THE BROOKINGS INSTITUTION

ADVANCING HEALTHCARE PAYMENT AND DELIVERY REFORM THROUGH CLINICAL LEADERSHIP

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WELCOME AND INTRODUCTION:

Moderator:

MARK McCLELLAN
Director, Engelberg Center for Health Care Reform
The Brookings Institution

Panelists:

JONATHAN GLUCK
Senior Executive, Merkin Family Foundation

WAYNE JENKINS
President, Orlando Health Physician Group

GREG PAWLSON
Executive Director, BlueCross BlueShield Association

CLINICAL LEADERSHIP IN CONGRESS AND LEGISLATION:

REPRESENTATIVE MICHAEL C. BURGESS (R-TX)
U.S. House of Representatives

REPRESENTATIVE ALLYSON SCHWARTZ (D-PA)

U.S. House of Representatives

TRANSFORMATIVE CHANGE IN THE DELIVERY SYSTEM:

Moderator:

KAVITA PATEL
Fellow, The Brookings Institution

Panelists:

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Executive Vice President and Managing Partner
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ANN HENDRICH
Vice President of Clinical Excellence Operations
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ELIOT J. LAZAR
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BARBARA L. McANENY
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REWARDING CLINICAL LEADERSHIP IN PAYMENT REFORM:

Moderator:

MARK McCLELLAN
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Panelists:

PAUL CASALE
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Chief, Division of Cardiology and Medical Director of Quality
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LEADERSHIP THROUGH INNOVATION: THE ROLE OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES:

RICHARD J. BARON
Group Director, Seamless Care Models, Center for
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COMMUNITY LEADERSHIP:

Moderator:

MARK McCLELLAN
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Panelists:

JEFFREY BRENNER
Founder and Executive Director
Camden Coalition of Healthcare Providers

BARBARA B. TOBIAS
Medical Director, Health Collaborative and Professor
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Director of Nursing, Nurse-Family Partnership

BUILDING CLINICAL LEADERSHIP:

Moderator:

CARY SENNETT
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Panelists:

DONALD CASEY, JR.
Vice President of Quality and Chief Medical Officer
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JACK COCHRAN
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SUMMARY AND CLOSING REMARKS:

MARK McCLELLAN
Director, Engelberg Center for Health Care Reform
The Brookings Institution

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P R O C E E D I N G S

MR. McCLELLAN: All right. Good morning, everyone. I'd like to thank you all for coming out on this rainy Washington Wednesday for what I think will be a very interesting discussion about "Advancing Healthcare Payment and Delivery Reform Through Clinical Leadership." I'm Mark McClellan. I'm the director of the Engelberg Center here at The Brookings Institution.

I am very happy to welcome the wide range of clinical leaders and other healthcare experts that we have here today. I think this is a little bit of an unusual meeting for one taking place in Washington in that just about all our presenters and many of you in the audience are clinicians, people with clinical experience as physicians, nurses, pharmacists, other health professionals. And that is the focus of our work today, as I'll talk about. We're launching a new initiative on clinical leadership to help drive policy reforms and real reforms in healthcare delivery.

In addition to the people in the room this meeting is being recorded for the web, so I just want to remind you that this is a for a broader public audience that we will be using in future work going forward. We will have, I believe, microphones available for comments during the course of the discussions today and we're certainly looking for a lot of your

input in this overall effort.

This is a timely initiative, I think, because of the challenges that we're facing today, greater challenges than ever before, to address the quality of care and the cost of care in our healthcare system. There is growing pressure to solve these problems, as I'll talk about in more detail over the next few minutes, but for a number of reasons I don't think we're going to get to sustainable solutions without a lot more and more effective leadership from clinicians in showing the pathway forward, not just in reforming institutions, but in reforming the policies that support better care and -- better healthcare and delivery.

The reasons for that, I think, are pretty clear. One is, as the debate about healthcare reform over the last few years has made clear, there will be a lot of public opposition to approaches to healthcare reform that are not driven by clinical goals of improving care for patients, for Americans, for their loved ones. Public opposition to approaches that could restrict access to needed care has become very clear.

Second, at the same time as the public doesn't trust others to lead healthcare reform, it doesn't trust solutions that just come from Washington or from private insurers or other third parties, there remains a continuing gap between the quality of care that is being delivered in the American healthcare system and the quality of care that could be

achieved in terms of better outcomes for people with every kind of condition from dealing with prevention challenges to dealing with serious chronic illnesses and care for major illnesses that are often life-threatening. At the same time a lot of these steps could help reduce the cost of care as well. You know, people who are best positioned to identify what those solutions are and the policies to support them are clinicians who are involved in the actual delivery of that care.

And then finally, just because clinicians are working hard to try to improve care today doesn't make it easy to happen. As you all know and as we'll talk about, many of our policies that are in place today, including our payment policies, make it very difficult to take steps to keep people well, to coordinate care effectively, to do it right the first time. As I've heard in many different instances through my career here in Washington and actually in clinical practice before, many of the steps that clinicians know could lead to better care are difficult to implement and sustain because you're kind of swimming against the tide. These are steps that often aren't reimbursed. They're steps that to the extent that they succeed they lead to lower payment and run afoul of other challenges, regulatory barriers and the like.

So this is why clinician leadership is needed. We need to act now to address rising healthcare costs. The sooner we start getting on

a better course, the more effective our solutions for the outlook for the nation's economy and fiscal situation can be. We need pathways to support these changes in care through changes in financing, and, again, we're going to need clinical leadership for that. And the kinds of activities that clinicians are undertaking as they engage in driving healthcare reform, well, in many ways they're different from what they were trained to do. They weren't part of traditional medical training. They require some expertise or awareness in everything from management and financing to leading complex teams. And those are skills that we think deserve some more support to help us drive to better healthcare delivery in the future.

So all of those are the topics that we want to address during today's meeting as we lay out a course forward for addressing these challenges in our healthcare system through clinician leadership.

To just back up and start going through the pieces that are contributing to this overall outlook that I've described, I'm going to talk a little bit about cost. Not because cost is most important, but it is an area of great significance now with the ongoing debate in Washington about how to deal with the fiscal challenges facing the nation and the difficult work of the supercommittee and Congress and the administration on getting us on a more sustainable path.

Now, what this slide shows is that on the spending side at

least the long-term challenges facing the United States and its fiscal outlook are driven primarily, if not almost entirely, by healthcare spending. This graph divides federal spending projections, past spending and future projections, into three categories. The red are the projected spending on healthcare entitlement programs: Medicare, Medicaid, CHIP, the new subsidies for health insurance coverage on the exchanges from the Affordable Care Act. The light blue area is Social Security projected spending. And the dark blue is everything else the federal government does: defense spending, all other discretionary spending, and the like.

And, you know, what you can see is over the past 40 years -- this chart goes all the way back to 1970 -- we've had a significant growth in the red part of the chart, the healthcare expenditures. There have been bumps in the past decade around the 2001 recession and the 2007/2008 major recession, but aside from the blips up associated with those kinds of events, the big underlying trend has been growth in healthcare programs. So, as you can see, spending projected on Medicare, Medicaid, and these other federal programs going from something like 7 or 8 percent of the budget today to a much larger percentage, 10 percent and more, just over the next 20 years and much more beyond that. Doing something to address these rising costs is absolutely essential to helping to get the federal budget into a sustainable balance.

We've taken some steps to try to do this, to try to spend the money better in healthcare. The Affordable Care Act supporters believe that that was an important step to make more affordable care available more widely, and to do so in a way that, according to the budgetary experts, won't add to the federal deficit. Actually it's projected to save money over the long term.

This chart divides the spending in the recent Affordable Care Act and the initiatives in the Affordable Care Act into three parts. There's the new spending, which is for subsidies to provide coverage to people who have trouble affording it now through their employer or don't have coverage available through their employer and for expansions of the Medicaid program. That's the dark blue on the top. It goes above zero because that's positive new projected spending. You can see it really starts to kick in after 2014.

And there are two sources of financing for that. One is the light blue. That's kind of new revenues coming from some new taxes on different parts of the healthcare sector -- insurers, pharmaceutical companies, device companies, and the like -- and some new taxes on higher-income Americans. And there's a medium blue part, which is projected savings within the healthcare -- within federal healthcare programs, and it's primarily Medicare in the form of squeezes on the price

increases that are projected to occur across the board in all of Medicare's regulated price systems for hospitals, outpatient care, Medicare Advantage programs, and the like. So that's a new reduction year after year of 1.1 percent, in some cases more, cumulative, so that adds up cumulatively to some large reductions in projected spending.

If you look at the past track record for these kinds of approaches, though, they do present some challenges. The idea of trying to squeeze down prices for the services that we're getting in our federal health programs when federal spending goes up, that's not a new idea. That's something that was kind of the core of the last round of legislation back in 1997, when we faced a federal deficit outlook that was driven in large part by concerns about federal entitlement programs and the Medicare Trust Fund.

That law in 1997 squeezed down payments to healthcare providers. It did some similar steps to reduce the updates for providers like hospitals. It implemented the famous Medicare Sustainable Growth Rate Program for physicians to limit increases in physician payments to try to keep overall spending growth for physician services in Medicare to the growth rate of the economy plus 1 percent. It squeezed down some payments to private plans and the like. But it's turned out to be difficult to sustain. In fact, every year since 2003 Congress has intervened, often at

the last minute or even a little bit after the fact, to head off the reductions in the sustainable growth rate such as the 30 percent or 27 percent reduction that's now projected to occur in 2012. And there have been, as this slide shows, a whole host of other legislation implemented over the past decade that in one way or another have offset some of those squeezes in payments.

And it's probably not surprising there are some real concerns again among the public about too tight restrictions on prices leading to access problems and quality problems in the Medicare program. I think maybe the upshot of this is that we may be coming to the end of the rope, the end of the line on our ability to try to sustain our healthcare system, and especially federal spending on our healthcare system, through spending down prices alone.

Even with these steps to address the rising costs of care in the Medicare program and other federal programs, the payment rates for physicians have been falling behind. And this gets to the points that I want to emphasize about the importance of physician and other clinician leadership.

This is a chart that shows the growth rate in spending, the growth rate in prices, the payment updates for different kinds of healthcare providers. The pink line, the formula update, is what's been projected to

occur under the SGR for physicians. The red solid line is what's actually occurred. The higher lines up around 3 percent, the dotted lines, are ones that are pegged to either what's happened with prices for other types of Medicare providers, like hospitals, or what would happen if -- the top line -- if the prices for physicians went up according to medical inflation. And what you can see is even with all these fixes that have happened every year since 2003, physician payments haven't kept up. They've been about flat in nominal terms and they haven't kept up in real terms. So even with the fixes coming in, this doesn't look like a very good, sustainable way to provide adequate funding for care.

The problem is, is that if all we do is try to increase the prices further, well, what we've seen over the past decade is we don't get there. And not only that, we're not taking any steps to really help the payment systems drive the improvements in care that I mentioned earlier and I want to spend more time talking about now and I hope will be a major focus of our discussion today.

And this is what I regard as real healthcare reform, so real healthcare reform is making care better for patients. It's through steps like improved prevention; through steps like improving the coordination of care for patients that are seeing multiple providers increasingly through today; it's about more effective and efficient care for chronic diseases that make

up most of our healthcare spending today; it's about more support that's focused on a patient in their entirety, not necessarily just when they come into an office visit. It's really about promoting wellness and efficient use of care even through steps that are not traditionally part of healthcare. It's about other new ideas that are made possible by the revolutions that are occurring in information technology and biotechnology, genomics, and other areas.

These steps are not easy to take. They require the kind of expertise and insights that clinicians working closely with patients and having firsthand experience with the healthcare system are best positioned to identify and then implement. It cannot be done from Washington. It cannot be done from state capitals. It requires clinical leadership. But it requires clinical leadership, I want to emphasize today, not just in taking steps to emphasize these programs -- we're going to hear from a lot of people who are implementing these steps around the country -- it also requires clinical leadership in helping to reform our healthcare policies to provide an environment that supports and encourages these kinds of clinical leadership steps. It requires steps that go well beyond just trying to push for another fix, short term or long term, for the physician payment system in Medicare, for the SGR. It requires a more fundamental approach to try and get us to policies that drive better

care and that get us on a more sustainable course with higher quality, innovative care.

That's clinical leadership. Real healthcare reform starts with opportunities to improve clinical care, and we're going to talk about a number of those opportunities today. So this starts with opportunities to improve our healthcare system, not to threaten access, not to reduce quality, not to ration, but to identify the real ways in which the actual care for patients can be improved. And this includes, as I just mentioned, better support for patients, better clinical management, better technical skills in managing a wide range of conditions that bring patients in to see health professionals, it means better coordination of care. And it starts with identifying these opportunities to improve care, but then it extends to changing the policies that can support those improvements in care.

How do we change the way that we pay for care? And then how do we have -- how can we develop convincing evidence that these steps to improve care will really lead to better results for patients and lower cost? Patients have unique confidence in this country in their health professionals. That's who they trust on healthcare, not the government, not insurance companies, but their providers. And so it's leadership from providers that can potentially drive these reforms and policies that could really improve care.

Just to give you a few examples of these, and we're going to be seeing a lot more as the day goes on. I'm going to talk a little bit about an example here from the delivery of cardiovascular procedures. This comes from an experience of Geisinger, who's represented here today, in their proven care program, in particular their cardiovascular surgical program. This is now a program that was focused initially on finding ways to improve results through better teamwork, through more reliable use of processes that have been proven to reduce clinical complications in cardiac surgery. This was not -- this did not start about saving money in the healthcare system. It started about finding ways to assure clinical excellence in care.

So number one here, what those involved in this program -- and Dr. Bruce Hamory's here today and I'm sure he can tell us more about this -- did was identify opportunities where there were excess morbidity, avoidable complications, and, as a result, costs associated with cardiac surgery, and where there was a lot of evidence available that steps could be taken by the team of providers involved in care to avoid those complications to get better measurable results for patients. Then they identified the practices that needed to change, with a lot of involvement from their clinicians.

And then they didn't stop there, despite telling the clinicians,

look, you've got to do more with less, you got to change what you're doing. They offered new support. They developed payment models that provided resources that were tied to getting better results for care, that were more bundled, that weren't just based on paying more when there are more complications and not supporting coordination of care and other steps that could reduce complications. And then they followed through on this by identifying actual evidence that these steps were working, that they were leading to better outcomes of care: reductions in mortality, reductions in wound infections, reductions in readmissions, improvements in return to work, and, as a follow-on to that, lower overall healthcare costs. So not just identifying the clinical steps and hoping for the best, but changing the policies that enabled doctors and other health professionals to work together better to achieve these goals and then documenting the impact on care in a way that could sustain these payment reforms.

These kinds of initiatives have happened in specific areas like cardiovascular surgery, but they've also happened at the level of population level improvements in care. This is a slide that I think, you know, seeing me up here, many of you are thinking, well, this must be about accountable care organizations, and I think that is an important theme in healthcare reform to help get the focus on better results and lower costs for patients driven by supportive changes in our payment

environment. But in this case, this all started, again, with leadership from clinical organizations.

One of my early meetings when I was administrator of CMS was with a number of CEOs from organizations like these who came in to tell me about a lot of clinical steps that they were taking to improve care, like using outreach to patients to promote use of preventative services; like using nurse practitioners and pharmacists as part of care teams for their patients with chronic illnesses to help educate their patients about their diseases, help them to adhere to their medications, help them take other steps and appreciate the importance of steps like diet and exercise modifications, to implement teams of care to prevent readmissions. And what they told me was, look, you know, all these steps that they were undertaking, they're working, but none of them -- none of them, none of them -- are paid for under Medicare's fee-for-service, SGR-associated payment system.

So we're getting killed twice when we try to implement these clinical changes: first in that they don't get reimbursed; and second, to the extent that they work, we get paid less for the stuff that Medicare does reimburse. So that's not sustainable. That's not providing the kind of environment, the policy support that can drive clinical improvement.

And their patients were very happy with these changes.

They have the outcome results, including measures related to patient experience with care. They just didn't have the environment to support the expansion of these programs.

So that's what led to -- and we didn't call it ACO at the time, but that's what led to this idea of having a second payment track, one that wasn't just based on fee-for-service payments to physicians, but it was based on what we and they really wanted to achieve, which was better results for their patients. So we agreed on a set of performance measures related to prevention and more effective management and results for chronic conditions, better patient experience, and we also started tracking overall Medicare costs for the patients treated by these groups. And the deal was they started getting payments on this second track to the extent that they showed improvements in results and lower overall costs, shared savings.

And as you can see from this chart, over time something like six of the organizations had received shared savings payments. Four of them have achieved reductions in trends in Medicare spending exceeding 2 percentage points per year. Now, if we could do that nationally, if you look at that -- remember that slide that I showed you earlier, if we could do that nationally on a sustained basis, then we are in a much different position in terms of the overall fiscal outlook for the Medicare program.

Nine out of 10 programs have saved significant results off of trend, averaging over more than 1 percentage point per year. Again, it doesn't sound like much, but if you think about all the debate around the payment squeezes and the ACA, it's on the same order of magnitude. So this is a different way to get there through clinical leadership matched to changes in policies driven by clinical leadership.

A couple of other examples. So, you know, when people hear about ACOs they think about large organizations and integrated groups. It doesn't necessarily have to be that way. There are a lot of small practices that are implementing changes along the lines that I've described. I'm going to talk about here involves a small oncology practice in the Philadelphia area. These were results published by Dr. John Sprandio in *Community Oncology* last December. What his practice did was organize a patient-centered medical home for cancer patients organized by oncologists. So, again, this is, you know, primary care.

You've heard a lot about the medical home activities, which are some similar ideas to what we're talking about here. This can also apply in specialties where specialists can have great insights into ways in which the care that they're providing for patients could be done more effectively and are not being supported now by payment systems and other policies.

So he focused on setting up a patient-centered medical home in his practice. They showed some very significant improvements in patient experience, reductions in use of emergency departments, reductions in patient stays. And now the idea is to link that to changes in payment to support these efforts. And that means a per-patient care management fee, something like a medical home, but targeted to the specialty, to enable the clinicians to support things like answering calls in evenings and on the weekends, and having a person available to help patients who might otherwise have complications that cause them to end up in the emergency room, and to help make sure that they're getting the most up-to-date, evidence-based treatments possible. Again, things that have not been compensated traditionally in our current payment systems for oncology.

So all of those are intended to be examples and all of those, I think, are examples of ways of improving care, but also ways possibly forward out of the challenges that we're facing with physician payments and Medicare today. The SGR problems are recurrent. It's a vicious cycle of, as I showed you on the earlier slide, of tighter and tighter payment, really chronic underpayment, making it harder to make ends meet in practice. And the fact that this is now a repeated short-term fix because the long-term solutions have looked too daunting from a cost

standpoint means that there's a lot of physician engagement, there's physician leadership on payment reform issues. But a lot of the oxygen from those efforts gets sucked up in just trying to do yet another short-term fix for the SGR.

And even if the SGR were fixed, it is not going to solve the problems that I just described that all these organizations are trying to solve because they don't provide, the SGR doesn't provide, enough flexibility or funding to improve care and lower healthcare costs in all of those ways that clinicians are trying to implement around the country today. And so that creates a need for a different path forward.

And some of the ideas -- and we're not going to have final solutions to all these problems today, but we're absolutely going to make this a priority for moving forward to resolve as part of this new initiative here at Brookings, some of the ideas that have already emerged from work that others have done and work that we've been involved with in collaborations around physician payment reform -- involve taking some of the elements of fee-for-service, not at random, but selectively based on clinician expertise, and moving those payments into a different kind of payment system, a shift away, at least on a limited basis, from fee-for-service.

I talked about some of those examples already. Many of

those fall into a couple of broad categories. One is taking some fee-for-service payments that are tied now to the volume and intensity of services, but that may not be supporting the best care at the lowest cost in the ways that clinicians have identified and, instead, moving it into a payment that could be used for more individualized case management, like that medical home for cancer patients that I just described before and like what's being done now in medical home payments for primary care.

And another component of payment reform would focus on care coordination, activities that are not done within a specialty, whether it's primary care or specialty services, but activities that need to be supported across specialties to build those teams, like in cardiovascular care that I described before; from not only the surgeons involved in care in the hospitals, but the cardiologists, the (inaudible ~~@ 27:01~~) providers, the others involved in care after the surgical procedure itself. In our current fee-for-service system with fragmented payments to each provider, they don't really get the support they need to build those teams, and a kind of care coordination payment could help us get there.

And there are a lot of different forms for how this could happen: as a bundled payment, pieces that could go along with the key elements of fee-for-service that remain; as other kinds of adjustments to payments. There are a lot of ideas out there, but that's kind of the general

principle: moving away from fee-for-service in a -- not just arbitrarily, not just across the board, but in a way that reflects clinical insight and clinical leadership of where those payments -- where you can get the most bang for the buck, of redirecting how those payments are used to get better results for patients at a lower overall cost to the healthcare system.

Coupled with this is a need for more accountability for what we really want. That's what's going to give actuaries and other policy experts and other people involved in policy making more confidence these steps really are going to lead to better results for patients at a lower cost and can be sustained.

