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Quality Care for Less Money: Can Regional Successes Go National?
Kaiser Family Foundation
February 15, 2012

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[START RECORDING]

Penny Duckham: We are here today partly timed around a new PBS film which I think you know will be airing as from tomorrow evening on PBS stations nationwide, and that's the spur for this important event. I think any of you who are familiar at all with filmmaking would know that documentary filmmaking is not for the fainthearted, and certainly not if the focus is on health policy issues which may explain why there are there are rather few documentary films about health policy issues. For that, I just do want to commend Lisa Hartman for her grit and tenacity in getting this off the ground as the producer of the film, and Tom Reid, who we'll be hearing from shortly, who uses his typical spellbinding storytelling to bring to light some of the more complex and possibly arcane issues which many of you in Washington of course grapple with.

As you know, this film looks at some of the regional success stories or perceived success stories in providing affordable care and that's what we are really looking at today. Then we will be turning over. My colleague, Jackie Judd, will then moderate the panel which will discuss in more detail the challenges in actually making some of these policies play out in the field. Without any more to-do, I'm just going to turn over to Tom Reid and ask him to introduce the film. We'll then

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watch a short clip, and then Jackie will moderate the panel. Thank you.

TOM REID: Hi, everybody. Thank you for coming. I need to say, just as an American, I need to say thank you to the Kaiser Family Foundation. This outfit has done fabulous work in teaching Americans about healthcare, health policy, about the problems with our rotten health system, and some of the ways to fix it. Among the people that Kaiser has taught is me. I was just an ink-stained political reporter who got interest in health policy, and Penny and Kaiser took me under their wing and taught me health policy. It's been fabulous.

I think some of us may have met here two or three years ago in this very room when we were showing the first showing of a film where we went around the world and looked at healthcare and other rich democracies. What we were trying to show in that film, what the film showed, is that all the other countries like us — I mean by that advanced, high-tech, free market, wealthy democracies — all of them provide healthcare for everybody. On an average, they spend about half as much as we do in the process.

We made a movie about how these other countries managed to do it; came home. Once you make a movie for PBS, they show it over and over. People see it at 3:00 in the morning. In the grocery store, these insomniacs come up to me and say weren't you in Germany seeing a doctor? People started saying

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to me, you know, you didn't have to go around the world. You could have found really good, high quality healthcare at reasonable costs right here in the United States. I said no, no, that's completely wrong. I wrote a whole book saying that's wrong, so that couldn't be right. Then we came upon work of Dr. Jack Wennberg and Dr. Elliott Fisher at Dartmouth who have proven this. They of course wrote the Dartmouth Atlas of Healthcare, and on this atlas, Elliott Fisher pointed out to us communities where we can find really high quality healthcare at way below average cost.

We went around the country in this film to figure out how people do that. Is it true, and how do you do it? We're only going to show a short part of the film here, but the most striking thing was in all sorts of different models, we found doctors and hospitals who found a way to get costs controlled. Group Health in Seattle; it's 900 doctors, 25 clinics and the insurance company all under one roof. Well, they made it work.

Grand Junction, Colorado, is more like a typical American town. Eighty-eight independents medical practices, fee-for-service medicine, two competing hospitals; and yet, in that model, they made it work. We saw this in other models, too. That was pretty striking. We showed this movie recently to somebody, and a fellow came up to me and said I know the lesson of your movie; maybe you don't want to hear this inside the beltway, but the lesson is we don't have to wait for

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Washington to get control over costs in the United States because doctors and hospitals all over the country are doing it already.

Today, we're just going to show you a few minutes of this movie and then have a discussion about it. I just want to point out the unsung hero of making a movie is the producer. The producer has to do all this stuff. I'm the guy who gets to be onscreen, but my job is really pretty easy. Our producer, Lisa Hartman, did a fabulous job and one of the great things she did is she hired this sheer perfectionist, Rich Lerner, to be the cinematographer, the cameraman.

Here's what happens. You go someplace to film something like the Baker Library in Dartmouth, and Rich says to me, he says, "Tom, get out of here and come back in two hours." Then he completely transforms the place with lights and cables and microphones. After two hours of this, finally I'm allowed to come in and sit down and ask a question. I ask the first question, and this always happened. Rich said, "Oh, I'm sorry. I'm sorry. I'm sorry, Tom. It's not right." He goes, and he moves something about two centimeters and then says, "Okay, this is going to be okay."

I just mention this because we're just going to go quickly through this film, but I think what you'll see if you notice, every time we interview somebody, the background is beautiful. [Laughter] no, I'm serious. Take a look. Maybe

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nobody would notice this, but Rich Lerner did that. He shot a beautiful film, so take a look. Thank you.

[VIDEO PLAYED]

JACKIE JUDD: I'd like to my welcome and invite the panelists to come up. While they're getting settled, for the next hour or so, we're going to be talking about some of the issues that Tom teed up in his documentary. What is, for example, an accountable care organization, what are the chances and challenges of replicating these kinds of plans across the country, and what are some of the early lessons about what may have worked and what may not be working. Everyone's mics are on, I can hear.

MALE SPEAKER: At least we're making lots of noise [laughter].

JACKIE JUDD: I'll make some quick introductions. Much longer bios of each of our speakers is in the packet you received. Elliott Fisher who you will recognize from the documentary; Dr. Elliott Fisher is the director of the Dartmouth Atlas of Healthcare. Carol Beasley is the Director of Strategic Projects at the Institute for Healthcare Improvement. Mark McClellan — welcome, Mark — is the Director of the Engelberg Center for Healthcare Reform at Brookings and of course a former CMS Administrator. Sean Cavanaugh is the Acting Deputy Director of Programs and Policy at the Center for Medicare and Medicaid Innovation at CMS. Welcome to you all.

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Each of our guests will make some brief opening comments, and then we're going to open it up for questions from you and from me. Elliott?

DR. ELLIOTT FISHER: Great. Thank you very much. What fun to be here, and Tom, what fun. I'm a little nervous about the role, but anyway. There is an emerging consensus about the problems facing the US Healthcare System. Unaffordable costs, remarkably uneven quality, but I think the sense of crisis that we're feeling is in part because of what we saw in Tom's film. That is we recognize that there's a tremendous inefficiency in US Healthcare and that we're spending a lot of money on things that don't provide particular benefits to patients. There's some issues around prices as well as to whether those are reasonable everywhere.

Our research over the last 20 years, and we've handed some of it out, suggests that a lot of the waste as was pointed out in this film is in unnecessary hospital stays, unnecessary visits, things that can be fixed, that can be improved through the science of improvement that's rapidly evolving. When Dr. McClellan left Medicare I can't remember how many years ago; a few years ago, we decided to try to work together to think about how could we take some of the principles that he had already applied in the physician group practice demonstration to get some more generalizable approaches to healthcare reform. There were four principals that we came up with that we've

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listed in some of our articles, but they're really interesting in the context of looking at these four healthcare systems.

The first is one problem that we face is we're uncertain about what we're trying to achieve. Is it about the business of medicine, or is it about trying to improve the health of our populations? Clarity of aim becomes critically important, and it's now national federal policy under the secretary's quality framework for the United States that the aims of better health, better care, and lower cost, all three for patients and for communities. It's clear as you watch what those places are doing that they're trying to do that.

The second problem facing US Healthcare is that we're doing it. We're flying blind almost everywhere. We've done a little bit of comparison with the Dartmouth Atlas, but there's completely inadequate information to help patients understand their choices, to help providers understand what they're doing in their practices so they can improve their practices, or to help consumers make wise choices among hospitals, among health plans, and among other providers. The second principle that we agreed was critically important was we need much better information that engages consumers, engages patients to help them make wise choices and lets them compare providers.

