strategies that should be employed during improving quality of healthcare.

But it's a chance to bring focus to what we do across the department. It's an effort that's got a lot of buy-in across all of the different sections of the department; led by the Secretary, presented by the Secretary to Congress on an annual basis.

So it's a great opportunity for us to, like I said, take the pass worth, get thoughtful input from the public on – on that strategy. And we also want to thank the Brookings Institution for offering input recently. We're bringing it into the draft of the strategy.

And then try to, like I said, bring focus across the department to what we do and quality – the wonderful thing about quality is that it's a huge field. There's a lot that you can do within it but we also know that to try to make a difference in any one particular place, you've got to focus your efforts. So we're looking forward to the National Quality Strategy helping us do that.

The other – another issue that is teed up by the – by the report just out is the wonderful opportunity that the IT infrastructure that we're going about, putting into place, offers for performance measurement for comparative effectiveness research.

It's been my great pleasure to work with my colleagues at the office of the National Coordinator, part of this, of course, but over the past year and a half, it really as been a joy to work with the folks at ONC as they go about their very important work. And we're working very closely on looking at things like performance measurement and how that might be implemented through meaningful use.

We certainly see the opportunities as well for comparative effectiveness research. ARC has been very fortunate in the past few weeks to invest – make some very significant investments in electronic infrastructure to support that kind of work.

Part of the Recovery Act was focused at comparative effectiveness research and we've had the opportunity to make investments along the lines of the prospect funding opportunity and for electronic infrastructure, distributed data networks, electronic data methodology conferences, things along those lines.

Through that work we're working with a number of specialty societies, American Academy of Family Physicians, American Academy of Pediatrics, American College of Radiology, American College of Cardiology, looking to work with the providers to say how do we best get the information to understand the effectiveness of the healthcare that's being delivered in this country.

I think that the key for us as we look to work with ONC to leverage the IT infrastructure that's being put into place is to be thoughtful and not arbitrary. And the good news is that that's been very – that's you know, on the level with everything that we've been doing up to this point. And we're looking to understanding the fruits of the investment that we've just made over the next – over the coming few years and hopefully feed that over into how that IT infrastructure evolves throughout the healthcare system. So we're doing it in the best way possible.

The final issue that tees up is well who's going to be evaluating all of this stuff. And we certainly look forward to working with CMMI to do that. ARC does have standing and plenty of opportunities for better evaluation of health services. So we are looking forward to your insightful, thoughtful and innovative applications to us.

MR. MCCLELLAN: Great; John thanks very much. And John you made the connections to the IT infrastructure and it's something that came up in the report and it's come up for appealing discussions today. So Farzad, I'll turn to you now.

MR. MOSTASHARI: Sure; hi everybody. Thanks for – thanks for having me here today. You know, in a way the connection to health IT that people make with CMMI today – maybe an analogy we can use is that we hope to be the fabric of that trampoline. Jump on us –

SPEAKER: Stretch to the top.

MR. MOSTASHARI: -- take it out. And I think people – the first thing to think about is the availability of the information for those who pay. And I guess something that I – and in terms of the quality measures in particular. And something that I would like to challenge us to think about is how that health IT infrastructure can also be used to provide that knowledge is power at all levels of decision making.

At the power to the edge, power to, and information to, the providers at the point of care and power and knowledge and information to the consumers and the patients as well. So I think health IT is not only the means by the afferent arm to perceive information but also the efferent arm to impact and to improve care and the safety times efficiency effectiveness, patient centers and so forth.

The other point I would make is that some of the investments that we've made in the infrastructure out there, the regional extension centers, the beacons, the health information exchange state grants, some of those structures can also be organizational supports for the work to come. And I'll give some examples of how that might be true.

Aaron McKethan talked some about the beacons in that context earlier – on the earlier panel. But most of all when I look at CMMI I kind of see where we were a year ago. We – there had been promising pilots, demonstrations, and good evidence in particular settings that now needed to be massively expanded.

There was a need to move quickly to set a strategy then move quickly. And encumber literally billions of dollars in a short time frame with the knowledge that there will be oversight and that to those whom much has given, much will be asked and – going to need to answer for those investments. Many well wishers; all of you here are here because you are wishing CMMI well and, like us, enjoying broad bipartisan support.

