THE BROOKINGS INSTITUTION

ACCELERATING HEALTH CARE INNOVATION TO ACHIEVE SYSTEM-WIDE IMPACT

Washington, D.C.
Monday, October 18, 2010

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Introduction:

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PANEL 1: EVALUATION AND IMPLEMENTATION FOR SYSTEM-WIDE IMPACT

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P R O C E E D I N G S

MR. MCCLELLAN: Thanks for joining us here today. I'm Mark McClellan; I'm the Director of the Engelberg Center for Healthcare Reform here at the Brookings Institution. And we are very pleased to be hosting today's event on Accelerating Health Care Innovation to Achieve System-Wide Impact, with a particular focus on the Center for Medicare and Medicaid Innovation.

I'm very much looking forward to today's discussion. We've got a number of great perspectives to share, and that includes all of yours. I do want to recognize the Aetna Foundation for their support for this event, as well as an earlier workshop in July, which helped us get our thinking going around how to frame this event and the discussion that you're about to be a part of. It provides a basis for much of the discussion that we're going to have today.

And I'd also like to thank everybody, not just the full room we have here at Brookings, but everybody who's joining us via web cast. And as a reminder, we do have press here; we do have press who are joining on the web, so please keep in mind that everything is on the record. We are going to have some discussion time during the course of this event. When we get to that point, raise your hand, we will have staff with microphones who will be roving around the room, you don't need to go anywhere, just wait for a minute to get the microphone to you.

Unfortunately, we're not going to be able to take any questions from the web participants, but we, again, are looking forward to quite a dialogue. And it's a very

timely topic. The purpose here is to help identify and address the significant challenges, both policy and technical, related to implementing the Innovation Center.

And, in turn, this is really about identifying ways to achieve rapid cycle learning about the payment reforms and the delivery system reforms that they can encourage and support and bring along, as I'll talk about, trying to create a virtuous cycle in order to get to better quality and lower cost in our health care system as quickly as possible, something where there's a lot of promise, a lot of good ideas out there, but the pace of change, the pace of improvement hasn't been as great as many of us would like and may not be fast enough unless some significant changes occur for getting us to a sustainable health care system. There's certainly lots to do. If you look at this slide, it shows just a few of the timelines established by the ACA and the stimulus legislation before that relate to improving quality of care. This is a relatively short time frame for achieving and in measuring significant improvements in care and reductions and cost.

On the other hand, even though this is an ambitious time frame, if the steps don't succeed, as many critiques of the legislation have pointed out, what we may end up with is further pressures to squeeze down prices, further restrictions on access, and larger, not smaller, gaps in quality.

So it's very important for these kinds of steps to come together. And they depend not only on the Innovation Center, but on things going on in the private sector now and in other parts of government.

For example, the national quality strategy and the next round of payment reforms like the meaningful use health IT payment should depend on each other. Both are aiming for the same goal of better quality and efficiency.

The Independent Payment Advisory Board that's supposed to be up and running, making recommendations in 2014 to lower health care costs and improve quality will have a much harder time doing that if it doesn't get a much stronger evidence base than what we have now. And in the private sector, lots of initiatives underway at the local level, and organizations need both reinforcement and evidence from the public side, as well. So that's really the background for our focus on the Innovation Center today.

And just to provide a little bit of historical context, this is obviously not the first time that CMS has sought to implement pilots and demonstration programs with the intent of improving quality and lowering costs.

Many of these previous demonstrations and pilots have produced valuable evidence and have had an impact on health care, but they also highlight some of the challenges ahead.

In this slide, we present the timeline for the physician group practice demonstration. When it was implemented on my watch at CMS, it was authorized by Congress in 2000 in the BIPA legislation, but because of the steps, and they're listed on this slide, in terms of pre-implementation, defining and refining the design, the solicitation process, the slide selection process, the waiver approval process through HHS and OMB, and then the negotiating the final contracts with the participating sites, it wasn't in 2005 that the actual demonstration got underway. It had some good ideas and some consistent or comparable results, but the final evaluation on this reform isn't yet done, and it's coming towards the end of 2010.

Now, not to say that this demonstration has not had impact on policy, it has, it was one of the factors that went into the ACO legislation and the scoring evaluation of that legislation, and it's certainly been looked at by many in the public and

private sectors as a model for other shared savings and accountable care payment programs.

But you get an idea, because of this timeline, the evidence on shared savings; the whole goal of that demonstration isn't as comprehensive as we'd like to move forward quickly and confidently across our diverse health care system.

And so that leads to the real goal of the Center for Medicare and Medicaid Innovation. It was intended to change this, to bring better evidence to bear faster on what works in payment reform and to provide the direction and the momentum for achieving quality improvement and cost reduction facilitated by the ACA.

It's intended to implement promising payment and delivery models more quickly, to determine their impact more rapidly and in a more compelling way, and thereby, to help assure that these reforms can diffuse out into the health care system more quickly and effectively, as well.

The CMI is supposed to be up and running in January, 2011, and has funding of $10 billion over the 2011 to 2019 period to fund and test innovative payment and delivery reform models, coupled with the flexibility given to the Secretary of HHS.

Under the Affordable Care Act to expand successful models, this has a lot of potential for influencing the health care system, but obviously compelling evidence would make that job a lot easier.

And this brings me to talk for a minute about how the CMI and these other payment reform initiatives that are part of the law, they're being implemented in the private sector now, aren't really health care reform in and of themselves, they interact with health care providers and patients, though, in a way that can make it harder or easier for them to make decisions that achieve better care at a lower cost.

And that's what I want to illustrate on the next few slides which starts with patients interacting with their health care provider, that is an increasingly complex set of interactions with a tremendous amount of health information generated through patient encounters. And in our health care system today, it is exchanged, at least to some extent, in order to support better decision-making.

But there certainly are lots of gaps beyond the limited patient registries and the alerts and reminder systems that we have today to help support better decision-making. And there's obviously a lot more that we can do through better electronic feedback to health care providers and patients through other steps to help improve the delivery of care.

Part of that, as well, is the importance of timely information from CMS and from other payers. And again, it's relevant to the CMI discussion because it's not just a matter of getting information from these pilots to evaluate them, but finding better ways to support the caregivers and patients involved in these pilot programs so they can actually achieve better quality care.

There's been a lot of discussion about using information from claims, as has been done in pilots before to come up with consistent performance measures, to help support measuring quality of care and cost of care, and therefore, impact on quality and cost, but it really should be viewed as a two-way street, and hopefully reinforcing a two-way street. With better measures of performance, it's possible to provide better data to the people involved in care delivery, and that, in turn, facilitates more improvements in care, and if those are measured and those lead to savings and additional incentives and support, you've created that virtuous cycle that I mentioned before for changing payment

in ways that support improvements in service delivery and improvements in quality and

cost.