Probably the most challenging problem facing American healthcare is the flawed conceptual model with under which most physicians are currently trained. We think that the way you

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produce health in American medicine is by face-to-face visits with doctors. The more face-to-face visits, the better off you are, especially if they're with specialists. If we look outside healthcare, what you see in industry is systems that are capable of improving and managing processes to make sure they're doing reliably what needs to be done.

The third principle that we both agreed upon when we started working together on the accountable care organization notion was we need organizations that will be accountable for those aims, striving toward those aims, and then rewarded in ways that allow them to redesign practice to improve care, to manage capacity, because we have a lot of unnecessary capacity in this system, and eliminate waste. Redesign care, eliminate waste, manage capacity through some kind of organizational structure that's capable of doing it.

The fourth principle that we saw as critically important was the financial incentives. We have financial incentives the reward that fragmentation. So we need to move toward incentives that start to think about how we're going to encourage docs to work together to coordinate care, to provide better care at lower cost, and be rewarded for doing so.

It is really telling looking at the four examples; Dartmouth Hitchcock was the one that was not named in the little clip where you saw Jim Weinstein, an orthopedic surgeon, examining a patient. All four of those systems are either

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already operating under payment models that reflect those four principals. They're all trying to improve care and lower cost. They're all trying to use information to improve the quality of care. They're all thinking like organizations that are capable of managing patients as populations and across time, and three of them are now participating under one of the shared savings or new payment models, and Grand Junction has been doing it for 20 years with their withhold for physicians.

I think we see in the movie the glimmers of the ways that healthcare reform now moving forward can start to improve US Healthcare, and I think we'll have a fun discussion about weather I've been smoking something the last five years [laughter] or maybe there is a possibility of change.

JACKIE JUDD: Carol?

CAROL BEASLEY: Great. Well, thank you very much. I'm so pleased and really honored to be here. I guess the perspective that I like to bring to complement the many things that we've learned from Elliott and his colleague's work through the Dartmouth Atlas is to bring a little bit of a field perspective. The Institute for Healthcare Improvement where I work was on of the early groups to formulate this notion of a three-part aim or a triple aim, that it was a new way for us to think about health system improvement, to consider health as part of the outcome, to consider per capita cost as part of our responsibility.

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We tended to put most of our emphasis in our early days into the quality of care and the experience of care corner of the triangle. Over the past five are six years, we've had extraordinary opportunity to work with about 100 organizations and systems around the world, and about 65 to 70 of those in the United States, in all sorts of places that are working on exactly what you see depicted in the documentary. So one of the questions that I suspect will come up for people is, is the only fertile ground for this west of the Mississippi, or [laughter] are there places where some of these ideas are being tried that would encompass the great variability and diversity of our country as a whole?

I would say to you the answer to that is yes. We have partners in New York City. We have partners in Washington, DC, and Montgomery County right next to you. We have partners in North Carolina, in rural North Carolina. We are partners in Memphis, Tennessee. We have partners in Flint, Michigan. We have partners in Wisconsin. We have partners all over the place who are a fairly self-selected group that are willing to look out into the future a little further perhaps than some, and who are taking action now to address the challenges that they see coming in the future, whether how big a role healthcare reform would play or not play was not even on the table when they started.

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They started because they could see that it was something that the country needed. We needed to do better on all three dimensions and they were willing to take a chance to try it out. They saw opportunities within their own systems. Some of these systems are very traditional-looking. They're pretty much integrated healthcare with the hospital and some office practices and maybe some outpatient surgeries and some nursing homes, and it's the usual kind of plain vanilla healthcare.

Some of them also have health plans associated with them. Some of them are health plans. Some of them are employers. Some of them are regional coalitions, sometimes very grassroots safety net based coalitions. So what we've been able to see is that there's a lot of will across the country in many, many, many places to try out ideas that the results of which would look very much like what you will see you when you see the full documentary.

When we think about change at IHI, we often think about three contributors to that: will, ideas and execution. I think that from where I sit having had the privilege of working in the field with a lot of these organizations, there's a lot more will than we might perceive there to be. There's will in red states and blue states, in rich places and poor places. There's a lot of will out there. What I think we're beginning to accomplish now is development of a set of ideas that can

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then be applied and adapted and embraced and improved upon, that are usable again across a variety of situations and settings.

Finally, I think this is the steepest climb, is how do you execute this stuff? Elliott made reference to using the science of improvement and really using rigorous improvement methodologies. I think we would say that probably the rate-limiting factor from where I sit is the capacity of systems to improve themselves. Having more supportive mechanisms for payment, having some regulatory tools available will help, but again, speaking from field experience here, I would say they're not sufficient in and of themselves to make the kind of changes that we need to make.

In the documentary you will see a lot of examples of medical practitioners learning, learning, learning relentlessly every day from their current performance, from the performance of their peers, from their patients. I think that is really the challenge that we collectively will need to embrace to make the Grand Junctions and the group healths and the wonderful organizations portrayed more the norm.

JACKIE JUDD: Thank you. Mark?

DR. MARK MCCLELLAN: Thanks. I just want to acknowledge the hard work that Elliott, Carol, the groups working with them have done to demonstrate how widely these kind of changes can be made around the country. Special thanks

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to Tom for bringing it out in such a clear way. I've never seen Dartmouth look better; definitely never seen Elliott look better [laughter]. It all seems to be coming together.

DR. ELLIOTT FISHER: The make-up guy was really good.

DR. MARK MCCLELLAN: That's right. I want to emphasize a point about alignment because this is hard work. The principles are clear. Just about every clinician in the practice, doctors, nurses, they want what's best for their patients. They want to avoid unnecessary costs. One of the big frustrations in medical practice today is that it can be really hard to do that.

One of the reasons you see so much variation here, and by the way, there are also a lot of variations in other countries, too, which see the same kind of relationships with some of the underlying financing and support is that we don't make it easy for doctors and nurses and health professionals and patients and employers working with them to do the right thing. We don't make it as easy as we could. I'd like to spend a few minutes talking about that.

One example of this came from that physician group practice demonstration that we started back in 2005 at CMS that Elliott mentioned where a number of physician groups and organizations including some represented here had come to CMS and said look, we're trying to do the right thing. We're trying to adopt electronic records to reduce duplicate services

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and get care well coordinated. We're trying to get out to our patients early about preventative proven treatments to head off diseases and complications before they happen. We're really trying to focus in on our patients with chronic diseases through nurse managers and other support staff like those that you see in the documentary to help them understand their illness better, to understand what they can do to prevent complications.

The problem is that we're getting killed. We're getting killed for two reasons. One is that none of those things I just described are paid for traditionally in Medicare or in any other health plan traditionally in the United States. Second is that to the extent that these things actually work, we get reimbursed less for the stuff that the health plans traditionally do pay for. An upshot of was what many of these organizations in the documentary had taken steps to accomplish earlier on and that was to get some alignment between their financing policies and the support, the regulations in their environment, and what they were trying to accomplish in care.

It doesn't necessarily mean you're not competing. It doesn't necessarily mean you need heavier kinds of regulation. It just means creating an environment that aligns what it is that physicians and other health professionals want; better care to lower cost with the way that health policies actually work. There were some examples of that that came up in the

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documentary and that Elliott has already mentioned, examples like paying on the basis of an episode of care and paying more when there are fewer complications, when the patient gets back to work sooner, when overall costs are lower and lower costs down the line, too.

Examples like accountable care organizations, examples like medical home payments that are also tied to some of these results in terms of better health and lower cost. This isn't necessarily easy for providers either. It does mean taking on some accountability for things that happen outside of those individual office visits. Taking accountability for some of these improvements that can happen with patients since resources are going to be tied to that, since that's what's gonna be part of the measurement. Not just being paid based on volume and intensity, but being paid based on better results.

