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PANEL II: PERFORMANCE MEASUREMENT FOR OLDER ADULTS:

Moderator:

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Panelists:

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PROCEEDINGS

DR. TALLON: Ladies and gentlemen, if -- one of the things that you all note in the program is that there is not a break scheduled. For those for whom that becomes a biological necessity, do it quietly.

SPEAKER: And outside the room.

DR. TALLON: And outside the room, right. And everyone standing in the middle, you're moving in the right direction. Thank you very much.

What the devil is this session doing in the middle of this? We have just had this wonderfully focused and clarifying conversation that says we know exactly what we're going to do, so let’s have a conversation about how to measure it.

We’ve just had a conversation that said, we’re sort of trying to figure out what to do, and we’re going to have a discussion about how to measure it. And I want to compliment the sponsors because I think actually with this session, the sponsors and the organizers have kind of nailed a critical question because the one central issue in measurement is, what are we measuring and how are we going to do it? And, therefore, measurement becomes the vehicle by which we have to focus the conversation and be wholly respectful of the conversation we just had, it is where we are, but also candidly, if we evolve the first conversation but we have not accompanied it with a discussion about how we measure what we’re doing, we will then, I assure you, all be at the point ten years from now when we will have this conversation about measurement and we’ll be starting in a place that has allowed different definitions and everything else to develop.

This is a lesson that I learned 10, 11, 12 years ago doing an assignment to design and create the National Quality Forum. I got a call from Chris Jennings in the White House. My administrative assistant said he’ll get back to you. And I said, you know, Chris -- incidentally, I’m Jim Tallon. You know that from the program, United Hospital Fund of New York. We are a policy shop, long-time service in New York City, a small philanthropy and policy shop, and we focus on family care giving and Medicaid among any number of other things. I said, Chris, why’d you call me? He said because you’re outside the Beltway, because you kind of understand this but you haven’t created a profile where you’re in anyone’s camp, and, most importantly, you’re politically smart enough to fall on your sword when this whole thing blows up, and nobody in this building will have to fall on their sword.

But in that effort, in thinking through NQF -- and I will only take responsibility for the early stages of getting it started, it has matured, my judgment is it’s matured well, others will take their own opinions -- we sort of came to this question of how do you think about what is being measured and in the simplest sense -- you’ll see from my bio I’m a recovering politician and a practicing policy wonk -- it was essentially that we had to think about internal measurement, counting something that was relevant to the people who were central to the care transaction.

And then we also had to think about measurement that was relevant to those who might be external to the care transaction, those who might be paying, those who might be monitoring, those who might be determining public policy, and you had to essentially try to figure it out so that it was one system and not two competing systems. And that was the challenge for me a decade ago.

I haven't figured any of it out, but at least it suggests I thought a little bit about the topic that we are facing, and I think that this is right at the core question: how do we think about moving this discussion forward in a way that we really do create a central measurement framework? And we have three wonderful panelists from different perspectives to explore this question, three physicians, my friend and colleague Diane Meier, whose roots and base are in New York City, certainly a national leader, the director of the Center to Advance Palliative Care -- you have the biographies. Someone who has been a distinguished leader and recognized for her leadership, Julie Bynum, assistant professor of internal medicine at Dartmouth Medical School and at the Dartmouth Institute for Health Policy and Clinical Practice surely understanding from the roots that Julie brings and her colleagues important aspects of measurement. And Gregory Pawlson, Dr. Gregory Pawlson, again, with a distinguished background, but now at NCQA where he really has had -- (Laughter)

MR. PAWLSON: It's okay.

DR. TALLON: Well, that's a step up.

MR. PAULSON: A recovering academic is the way I phrase it.

DR. TALLON: That's good -- where his roots are, you know, deeply involved with HEDIS measurement and the like.

So, three great perspectives, they are differing perspectives. I think they're all basically addressing this question -- how do we get measurement into the center of this conversation? And we are not starting with a template. We are starting with some fresh thinking. And one of them, it starts with Diane. I'm going to go to Diane to kick it off.

DR. MEIER: Thank you very much, Jim. It's an honor and a pleasure to be here and I want to thank my many partners in the work that --

DR. TALLON: Do we have a mic?

DR. MEIER: Can you hear me?

MR. PAWLSON: Put it up a little higher.

DR. MEIER: Higher? How's that?

MR. PAWLSON: That's much better.

DR. MEIER: I want to thank my partners without whom none of the work we've done in palliative care in the last 10 years would have been possible.

And like Chad, I am also a health and aging policy fellow this year and my placement is actually on the Hill, on the Senate HELP Committee, so let me say that I am not speaking for the Senate or the Senate HELP Committee or Tom Harkin, but only for myself today. It's been an interesting time to be on the Hill the last couple weeks.

My remarks are going to focus because both the limitations of time and because I think focus will give us an example that can apply more broadly, and my remarks are going to focus on the cognitively impaired in nursing homes, that component of the long term care continuum.

It is pretty well known that there are very high levels of misery in nursing homes, particularly among patients with cognitive impairment, who, once they get to a nursing home remain there for the rest of their lives. Much of this misery is iatrogenic. It is due to how we pay for health care. It is due to how we regulate and measure the quality of health care. And it is due to how we train or do not train the workforce that takes care of these patients. Some of it is endogenous to the situation these patients find themselves in, but much of it is fixable by how we deliver care.

Secondly I would argue that much of the misery, not only in that patient population, but in others, is remediable through improving access to high quality palliative care which has been shown in virtually every setting in which it's been studied -- outpatient, nursing home, hospital, community -- to dramatically improve quality and to reduce cost by reducing churn, essentially. And then I'm going to try to very briefly list what I think the steps are that are necessary to accomplish that goal.

So, who is the nursing home population with advanced dementia? They are in that very high cost, high risk group, that relatively small number that drive highly disproportionate costs. About 60 percent of advanced dementia patients admitted to a nursing home are dead within two to three years of their admission. This is a mortality rate that is equal to or higher than that of most advanced cancers.

So, we don't tend to think of this patient population as terminally ill, but it is.

The satisfaction level with care in that setting is the worst of any care setting in the health care continuum. Joan Teno's data looking at family satisfaction with the last place of care comparing patients who died in hospitals, patients who died in hospice, patients who died in nursing homes -- actually, nursing homes and hospitals were neck-in-neck for the worst place to die, but in many respects nursing homes were found by families to be worse in terms of the caring, the continuity, the human compassion, that families were looking for that they said they did not receive, not only from physicians, but also from other health professionals.