And, you know, it also highlights a point that I think comes up too often or doesn't get addressed often enough in our current payment reform debates, which is that instead of focusing on the next round of SGR reform as a question of, you know, how should the pie of physician payments be divided up between different medical specialties, is a recognition that how physicians are supported and how other clinicians are supported, it may have some implications -- those payments may have some implications for the direct cost for physician care. But they have even bigger implications for the overall costs of healthcare. Remember physician services are under 20 percent of medical spending, yet physician decisions and other clinician decisions have an impact on more

than 80 percent of healthcare spending. And this emphasis on clinical leadership focusing on the overall impact of care decisions for patient outcomes and for overall cost of care is a way of changing this debate, not being about just dividing up a fixed physician pie and just focusing on one silo and, instead, making it about how we can get overall costs down.

This graph's a little bit hard to read, but it's intended to emphasize this point that the left-most column on the chart divides Medicare payments before some of these kinds of reforms we've been talking about are implemented into three parts. The two biggest parts, the different shades of red, are the non-physician spending part. Many of those are payments that definitely represent valid and needed care. Some of it, though, represents care that's avoidable complications, duplicative cost, opportunities to reduce cost while improving quality.

If some of the payment reforms in physician payment that we've just been talking about could be implemented, that would take a little bit of money away from traditional fee-for-service payments for physicians. That's that bottom blue section. But because of its consequences for overall costs, it would mean actually enlarging the pie of support services for physicians and the financing that goes along with -- through those kind of care management steps focused on individualized patient care, through the care coordination steps, and the payment

reforms that I was just describing.

So that's the general idea here. And this is not -- this can't just be pie in the sky, you know, hoping or crossing our fingers and hoping for the best when we, you know, make some payment change, but it's going to be tied to measures, evidence, accountability. And again, those are areas where clinician leadership is absolutely essential.

So we're going to be talking about that a lot today. The examples that you're going to hear about of clinical leadership to implement payment and delivery system reforms span a broad spectrum of activities. There's a panel on delivery system transformation that's going to focus on the challenge that clinical leaders face when they are trying to change the way care is delivered in their organization to benefit patients. This is a challenging process. It requires providers to work together in ways that they haven't before. It requires changes in the way that care is delivered within specialties that can be challenging to implement, especially with limited resources available, especially with many of our current payment and other regulatory policies.

We're then going to talk about payment innovation. Again, this linkage between clinical leadership and identifying ways to transform care, and clinical leadership in getting the policies changed to create an environment that makes it easier to do that. So we'll have a number of

examples about changes in how healthcare organizations can be paid, how providers can be paid within organizations, how other policies can change to support better care and to drive effective clinician leadership.

And then finally, we're going to have a panel on community-based clinical leadership, how many of these activities, especially involving vulnerable populations, require going outside of traditional healthcare approaches. And again, clinician leadership to identify the best opportunities for doing that, how to put different community resources together in new ways turns out to be absolutely critical.

So we're going to try to cover all of these topics today in a range of initiatives. And what I think will come out of this is a recognition of both the importance and the opportunities for driving more effective clinician leadership. This does mean, I think, different ways of approaching -- of clinicians approaching their job. It is about the patient in front of them, but is also about how to change the way that care works for that patient and how to change the policies to enable and support those changes in care delivery. It's a different set of skills than many physicians are used to and it's a different set of arguments to make with policymakers here in Washington as well.

To support all of these efforts we're very pleased to announced a new initiative today here at Brookings, the Richard Merkin

Initiative on Payment Reform and Clinical Leadership at The Brookings Institution. The Merkin Foundation is supporting this initiative -- we're very pleased -- through a $3 million grant. Dr. Merkin himself has a distinguished history of clinical leadership in healthcare reform. His endowment for the foundation reflects that. He was the -- he has been the CEO and the founder of the Heritage Provider Network. Heritage, which was founded in 1979, develops and organizes and helps medical groups and independent practice associations deliver more patient-centered care.

Now, Dr. Merkin, unfortunately, can't be with us this morning for the announcement, but we're very pleased to be joined by a representative from the Merkin Foundation to help kick that off. And Jonathan, if you don't mind coming up for a few remarks now, that'd be terrific. Thank you.

MR. GLUCK: Good morning. Thank you, Mark. Dr. Merkin sends his apologies. He would have liked to have been here, but, unfortunately, is unable to join us.

My name is Jonathan Gluck and I'm with the Merkin Family Foundation. I have the privilege of presenting Dr. Merkin's remarks to you today.

For over 30 years, Dr. Merkin has dedicated his life to transforming our healthcare system. During that time he has found that

there are many ways to help physicians improve patient care. Today's challenges, however, require looking at how we deliver healthcare in an entirely new and different way.

When Dr. Merkin founded Heritage Provider Network over 30 years ago, he was an emergency room physician. Heritage began as a small operation in Bakersfield, California. It began at the behest of one of the health plans which believed that better care could be provided only through the coordinated care that could be delivered by primary care physicians. Heritage's efforts proved successful to the point where today it is the largest IPA in the state of California. It's in seven counties as well as in New York and Arizona.

It provides medical care to over 700,000 patients and employs 3,000 individuals. Its medical network is comprised of 3,000 primary care physicians, 30,000 specialty physicians, and contracts with over 100 hospitals.

Now, Dr. Merkin believes that the only way to successfully provide for a population's healthcare needs in a cost-effective manner is to do everything possible to ensure that the patient remains healthy, reducing the need for the costly ongoing treatments that would become necessary should the patients become ill. To this end, he has created a myriad of care programs, ranging from sophisticated diabetes

management programs to Coumadin clinic to home-visiting doctors and pharmacists. He uses and has created sophisticated data mining techniques that risk stratify each of Heritage's members to determine which of the care programs available are appropriate for each of the individual members. This is the basis for what today we are calling accountable care. We like to think of ourselves as one of the original accountable care organizations.

Dr. Merkin is also a leader in the effort to change healthcare delivery. To this end, earlier this year he created the Heritage Health Prize, which is a $3 million predicting model and contest that we believe will change the world. The prize will reward a radical thinker who creates an algorithm that identifies the number of days an individual will spend in the hospital in the following year. We believe that once those individuals have been identified, we can identify the specific individuals for whom preventive care will help prevent the hospitalization and that preventive care can then be provided to the individual, thus reducing the long-term healthcare costs.

In addition, the prize seeks to introduce a new group of individuals to the field of healthcare, specifically those individuals who today would either go to work at Google, Goldman Sachs, or Yahoo. We believe we've been successful as the first progress prize, which was

awarded just over a month ago, was actually won by a hedge fund manager from Florida.

Now, Dr. Merkin's leadership has forged the following simple rules for providing quality healthcare. First, patient care comes first. Second, the physician-patient relationship is the foundation of quality healthcare. Third, physician and patient education must be proactive and ongoing. Fourth, physicians will make effective decisions for their patients given the appropriate tools, information, and support from their peers. And finally, utilization and quality management is a physician-to-physician process.

While the preceding sounds relatively simple, in truth it requires constant and vigilant monitoring and oversight to make sure that the physicians, nurses, other care managers, employees of the organization are performing the minutiae that make up day-to-day quality care management. And while we would all likely agree that the principles previously articulated are the foundation of quality healthcare, they do require one thing in short supply today, and that is clinical leadership.

Further, as we all know, while successfully directing the day-to-day operations of a large organization requires effective leadership. Change requires even more effective leadership and radical change, such as that required in the healthcare system, requires radical leadership. Put

simply: Today there are too few truly effective clinical leaders, which leads directly to the difficulties we encounter whenever we begin discussing payment reform.

And payment reform is necessary. The current payment system has created a host of problems from a shortage of primary care physicians to the creation of incentives that do long-run harm to patients. Dr. Merkin believes it is critical to address both clinical leadership and payment reform together, as only in that manner will we be able to achieve truly radical change.

Now, when one reflects on those who have the ability to help achieve radical change, transformative change, The Brookings Institution and, with respect to healthcare, specifically the Engelberg Center for Health Care Reform at Brookings, both come immediately to mind. Brookings is the right place and now is the right time for an initiative on clinical leadership and payment reform.

The Engelberg Center has a unique and respected capability in both developing ideas for healthcare reform and in leading collaborative efforts to implement those ideas. The Center has extensive capabilities to develop and analyze reform ideas, such as its work on bending the curve of rising healthcare costs and on methods for measuring the quality and cost of care. The Center also has an extensive experience with practical

implementation, such as its work to support a public-private network for drug safety surveillance and its learning network for organizations that are implementing accountable care payment reforms. It has the distinguished record of working with academic collaborators, patient groups, provider organizations, healthcare payers, businesses, and other stakeholders on solving practical problems in healthcare reform.

The Center is also distinguished by its clinical leadership. Dr. Merkin is very pleased that this new program is supporting experienced clinicians at Brookings, including not only Dr. McClellan, but also Dr. Cary Sennett and Dr. Kavita Patel, as well as providing additional resources for further work with the community: physicians, specialists, academic medical centers, and allied health professionals.

The need for transformative change in healthcare is tremendous. This initiative will begin creating that change. Dr. Merkin is delighted to be able to support Brookings in meeting this critical need. He thanks you for being here today. Thanks. (Applause)

MR. McCLELLAN: Jonathan, thanks very much. We're very pleased to have this support and to have -- you know, you heard about a lot of examples of clinician leadership from the work that Dr. Merkin and the Merkin Foundation has done already. We expect as a result of this new support be able to drive forward many other kinds of examples of

clinical leadership in the same spirit, in a wide variety of settings around the country. As Jonathan mentioned, this is going to build on a number of activities that we have already underway: our learning network, our collaboration with a number of academic medical centers, ongoing work which we expect to expand as a result of the support with medical and other health professional associations, clinical fellows, and other clinician leaders around the country.

But really all this expansion and all this new effort is starting with today's work. And we're very pleased to have with us so many clinical leaders, such a wide range of health professionals here today, both on today's panel and then joining in the discussion. These participants, as I mentioned, just about everyone you're going to be hearing from is a clinician, which is something I'd like to see more of in these efforts here in Washington to drive policy reforms. And they comprise health professionals working with government, working with payers, working academic centers, working in clinical -- in small practices around the country, working in more integrated systems, really a spectrum that, hopefully, can drive a very effective conversation and very effective discussion about the path forward on clinical leadership for healthcare reform.

So I want to call on these leaders throughout the day, so not

just the ones who are in the panel, but the rest of you who are here participating. And I'd like to start that right now by asking a couple of those leaders who are here with us, a couple of the clinician leaders, to make a few comments at this point on thoughts that they have about where we should focus our efforts today and how this fits into their experiences with trying to lead healthcare reform. To that end, I'd like to call on Wayne Jenkins and Greg Pawlson for a few minutes of remarks.

Wayne, you're the -- Wayne is the executive director for -- I'm sorry, is the president of the Orlando Health Partners in Orlando, and is very much involved in trying to implement some of these steps now. So, Wayne?

MR. JENKINS: Well, thanks, Mark. We were here yesterday with the University of Florida for your AMC Vanguard Group. And we also participated in the ACO Learning Network. I think this is going to be very helpful for us. And what we did two years ago at Orlando Health, we're a multi-hospital system obviously in Central Florida, and one of the things we've done is partner with the University of Florida around this idea of clinical integration both locally and regionally.

Two years ago, when we adopted this clinical integration to better patient care, physician-led, that was our strategy adopted by our board, one of the things we realized we needed to do is we started a

Physician Leadership Academy. We put 35 physicians in the first year, 35 physicians in this next year, but we're really looking how we go forward with that. So I think it's going to be very helpful to us. The clinician's sort of the next step below our leadership level, who many of us have sort of had formal training, that's going to be helpful; and then those of us who are interested in influencing policy, to learn those techniques in addition. So, much appreciated.

MR. McCLELLAN: Great. Thanks for the perspective, Wayne. Greg?

MR. PAWLSON: Good morning. Just a coupe of points. And I've been in the healthcare system for a long time and have seen it from the perspective of an academic practice and a health plan, the George Washington University Health Plan. I was 10 years at NCQA and just recently moved to BlueCross BlueShield Association.

And I think we're at a very critical turning point, as you're sort of alluding to, Mark. And I think the key is that we need to keep focused that while the financing of healthcare is intensely political, I think the rest of it is really increasingly evidence-based and evidence-pushed. So outside of financing we have the other key elements of the healthcare system being benefits design, which is, I think, increasingly value-based and value-driven. Payment -- or, I mean, patient engagement is another

big piece that is -- should be evidence-based in all of its facets. The care delivery system changes and obviously the reimbursement system.

A couple of other points. One is I think there's an incredible opportunity for alignment between payers and clinical delivery systems at this point. We've struggled with this for 80 or 90 years. We haven't gotten it right yet. We better get it right this time around.

I think there's also an incredible opportunity and need -- and some of the things that we're going to hear later on from CMMI I think are examples of this -- where we really have to get now alignment between the public and private sectors. We're not going to have an exclusive public sector system or an exclusive private sector system, so we're going to have to learn how to really work together. And I would point out that through a lot of changes, like Medicaid, and I'm reluctant to call it "managed care" because there isn't any unmanaged care anymore, but Medicaid solutions depend on private sector delivery or private sector payments, including an increasing number -- New Jersey is looking at putting virtually all of their Medicaid patients into private sector entities, including the dual eligibles, which is a huge challenge. And I think a lot of other states are looking at that.

And then finally, in terms of thinking about clinicians and their role, when you think about the sort of four pieces of the value

equation -- and I sort of look at that as on the sort of quality benefit side of things -- clinicians ought to be heavily engaged and ought to often drive those conversations, including starting to really look at appropriateness and where there is value in clinical interventions and -- or where there's benefit in clinical interventions and where there isn't. And on the sort of cost side of the equation, they obviously have a huge impact on volume.

I think the remaining lever, which was the one that gets played all too often, as you sort of pointed out, is the price lever. And that's the one that will get played if we don't deal with benefit, quality, and volume.

MR. McCLELLAN: Greg, thanks for the comments and I appreciate your especially trying to tie a lot of these initiatives that people hear about lately as potentially being promising, like benefit design and patient engagement, back to clinician leadership. Even in areas like, as he said, public-private collaboration, if there is a glue that can hold that together it's probably going to come from clinicians laying out a viable path forward that both the public and private sectors can get behind.

I am hopeful that we can tie a lot of these ideas that are being discussed and are being implemented in healthcare policies back to clinician leadership. That is the focus of the day. And I want to thank Wayne and Greg for starting us off in that direction.

Now, we're about to move into the next steps on the agenda, so let me give you a little bit of an overview of where we're headed, and this is all information in your packet. We're going to next have a discussion about clinical leadership in Congress with the help of two congressional leaders with extensive healthcare experience. Then we're going to have a short break. We don't believe in a lot of breaks here at Brookings events, so if you do need to get up and stretch your legs between other sessions, that's okay, we don't take it personally. We just have a lot going on today.

After we return from that break, though, we'll have our first panel discussion on "Transformative Change in the Delivery System," and then go straight from that to a panel discussion about "Rewarding or Supporting Clinical Leadership in Payment Reform." I think it's really about support. It's not so much incentives as it is helping make sure providers don't have to swim against the tide to implement the kind of steps that they think are really needed to improve healthcare.

We're going to have a lunch break with lunch set up outside, but coming back in the room to eat. And then that'll be followed by a keynote address and discussion with some leaders from the Centers for Medicare and Medicaid Innovation. And that discussion about the role of CMS will span across a range of initiatives that CMS is undertaking now

with the intent of supporting clinician leadership.

We'll then go into a panel discussion about community-based reform, including some examples from New Jersey, as Greg was just alluding to. And then a final panel on sort of how do we put this altogether? Where -- what do we need to do in terms of better support for building up clinical leadership to help make all this happen?

So that's going to be the overall course for the day. Before we move on to that next step this is a good time if there are any questions or comments or any other issues that those of you who are here would like to get on the table. We've got microphones, so any comments, thoughts, to help us get going on this discussion.

Everybody thinks we're on the right track? (Laughter) I know too many people here, so I know you're not bashful.

Well, we are going to start this first panel in just about three minutes, so between now and then I just want to remind you that you've got information in your packets on all the participants. We're not going to be doing -- all the participants in the panels. We're not going to be doing long introductions so the panels get going. We're going to try to get right into discussion there. So please feel free to take a look at that.

We also will have, subsequent to this meeting, more information available on our website about the new leadership initiative

and payment reform and delivery reform that we announced this morning. And we're looking forward to more opportunities to collaborate with all of you. Those are going to include some ongoing outreach and interaction building on what we've been doing already here with a range of medical and health professional associations who are all committed to the same goal as well as a number of collaborative initiatives with academic organizations around the country. Wayne mentioned the AMC Vanguard work that we're doing already, and that's going to expand, too. So we really welcome further opportunities to work with those of you who are here today on the key issues that we're facing.

A big focus of this work initially is going to be on some very practical problems around Medicare's physician payment system. And when we start our panel in just a minute we'll be delving into that issue in particular as well.

You heard my earlier remarks, some of the directions that our work on physician payment reform is exploring. And again, that's not just based on stuff that we're coming up with here. It's based on the actual experience of clinical leaders around the country who are trying to change delivery and need some reforms in physician payment to support that.

So we're going to be starting this panel in just a minute.

We're going to have, like, I guess, about a one- or two-minute break here if you want to stretch your legs. And very much looking forward to spending the day with you on making progress on clinical leadership and healthcare reform. Thank you very much. (Applause)

(Recess)

MR. McCLELLAN: All right, thank you all for getting back to your seats, and I'm very pleased for this part of our day, where we're joined by two congressional leaders in health care reform. We're going to hear from both Dr. Mike Burgess, who's the representative of the 26th District of Texas. He's a member of the Energy and Commerce Committee, which has a large jurisdiction over health care, and prior to that, he was a physician in practice for quite a while, for decades. And he's been extensively involved in health care legislation, legislation on reducing costs and reducing regulatory burdens, legislation related to choices for Medicare beneficiaries and on Medicare physician payment, obviously. He's played a significant role in bipartisan efforts to promote food, drugs, and consumer product safety as well.

We are also very lucky to have with us Congresswoman Allyson Schwartz, who has also played a central role in debates about health care, including debates about issues related to health professionals. She's the founder and co-chair of the Health Care

Innovation Task Force, and she's actively involved in the ongoing development of new health care delivery models and how legislation can support that. She's currently deeply involved in efforts to reform the Medicare Physician Payment system, including repeal of the Sustainable Growth Rate.

Actually, both of you have sponsored legislation to address that problem. And we're very pleased to have both of you today for this event on clinician leadership in health care reform.

And Dr. Burgess, if you don't mind, maybe I can start with you. You're a physician. You're directly involved in leading health care policy reforms as a member of Congress. How has your clinical background served you in Congress? I know you've actually written some about this.

DR. BURGESS: Well, you're kind to mention that. We can go into that in more detail if you'd like.

But, honestly, you know, you do stop and think when you sift through some of these dents -- policy pieces or dents instructions to federal agencies -- how would this have made my job easier in the treatment room or in the delivery room or the operating room? In the fundamental unit of production that was the American medical system is that interaction that takes place between the doctor and patient in the

treatment room. And does what we are doing legislatively add value to that? Does it make it faster, better, cheaper, smarter? Or is it only going to add additional layers of things that have to be completed before that patient gets the desired care or the desired treatment?

And that has been one of the tough things for me to watch this, and I'll just tell you, you know, clearly politically I was on the other side during the last session of Congress. But I will share with you that I reached out to the transition team shortly after the election. I reached out to Chairman Waxman shortly after he was selected as the new chairman of the Committee on Energy and Commerce in January of 2009 and said look, I didn't give up a 25-year medical career to come and sit on the sidelines, please call on me, let's be involved where we can.

There are plenty of places I can't go, and I would readily admit that. I don't know what I would have done, for example, if someone would have said we know you care deeply about the SGR and you want it reformed; could you help us with the public option or at least not speak so harshly about it when it comes up? I don't know. No one ever tried. That was perhaps one of the big failings in all of this, and I understand that there were people who had been there for generations.

There were three committee chairmen who basically had been elected during the Watergate election when I was just a child, you

know (laughter), maybe in college, you know, maybe in medical school, (laughter), but, still, it was a long time ago, and these three committee chairmen had very set ideas of what they wanted to do to the health care system.

Now, you know, I'm just taken back to four years ago when Newt Gingrich and Ron Wyden were writing in, I think it was the annals of internal medicine, and Mr. Gingrich said you know, most breakthroughs in health don't occur as a consequence of focusing on financing; they occur because of focusing on a new way of delivery or perhaps a new way of delivering something that was previously delivered.

And, you know, that's true. Last night I was having a meeting with the dean of one of the medical schools back home. He's a gastroenterologist by trade, and he reminded me that when -- you know, he was about my age -- when he was in training, everything was focused on the treatment of peptic ulcer disease. You know, the resident going through a GI residency right now -- I mean, that's interesting from the historical perspective. It's kind of like when I was in medical school, we were all brought down to a hospital to see the kid with diphtheria, because we'd never see another kid with diphtheria in our clinical lifetimes.

Things change. And you know that. I mean, the evolution happens. It's almost unstoppable. The problem is things up here tend to

be sort of ground in and rooted in cement, and people change very, very slowly or in a very unwilling fashion. And you referenced the SGR -- we'll get into it -- but the SGR is probably front and center in that principle.