There are lots of examples of these kinds of things happening around the country. There are also examples on the patient or the consumer side. One of the examples in Tom's documentary involved generic drugs, where giving providers information about use rates of generics led to some changes in their prescribing behavior. Well, health plans including Medicare Part D plans have also had some real success in doing that by, you know, here's an idea: letting the consumers save the money when they use the less expensive drug.

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Most traditional insurance plans, if you switch from a brand to a generic, you might save a little bit, but under a lot of the plans that are now more popular in part D, consumers get most of the savings and go from paying $70-80 a month to $1 in many part D plans. That's led to a huge shift in the use of generic among seniors.

If you think about where some health plans are headed now with other aspects of their benefit design, it's not just something as simple as high deductible healthcare, but giving people with chronic illnesses a chance to save more money when they go to providers that are getting better results at a lower cost, when they take steps to use proven effective treatments for their diabetes and other conditions more effectively. These kinds of value based insurance design approaches are reinforcing the changes that providers and consumers together would like to see to get to better healthcare and lower cost.

We are still a long way from solving these problems, and I think that's one reason you see so much of these variations persist here. Other countries, while they do have lower cost per capita, are also struggling with quality of care and efficiency issues in trying to move to systems there as well that get better alignment between our financing policies, our regulatory policies, and what it is that doctors and patients really want.

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I do want to emphasize the same point that Carol did, that very often, lack of evidence is a real problem here. My hope and expectation from seeing how some of these steps have worked is that if you provide a more supportive environment for doctors and patients to do the right thing, then you do tend to get better data. There are still more things that we can do to help get standard approaches to measuring quality, to help getting those measures out there in ways the patients can use in making decisions not just about brands versus generic drugs as they're using today, but also about which place is really best for them to go to for their elective surgical procedures, and maybe even for their care for their chronic diseases like diabetes. That's something where I think we all still have a ways to go.

I want to agree in the end with something that Tom said which is that the solutions here don't have to come from Washington. The leadership here really needs to come from people who know the most about where the opportunities are to improve care. That's the doctors, the nurses, the health professionals, and the patients who are working with them.

As we continue to have debates about fixing the SGR problems and so forth in the short term, I'm really looking for and hopeful about more clinical leadership, more leadership from out there in the world healthcare delivery to get this alignment to happen, to show that it can be done. We can get

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is to better care at lower cost. We can measure it, and we can redesign our payment systems, our benefits, the environment for medical practice so that these kinds of improvements in care, these kinds of really high value approaches to care delivery aren't just an accident to circumstance, something that people had to work hard to accomplish in isolation but really do become much more systematic part of our healthcare system.

JACKIE JUDD: Thank you. Sean?

SEAN CAVANAUGH: Thank you, and I want to thank Tom again for the documentary. I mean with all the brain power up here, we are consistently reminded ultimately, it's the storytellers who can really generate an impetus for change, and I think your work is part of that.

I wanted to back up just a second and go to the budget. If anybody's been to enough Kaiser events, you know we have a big federal deficit, and it's really driven by healthcare almost entirely. That's true. I used to work at the state level; it's true of all the states as well. So we've got that situation, and that's going to change. We will fix the deficit problems ultimately.

There's two paths to fixing the changes. We can fix it as a budget problem, and create more problems in the healthcare system, or we can fix the budget problems through improvement in the healthcare system and benefit both healthcare and the states and the federal government. That's the stark path that

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we're on, and I think some of the thinking behind a lot of the affordable care act provisions and the creation of the innovation center.

Actually, Mark, you credited Tom Reid, but I think it was actually one of the deranged people in the supermarket who had said that the solutions weren't gonna come from Washington, DC. And we're trying to proceed very much on that premise, which is we are not trying to drive change and define change, at least at the Innovation Center, from the Federal government. We're trying to find out where providers are and meet them where they are and help them get to where they're trying to go.

Your documentary and the work of Dr. Fisher has shown there's plenty of people who have either figured it out or are working on figure it out, want to figure it out. What they don't have is supportive payment systems that make a business case for them to pursue this. We're trying to create those. Again, an array of those business cases, depending on where they are and how they want to move forward.

Data; a lot of our models will involve intensive data sharing. Medicare claims data, which they haven't had previous access to, which speaks to what Elliott mentioned. Some change in expectations both within our models, our specific new payment and delivery system models, but more broadly, public reporting and accountability so you change the culture of what

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should we expect from the healthcare system. You'll see a lot of that out of CMS.

Again, the levers are many. CMS has some, and they're very powerful, but we need to align them with levers that other people are using. There's been a lot of focus. The innovation center has been blessed to be funded by $10 billion, and a lot of the people who come and meet with us talk about what we can do with you for part of the $10 billion [laughter], and our mantra has been forget the $10 billion. Think of the $800 billion. What do you want to do with the $800 billion differently than you're doing today that could benefit you and us?

It's a couple more zeros. It's big money. We have the ability to tweak how that goes out and test new payment models. Under the Affordable Care Act, if we prove a new payment and delivery system model works, the secretary can expand the scope of these demos and take them, in fact, to the national level. Those are the comments I wanted to make, and I look forward to the questions.

JACKIE JUDD: Thank you. Thank you all. Sean, the most interesting word in your title, I think, is innovation.

SEAN CAVANAUGH: Not acting [laughter]?

JACKIE JUDD: Maybe inside the beltway, acting would get it, but we do have a nationwide audience. We're webcasting. In any case, fill us in a little bit about the

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pioneer ACO models. What are the most interesting ideas you're seeing there? As I understand it, another $1 billion may be going out the door at the end of March with the innovation challenge grants. What kinds of projects are coming to your office?

SEAN CAVANAUGH: So first, thank you on the pioneer model. As you know, the Affordable Care Act created the Medicare Shared Savings Program which is creating accountable care organizations that, based on a lot of the work of people on this panel, the notion is groups of providers, doctors, hospitals, lots of configurations can come together and accept accountability for the costs and quality of a defined population of Medicare beneficiaries.

In doing so, if they drive both improvement in quality but also generate cost savings rather than, you know, tearing off their nose to spite their face, they will actually benefit. CMS will share some of those savings with them; so trying to create a viable business model for this form of improvement, that's a permanent feature of the Medicare program now.

At the Innovation Center we wanted to sort of turbo-charge that. We wanted to get out a little bit earlier with some of the leading organizations to really define — we're putting them at higher risk meaning if they generate savings, they get to keep a higher share of them; on the flip side, if they don't, they can generate greater losses — and really have

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a vanguard of these organizations show how much change is really possible and set the standard and also, learn some things so that as we learn things from the pioneer experience, we can gravitate those lessons into the permanent Medicare Shared Savings Program.

The second point you made was in keeping with our philosophy of not defining change from Washington, our most recent initiative, we announced what's called the Healthcare Innovation Challenge, where we sort of threw it out to the public and said here are our goals, which is improvement through cost reductions and quality improvements and creating a new, better workforce. You tell us how you'd like to do it. Come to us. We've got $1 billion to spend on these.

We've gotten an overwhelming response; it's been really incredible. We are at the point where the applications were due back at the end of January, and end of March, early April, we'll be announcing the first round of those.

JACKIE JUDD: Are you able to describe at all kind of the most hopeful idea you've seen?

SEAN CAVANAUGH: No for two reasons. One, they're going through a technical review now, so I haven't even seen them, and two, just federal contracting rules. We're not allowed to talk about the nature of these. This is all very rapid cycle. They will be public in the springtime, so it's not like waiting a year.