MR. MCCLELLAN: Great; I appreciate the connection to, you know, back to the – absolutely.

MR. MOSTASHARI: But I just want to highlight maybe four things that we did I think well that might be – might or might not be lessons for CMMI. I think – always dangerous to overly generalize. But the first was to kind of be bold in division but with an on ramp.

And there's going to be this tension with, I think you already heard, speed, which means you go with people you already – that are already doing this well. You go with measures that are already out there. Alright, the need for speed versus the need for real innovation disruption and, you know, I think there has to be both and how you manage that tension. You know, make it bold but make it achievable. That's a real inherent tension and in some ways we manage that by having a transition period where you go start with what you can do today but very clearly lay out where we want to go.

The second is to make sure that people can really play. And one of the ways we did that was by providing supports, technical assistance supports in the form of the region – health IT regional extension centers and to some extent the state HIE Grant Program so that you

can create that infrastructure. You can create and – and catalyze the folks who can be in the rural communities and the small practices, not just the same, the usual suspects.

And setting goals, guidance, providing guidance, but providing a fair amount of flexibility and how to get there. So being less prescriptive up front in terms of setting very clear goals but being less prescriptive in terms of how you get there.

What I wish we had is what you talk about in this report; clear, national priorities that identify those big hairy audacious goals; that we can say this is the goal and that we can work backwards from the very – not just the broad aspirational, but from the very, very specific health and healthcare goals. And then being able to rapidly monitor and adapt because if there's one thing that we know for sure, and this is not easy in Federal Government, but is that we're going to need to be flexible.

MR. MCCLELLAN: Great; now I appreciate all of the comments and the connections to the work that you're doing at ONC. It does seem like the ONC experience starting with the stimulus legislation is kind of a precursor for all of this.

If I could just start with you Farzad, is – have there been – clearly have been some conceptual interactions with the Center for Medicare and Medicaid Innovation, D.C., the work that you're doing through beacons and the extension centers and so forth, playing into the next set of projects as they come out of CMMI?

MR. MOSTASHARI: We want to be the – we want to be the fabric of the trampoline that gets – gets jumped on. So we certainly hope so.

MR. MCCLELLAN: Great; let me ask other panelists. Any reactions to what you've heard? Anything you'd like to add?

MS. SAFRAN: I would; yeah. So you know, it's striking as I was listening to it, as far as I was outlining in those four bullets how much they resonated with our experience of what contributed to early uptake that was substantial in early success.

And so maybe there is something there, given the synergy in two very different sets of activities that we were doing but very different – very similar alignment in the four things that we're saying led to early and rapid success for us to take away for CMMI.

So that bold vision that you talked about, that lays out where you're trying to get to, and I think we have that with the Triple Aim, and at the same time an on ramp that allows those who are ready to engage right now to start to engage with that vision and then build a strategy for allowing others to come along I think is really critical.

The technical supports analogous to what I was trying to describe of the importance that we've seen of ongoing data and support to these organizations that really are trying to transform care because we've transformed payment and incentives.

And so you know, the metaphor or the reality of the regional support centers and what those might provide together with the report formats that have been developed for providing feedback, of course, really an interesting parallel; being clear about the goals but not prescriptive about the form I think is a really key lesson that we've heard a couple of times this afternoon, Mark.

And then monitoring how we're doing in the development and continuing to adapt which, you know, we're going to have to do because – because we've got the clear vision, the Triple Aim, but how we get there over time we're going to have to keep adjusting and we're going to need ongoing data and support.

And I would add to that a sense of partnership that, you know, we're not sort of making a deal and going back to our respective corners and watching to see do you succeed or do you fail. But we're going to be critically interdependent in the success here.

MR. MCCLELLAN: Yeah, go ahead.

MR. KANG: Maybe two reactions, one to Jason. I mean – and we have heard this a couple of times also from the previous panel but this issue of being clear about the goals, having a template around the goals and the measures but not the form or the design or the delivery, I think is very important.

To give you a concrete example, CIGNA actually has seven of these accountable care organizations kind of contracted for and we were very clear about the metrics of success and kind of the payment approach.