MR. McCLELLAN: Interesting to hear about how maybe focusing on the clinical issues can help break through some of that cement that you mention.

I know, Representative Schwartz, you've been working hard on this, too. You've got close connections and a strong commitment to the health care system and to improving it, and you've been involved in some very interesting health care work in Pennsylvania. You've got doctors in the family. How has all that shaped your activities in Congress?

REP. SCHWARTZ: I did go through medical school as a spouse. (Laughter) We could talk about it, actually, if you wanted to, about what it means to the family.

But I also worked in health care for almost 20 years in the mid-'70s -- I'm dating myself here a little bit -- for a fledgling prepaid capitated system. I was responsible for helping to develop the delivery system, as we were trying to see if we could actually do such a thing as change some of the delivery system to improve health care delivery for both the providers and the patients, and we had some success. I went off and started and ran a health center for a dozen years in Philadelphia and

then got elected to the state senate where I did a lot of health care policy.

So, yes, there's no question of being on the side of what is it really like to organize, to support, to be able to make a delivery system work, again to provide the greatest quality health care for patients and for all Americans. So, I have some experience in doing that for 20 years.

Then I did a lot of work in helping to formulate how public policy supports that effort, which is, I think, ultimately knowing about the patient-doctor relationship, which it does come down to. But it's also how do we make sure that Americans have access to quality, affordable health coverage, because it's about the patients that you see and provide care for.

But my guess is that some of the financing does enter into all of this. It isn't a complete, pure system. You do have to think about and do whether this person can afford the treatment you're recommending. Can you get them to the treatment? Do you have the right providers to be able to offer it? Do you have the support that you need to be able to do that in all the ways that you can suggest to us? And you have.

So, I think we did some remarkable work in the last session. And things do change around here. I'll just say the last year's been really different for me -- to be in the minority and to have really a very different leadership. And so things can change on a dime here, too. So, I feel very

strongly, as many of you know, about supporting TT in academic health centers and the fact that we want whatever we do to be dynamic, to be responsive, and to have doctors and medical personnel in hospitals really be in charge of what is the best way to provide health care to your patients. That's very important to me. And so we do need to have a financing system, both public and private, that helps support that. And right now, as the season changes in that financing, certainly under Medicare, and as a member of the Ways and Committee obviously weighs in on this in terms of Medicare, I am looking for bipartisan ways for us to support those changes. And we're really calling on clinicians and clinical groups to step up and embrace new ways of delivering care so that you can be in charge of it.

You know, we can give you the tools from a financing point of view for you to be able to use evidence-based medicine, evidence-based practice to evolve these new models of care that enable not only physicians but all medical personnel to be able to do what they really want to do, which is to provide the right kind of care in an appropriate time to help their patients be better and for all Americans to ultimately at the end of the day see healthier outcomes.

In the process, we'd like to save a little bit of money. That would be helpful to us to sustain public assistance in Medicare and

Medicaid but also in the private sector, as we see the issue of economic competitiveness and the high cost of health insurance for our providers really being a drag on them in terms of their ability to create jobs and grow the economy. So, as someone who cares about health care and getting good, quality health care to my constituents and to do that research and education, Philadelphia has a lot of -- how many of you went to medical school in Philadelphia? I'll be there'll be a few of you. So, you know that that is a big -- that is an important part of our economy. Someone told me create one in four physicians in this nation. That seems high to me. But even if it's off by some, it is actually pretty remarkable the work that we do and I think we want to continue to do in being on the cutting edge, not only of the medical science but of the delivery system reform, and we want a payment system that supports that.

I'm always trying to work in a bipartisan way, and Representative Burgess has been supportive of, for example, the SGR repeal. Look, this is a system that as far as I can tell -- I wasn't here when it was implemented, but it was suggested anyway, recommended or passed -- but the idea was that, you know, we don't really know how to do this. Doctors are really smart people. We're just going to cut your reimbursement and you'll figure it out. And that kind of didn't work. So, it didn't work for you and it obviously didn't work for Medicare.

DR. BURGESS: It drove the volume part of the equation through the roof, because we had to pay our bills.

MS. SCHWARTZ: Exactly. And there is a bit of chasing what is reimbursed, which is not what you want to do for patients either. So, it has led to some over-utilization, some (inaudible) utilization, and we know it's not working. So, I support full repeal of the SGR. But even that's not enough. We need to replace that payment system with a new payment system that will understand that there needs to be a transition period for you to be doing the work you have to do in developing your delivery system, for us to learn from that experience over the next five years, and then to offer options -- not a single -- I actually don't think there should be a single model of reimbursement, but that they offer physicians, physician groups an option of how you want to be reimbursed and that will in fact improve quality, a bigger value for our public dollars, and move us in a direction that we all know we're going in, which is, you know, really better, more coordinated care that actually gets people the care that they need and it'll help them be healthier at the end of the day.

So, that's what I'm working on. Love to see the Super Committee help us get there. But we're going to have to do it anyway.

MR. McCLELLAN: Now, you've been involved in this for some time, including in some bipartisan efforts, including a briefing that I

participated in where there didn't seem to be a lot of ideas on table.

MS. SCHWARTZ: Yes.

MR. McCLELLAN: And, Dr. Burgess, earlier this year the Energy and Commerce Committee had the hearings on SGR reform, and there were a lot of physician leaders present there, some of whom are actually present here, who described some ways to get to a better payment system in Medicare and maybe save some money at the same time. What's your latest take on why this time might be different than all the usual last-minute short-term fixes?

DR. BURGESS: Well, if you'd had this conference in the middle of June, I would have said I'm very optimistic that we're going to get this fixed. But that limit discussion then intervened, and things went off the tracks.

But you're correct. Both committees of jurisdiction -- Ways and Means and Energy and Commerce -- have had hearings for the first time since 2006 on repeal of the sustainable growth rate formula. Both committees have hired staff specifically to deal with the sustainable growth rate formula problem, and all of the air doesn't go out of the balloon at this point. Something will have to happen before the end of this year. I feel comfortable that it will. If I ran the zoo, it would be a three-year period of stability. If it turns out to be two years, that's still a victory; anything less

than one year is a failure. So, with those broad parameters, I think something will happen before the end of the year.

I personally don't think it happens in the Joint Select Committee. The Joint Select Committee is all about cutting. The SGR formula reform is all about the opposite of cutting. So, I think the missions of those two things are quite different, and so the Joint Select Committee probably shouldn't be the one in charge of this. I don't think they can use up all of the pay-fors. Some are relatively obscure, and I'm not going to articulate them this morning. But there are some pay-fors to get us a period of stability passed this year. And then the work that was done -- the committee work, the hearings, the staff work that was done up until the middle of June when sort of the wind went out of the sails -- is still available to pick up and carry on and get this thing done.

There's going to be, of necessity -- there's still going to be a lot of debate that needs to take place, because right now the debates sort of taking place in the committee rooms up in Washington, D.C., but as I go around the country and talk to doctor groups, there is far from unanimity of opinion outside from physicians about what the future should look like.

And I think the one thing that's different this time than any other time that I've served on the committee, and I've been there now since -- this is my fourth term on the committee -- but this time it was sort

of like it was opened up to suggestions: Let's hear from you. I mean, everybody gets the fact that the SGR is bad and got to go. We don't need to hear that anymore. We all understand that we've got it -- we're all in that -- but wanted your suggestions. And so the various specialty groups have come to us. The AMA and the American Osteopathic Association have come to us and talked about what they would like to see, some things they're doing within their specialty societies.

So, I would say this is all a positive direction that things are moving. It's not going to be solved by the end of December, and that is a shame that we were giving a one-year retrieve in the lame duck session last year. I thought we could get it done. I miscalculated about how disruptive the debt ceiling debate was going to be. But, for better or for worse, all of that will be past us and there is still the work -- that foundation has been laid to a solution to this, and I just encourage your participation. It is so important, and, again, going and talking to doctor groups -- I've talked to six individual doctor groups last week when we were home -- or out doing district work and, yeah, I get all the complaints, but you've also got to come to the table with some solutions.

MR. McCLELLAN: Maybe as a follow-up on that and, you know, there's obviously a lot of attention on the SGR. But if we could maybe focus a little bit more on -- you've got a lot of experience not only in

the health care system but working with health professionals and others in trying to solve some of these very difficult legislative challenges. So, I'd really like to hear -- of course, what I most wanted to ask is what would you tell physicians, nurses, other health professionals about the most effective way to get involved to influence this process? I'm picking up on what you just said, Dr. Burgess. It sounds like coming forward not just with talking about the problem and maybe not just saying -- I don't want to words in your mouth -- I'm just saying, you know, I mean, you fix the SGR but how? And how can you in a way that addresses some of these core underlying policy problems? And we're operating in an era of big deficits and big concerns about government financing for health care more generally. A theme for our day is about how physicians and other clinicians can help lead that. What's your take?

MS. SCHWARTZ: Well, because I think that -- and I think there are probably some representation in the room -- we've worked very closely over years but certainly in the last few months. In particular, a lot of the associations that represent physicians here -- and there are many of them -- you know, have actually stepped up and put forward ideas about how to fix the SGR, for example, and how to move forward. And they've been very constructive. We've worked very closely with them, and as later today I talk about the framework which I just laid out to you earlier about

how we do this very consistent with what the AMA and the Osteopathic Association and the American College of Physicians and a number of the specialty groups as well have said they support. And, again, the framework is basically in transition. I actually think we need more like a five-year transition rather than two or three to be able to really look at the models and a replacement system with some understanding of what that transition really means and, again, a variety of models that work, given the variety of practice settings and variety of the geography. That matters as well.

And so we've been working very closely, and in fact the American Osteopathic Association and the American College of Physicians have already supported my framework, and we're working closely on the legislation. AMA is close. They've been really very, very helpful and engaged, which I appreciate, and even the American College of Ob/Gyns -- I mean, a number of -- again, your leadership, your association here that really does drill down on how do you get this done? You know, what do we have to say? What should the legislation look like? And to some extent I will talk, as well, to individual physicians at home and nationally, and mostly they will share with me what some of the issues are as they see some of the problems. But they spend every day seeing patients. I mean, you know, they don't come home and then say okay,

here's how I want you to reform the insurance system, here's how I want you to -- here's the best way for you to find the dollars. That's kind of our job to do. And I know -- and I guess I won't -- many of us are very skeptical. We are just a few days away from hearing from the Joint Select Committee. It is still possible for them to find a way forward, to reduce our deficit, and also meet our obligations in this country. I don't know if they get there. I certainly agree that we're going to have to fix the SGR and have a replacement whether they do it in Super Committee or not. But let me say this. It's $300 billion to do full repeal if we do it before the end of December. It goes up after that, because we keep not doing these reductions from our budgeting point of view the way we do budgeting if it's still -- is on the books as an expectation. And so we've got to do this, and the Super Committee is an opportunity for them to figure out how to pay for that and how to repeal it. And then that gives us the tools to be able to repeal it and replace it with something much better for physicians in this country. So, I wouldn't give up just yet. There is a chance -- I mean, even as we move forward toward the end of year, we have to do it on our own through the Committee process, and I would agree with Mike that I have tremendous respect for our committee process, and I served on the Ways and Means Committee. I'd rather be the one in the committee rooms having some say about this. Mark knows something about this. But there

is a chance for us, because we do know what -- I think many of us do have agreement about how to move forward. We really do. And I've been on panels with some bipartisan -- again, I want to be sure it's flexible, that there's response, that we can learn from the experience over the next five to six years is enormously important.

So, your question as to how you can get involved: I think the most important thing for you to do at this point is to really examine how you think the delivery system could change, should change to give you that responsibility to provide health care in a way that works, again, for physicians, for providers, and for the patients you see. That is what the next four to five years are all about. Instead of saying to you we want you to step up, we want you to explore these options, we want you give feedback to the administration. They've been quite responsive. I think if you look at the ACO regulations, there was a lot of reaction to the initial ACO regulations, and they made significant changes, because they want it to work. I want it to work. So, I think what you do in the next few years will inform that payment system that replaces SGR. So, I would ask you to step up and tell us what's working as well as what's not, because we want to replace it with a system that works, and that's where you really have a tremendous opportunity and maybe even responsibility.

MR. McCLELLAN: Dr. Burgess, any further advice for

clinicians like these?

DR. BURGESS: Well, it is so good that you're doing this, and I remember now it's been 15 years ago when I went to a lecture about taking back medicine. I said yeah, that's for me, let's take back medicine. And one of the individuals who spoke was a management professor from the University of Texas at Dallas, and I thought what in the heck is this guy going to tell me that's worthwhile. And what he said was that doctors cannot -- you have to develop the leadership expertise from within your own ranks. You cannot go and hire a consultant. You cannot put someone else to do this work for you. You have to develop the expertise within your own ranks. You can't farm it out. And I think he was exactly on point. That's why I'm so glad that you're doing this.

Look, in my perfect world, we have vastly expanded, consumer-directed health care for big sections of the population, but I also recognize that there are people who simply could not manage their health care existence in that type of world.

Don Berwick has talked about 20 percent of his patients spending 80 percent of his money. He knows who they are. They're people who are eligible for both Medicare and Medicaid simultaneously. They don't move around a lot. The population is relatively fixed in space and time.

So, why don't we develop a better way of delivery care for this subsection of the population, who could never be managed in a consumer-directed health plan? What they need is a doctor. They need a doctor to take care of them. You have doctors who are willing to do that.

Now, the ACA response to this was to develop an entirely new federal agency, the Federal Coordinated Health Center or whatever it is. But realistically, Don, you had broad demonstration project authority within CFS. Why not try? Whether you call it direct primary care, concierge physician, whatever you want to call it, but put somebody in charge of these patients' medical care, and I think you'll find care that's delivered in a timely fashion in a much more cost-effective way, and the patients will get better care ultimately, and that's got to be the ultimate goal.

So, there are a variety of solutions out there. To say one thing is going to fix all of the problems I think is preposterous, and that goes, you know, sort of a notion behind driving the ACA that I pushed again so hard. You know, American medicine is multi-faceted, your patients are not all the same, and it is going to require a variety of approaches. What works in Philadelphia will not work in Muleshoe, Texas. It's just a given. They are two different worlds, and they're going to have to have sensitivities to the differences of those worlds.

MS. SCHWARTZ: I just -- I do want to tell you, and you may have seen this, I think there is a lot of opportunity to offer a variety of options, and I'm sure you'll be talking about this during the course of the day. Just this week, CMOS did come out with -- you know, we have certain models within ACA, but in fact if you are thinking up doing delivery system reform in another way -- and I hope you talk more about this later -- we want to know about that, we're open to it, it does have to fit in to one of our regulations. I think the opportunity is pretty -- it is not a one-size-fits-all by means. It's just tremendous opportunity -- and I think I'll hear more about that from Dr. Barron later, but it's -- and I was impressed myself that they are really open to private initiatives that are not publicly driven, and, you know, if they work they can be incorporated as well, and I think that that is an enormous opportunity. Again, it puts a lot back on you, in a way, to define what that is and to communicate again what works for you and whether we can expand that. A lot of this is also about the good models out there: How many of those can of those can we duplicate? How many can we scale up and make sure that we reach out to other patients and populations across the country.

MR. McCLELLAN: Does seem like a couple of common themes. In order to get this problem really solved, a lot of the leadership is going to have to come from clinicians like you, that solutions are going

to be diverse, and there some real work ahead to get that done, but with the leadership from the clinical community there's a real opportunity for some bipartisan action.

MS. SCHWARTZ: Oops.

MR. McCLELLAN: We have just -- we asked you to stay for just a minute or two more, may be time for one or two questions or comments from those of you who are here. We've heard a lot from both of these members already. Any final thoughts or questions from you all?

MR. FRIEDMAN: I'm Jerry Friedman from the Ohio State University Medical Center. I want to thank you for all your comments this morning.

I'm curious about your views on the future of graduate medical education irrespective of what the solution is. We are seeing a looming shortage of doctors. We're being asked to train interdisciplinarily. Where does Medicare play into this? Medicare has, since its inception, supported the education of physicians. We certainly have medical students now who are concerned about whether or not they'll have a residency slot when they graduate, and the Super Committee has obviously got their Sonics agenda as well. I'd appreciate your thoughts.

DR. BURGESS: Perhaps one of the failings of the ACA was it didn't address what you describe as a looming physician shortage, and

whatever the effects will be of vast expansions of Medicaid and huge federal subsidies and the exchanges, there will be more patients in the cue, and what will happen at the end of that cue is anyone's guess. I mean, I don't think the problem's been well studied.

Now, there were some opportunities in the health care reform legislations that went through. Some of the things that -- although I did not support the House version of the Bill, there were some things on the House side that I thought were perhaps a little bit better structured as far as the funding, both the direct and indirect funding for graduate medical education. But they kind of fell off in the Senate bill. Now they are -- I mean, the landscape is uneven, and I will readily admit to you that that is a problem and one that we will have to address. I mean, this is not something that can be fixed by anyone other than the people who actually write the checks at the end of the day in the appropriations process, but it does have to happen.

MS. SCHWARTZ: And one of the things that wasn't mentioned in my resume is I also started the Academic Medical Caucus within Congress, and it's bipartisan, and really appreciate support in that, and was a very vocal, both publicly and within the discussions around, to be supportive of a GMA and IMA and protecting the role of teaching hospitals and admission teaching. So, they also might be involved with

some of the -- and hopefully involved -- with some of the delivery system reform. I feel very strongly that that mission of teaching medical students and residents is as expensive and enormously important.

In ACA, as you probably know, we direct some of the unused residency slots. There were about, I think, 600 across the country to be used. If the institution didn't want to use it to direct them to other institutions that would actually fill those slots with some preference for primary care because of the need for primary care physicians. There are some other things in primary care, as you may know, in terms of enhancing reimbursement. And I have, since then, continued to be a little bit of a -- well, I do other work, and SGR has been kind of my one note recently, making sure I also say do not interview with GME and IME. It's enormously important to have some stability for the teaching hospitals, and knowing of that support for medical (inaudible) and residency is really important.

I do have a son who is finishing his cardiology fellowship and a daughter-in-law who's finishing her residency in pathology. So, I am well aware of, you know, the next generation of physicians all of whom are asking about what's next, obviously. But, you know, committed again, I think we started out with to patient care and to research and advancement and, you know, to what's going on in health care in this country and

committed to that. So, we need to make sure that there -- I think there is a real shortage of physicians, and we've ignored some of that in terms of whether we should have new residency slots -- I working on some language legislation to see how reaction might in fact -- some people think we need 15,000 more residency slots in this country. So, I mean, it's just how we do that or we pay for it, how to protect that mission. And so, again, if you work in an academic medical center or you came through one, to really make sure that you talk about that as well. There are other goals and missions in the health care arena, and teaching and preparing the next generation of physicians is certainly one of them.

MR. McCLELLAN: Well, thank you all for the comments. I'm sorry I have to cut this off. We've got a busy day, you all have a busy day. Clearly a lot of opportunities for clinician leadership in helping what sounds like a critical phase of not only reforms for physician payment but reforms of academic medical centers and other parts of our health care system, too.

(Recess)

MS. PATEL: Well, welcome back. Thank you. This morning was a perfect segue to our next panel, which is going to be an exciting look into very different aspects of clinical transformation with an eye towards keeping towards the theme of the day, how clinicians can lead and how that will take us forward.

So, my name is Kavita Patel. I'm a fellow and managing director here at the Engelberg Center and an internist by background and a primary care physician. I'm very excited to help moderate this panel, which means I'm going to try to be as quiet as possible, make sure you all get a chance to interact with this esteemed set of panelists. And so to that end, we have an amazing group here. Their bios and full credentials are in your packets. Without taking too much time, I just want to do some very brief intros.

And building on what both the congressman and congresswoman said as well as some of the remarks Mark made, as well as kind of this effort around what Dr. Merkin has been a leader in in the past and the present, I'd like to just say that the goal of this session, especially for our panel, is to illustrate from our different vantage points how clinical experience and how leadership has played a role in transforming these systems of care. And interestingly enough, that involves also some failures and roadblocks as well as some successes. So, that's just a brief overview.

So, just starting all the way with your left and then we'll work our way down. I'll introduce folks and then ask each of them to give some brief remarks, and then we'll open it up for questions and an interactive discussion and then move from there into our next panel.

So, all the way to my right and to your left is Dr. Kevin Schulman. He's the professor of medicine and the Gregory Mario and Jeremy Mario professor of business administration at Duke University. Seated next to him, Dr. Eliot Lazar, senior vice president at New York Presbyterian Hospital. Next to him is Dr. Barbara McAneny. She's the founding practice partner of Oncology Hematology Consultants in New Mexico, and a member of the American Medical Association Board of Trustees. And then immediately next to her, Ann Hendrich, who is a clinical nurse and vice president of clinical excellence operations, as well as the executive director of the Ascension Health Patient Safety Organization at Ascension Healthcare. And to my right, immediately, Dr. Bruce Hamory, executive vice president and managing partner of Geisinger Consulting Services and at Geisinger Health System, and most recently prior to that was the chief medical officer for Geisinger Systems.