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JACKIE JUDD: We've heard so far a lot of different ideas for new models. Mark, is there one single definition that everyone agrees is a description of an accountable care organization, or are there lots of different projects under that big umbrella?

DR. MARK MCCLELLAN: Well, I don't know that there's a definition everyone agrees with. I think as Elliott pointed out, there are some key features that include this focus on better results at a lower cost measurably for a population of patients, and then the features of the care delivery drive getting to that. We're not focused on a specific doctor-hospital structure so much as we're focused on what works best in the particular community for getting those better results for patients.

There are some capabilities I think others have fleshed out that seem to go along well with that. I would just emphasize that the goal here, and Sean pointed this out, at least implicitly, I think, that the vast majority of healthcare providers in this country are not part of fully-integrated organizations. Yet there are still a lot of opportunities for them to coordinate care better, to work in many ways with primary care doctors who work the specialists or work with hospitals, and post-acute care providers; to take a more systematic and comprehensive accountability for getting better results for their patients.

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There are a lot of payment reforms that can help move in that direction. I would call all of those in some sense moving in the direction of accountable care. The accountable care organizations are kind of the most comprehensive approach to that where you've got an identifiable organization taking responsibility for getting better results and lower cost trends for a population of patients; being able to measure it, being able to deliver on it. I think those are the key features for

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JACKIE JUDD: In you're opening comments, you talked about the need for real evidence. Does this work in terms of saving money and delivering better care? How many years away are we from that point of knowing whether these new models work? What I'm getting at is are we at the beginning of the beginning?

DR. MARK MCCLELLAN: Well, hopefully, we're past the beginning of the beginning, and Elliott should comment on this, too. There are a number of organizations that have implemented these kinds of reforms and are doing well with them. As you've heard, some of the communities, or some of the groups in the documentary were already doing something like this. This notion of what they called in Grand Junction a withhold based on quality and cost, the money left over at the end of the year would go to the providers.

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That's the same idea of shared savings meaning you get paid more not when you do more procedures or have more complications, but when you get better results at a lower cost for your patience. It's not really about profits so much for these physician groups. They're barely making ends meet, but it they've got more resources they can spend on the stuff that really matters for patients like spending extra time with the ones who need it, like implementing electronic records or paying that nurse manager in a way that Medicare otherwise wouldn't reimburse.

I think there's plenty of evidence that these approaches can work. For some of the newer ACOs, like in Blue Cross of Massachusetts and some of the private plans like Cigna and Aetna that have implemented some of these steps already with physician groups, and some of the physician group practice demonstration programs, they're achieving at least one or two or more percent off spending growth per year.

If you look at those charts that Shawn alluded to with the budget, if we can bring down healthcare spending growth overall by a couple of percent per year, that would go a long way toward taking care of the longer term fiscal problems that we're facing. The evidence is emerging. I think not all these are gonna be successful, and hopefully we're going to be learning a lot more and more quickly about what's working and

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what's not, and how to help get this alignment and support providers in doing what's right.

JACKIE JUDD: Elliott.

DR. ELLIOTT FISHER: There are just two things I'd want to add. First, the early evidence from the alternative quality contract which is the ACO model in Massachusetts — global payment under fee-for-service a model with strong quality incentives — is very promising. They've shown that they can improve. They've all improved quality a lot. They are bending the cost curve, primarily initially by shifting patients from high-cost hospitals to other hospitals, but the interesting thing is that it's not only succeeding in those places that have adopted, but everybody else is wanting to join so that now 70-percent of the physicians, I think, in the Blue Cross network that are participating under Blue Cross of Massachusetts are choosing to join the alternative quality contract. People are speaking with their feet in trying to join this new payment model.

I think the second thing that I want to say is that we see incredible diversity in the kinds of organizations that are stepping forward to try to play under this new payment model. You know, Mark and I have been working with five sites around the country in the Brookings-Dartmouth pilots that started a few years ago to join with a private payer to pilot these models.

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They're very diverse systems, from a fully integrated delivery system in Carilion in Virginia out to Tucson Medical Center which is associated with a group of completely independent practitioners, and all of those across that diversity of models, you see people figuring out how to do this.

It is hard work to do the improvement work. They have to figure out how they're going to get a hold of the data. It took Grand Junction a few years to figure out how to put the data Systems in place and feed them back to the docs. I think we're beyond the beginning, but I think we have strong evidence that it could work, and we have to learn as quickly as we can how to make the models work even better.

We will have trouble as long as providers are in these complicated mixed models. It's very hard to do global payment for your Medicare population, and everybody else is fee-for-service, then you're going to have a hard time changing your organization.

JACKIE JUDD: I have a very basic question that I was left wondering about after watching Tom's documentary and hearing the four of you speak. That is how is quality defined? How is it measured, and who makes those decisions? How do we know that people in Grand Junction or Seattle, for example, are healthier for being a part of these new models?

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CAROL BEASLEY: Maybe I could take first crack at that. When we speak about quality, and we speak about the experience of care, we're really talking about two facets. One is those things that research tells us are best. We take our guidance from the institute of medicine, so is it safe? Is it effective? Is it patient-centered, timely, equitable and efficient? Is it all of those things that many of us have used as our North Star for some years since the Institute of Medicine released its influential report?

The other side of that is subjectively, how does it feel to me? Do I have access when think I need it? Do I get care from people that know something about me, that know something about my needs and preferences, that know something about my circumstances? We think about that in the experience corner, and what we're starting to see with some of our partners is that as the reliability of care gets better, so we have one of the parties we worked a lot we have and learned a lot from is Health Partners in Minneapolis, Minnesota, area.

They have really gotten their diabetic care to a highly reliable level. If you were a diabetic in their system, they're getting closer and closer to perfect reliability. What they can see is on those clinical measures, did we do all the stuff we were supposed to do? Yes. Increasingly, the answer to that is yes, we did everything. They can also see it in reduced heart attack rates. So their heart attack rates are

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down by two-thirds. Their amputations are down. There instances of blindness and retinopathy are down.

You can start to see the impact of that and things that actually matter to the health of patients. You saw some glimpses of that in the documentary where the gentleman from Boeing said it used to be in the high-risk pool, and I'm not anymore because I actually got my issues dealt with successfully so I'm not at that kind of high risk any longer.

Increasingly, we do find that there's a little bit of a difference in culture. The public health folks are used to talking about population health and burden of disease, and life expectancy, and healthy life expectancy, and quality-adjusted life years, and all of the sorts of measures that are not yet common currency. We don't yet have quite as much of a shared language as we need between the medical side and the public health side, but those measures do exist. To be able to bring forth both scientifically-validated practices that represent quality and the subjective experience of can I get care that meets my needs, and then something about what's your actual health status?

We have systems that are saying the health status of our collection of people, our population, is either stabilizing; it's not getting worse as people age and as they deal with their diseases, or in some cases, it's getting better. I think that we're in the early days of becoming very

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facile and very comfortable with those sets of measures, but the measures to exist and they are being used.

JACKIE JUDD: Sean, could you take that question? I mean just the other day on Kaiser Health News, there was an article about teaching hospitals objecting to some of the quality measures and whether they were truly representative, and told the whole story of what was going on in these institutions.

SEAN CAVANAUGH: Well, measurement of quality is complicated as defining the quality. As Carol said, we've — in the planner program, and in the ACO program generally — tried to follow a lot of those different things that the IOM has identified, and measure and care about many facets of quality.

You asked an earlier question, are we at the beginning of the beginning? In quality measurement, we're definitely not at the beginning of the beginning. We're worlds ahead of where we were 10 years ago, and I think it's going to just explode even further. I don't think we're where we're going to end up, but we're in a pretty good place, I think, and we're far ahead.