There's a very high prevalence of churn in this patient population, in and out of hospitals which again is driven entirely by how we regulate and pay for health care for these patients. And there's a very high prevalence of treatable and preventable pain and other sources of suffering. Four percent of these patients have daily pain that is described as excruciating. This is clearly unconscionable and neither necessary nor tolerable.

So, I've described a system that needs improvement. Let's begin by saying what do patients and families in this setting want? Does this quality of care I've described meet their goals? And the answer, of course, is no, it doesn't. And there are a number of studies that show that what residents in this setting, those who are able to communicate, and their family members, their surrogate decision makers who are able to communicate, say they want is -- they don't say they want maximum life prolongation. They don't say they want cure of dementia. They're much more realistic than we are as providers. What they want is recognition of the personhood of the resident even though they are cognitively impaired. They want attentive and loving personal care. They want continuity of that attentive and loving personal care. They want more time and attention from doctors. And they want consistent, caring relationships.

We're not measuring those things, we're not paying for those things, we're not rewarding those things.

So, what is palliative care and how would it better address the goals matching the treatment that these residents get to their goals as families? It has three domains. Basically palliative care is health care focused on relief of suffering and support for best possible quality of life for people with serious and advanced illness. It is not prognosis driven. You do not have to be within six months of death or three months of death or a year of death to benefit from palliative care. You have to have need for it, not be labeled as dying.

So the three components of palliative care, one is assessment and treatment of pain and other symptoms. The second is attention to transitions of care and continuity across those transitions. And the third is communication and relationship, and finding out who this patient is, who this family is, what it is they're trying to accomplish, what their hopes are, and then making sure that the treatments that are in place actually match the goals.

Why isn't this happening already? First of all, the financial incentives faced by hospitals and nursing homes reward hospitalization, reward churn, because each time the patient comes back to the nursing home they're back on the acute care benefit for 100 days, 120 days, and they get paid a lot more when the patient's on the acute benefit than on the long term benefit. Secondly, the regulatory incentives in nursing homes, even with MDS 3.0, view the normal progression of chronic debilitating cognitive impairment as measures of poor quality.

So, the normal progression is people become more functionally impaired. The normal progression is, people refuse to eat and drink, because that is the natural progression of brain failure and dementia. Each of those things is viewed as a measure that the nursing home is not delivering good quality care.

So, what does the nursing home do? It responds to those regulatory and payment incentives, it sends the patient to the hospital for a feeding tube. And so the system is perfectly designed to get these results, it's how we pay for it, so that's what people do.

And then last, and I think critically -- and as mentioned by my colleagues on the prior panel, is workforce. Doesn't matter how we change the regulations, it doesn't matter how we change the payment. If the workforce is still trained to do what it's been doing, nothing is going to change and so it is critical that there are policy requirements that say you can't work in a nursing home unless you demonstrate competencies -- in geriatrics, in palliative care -- and we're going to measure the performance of nursing homes based on delivery of care that's concordant with that type of quality.

So, I would argue that if we can agree that the goal in the long term care setting and in all settings, for that matter, is to match the treatment, the quality measures, the regulation, and the payment to patient and family-centered goals. Hopefully we all agree with that.

How do we do that? Well, in the nursing home we ought to mandate that every admission goes through a process called the Physician Orders For Life Sustaining Treatment or Medical Orders For Life Sustaining Treatment -- the POLST or the MOLST -- which basically says to patients and their surrogates, what are your goals here? Is your goal -- do you want to go to the hospital if you develop another pneumonia? If you get to the hospital, do you want to receive antibiotics? Do you want to receive intensive care unit care? Do you want to be on a ventilator? Do you want to have a feeding tube? Do you want to have CPR? And there's no judgment in that question. You could say yes to all of those things and then when you got your next pneumonia and you needed a ventilator in an ICU, you would get it, but what we would measure is how concordant the care delivered was with what was said up front in terms of goals.

Most nursing home residents and their residents do not endorse that full range of goals when they're admitted to a nursing home. Most wish to avoid the hospital. Most wish to remain at home, which in this case is the nursing home, with familiar care providers, but if they do endorse those goals, they'll receive that care and we won't be measuring what care they got, we'll be measuring whether the care was concordant with what they said they wanted. We don't do that right now. Even MDS 3.0 does not do that and that's, you know, the first chance we've had in ten years to change how nursing home quality and regulation has changed.

Secondly, we should be measuring and rewarding continuity of relationship in nursing homes. The churn and turnover of nursing home staff is about 100 percent per year in most studies that have looked at it. Nursing homes should be rewarded for retention and consistency of relationships, so that there are families caking care of residents in nursing homes, not faceless strangers turning over every month or two, as there are in many places today.

Thirdly, nursing homes should be regulated and paid based on demonstrable training and competencies of their aides, their nurses and their physicians in geriatrics, in palliative medicine -- because those are the needs of the patient population. And if they don't train their staff and demonstrate competencies, there should b financial punishments for that. And, again, this is a policy fix. There's no other way to do it.

And, lastly, I think payment should be matched to the degree to which care is concordant with patient- and family-determined goals. That is, if we send somebody to the hospital and they end up in the ICU, and their prior express wishes said they didn't want that, there should be strong financial disincentives for doing that.

That's how we drive a patient- and family-centered health care system.

And while I selected my remarks today to focus on this extremely vulnerable, cognitively-impaired population in nursing homes, I think the same principles apply across the entire long-term care continuum.

DR. TALLON: And Diane, let me just -- I may just follow up a bit on these. You've offered us, conceptually -- and why I knew this was going to be an interesting presentation -- conceptually a very different look, because the logic of the statement that I think you just made is if I want that ICU treatment, then the frequency with which I go to the ICU could conceivably be a positive measure.

DR. MEIER: That's correct.

I mean, my argument is that if we start with what patients and families say they want, and measure the degree to which care honors that -- and obviously, we can't be 100 percent perfect -- then we're starting with the object of all this spending: the patient and the family. And that's where we should be starting.

DR. TALLON: And to take it the step further, then, that conceivable could create a very different financial profile in our care of patients who clinically would look alike.

DR. MEIER: Exactly.

DR. TALLON: Live with it and enjoy it -- right? That's the right thing to do.

Good. Good Start.

Julie? Would you take us in a -- in your direction.

DR. BYNUM: Which is likely to be different.

MR. TALLON: That's the set-up here. I mean, this is -- we're entering into this conversation, and thinking some new things.

DR. BYNUM: So, I'd first like to thank the people who invited me here, because this is a real honor for me and most of, or many of, the mentors who have led my career forward are actually in the room. And that's a really wonderful thing for me.

I'd like to thank Diane, because you actually raised some very important specific things of what to measure that are actually in some of my grants that I'm intending to try to learn how to measure as part of my research career.