There are a lot of different payment models being tested now in the

private sector and in the public sector. This slide shows some examples. On the left

hand side, they start with paying for reporting, the physician quality reporting is an

example of that, paying for care coordination such as through medical homes, paying for

actually achieving improvements and results or performance as an episode based

payment, and then on across to actually paying for better value at the patient or

population level through shared savings programs and partial or full capitation programs

where the payments are also tied to actually achieving better results of care.

So lots of these kinds of examples underway on a base of a payment

system that pays mainly according to volume and intensity, not on the resulting costs or

quality that patients receive, and a lot of potential for building on this going forward.

This slide, going back to the one I showed you before, helps show how

that can happen through better performance information given to patients about

providers, and getting better information from patients to improve this data exchange

process, and really over all to put the pieces together to enable us to test different

payment and delivery models, identify those that have the greatest potential for improving

care and building on them.

Again, this virtuous cycle of payment reforms linked to changes in health

care delivery supported by improvements in data flows that gets to measurably better

care and support further improvement.

So that's the kind of background that went into our planning for this event

today. We wanted to turn this sort of theory, which many people have been talking

about, into reality. That's the big challenge that's ahead for CMI and really for all of us in

the public and private sectors who are working to do something to get us out of this

unsustainable course that we're on in terms of quality, cost and access to care. There

has been a lot of work going on already to support the Innovation Center, a lot of great

articles and op eds, a lot of discussion about this in other public forms. This is all a

recognition of just how important CMI is and how important of a role it could play in the

implementation of the health care reform legislation.

Today's discussion and the underlying paper that you have in your

packet and the further work that's going to follow from today's discussion is intended to

build on all of this prior work and also incorporate a lot of perspectives from many

different stakeholders and leaders about how CMI can best be implemented to spur

innovation and facilitate rapid testing and multiple models and rapid cycle learning.

We're trying to take a comprehensive look not just at the Innovation

Center, but where it fits into overall health care reform and how the other levers that are

available to HHS, to the federal government, and on the private sector side and at the

local side can all work together for maximum impact.

So that's what led to us inviting a diverse group of participants to start

brainstorming around these topics at a workshop that we held in July. It included

perspectives from federal and state officials, private health plans, provider groups, patient

advocates, private equity firms who have a lot of experience in seeding innovative efforts

early. From this discussions, a number of key themes and areas of consensus started to

emerge, and that's the basis for the paper that we provided to you today.

And just to help warm that up, and that's what we're going to focus on in

this upcoming discussion, you can turn to page seven of that paper, and I've been trying

to follow along with the slides, a lot of paper for this, but it's a, you know, this is an

information intensive system, right.

That slide has a high level summary of some of the areas of early

consensus, where there seem to be a lot of common ideas about how to go forward, and

we're going to be talking about some of those in greater length over the next few hours.

This includes methods to streamline the pre-implementation process for

Medicare payment reform. How do you get these promising models off the ground

quickly? For example, templates can be used to make the application process more

predictable and faster, and the clearance process within government, as well. Starting

with models that have already demonstrated through private sector implementation or

other implementation, some proof of concept can help.

Second, methods to improve the evaluation process, another place

where time could be reduced, and that includes that bidirectional data feeds that I

described earlier, so payers and providers involved are getting quicker feedback and can

make changes as a result faster, so you're going to see effects faster that way, as well as

having a common core set of pre-agreed metrics that are already being collected, so you

don't have to take the time and effort to set them up in each particular case.

Also, methods to diffuse promising models more quickly. There has

been a significant amount of experimentation, piloting already underway, and CMI could

facilitate a national platform for this kind of – for improving knowledge sharing across all

of this.

So these are some of the ideas, there's a lot more we're going to talk

about today in terms of putting it all together to get to better care at a lower cost. So

we're going to come back to that starting with our first panel. The first panel is going to

talk about implementing CMI for efficient evaluation and system-wide impact. After that

presentation, we're going to have discussion and feedback on what's needed to reduce

the cycle time of implementing these reforms and changes in health care delivery

together and effectively between pilot solicitation and implementation and evaluation and

dissemination to meet the needs that we have in our health care system to get better

care at a lower cost.

　　　　　So if the first panel represents a needs assessment of what's required to

spur innovation and facilitate rapid cycle testing and learning, then the rest of the

afternoon is going to focus on the key role that HHS can play in helping to lead and

provide momentum for these changes that need to occur beyond HHS, in our whole

health care system.

　　　　　We're going to have CMS Administration Don Berwick with us to deliver

a short keynote address about the Innovation Center and his views on it and some

discussion around that. And then we'll have a second panel later in the afternoon to

broaden this discussion to areas where HHS can play a key leadership role in

transforming the health care delivery system that we have today, which will require a

concerted effort not just across different parts of HHS, but also with stakeholders in the

private sector and in state and local government. So I'm going to take a breath, and

that's an overview of where we're headed. And I'm going to take a breath and call up our

panelists up to the front of the room.

　　　　　And while I'm introducing them, if you all could come on up. I'd like to

start with Doctor Al Dobson who's with us today to help get us started with some opening

comments. He's from the – North Carolina, where he led the development of Community

Care of North Carolina, which is a Medicaid care initiative that has subsequently become

one of the so called Section 646 demonstration sites. That's one of CMS' community level payment reform demonstration initiatives, multi stakeholder, multi payer.

He's also been actively involved in many health policy initiatives both at the state and the national level, including not just during his time as Director of Medicaid of North Carolina, but also now as a visiting scholar here at Brookings. Al is going to talk about implementing the CMI for efficient evaluation and system-wide impact. You guys can come on up.

And Doctor Allan Korn, Senior Vice President and Chief Medical Officer of Blue Cross and Blue Shield Association, is joining us for reactions, as well as Doctor Polly Bednash, the Chief Executive Officer and Executive Director of the American Association of Colleges of Nursing, and Lisa Suennen, who's the Co-Founder and Managing Member of the Psilos Group, which is a health care focused major venture capital firm.

We also are going to have with us shortly, they're on their way over right now, I've been getting GPS coordinates from their car, Doctor Aaron McKethan, the Director of the Beacon Communities Program. Aaron is already here. Our GPS coordinates are slightly outdated. And Rick Gilfillan, the Acting Director for the Center for Medicare and Medicaid Innovation, as well as the Director of the Performance Based Payment Policy staff at CMS. So if all of you could come up, we'll get started.