I used to work for the State of Maryland as a hospital regulator as recently as the late 90s, and we regulated the price of hospital care. The hospitals came in and used to say you should be measuring us on quality, too, and we'd all look around and start laughing because [laughter] we knew that was

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impossible, and it was sort of a smokescreen they were throwing up the. We didn't know what quality was.

Consider where we are today where first of all, the Maryland rate system does measure them on quality, and fairly sophisticated measures. I think we're in a pretty good place, but I also think measurement of quality is really going to explode.

JACKIE JUDD: I want to tackle two more issues before open it up to the audience. One has to do with the cultural impediments to forming the kinds of organizations we've been discussing. I was talking to a colleague a few days earlier preparing for this event, and she said doctors are cowboys. They don't want to be corralled; they don't want to be organized. So Carol, I would ask you what are the cultural issues that would make creating a grand junction in other parts of the country really hard?

CAROL BEASLEY: Well, I'm not sure that I've seen it be as hard as you might be suggesting. I think part of the reason for that, and it's well-depicted in the documentary, is that so much of what we're talking about really relies on fulfilling the potential of primary care to do a very great job at taking care of the whole person, anticipating their needs, dealing with them over time. I'm not sure that the cowboy label is fairly applied.

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The folks that we deal with day in and day out, many of them serve operating within primary care, but really across specialties, once they get the system to start performing in a way they really serves patients well, that really allows them to deliver the kind of care that they intended to deliver when they were growing up and decided to go into medicine, what we find is that this kind of work can lead to skyrocketing levels of what we at the institute would call joy in work.

There is an astounding consistency to what people say. It's like, oh, now I get to do the kind of medicine that I always wanted to do. Now I'm not all tied up in five-minute appointments that barely scratch the surface of the needs that I see before me.

JACKIE JUDD: Do you hear that from specialists?

CAROL BEASLEY: Yes, we do in the sense that a lot of specialty care — and we've worked a bit with some of the veterans' health organizations on this. Their experience was that a lot of stuff that was getting referred to specialty care was fairly simple stuff that really didn't need to go there.

One of the things they did that we thought was quite some innovative ways to pair up their primary care doctors with their specialists and really skill up the primary care doctors so that the more routine, more manageable issues wouldn't have to be referred in, and so that the specialists could do what

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the specialists do best which is take care of the really hairy complicated stuff.

I don't know that specialists get a great deal of gratification dealing with stuff that could have already been dealt with by somebody else in a simpler fashion. I do think that from the point of view of professional satisfaction and professional growth, there are some real upsides here.

JACKIE JUDD: Elliott?

DR. ELLIOTT FISHER: We had a social psychologist with us on our pilot site visits to the Brookings-Dartmouth ACO pilots, and one of the things she observed was among a group of completely autonomous cowboys out west in Tucson; they would've been happily labeled as cowboys. They were completely autonomous. They felt their identity was as individual practitioners, but what emerged was a shared identity of collaborating to improve care in the quality. So part of their shared identity was as independent practitioners trying to work together to improve the quality of care. It's very much what Carol says. I think there people want to do the right thing. They have not been in systems, whether payment or delivery systems, and that allow them to do so.

JACKIE JUDD: Mark, I want to talk about finances with you. There was a back and forth among three experts including Don Berwick and Tom Scully a while ago in the *Wall Street Journal* and they were debating what the cost is of launching an

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ACO, and the prices were from $10 million to $35 million. It was an impossible obstacle to get past for some solo practices, certainly, and for small group practices.

Why is it that expensive, number one, and what kind of impediments does that put in front of some providers? Does it give hospitals, for example, the leg up in forming ACOs?

DR. MARK MCCLELLAN: Well, no question that there is some investment required to do the kinds of changes that we've been talking about today. It means not only maybe investing in some IT equipment. By the way, a lot of those pilot sites got going with something far less than a fully integrated Electronic Medical record; just some basic capabilities online of tracking where patients with common illnesses were getting care and helping to make sure they were getting the best care.

It's not necessarily a huge amount of money, but it does take some time and effort for the providers would need to work together in new ways to get together to identify those opportunities for improvement, and then to implement the changes together to make it happen. No question, this is an investment.

Sources of paying for those investments can be some of the programs that Medicare and private insurers are implementing. That Blue Cross of Massachusetts program that Elliott mentioned included some significant upfront support, both financially for especially primary care practices and in-

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kind in terms of providing the kind of data that I was just describing that can help the practitioners know where they need to direct their efforts to reach the goals.

It can come from health plans. A number of hospitals are making investments in support for smaller groups. CMS has tried to start some programs that are more targeted to small physician practices, and I think those are good steps. I think there's probably more that can be done to align a lot of different programs that are out there now.

If you're a practitioner, if you're a physician in independent practice, you're reporting on a variety of quality measures. You've got an opportunity to participate in health IT payments. You've got an opportunity to participate in a range of other pilots as well as the MSSP program, and again more steps that can kind of align those in terms of the measures, in terms of the requirements and so forth are all going to be helpful as well.

It is work, that there are more opportunities coming for physicians to be able to overcome that, not just through working with hospitals, but through working with health plans, certainly private plans, and Medicare. A number of groups are getting some equity funding for their kinds of investments in these activities, too. There also are community-based programs.

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Lots of resources are out there, and this is a plug for some of the stuff that we do at Brookings and Dartmouth. We're trying to help physicians and other smaller clinical practices to see how they can take advantage of that to make these changes in their practice.

JACKIE JUDD: Okay, thank you. I'd like to open it up now to questions from all of you. There are two women on either side with microphones. Wait until the mic gets in your hand. Stand up, tell us who you are, what organization you represent, and what your question is. If any of you have a question for Tom, he will jump right back up at the podium. So somebody raise their hand. Right there.

BRETT ANDERSON: Brett Anderson, I'm actually part of Booz Allen and the new Health Care Delivery Science Program up at Dartmouth that Elliott's part of. The question is I guess for the entire panel. As we pull up from the PGP demo and we look at the results of those five or six years, it seemed as though there were some places like the University of Michigan that did very well. They achieved some shared savings throughout the entirety of the program. Others, like the Billings Clinic really didn't.

Then there are some kind of in the middle like Dartmouth-Hitchcock the did in some years, didn't in others. I'm wondering as you guys talked about really learning about what we see as success factors, are we also learning about what

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are the potential potholes that ACOs are also encountering and things that they should then avoid as they start up and try to achieve their shared savings?

JACKIE JUDD: Good question. Elliott, do you want to start?

DR. ELLIOTT FISHER: Well, I can speak directly to the Dartmouth issue since I've been part of some of the conversations inside Dartmouth-Hitchcock about why we stumbled. They believe it was a lack of attention to the consistently paying attention to the issues of chronic illness care. So they got a bunch of care managers. They put them in the primary care practices. They started to reorganize primary care practice, and then they got distracted.

The care managers started to pay attention to other things like filling out prescriptions for the docs who were busy and didn't want to pay attention to them and get distracted from the care management work. So I think focus was one of the things that one saw in that program. I think one of the questions that many people within the beltway have worried about with pilots is as soon as it's seen as a short-term initiative, that might go away and three years, there's not much reason to really make that substantial investment that may be required to make fundamental changes.

One of the things is making sure we try to align it so it's multiple initiatives that are lined up, and Dartmouth for

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themselves had just one payer who was the participating in this, and everybody else was fee-for-service.

The second is let's try to get a consistent long-term goal that people know they're going to be heading toward for a while, and not have them feel that the rug is going to get pulled out from under them if they start to make some changes. I think the variation across systems, we really do need much more of a case study. I would love to have 10 policy teams go in and say let's see if we can figure out why worked in this place.