But I would like to spend a little bit of time talking about is not necessarily performance measurement from the perspective of what to measure, but in whom to measure is really the key I would like to turn a little bit more.

And I'll make some comments that feed into the idea of the accountable care organization -- why that idea, from my perspective arose, a particular model that gives us some insights into that potential success of an ACO or its lack thereof. And then close with how I think performance measurement, thought about broadly, can influence change -- organizational change -- not just the care that happens in individual, for individual people in their settings.

So what I want to start with is a common question that I'm asked by my physician peers.

My physician peers say, "Julie, you're a geriatrician. You're connected to lots of people. My 83-year-old mother, who's actually quite independent right now, is moving to New Town, U.S.A. Can you recommend a really good doctor for her?"

DR. TALLON: No.

DR. BYNUM: That is a very hard question.

And it's a hard question for many reasons, but I think that first and foremost for me is that if we want to understand the care that aging populations get, it's not going to be about "the doctor" that the person gets the care from. It's going to be about the providers, the group of providers that collectively provide the care over a period of time for this woman.

So I think of this very much, as Diane does, from the patient's experience. From the -- and it's not even a patient, a person's experience.

So if I think about that 83-year-old woman and what she's going to need over the next decade -- which may be her last decade but, like Chris, I really like aging, so I hope it's not her last decade -- what is she going to face?

She has, likely, multiple medical conditions. On top of that, she's likely to develop functional decline in that time period. And she may very well die. So it's going to be a tough 10 years.

With that, in her health care delivery she will see many different doctors in many settings. She'll likely go to multiple hospitals, rehab settings, home health agencies and residential facilities -- assisted living and nursing home and others.

So you can see why this question is really hard for me to answer -- "Where can mom get really good care?"

And it's one of the reasons I went to Dartmouth, where we can think about systems of care in a different kind of way than what we usually do within silos. And it was really why I became interested in thinking about how to measure the health care we deliver to a population of older people, and what led to my involvement with developing data sets around Medicare that can inform the accountable-care organization development.

For those of you who may not know, the idea of an accountable-care organization is that there are a group of providers who take accountability for a population of people over time.

Now, this doesn't really exist in the fee-for-service market at the moment, as I think everybody recognizes. But it does sound familiar to some other things you might have seen in risk-sharing integrated health systems, or capitated systems. This kind of idea exists.

But the closest thing, probably, in the fee-for-service market currently is the Physician Group Practice Demonstration Project. And in that demonstration project there's an element that happened at Dartmouth, so I'm, going to tell you a little bit about some insights from that program.

What the Physician Group Practice Demonstration did was to say, as a group practice you can get some financial gain by meeting certainly benchmarks of costs and quality for a population of people that receive care from you.

So the first insight that I want to share with you how my organization went through the process of saying, “Who do we care for?” Had they ever thought about the population of people for whom they cared?

And that was an enlightening process for the organization. Because Dartmouth has three -- it has a tertiary care hospital with a specialty physician group practice, with primary care, as well. But I think there were some surprises about who we care for.

So, let’s talk a little bit also about what those surprises led to.

So some of the measures were around things like diabetes care. And when they looked at the data, you realized-my goodness. The diabetes care we need to do is actually a primary-care kind of delivery system, where tertiary care -- so many of the patients who are attributable to us are outside of our direct system.

So we needed to develop connections to other providers in the community. That was a learning process, to understand that the kind of connections to make chronic care happen don’t happen just in the hospital or just in the specialist’s office, or just in the primary care office. It happens across a group.

Take congestive heart failure as another example.

So, for congestive heart failure patients, we think about quality in the hospital. And that is often -- much of our measurement is quality in the hospital. Our performance measure is hospital-compare.

But when you do the physician group practice model, you also have the congestive heart failure patients who see your doctors who aren’t in the hospital. So now you have a new incentive to actually maybe prevent hospitalization. Because it’s a different set of patients that we’re measuring. We’re actually measuring more population-based group of patients.

So there were some really interesting insights about who the partners are.

Now, I want to come to a theme that I think everyone is going to talk about, of the re-admissions and what that means. Because, again, another -- this is a more recent learning experience through our physician group practice experience. And also, not directly related to the demonstration, but in our community, which is rural, we've experienced -- the best way for me to describe it is an exodus from the physician provision of care in our long-term care facilities. There are very few providers who can meet the financial challenges of providing care in long-term care.

And the hospital providers recognize: well, how do reduce re-admissions if we don't have reliable relationships with our home health agencies and our nursing facilities?

So there was a real shift in the need to reach our and partner with the community providers in a way that was more than, "How do we discharge our patients quickly?" But "How do we now partner with them to actually reduce the amount of times they come back?" -- as Diane already alluded to.

So the traditional performance measures that we talk about have really followed the silos in which we pay for care. We measure care along the lines that we pay for care. And the problem with that is, in the longitudinal experience of a person over time, and their possibilities for re-admissions, and multiple re-admissions, and their goals of care even -- and the costs of that care -- really are difficult, if not impossible, to measure, and hard to hold anyone accountable for.

So my mentors -- I've heard the story of "there's no business model" for doing this longitudinal care. I've heard that story through all of my training. Because I decided very early to go into geriatrics. And I think when we move measures to a group of providers for a population of patients, we are freeing ourselves a bit from some of those business-model constraints.

I think, just to make that clearer, the ability to make investments in relationships has not been a high priority for an organization until there's actually a financial tie. Their performance measurement -- and their payment, which is tied to their performance measurement

-- can now drive their interest in actually, truly collaborating and integrating care, even in a fee-for-service market.

So, I’m really talking about Medicare, and not the long-term care market. And the reason is that’s where I have my data, primarily -- and where a lot of money is.

But I see some of these new models of thinking about groups of providers, and bundled payments as real opportunities for the future. But one of the things Dr. Tallon, I think, said to us when we were thinking about the session, to think about the frontiers -- I think breaking the siloed way of measurement in thinking of paying for care in the acute-care world is a really important step forward. But the next frontier is the Medicaid and Medicare silo. Because for the most frail, what goes on between the two environments actually affects the longitudinal experience of that person even more greatly.

And we know from lots of work that the cost-shifting issues really can influence both the quality and the overall costs that we end up having for this frail population.

So -- I’m going to stop my comments there.

DR. TALLON: And that implies that -- I listened to Mark do this presentation in other settings -- that in order to get to the measurement that you’re talking about, you have to move fairly far along the integration continuum. That, I mean, we have to be able to think about a group taking responsibility for a population, and then we can think of that measurement and sort of getting a little organized, and having some add-ons and things like that doesn’t -- you’re talking about getting to a pretty substantial degree of coordination and service delivery.