MR. DOBSON: Well, good afternoon. Why everyone is getting set, thanks, Mark, for the opportunity to be here and be part of this discussion. I'm going to start off by just hitting some high points of what we think are some initial points related to the Center for Medicare Innovation. First, when we look at the Center for Medicare Innovation and what it can do, clearly we're trying to move the bar a lot faster than we have in the last decades, which means we have to identify quickly promising models. So,

you know, we need clear templates for evaluating payment and delivery system reforms versus, you know, the traditional practiced of negotiating design individually with individual test sites and then evaluating it afterwards.

You know, a potential option for CMI would be having clear templates, related payment and design and delivery systems with clear criteria up front for people who apply, and communicating those to the applicants so that CMS can determine quickly which proposals have merit.

Standardized templates also convey a consistent expectation of what the outcome needs to be. You know, we did that in North Carolina with Community Care, we had a pretty broad brush as we developed systems locally, but probably a better – even a better example is within Medicaid.

Medicaid is used, template waivers such as the money follows the person as a way to ease the administrative burden and get programs moving within a framework fairly quickly. We can also leverage models with demonstrated proof of concepts and build evidence around them. We have plenty of proof of concepts out there, examples being ACO's, medical home, bundled payments, both not only in federal government, but also in private sector. So CMI could use these proof of concepts to select pilots broadly versus seeding a whole bunch of new ideas.

They could build an inventory of these models that are already tested by states, not only locally by government, but also in the private sector, and examine how these can be shared and built out and scaled up in a more large scale national pilot.

Also, the results need to be timely and transparent so that we can learn as these different models are rolled out. And again, I think we've got plenty of proof of

concepts out there to put in some coherent national innovation around ACO's, medical homes, bundled payments and many others.

Implementation should also be with policy goals in mind. In other words, you know, we're building for the future, so we need to have at least some idea of what we want the delivery system to look like in the end. You know, our traditional approach has been that we've done small pilots, but they haven't been done in such a way that we can ask for the key policies questions about when we're done, what are the impacts at the local level around quality, disparities, cost. And often they're built in such a way that we don't know how we're going to diffuse them on a larger scale.

So one of the ultimate goals of CMI is to disseminate models that have proven to be – to work and disseminate them broadly, and not just around Medicare and Medicaid, but look at their impact on the broader delivery system, whether it's, you know, Medicare and Medicaid, but also the private insurers.

And if we can't get multi payer initiatives up as part of these demonstrations, we should at least have national consistent cost metrics to facilitate the valuation of these new models that have been spurred by the public system and visa versa so that we can look over spillover effects.

The other part is, you know, clear metrics. You know, different metrics are used often in different projects, which gives us apples and oranges to compare with. So one of the key things that CMI can bring to the table, and CMS, is really core metrics could be system-wide. They should be used to look for unintended consequences such as cost shifting between public and private payers, look what's happening to health disparities, look what's happening to quality. If our goal is better quality at lower cost, we need to have consistent measures as we look at those.

We also should spur innovations through performance standards and results rather than design standards. We typically do RFP's, which are very, very, very specific, on how the design of the program is meant to occur.

And ultimately I think we will get much more spread if we are broader and more flexible in our design characteristics and leave the standards and the results. The outcome results is what we hold constant. Again, in our experience to North Carolina providing a broad brush in allowing the local communities to organize themselves in a way that was within the parameters we set out, gave us the local variation, but with some consistent results.

Some potential examples of this would be we're not sure exactly what the ACO structure needs to look like. What are the variations that may occur? Integrated delivery system, virtual networks, you know, public, private, what characteristics does that look like? The last part is -- and the thing I'd like to address is around the need for ongoing performance evaluation, and particular around timely data, and timely and relevant data. As Mark talked about, we have a lot of work to do within the next very short period of time to really bend the cost curve, so we can't wait ten years to find out what's working. There needs to be an ongoing evaluation and adjustment in the process. And we shouldn't be scared to discontinue those projects that are not showing results.

Our traditional evaluation project for most demonstrations have been post-op. I think it's very important that CMS and private health plans provide timely and ongoing claims data. Until we build out a really robust clinical HIE, you know, our claims data set is probably our most reliable way of doing cost and quality evaluations.

That's not to say that we shouldn't take those claims data sets and enhance them with clinical data and data from other sources, but as Mark illustrated, this

timely feedback will do two things, one is, it will provide actual data back to the communities to adjust their pilots, to know whether they're meeting their performance standards, but also will put back to CMS and to the private insurers meaningful information to judge the success of the demonstrations. So, therefore, HIT can be leveraged across those data and real time evaluations, and CMI should endorse and support pilots that include the efforts in integrating the clinical information with the claims information.

One of the major things that needs to be done is to have a standard set of data feeds and templates for data exchange and evaluation by the different pilots. Again, in our 646, it's taken quite a while to get data feeds out, and again, I think one of the things that we can have a standardization of ways to put data to our pilots across all our demonstrations, then we will get there a lot faster. So that concludes some of the core points and key points from our previous discussions, and I look forward to the discussion with you guys.

MR. MCCLELLAN: Great; I'd like to thank you all for those opening comments. I'd like to remind our panelists that they have attached to the back of their chairs a little microphone that they can use for making comments going along here. We're a do it yourself group here at Brookings, so get that attached on.

And what I thought I'd do is just go down the line here with you all, Allan, starting with you for your comments reactions to get this discussion going. Any key points to add or clarify from what you've heard so far?

MR. KORN: I want to ask what should the delivery system look like in the end. You know, I have a hobby that's architecture and I like the way (inaudible) put it, you know, let form follow function. I want to ask the question, what should the delivery

system do at the end? A regular form, if you're doing it right, that's fine. Lots of kinds of cars in this country, they all get you from point A to point B and they're all, by the way, safe.

Now, one of the reasons that we've been so long in getting the answers to the questions that are asked today, and how many hours, Mark, have we spent in this room and others talking about this, is that those people making the decision aren't on a burning platform.

And the fact of the matter is, there is a burning platform in this country, it's called safety. And I think if we actually want to get things to move quickly, we put the people who are engaged in this effort, including CMI, on that platform. And the first thing we do is we make care safe. An attribute of every accountable care organization, however it defines itself, needs to be chasing zero defects, it's time. We've known about it for more than a decade, we need to fix it. And so if we're going to innovate, on whose behalf are we innovating? We've been to a lot of meetings, and we can all make an argument that health plans have an agenda, CMS has an agenda, Congress has its own agenda, providers, et cetera, we all have agendas, but how about putting the patient in the middle?