The danger of what we're doing now is we're starting this experiment with lots of private payer ACOs and Medicare or the Medicare Shared Savings Program. As I understand it, Medicare's investment in the evaluation is going to focus only on the innovation center demonstrations, not on the Medicare Shared Savings Program. So we're missing the opportunity to learn from the private sector ACO activities, and we may not even learn a lot from the Medicare Shared Savings Program. We would be wise to invest in that learning so we can actually — instead of guesses and one anecdote about Dartmouth, we'd get a few more systematic points of data.

JACKIE JUDD: Carol?

CAROL BEASLEY: Not knowing the details of how each of the participating pilot organizations fared on that, I'd just make one comment about the design of this which is that it's a

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big challenge to learn quickly as you go, but a three year learning cycle to figure out if something worked or not is kind of a long time. One of the design ideas that we might take forward is to figure out how much could we learn in the first six months and the second, or even in the first month, in the second month, and the third so that our learning systems and our valuation systems are geared for faster detection of outcomes plus or minus.

I think one of the things that I've learned in doing improvement work at IHI, and I think that we teach others, is that sometimes a failed test teaches you a lot more than the successful one. The idea of looking at the failed tests I think is a crucial challenge and a vital activity to take on for the advancement towards the aims.

JACKIE JUDD: Is there a question on this side? Yes, up here in the third row.

PAUL COTTON: Hi, Paul Cotton with the National Committee for Quality Assurance. Excellent panel; I can't wait to see your full documentary. It looks awesome.

My question has to do with you had talked about how the payment systems haven't been really supporting delivery system reforms. We seem to have an opportunity now in that Congress is once again trying to do what they call the doc fix and reform the Medicare physician payment system. Is it time now

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for Congress to step up and ensure that there are rewards in the payment system for patient-centered medical homes and ACOs?

JACKIE JUDD: Mark?

DR. MARK MCCLELLAN: I think so, and I've been saying that for a while [laughter]. I had an opportunity to testify again this past year and the Energy and Commerce Committee on the SGR, and I went back and looked at my testimony from three years ago, five years ago, and sort of the same thing.

This is a tough problem because physicians are facing an urgent crisis. We can't have 20-, 30-percent reduction in payments happening as a cliff and expect there not to be any impact on access. There's not as much evidence as we'd like on how different kinds of payment systems for physicians would really impact longer term costs.

That said, based on a lot of the work that we and collaborators are doing, I think there are now far more examples around the country than there used to be of physicians getting paid differently and getting both demonstrably better results and savings. This applies not just in primary care where approaches like medical homes, I think by the way, importantly link to some accountability, so medical homes that involve more payments for IT systems and process of care are good, but if you really want to see an impact, the ones that have had a bigger effect have also had some accountability for

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actually using those tools to get to measurable improvements in patient outcomes, fewer complications and lower overall costs.

We've been a bit behind that the on the specialty side, but there are a lot of examples there, too. We were talking about specialist earlier. We've been working with some oncology practices around the country that, in traditional Medicare reimbursement, fee-for-service, them have the bulk of the practice revenues coming from the chemo and radiation services that they administer. They don't particularly like to be paid that way. They want to make sure that the patients get the appropriate treatments that they need, but they'd like to have more support for things like spending time with patients, going over a care plan and expectations, being able to manage patients more effectively outside the hospital, that they maybe head off an emergency room visit or an admission, things that we've talked about a primary care, and they're not reimbursed for specialists very well either.

Health plans like United are now implementing programs with some success that are changing that, that are tying payments more to what the oncologists say they want to be paid for, having some accountability for results, showing that the patients are getting more, not less evidence-based care and are having fewer complications. So, we may not have a solution for the whole country, but I mean something Congress could consider right now is at least opening up an opportunity for physicians

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who are moving into these new payment systems, that have a demonstrable impact on quality and cost, to have some reward and support for doing that rather than just doing and another simple extension of kicking the SGR can down the road.

If you look across the board, I mentioned oncology, but orthopedics, cardiology, nephrology, as well as primary care, there are lots of examples that I think are ripe to get that kind of support from payment reform.

DR. ELLIOTT FISHER: I can't take off my Dartmouth hat completely here. I think there's another policy prescription that ought to be thought about, which is that we ought to be thinking about withholds rather than cuts. The same thing that you can achieve through cuts, you can do through a withhold, except the withhold creates, just as it did in Grand Junction, an incentive for the docs to start thinking differently about how they're practicing.

I would also think it should be done at a global level so the withhold is from hospitals as well as from physicians, and it's at a regional level which gives them some encouragement to stop the local medical arms race which is bankrupting our children. John Skinner and Jim Weinstein and I wrote something in JAMA that I'd encourage you to take a look at. We ought to be talking about how to get the incentives lined up to get physicians and hospitals moving together, and this SGR is a perfect opportunity to start this conversations.

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JACKIE JUDD: There's the question over here, and until the mic gets to her, I wanted to ask a quick question of Sean, though you may be a little bit constrained in answering it. Maybe somebody else on the panel can. That is late next month, of course, the Supreme Court is going to have three days of hearings about the Affordable Care Act. What are your worries or hopes in terms of a ruling and how that may affect what's in the pipeline regarding the ACOs? Is there a plan B for example if the court strikes the law down?

SEAN CAVANAUGH: I will answer this extremely narrowly [laughter].

JACKIE JUDD: I thought you might.

SEAN CAVANAUGH: I'm not a lawyer. I know at least some of the challenges on a related to many of the payment and delivery system changes. The primary challenge is to the underlying mandate. We're supportive of the Affordable Care Act in its entirety, but I think we don't perceive the innovation center and the types of changes we're trying to make as a primary target.

JACKIE JUDD: Although some of the money is being funded through the ACA.

SEAN CAVANAUGH: Correct.

JACKIE JUDD: A lot of it.

SEAN CAVANAUGH: Yes.

JACKIE JUDD: So?

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SEAN CAVANAUGH: Right, so if it was struck down in its entirety, but again, I go back to my introductory remarks. You could take away the $10 billion. We still have the $800 billion.

JACKIE JUDD: Yes?

SEAN CAVANAUGH: Don't take away the $10 billion [laughter].

DR. JOANNE LYNN: Hi. I'm Joanne Lynn. I'm the Director of the Center for Elder Care and Advanced Illness at Altarum Institute. I was noticing a really interesting shift between the documentary and the conversation. The documentary was using almost all the term this community did whatever, and all kinds of good things. The conversation has been doctors, hospitals, and insurers can do X, Y or Z.

I wanted to call you back a little to thinking some about whether, at least for some populations, and at least for some of the things we need to tackle, that may be an unfortunate shift. As I go around the other countries, every other country has the local integrator that involves social services, hospital-type services, and supportive services of the medical type in the community.

I'm working mainly in elder care, so its people who are very, very sick. The fate of most of us as we get very old of having multiple conditions that include some social services issues and some Medical Services issues, and they're very

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expensive. We almost undercut the possibility of there being local action by our antitrust rules, by our concerns over competition, by the mental model Elliott was talking about, the mental model of face-to-face. There's also a mental model that underscores the cowboy approach in denigrates any collaborative work locally.

Yet, there's nothing more localizing than being very sick and old [laughter]. No one goes to Mayo for spoon feeding. You're actually tied to where you live. Should we deliberately try to enhance what the documentary was seeing this community action and at least try out the elbow room of giving the communities a little bit of rope to manage their own system, which would mean data that actually reflects population wellbeing and personal care plans and so forth that reflect a balance of what the community can provide and with the people really face as a community [interposing].