And, I mean, is the key element the assumption of responsibility for some definable population of people, to be able to do the measurement that you’re talking about?

DR. BYNUM: Whether they’re tied to each other specifically, they will need a -- some sort of legal arrangement so they can share savings and share payment.

But what I’m seeing in my own organization -- I really want to keep this tied to what’s going on -- is in the six or seven years that I’ve been here, and the PGP practice has gone on, what I’m really seeing is what seems to me an organizational cultural change.

There is now a new mission statement for our organization that says, “We are about creating the healthiest population.” Not about our margin, or about advancing our neuro-surgical unit, but it’s about creating the healthiest population. And that is, I think, starting to think about measuring, for the PGP practice, who do we actually care for? And who do we need to partner with, has led to that, or contributed to that realization that creates a cultural shift.

DR. TALLON: thank you.

Greg, let’s have your insights into this -- which are substantial. And I’m sure we’re going to hear a third perspective that’s interesting.

DR. PAWLSON: Thanks.

You know, having talked with you all before, but not having really rehearsed what we were going to say in any real way, I think it’s remarkable —

DR. TALLON: You should try to be a moderator —

DR. PAWLSON: I know. I think it’s remarkable, for the amount of congruity that there is. And so I’ll start with that.

One of the things I have to share is that, in reflecting on Diane’s remarks, I had the very great privilege of practicing in a nursing home environment for about 10 years with Joan Tino and Joanne Lynn, whom many of you know -- and the struggles that we had to try to do what was talked about by the first panel, and what was talked about by Diane -- against the stream of the financial system, of the payment system for health care in this country. It actually ended up that all of us left and the practice dissolved.

And honestly, I think we were doing a lot of the really, the right stuff, in terms of having one physician who would follow all the patients at the hospital, but handed off -- exactly. We had hospice care through Joanne’s intercession, applied to patients.

We had nurse practitioners in the nursing home. We had social workers following patients. We had almost, not quite, Mary Naylor’s model, but close to that, in terms of how we did a hospital follow-up. Because a nurse practitioner basically followed the patient from the hospital to the nursing home, or back into their home practice.

And financially it was a total disaster.

So I just want to stress a couple of things, and then sort of talk a little bit about measures, and measurement.

First is, I think you've heard three or four key themes. One is "populations." We have to start thinking of populations in health. And they could be large populations, or they can be very distinct populations, like the patients that you talked about in terms of late-stage dementia in nursing homes.

But we have to define and think about those populations. And we've got to have providers who are trained to do that.

And one of the great privileges in my career was getting an MPH degree, and suddenly -- oh my goodness. There's more than the "visit" that I learned in medical school. You know -- people exist outside of that.

The second is the organization of practice. And I don't think we're going to have any one model of how practice is organized. I hope that the accountable-care organization kind of thing -- and I think we ought to call it the "person-oriented accountable care organization," because that's another theme that I think you've heard. We have to maintain that "person," as well as "population," orientation.

It's got to be organized. We cannot have lone rangers, you know, galloping out into the sunset in the West, taking care, especially, of frail older patients, but virtually any patient population. That doesn't serve very well.

The third is that we need to have the right measures. And that's a critical piece because, increasingly, those who pay for care are being forced to ask the tough question, "Am I getting the value that I want out of this care?" And that's a tough question. It's a very tough question -- to both answer, and answer reasonable.

And then, the final thing -- that has to be tied to reimbursement. There's absolutely no way you can do it -- I despaired of our geriatric fellows as they sort of launched out into practice, and if they didn't got to the VA, or an organized system, you know, like Kaiser or Geisinger, I despaired at their future in many ways. Unless they went into academics, and that's another whole set of –

SPEAKER: Despair.

DR. PAWLSON: -- of despair. Yes.

So let me talk a little bit about measures and measurement.

One of my roles is often to sort of throw a little cold water on things, unfortunately, because I've lived the last 10 years trying valiantly -- I hope valiantly -- to produce measures that actually measure what we really want to do and what we're interested in. And it's a very tough job in many ways. And I'll sort of tell you about that.

So where are we in being able to measure the value -- and I'm talking about cost and quality -- of care, especially of long-term care patients? I'd give us about a C-minus -- on the measures.

Now, there are 3,000 measures or so in the ARC Measures Clearinghouse. And I'm sure that everybody who's done research in this room has measures that they've used in their research projects. But those measures are applicable, often, only to a very distinct population, with the data that you generate. And the data ain't there if you haven't generated it yourself. So I'd give us about a C-minus on measures.

But I'd give us a D-minus on measurement. And that means actually applying and using those measures across more than one small demonstration or research project.

Now, it's great to have the measures and the research projects. I'm not demeaning that at all, and I think we need to continue that kind of development. But eventually you've got to start comparisons across, so you can say, "Well, outside of this randomized, controlled trial where I was able to do all this stuff," what is the impact and how do I measure it? So where are we? Well, as has been alluded to, most measurement in the past has been tied to the institution, not the person. It's striking. And it's reinforced by everything. You know, it's our educational system in health care, medicine, it's the way we pay for things.

And so what do we have? We have measure of the congestive heart failure, of patients in hospital. Well, they don't stay in a hospital very long. And especially in long-term care -- I mean, there's been a number of people in the room that have written papers about how many transitions the average patient has in a given year, whether it's a transition from a hospital, a doctor's office, or nursing home to rehab facility, back home.

I used to -- we called them the "bouncers." I mean, we had a life-care community. And there were patients I had that were in 16 or 17 different places in a given year. And we actually looked at that one year. So -- they move around.

And so a measurement that doesn't follow the person is sort of problematic. We can get something out of it, but it's very, very problematic.

Re-admissions is a great example. I just saw a paper -- it happened to be on HSR -- on neonatal. And all the variance is in the outpatient environment for that. Very little in the hospital. Now, I think that probably varies by type. But there you have it. So -- or in institutions.

Another reason for the sort of institutional focus -- it's not just sort of malevolent people in measurement, I don't think, or the reimbursement system -- but that's where the data is. And it's trapped there. So you have the hospital dat. And you have the nursing home data. And you have the outpatient data. And they never touch.

And so the patient, when they move from -- it doesn't follow the patient, it follows the reimbursement system -- if I could trace it anywhere.

Thirdly, even within institutions, we've got very limited data on quality and cost. And maybe this is touting NCQA a little bit -- much -- but the best data we have is actually in health plans. And virtually the only really good comparative data we've had has been in the health plans -- until the hospitals have started to get some. And there, it's only a few measures yet.