Let's innovate for the benefit of the American people who will ultimately access this system. And if you ask them what the attributes of this system should be, as we have, they're going to tell you, I want to be safe, I want to have access to care when I need it, I want to know what's wrong with me and what my choices are, and someone needs to teach me the secret handshake so that as I progress through my illness, I know what's going on and I'm a part of the discussion.

So I would say that to make this thing real and move, the innovations that we need should be initially focused on safety. And I would suggest that if CMI really wants to give the academy award for safety right out of the box, it finds the person who can invent the seatbelt, air bag and child restrain seat for hospitals, there's innovation. How do we make care safe? And I think once we get to that, everybody will be engaged. The Blues certainly are we have a national safety agenda that's going on today. Our data, as you know, have been pulled, 50 or 60 million of our members are in a consolidated base that after much angst, we've agreed to share, and I think it's going to make a significant contribution to this entire effort.

So I would plea that the attributes of any delivery system should be defined on the expectations of what we wanted to produce. And I don't mean the generalities, better care or lower cost, yeah, let's start with making it absolutely safe.

And by the way, that means that we no longer do marginally effective or medically unnecessary procedures, because however good the outcome, they're not good, and they're unsafe, because you're all risk and no benefit, and we'll be avoiding hospital, avoiding infections and all the things that we know are out there today.

The other thing about some of these measures, that we avoid the endless discussions about risk adjustment. Death is pretty easy, it either happens or doesn't. And if it was related to something that wasn't present when you entered the hospital, we don't have to risk adjust that, it shouldn't have happened. So I would say that let's create – let that platform burn, it has for ten years, unfortunately it's not consuming itself, it keeps burning, but let's put those of us who have to solve this problem on that platform.

MR. MCCLELLAN: And the measures are ready to go for that based on your experience?

MR. KORN: You know what, you know, Mark, if we can avoid some of these arguments about my patients are sicker, you bet they are, they're there. We all know what we need to be doing.

MR. MCCLELLAN: Thanks, Allan. Go ahead.

MS. BEDNASH: Thank you. Well, I come to this from a perspective of the provider supposedly and was asked to talk a bit about the provider group I represent, and those are nurses. And I enjoyed being at the first meeting regarding CMI, and I appreciated the report and its focus on the need for great data and the need to be able to analyze and have rapid transformation occur out of the data. But I think part of the process is missing when we focus only on a data, and that is, how the processes of care are designed, who's involved in the care, and who's doing what. And then any conversation about innovation must begin with some kind of a focus on how care should be delivered, who should be involved in the care delivery, and how it should be organized. We cannot achieve quality, safety, effectiveness. You ask about finding those seatbelts and those car restraints for the hospital, I would assert that they're there and they're not recognized adequately, and those are the nursing staff that are there.

So we can adhere to an environment of innovation without understanding that providers who think they own the process are missing an important and fundamental part of how we achieve innovation.

And I want to quote something you said last time, Lisa, and that is that the team is everything, the team is everything, that the team is formed to deliver care is

the most fundamentally important aspect of achieving the goal of innovation and assuring

high quality care.

        And I would also assert that no one clinician should be so focused of any

attempts at innovation. You are probably not surprised to hear me say that a physician-

centric approach to innovation and innovation and care is flawed. Additionally, the array

of statutes, regulations are just historical practices that inhibit a more nuanced view of

how care teams should be designed and how the multiple providers can practice can be

challenged and should be challenged by CMI in any attempt to foster innovation.

        As you may be aware, there are no national standards for how scope of

practice is defined for advanced practice nurses such as nurse practitioners, anesthetists,

or midwives. The variation in regulations and statutes defies human understanding.

        As an example, a nurse practitioner in Kansas City can walk across the

street to a different state and have his or her practice authority change by the simple act

of ambulation. The variability of practice authority is not evidence based. If rules or

regulations were evidence based, this variability would disappear, and the most

expansive scope of practice would be possible.

        What is different about Portland, Oregon and Huntsville, Alabama where

a nurse practitioner can practice in Portland, Oregon with complete independence, but

have markedly limited authority in Alabama?

        A long trail of evidence exists over the 40 plus years of nurse practitioner

practice that is clearly shown, safety, quality and cost efficiency of care provided by these

individuals. So we can only guess what makes the changes in these laws so difficult. So

if we're to follow the recommendations made in the July meeting that we should quickly

understand where the winning innovations area and spread them widely, then we wouldn't have this variability.

And if we really believe we should use evidence for practice and that the evidence regarding advanced practice nursing would have eliminated these variations, and the innovative models of care that exist that were designed and implemented by nurses such as nurse managed clinics and transitional care models would not simply be demonstrations at this point in history, but would be evidence based innovations and care delivery with outstanding outcomes that are respected and disseminated, replicated and reimbursed.

So I would urge that the next stages of work to support a foster innovation have several essential components. First, any proposed innovation designs must include specific indications about how a team of health professionals will be incorporated in the innovation, with clear indications of how the organization of care will look at the fullest use of the various health professionals who are on the team. Second, I would also assert that any effort to create data sets that will allow rapid assessment and transformation of care include a series of measures that assess all elements of the team; creating performance measures that are solely focused on one provider's impact will leave a void in understanding the impact of care.

Third, I urge the CMS to address the recommendations included in the recent IOM report in the future of nursing and use the power of the regulatory frame work to challenge the limitations and scope of practice.

The IOM report recommends that the Center for Medicare and Medicaid Innovation should support the development and evaluation of models of payments and care delivery that use nurses in an expanded and leadership capacity to improve health

care outcomes and cost, and performance measures should be developed and implemented expeditiously where best practices are evidenced to reflect the contribution of nurses and ensure better quality care. Thank you.

MR. MCCLELLAN: Thanks very much, Polly. And on that last point about scope of practice and compelling evidence related to the need in some cases it sounds like for changes in scope of practice, do you have some specific thoughts for how CMS can make that happen? Can you do a demonstration on one side of the street that would then be applicable elsewhere?

MS. BEDNASH: Well, I think CMS has tremendous power by being able to state a set of expectations about what should be incorporated in the design. And saying in the design that providers should be able to practice to their fullest potential according to their education and their competency and for the project to have to show that there's a reason why in one place they shouldn't be allowed to do that, what is the difference?

They require a specific and explicit demonstration of what the differences are. I don't think those differences exist, and it would push the envelope on what ought to happen around scope of practice authority. If evidence were the answer to the design of these standards, then they wouldn't exist. The evidence is there, it's been there for 40 years. This has to do with something very different in innovation or concern about safety and quality and efficiency.