We were silent on who received that payment. And what was interesting was -- and out of those seven, if you recall when Elliott Fisher wrote about these accountable care organizations he had in mind an integrated delivery system. Well it turns out, out of those seven only two of them are in an integrated delivery system. Three of them are multiple specialty physician practices and two of them, the other two, are primary care only practices.

And I actually think that that, from a delivery system or design perspective, you're going to see all sorts of approaches. But from an evaluation perspective, we are evaluating them on the same outcome metrics and the same performance measures. And that's kind of I think what CMI needs to kind of walk – kind of get – walk that balance there and allow that innovation.

Now let's take it one step further. One of those practices has actually, within their delivery system, has created a – let's call it a nurse swat team of advanced nurse practitioners where they are managing the high costs, you know, really sick, frail, chronically ill – and we didn't specify that. That just happened as a matter of innovation and let it happen.

So I think that this issue of letting the delivery system kind of figure out how to get there is a really important – and not to be prescriptive on the design.

MR. MCCLELLAN: Jason, do you agree with –

MR. HWANG: Yeah; absolutely. I mean I think that, again, despite the fact that you may have the support of a payer like CIGNA, there are still external hurdles that are needed to – either it be overturned or overcome somehow. And some of the regulations that I mentioned still stand in the way.

You know, there are ratios required, there are physician supervision requirements that all prevent you from really having I think the freedom, the degrees of freedom necessary to innovate as much as we would like to see.

MR. MCCLELLAN: I want to pick up on all of your discussions about having the goals in mind and being clear about what they are but not being prescriptive in exactly how they're achieved. I think there still may be some concerns out there that if you have some broad common goals that that's somehow going to get away from either individualized care or at least some aspects of care that are very important, in particular, subgroups of patients or particular

individuals. And I guess the response to that is that if you make the outcomes more about the people themselves and what they want, and we had a lot of discussion about patient experience –

SPEAKER: Right.

MR. MCCLELLAN: -- for example. That might be one way to address it; other thoughts.

MR. WHITE: If I might, just to respond to that, I want to amplify something that Jeff said when he was making his presentation which is that when we measure quality now we agree to measure what we can. And it's so important to be able to say what is important to measure and what is important to look at and then figure out where the data comes from and how you put it together.

You know, we talk a lot about the clinical infrastructure, the IT infrastructure that supports clinical care supplying data and it will in droves. But I don't want us to presuppose that that will be the only data which we need.

There's going to be data from all over the place, going right down to the level of going to people and saying so how was that for you, are – do you feel better, and incorporating that in a thoughtful way that when it gets down to those individuals it means something to them because, you know, as much as we all care about the healthcare system as doctors or, you know, people in charge of large organizations, we all care about it as people who get care and whose families get care. And that's ultimately what we need to see it come to.

MS. SAFRAN: Mark, I'd say a few things that can help ensure that this gets approached in a way that keeps it patient centered; one as you point to is patient experience measures being part of the mix of what matters.

But another, importantly, is that having clinical outcome measures that are part of the mix of what matters actually, in our experience, is forcing a kind of patient centeredness that you might not expect.

And what I mean by that is for the first time for practices to have to take accountability not just for delivering the process of care, getting the tests done, but actually

making sure that when the patient walks out the door that they are able to keep their diabetes or their blood pressure, their cardiac disease under good control.

It means engaging with that patient in a way that you really understand their life circumstances and what kinds of barriers, whether they're financial, motivational, or cognitive, are going to get in the way and helping to address those. So it's actually generating a patient centeredness by having accountability for outcomes that I think is really important and instructed for us here.

MR. MOSTASHARI: So there are, you know, there are three answers that one could construct for this. One is to say you find the measures that – like patient engagement or, you know, some very parsimonious but broad and comprehensive measure of care coordination, patient engagement, safety that, you know, covers all of the bases. That's approach one.

The second approach is to say well yeah, you focus on some things but what you learned from those can then be applied broadly. If you learn how to control A1C or blood pressure, right, being able to understand the processes around patient engagement, around quality measurement, around decision support, around the registry functions, patient reminders, patient education, team based care, medication adherence; all of those things that you have to learn how to do are going to come in quite handy when you work – move onto cancer screening and kind of elides the issue.