So, you can tell absolutely they have the bona fides and the credentials. I think more importantly, as we get into it, each one of them have had a crucial role personally as well as professionally in really helping to not only lead and take clinical transformation into the next era, but have had to face the very question that Dr. Burgess raised which is, how do you cultivate a culture of transformation? And how do you do this? It's not easy, it's not prescribed, and as I'm confident some of them

will tell you, it sometimes goes punished and it's often unfunded. So, this is all done in times when resources are scarce, yet the critical mission and the need for it is at an all-time high.

So, Kevin, do you mind starting us off with some of your thoughts? And we'll go from there.

MR. SCHULMAN: No, thanks, and thanks for inviting me. So, I get to give the academic presentation. All theory and no practical experience. Actually, I run a very large research group.

You know, I think when we talk about -- I think there are two really essential concepts here. One is leadership, and then leadership for change. And we've obviously had lots of leadership in healthcare. We've built big institutions, we've built big infrastructure, we've created a lot of things in healthcare delivery system. You can go anywhere in the country -- in Europe, I kind of say, we go visit cathedrals; in America, we come visit hospitals. The only problem is, we can't afford those anymore.

And so, we have this question of what is leadership for transformational change? What is transformational change? And that gets back to a couple of things that we do at the Business School.

And the first major question is, why do people change? All of you are running successful businesses, all the people running pieces of healthcare system are doing very well, especially compared to the rest of

the economy. You wake up in the morning and, you know, we're doing pretty well. Do we want to change?

When you look out in the broader economy, why do firms change? And I'm generally convinced there's only one reason why firms change, and that's because they're afraid they're going to be killed by a competitor that day. And absent that, people don't change.

So, one question for the policymakers, for all of us to decide is if the supercommittee -- is it the deficit? Is this the final point where we have to get serious about change? And so that's one issue.

If in fact we're in agreement that we have to change, we have to change to be something more, one question is what is that destination? There's a lot of different ideas about that. I go and visit Indian heart hospitals, not as an example of justice, but as an example of efficiency. So if you want bypass surgery for $2,500, you can get it in Hyderabad, India, by a surgeon who does like, three to four times the volume of any surgeon in the country. All right? So, there are other models out there at substantially different price points we could observe.

I will tell you, also, for a 3- or 400-bed hospital in Delhi, the entire management team is about half the size of people in this room. Obviously there's no single committee at your institution that's smaller than double the size of the people in this room. Which brings it back to,

how do firms change? And there's a vocabulary of change that we don't learn in medical school about how organizations transform. There's a variety of different ways. There's ways in which you're creating these ACO products, there's service line products, you have a team of people, you go off, you build a whole new infrastructure, and then you keep the old infrastructure and you have the new infrastructure, and that's called cost increasing. You've doubled the size of your firm.

Venture capital. Every single firm, every single biotech firm out there has a venture capital, or pharma firm has a venture capital arm. Why do they do that? Why do they say they do that? They're prospecting for new business models that are not invented here, okay? We're not smart enough to figure out what the future is, let's go find a couple people that are entrepreneurial and trying to start something up and see if we like that idea so we can bring that business model inside.

Acquisitions, we're doing lots of acquisitions right now. Hospitals are acquiring physician practices, whether that's improved the efficiency of care or to have leverage against the payers is really a critical issue for us to address. So, we do do some of that, and that's a critical structural issue, do we do the right kind of acquisitions?

And then finally, organizational change and partnership. I love to say that at Duke, if you walk into our original hospital building

there's the original chairs of all the departments at the Duke Med School written in bronze in the front hall. We're an organization, we have exactly the same departments today as we did then. We're an organization with our org chart written in bronze, okay? There is no other firm in the United States that has an org chart written in bronze. You know what the skill we don't have is? Structural reform.

You know, how many of you have been in years and years of processes of moving from hospitals to service lines? Or in our firm we just -- at the Clinical Research Institute, we got 1,300 people and we've realized, actually, no one in the management team has ever been through a transformation, a structural change, in their entire business career. So those are a set of skills and vocabulary that we need to learn.

And one other final thing we have to learn as part of that is the difference between fixed and variable costs. Almost all the policy initiatives in Washington are around variable costs. You could do a great job managing, keeping your heart failure patients out of the hospital, and you know what? The people in the hospital are still paying rent, they still have 10,000 administrators, there's still all the same organizational structures in place. We haven't done one iota to transform the business of healthcare.

So, as part of this, how are we going to deconstruct -- a final

thing. You want to pay for the SGR, get rid of all the administrators, okay? There's lots of non-value-added things in healthcare that we've created over time, either because we've not filled those roles or we haven't concentrated on those roles, or we've made this mistake of focusing on variable rather than fixed cost. If we're going to have some room for growth, both for innovation in products and innovation in service, we're going to have to tackle the fixed cost thing, and that's going to have to be a core competency of organizational innovation.

MS. PATEL: Thank you so much, Kevin. Eliot?

MR. LAZAR: Sure, good morning. Thank you for having me.

I'm going to build on some of the themes that Kevin spoke about, and although my remarks will be directed towards physicians I think they're really applied to just about any healthcare professional with a clinical background, be it nursing or other technical folks. And I'm going to try to frame my comments around the physician as leader and leading physicians.

So, let me start with the idea that the concept of a physician leader is really a heterogeneous one. We have physician leaders who are clinical leaders, educational leaders, leaders of departments, divisions, leaders of institutions, organizations, and so on and so forth. And I think

you'd agree that being identified as a leader in one setting or venue doesn't necessarily mean that those skills are transmissible to another setting or venue, and we often make that mistake. Number one, the skill set may not be there, and, number two, the desire or interest may not be there.

I would also, again, build on a point that Kevin made to say that the traditional medical hierarchy -- and we're going to speak a little bit about that in a moment -- doesn't necessarily parallel those folks that we would ask to lead transformational change. So you know, a chair or chief may wind up not being the best individual to lead, say, a particular clinical initiative.

There's a very young anesthesiologist who works for me, he's one of my quality and patient safety officers. He's literally in his second year out of training, actually spent a lot of time with Dave Nash at Jefferson, and really comes to this with the right mindset. He's probably been more effective in some organizational efficiency activity than many of our more senior clinical chairs.

As we think about the role of traditional physician leaders they really, I think, fall into four specific role types. First and most desirable is when the traditional leader -- the chair, division chief, and so on -- becomes the champion for the effort. One of our chairs has become

very passionate about the issue of the patient experience and satisfaction. She herself is the leader of the task force, attends every meeting, drives the agenda, demands the performance measures, and so on and so forth. So that really is most desirable. Unfortunately, it's not always what we have to work with.

The second is where the traditional leader delegates to somebody else. So, a chair may not have that particular interest, expertise, or time, but delegates somebody else in the department, another colleague. Again, we have a particular department where the vice chair is extremely passionate about reducing readmits and length of stay. The chair is not so inclined, much more interested in some of the department's basic science pursuits, but clearly has endorsed the person to whom he's delegated. Has put the chairman's moniker on those activities, his imprimatur, and it's very effective.

The third model is where the traditional leader is neutral. And I think many of you would agree that we deal with that by perhaps recruiting peers or other folks in a similar level to sort of champion the effort. Neutral, I think, can be dealt with indirectly.

The fourth role type, which is the most problematic, is where the traditional leader is the obstructionist. Whether it's a clinical chair or president of a medical staff group, or whomever, they really just don't want

to see change happen. And unfortunately, in those situations we really have no choice but to sit down with the individual and deal with them on a pretty direct basis.

So let me just make one or two comments about the notion of leading physicians. So, who are we dealing with? Well, we're dealing with folks that are bright, a group generally resistant to change, a group that arguably may be frustrated by either the perception of the reality of less control than they may have had in the past. A group very schooled in the use of evidence and data. So, where does that leave us?

Number one, transparency and honesty above all else. I think many of us have heard that, you know, our physician staff, whether in academic centers or community hospitals, question whether they're being given accurate and honest information and that's really what they want. And we have an obligation to provide it for them if we expect them to be involved in the kinds of transformation that are required.

We use data, but obviously if the data is high-quality and we have to think about it from the point of view of the critical reader. If there are issues with the data, limitations -- physician attribution we hear about all the time when we're dealing with M.D.-level data. We've got to make that clear up front, and often the docs will challenge but if moved by good evidence can be compelled by it.

I would close by saying that we also need to be very consistent in both message and methodology. One of the things that we hear and I suspect we're not alone by many of the docs is, we seem to be picking the improvement process du jour. You know, we go from this one to that one and we don't seem to be consistent, and why should I get enfranchised if I know that a year from now somebody's going to be changing that? So, consistency of both message, methodology, and leadership from the top is very important.

The final point I'll make is that obviously progress is not always in the kind of -- is measured in the magnitude that we look for. Desiring perfection can be the enemy of good.

And I'll stop there.

MS. PATEL: Great, thank you. And I know Dr. McAneny has some slides. I'm going to hand you -- and you can just forward them as you like.

MS. McANENY: Hand me the clicker -- okay.

MS. PATEL: Direct your attention to the easy-to-see screens in the corner.

MS. McANENY: Thank you, also, for inviting me to speak today. I don't represent a large integrated health system, and it's going to be my goal to convince you that it may be necessary, but it will not be

sufficient to work simply with large, integrated health systems because, for example, in oncology where I live 80 percent of the cancer care is delivered in private practices. And if we then make wonderful transformational changes in all the major institutions, I would like to try to convince you that that will not be sufficient to get us where we need to go.

And the first one is, because a lot of patients are treated outside of large, academic, or vertically-integrated institutions and we need to focus on that as well. We also need very much to look at the fact that hospitals -- and I agree with Kevin -- are very large, fixed-cost institutions, and I would say that they're relatively inefficient. Hospital-based physicians tend to be not have any incentives to save cost, to keep people out of the hospital. And one of the things that I'll show you as I talk through my experiences, that as I started working with my hospital health plan conglomerate, you know, bilateral monopoly systems, that they were not very interested in any of the changes that I was trying to make, and even the cost at that instance is a significantly more. Even MedPAC comments that the same service purchased by a physician in a hospital-based system costs 150 percent of what it costs in a physician fee schedule physician.

And then finally to the workforce comments earlier, the American Society of Clinical Oncology did a study some years ago looking

at the number of oncologists being produced versus the demand for need. The need will go up 148 percent, the number of physicians will go up 113 percent, which means that in about 15 years, 1 of 3 cancer patients will not see an oncologist.

In order to deal with some of the issues of that, in my practice in New Mexico one of the things that we did was we recognized that having our bilateral monopoly wanting basically to put us out of business, that we needed to become very efficient and it was not in our best interest to have patients in the hospital. We did this years before we were worried about cost savings or anything else.

So, one of the things that we did was started developing a system of care which, had I known of the label at that time, I would have called an oncology medical home. But basically what we did was set it up in a way that we could keep patients out of the hospital, manage their care, proactively make sure that they tolerated all of the complicated treatments that we did for them.

And then in interest I looked at the amount of savings that we were generating. This data that's on this one is Medicare data for 2010. This is out of one oncology practice, and it's a significant amount of money. The issue -- I presented this based on the data that I could pull for one particular health plan in my market, showed it to that health plan who also

owns a hospital who said, why would we want you to cut down the amount of hospitalizations and cut down the amount of imaging you're doing and cut down on our ED use? That's not going to help us get where we want to go, which is to be more profitable. And if you have any doubts about that, look at the large number of consultants and legal firms who are working very hard to convince oncology practices to move into hospitals because they can make more money if they do that. A quarter of oncology practices sold to hospitals last year, about 50 percent of cardiology practices. So there's money to be made by putting physicians into hospitals, and I would suggest that perhaps that's not where this country needs to go at this point.

So I looked at this data in my practice, and this is actual data -- what this is, is Medicare for 2010 -- and looked at the structures of what we could do to make a difference on that. And then I realized that this is very carefully divided. The revenue side of the ledger goes to the payers, the expense side of the ledger comes to me. And that's very useful for the payers, but it isn't sustainable in a physician practice. And, therefore, I figured out that one of the things we better do is figure out how to do some different fee structures, and I have been unsuccessful -- I'm one of the failures Kavita mentioned -- unsuccessful at trying to sell this to any of the health plans.

I did get the one health plan that didn't have a hospital in my market to actually look at this and consider my bundled payment that I would like to do, but then as soon as the hospitals got wind of this they threatened them with a high hospital day rate and that was the end of that.

But we did create a process by which we can do a bundled payment, and I've been working on this to Congresswoman Schultz' process. It's been taking about five years to work through this where we set up a way to do bundled payments that is transparent, that is sufficiently clinically and economically integrated to satisfy the antitrust requirements, and is actually a workable thing. So, we would create a process by which we have reinsurance protections.

My theory is that I would like to have Medicare set up an account for me and let me bundle the payments and let me manage oncology payments, the whole works, the whole continuum of care. Put that money in a reserve account that I draw down against. I would first buy some reinsurance, and I would make sure that I had good demographic loops, because a few extra folks who want to go for proton beam can break the system.

You put patient stratification and you fund the patients as you move there. You know that they're patients of multiple levels of complexity. You can come up with average payments. I can do this from

my practice. You have reimbursement accounts that you can then say, I will need to put various amounts of money for each given patient, each given diagnosis and stage into specific accounts that I can then monitor and I can keep this as a transparent system. So, the best way to mess up a partnership of physicians and hospitals is to let somebody think that you're not giving them the money they're entitled to. That'll end it pretty quickly. So, it has to be transparent.

We can put the money into these reserve accounts. Any unused allocations then I can put into a different account and be able to use that because, you know, not all people are exactly on the average payment and that gives me a reserve for high complexity payments, and I can have a quality pool where I can make sure using internal mechanisms that patients are actually getting what patients need when they need it so that the quality is there. And if I can do this so that I could have a bundled payment in this manner, that takes you back to the amount of money that you could save, which I showed on the previous slide.

And I think doing something like that, working with the community practices which are small enough -- if you asked me how much it costs for me to do printer cartridges, I know that, and we really can get down to that level of granularity. That, I think, is where we're going to make some significant cost savings.

And with the medical home part of this, my patients are thrilled not to go to the ER and sit for six hours. They're thrilled not to be admitted as long as the national average. They're pleased the fact that they can call us day or night.

Now, one of the issues and one of the challenges we have is that the younger generation is smarter than I am and they have figured out that they don't want to work that hard if all of the benefits are going to accrue to the payers and not to them. So we will have -- it will take some degree of resources to make sure that physicians continue to be willing to work this hard. You know, if this weekend somebody calls at 2 a.m. to be admitted, it's me. I'm there in the hospital admitting them in the morning.

The issues really will be putting enough of the resources into the physician practices that they can become and continue to develop into very efficient machinery for taking care of patients and giving patients what we want. And if we do that, then we will save money in that expensive fixed-cost system called the hospital.

Thank you.

MS. PATEL: Thank you so much, Barbara. I think, Ann, you had some slides. Just go ahead and click "Next." There you go, thanks.

MS. HENDRICH: Thank you. My comments and thoughts today really stem from reflecting on the Ascension Health journey to zero,

and now our high reliability pursuit of clinical transformation of care.

The bold goals that we set now, eight years ago, to reduce preventable mortality and also to eliminate serious safety events required that we engage deeply hundreds of clinicians across our system. This transformation work has shown system-wide improvement in both quality, safety, and also cost-effectiveness. We are a large, complex system, and we've seen the impact this engagement has had in multiple states.

Just a couple of slides here. I'll put this one up as I'm talking. We are not simply a system of hospitals. This graphic represents the complexity and the diversity of the care environments that Ascension provides for the communities that they serve in more than 20 states.

It's also important to note, I think, that the majority of our physicians are not employed. In fact, very few are employed with us. Many of our physicians have partnered with our care teams in numerous ways to improve clinical care quality and improve access. They've done this by dramatically decreasing hospital-acquired conditions, and also set new benchmarks in these areas for the nation around birth trauma, reducing injurious hospital falls, and pressure ulcer prevention. We have nearly eliminated hospital-acquired pressure ulcers.

These improvement efforts were not contained just within hospital settings. A similar impact can be seen in our creative disease

management medical home programs in the communities that we serve that have reduced episodes of illness, and also in acute care hospitalization.

I want to briefly share with you a couple of examples that I think highlight this. We are one of several sites that were selected by NCI for the National Community Cancer Care Program. And as has already been stated, as most of you know, cancer care delivery in this country, the majority of it does occur in clinics and in community-based hospitals, and that really was the focus of this initiative. How do we improve the disparate nature of oncology care delivery and reduce redundancy and, frankly, over-treatment?

To no surprise, we found that when you support busy clinicians with care navigators, tremendous improvement occurs at the patient care level. There is higher quality, less cost, better patient experiences. But what I would challenge us to say is, are we still building workarounds? Because these care navigators are designed around the broken system that we currently have. So yes, it works, but it's still adding additional cost to what is a fragmented system that needs -- is in bad need of transformation already. So, these findings suggest that there's sufficient complexity between subspecialists, even in our comprehensive care cancer programs.

Another key finding from this work that I want to talk briefly about is to assure that palliative care teams are also part of our care models. I want to share with you briefly one of our care navigators and palliative care team members shared this story about a patient that I'll call Mary who had been hospitalized six times in less than two months, primarily for symptomatology because the outpatient environment did not support the care needs that she has. There was really no reimbursement for that type of care.

On her sixth admission, the palliative care team simply asked Mary, what is your goal for this hospitalization? And she said, I simply want to go home, to be able to die at home, to be able to take fluids, and not have abdominal pain, and sit on my patio. Within three days, the palliative care team actually made that happen for Mary. My question is, why doesn't that happen for every patient, especially at the end of life?

So this case demonstrates the patient and payer impact when providers in the care team are aligned. Unfortunately, this is not easy work because the incentives right now are not aligned with the kind of care model that I just described.

The last story that I'd like to talk briefly about is another example. We currently have an R18 grant with the Agency for Health

Care Research Quality, which is targeted around reforming medical liability. We have engaged five of our largest obstetric delivering sites, and as many of you probably know, obstetrics is one of the most litigious areas in medicine.

We have trained more than 200 physicians, more than 300 nurses with our team steps training. These are obstetricians who were trained to never disclose to a mother any unexpected event because it would increase the hospital or their own medical liability. After this training, now we can say they have developed a bundle for one of the most difficult labor presentations which is called a shoulder dystocia. And when this presentation occurs, an infant often sustains either temporary or permanent lifelong injury to the arm and the nerve in the arm, decreasing functionality for a lifetime.

Our obstetricians and nurses designed a bundle of maneuvers that is actually reduced this rare event by more than 50 percent in the last 14 months. There have been no claims at these hospitals. It's still to early to draw conclusions, but what we do know is that these obstetricians have now implemented this shoulder bundle, five states, five different models of medical mal caps, et cetera. And as one of my physician colleagues said to me recently, if I had known today -- known then what I know today, I would have been a better doctor for the

last 20 years.

So, there is full engagement of our physician leaders, and an indirect benefit of this has been that medical premiums for these physicians have been dropped by 10 to 15 percent based on the work that we're doing. We've enrolled 6,500 mothers and infants in this study. We're well on our way to about 20,000, which will be one of the largest medical liability studies ever published in the literature, to our knowledge. So, I would encourage you to watch for that study, and we will have actuarial analysis of the liability and premiums' impact over time.

So in conclusion, let me say that clearly as it has been said many times already, it is possible to fully engage physicians and nurses, and our goal at Ascension is to continue to discover how to best partner with our clinicians to lead this transformation change, and also that all of our clinicians and nurses are fully practicing within the scope of their licensure to lead this transformation.

MS. PATEL: Great. Thank you so much, Ann. Bruce?

MR. HAMORY: Well, good morning. Geisinger, as you know, was a physician-led integrated health system. We have physician and administrator teams who lead our organization at every level.

We have not adopted the view that every physician needs to go to business school. We think there are people trained to do that.

Doctors need to have some skill, but those teams share accountability for the budget of their operating unit, whether that's a service line, a division, a department, a hospital. For their budget, the levels of their quality and services, market growth. They have hire and fire responsibility for their staff. They coordinate and are responsible both for the inpatient and the ambulatory components, and they have some responsibility for the strategic planning of their area.

Our physicians have led a number of the development issues. You've heard Dr. McClellan talk a moment about proven care for the acute side with cardiac; mentioned briefly that we've done similar things in the outpatient area and in diabetes, for example, with the reliability bundle, have been able to demonstrate a 40 percent decrease in vascular complications, amputation, loss of vision, stroke, heart attack within 600 days. Our OB folks have put a pathway together that extends 10 months and has reduced low birth weight admissions to our NICU by half.

So, our physician leaders are required at our place -- and I would submit, at yours -- for success in changing the organization. For us, this has been about a 10-year journey. We started with an organization at that time that had an 85-year history, and a number of physician leaders in place. Like some of yours, I expect, many of those individuals got there

because they outlived their predecessor. And so, one of the things that my boss and I did was we evaluated those individuals based on performance, and over the next 2 years changed 75 percent of our physician leaders -- 75 percent.

Now, we don't have tenure, as my boss who came from a medical school said. So, that's easier for us to do than perhaps for some. So, we set performance expectations.

We have some criteria that we use. First, doctors have to want the job. This is not something you assign, not temporary additional duty as assigned. This is a job you have to want to do.