MR. MCCLELLAN: And if it's not addressed, it could really slow down the implementation frame that we just talked about.

MS. BEDNASH: It will slow down implementation, absolutely.

MR. MCCLELLAN: Okay, thanks. Lisa.

MS. SUENNEN: Hi, thanks very much, Mark. I really appreciate being included in this process. I'm not sort of exactly the same as everybody else up here coming from a venture capital background as I do. And I think what CMS is trying to do here is really important to our nation's economic health, so I'm definitely a support of it.

One of the things that I worry about is that some of the things that we've talked about here in through other meetings such as ACO's and pay for performance are ideas that have been tried before under other names, you know, like practice management and capitation with bonuses and things that didn't work out so well the first time around, so I think it's going to be very important for us to learn from history, as well as create new history.

I was asked to weigh in specifically on a few items, and so I'm going to work through those here, and one of them is this program feasible, and I think it's definitely feasible. I think the issue here is defining value in true qualitative and quantitative terms. For instance, we can talk about metrics and data, but one of the most important metrics in knowing whether a health care system is working is patient satisfaction. I think you talked a little bit about that, Allen. And I think understanding what that means to patients is a lot different often times. It might mean how fast did they get their appointment and whether they got particular good quality care, as many of us would define it.

With respect to the completion of the program, one of the questions asked is, is it complete, and there were a few things missing for me. One of the things, and I'm sure there'll be more work done, how applicants to this process are going to be qualified.

You know, really I think much of the input to this process has come from large corporations, great corporations that have done a lot of good work in the health care field, but young companies are where a lot of innovation comes from.

And, you know, a lot of the larger corporations have to tie themselves in knots a little bit to make changes to their system to do things differently, and that's always a worry for me. You know, when somebody says, sure, sure, we can do that, we haven't done that before, but we can do that now, you know, they kind of have to kill their own children sometimes to change their business models and that doesn't always work in a sustainable way. So I would caution, you know, the consideration of applicants in that manner.

And secondly, the due diligence process and how are these programs going to be vetted, these applications, and how, you know, what's the intensiveness with which they will be reviewed before selected for grants or what have you?

And, you know, particularly around things like operational fundamentals, you know, and the team, and you know, are you going to take the time, are we going to be able to take the time to really interview the team members so add input to the team members to make sure that the leadership of these programs can be effective even if the idea is good. A great idea can be killed by poor leadership, and that's something that really needs to have a lot of attention, as well as thinking about it from what I would say is a business standpoint.

How does the budget and the financial requirement change over time, and how do you allow for that to happen as you learn about programs as they evolve? Thirdly, I think the project management and how you manage these programs on an ongoing basis is really essential. The way that we manage programs with new

companies or we invest in them is, we sit down at the table with them all the time and

work with them hand in hand to make sure it works. And we provide them with directions

and ideas and information, and when they aren't effective, we change out leadership or

we change direction or we change strategy, and I think that's really important learning

from the private sector, is that most of these young ideas don't work the first time, but

every company that we've successfully exited for a large multiple almost died somewhere

along the way.

　　　　　And so, you know, figuring out how to prevent them from committing

suicide is important, and working with them to help them be successful in a very hands

on way is important. So I would urge CMS to think about things like boards of directors

and include people from the organizations and from the institute to sit, you know, monthly

and work together in concert is really important.

　　　　　I think that CMS is going to need a lot of patience for these things. You

know, as you cut costs, the money has got to come out of somebody's pocket, and

they're not going to be happy about that, and the political consequences of that can be

very difficult, but they're going to have to be faced. And one of the ways I think that we

could maybe accelerate moving in some of these areas is flexibility around existing

regulations, and you do mention that, Polly.

　　　　　You know, everybody knows, for instance, that provider choice adds cost

to the system, you know, but it's hard to cut down the number of providers that are

allowed to participate. And so figuring out ways to waive any willing provider laws, for

instance, might be a way to advance an objective, although it might be politically difficult.

　　　　　The same thing around interstate medical practice laws, being able to

practice across state lines for telemedicine, for instance, well known that it can improve

quality and cost, but politically it's been very difficult to institute. But to the extent we can forge ahead on some of those regulations and provide flexibility there to effect programs, I think that would be a good thing.

With respect to some of the lessons learned in the private sector, you know, I was asked, you know, what do we do to make sure our companies succeed, and, you know, as I talked about, you get what you inspect, not what you expect, meaning you have to be very hands on. But also we do things like tie funding to milestones, so we don't provide all the money a company needs up front, we provide a certain amount until they get to a particular measurable goal, and then the next amount at that point and the next amount working together to move, you know, move down the field.

We also spend a lot of time thinking about when to cut our losses, you know, when is it time to fire a CEO or a manager of a program and bring somebody else in, when is it time to say, you know what, this just didn't work, cut it off, you know, take the money out and run.

Then I think of something that has to, again, be built into this process. It's not really typical of these types of government programs. And you need to really be fairly emotionless about it. You know, people can't get too invested in their ideas.

The last thing I want to say is, again, you know, small companies are the ones that don't engage with government most often. They are not probably here represented in the room except maybe through me and others. And, you know, small companies are really where the big disruptive innovations tend to come from. And I would, you know, urge CMI to figure out a way to engage small companies in the process, because they don't usually have the money, they're afraid of it, they don't

understand it, and if there's some sort of ombudsman process or whatever to engage small companies in this delivery of ideas, I think that would be a really wonderful thing.

If you look around and think about, you know, all of the companies that we lawed in health care are the ones that have 100 and 120, 140 year histories, but if you look at technology, the companies that are the big leaders say have been around for, you know, maybe 20 years, and that's a good thing, that's considered to be a plus.

You know, so we have to really think about who's going to be able to change the world, you know, our health care world, and be successful and expect that it's probably going to be not just the usual suspects, but often some new suspects that we haven't seen before.

You know, with respect to that, that's really my last thought is, it would be wonderful to find a way to engage more companies here, whether it's through the types of programs like minority owned or women owned investments that, you know, that the government has used in the past to engage non-traditional companies, it would be nice to see something that engaged the small companies in a meaningful way.

MR. MCCLELLAN: And you all have experience with that in health care delivery, so this is payment reforms tied to health care delivery forms, and there are groups out there, you know, even though this is health care, where there's lots of institutions and so forth, there are groups out there that fit the bill that we're discussing?

MS. SUENNEN: Oh definitely. You know, the thing that we find often is, if we see a new idea that's so wild and we call all the big experts in the field, from the usual large insurers, large hospital organizations, and when everybody tells us it's a terrible idea, we know we're onto something. You know, there's a universal score and we know there's something there. We, you know, we really think about it that way.