And the third approach is to say you know what, some things, some measures matter more than others. And to start with some principles and say, you know, longevity, well there are some things that you can actually answer that question epidemiologically, scientifically. And maybe we should start somewhere that has as broad an impact as it can have on whatever principles we choose. Whether it's quality of life, you know, longevity of life, whatever we want to choose, safety, but focus.

MR. MCCLELLAN: And Jeff you also mention it in your comments and I think that, I think it's in the report as well, that we've had a lot of emphasis in this even on provider payment reform because that's the focus of CMMI.

But you also mentioned the importance of patient choice, opportunities, and patient information, patient incentives as also a powerful, maybe even a more powerful way to drive in innovation and drive in disruptions.

It goes back to your point, Jason, about how these really disruptive innovations have come in in other industries. You find a patient group that's not being well served and you have an opportunity to really brig a while different structure for serving to bear.

MR. HWANG: Yeah; maybe if I could (inaudible) because Farzad said something which I'd like to – the use of information (inaudible) even though you had a payer up here talking about it, it really was I think the most practical use for information and incentives right now, is more with physicians and with patients. And actually trying to create and the construct of information and incentives that create value, really is what we're trying to do here. And that – and ultimately it ought to be based on comparative effectiveness research around kind of what – what are your options and what is kind of the right thing to do.

I – on a concrete, you know, right now health plans for some of the reasons that the previous panel mentions, currently has the best data available with regards to what's occurring on the system, totally, from a holistic – or from a community or population perspective.

And what I actually find is many of the physician practices are hungry for that information. And so concretely, we are delivering gaps in care to the point of service for a point of care into the doctors' electronic medical records.

An interesting study we just – is that the practice actually achieves statistically significant improvements in gaps in care just with that information delivered at the point of care; 10, 15% better than the community.

Predictive models, the output of predictive models; it turns out health plans are very good at trying to identify risk early. Physicians actually – if they really are talking about trying to manage health and wellness, are interested in trying to get that information for their own purposes.

And then Dana talked about management reports. I think that kind of lining up that information with payment incentives on the physician side and then lining up that same

information with beneficiary incentives on the – whether it's value based benefit design or – I think really then creates that nexus where everyone is incented to do the correct thing; improve quality, lower costs.

MR. MCCLELLAN: I'd like to open this up to discussion from those of you who are here. So same as before; raise your hand if you've got a question and – in the back, Jerry.

MR. SHAE: Jerry Shae from the FLCIO. Thanks first, Mark for another great event from the Engelberg Group Center. It is very, very helpful. You know, I think a lot of us share the excitement, to use Don's word, about the present moment, You know, we were working on this stuff so long it was like we're finally at scale or w have the potential to be at scale.

I want to suggest to you in a much more common sense of things in the healthcare world out there is confusion and frustration. And I mean by the people who are paying the bill. And I want to suggest it is critically important, as CMI gets geared up, that we look for ways to actively engage purchasers in this process.

Look at the situation that's going on with health premiums. Whatever they went up last year, you know, consumers ate every cent of that stuff on average. It is going to get worse and people do not see hope around the corner in this situation.

And I have just heard this from employers that they see no alternative but radical benefit redesign while we're talking in Washington about could we make things better through quality improvement.

And you know, it's easy to say well you should but the uninvolved purchasers in some way, consultants and so forth, I just think there's a simpler way to do it and a much more important thing that we get to soon.

I think the Center has to prioritize some things and things out there that resonate with people quickly, which are probably the simplest things, the most proven things, and focus not on just the new innovations but on engaging people in promoting the existing innovations that we know work. And in the purchaser case, that means going to their insurers or directly to the providers and saying we want this in our contracts. If it's good enough for Medicare it's good enough for – if it's good enough for Indianapolis to take the – it's good enough for us.

And you know, we just don't – we don't have tomorrow. It was probably 25 years ago or so in one of these rooms where I first heard the word unsustainable in relation to health costs. We were at cataclysmic. And if we don't understand the urgency of that and in the model that we're doing innovation, extremely important stuff, think of some way to actively involved purchasers that gives them hope. This thing is going to go up in flames.