In nursing homes, we've got very little. And outside of that, in ambulatory care or in home care, virtually nothing.

And, finally, outside of the visions of a few groups within CNS -- and we have, partly, Mark to, I think, thank for this, there's been relatively little focus on developing measures and measurement for the populations that we're really interested in here today. It was an amazing sort of awakening at how little emphasis there is on these very high-cost special populations within the framework of health care, even in the Medicare program at times.

So how do we get out of this quagmire? This is not good place to be.

So, first and foremost, I think we need to start to develop measures across settings. And I think any of the patients or situations we've talked about today sort of demonstrated that.

Accountable-care organizations, if they're going to work, are going to have to move and look at data across institutions.

I think that there is especially a strong need for sort of care-coordination and so on. There was a thing in the New York Times which I know was sort of controversial, where United Health Care said they weren't going to start -- they were going to pay half for admissions where they didn't get notified within 24 hours.

Well, I think the other half, the hospital shouldn't get paid if they don't notify the primary care Harvest Plus within 24 hours. Now, I realize that I'm picking on hospitals a little bit. And, you know, there are problems. I've been in ERs where there have been frantic calls to multiple people and they can't find any health care provider who will admit having any relationship with the patient they're trying to admit. But that's another issue.

But it does illustrate how poor the hand-offs are. I mean, if they don't even tell the payers, you know -- I mean, we used to routinely find our patients in the hospital because the ER docs or somebody else would admit them and, you know, it just happened to be we had somebody making rounds every day and looking at the list, and that's how they found them.   And I suspect that happens in some of the post-hospital follow-up kinds of stuff. So that's one thing.

And we do really need to move to "accountable entities." We need to look at cost and resource use. We are not going to escape that. That era is over.

And I think the failure of health care reform -- even if we get dribs and drabs, and hopefully a little bit more than that in the next few months, is going to be intensely, I think, on costs. We've already heard from purchasers that with the failure of health care reform, right now, their emphasis is going to be even more strongly on cost. And the President's speech last night certainly illustrated that on a larger level.

The second thing we need to do is really develop cross-cutting data sources. And thank goodness AARA and, for kids -- and, you know, this was a big plus -- CHIPRA, passed already. And so there's really a huge, I think, opportunity out there around the implementation of the AARA legislation, especially in the funds that are going into creating health information exchanges, creating new ways of linking data between different sources, creating new ways of using data. I think it's four $15 million grants that are being let by ONC to explore different areas related to those things, including, you know, secondary use of data, which is, to me, "measurement."

So there are some real opportunities to start to knit data across organizations, so that we can really start to measure at the level that we really need to.

Third is that there really needs to be a public focus and a push for measures and measurement in special populations like the ones we're talking about today. And I sort of have welcomed and celebrated Mary and other people's work in getting the Long Term Care Quality Alliance going. I think that's going to be an important voice in trying to bring attention to this area.

And, finally, I'd like to just provide a word of caution about what kinds of measurement we're going to be able to do in the relatively near term. And that is, we have to be very careful about what seems to be a sort of a rush towards -- quote—"outcome measures."

I love outcome measures. I think that if we could do them, that's what we should do. But there's some really, really big problems with those. And when you start to think about it, some of the things that are really critical in the right kind of care systems we can measure with structural kinds of measures that are really linked to -- and process measures that are really linked to -- good outcomes.

The VA and Kaiser and so on have certainly demonstrated that organization of care has a huge impact on quality. There's no question about that. So we can't abandon that.

And the problems that you get into with outcome measures are, first, sample size. And it's amazing to sit and start to really sort through data and see that, "Oh, congestive heart failure. Really frequent." How many does each primary care physician have, of patients with congestive heart failure that you can define as really having congestive heart failure, and not just swollen ankles or something, like most of my elderly patients who are labeled that way actually had?

Secondly, there's a remoteness of outcomes to the clinical process. The outcomes may not occur for years. And that's not very useful in terms of feedback and changing systems.

Third is there's an awfully small variance that's due to provider inputs. It's very humbling. When you look at the variance in terms of, like, hypertension control, about 85 or 90 percent of it's with the patient, another 5 or 6 percent is with the system, and about 3 percent is with the clinician. Well, you combine that with sample size issues, and only a small amount of variance due to that provider, and you've got big problems.

And then you have the whole complicated issue of risk adjustment -- which, hopefully, we won't talk about for the rest of the day, because that's a three-day topic unto itself.

But those are all problems that you get.

So I think having the right structural and some process measures, and especially around these special, you know, these groupings of populations, and then going into this emphasis on population health, organized provider groups -- those kind of measures linked to the right kind of reimbursement will move us forward so that in five years we won't be sitting here saying the same stuff.

Thank you.

DR. TALLON: Let me just -- I'm going to go to questions, but let me pose, actually pick a comment I think that Mark made in the first session, where he said, "Well, wait a minute, the Congress is doing all this stuff, and we're the people they talk to." And, you know, what are we going to tell them that they really ought to do?

And so in a sense -- and, you know, let's all maintain a smile this morning and assume that we have a comprehensive piece of legislation that passes that does exactly what we want it to do -- somewhere in all this -- and Secretary Sibelius has mentioned this on a number of occasions. She's said, "You know, I look at this thing and there's all these 'the Secretary shall -- '."

And so, you've brought very differing but very constructive comments to this. So let's say you wake up one morning with "the Secretary shall." In the general area in which we are talking, taking chronic illness, older Americans, and advancing, broadly, measurement. And whether it is content or process, where do you take that?

Literally, where do you take it? Well, location, locus. And then how do you evolve the conversations that we have been having? And nobody was rehearsed on this one, so I make these things up. So, does anyone want to jump in on that one?

DR. BYNUM: Can I make a naïve response to start? One of the things that I've heard, again, from my mentors and as I've learned, is that people perceive performance measurement and financial structures as impediments. And if it's the "Secretary shall" would be not measure X, Y, or Z, but create a system in which local providers are able to innovate as opposed to being limited by whatever the particular incentive structure is. I mean that I guess in a more philosophical way around measurement and not necessarily specifying you must do it this way or with this measure, but allowing a measurement system that creates the incentives and change that go the right direction without specifying necessarily, specifically, how to do that. Getting at the person's question earlier about no one's asked us in our particular community where we have this problem as opposed to that problem, and we need to fix the problem with this particular ethnic group or this particular high-risk population, that the sweeping "you shalls" may not apply as well to specific special needs populations.