MR. MCCLELLAN: But do you back it up with milestones along the

way?

MS. SUENNEN: Of course, milestones and data.

MR. MCCLELLAN: Great; Aaron, I'd like to turn to you next and then

come to Rick for some comments to close out this opening round from the panel.

MR. MCKETHAN: Thanks, thanks very much, Mark, and it's a pleasure

to join this all star cast and all of you today. I was asked to talk a little bit about the

Beacon communities, which I will in a minute, and think through some of the very early

"lessons" from the implementation of Beacon communities as we think about broader

innovation capacity.

The big disclaimer, of course, is that Beacon communities are very early;

we just got started, so it's probably – we're just considered as rough draft lessons, if

anything. But for those that don't know, there are 17 Beacon communities that are each

setting specific health goals around the country, from Maine to Hawaii, cost, quality,

population of health really aligned with the Triple Aim, and they have support from the

Office of National Coordinator for Health IT.

And you can think of a Beacon community in Indianapolis, which is,

among other things, working on finding specific ways of avoiding preventable hospital

readmission for chronic patients. Or in North Carolina's Beacon community, where

they're trying to reduce emergency department visits and complications among children

with asthma in that community, or adverse drug events in Mississippi and other

communities. So the notion of setting specific health goals at the community level, not at

the provider level, per se, limited to hospitals or physicians, but at the whole community

level has proven so far to be a very powerful, motivating device that's happened to the kind of social capital that exists in the Beacon communities.

Of course, it helps a lot that the communities are working together toward common measures. If you're really trying to reduce hospital readmissions or improve complication rates among diabetic patients, for example, what do we mean by that exactly? And so we spend a lot of time, more than I would have guessed, on helping the communities move towards something that looks like a core set.

The other interesting aspect of our work so far has been that there's not one specific intervention in each community that is designed to be the thing that's going to lead to the achievement of that performance improvement goal. There are multiple things implemented together. So you can take the example of Indianapolis working on hospital readmission, they're engaging private pairs around value based insurance design, they're implementing care managers, they're expanding the use of their physician reporting and performance feedback systems, they're providing telephonic support and real time support for patients. There's a whole lot of things happening in the service of that very specific aim at each of these communities, which makes the job of evaluation of the discreet pieces of each Beacon community really challenging.

It's not clear whether it was the care manager that worked in the hospital calling those patients and ensuring they have their medications reconciled upon discharge, or some other activity going on in there that actually led to the results.

But I think, at least in our context, we think a newer appreciation and a comfort level or tolerance for the kinds of research evaluation designs that involve multiple interventions happening at the same time all moving toward a specific set of common measures has been an important step.

The idea is we're not going to incrementalize our way into fairly substantial improvements in performance quality cost and population health in these communities. It really is going to take a lot of things coming together at once to get there, and the evaluation and data analytic capacity to actually know whether all these reforms at the community level are adding up to real improvement.

The communities are in different places developmentally and they're – whether they have any kind of real systematic community-wide data to know are your interventions working, they're hoping that we can be part of a broader network working toward the kinds of data analytic capacity and timely information from Medicare and Medicaid and private pairs that Allen Dobson mention in his paper.

And we would echo that, and, A, it's important to know, are these interventions leading to some improvements, can we have the basis for evaluating results at the community level or the population level, and can we identify specific opportunities to improve care where in the opposite data it really becomes hard.

One big missing piece is the topic of today, which is ensuring that the payments are actually aligned with the kinds of quality improvement activity that's going on in these communities, and that's why we're spending a lot of our time helping the communities be as ready as possible for the kinds of accountable care and other payment models that will, over time, reinforce the quality improvement activities, and thereby, avoid this sort of chicken and egg phenomena that we so often see. Can we find ways of reducing readmissions? Yes, but doing so without payment to back it up make it really difficult.

So we view the Beacon communities in a glide path for the longer term help system improvement where financing ultimately becomes a key part of reinforcing the performance improvement gains.

I think finally a tolerance for understanding the risk and encouraging these communities to push themselves in ways that they may not have done in the past is a really important part of any innovation capacity. We all have to learn to tolerate a bit more when some interventions that were tested and measured carefully don't tend to work out. Dayo gives us a sense of how we can course correct and iterate our way towards something that will, over time, work.

So it's a coordinated mess, you know, coordinated in that we have clear goals and clear performance measures to back those up, but a whole range of steps and interventions that will hopefully get us there. And I think there are a lot of core areas where our country is headed and overall innovation capacity, including the gentleman to my right.

MR. MCCLELLAN: And it does – I think most of the audience here knows this, but since the Beacon communities were part of the health IT legislation that was in the stimulus bill, you're sort of a year ahead of where a lot of the activities funded under health care reform legislation are headed, so some useful points for –

MR. MCKETHAN: Basically added pressure.

MR. MCCLELLAN: That's right. Well, speaking of added pressure, Rick is, you know, one of the pieces of advice I got when coming to Washington, and you're a relatively new transplant still, is start with low expectations. And I'm not sure you've been able to do that.

MR. GILFILLAN: Yeah, right.

MR. MCCLELLAN: Pretty much people think that the CMI can really make a difference in these efforts or Medicare led payment reform can really make a difference in our health care system, so I'm looking forward to hearing from you.

MR. GILFILLAN: Thanks, Mark, and thanks for the opportunity to be here with you all today, and for the work you've done to date, thinking about how the Center for Medicare and Medicaid Innovation, CMMI, can be successful. It's been great work. I think the paper is filled with on target ideas about ways that we should think about operating.

I'm not going to go through them; I think Allan did a great job. A lot of those things that we've talked about, some are things we haven't talked about, so we appreciate the input.

I'm going to be a little vague because we're kind of early in the game here and we're kind of doing things you might expect us to be doing, we're putting a team together, looking for bright, committed, interested, experienced people, so if you know any, feel free to send them our way.

We're working on things like budgets and an initial plan and we'll be I think having more to say about that not too far down the road. But what's – I just thought I'd share with you a little bit some thoughts and then kind of what are we thinking about as a team.

I want to go to Allan's point for a moment about safety, clearly a critical point, one that I'm sure Don will touch on when he's here. We do think it's essential and we think there's great opportunity and it's something we should all address. And it's remarkable to think that Toyota had eight deaths a year due to accelerator problems and recalled ten million cars and we've had somewhere between 50,000 and 100,000 deaths

a year from, you know, care related incidents, and we still can document that we're doing better ten years after we first kind of identified that, so a very important issue.