At our place -- and I suspect, at yours -- they need to have respect as a doctor. Your colleagues have to know that you know how to take care of patients. They have to be a good communicator. They have to have some evidence of ability to perform and lead in another setting, so we put people through committee assignments and a variety of things, and they have to be able to work in a team and respect their colleagues. So, this is not a time for the neurosurgeon to yell.

They also have to be willing and able to confront bad behavior by their colleagues. Most physicians are of conflict avoidance, and they need to have some vision for the future and the ability to excite others about achieving that vision, and do this in a way where they're not

a shop steward. This is not you're representing the interests of your group against the entire organization.

So, we have a formal process to identify these folks. They can be self-identified during their annual evaluation, their chief can nominate them, and we have questions for each of those on every annual evaluation. This creates a list for us as senior leaders to identify people for assignments to committees, for assignments to work groups, and a group of about 30 physicians and 30 administrators are identified each year for a seminar series that's led by our CEO and a member of our board who is a professor at a business school at a local university.

Now, we find that of the people who attend that course, who've expressed an interest, about a third decide they're not interested, and that's similar to other reports in the literature. We have had a number of successes with this. Chief of pathology at one of our hospitals, chair of surgery, and so forth. We think you have to provide a career ladder for these people that, you know, if you take somebody and they're going to stay in one job, they're going to be chief of the quality operation or the chief of X forever -- that that is not a good option.

So, what do we need to get this done? One, we need a different selection and training process for our medical schools. We are all selected as best athletes, not as team players, and this is basketball --

for my colleague from Duke.

MR. SCHULMAN: Thank you.

MR. HAMORY: And so it's a team sport and we have to learn to pick people who work in teams and train them that way. They need to be more process-oriented. We teach people the Krebs cycle, we don't teach them how organizations work. It does not require a business degree for everybody.

Residency competencies have been changing. The ABMS, as you all know, has changed some of that. That needs to accelerate. It needs to be linked to changes in the nursing school curriculum. It needs to be linked to changes in the curricula for administrators. Administrators are still being trained as heads in beds, and as a guy who has run a couple hospitals, I can tell you that's not the future. So, that concept has to change.

So in effect I would offer one other thought. Evidence-based medicine should apply not only -- or EBM should apply not only to evidence-based medicine, but I think also to a concept that Steve Shortell proposed in an editorial in *JAMA* a few months ago, which is evidence-based management. And it's the link between those two, driven by clinicians who know their patients, know the system, that I think can really help us forward.

Thank you.

MS. PATEL: Thank you so much. So I want people who have questions, go ahead and raise your hand in the audience so we can get mics to you.

I just want to quickly summarize and thank our panel, but also say that I think what you've heard is reflective of a large degree of what we see in healthcare in general. There is a great deal of variation. Variation in settings, a great deal in variation, including -- I think it's classic, Kevin's example of these bronze outlines of shares all the way through Bruce offering that, you know, if people can't cut it we let them go. And then, we also find that people identify themselves as leaders, and that might not be facilitated in other settings as easily.

And to Barbara's point about how do community-based practices as well as a question that we often receive at the Engelberg Center, where do small practices fit in this very large and often confusing frame of misaligned incentives and transformation? And I think there's a very important role in clinicians thinking through all these very rapid market changes in the way we deliver healthcare. And then Ann reminded me at the very least how much, especially for physicians, how much malpractice and liability issues play often a really inhibiting behavior role in the care that I think clinicians want to see.

And so if I had to summarize, I would say that, you know, we can do work in Washington -- or at least try to, as you heard the Congressman and Congresswoman point to -- in realigning or fixing the misaligned incentives. But then, we really need for folks like those on the panel to actually help to both lead clinicians and, as Eliot said, to also be the leaders themselves.

So do people have questions? I've got some based on some comments here. But we'll just make sure we can get mics to you before you ask the question. And just please give us your name when you ask. Thank you.

MR. PAWLSON: Greg Pawlson from BlueCross BlueShield Association. It's been a very interesting set of commentaries.

Let me just push the envelope a little bit and ask the panel members to really reflect on what changes do you really think are actually going to result in a net improvement in the value equation? In other words, where we see both some improved quality or a benefit, you know, change? In other words, more effective care.

But also, that we don't, in a sense, trap whatever efficiencies or savings we might be able to do, they're not trapped in the system. And I think Kevin's point is an incredibly important one, is that we -- at every level of the system that I see, whether -- and we've all pointed at

everybody, we've all blamed everybody. We've blamed the hospitals and the insurers and the doctors and the pharmaceuticals, et cetera. And in a sense, that's partly true because all of us have the kind of institutional structures that are not necessarily the most efficient.

So, how do we really break through what I think has been a real problem in terms of improving both the benefit, quality side, but also the actual expenditures? Because ultimately, it's people who pay for healthcare. It's taxpayers and it's consumers, that's who pays for it. And I think we're at a point where, you know, the alternative is no education, no roads, no whatever.

MS. PATEL: Bruce, I know you wanted to respond. Anyone else who would like to.

MR. HAMORY: Well, I think it's a great question. We've tried to format each of the approaches to satisfy the needs of at least four constituencies: the patient, the provider, the payer, and the purchaser. And we've been able to show both with medical home model with several of the bundles that we can improve the patient experience and decrease their out-of-pocket cost because they have fewer co-pays and deductibles and all that stuff.

We can provide cardiac care to our health plan at 38 percent below the rates they pay anybody else. We have been unable, I will tell

you, to sell that to Blue Cross. Unable.

MS. PATEL: Well, there's someone here from Blue Cross, see.

MR. HAMORY: Well, no. That's why I'm looking right at him, okay? (Laughter) Because at the end of the day, our health plan is taking your market share. They have lower rates because they can pass those on to the purchaser. And in fact, sometimes I show a slide of the front page of a newspaper that says, local teachers got a 10 percent raise in pay because they switched to a Geisinger health plan and they're paying enough less for their premiums to account for that. And our providers, we have been able with the standardization of care, the reliability of care, to decrease our internal costs so that it really does become win, win, win, win, win.

I do think that we've got to change the way that bills are handled. We have as many people in the finance office in billing as we do nurses. Now, my CFO gets upset when I say that, but I will tell you that dealing with, you know, 42 insurance companies and the feds and the state and all that, there needs to be some alignment. And if that were one policy that came out of Congress, it would probably cut 20 percent off the top.

MS. PATEL: Barbara.

MS. McANENY: Yeah, I would like to address that as well, because what we've done in our practice on the ground -- and we have been electronic since I shredded the charts in 2002 -- is we can be data-driven. And we focused our entire structure around the patient, and that's what resulted in the shorter lengths of stays and everything else. We never put anybody in the hospital without a goal. We're going to fix this problem and then you're going to come out and we're going to continue the continuum of care there.

I think we're going to have to get rid of some of the fragmentation of the hospital who doesn't work as part of the practice. I think we do have to make sure that as we design it around the patients, our patients are thrilled with the care that they're getting because they know that if they call us day or night, somebody is there who knows them, has their chart, knows their data, that's key.

I think the other thing that I was going to mention is -- since you're a payer -- is that we do spend a huge amount of time -- and the AMA has done a remarkable work on looking at the payer report card saying that the payers pay according to their contract, about 80 percent of the time. Goes up and down a little bit bearing on the payers, but it's not 100 percent. This means in my office again -- and I was going to make the same point. I have to employ a huge number of people simply to

manage the money, and I employ three people simply to get free drug from pharma, et cetera, for when we can't provide them with chemotherapy.

If the AMA numbers show that about -- the average physician spends -- the average physician, the average family practice physician is spending about five weeks per year working on getting prior authorizations and trying to be paid fairly for the work that they've contracted to do. So, if we could eliminate that, that's another 300 patients per doctor. That will help us with some of our workforce issues.

I also think disconnecting the hospitals and the physicians will be useful. I think we will swing that pendulum back in a few years, because of the various things I talked about. If you're an employed physician, you're just not going to work as many patient hours as when you work for yourself. And with this shortage, we're going to need doctors working hard, seeing lots of patients.

It costs more to do it hospital-based. We're going to have to figure that out and pull people back out, and we need to make this process very efficient and very patient-centered.

MS. PATEL: Eliot and then Kevin.

MR. LAZAR: Yeah, I would certainly echo what my colleagues have said, but if you take the four Ps, harmonization within

each silo and harmonization across the silos, I think, would take us a long way.

I'll give you a couple of very, very brief examples. We provide cardiac data reporting as many states require, but we actually have to do it in duplicate with two sets of analysts who were doing two sets of data abstraction because one is for regulatory purposes to a regulatory body and the other is through a professional society, because that's what the payers would like us to do.

We have electronic health records that are closed platforms, they don't talk to each other. Like probably all of you, I'm amazed that, you know, I can go anywhere in the world and use the card and get money, but I can't get an EKG from the guy across the street. And I think until we're able to break down some of those silos and really embrace this concept of harmonizing across same indicators, interoperability, and so on, I think it's going to be a tough road.

MR. HAMORY: Can I just add to that quickly? I mean, it took -- and I'm not sure they're there yet, but it took -- most of the large systems in Pennsylvania -- Geisinger, Pitt -- have the same computer system. It has taken the state five years to be able to take standard vaccine data and put it into their data set, and they still can't return it to us so it's in ours. We still have to log onto their website to see this.

So, I would just submit this starts with government.

MS. PATEL: Starts and it might stop there. Kevin? (Laughter)

MR. HAMORY: True.

MR. SCHULMAN: You know, I agree with Bruce. You don't need to go to -- everyone doesn't need to go to business school, some people do. But --

MS. PATEL: Does the business --

MR. SCHULMAN: We can't handle everyone going to business school anyway. And on that side, actually there are very few places to go to business school and to look at healthcare. There are very few faculty that actually concentrate on this industry. There's only -- we just formed a group of a whopping 10.

But you know, as you see the idea of the thought that Bruce is putting into his -- to Geisinger and how this has evolved over a decade, you know, one question that's legit is to go back and ask is your institution doing that? And if not, why not? So, you know, we've had a conversation with 6 healthcare systems as exemplars, and 5,544 that are non-exemplars.

You know, within the same financial construct, we keep talking about reform, but they're doing it. It's painful, but they're doing it

because that's what they decided to do as a leadership group, and they've actually structured themselves so they're like-minded people doing that. We don't have huge numbers of examples of that.

We have lots of examples of leaders that build new buildings, leaders that build new whatever initiatives that couple onto the old initiatives, and some set a transparency on that. We don't call a question. We're not publishing in the newspaper every day, this person is leading your community to ruin because of the way they're running their healthcare system. Even the boards, I think, don't think understand it.

One of our local hospitals voted for a 30 percent BlueCross BlueShield rate increase in terms of making an acquisition. You know, that's the only way to justify the acquisition. So, you know, we need to have transparency and some set of accountability. These are community benefit organizations, they're not for profit, and clearly some of them are being run that way, many others it would be questionable.

MS. PATEL: We have more questions in the audience, so just -- I think we had one up here, and I thought we had one back there as well.

MR. CASEY: Hi, Don Casey from Atlantic Health System in New Jersey. I know many of you and am very jealous of the accomplishments you've achieved.

But relative to physician leadership, I'm interested, if you were to do one new thing that you haven't done before to enhance physician leadership in your organization, what would that one thing be? If you had a wish list.

MR. SCHULMAN: You know, I would say what Bruce -- you know, what we lack is general management, right? Our dean at our medical school ran a whole million-dollar lab before she was put in charge of a billion-dollar medical school right before the financial crisis. You can't think of a pathway to success that's, you know, more fraught with peril.

We're not organized -- you know, Bruce said we're all silos. I could be the head of quality and I could have done that for 20 years, but I'm not general manager. I have no idea what the finance guys do, or heaven forbid what the nurses do. So if you really want to have leadership of an organization, you know, you go look at what people do in other businesses.

This is a lot about plagiarism. Business is all about plagiarism. If you see a business model that works, copy it.

SPEAKER: Right.

MR. SCHULMAN: Right? And we're not socializing ourselves to that. So the idea that you get a $20 million unit, and if you do well with that you get a $50 million or $100 million unit means you build

skills, I can test you, I can build accountability, I can give you coaching because I actually observe what you're doing in a meaningful way and help you move forward. And that's not a process that any of us have.

MR. HAMORY: Well, we do a lot of that. I think the thing I would do differently is, I would rotate -- and we talked about this -- I would rotate physicians in leadership to different specialties because they really need to understand the upstream and the downstream.

And the cardiology guys are great or the surgeons are great, but they have no idea what goes on in the primary side, and vice versa. They may have very little idea what goes on outside the operating room. And I think my own personal experience was that I grew up in adult infectious disease and did hospital epidemiology for 20 years. So, I literally saw everything in the hospital from the roof to the sub-basement where the vacuum units were, and interacted with all the different people and all the folks in hospital administration. And you know, it's a unique perspective, and there needs to be a way to give other physicians some of that.

If you look at the way hospital administrators have changed, they rotate them, right? They start out as a junior assistant-something in charge of pharmacy and then they rotate to other areas of the hospital until they get that broad view. And as physicians, we don't. Once we get

into a specialty, we're siloed.

MS. McANENY: The one thing that I would do is, I would -- and of course it all costs time and money -- would be to help the physicians to interact with other people who are in their role elsewhere in the country, because otherwise we tend to get very provincial.

And one thing we started up about a decade and a half ago was a little group called Oncology Circle, which was six practices our size in different markets, so that without fear of being accused of collusion we could set -- we could show data to one another. We could create data that says, what do you pay your doctors? What do you pay your nurses? How much do you buy this or that or the other thing for? How do you structure yourself to be more efficiently?

We all helped one another learn, and now it's grown to 30-some practices, and we have a lot more significant data ability. But that plus the electronic record that we all have to be in this allows us to really look at this in a way that I can take the program that I've delivered in our practice, and I can scale that across those 30 practices in a heartbeat because they're all kind of doing that, we're just not organized to publish it and let you know about it. So, if I could get more of the doctors to be able to share that kind of data, share ideas across different sites of service, that would be fantastic.

MS. PATEL: Eliot and Ann, briefly, then if we have another question.

MR. LAZAR: Sure. I mean, there are clearly places around the country -- Geisinger, I think, is one of them -- that have extraordinarily advanced IT platforms and are able to perform the kind of analytics that are really meaningful. But if you take a broad swath of hospitals literally across the country -- you know, every state, you know, in the U.S. -- the ability of providing physicians with meaningful data that's actionable that they can work with is really not there. Clearly, I don't think my own place is where we would like it to be, and that would be something that I would very much like to do.

Physicians are innately competitive. I mean, that's how they got to be sort of where they are. And there are many, many examples of, you know, Hawthorne-style effects by simply providing docs with, you know, comparative and benchmark data, and I'd love to see us be able to do that in a much more meaningful way.

And then, of course, the issue of combining outpatient and inpatient, particularly with voluntary private practice medical staffs is certainly a daunting challenge.

MS. PATEL: Ann?

MS. HENDRICH: I would just briefly echo, the one thing I

would do is that when you get busy clinicians in the room, is to have a powerhouse around them, supporting them, and open the books. And we just launched five Affinity groups: orthopedics, cardiology, oncology, bariatric surgery, et cetera. And when we united clinicians from across the system, didn't know each other, some employed, some not, within a matter of minutes they had congealed on the price point differences just as was represented around someone who thought they were getting the best price on a screw for a joint implant. And there was a $300 difference in our own system for a screw that looks like it comes from Home Depot.

So, you know, give them the support they need to make those critical decisions and ask the questions. And they said, let's go after this together. I don't mean to oversimplify it, but it is giving them the information they need to transform practice.

MS. PATEL: So we're up on time, and we're not taking a break, but I want to, before we thank our panelists, just set up for our next panel, which is on payment reform. You're going to hear a lot of the same threads. Something that we'll work on at Brookings is finding a way to cross all these issues in promoting pathways to do this.

And I can't emphasize and underscore something each of you have said around the role of training kind of the next generation of clinicians, writ large. When I was doing this there was no one I could look to to say,

here's a pathway for transforming clinical care and here's how you do it. And it's not that simple, but we need to see more models like there.

So, please join me in thanking our panelists. (Applause) Thank you.

MR. MCCLELLAN: And we are going to go right into the next panel. I know some more of you had some questions and comments and this panel is going to provide an opportunity to continue to discuss these issues.

It didn't take too long in the discussion of clinical transformation and clinical leadership to drive practice reform to get into issues related to payment reform and other policies; policies related to antitrust, policies related to liability reform. They obviously have a big impact on the environment of medicine, of medical transformation as well.

And that really brings us back to the theme that we started with this morning that real health care reform is going to start with clinical leadership but that can't be the end of it. The leadership has to extend not just to the changes in practice that we described -- and that the panelists have been eloquent in talking about in a very diverse range of settings -- it's got to extend to changing the policies that can make it easier or harder to implement these changes and practice. So that's what we're going to turn to in this panel: how do you provide support for aligning the policy

environment, particularly, the payment environment with the kinds of clinical transformation that you heard about on the last panel? And we're going to discuss that from a number of angles.

A lot of the attention gets focused on, I guess, what you might call the external side; what payments health care organizations -- whether they are small medical practices like Barbara's or larger organizations or integrated systems like Geisinger -- are receiving, and how does that impact the resources that they have available and the support that they have available to implement changes.

And, while I think the external side is very important, it's also important to think about, I guess, the internal side within an organization.

Many groups have talked about moving to salaried physicians, for example. Many hospitals now employ salaried physicians. But if those salaries are set every year based on the volume and intensity of services that are brought in within the specialty, I'm not sure if that provides the same kind of support internally for driving some of the team-based changes and changes towards keeping care well coordinated and keeping patients healthy that we heard about on the last panel.

The heads-in-beds notion, as well, and hospital administrator incentives that many hospitals still have today is maybe another example to that. As Barbara said, though, if you don't tie the internal incentives and

the internal payment systems to the right kind of support, you may get less effort, and probably what we need least today is less productive health care; so, a number of internal issues in payment reform as well.

And we're also going to talk about putting the two together, the interface between payers and physicians and other clinician-led organizations and how to make that interface work as efficiently as possible.

You heard on the last panel that there are some examples of that not working so well, and a lot of frustrations around the amount of administrative work and paperwork. And on top of that, a lot of the changes in delivery that we've been discussing today really need the support of different kinds of payment systems, payments that aren't based just on volume-intensity, payments that reflect some of the kind of new bundles or movement away from fee-for-service that we've heard about at some length today.

How can those systems be implemented? It requires different kinds of trust and different kinds of interactions between payers and the health care organizations themselves, and therefore, it requires a lot of leadership in charting these new paths.

So we've got a great group here with us to start this discussion. With me on the stage today -- I'm going to introduce them in

the order in which they are going to make some opening comments. With me today include Paul Casale, who is an Interventional Cardiologist at Lancaster General Health System. And Paul also serves as Chair of the American College of Cardiology's Payment Reform Work Group; also very glad that we've got some other representation from ACC here today. Jack has been working with us in our efforts at Brookings leading up to this new initiative on behalf of ACC; so very pleased to have their involvement here.

Also with us on the panel is Tom James who is the Corporate Medical Director for Humana. Tom has played an important role in leading Humana's efforts to implement innovative payment reform to support the kinds of delivery reforms that we've been hearing about here. He's worked with us in the past on some ACO pilot-related activities but also has been involved in a number of other payment reforms at Humana, so can speak to some of these issues from the payer's side.

Then we'll be hearing from Gene Lindsey, who is the President and CEO of Atrius Health and its largest affiliate Harvard Vanguard. Gene has led their efforts to respond to payment innovation opportunities and the State of Massachusetts and has really helped shape the linkage of payment reforms towards accountability at an organizational level with reforms in how Atrius as an organization is actually delivering

care. Having all those things move together is a big challenge and Gene has a tremendous amount of experience with that.

And then, also, we've got with us Greg Schoen who is a practicing family physician at Fairview Health Services. He's been involved for 20 years in this kind of interface between physician practice and systemic delivery reform working on issues of compensation for the employed physicians at Fairview, and so a lot of experience particularly on the internal side.

I'm sure that the opening comments we're going to hear from our panelists will lead to some more questions, some more opportunities for discussion. And just as on the last panel, I hope you all will get ready to participate in that. But right now, I'd like to turn to Paul to start us off.

MR. CASALE: Sure. Thanks Mark, and thanks for inviting me to participate.

I think I'll start with just a brief story, I think, that highlights, you know, great physician leadership, and also highlights our broken payment system and then lead on to where we're moving.

And I'm in Lancaster, Pennsylvania. It's a traditional community hospital, I think, typical of where 80 percent of care is delivered around the country. And over 10 years ago, one of my partners -- I'm in a 20-person cardiology group -- really, whose expertise in heart-failure

identified that these patients kept coming back in the hospital and we needed to do things differently and he was very innovative.

He sorted out a way to identify vulnerable patients. He hired a large number of nurse practitioners. He created the congestive heart-failure floor in the hospital. He created probably the largest congestive heart-failure outpatient clinic in the country and did a tremendous job on remote monitoring and really put a terrific system in place.

And the result of that, is -- if you look at hospitals compared -- right now, you'll see that Lancaster General Hospital has the lowest readmission rate for heart-failure in the State of Pennsylvania and the third lowest in the country; so great results.