DR. PAWLSON: I think one of the real plusses that's sort of hidden in some of the health care reform legislation is the pilot concept because, as Mark knows -- and maybe we should be asking him what this "shall" is since he sat in -- you sort of got some "shalls" -- yeah, that's right. I know, you got some "shalls" as CMS administrator. I think the key is that the pilots allow the movement of limited implementation rapidly to the entire system without further legislation.

The thing that I think has killed CMS time and time again, and it's not that they haven't tried. I mean, people sort of missed the thing that it's the political system and ourselves that are the worst part of this. I mean, it's sort of like Pogo, "I met the enemy and he is us," because it's the resistance from clinicians and hospitals and nursing homes and, you know, some in long-term care as well, to be able to change and be nimble and then resist, oh, no, we can't change the reimbursement system. So I think these pilots with real looking at how they are going to, I think, show very convincingly that some of these things -- and whether it's, you know, Chad's model or Mary's model or, you know, in accountable care, these things do work. And there's a heck of a lot more evidence that they work than for the reimbursement we do for a lot of procedures to be very honest.

I mean, I've never understood how health services research has to go through 15 sieves while all you have to do is declare that gastric freezing stops ulcers or that, you know, giving anti-rhythmic drugs prevents sudden death -- neither of which obviously work -- and all of a sudden it's reimbursed. But, uh, no, can't do that. And so I think these pilot -- this pilot concept and building into the legislation and its innovation things, as I understood it, they will be able to do pilots without having to go back to Congress and say, oops, we've got a new 50 things, because, as we know, the political process is very difficult. So I think there's some hope if we can get some of those things passed. And I think those are the kinds of things that could slip into legislation reconciliation or some other stuff if we don't get a comprehensive bill.

DR. TALLON: Diane, you want to jump in on this?

DR. MEIER: I think the important thing to say is that all of the pieces have -- it's just as people have argued -- you can't do health reform piecemeal because everything depends on everything else. The same is true in what we're talking about today. You can't suddenly start doing population health measures without changing delivery systems and the infrastructure that provides a patient's live-in. You can't change the delivery systems without changing the payment methodology. You can't change either of those things without changing the regulatory oversight surveying process. And none of these things will work if you don't change workforce training and incentives. So they really do have to happen together, not in lockstep perhaps, but in the same decade if we're going to see change that lasts. And I think the fact that it says the "Secretary shall" gives the Secretary enormous latitude and power, I hope, within the Executive Branch, through regulation, through rulemaking, to move things along that are not going to require a vote of 60 Senators, hopefully.

DR. PAWLSON: I'm encouraged by some of the ONC moves, too, because they seem to be paying attention to all those things, the data systems, the training, that kind of stuff.

DR. TALLON: Let me frame it differently -- this is just my last one and then we're going to go to a question -- let me frame it differently and let me actually be the devil's advocate in all this because I think, Greg, you said, look, we're moving into an environment here in which costs and accountability pressure just becomes more and more central. And in a sense, I think that it does, it is what flowed out of the first conversation this morning. We are into nuance and complexity and maybe in a reality, Diane, you started this and said, look, here's a group of people I'm thinking about, and I'm actually thinking conceptually very differently about them. I'm thinking that they could have very different clinical experiences and if it meets their preference, that's still good and, okay, that's what I'm trying to do. And we've looked at a number of things and thought we're going to have some pilots and things like that, and so let me be the devil's advocate and say you're going to get away with that for about 24 months. And then somebody is going to say, whoa, I've got to figure out how to get the central tendency in this.

So what's the key? Is it an organizational measure? Is it a -- is there the concept of a central measurement, common measurement, theme that you can think of or vision, or are we going to say to people, in this population we don't have the easy central tendencies that are going to let us do what we need to meet that model? What do you think?

DR. PAWLSON: Twenty-four months is a tough timeframe.

DR. TALLON: Well, I'll give you 36.

DR. PAWLSON: And I'll tell you why, Jim, because I think a lot of this, if we do it right -- and this is a tough challenge -- will come out of our ability to measure much more adroitly in data systems that are fairly rich in both clinical and administrative data across institutions and where you can capture and sort of go to an opportunities model. So I was thinking as Diane was describing -- and I would agree with you, although the one thing that I didn't quite agree with is I think we've got to be careful about offering things that are futile. I mean, we're really going to have to tackle that at some point because we're already doing things to people that have very, very small marginal benefit. And when that becomes sort of infinitely small at an infinitely or very high cost, that's where our cost problem is. It's not all on the waste side. I'm sorry. I think we ought to go after waste first, but it's those things that are $1 million per quality adjusted life minute gained that are getting us in trouble.

But aside from that, I think we can get measurement at an accountable care organization level that's pretty rich out of that kind of thing, and it's sort of an opportunities model overlaying by resource-use cost, which we can measure, again, because the sample sizes are big enough and so on. And if you're not in an accountable-care organization, we're going to put you in one. And that's everybody that's left, and if that looks pretty bad, too bad. Get out of it and get into one that works.

And I think that's the kind of stuff we're going to have to push because if we continue to sort of say, ah, nobody loses -- I remember when I was a health policy fellow on the Hill and it was during the Medicare catastrophic legislation -- when it passed and not the next year when it got repealed -- but I remember this discussion among staff about the DRG system and how some hospitals were losing under the DRGs. And I said, see, they're thinking, that's what it was supposed to do, right? So we're going to have to figure out a way to sort of tolerate that, and if the disorganized system doesn't perform well, then the reimbursement for that is just going to go down until people are forced out of it.

DR. TALLON: Julie, do you want to jump in on anything before I go to the audience?

DR. BYNUM: The only thing -- just on that last comment about places that run inefficiently and do poorly. We do have to be careful about they serve populations and some people will be forced to stay with those organizations. And we need to -- it may not be that they can revamp their poor quality or poor efficiency ways as we cut their payment dramatically. So that's just a caveat and careful -- something that will require care.

DR. TALLON: Will you please identify yourself when you stand? The hand up that's closest to me, the gentleman in the blue.

SPEAKER: Todd (inaudible) and I'm a freelance writer. I'd like to ask the panel to comment on the intersection of medicine and politics. Dr. Meier said 60 percent of the people in nursing homes with advanced dementia will die within 2 to 3 years. Are you saying that if hospitalization is reduced, they would die anyway?

The second question is, if you move toward fewer hospitalizations -- and again, Dr. Pawlson talked about futile care -- there will inevitably be some family members who will say you killed my mother; she had pneumonia and you should have sent her to the hospital. Is that because Medicaid is worried about budgets? And if when that happens, won't we then have death panel discussions as we had this summer? So how would you deal with all of that?