JACKIE JUDD: Carol, do you wanna take this?

CAROL BEASLEY: Yes.

JACKIE JUDD: Thank you.

CAROL BEASLEY: I'd be delighted. We've had the good fortune of having some great help from Joanne on some of the learning that we've been doing at the institute around regional approaches. It's true that you go into terra incognita because there aren't readymade institutions that generally are doing this work, that there are places where coalitions and

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collaboratives are coming together. One of them is right next to you in Montgomery County. There's a grassroots coalition that's come together to really serve under insured and uninsured individuals systemically that has medical care and social care and all sorts of stuff stitched together in a kind of resourceful, scrappy kind of way.

We're doing some work in Central Michigan in a dozen or so counties centered on Saginaw, Michigan, and really, the catalyst for a lot of that has been one of the big employers in the area, Dow Chemical. This collaboration includes the health system and the public health system, the mental health system, and the businesses and the insurers.

One of the things that they're interested in and one of the things that motivates them to come together across sectors is the feeling that in Michigan, they're striving for an economy that has enough vitality and enough health in it that the kids who grow up there up there could possibly stay and have a life, and to prevent or avoid the fate where health care takes so much of the wealth of the community that other opportunities are impaired.

We see similar work going on in Memphis where there's a great deal of interest in catalyzing the faith community to be an active part of health promotion and to really be detecting health problems out of the community long before the healthcare system may even be aware of them. So we are seeing some of

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these, but I think Joanne's point is good. We don't have readymade institutions. There is some experimentation going on here, but there's a long way to go to really learn what it's going to take.

DR. MARK MCCLELLAN: Can I just say a couple of hopefully quick things about this? One is there are, as Carol said, some community-level examples, and it's kind of interesting to watch how they've evolved. One I'll give is the Indiana Health information exchange which started out as one of the leading early efforts to share data across different healthcare providers. They found that model was very difficult to sustain financially for all the reasons that we've talked about before, so they're now funded in part by the same shared-savings approach.

They have now a multiplayer payment system in place that includes Medicare as well as Wellpoint and Medicaid and the state employees' program where they are getting paid in part for improving outcomes at the community level for a wide range of patients and a wide range of conditions, heart disease, diabetes and so forth. That's helped. It hasn't solved. It has helped with their problem of sustainability, and they're not just about IT anymore. It's really evolved into more of an effort to identify the biggest gaps in public health at the community level.

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They've had some particular problems in diabetes and getting patients with diabetes into just basic coordinated care that they focused on in the short term. It seems to be making a difference. I also wanted, as Joanne well knows, when we talk about problems of coordination and quality, the biggest problems are not with only the patients with diabetes. Although those are significant problems, the patients who have multiple chronic conditions and are frail, I think there's a fragmentation problem when you care for diabetes. Someone who is dually eligible for Medicare and Medicaid and is not only in fee-for-service or fragmented payment systems, but actually different payment systems, they do not coordinate well.

It is a horrible set of quality of care problems for these patients. For those of you who've cared for a parent who's going through Alzheimer's and the different conditions that go along with it, you know this. Nobody is there, not nearly enough is there to help you and help them get the care that they need which is often just about supporting good quality of life, that basic stuff then Joanne was mentioning.

It's not high-tech, but it's not being done very well in our care system. This goes back to an earlier discussion we had about the quality measures, and I do think we have some real gaps there still. One of them is in this area of risk adjustment. Some of the providers that have perhaps a more significant share of high-risk refers patients feel like aren't

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adequately addressed and in some of our administrative data systems now. Hopefully, we'll keep making progress on that.

Another problem is just having the measures of quality that patients really care about. One of the biggest gaps in those areas is for these patients with frailty where even though we're making progress on ACO implementation and the like, and there's some good measures included in the pioneer program and the MSSP program, we don't have great measures for particularly this kind of patient population. We don't have good measures for do you have a plan of care in place? Is it being followed? Are you getting care that you want? Those kinds of things are very important obstacles to making more progress on high quality of low-cost so the public can have confidence in them.

JACKIE JUDD: Is there a question over here? John.

JOHN DONNELLY: My name is John Donnelly, and I want to identify myself actually through Tom. We are members of the same Kaiser Journalism Fellowship Class of 2007-2008 [interposing] yes, sorry. Under the artful direction of Penny Duckham which we are eternally grateful for. I'm so happy, Tom, to see that your book and your film from that year also led to the film here today, is that right? So that's a pretty amazing follow-up on the Kaiser Fellowship.

My question obviously is to you, Tom. You talked about in the film, the four different cases that were quite different

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to show that there's all this innovation happening around the country. I'm interested in commonalities if you saw anything. The commonalities of the instigators, of the catalysts, the people who really got these things going. I wonder if that kind of approach, any kind of approach, should actually target this group of people or maybe it's a combination. Maybe it's a community that has many different players working to the same goal, but I wonder if looking at the communities as you are saying is a way to advance this at a quicker rate?

JACKIE JUDD: Tom, do you wanna go back up to the podium? While you do, I did want to recognize someone in the audience. Barbara Trehearne from Group Health in Seattle is here and may want to make a few comments after Tom. Go ahead.

TOM REID: Got it. We asked everybody. If you see our movie, you'll see we asked everybody how do you do this? What does it take? Elliott telegraphed it at that the beginning of the movie. We just saw him; he said there are doctors who've decided that they not only have to worry about the physical health of their patients, but also the fiscal health of their communities.

Regardless of the system or the structure or the size of the city, east, west, north, or south, we found docs who actually said that to us. I cost too much, and I've got to get costs down. We went to a hospital; I love this. We went to

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the hospital in Everett, Washington, the Providence Hospital. It was the Sisters of Providence who started it.

They walked across the continent from Montreal to Puget Sound and opened a bunch of hospitals driven by the mission to care for the needy people in those communities, and 110 years later, I'm in the lobby of the Providence Hospital talking to this 44-year-old Jewish man who's the CEO of the hospital and he says I've got to keep my costs down because I have to care for the neediest people in my community.

He still had that mission. I think that was common. Everywhere we went was a sense of obligation to worry about costs as well as quality and access. Then the other thing is everybody agreed on this. Every town I went to, they said you've got to have a leader. You take these doctors in Grand Junction, Colorado. They make probably 15- to 20-percent less than a doctor in the same specialty and some other city in Colorado or across the border in Utah.

Why do you do that? Well, Dr. Herb made us do it. There's a leader in that community, and he said you want to practice medicine here, you're welcome. It's a great place to live, and by the way, we're going to withhold 20-percent of your fee and pay it to you if you're doing good work. The leader kind of required it, so it takes a sense of commitment to the community. We found that in common everywhere, and we found everywhere a leader who was driving the sense.

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JACKIE JUDD: Tom, I'm not sure about the research you did ahead of time, you and Lisa I should say, but did you talk to hospital officials who said this isn't for me, this isn't for us, this isn't right for our community, and what were their reasons?

TOM REID: They make more if they'd don't keep their costs down. Here's the deal —

JACKIE JUDD: My guess is they would also say to you I care about my patients. I care about costs.

TOM REID: But I can't get costs down, you mean? The thing is we focused on the good news in American healthcare. I almost thought that title was ironic, *U.S. Health Care: The Good News*, but there is good news in US healthcare. It's in our film, but there's also bad news. There are counties, there are referral regions that cost way more to treat the same ailment as Grand Junction or Seattle.

We didn't go to the bad guys. The original plan would be go to see some low-cost places and see some high-cost places and see what the difference is. I think there were probably two reasons we didn't. We ran out of time. If you do a movie on PBS, it's an hour-long movie, but they come on at the beginning and say PBS is great; please send money. Then at the end they say wasn't this a great movie? Please send more money [laughter].