The problem is, we were a private practice of 20 and the cost of doing that -- much of which was not reimbursed adequately -- led ultimately to the group being bought by the hospital because of the cost of that plus, obviously, the changes in reimbursement with imaging -- as was brought up by some of the other panelists -- has led us to be employed by the hospital. But that may or may not have turned out to be a great thing, but we'll see. But again, I think that highlights where our current payment system -- as Mark had brought up earlier -- doesn't really promote innovation. I mean, and this was really great innovation from a decade ago. Now it's pretty standard, but back 10 years ago, it was fairly novel.

So we have moved with great interest in bundling. Bundling, I think, really presents a great opportunity for the physicians to really move care in a more aligned direction, and that's where I think the ACC has been very helpful. They've really created over the years a set of tools that I think will be very helpful as we look to bundling.

And, specifically, what we are looking at are the clinical practice guidelines that the American College of Cardiology has developed over a number of years; the registries and the appropriate use criteria. Because again, I think in cardiology, there's a lot of data looking at variation around imaging, looking at variation on procedure. And those tools, I think clinical practice guidelines really provide us with the evidence of what we should do. The registries, they tell us what we are doing.

And as some of the other panelists said, what physicians want is good data. They want data that tells them how they're performing and where they need to change and benchmarks them against other cardiologists.

And, you know, cardiology, if it doesn't have anything, it has a lot of data; and so, that actually can be very helpful. We have lots of performance measures; we have a lot of quality measures.

But I think the area of appropriate use criteria really has a lot of promise. The focus tool, which looks at appropriate use criteria for

imaging, not only allows the physicians to get decision support at the point of care -- that's really all of what we're looking for, to remind the physicians what's the appropriate test at the appropriate time, but also provides education back; and then, more recently with the appropriate use criteria for PCI.

There is a pilot that's currently underway that the ACC is involved with in Wisconsin. Just to highlight one called SmartCare, where they're looking at chronic cardiology disease and they're using all these tools. They're using the registries, the PCI registry for the intervention, using the PINNACLE registry for the outpatient data and combining that with the appropriate use criteria and evidence-based guidelines to really look at how to bundle care and how to do decision support and share decision-making, you know, at the point of care.

So, and I'll just add one comment at the end. Since I'm from Lancaster, most people, you know, think of the Amish, right? I mean, that's what you think of Lancaster, Pennsylvania. Well I can tell you, the patients are part of this equation as well and I can tell you that there is no more engaged physician than an Amish patient because they pay cash.

And so, when they come into my office, they want to know what is the appropriate test. They want to know what the alternatives are. They are looking for evidence-based care and they want true shared

decision-making. And I think it's important to remember we need the patients as part of this equation, as well. Thank you.

MR. MCCLELLAN: Great. Thanks, Paul. Tom? Yeah, we've got -- hopefully you got teed up there.

MR. JAMES: Well, thank you very much for having me here today. And, I guess I represent that one segment of this topic, that is clinical leadership that's involved with payment, because I come from the insurance industry.

Now how did I get here? Well, in part, I'm glad that you invited Representative Schwartz because she made the comment about their failed attempt at capitation.

I was Dr. 0202 in the Philadelphia Health Plan, so at least now I know where the decisions were made. That particular series of events between my two residency programs helped shape the direction in where I went as a medical director within a small health plan in Louisville, and now I'm within Humana.

I think that the role of health plan leaders -- medical directors there -- it's a role that many of you in this room could give this same talk because many of you have been there. But you understand full well that medical directors within an insurance company bring in a unique set of skills. We're looking at the patient from a global perspective but we're

looking at it from a population point of view.

The training I had in Philadelphia was looking at the individual as a single person who deserved my entire attention in the exam room. But as a medical director, I'm looking at it much more from a population point of view. It's a different perspective.

The role of a medical director is also that of a translator. The times that I spend at Humana or any of the other insurance companies where I have been in talking to the actuaries, the sales people, and then being able to talk to the medical community, we're speaking different languages, and that creates this tower of babble that we call health care today.

But medical directors within health plans have been largely isolated, kept within their own structures and not out. And this is what I think can be a great opportunity, is being able to advance that whole cause.

Where we find ourselves in health care is with the entire misalignment of incentives. So as a health plan medical director, I'm very much concerned about where the stars are going; that is the CMS incentives, and that's entirely different than where the PQRS is going and where hospitals are incented, so that we create for ourselves a dangerous kind of situation, but there are opportunities that we can proceed.

And so what I'd like to do is just give you three examples where personally I've been involved. And one of the biggest ones and most recent ones has been the work that I've been able to do with you, Mark, with Brookings and Dartmouth, with the commercial ACO project and the pilot that we have in Louisville with Norton Healthcare.

This has brought me, as an insurance medical director, working directly with the medical staff and the medical directors of the Norton Healthcare system in looking at the whole integration of how we're going to be moving what has been a typical fee-for-service system into what our vision is, that is of improving care and lowering costs and doing so in a step-wise progression towards going from upside risk to upside-down risk to ultimately to capitation.

We all know the pathway. We're all working together. It also helps that, on weekends I'm a clinician. I put on my stethoscope. I'm part of the Norton system and that gives me entrée within the medical community.

By the same token, the second one that I have here of working with the local physician organizations, primarily with -- in this case, the Greater Louisville Medical Society -- in developing a care coordination project. Well, this brings in the doctors who are not aligned with hospitals who are all in solo practice and align themselves with the

medical society. They don't have any management experience.

So, as a physician who still does see patients, and being part of that role, I've become a valued resource for them as they're starting to learn how do we go about creating a care coordination process that will ultimately improve them, and how do we work with the hospitals and the nursing homes in Louisville; and then, finally, the role of a medical director working within the local business community, particularly with the UAW Ford Community Health Initiative and with other organizations. This brings the opportunity for a medical director who can speak a business language sitting in the same room with a group of physicians and hospital leaders and being able to serve in that role of translation.

And that's where I see the -- the role for health plan medical directors is one of moving outside the walls of the insurance company; no longer just being in there. And you know we all know the perception that health plans, medical directors are the place where you go when you finish practice. That's not the way we are -- we now have a new practice and that practice is working with physicians in the community, learning how to do trust, providing information; the skill of letting to of control that most physicians in practice don't have, and learning how to manage around the periphery. And with that, I'll stop.

MR. MCCLELLAN: Thanks, Tom. Gene?

MR. LINDSEY: Well, you've taken my words for me. I'm physician M238 in the Harvard Community Health Plan System. And actually, as I was listening to you speak, reflected on the fact that I hadn't seen a fee-for-service patient until the mid-90s.

While having started in an organization that was constructed essentially as a pilot to test the question of whether or not prepaid health care could conceivable improve the integration in the delivery of health care, I lived on a little island until a causeway to the mainland was built in the mid-90s. And then in the late 90s, Helen Hunt blew up the island with her Oscar-winning performance in As Good as it Gets where she had a -- some people remember the performance -- you know, had a screaming match that the audience in the theater stood up and applauded about her relationship with her prepaid healthcare organization.

Our organization, currently Atrius Health, is about 50 percent the legacy system of the old Harvard Community Health Plan staff model. About 25 percent of it is the old Harvard Community Health Plan group model. And then, in the last couple of months, we've added what used to be called Fallon Clinic and is now called Reliant Medical Group so that all of us together as Atrius Health deliver care to about a million people in eastern and central Massachusetts.

There are about a thousand physicians. We have about

2500 licensed health care providers, about 7500 employees, and our revenues -- or, I would say our cost structure -- since we'd rather think of it in terms of that -- is about $1.8, $1.9 billion. But we probably direct more like $3 billion to $4 billion worth of health care because we still have about 40 percent of our patients now coming to us through fee-for-service systems.

We began thinking about the fact that this moment was coming about right after the IOM's report, Crossing the Quality Chasm, began to ask ourselves what would, indeed, we need to do to practice and be like that picture of IDO care. And it was a daunting evaluation but we began to slowly do things. Now, I think we truly, in retrospect, were acting our way into learning.

We've traveled around the country. I've been to hundreds of events like this and spent lots of time visiting organizations that I admire, like Geisinger, ThedaCare, Group Health; spent time with folks at Keiser, spent time at Virginia Mason, and tried to extract from their practices what might be beneficial to ours. Each has a slightly different culture than ours. Their physicians are similar but not exactly the same.

Their markets have many similarities. Patients are pretty much the same everywhere but they live in different environments. And so, trying to go through the process of distilling what we've learned into

something that will be beneficial to our organization, to our clinicians, is very important.

I think most of what I want to say will probably come out in the question and answer period, but what I would say is this: that what we've learned is that we shouldn't be distracted by the political conversations that are going on around us, although we should be active participants in those conversations. But internally, we are very, very focused on the process of what Heifetz calls adaptive change. And the core to our concept has actually been very nicely enunciated by my good friend Mark Barden in his book about ACOs, and it's the transition from "I" to "We".

Years and years ago, the theologian Martin Buber described it in terms of "I" to "thou". It's where the individual really becomes a part of a community and recognizes particularly a professional, a healthcare professional that the responsibility is more than issues of personal income and institutional survival, but how do we work within the community to actually raise the level of health for everyone. So, literally, our mission is to bring the triple aim to life and make it sustainable in our community, so going back to that.

MR. MCCLELLAN: Thanks very much, Gene. I'm sure we will come back to that. Now, turning to Greg.

MR. SCHOEN: Again, thanks for inviting me here. I guess I'd consider myself more of someone with a story to tell than an expert.

Fairview Health Services, in 2009, made a decision to move towards setting themselves up to be aligned with payments for ACOs coming forward, and in so doing, we looked at our current compensation system. And you mentioned I'd been doing this for 20 years with Fairview for compensation. We are on an RVU-based model, very productivity-driven, a hundred percent productivity-driven, in fact, and about five percent upside for some quality inpatient satisfaction components built into the model.

And so, that model was perfectly designed to get physicians to work more and more patients into their clinics, whether they needed to or not. And as we're moving towards an ACO and looking at population management, we needed them to change their thinking to focus more on what's doing the right thing for the patient in the right place at the right time at the most cost-effective way. And as long as we continued to pay them on RVUs and transactions in the office, we weren't going to get the innovative thought in changing the way we delivered care.

So once we went into the model of developing care model innovation, we needed to have a compensation model to support that. And I think the support, first of all, needed to come from the organization

to say, "We are making a fundamental change. We're not longer going to tweak the existing system the way we'd been doing it for years but we need to fundamentally do something different." So how do we go about that change?

And I think the process that we went through from a physician leadership perspective really was focused on an old Harvard business review article that is from 1997 that talks about fair process, and I think the initial step of that was engagement.

What is the compelling vision that we can communicate to the physician so that they understand why we're heading in the direction we're heading? First thoughts from docs were, you know, they're picking on primary care. Of all people, primary care; the cornerstone of an ACO, "Why are they doing this to us?" How do we change that and twist that to, "Why are they doing this for us?"

So some of the compelling vision was, if you're at 5000 RVUs, you're at median; sounds great. You want to make 25 percent more than that, go ahead and generate another 1250 RVUs, and they'd look and say, "How do I do that?"

In the new model of looking at compensating for quality for patient satisfaction, for managing cost of care, and then changing the productivity component instead of RVU-based to a severity-adjusted

patient population panel.

And then, also, the thing we heard over and over is, "Yeah; I see these 25 patients a day in the clinic and then I spend another two and a half hours on the phone, filling out forms. There is a lot more to what I do than what you can identity in RVUs," so we built in something in clinical activities.

And so, within the context, we said, "We're going to reward you for all those other clinical activities. We're going to compensate you because you do have a more complex panel of patients." And in so doing that, there is an upside that you can be compensated at 50 percent above median for your given primary care specialty. That got some eyes to open. And so that was the initial step of the engagement of why we're doing that.

So then, what do we measure? We engaged the frontline physicians who are interested to sit down on ad hoc groups to develop the metrics to debate of, are these quality measures really measuring quality? Are they proxies? Are they outcome measures, process measures? But we handed that to the docs and said, "You guys come up with the metrics that you feel are reliable data because physicians always want reliable data. If their comp are being messed with, it's got to have something that they have trust in -- and the same things with the other measures that we

did for total cost of care, for patient satisfaction -- and we took those from the ground floor and built the model from the bottom up.

Once we had that, we had that core group of people who were interested and involved, then we needed to go out and bring that story to the rest of the group so that they could understand it and buy in. That took a tremendous amount of time and effort to do that, and we needed the organization to free physicians up from their clinical practice and not feel burdened by not getting paid for their RVUs while they were doing that; so, numerous presentations to small clinics, big clinics, groups of clinics. Wherever we needed to meet with physicians, we did that so that they had a full understanding.

And in the Heifetz model, that raised the heat to a point where we needed to provide some level of breathing space, so we built in a guarantee to continue a salary of existing for a period of time while we were transitioning to the new model and then gave them six months advanced notice before we implemented any of the changes.

And I think the combination of all those things; developing the model from the ground up with the physician involvement, giving them some room to breadth while we were implementing the model, and then also understanding that we're making this up on the fly. We can't find benchmarks for a lot of this out there anywhere.

And so, given that, it is an iterative process and we continue to engage physicians to get feedback on a daily and weekly basis to monitor that and to make changes to the massive change in the model. But now we're in the tweaking stage of refining the model, so that's something that is meaningful and incense the right behaviors to get the outcomes we're looking for. Thank you.

MR. MCCLELLAN: Greg, thanks for those comments. I would like to open this up to discussion in just a second, but I do want to pick up on one comment that seems to be emerging, is, you all talk about alternatives to silos and to volume-intensity or RVU-based payments. Those new payment systems have to be based on something. And, Gene, you came from an environment earlier on where it was just an overall capitation payment, but I know that you all have put a big emphasis, as Greg was emphasizing as well, on measures that relate to quality and to what you're really trying to accomplish for your patients.

As Greg just said, there don't seem to be all the relevant measures out there that you'd like to have, let alone the data available in a timely way to support it. Can you all comment on how the data and the measurement issues play into getting accomplished what you need to accomplish in terms of clinical leadership on payment reforms?

MR. MCCLELLAN: You know, I really believe in -- we're

throwing around a lot of names from Harvard Business School and places like that -- Chris Argyris' concept of double-loop learning, and asking in your analysis what part of the problem are we. And certainly, if you move from Managed Care 1.0 to what I consider now Managed Care 2.0, what part of that analysis was that we weren't focused on quality and we didn't have the patients' centricity that the IOM called for and as we are making the transition to a practice that's much, much more focused on the needs of our patient, the need for data and looking at them truly as populations emerges. So, probably our most significant investment over the last 12 years has been into a very robust data warehouse.

We have the good fortune of having all of these million patients on epic. But Epic, in and of itself, doesn't give you much actionable information at a population level. So we've had to construct data warehouses with tools over Epic to extract the information that we want, and we now have developed robust ways of bringing claims data and in merging that in sort of final pathway towards a greater understanding of our patients, and have taken the final step now, or beginning to take it to take that data to small groups, as someone else described here, and ask clinicians what do they think about it and why is it that they are all doing things differently. And that ties in nicely for our Lean concepts of standard work.

And the emerging reality that Lean produces safer care that you can actually see in places like Virginia Mason has literally a fall in malpractice claims. So it all sort of begins to hang together around a very data-oriented approach to what we do, which is a sweet spot of our docs; they love data and they're heuristic; they like to solve problems.

And so, if you give them data that isn't blaming but it's actionable, you address a particular issue. And that's one of the reasons why I like Lean, because it's basically scientific method and they construct experiments themselves and come up with changes that really make a difference.

We have now dropped our cost of care, TME, for our commercial products to a little less than one percent year-over-year increase with a -- you know, against trend savings that approach $100 million. In our Medicare population which has, up to now, been primarily Medicare advantage -- those are the only people we have data on -- we're down below one percent against year-over-year as well.

So I think that when you use this sort of data and apply it to physicians in a way that they see their opportunities -- because we certainly want to maintain physician compensation -- you can make progress against what otherwise seemed to be significant, almost impossible odds. I like the picture of Don Quixote that you got. I was

thinking you were going to use the one from Coso, which actually makes him look pretty defeated. We're still charging the windmill.

MR. JAMES: And I was going to say, Humana's been involved with Medicare Advantage risk arrangements with 200,000 people in MSOs in Florida for nearly a quarter of a century, but that's not where the bulk of medical practice is today.

Now, the model that we've got with Brookings and Dartmouth for a commercial population, which is much less stable -- people are changing all the time and involving a group of physicians who have just started to gel -- is much more typical of what's going on in the real world. But what we've been learning on this is that there is a request for data, but that's not information.

What we are learning is that, by being able to start providing useful information that let's the physicians take action -- and we do some back and forth -- it's changing the way the insurance company produces data to become information that's actionable and it's a different way for physicians who are used to looking at laboratory data to start thinking in terms of population data. And that's why we have setup a time-table to get to a full risk basis. Otherwise, it would be just like my experience with the Philadelphia Health Plan and be sunk by three patients.

MR. CASALE: You know, the American College of

Cardiology has certainly been a leader in data, as I mentioned with the registries, guidelines, et cetera. But to the point, as others have said, it's really real-time data, that's what you want; that's actionable. So the best example is really door-to-balloon time. You know. That data is immediate.

If I go in at two in the morning and I treat someone with acute MI and put a sten in, the next morning, I get an email and it tells me what my door-to-balloon time is. And if there was a problem with it, they explain, you know, where the delay was: was it getting it from the ER to the Cath lab or was it the ambulance didn't transmit the EKG, or whatever? That's the data doctors want.

Just as you said, doctors love data. They want it to be actionable. And I think that's where the appropriate use criteria is really advancing, because we can now provide that at the decision point at the point of care.

So the physicians then get the feedback immediately, you know: "Is this an appropriate stress test for someone who's pre-opt for, you know, a hip replacement or not --" and educate them why not. So I think those kinds of data are really what the physicians are looking for.

SPEAKER: And I think the biggest thing with data is, not only does it need to be timely and actionable, but when you present it, you

have to divert the discussion to something that's meaningful and useful and not an attempt to invalidate data.

That's generally the first thing we get when we walk into a room with data, is, when you break it down to individuals, they're all trying to identify low-end, skewed population; all of those things come into play. And when you try to take all those variables out and focus the conversation on moving forward to a better place, you get better results with that. And so that's kind of rule number one when we present data, is, ultimately it becomes transparent but the focus needs to be on "How does this move us forward?"

And if there is purposeful challenge to data, that makes sense; we'll do that on a bigger scale, but in this room, we need to focus on how it's going to make us improve.

MR. MCCLELLAN: I'll see if there are comments here. Barbara, you want to go ahead? Wait for the mic.

BARBARA: On the theme of acquiring and using data: it would be incredibly useful if we wanted to create integrated prepaid bundled care units that are not in major institutions that have, you know, staffs of thousands crunching it to make this data accessible so that physician practices who wish to come together who wish to create a bundled payment, which is a very scary idea because if I get it wrong, I'm

out of business. We're betting the farm on this one.

The issue there is, when we have tried to get data on how much it cost to do a various thing, the proprietary roadblocks all come up. "We can't share that with you; that's proprietary."

We make a request that goes up the chain at the health plan; it never comes back down. So how can we break down some of the barriers to allowing people to get true cost data so that we could price a bundled payment appropriately that something that will be sustainable in in a given market?

MR. MCCLELLAN: And just to keep this moving, I don't think everybody needs to answer every question, but I might pick on a few of you for some of these but, Tom, maybe you can comment on that.

MR. JAMES. You know, I'm glad you asked that question. This is really one of the huge debates that are going on as to what kind of information do we need. We had a meeting at AME a few weeks ago with health plans employers, consumer groups talking about just some of these kinds of issues. And there are those, for instance, within the physician group who would like to have resource-based units, standardized dollars and know this is how we compare one physician to another; this is how we understand we're using resources.

The employers in the room are saying, "We don't spend

relative resources; we spend real dollars." So there is the need to have two kinds of units: real expenditures and standardized pricing.

MR. LINDSEY: We live in a very fortunate environment because our Attorney General has made sure that there's lots of data for everyone to look at.

Internally, our best dataset is we're self-insured. By the way, we don't own a hospital so we operate in 35 different institutions out of the 65 that exist in our state; maybe, now, 38 different institutions.

But anyway, the thing that we've learned from our own dataset is that what we're doing yields -- so we have about 75,000 employees but they have children and spouses. And so 60 percent of that population gets their care from an Atrius physician, and the other 40 percent has chosen not to get their care from an Atrius physician for whatever pre-existing or private personal reasons. We're fine with that.

But, within the 60 percent that we care for, our costs are about 80 percent of what it is in the other groups, so that gives us an immediate comparison to the fact that our methodology -- and we have the highest measured quality in the state by the MHQP, which is a consortium of data that exists across several domains of measurement within our state. So we feel comfortable that our method, based on our own data, is applicable.

We use the same institutions. Many of them are Longwood area tertiary hospitals, so that we know that our methodology works to differentiate ourselves from other people, even in our own environment.

And in fact, I've seen data from one of those institutions and their employees similar to ours, and ours is literally two-thirds of theirs. So you can imagine -- I truly believe this methodology, this approach to care works and our clinicians are literally compensated at equal levels or higher. So there's something about it that is beginning to be an issue; so worth noting.