DR. MEIER: This is why I stressed so repeatedly, perhaps numbingly, the issue of matching treatment to patient and family goals and really helping patients and families. And in this patient population, the long-term care population, it's very frequently not the patients, at least in the elderly group because there's both extreme functional and cognitive impairment in that group. But when people understand the nature of the disease course, what the future is likely to hold, what their options are, and the pros and cons of those different options, 90 percent of the time they make a choice for a more conservative care plan. Ninety percent of the time they say, no, I don't want my loved one going in and out of the hospital. We've been through that. We don't want that anymore. But that decision cannot be made until the patient-family unit is informed about their choices and actually given the option.

The 10 percent who go for futile care are going to go for futile care because it's futile in the eye of the beholder, not futile in their eyes, religious strictures, cultural strictures. I don't think we should try to eliminate that, and I think we could be accused of death paneling if we try to eliminate options based on population characteristics. But I do think if we got serious about informing patients and families of what is the nature of moderate to severe dementia. What is likely to happen? Pneumonia is inevitable. The difficulty swallowing is inevitable. Here are the options we face at that point. And doing that 90-minute discussion, that we would avoid a huge amount of burdensome, very expensive, care that actually in many studies shows does not diminish mortality; it actually increases mortality. The more aggressive the care at the end of life, the higher the risk of death in several studies, the opposite to what the press seems to think.

DR. PAWLSON: Yeah, I think that Diane's -- I mean, that's a very, very perceptive question and the public is obviously very, very fearful that somehow cost reduction will result in drops in quality of care. Well, our work and the work actually of your colleagues, Elliott Fisher and Jack

Wennberg at Dartmouth, have shown that there's very little relationship between measurable quality of care and the cost at this point. And so the key point here is taking the time to really inform patients.

And some of the shared decision-making stuff that Dartmouth is also pioneering has shown that when patients are given the right information, they often make more rational, I would say, or some would say conservative, choices --

DR. MEIER: Well informed.

DR. PAWLSON: -- well-informed choices, yes, than their physician might make for them. But we often buy it -- it's not that physicians, I don't think -- I think rarely do they really look at a patient and think, oh, I can make money off of this patient. It's that thing of you're doing something you really feel like it's the thing to do. I mean, it's -- all of us have that. It's not unique to physicians. I mean, you believe in what you do. Most, hopefully, do. And so there's that shading, and that's why it's so important.

And that's why the reimbursement system has to change because the 90 minutes that you just talked about, boom, you're not reimbursed for that. And yet the outcome in terms of both quality and cost are better if you have that conversation. And that's really -- I mean, that's the main focus we ought to have in the near term.

DR. TALLON: Julie?

DR. BYNUM: I want to make just a follow up on the comment you just made, the issue of what patients think are motives of physicians. Pretty interesting. I just completed a qualitative study of people ages over 80, 80 to 90 years old, and asked them about their decision process in the clinic. And it was a group of 29 and 6 of them specifically said, well, you know, the doc's making money off of that. He refers me to specialists, but I'm not going to play that game, or something along those lines. So patients actually sometimes do perceive that the physician's judgments may not be in their best interests, which is a real problem for our profession.

But I want to come back to this question about the hospital as perceived by people as the place that saves lives for this population because we talked about it in the context of nursing home. But I just want to step back a little bit to say what we know about hospital-based care and elderly patients, when we put them in bed, they lose muscle mass. They're at higher risk for iatrogenic things and, frankly, we know from the home-hospital intervention that there's a lot of care that can be provided outside the hospital that we traditionally think of as in the hospital. And maybe outcomes could even be better if we avoided some of the iatrogenic risks. So there's a cultural norm or societal belief that the hospital is the best place to receive your care -- and they turned the lights out so I must be done speaking --

DR. PAWLSON: That's a subtle signal that time's up.

DR. BYNUM: Yeah, sorry. But I just think that is a value just like the hospital: the doctor runs the team and the doctor is the most important person on the team, the hospital is the most important setting for care. That is a cultural belief that we have that I think we struggle with when caring for aging populations.

DR. TALLON: Great answers. The woman on the aisle.

MS. FISHER: Thank you. Annabelle Fisher, licensed clinical social worker. I have a question. I'll make a comment first about the reimbursement rate, it is obviously very low.

DR. TALLON: Can you speak up just a little bit?

MS. FISHER: Can you hear me now?

DR. TALLON: I can now, yeah.

MS. FISHER: Our reimbursement rate's obviously low. I have worked in some of the top teaching hospitals in the United States. I will say that the younger generation -- those of us in our sixties -- are challenging docs and beginning to say no, as opposed to my parents who would go to the hospital and say, you know, yeah, yeah, yeah.

My question, though, has to do with regulation and outcomes. And it could be -- well, you have the federal government that regulates nursing homes, but you have JACO that regulates hospitals. Now, I remember working with Visiting Nurse Services when I lived in Seattle. Who founded JACO? I mean, JACO -- when you talk about quality and outcomes, JACO can go in there and do whatever, but the federal government, I think, would have a little more credibility or power. And I'm not for federal government taking over health care, but you have a difference in who regulates and keeps the hospital and/or a nursing home accountable. So if you have to show outcomes and confidentiality and HIPAA, if you want to show outcomes, which I guess you need to do to get your money, how do you get hospitals to fess up, and nursing homes as well, when you have the federal government running nursing homes and JACO running hospitals? Does that make sense?

DR. TALLON: I spent nine years on the Board of the Joint Commission and I could do a Joint Commission answer. Does anybody want to jump in on -- let me just do the point of fact and Mark is the person who probably could really do this answer.

The federal government sets the rules. The Joint Commission acts on behalf of the federal government in looking at the terms and the compliance with the terms. The Joint Commission has different lines of work, some in home care, some in nursing homes, where it is not as dominant as it is on the hospital side. And you also have the states as players in this also. It's kind of a conversation that's going to take us off into more time than I want to put into it, honestly, at this point.

Anybody else want to jump in with a comment?

DR. PAWLSON: Just a quick comment. I think that -- I mean, obviously there could be a whole week's seminar on the relative roles of the federal government and the private sector in influencing or regulating quality and so on. And I think it's a very useful thing to look at because I've always had some concern that the same agency that pays for care also evaluates and regulates. And maybe it's a matter of the separation of church and state and some of those things, and yet those three roles obviously overlap and have to be sort of very articulated and coordinated or they get out of phase and then it's a real disaster. And having worked in nursing homes and having then spent time on the Hill legislating over 87, being a health policy fellow during the creation of 87, and then having to go back to the nursing home and live under those regulations as they were imposed, very interesting experience to say the least.

DR. TALLON: Let me get to the question of the other woman on the aisle on the other side.