MR. MCCLELLAN: Well it's –

MR. SHAE: I mean it's just –

MR. MCCLELLAN: -- push a little bit on this. I mean Allan Korn talked earlier today about, you know, within this framework of goals and focusing on the end about emphasizing safety, things that should never happen. Are there other goals, specific goals, along those lines that you have in mind but that you think will be most compelling for purchasers?

MR. SHAE: -- here and I have the luck of being with him on various panels, you know, and he presents this very effective sort of look at safety. We can't look at safety. We have to look at two things that we can do better that would make things safer and would save money.

That's the purchaser end of this deal because if you don't say to them save money they're just going to go off on their own and do whatever they need to do to live in the, you know, the current business world. So it's got to be two things, not the whole concept. That's my point.

MR. MCCLELLAN: Yeah; you all are dealing with purchasers a lot. They are the ones who are underwriting all of these ACO –

SPEAKER: Right.

MR. MCCLELLAN: -- and other reforms. What's your sense about ways of addressing the urgency that Jerry has emphasized.

MR. KANG: I know – Dana, we haven't rehearsed this but I do think that there is definitely urgency. Now CMS is not here but I was pleased to hear both Rick and Don talk about speed. They are really worried about speed and getting out there.

So I can't speak for them but – I actually think the – what I'm hearing from an urgency perspective and how I think the plans are beginning to react actually is most health plans

now are in a – essentially in any willing provider kind of mode. Doctor – kind of are in all of our networks.

I think actually employers are now pushing us to say look, enough. We already know there are certain doctors and hospitals that are high performers. We just want – give us a health plan that only has those doctors and hospitals contracted.

So I actually think you are now going to see a move away from kind of open access to anyone and really a trade off between access and the cost and quality of care. And I just hear that urgency and I think employers and TAF heart refunds and whatever. I think they are ready to move in that direction.

MS. SAFRAN: So I guess – here's what I'd add to that. I absolutely agree with, you know, what Jeff sees coming. That's what we see coming too. But I loved Jerry's comments and I would say, you know, if we could seize on that to encourage the purchasers to be a demand side for payment reform – we see that starting to happen in Massachusetts.

And you know, you might say we're the canary in the coal mine because we've got an individual mandate and suddenly we've got a lot of focus on why does healthcare cost so much and why does the rate of healthcare go up so much higher and faster than the rest of the economy.

So we're starting to see a demand side for payment reform. And if we could, coupled with that, have folks understand that, you know, the system that we've got right now is delivering to us just what we've incented it to deliver; more – more complex, higher volume year after year after year.

But there isn't a patient out there who feels like they're in a system. And so talk about the fabric that we want to put underneath and, you know, the trampoline that we want to make, you know, to create – to have payment reform and accountability for the whole set of resources that are spent on care and on top of that accountability for using those dollars to produce better care and better outcomes.

I think that is the Triple Aim and if we can get employers saying, you know, enough of this, you know, paying for a piece now. We want to pay for the whole thing but we want incentives around quality and outcomes. I think we –

MR. MCCLELLAN: And you're starting to see that in Massachusetts of employers moving more towards paying for the best overall care at a lower cost and what, having consumers pay the difference or something like that?

MS. SAFRAN: Absolutely; we are – we're seeing what Jeff talked about, which is employers saying okay, enough of this, you know, the whole network, you know, every provider is in the network. We're willing to limit choice.

But at the same time now that we've got the AQC model out there and we – and we can offer trends that are declining over time, we're starting to see the opportunity to have a limited network that might be built off of providers who've committed to bring down trend over time while at the same time delivering better quality and better outcomes. So if we could have employers starting to ask for that, I think we'd be getting somewhere.

MR. MCCLELLAN: Okay; other questions or comments. Yes, you in the back.

MS. GAUTHIER: Hi, I'm Anne Gauthier with the National Academy for State Health Policy and by saying that I'm from the National Academy for State Health Policy I will preface my question. We have a wonderful opportunity at the federal level with funding.

We've got a number of leading states and not as – there are not 50 but they are trying to do a number of the things that have been described today, starting even with Allen Dobson's model in North Carolina. So my – I'd love to hear you comment on what you see as the role of states in accelerating innovation and working with CMMI and I don't only mean state as Medicaid, I mean states as purchasers, states as regulators, states as purveyor of the public good, and even as innovators.