So what we have decided is that we're going to treat all of our patients exactly the same, whether they're fee-for-service or global payment, and that we're embracing, you know, the Federal ACO Medicare populations so that we can exactly apply to them what we do for our Medicare Advantage patients, with the expectation that the payment will be on the other end in a form of savings that we'll be getting back.

Now, we are a large enough system to be able to make that sort of bet on ourselves prospectively. But I think that the major motivation for wanting to be a part of that Medicare process is that we will get a rich data-feed that we think will allow us to be even more focused in program development, because we believe that the future does lie in the focus care of special populations like yours and that, to know exactly what

we need to do for them to offer them better alternatives to the hospital is something that we can only glean from looking at them in large numbers and thinking about them as not only individuals, but as individuals grouped together have very similar needs.

MR. MCCLELLAN: And that experience of the Medicare flows may end up being useful for kind of -- and it's a smoother pathways to other --

MR. LINDSEY: I think it's extractable to our commercial population as well, and so we're hoping that there will be a cascade of benefit for looking at the most --

MR. MCCLELLAN: And we're going to hear from Rich Baron about some of the things that CMS is doing to make that data available not only in the new shared savings program, but also in a any bundle payment options and things like that. And a question over here?

MS. FISHER: Thank you. My name is Annabel Fisher. I have a confession first before my question. I am not a physician and I am not a nurse. However, I am a licensed mental health provider and have worked in some major teaching hospitals as a social worker prior to my masters -- whether it be Mass General, San Francisco General, Harborview Medical Center -- and I'm aware of all the issues that you all are facing.

I think -- like, my question relates to -- I keep hearing that docs need to be medical directors. And I'm wondering, having worked in some obviously top teaching hospitals, and also Hopkins, and aware of all the politics that are involved in hospitals, and now I'm recently retired and on Medicare, and now it's not such a great program and providers are dropping out. And if I were in private practice, I would not be accepting Medicare or insurance, but pay me and work out a payment schedule. So that's how I feel and I don't see anything wrong with that.

I believe in competition. Humana, like any other Medicare Advantage plan, gets a higher reimbursement rate than the regular Medicare programs. It's an HMO and I personally believe in a PPO, and I'm aware of Keiser and Group Health and all that.

So my question is -- and it kind of goes to the first panel as well -- and I can still do work, and with the military, which I have done as a mental health professional. Do docs need to be medical directors? Do they need to have some background in business law? I was in graduate school. We were offered a dual masters, an MSW and an MBA; I just couldn't afford to go on for another year.

MR. MCCLELLAN: So what should the medical director --

MS. FISHER: So the question is, do docs need to be medical directors? Can you have someone from another profession?

Can it be someone in business? And that's all I keep hearing.

MR. MCCLELLAN: Or nursing or other health professionals. What's your experience with how medical director jobs can and should work going forward?

SPEAKER: Well your title says clinical leadership, and that's part of the rule. It does not have to be physicians, but physicians should not be excluded either.

MR. MCCLELLAN: Go ahead, Paul.

MR. CASALE: You know, we really -- at least at our institution -- we have really promoted the dyad. I mean, I think the physicians are -- we want physicians to take care of patients. We want them to lead because, again, they know, you know, where you can save the money, how best to do the clinical part. But certainly, as the other panelists have said, we don't think they need to go to get their MBA and we think that there are administrative support that can do that. So I think with the dyad model, it seems to work for us.

MR. MCCLELLAN: Bruce, did you have a question?

MR. HAMORY: Bruce Hamory. I want to put a preposition forward to you and ask a question. The preposition is -- or proposition maybe -- is that, we keep talking about bundles as a payment mechanism. There's an alternate meaning for bundles which is reliability bundles, and it

comes from, example, the ACA things, and they have different scoring mechanisms.

In a reliability bundle, you line up all the things that need to be done for patient or a particular group and you pay doctors for getting those things done, believing that the science says, if you control diabetic's hemoglobin a1c to x, you get a better result. The rest of this becomes score-keeping at the end: what's the cost? Did they live or die? Did they lose their leg? Because you can't manage that in real time. You can only manage the population or the patient according to whatever the guidelines are. So that's a proposition. You can agree or disagree, and I'd love to hear that.

But the question is, we've incorporated that into comp along with a bunch of the other things that you've mentioned, and our physicians have done well with that and we believe we've driven a lot of change in patients. So, would be interested in both the proposition and the application --

MR. MCCLELLAN: And when you say you've done well with that, do you track that into impacts on results and cost for patients?

MR. HAMORY: Yes. I mean, that's where the proven care cab comes from; that's where the diabetes thing I mentioned comes from; that's where a lot of medical home stuff comes from. And it has resulted

through various mechanisms and also our ability to pay folks at or above market rate.

MR. SCHOEN: I think trying to answer both of your questions here. We acquired 40 some clinics -- we, being Fairview -- over the course of probably about 15 years. What we saw most frequently was a retraction from involvement in the business aspect by physicians saying, "Ah-ha; I no longer have to worry about the finances. I'm going to take a backseat. I'm just going to see patients." And more and more over time, it became what the organization is doing to me with top-down decision-making, and there was a demand from the bawls of the organization to get stronger physician leadership at the top.

You made the comment before about, you put your stethoscope on on the weekends and that builds credibility and acceptance among the physicians. And so I think from both of those perspectives, you do need physicians in leadership positions to keep the organization moving forward.

To your point, I don't think you can do it without dyads because physicians -- not many of us will have the amount of business training that's necessary to really understand all that and we shouldn't need to. We should be able to focus on the medical aspects of what we're trying to deliver and get support from people who are the experts in the

business model. So I think it's a dual structure that needs to be present really to be successful in the long-run.

I agree with the concept of the bundles that we provide care, and how we manage care need to be what directs the compensation, and that has to be driven by physician expertise and best practice, or that also won't be accepted.

MR. CASALE: I think that this is a critical question. And I can tell you that I started my career with no interest at all in management or business. And in fact, I was attracted to a prepaid medical group because I didn't want to think about those things. I only wanted to practice.

By 10 years into my career, I realized that the business people who were running the organization were not exactly aligned with what my practice needed, and so I became involved through a variety of different things in the governance of the organization and continued to practice more than 80 hours a week until 2008 as chairman of the board. My evening job was that. And my day job was clinical all the way: hospital-based cardiology, office-based cardiology, very active. I probably had 100,000-patient office encounters over the course of that third of a century.

But along the way, there's never been a place in time where

medical management -- as good as it could be from a lay medical leader -- fully understood what happened when I shut the exam room door, so there has to be some interface between practice and management.

And so, I turned out to be the first physician CEO of this organization that I've described, and we've always depended upon the CMO to sort of be the spokes person for the medical group.

But there really is a role for someone who understands the experience that the other clinicians have. Like it or not, we shouldn't be a physician-centric practice; we should be a patient-centric practice. But our patients actually expect from the physicians a leadership role. And as we move towards times when we're going to have to have panel sizes that are a 5,000 and 7,000, perhaps, because by 2020 there will be one primarily care physician for every 10,000 American adults, so the system is dead.

There is going to have to be a huge transformation, so physicians are going to have to lead that transformation and morph their talents into being able to be team-leaders. And so, it is unavoidable that physicians will have to have at least some rudimentary experience about how to have difficult conversations, how to construct budgets, how to live within a budget.

So the little cottage industry that we all used to enjoy, it has no chance of (inaudible) right. We're no longer ignorant; we're just inept.

And so the whole challenge of the next 10 years is to replace what is now a very fragmented system that is fragmented because of our system's ineptitude and to assist them, that is coordinated around the patient, but that effort has to have at least some of its leadership coming from physicians and nurses who understand collaboration and patient centricity.

MR. MCCLELLAN: And how important -- and maybe those of you who haven't spoken could get to Bruce's question of how what goes into the bundles plays in. Obviously, it's going to be a consequence of the kind of physician and nursing and other health professional leadership that you describe, but how important is that in helping to move care forward?

SPEAKER: This is what I've learned from this whole process, is that, any kind of a contractual arrangement between a payer and a health system or physician group has got to be based just as in business on win-win propositions. So the payer may have experience with bundles among some physician groups, but if that doesn't work for your group, there's no sense having that enforced.

So what we end up doing is negating how is that bundle going to be worked so that the physician groups can live with it and feel that they are going to prosper; and it becomes our role then to create the systems that will adjudicate that.

MR. CASALE: Just one quick comment on the bundle

because, again, taking off my cardiology hat and putting on my director of quality hat, you know, we had a concern over our mortality related (inaudible), so we -- and this is independent physicians. And these people -- there was no compensation related -- and we put in the bundle. You know, the six steps to -- you know, in the first six hours to improve mortality.

And the physicians -- and in fact, the entire staff -- the ER staff, the ICU staff, all the physicians rallied around it and we showed dramatic improvement in mortality. And that's what you're looking for because you can engage physicians over things that, you know, they relate to. If you can improve care, decrease mortality, get better outcomes -- just like door-to-balloon time, decrease mortality from MI, you know, direct correlation.

When they see large checklists of things that they cannot relate to and are getting payment tied to, they are just turned off and see that this is just time that could be used taking care of patients.

MR. MCCLELLAN: There are comments?

SPEAKER: Hi.

MR. MCCLELLAN: Microphone.

SPEAKER: I work for a healthcare policy firm that is contracted by CMS, and my job is to score for quality, quality improvement

and chronic care improvement programs. And I'm seeing that there are not a lot of two-way interaction between the clinical side and the managed care side.

I see a lot of passive interventions and not a lot of results that are in place in third-party payment systems. And I was wondering, is there any active involvement in merging, I guess, to improve that communication in the process for collaboration? In acute care setting, we do have the checklist of things to improve quality. Like you mentioned the door-to-balloon time; that's one of the things that we're looking at, but what about at the managed care side? I'm looking at HEDIS measures and other things that are useful to measure for quality. But that is not by far an exhaustive list; it's very limited.

So I think that there needs to be communication. And this is -- as a provider, we should be asking the managed care organizations, these are the things that we need to be looking at, and these are the things that define quality, because right now it's not defined.

MR. MCCLELLAN: And Tom, you've commented earlier about some issues because, like, CMS stars and PQRS and hospital payment measures, many of which are -- many of these are process-oriented measures. There are differences, and I think you were implying some significant gaps between them that might go to this issue.

MR. JAMES: Exactly; and I think that's -- it may be perception, because health plans have been engaged in creating incentives for physicians to engage in activities which are truly quality related, but it may not be the same set of measures that physicians are incented for. So we ended up with this calculation of -- a physician has -- or a practice has this many patients from our health plan or another health plan and this many Medicare people. Who's going to bid for this physician to engage in which type of quality activity?

The more that we can get ourselves engaged -- and I know that Dr. Conway has felt this himself as an important next step, is creation of alignment of the quality metrics, so we get our country moving, paddling the oars in the same direction.

MR. CASALE: I think that the issue of quality is probably one of the biggest problems in communication, because a lot of physicians think of quality as something that's very technical. You know, "My pump time is that." And patients often think of that too. I think that the really transformative concept in Crossing the Quality Chasm was the definition of quality as being patient-centric, safe, timely, efficient, effective and equitable care.

And we've really been engaged in a great debate about that last issue, equitable. I totally believe that Martin Luther King was right

when he said that the greatest form of human injustice was inequity in healthcare. And we, as a nation, are struggling with how to resolve that aspect of quality so that when we get into a conversation about quality, we're talking about a multiplicity of different things.

In Minnesota Health Partners, there, went to shopping centers or someplace where you do marketing sorts of things, and asked people what their concept of health was. It's certainly not my concept of health. They didn't talk about hemoglobin a1c's or blood pressure or, you know, anything other than being the -- to be healthy meant that you were able to meet your family's needs, take care of the people you loved, generate an income. If you couldn't do those things, you weren't healthy. If you could do those things, that was their sense of what was health.

So we have this big, big conversation where people are talking about different things and we really need to be focused. And I think this is one place where healthcare organizations can come together -- our specialty societies -- about having a uniformed sense of what it is that we mean quality to be.

I really applaud the fact that, in the ACO environment that I and CMS are putting forth, the quality metrics are largely weighted towards the patient's sense of what quality is. And I think that's a right first step because, unless it is actually delivering a product that people want

and can feel the quality in themselves in terms of service, et cetera, we'll still be going in circles around what is quality.

MR. MCCLELLAN: Other thoughts on making progress on this?

SPEAKER: I think he summed it up pretty well.

MR. MCCLELLAN: Yeah, okay; a challenging area. We are out of time for this panel. We are going to be continuing this discussion after lunch, and this is actually a great transition to our lunch speaker.

Dr. Baron is going to talk about the range of initiatives at CMMI. Patrick Conway is going to be here later too, so a lot of opportunities to follow up on this issue of alignment and reducing the cost of getting to quality measures and support systems for improving care, and clinician leadership is obviously a critical part of that.

So I'd like to thank our panel for driving this discussion forward. Thank you all very much.

(Applause)

MR. MCCLELLAN: And in terms of logistics -- so lunch is right outside in the hallway to your left. Please get it, bring it back in, take a break and we're going to start up again at 1:15.

(Recess)

MR. McCLELLAN: Dr. Baron continues the pattern that

we've had all day today of being a distinguished clinician in his own right. Currently he's the group director for Seamless Care Models at the CMS Innovation Center, and, as I said, he has a strong background in healthcare. He was a practicing physician at Greenhouse Internists in Philadelphia and was also chief medical officer and senior vice president for medical affairs of Health Partners. And during that career in internal medicine and clinical leadership, he received the level 3 recognition as a patient center medical home at Greenhouse from the National Committee for Quality Assurance. He's also collaborated with physicians in Medicaid health plans around the United States to improve care through the Best Clinical and Administrative Practices Program, and he's a past chair of the American Board of Internal Medicine's Board of Directors, a current trustee of ABIM, and former member of the NCQA Standards and the Board of Directors for the National Quality Forum as well.

Rich is overseeing a number of initiatives that CMS has announced and a number that are in process now that go to some of the core issues that we've been discussing today about finding a pathway to reform payment to support clinical transformation and care about finding ways to bring data from payers -- in this case, Medicare and Medicaid -- into a better ability to support those efforts in the form of turning data that may not have been so timely in the past into more timely and actionable --

a basis for actionable information and a number of other initiatives as well.

After Dr. Baron's remarks, we'll hopefully have a few minutes for questions and discussion.

So, Rich, please come on up. Thank you very much.

DR. BARON: Thanks, Mark.

There's really no audience that I'd rather be connecting with than you who have taken time out of really busy schedules to show up and think about, together, the issue of what is the role of clinical leadership in healthcare innovation? And, as Mark said, literally until March of this year, I was in a community-based practice. The reason I took the job that I have now is because I think a lot of it is about how we think about resources, and I hope by the end of a brief overview of some of the things we're doing at CMMI we can have a conversation broadly about how thinking about resources is not limited to those of us on the payment side but actually has a major role for folks who work on the delivery side.

I really want to thank you for the work you do, and I think we really are poised for a major change for lots of factors I think now really is different. I won't go through this.

I hope many of you know this. There's a famous quote from James Robinson, Jamie Robinson, "There are many mechanisms for paying physicians. Some are good, and some are bad. The three worst

are fee-for-service, capitation, and salary." (Laughter) "Fee-for-service rewards the provision of inappropriate services, the fraudulent upcoating of business and procedures, and the churning of ping-pong referrals among specialists. Capitation rewards the denial of appropriate services, the dumping of the chronically ill, and a narrow scope of practice that refers out every time-consuming patient. Salary undermines productivity, condones on-the-job leisure, and fosters a bureaucratic mentality in which every procedure is someone else's problem."

Well, you know, so there you have it with respect to how we're going to do physician payment. (Laughter)

In the current system, clearly, you know, we do acute care really well, but we have -- actually, I guess it's 50 million uninsured and most critically, for purposes of our collective conversation, uncoordinated, unsupportive, unsustainable, and we believe that innovation will transform healthcare from what's a producer-centered state to a patient-centered state. And we see ourselves as a payer as part of the solution. But I would invite you all to reflect on the ways in which your own institutions are organized as producer-centered organizations to get to the future system that we want: affordable, accessible, seamless, and coordinated person and family center.

CMS has a mission statement now. This was one of Don's

high priorities. When I talk to physician audiences, I appreciate it when people don't burst into laughter when I present CMS as a trustworthy partner, and it depends on how close you are to relying on checks from CMS to making your own payroll. And let's just say in physician societies, this is not a resonant mission.

But it has been a really interesting organizing principle within CMS, and I think one of the things that's made people realize is that if we care about changing the delivery system from the payment side, we're going to have to do that in serious partnership and discussion with the delivery system side.

And when we think about measures of success, we're thinking about the three-part AIM, which is now embedded in the National Quality Strategy so that the $1.2 trillion federal spend on healthcare has a purpose: better healthcare, better health, and reduced costs. And, again, I would invite each of us to reflect on if that's really what we're about, how do we know if we're getting it? How do we align resource allocation and compensation and budgeting and all sorts of things with those goals?

The Innovation Center, as I suspect most of you know, is created by the Affordable Care Act, and we are supposed to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care. And we

have $10 billion, which sounds like a lot of money, but it's about a tenth of 1 percent of what the federal government spends annually in the Medicare and Medicaid program.

But the coolest thing about the Center is this opportunity to scale up, that if in the language of the Act to the satisfaction of the Medicare actuary and the secretary one of our innovations works, does those things, the secretary can scale up that innovation throughout the Medicare and Medicaid program by administrative fiat rather than having to go to Congress for approval. So, that's what caused a lot of us to run away and join the circus that is CMS.

Our work is organized in three broad areas: patient care models, which is basically bundled care; the community and population health models, which is still very much a work in progress, more sort of community health, public health; and then I do this seamless coordinated care, which is basically people over time and across institutions so the major areas programmatically are variations on ECO models and models of high-value, comprehensive primary care.

In terms of how we actually do the work, we solicit ideas from the public. We select models. We test and evaluate the models, and we try to spread them. We consider ideas, define a concept, move them forward.

This is to show that there's a bunch of things out there in our portfolio. The most recent, which I've already been asked about, was the Health Care Innovation Challenge, which was announced earlier this week. I think the major thing I'd say about that, for your purposes, is that up until recently we were advised by the Office of General Counsel at CMS that we did not have grant-making authority. We only had program authority, and so when people came to us with good ideas and said will you partner with me on this, our response was we'd love to but we can't.

Basically, the shape of this program is in light of a revised opinion from the Office of General Counsel. Maybe your lawyers never changed their minds, but the Office of General Counsel told us actually maybe you do have grant-making authority. So, this is an opportunity for us to be supporting more individual kinds of proposals, the details of which are out there on the website, and I'd rather refer you to that than spend a lot of time talking about that, because we have a lot of ground to cover, and I do want to leave some time for conversation.

Broadly, as I said, a big part of my portfolio is advanced primary care practice models, and the major -- I thought a lot about primary care before I joined the government, and a lot of leadership that I got to do at the Board and other places was to try to talk to colleagues about what do high-value models of primary care look like and can't we

move in that direction? Why is it that most primary care offices aren't doing e-mail? Why is it that all over the country people make their patients come back for prescription refills or to discuss lab results? And in trying to develop some of those new models, the message I heard clearly from colleagues was we'd love to practice that way, it's consistent with our professional values, it's why we went into healthcare in the first place. But we can't get paid for that and we need changes in the payment system first.

So, now that I switched to the payment side, I'm acutely aware that changing the payment system doesn't automatically give you the high-value primary care models that you're going to need to have and that clearly we're going to have to do this together, that it is a shared problem, that to the extent that primary care -- and this is going to be a theme in all the programs that I talk about -- the delivery system generally has organized itself around revenue streams from a payment system that we all agree are dysfunctional. But that's how we've organized our practices. As we start reorganizing the payment system, we're going to need to see a reorganized delivery system to match it, and that's very true in primary care.

Because it's a fragmented payment system, we were interested in multi-payer models, so the big initiative that we had out there

was the multi-payer advanced primary care demo. That's where there were already states where multiple payers had gotten together and said we are willing to pay more for high-value primary care, and CMS came to be a guest at their table.

But interestingly, if you look at those states, almost all of them had state-level either legislative or executive action to suspend antitrust regulation for purposes of payers coming together to talk about new models of primary care and new payments for primary care. Without that, those conversations couldn't happen.

And I learned in my second week on the job, when I proposed a program that would look like one of those state programs, I learned from my colleagues at the Department of Justice that such a program was collusion, because the exemption available to the states to do this is not available to the federal government.

So, one of the challenges in terms of trying to coordinate payment for innovative models -- that's something CMS is thinking a lot about as a reference payer, as a standard setting payer: Can we innovate in payment in ways that other payers can parallel us, and will that be a big accelerant in delivery system transformation?

And we do think primary care is critical, and I already talked about the way in which the barrier in transformation in practice is

transformation in payment, and really looking at these additional models.

To me, the most interesting thing about the Comprehensive Primary Care Initiative, the letters of intent for which closed yesterday, was the strategy of really trying to drive payer alignment. It's the first time CMS ever issued an RFA where the respondent was a payer, not a provider. And our idea in thinking about that was to say everybody knows what an MRI of the right knee is. There's a CPT code for it. It's on the fee schedule. It's a clearly delineated, specified service. Most contracts in the country are a percent of what Medicare is paying. So, we have this service. It's defined. We price it. People reference, price it off us, and life goes on.