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We get 52 or 53 minutes. We ran out of time, and we also ran out of money. We didn't have enough money to go to all the places we might've gone too, so we just focused on the good news. We had a showing like this in Manhattan a couple weeks ago, and a guy from a very notoriously high cost hospital in Manhattan was there. He said this movie should never be shown on TV. It's outrageous. The very idea, that the things those other towns are doing I could do in this very, very difficult setting of healthcare in Manhattan Island, New York, New York.

It's just too hard, and I think that's the general attitude. Gee, that's really interesting that these innovators have seen these ideas, but we couldn't make it work here. It's too hard. My argument is we could. They could do it. New York could do it if they had that sense of community and a leader to drive them as we found in the other communities.

JACKIE JUDD: Thank you. Is there a question on this side towards the back there?

SEAN CAVANAUGH: Can I just supplement that? There is a New York institution that has probably the most poverty-ridden, disease-ridden population in the country, in the Bronx, that thinks they can do it. They're in a pioneer ACO.

DR. ELLIOTT FISHER: I was just going to —

CAROL BEASLEY: [Interposing] New York City Health and Hospitals Corporation, the public system has been very, very

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active in this. So again, I think it is a little risky to just kind of imply that a worse regional result means that everybody in the region is out of touch and not doing their job. Often there are really great bright spots, even in a region that has high cost.

JACKIE JUDD: Well, it gets to an issue that Penny and I were talking about with Elliott last week. That is cynicism from many different sources and the worry, the legitimate worry I think, that this is the latest thing. This is, I read somewhere HMO in drag [laughter], that ACOs are HMO in drag is what I read from one critic or one skeptic. That has to serve and then another impediment in developing these models.

DR. ELLIOTT FISHER: It's really important that people understand the differences between the old HMOs and the new ACOs. The old model was put all the risk on the docs. The new model is shared risk and thoughtful actuarial models. The old model was no quality measurement. The new model is quality measurement.

JACKIE JUDD: And patients have more flexibility.

DR. ELLIOTT FISHER: The old model was lock them in. The new one is choice. It's a very different approach with the underlying principles said let's try to improve care and achieve lower costs the same.

JACKIE JUDD: Yes?

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FEMALE SPEAKER 2: Yes, I just wanted to mention that in listening to you, it strikes me how much electronic health records and information technology is just sort of the backbone of this.

JACKIE JUDD: Can you hold it a little closer?

FEMALE SPEAKER 2: I'd like to hear the panelists describe your impressions of have we made the adequate advancement? Are there standards out there, and will this be a hindrance to making these initiatives move forward in terms of widespread IT adoption and standardized practices in terms of quality?

JACKIE JUDD: Mark and Sean, do you want to take that?

DR. MARK MCCLELLAN: I guess I've got mixed views, and my emphasis would be that health IT is an enabler. It's a tool that can be used to help support these goals along with a whole lot of other necessary steps like spending the time, like looking at the practice and looking at the opportunities for improvement. IT can obviously help provide the data and the timely information to impact all of that. I wouldn't get too hung up on IT for its own sake.

As I mentioned, some of the groups that we've worked with and been able to make a good deal of progress with something for less than a fully integrated electronic record. I think what a number of our pilot sites have done is taken a step-wise approach to this where they take some investments in

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improving IT, and then make some more the next year, and some more the next year. The key thing with each of the steps is they're tied to some specific goals that go beyond IT for its own sake.

We have a problem in delivering care to diabetics or in coordinating care for patients with heart failure or in some aspect of our preventive services. The foremost focus is on solving those problems, and IT is part of the strategy to get there. I do think that the IT investments so far are making a difference. It's clearly been a lot more take-up in the last couple of years in conjunction with the meaningful use regulations.

I guess I'm still concerned that even with more take-up, there's still a lot of limitations on the ability of those systems to communicate in a timely way across different providers. Within providers, they're clearly better, but a lot of the problems that we're facing are between the specialist working with the primary care doctors, each of them working with the hospital, all of them working with the community-based providers that are delivering long-term and supportive services. I don't know that we've solved those problems with the IT systems that are on the shelf right now.

JACKIE JUDD: Okay. Barbara Trehearne in the front row, do you want to say a few words about the experience of group health in Seattle? I hope I'm not putting you on the

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spot. A mic will come down to the first row here. I hope I pronounced your last name correctly.

BARBARA TREHEARNE: The only thing I would say is this notion of community and leadership in the organization, and two things; one, our medical director, Dr. Michael Soman, who is in the film was really our champion for the medical home model. Initially a lot of us said yeah, sure. He persisted and we all persisted together and successfully implemented across 25 primary care clinics this model, but more importantly, have used a lot of lean methodology to really focus on the continuous improvement.

This notion of really sticking with it month after month, really looking at our measures and our metrics and being able to say are they telling us what we need an to know, and are they giving us the information? Are our providers getting the information that they need in order to make their own improvement at the individual level as well as at their local clinic level and then beyond? So the leadership component is important.

The other thing I think that's really important is not just community within the organization and outside the organization, but it is really the spirit of pioneering. I was saying earlier to someone that we're our own worst critics. We constantly look at ourselves and say oh, we're not good enough.

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We really have to be better. So there's something about the sense of pioneering.

We were formed over 60-some years ago actually by people in the community who came together because healthcare costs too much in our community. Our original physicians who joined the organization were actually outlawed in our community by the medical organizations and were thrown out and all of that. So we come from a strong sense of a pioneering spirit that has really persisted, but people who come to the organization I think get a pretty clear message about what that really means.

It permeates the environment and I think it makes it a huge difference. I think the ability to have the data that does tell us that we are doing a better job for our patients, not just at the individual level, but at the population-based level as well.

JACKIE JUDD: Okay. We're gonna have to wrap up in a moment. I want to give the final word to Mark McClellan.

MARK MCCLELLAN: I'm not sure [interposing]

JACKIE JUDD: Well, here's the question. What I want to ask is hope and expectation are very different things. What is your expectation about what you will be able to say about everything we've been discussing today in three years?

MARK MCCLELLAN: I think that we're gonna see a lot more progress. I'm reasonably optimistic, and part of that

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stems from pessimism you were talking about earlier, some of the lack of evidence of these systems working and the like. The pressure to find a better alternative is just going to keep increasing. What I've seen over the last few years is a lot more physicians versus healthcare providers, employers stepping up to take on some of these challenges because they see the alternative approaches aren't working.

You can kind of see that happening more with the current SGR debate where if we don't solve these problems, the fiscal pressures are not going to go away. There are going to be more squeezes down on prices. There are going to be more problems with access potentially across the board, certainly for more vulnerable patients, but affecting everybody. There are these big gaps in the quality of care that patients are getting. There's a big gap between the care that many providers would like to deliver and what they feel like they're able to deliver in the current system.

With an era that should be headed towards much more personalized medicine, much more of a prevention orientation, that's where science is taking us, these kinds of reforms really have the across-the-board momentum behind them, fiscal momentum, technological momentum, and they're in line with what providers and patients really want. It won't be easy. There will be a lot of stumbles along the way. I'm sorry to tell you, Sean, but a lot of these pioneers and pilots are probably

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not going to work [laughter], but compared to a few years ago, we've made a lot of progress, and I think a few years from now, we'll hopefully see a lot more.

JACKIE JUDD: Okay. Thank you so much. Thanks to all of the panelists. I also want to thank Tom Reid, Lisa Hartman. I think everyone can stay if any of you have some additional questions. Most of all, I want to thank my colleague, Penny Duckham, for putting together what I think was a really terrific event and conversation. Thank you [applause].

[END RECORDING]

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