MS. PARIS: Hi, I'm Judy Paris. I'm a clinical social worker and an expert in long-term care and palliative care.

In terms of measurement, I'd like to return for a moment to what Diane was saying about the importance of measuring the concordance of people's goals and delivery of care and the importance of palliative care in that. And until we are in an era where we have the post or an electronic health record where we can do exchanges, some of the research that Diane was talking about was as a result of the National Mortality Followback Study, which last was done in 1993. So I just wanted to let the room know that in your travels as you're arguing for things if you want to be able to measure this concordance, it's something that MCHS has done through the years and could easily do again.

Thanks.

DR. TALLON: I don't see that there's a need for a comment on that.

We'll take it over here, this gentleman. Microphone's on its way.

MR. COOPER: Barry Cooper, Companion Chair Association. Going back to the earlier session where Carol Raphael was clearly frustrated in terms of the real-world problems of evaluating programs for evidence-based purposes and not being able to listen to her front-line nurses when they came up with some very valid improvements in the quality of care. My first question is, how are -- are we properly collecting these nuggets, these insights that are coming to us when we do comparative effectiveness studies for example?

And the second question is, is the evidence-based program that we're following over time, the improvement in outcome perhaps, due to a lack of fidelity testing?

DR. BYNUM: Just one comment about that. I make something of a distinction in my mind -- and maybe it's because of where I come from -- between the policy and the rules set out and the quality improvement efforts that go on through organizations. And I would think of organizations like IHI and collaboratives are the places where those nuggets might be shared that you're talking about. And I would think of those kinds of organizations as opportunities to actually learn from each other and share on the implementation side.

DR. PAWLSON: There's also, I mean, I'd have to -- because I could share the committee that oversees it, their advisory committee, is the AHRQ Innovations Exchange. You know, I don't think we have the ideal model yet for sharing innovation. It's remarkable how we keep reinventing the wheel, and part of that is, you know, I think, is research grants and we all like to get them and, you know, there's always some nuance and stuff. But there's sort of an accumulation of knowledge in certain areas, and getting that out to the right people, I think, has always been a challenge. And I've been very intrigued with the efforts of AHRQ in creating this Innovations Exchange because what they do is they put whole case histories with contact information there. So if you're like thinking, well, gee, I'd like to improve care for such and such like you were talking about, Diane, if your innovation is up there, somebody can look it up, see how you did it, what the population was, and then if they need to call you and say, what are the really key things that I need to do.

DR. MEIER: Well, I want to comment just from my experience with scaling palliative care in the United States, which was basically through a technical assistance model that was very generously funded by private sector philanthropy, many of which funders are in the room right now. That was never -- you know, that may be amenable to federal funding through the various innovation mechanisms in the new reform bill, but prior to that you could have brilliant NIH funded, high-quality research published in the New England Journal of Medicine and not a penny for application, diffusion, dissemination, and scaling. And that's been -- has not been the purview of the federal government heretofore. It's been the purview of private sector philanthropy which has done a great deal of good in how it's applied its money, but with federal support you could see all these brilliant ideas that all these people in this room have studied and proven actually get to patients and providers in real communities. And that's been a huge deficit in the field of geriatrics in particular and health care more broadly.

DR. PAWLSON: Do you think the Innovations Exchanges that --

DR. MEIER: Well, that's what I'm hoping.

DR. PAWLSON: -- under HIT, yeah, might help with that?

DR. MEIER: The other thing that might help is it seems like there's an intermediate career path. There's the researchers who are developing models testing them, there's the clinicians who are delivering stuff, and then there's the people who have helped implement and disseminate. And that's a different set of skills which many of us who write grants don't have. And when we talk about workforce that may be another element of the workforce development that we should really be thinking about and funding.

DR. TALLON: While we're coming up to 12:00, let me -- and I apologize the question time is limited always -- I'd like to go to the panelists. You've listened to the conversation. You've listened to each other. And do you have a takeaway message that you'd like to offer from our measurement panel to everybody else today or your insights? Julie, can I just start with you and any closing comment you want to offer?

DR. BYNUM: My only closing comment is how grateful and excited I am. As much as everybody's been feeling down about legislation, as somebody who's relatively new to the field of aging and geriatrics and thinking about how we can do it better, I'm really heartened to have this group of such high-quality people thinking and working ahead of me so hopefully I can do even more as we move forward. So I hope there's a real positive feel of potential change.

DR. TALLON: Greg, you can take a contrarian view if you want.

DR. PAWLSON: Well, it's just great to see the baton picked up. And one of the joys that I sort of miss a little bit now is the interaction with geriatric fellows and young faculty with that kind of idealism. And I think we have moved the field forward. I mean, geriatrics and long-term care -- and it's not just -- and the realization of the things that I talked about and that we have to look at populations to go back to that theme, we have to think about organized care systems, that we have to measure, and that we also have to change the reimbursement system. And those were the things that are -- there's pieces of all of those things in the health reform legislation that sort of match up with some of the pieces that came through an era. And it makes me even a bit more positive and enthusiastic about the future.

DR. MEIER: Well, I also want to close with an optimistic comment and say that despite the current payment system, despite how care delivery is organized, palliative care has gone from nonexistent 10 years ago to present at 70 percent of hospitals with more than 100 beds in 2008. And it did that thanks to private, very, very strategically invested private sector philanthropy and implementation efforts. And so change is possible within the current perverse constraints of the health care system.

And I think that the notion that the private sector can do it alone is obviously incorrect. But what we're seeing here today is a very good example of partnership and collaboration within the private sector, and I think it's very powerful. And if that could be leveraged through private-public partnerships and collaboration or spread of models that have been proven effective; we know what works. It's not that we don't know. We just don't know how to spread it or we haven't effectively spread it. Then I think a lot of good could be done with or without passage of the health reform bill.

DR. TALLON: Dr. Meier, Dr. Pawlson, Dr. Bynum, I turn it back to Dr. McClellan. Thank you to my colleagues and thanks to all of you.

DR. McCLELLAN: And, Jim, thank you very much as well. Thanks to all of you.

Well, let me continue the note of optimism that this group was able to end with, one short-term issue. So we're going to take a break now, so everybody take a break. There are lunches in the hallway to the side of this room. And for those of you who are in the, as I understand it, overflowing, overflow room, lunch is as well to the side of this room. You can exit out the side or exit out the back and go to the side. Take a break.

We're going to try to reconvene here with your box lunches in about 20 minutes, at 12:20, and at that point we're going to have a -- I think, hear from some very interesting people about some new ideas and opportunities looking forward for addressing some of the problems that we've talked about this morning. Thank you all very much.