And – I'll tack on – I know that what none of us want is for the innovations at the state level to go at cross purposes with what's going on in the private sector and what might be developed at the federal level. So I'd love to hear any of you noodle on this.

MR. MCCLELLAN: Sure; well certainly have been a lot of areas that have come up already where a state, both regulations and state initiatives, have had positive – can have positive and negative effects, substantial effects on this overall set of activities.

SPEAKER: So three quick thoughts. I'd be curious – I mean I actually think that the most successful IT kind of infrastructure investments have actually occurred in states where the states are very, very active. Because it's really hard to get all of the stakeholders together in a way without kind of a neutral governmental -- so I think the states have a big role in health IT kind of promotion; that's one.

Second is the payment. You've already mentioned Medicaid; and being kind of consistent around performance measures and et cetera between all payers, very important. And then third, actually, we've already touched on this but there are prescriptive practice rules and those are held at the state level.

They're not held at the federal level where to Jason's point, if you want to kind of have different models, states will have to be prepared to kind of wave those rules in the context of innovation or whatever. So those are three kind of concrete things I can think of; there may be others.

MR. MOSTASHARI: Yeah, we – for Health Information Exchange, we did pursue an explicitly state based strategy and I think it was the right one. It's not without its challenges because of the variability between the states but that's also an opportunity.

One of the things that we found is that if you really get to know a state and if you really worked with a state that knows itself, there are tremendous assets that are unusual, unique, and every state can build on that you just didn't know about. And there's some really neat models of innovation that we're finding by going through the states.

And obviously, from a policy perspective, from a convening perspective, from a privacy perspective, regulatory purchasing, there are things that only states can do. So we must partner with the states and I think it's a – it's not without its challenges but it's got tremendous gains potentially.

MS. SAFRAN: One additional thought on that Mark, which is, you know, there's quite a number of states that have multi payer collaboratives for purposes of performance, measurement, public reporting, and so forth.

Those – most of us, I think would guess are the places that are most likely to be a good on ramp for testing some of what we're talking about because not only do they have the infrastructure to do the measurement and the reporting but they – because they're doing that, they probably have a healthcare deliveries system culture that's more ready to deal with some of the changes that we're discussing this afternoon.

MR. MCCLELLAN: And as we heard from Rick and Don who went out of their way to emphasize as the Center for Medicare and Medicaid Innovation and so it's hard to see how you get the Medicaid reforms evaluated and leading this effort without a lot of state leadership too. Can we have –

MR. MOSTASHARI: Sorry; I just want to underline something that Dana said either though in terms of the common theme; technical assistance to the states is also another critical thing not to – it's not enough to say, you know, partner with the states. We actually have to provide resources and best practices and convening and so forth.

MR. MCCLELLAN: Well we are about out of time. I'd like to thank this panel for their comments and a really simulating discussion. Obviously not the last word. I just want to make a few final comments here.

The feedback, the discussion from all of you here in the room has been terrific. And we also appreciate everybody who has joined us on the web. There are clearly some – some further work to be done.

We've had a lot of discussion today about the initial report and about some of the themes in it like having clear ends in mind and common metrics to get there like the importance of providing a way of bringing along a range of organizations, particularly some disruptive and nontraditional approaches to delivering care, like the importance of supporting information technology and other technical assistance and finding ways to make sure this works for particular consumers, individuals getting the kind of care that's best for their needs.

So there will be more coming from us on this. We intend to incorporate the ideas and points from this discussion as we revise that work into some subsequent papers and probably some subsequent events and activities related to these very important topics of healthcare innovation.

I also want to thank not just our panelists but the ETNA Foundation for their support. Jeff Kang and Al Dobson for the extra effort for their kick off presentations and a very hard working staff here at the Engelberg Center and at Brookings for bringing this together, Josh Feffer, Molly Chidester, Iris Chan, Sophie Shin, Aaron Wireder, Beth Rafferty, Mark Zezza, and especially, who put tremendous amount of effort into this meeting and bringing the different events and schedules and everything else together, Karen Matsuoka, who's a terrific effort on all of this. So thank you all very much for attending and I look forward to the next session.

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