But we are focusing and taking kind of a Triple Aim perspective. And I want to – and Don will talk about this, but I want to be clear, we think that it is a time where we have to think about all three dimensions, we have to talk about better health, and that's not just health care, that's a lot of different aspects of health, obviously we need to think about better care, and we need to think about doing it in a way that produces better cost and lower cost, and we think there's more than enough money in the system if we get folks thinking aggressively about all three of those.

So that's our frame work. It's not general, it's very specific. We'll have metrics within each of those dimensions that get at performance for lots of different kinds of entities. But we think there's no pass to ignore one of those dimensions. One needs to think about optimizing along all three. We need to do it for individual patients and we need to do it for populations.

So what's on our mind? Speed, how do you do this fast, right, and well, and how do we do this in the age of Facebook and the social network, dimension, saw it over the weekend.

Do we really think about RCT's and, you know, two years to develop the measures in a world where Facebook can come up and be disseminated the way it has as an example? So that's one issue we're thinking a lot about.

Related to that, how do we think about kind of, you know, the industry and the industry being able to resolve issues? I remember going to a meeting back in, I think it was April or May, and I heard talk about metrics, right, what are we going to do

about metrics. Well, here it is what, six months later, you know, and I hear what are we going to do about metrics.

You know, what if we locked three analysts and, you know, six policy people in a hotel room in D.C. for a week and said get to the bottom of this metric thing or get to the bottom of this patient attribution thing, you know, or get to the bottom of this case mixed adjusting thing? What are we going to do in a world where HCC coding is the best we can do and everybody is worried about, A, am I going to optimize HCC coding, and B, doing it, is it going to result in a run on the trust fund, right. How do we think those issues through as an industry and how do we get at them quickly and how do we do that sort of work as an industry with lots of different parts, but sharing many of those same critical questions, so we think about that.

We think about who should our partners be, who are our partners, are they people interested in doing innovation on the side and maybe doing – delving into a little of this, a little of that, are they small companies who are creative and excited about some specific idea, are they partners who have committed to pursuing the Triple Aim for their population, not in a hedged way, not in a little bit of on the side I think I'll do a little of that quality stuff, but as an organization, say we are committed to delivering Triple Aim outcomes for a population, and within that, we're interested in pursuing innovations that now become for us institutional imperatives, not nice ideas, not something to work on, the imperative is, I need to figure out how to do that, how would that be for a partner as opposed to some of the other partners you might think about.

We're thinking a little about portfolio management, big or small, how many. We might learn something from other sectors certainly about that, an important question for us in a world where someone says there's a lot of good stuff out there today,

let's go study it, find out whether or not it works, and double don on it if it does, right, so portfolio management is an interesting question.

And I raise these because we're interested in hearing peoples thoughts on these kind of issues that build off I think the document that you all produced, but kind of go to the next stage of, okay, now you're actually playing this out, how would you go at it.

Partnerships, who are the partners? Hopefully it's Blues plans it's local insurers, it's national insurers, it's providers, it's hospital systems, it's doctors, it's nursing organizations, and it's nurses, and will those partners come forward and say to us and work with us, and not just CMMI, but CMS, and say we are ready to talk about delivering those outcomes for our populations, so that's a critical issue for us. We're thinking about evaluation methodologies, and I'm sure there are people here who know a lot more about evaluation methodologies than I. But we think probably this is not going to be your father's innovation activity, and it's not going to be your mother's evaluation methodology, and we need to learn more about that.

And we're interested as an industry, again, in rapid – as part of the industry, in rapid development of an understanding, a deeper understanding of what those methodologies are and how we should deploy them, both in starting some of these initiatives, some of these innovations, and obviously in planning for evaluations right from the get go.

And then we're talking about diffusion methodologies. And again, it's interesting to think about diffusion in a world where things are changing as rapidly as they are, and we're thinking hard about what do we do to really accelerate not just the emergence, but the spread of new innovative ideas, what do we do about spreading and

setting up medical homes, ACO's, bundle payment systems, to be widely enough

dispersed to evaluate in different contexts, and then ultimately, hopefully if proven

successful, diffused further after that. So those are kind of some of the issues we're

thinking about right now. And I'm really looking forward to any thoughts you all might

have about those or any other issues you think we should be thinking about, but it's a

pleasure to be here with you and I look forward to hearing your thoughts.

        MR. MCCLELLAN: Well, Rick, thanks for the comments and thanks for

the challenges back to the group. Let me ask the people on the panel first before we

open it up to a few minutes of discussion, any reactions to what Aaron or Rick has said?

I saw a good deal of head nodding while Rick was making these comments, but as you

pointed out, Rick, the hard thing is, well, how do you actually do it.

        For example, if you want partners in this program that are firmly

committed to the Triple Aim, you know, is there an objective measure in that, how do you

go about identifying those companies? Is it just knowing the leaders, Lisa, as you said, is

there something more that CMS could be doing around evaluation and around getting

metrics implemented and doing it all quickly? There certainly are some further

challenges in moving along the framework that we talked about in the paper.

        MS. SUENNEN: Well, I mean just to your – since you called me out

there, you know, one of things we think about these things is, how you align everybody's

incentives, who's on the management side of the thing, not just the recipient side, but,

you know, how do you align -- and particularly the financial incentives, because that

seems to be whatever (inaudible) you know, the incentives of the managers of the

programs and how they're going to benefit from it personally and professionally, and from

a corporate standpoint, as well as CMI and the constituent organizations that are there, I think that's a really important part of it.

SPEAKER: I would also add that, you know, you challenge us about you can't – do we know how to decrease readmissions, but you can't do that unless you fix reimbursement. I would submit that we ought to add a few words to the English language here if it's going to really work. We ought to start with pro imbursement, let's call that traditional capitation, we all get that.

Then there's pre imbursement, that's the venture capital model, we'll pay you along the way in aliquots, when you achieve certain, you know, benchmarks in care, fine. Then we have reimbursement, which is what we do now, when the care is over, here's your check, whatever happens didn't matter. And then we need to add unimbursement, because if you do a really bad job, wait a minute –

MR. MCCLELLAN: That's the way the world works.

SPEAKER: And so I think that if we're really honest with ourselves and we want to begin to sort of implement some of these, the discussion has to move from everybody gets retail, and if you're terrific, there's a lot more money to – wait a minute here, there needs to be some recognition of the value that you deliver through this care delivery process.

But only one of those four words exist in the English language today. We have to do something about pre imbursement, pro imbursement and unimbursement, right?

MS. BEDNASH: Well, I think that idea. I've often wondered why it was that you gave standard maybe some minimal or some quality care, you could get paid, but if you gave good care, we'll give you more. There's something perverse about that.

One of the things that I would ask is, some look at why the evidence based innovations that have had an effect on things like readmissions have not been spread, have not been disseminated. What are the structures, what are the historical practices, what are the vices against where those models came from that keep them from being disseminated widely?

SPEAKER: And that includes reimbursement, but a lot of other institutional and organizational tactics, too.

MS. BEDNASH: Absolutely, you look at the transitional care model again that Mary Naylor has done all the research on about how you can keep chronically ill individuals with multiple illnesses and a very poor social fabric or social network out of the hospital, provides care by advanced practice nurses, and there have been years and years and years of these models being disseminated, replicated, and replicated, but it's not a standard for care at CMS, it's not something that can automatically be reimbursed for, it's continued to be a demonstration, so it gets demonstrated over and over and over.

When does it become the standard for care rather than something that we're doing experiments with? So there's a lot of evidence out there already about what works about keeping people from being readmitted, most of that driven by nursing practice Chad Bolt's work on the guided care nurse, why isn't that just a standard expectation that would automatically be reimbursed? It has tremendous cost savings.

SPEAKER: I think some of the other work needs to be done looking at the structure of collaboration which brings us together. I think when you see these innovations, they're usually in a silo where there's not the ability to translate them to larger groups, and I think Aaron can talk a little bit about the notion of the Beacon

communities, where you've gotten a lot of partnerships around a geographic area or community that aligns, you know, proprietary interest in a non-proprietary way.

MR. MCCLELLAN: Especially around Triple Aim.

SPEAKER: Around Triple Aim outcomes, which gets you to taking down some of the traditional silos, where it's not just about my silo, you know, being a winner, and this silo being a loser, which typically happens when you're talking about readmissions or decrease in cost. So I think really looking at what structures will be effected in bringing all the parties together to get a health care system going locally is extremely important work for –

MR. MCCLELLAN: Providing the momentum to do that.

SPEAKER: Right. It's been a great discussion. We have just a couple of minutes left and I'd like to open it up to those of you out here. So hands up and wait for a microphone if any questions or comments. Okay, over here.

MR. PESSICK: John Pessick with Miter. We operate fairly funded R&D centers. And I was fascinated by the talk that Doctor Dobson gave. I wrote down two notes and I'll just share with – one was D.C. mind sets. I was so happy to hear Lisa then come along and talk about that.

The other idea from industry is, and I wrote under that, by the way, public health ROI, which I think is what Mark was getting at, you know, there's safety, there's the Triple Aim, you know, that's there.

Concurring engineering was the other big idea. In industry, when they want to advance something from the beginning of an idea to production, you have to start looking at the implementation aspects in parallel with development.

And particularly for CMS, the execution of ideas takes a long time. To get them into the systems is arduous. And I want to say more about that, but I know something about that. And so it would be useful to look at concurring engineering as part of the process. Another question when Mark came out, that is, is $5 million a year enough or a $20 billion portfolio for all early stage ideas, and I think Lisa might have things to say about that.

The other thing is one process doesn't fit all. In D.C., you can have early stage people, then you have investment bankers who do mid cap, then you have brokerage firms that handle large cap. And so one process may not work for every kind of idea. We ought to have some that are pretty far along. Let's take a different path on some of those, you know. And then if we say to some, the evidence isn't in yet, treat them differently, but don't treat them all as being at the same stage gate in the beginning, I don't think that will work.

MR. MCCLELLAN: And, Rick, you made that comment about portfolio diversity and portfolio management, any comments on –

MR. GILFILLAN: Yeah, one comment. I think that there are concepts to use that are helpful for many different industries, and there are some; you know, that come from the entrepreneurial world, the investment world, health care, policy, et cetera. I don't want to leave here or leave you with the impression that we are necessarily taking one of – any one of those as the kind of framework for how we are going about our work.

MR. MCCLELLAN: Time for one more.

MR. BOOKER: Hi, my name is Roger Booker; I'm a Vice President for an entrepreneurial company here in Virginia that has been focusing specifically on providing lower cost solutions for senior care health providing. We've been very blessed

to develop technology out of the University of Virginia and to actually take that technology and create a company around it which was launched in 2009.

As we have continued to work on our technology, we partnered with non-profit entities to advance our technology in the senior care environment, specifically with the Good Samaritan Society, which is the largest not for profit senior care provider in the United States.

We've been very fortunate to work with them to secure some private grant money to actually do a 1,600 person long term analysis study randomized and being managed through the University of Minnesota to actually show the efficacy of our solution set on a much broader scale. We've done that in a small scale already and have demonstrated 75 percent reduction in care. But we're also trying to move the model from a reactive model to a preventative model. And so I'm very pleased you have a venture capitalist on the board. Several of you have already talked about the benefits of entrepreneurial companies, and I think our company, WellAware systems, is already right in the midst of that. And we'd love to find ways to work with every one of you.

MR. MCCLELLAN: I think there are a number of companies like this that are – Lisa, doing innovative things. Just to highlight one challenge is that typically these are going to focus on specific outcomes for specific populations and not, which is a step removed, I think, Rick, from the bottom line Triple Aim, actually showing that the health for the population is getting better and costs overall are going down, and I think that is a challenge.

MS. SUENNEN: I don't think that's true, Mark. I mean I think there's a lot of companies, I could name a couple that come to mind that are looking at it more systemically, looking at how to take people out of hospitals –

MR. MCCLELLAN: So you're fine with keeping that same systemic goal even for a small company?

MS. SUENNEN: Yeah, and not every company will qualify, sure.

SPEAKER: Yeah, but I would also say that, clearly, the portfolio I believe will be broad enough so that we can, in a way that ultimately ties to, you know, whatever a total population experience would be, that we understand that there are some populations for whom there may be real opportunities to make a difference, and we certainly will be paying attention to those and hopefully hearing from people who have proposals to address narrow segments. The key point is that they need to address all three dimensions, I think.

MR. MCCLELLAN: And they need to get to that bottom line, right?

SPEAKER: And they need to – I think – and I guess I'd stress, you know, one thing you can probably expect to see is a pretty rigorous level of attention to understanding data and outcomes along all three of those dimensions, and yes, I think that – so we'll be looking for that. But if someone has information or an initiative where they can demonstrate meaningful change on three dimensions for an important – for a segment of care, you know, we're all ears.

MR. MCCLELLAN: Okay, great, sounds like some great opportunities coming up. I want to thank our panel for an excellent discussion to start all stars off today, thank you.

(Pause)