What happens when you try to introduce a new service: comprehensive primary care, patient center medical home, care bundles, call it whatever you will? Now you have two problems. You have the problem of you have to specify what that service package is in a way that we already did for the knee MRI, and then you have to price it. But if one payer does that, that may not be a powerful way to drive transformation and delivery system, and certainly in primary care a lot of the early efforts at patient center medical home projects that were single-payer efforts didn't do so well, because it was a 3-foot rope for a 10-foot hole with one payer saying sure, we'll support this, but the other payers didn't come

along. So, payer alignment is a critical aspect of what we're looking for in this program, which involves more generous support for primary care, up to $20 on average per beneficiary per month for Medicare.

But I certainly want to be talking about accountable care organization initiatives and point out that the shared savings program is a program congressionally mandated. I know you all could have told me that that's Section 3022 of the Affordable Care Act when Congress said to CMS you will have a shared savings program. That's the thing for which the Notice of Proposed Rulemaking came out in March that generated a healthy reaction from the community, and as Jon Bohn said, we knew we were going to get it wrong, that's why we put it out there so you'd tell us how to get it right. And the final rule came out, as you know, a month ago.

The important thing about that program is it's a program. Anybody who meets the criteria is in it. It's there. It's a part of the Medicare system. We in the Innovation Center are doing variations on that theme, and sort of three things we did -- and they can be thought of as to support that program, because Medicare wants to learn a lot to make that program better -- the primary sale model was targeted toward people in the delivery system who said we're already there, we want global payment, we want to handle risk, we have the information systems, we have the clinical capacity, the integration, we think we can move forward

with that. That's one end of the market.

Another end of the market that everybody was worried about at the policy level is if the only people who come into the ACO world are large, integrated delivery systems or hospitals, is that a situation where we've got the fox watching the chicken coop? Could we get some leverage involved if we get primary care docs being ACOs where they actually have a share of shared savings? Could we get that happening? And one of the problems was would they have the resources to develop the infrastructure that they needed?

So, the Advanced Payment Initiative is targeted to that end of the market and explicitly to the small end of the market. If you don't have a lot of revenue to play with, you can talk to us about can you get some money up front to get into this program.

And then we offer learning sessions to try to explain to people what this is, and we're actually doing the last one tomorrow and Friday, and they are going to be web screens, so if people want to tune in to that, they're free and available.

But there are competing goals in trying to put together the ACO program, and it's important to think about those, that it really is a shared savings program. And one of the problems with some of the large integrated delivery systems is they say to us so, wait, you want me to give

up a dollar in revenue so that I can get 50 cents in savings. Explain to me how that's supposed to work. But those really are competing goals. If CMS doesn't save money in this program, we can't be, shouldn't be doing that. We're very worried about anti-competitive behaviors. If we drive aggregation in marketplaces, you know, we've got data out there to suggest that maybe people raise prices when they consolidate market power. Shocking, but Bob Barrinson has literature to suggest that is something that happens, so we worry about that.

We do need to be able to say to the public when we create these environments that quality of care is preserved, so we need quality measures. We don't want to be totally burdensome about that. We've got to do it in a hurry. We've got to share data. Just a bunch of different things going on there.

And, again, already talked some about this, but the critical thing about Pioneer is it moves in the third year under one of the tracks. It's a truly global payment to the organization. And I'm going to ask this question for the first time of you now, but it's going to be the last question I ask you, too. How will your organizations allocate resources and allocate salaries and budget support in an environment where fee for service has gone away and you're handling a global amount of money? And if the answer is you're going to turn to the bookkeeping systems you have in

place and track RBUs, then we might as well never have bothered to put out a program like this. So, we're really going to need to be thinking creatively together about what happens to the money after it hits the healthcare institutions. If we're trying to walk away from fee-for-service payment, we hope you are, too.

Talked some about the Advance Payment Initiative. And, again, it's integrally as advanced payment.

And then the care bundles. Again, talking about some opportunities here. I would make a couple of observations here. You know, you look at a hip fracture and whether it's your mother or your spouse or somebody and they get the care they get. And then they start getting all these bills and there's one from the emergency room, and there's one from the anesthesiologist, and there's one from the podiatrist, and there's one from the post-acute treatment place.

And there are two questions that occur to me when I think about that. One is, like, is it a surprise that the person needed all of those services? And if so, if those are really all the services that they need, why do we buy them the way we buy them? Would you buy anything else that way? Would you buy anything in pieces like that? First, that's going to be the most expensive way to buy it, and second of all patients begin to wonder, well, if they can't bill together maybe they don't actually talk to

each other about the way they provide these services, which many of us know turns out to be actually pretty perceptive on the part of some of the patients.

So, this is an opportunity to say, okay, we're going to put it together in a package, we're going to say what's in that package, and we're going to invite healthcare institutions to step up and say that's the package we're going to provide.

The first one out there now is acute care hospital stay only. It's for all DRGs who are paying the hospitals, and the physicians aren't in the bundled payment physician service but an opportunity for shared savings is available to hospitals and participating physicians. So, hospitals can share savings in this program with physicians, but we want to move to models where they not only include physician and hospital services but they include post-acute care and ultimately to where they go to prospective payment. You know, what does it look like to manage a DRG that includes post-acute care and all physician services? And, again, we need to get thinking about that, and I hope we have ways to think about that that go beyond just a fee-for-service world.

Partnership for patients I think many of you know about. Again, a sort of broad patient safety initiative outside our usual frame, and the idea is that the government loses a lot of money based on unsafe

care. Clearly, we're going at that with respect to some of the readmission stuff. But the idea is can we help support infrastructure that would build patient safety, and many of you probably have signed up with the Partnership for Patients, but there it is.

There's also the Community-Based Care Transitions Program. Since we know that a lot of the costs come with poorly managed transitions of care, not to mention a lot of the quality impact, can we create community-based organizations that represent this kind of capacity in communities? I think it's an open question whether the integrated delivery systems or hospitals will take this up on their own in a reliable, successful way, and so this is kind of a parallel strategy for that, again, information about that.

And then many of you know about the Innovation Advisors Program disclosed yesterday. I hope some of you even applied. But the broad concept is to try to have partners throughout the delivery system in the U.S., people with whom the Innovation Center has a relationship and people who are getting some additional training in a lot of the things that you all are thinking about today -- leadership skills, change management skills, financial skills, quality improvement skills -- and trying to get a little bit of that from us but then be embedded in their home care institutions. This is a relatively modest commitment.

The first wave of applications just closed, but there will be subsequent waves of this program, and it's a modest stipend and a modest commitment of time on behalf of the Innovation fellows, and we're looking to deepen these skill sets.

There's a care innovation summit in D.C. that we're sponsoring in January. Again, information to hear about that.

We're probably -- you know, what are we thinking about at the Innovation Center? We're thinking about how does the tool of payment drive and support innovation on the service delivery side? And one way to think about that -- and I think in the most recent thing that we've released, the Innovation Challenge, we're functioning, in a lot of ways, more like the familiar model of a foundation. If you have a good idea, come to us, we'll support the good idea. If the good idea works, the world will know about it; we'll try to figure out a way to institutionalize it.

It's an open question whether the best way to really do this is to be testing innovative service models or whether, actually, payment models are ultimately more scalable, that if we have the right payment model, whether it's care bundles, whether it's ACOs that create a different set of boundary conditions in which your organizations are operating, will you be able to operate in a way that moves us closer to three-part AIM outcomes? And at the end of the day, that's what this is all about and

that's what we're trying to do.

And the question I would ask is in that world that involves more global payment, in that world that has us as a payer and lots of other payers trying to run as fast as we can away from fee for service as a payment, what are you folks going to think about in terms of how you do everything from deciding what the staffing is in the primary care unit to how much you're going to invest in information technology to what salaries you're going to pay to people who work in your institutions?

So, thanks for the opportunity. I'm happy to take some questions.

MR. McCLELLAN: Thanks very much, Rich, and I think that would be a good question to ask you as well, but let me instead turn to the people who are participating today.

Questions or comments for Rich?

Yeah, go ahead.

MR. HAMORY: Bruce Hamory (inaudible). Just a quick -- because, agreeing with the end point, I understand the transition from where we are now to end state -- the transition from where we are now to end state is also a concern. Technology (inaudible).

MR. McCLELLAN: So, Bruce is asking about the transition from where we are now to the end state.

DR. BARON: Clearly a work in progress for all of us. I mean, you know, so the Innovation Center is putting out these programs. I think the programs are accurately read as a signal of where we'd like to take a more accountable payment system.

Now, between us and getting there are a number of things. There's can we actually deliver the goods on the stuff that -- or, more accurately, can the delivery system deliver the goods with those new payment models? One set of issues. Another set of issues is are they going to be feasibly scalable?

But if I were out there, I would be looking at the Innovation Center models that I know I raced through but I wanted you to be familiar with all of them as a kind of roadmap for where payment is likely to go. And your business is still your business, and it's still dominant fee-for-service and it's still dominant composed of high-margin services. But I would not consider it prudent to predict that five years from now that's still going to be a viable business model. And, absolutely, leaders of delivery systems say to us I feel like a guy with a foot on the boat and a foot on the dock and I don't know what to do. And people can bet against whether we're actually going to change the delivery system.

The thing I'm most struck by is the number of healthcare delivery system leaders that I need who say we're pricing in a 10 or

20 percent cut in Medicare revenue over the next few years. Now, the building I work in -- we're not saying publicly that there's going to be a 10 or 20 percent cut in Medicare fees in the next 5 years, but the market's starting to behave like that may happen. And I think people need to contemplate a world of less resources and how they're going to manage in it.

MR. McCLELLAN: Barbara and Tom, and if the questions go quickly we'll get them both in.

MS. TOBIAS: Okay. One of my concerns as I read even the revised ACL model will be that the only mechanism that people can think of to get away from fee-for-service is full employment, which means that in markets where there is a dominant hospital or a dominant health plan, which is a significant percentage of the market, how then do you end up avoiding the situation where all of the physicians become employed? The costs then, according to MedPac, go up and there's no competition to allow new innovators in the area to compete. So the general prices just continue to rise and we get exactly what we don't want?

DR. BARON: I think that's clearly one of the many nightmare scenarios to which we could be heading. I think the role of antitrust regulation with respect to physician aggregation and health system aggregation, clearly that's going to be an important set of

considerations.

The role of physician employment, you know, ultimately what's going to happen is people are going to be doing a different kind of business than they're doing now, and meeting population health needs on a global budget people are going to have to make some hard choices with respect to who they've employed and where they've allocated resources. And so if we're going to take cost out of the system, I would hope it would be a group of people looking at each other who actually have patient care accountability who are driving that conversation.

MR. JAMES: Yeah, Tom James with Humana.

I'm aware of a number of physician groups around the country that want to engage in some of these different programs, but because they're relatively unsophisticated groups, they feel they can't make any application. Is there a help process? Because they all feel that it's going to be the hospitals and the large groups that will have this sophistication to be successful applicants.

DR. BARON: So, they should definitely take a look at the advanced payment ACO track, because there is support there. They should probably look at the most recently released initiative that is pitched toward smaller groups of people.

MR. McCLELLAN: We're about out of time, but I want to put

you on the spot for one -- with respect to this question you put up for all of us here, the role of physician leadership in these new payment environments. What do you see as the biggest obstacle the physician leadership could help overcome in the effort that you're trying to implement now but you're not quite seeing a step up as much as you'd like?

DR. BARON: That's a great question, and I would say, actually, I have a very clear sense of that. I think that what physicians share, what makes them physicians, is that they went into it to take care of patients. And ultimately the conversations that people have to be having in boardrooms and as they try to figure out what to do with all those employed physicians can't be do you get to make more than I get? Do you get to make what you made last year? Those conversations have to be about what's best for patients. They have to be about how do we meet the needs of the people we're supposed to serve? And they have to be structured that way. And they have to be structured that way by the physician leaders who are leading them. I would say that the only legitimate conversations to be having in an environment of less is how do we take care of our patients? And I'm not seeing as much of that as I'd like to. I'm seeing a lot of shadow pricing and following fee-for-service allocations.

Two quick things to share. I'm stunned at the number of physician practices I'm learning about who measure productivity based on cash collections. And let's just start with that says that a group of doctors are looking at each other and saying we think Medicaid patients are worth 40 percent less than Medicare patients; we think that commercial patients who are well insured are worth more than Medicare patients. That's what we're saying to each other. And I will say that one of the proudest innovations, one of the things I'm proudest of that I did at Greenhouse -- I know we're out of time --

MR. McCLELLAN: You go right ahead.

DR. BARON: -- was that we were a level 3 patient center medical home. We were doing a ton of patient care by e-mail and telephone, and as the owner of that practice, I came up with shadow pricing for e-mail and telephone and added it to the physician productivity metrics. And I said nobody's paying me for us to do this, but as we look at each other and say what does good patient care look like, it looks like that. And I don't want you to feel like when you're sending e-mails on Thursday night nobody recognizes that as a contribution to patient care. Actually, I do. And in running my own business I could do that. And all of you as leadership in healthcare organizations -- you could do it, too. And I think the more we have those conversations, the better off we're going to be.

MR. McCLELLAN: Rich, thanks very much for the presentation and thanks for the challenges. (Applause)

MR. McCLELLAN: All right. After that, we're going to continue without a break into our next panel. So if our panelists -- Jeff, Barbara, and Elly -- could come on up, we'll get started right away.

We've talked this morning about clinical transformation and how clinical leadership is needed to drive changes in delivery of care. We talked about mashing that up with changes in payment reform. Rich's presentation was a nice way of putting some of those ideas together from the standpoint of CMS. Come on up.

And what we're going to do now is take another step in terms of opportunities for clinical leadership, and that's clinical leadership in the direction of community-based reform. So why stop just with reforming healthcare organizations, healthcare delivery, and healthcare payment when there are so many other opportunities outside of traditional healthcare to drive improvements and reform?

And this is probably particularly important for patients in the community who may not have that good of ties to the healthcare system or may have opportunities while they're out in the community to get better support for staying healthy and managing their problems. And that's going

to lead us to a lot of discussion of vulnerable populations, as well. Now, this format for this session is going to be a little bit different than what we've had so far. We're going to start off with a presentation from Jeff Brenner, who many of you may know, he's a family physician from Camden, New Jersey, who served as the executive director of the Camden Coalition of Healthcare Providers since 2003.

Camden Coalition is nationally recognized for its accomplishments in these areas of community-based delivery reforms for some particularly challenging populations, the work that Jeff and his colleagues have done. It's been highlighted by Atul Gawande and others.

Jeff is going to talk about their experiences, their challenges and what they see as the biggest opportunities for clinical leadership, meaningful clinical leadership going forward. And again, it fit nicely with I think what you've just heard.

Then after that presentation, we're going to have a discussion that will also involve Barbara Tobias and Elly Yost. Barbara is also a family physician. She's the Robert and Myfanwy Smith -- have I got that right? -- chair of Family Medicine at the University of Cincinnati College of Medicine, the medical director for the Health Collaborative of Greater Cincinnati. That's a community-based organization whose mission is to employ collaborative leadership in identifying issues,

developing programs, measuring outcomes and reporting, with the explicit goal of improving the health of the population of Greater Cincinnati. It's a very community-focused effort. And she's going to talk about clinical leadership for a multi-stakeholder, community-based collaborative effort like that.

And then Elly is a nurse, director of Nursing for the Nurse-Family Partnership. That's an organization that helps communities leverage resources, including nurses, to address the needs of vulnerable first-time mothers. She's going to talk about her experience in these community efforts to improve pregnancy outcomes, child health, and development of economically self-sufficient families, again, going kind of beyond the traditional scope and goals of healthcare and very much needing clinical leadership.

So with that, I'm going to turn this over to Jeff. Do you want to come up here for this or whatever is easiest? Okay, thank you.

MR. BRENNER: Thank you so much. It's nice to be here today. Cary, thank you for the invitation, and Mark, as well. I want to talk about the work that I've been doing in Camden and reflect a little bit on some of the things I've learned about leadership there, and talk a little bit about where I see some of the path forward for the kind of work I do and the characteristics that we need in leaders. It feels to me like we're at an

inflection point in our country and our healthcare delivery system and there is really a profound leadership crisis. And as I look at the leadership crisis in healthcare, it looks to me a lot like the leadership crisis we've had in our financial industry, in our political system, and in other parts of our country, as well.

In healthcare, we have -- I believe deeply in symbols, and I think in healthcare the symbol of leadership has really been the physician scientist or the physician technician, and we have rewarded physician scientists and physician technicians. We have used a lot of NIH money. We have, through our CMS, RVU fee schedule, we have really elevated our physician technicians and scientists to a great extent, and that system has succeeded.

Since World War II, we have built an unbelievably skilled and complex delivery system that really does amazing things, but I think we've exhausted that leadership model. And as all of you know, we've created a system that's unaffordable. We misapply our wonderful technology on a daily basis. It's become a reductionist system that's not organized and not holistic.

And as I look forward, I really feel like the fixes to this are really it's not a technical problem. Someone said earlier about adopted leadership, that the failures in our delivery system are not so much

technical problems as really leadership problems. And when I say "leadership," I mean that there are a problem with our values, a problem with our -- that it's a moral problem, and it's probably not a problem that purely insiders can fix. You know, I think today we are insiders at The Brookings Institution talking about the delivery system, but that at some point, probably baby boomers, the 85 million baby boomers that are headed like a freight train to the delivery system that's ill-equipped to deal with them and deliver organized care, are going to have to stand up and say they've had enough and that it's probably not -- it's not possible to change 18 percent of the economy purely through an insider strategy. And I'll talk a little bit about that today.

I want to talk a little bit about the city of Camden and the work that we're doing. I'm a family doctor, I've spent most of my career for the last 12 years as a front-line primary care provider, a family doc.

I graduated my residency in Seattle and moved from downtown Seattle to downtown Camden. And if any of you have visited Camden, you might know, it's really one of the poorer cities in the country; first, second, or third poorest; first, second, or third most dangerous city. Three of our last six mayors have been indicted and convicted of corruption. We've been in various levels of state takeover for many, many years. It's a very complex place to work and to live. I lived there for about

eight years, as well. And you get to see the very naked exercise of power in a democracy and sort of the inappropriate use of power in a place like Camden. You get to see what the impact of bad leadership is on people's lives. And you get to see the connection between sort of almost the lack of values and the lack of morals at the leadership level and how that plays out in people's lives.

And certainly as a clinician, you get to know people really well. I speak Spanish, so I was working in a three-exam-room office, running from room to room, seeing kids, adults, delivering babies. I did OB for about 10 years, and carried my own cell phone, was on call for my own practice.

I really retreated from the medical world. I really felt like Camden was going to -- I was going to make a bubble. And I really felt like, as I was in training, that there's a lot of unethical things going on in healthcare, and that being in a small three-exam-room office was my ideal place to be; that I could really unplug and disconnect from all of the things I saw in the delivery system that I felt like were unethical and create the sort of idealized medical office.

So we were paperless, we had all electronic health records. We did group visits. We did open access scheduling. You know, I felt like for Medicaid patients, that we were breaking new ground. I used to kind of

lay awake at night imagining how would I ever get to 100 percent on everything, like mammogram rates and hemoglobin MC, what it would take, like how would you have to just break the system in part and reinvent it.

The problem is that my sort of little bubble in my office really burst by the fact that New Jersey's Medicaid rates are some of the lowest in the country, and they got worse and worse. And I knew how to make capitation work, and many of my Medicaid HMO's started switching me back to fee-for-service, and I couldn't make that model work with the style of care. So, my office went under. And when offices in Camden go under, they just get boarded up. So my office is empty at this point. And, you know, that was sort of a profound humbling for me and sort or my idea that I could make a bubble and sort of hide in there and kind of reinvent healthcare in my little office, that wasn't really going to work.

So somewhere in all of this I got very interested in getting to know my other colleagues in small offices. There are still small offices in Camden. They're sort of rapidly going away, but put together something called the Health Provider Breakfast Group, which is literally a bunch of small solo practice practitioners in Camden hanging out and having breakfast. We did that for about three years. And we do what doctors do when you get them together, they complain a lot, and really felt like we

had a lot of shared problems, since because we weren't going to the hospital anymore seeing our patients, that this was really the venue for us to get together and share things. And it wasn't just physicians, this was nurse practitioners. There are a lot of nurse practitioners in the city of Camden, and PAs as well, delivering care in underserved communities.

We eventually incorporated. We invited the hospitals onto our board. We tweaked voting power because we were concerned they were going to take over. We invited the federally qualified health centers onto our board. Now we have social service providers, behavioral health providers, and I'm proud to say we have two community residents on the board as well, which has been a really interesting experience.

We run a portfolio of different projects that are broadly aimed at improving quality and reducing cost. And my goal in Camden is for Camden to be one of the first cities in the country, that's also one of the poorest cities in the country, to bend the cost curve, because I really feel like in the moral and ethical vacuum of healthcare that it would say something really important. If a place as poor as Camden could pull this off, it would really say something to the rest of the delivery system, that it's not a technical problem, that it's an adaptive problem, that it's a values problem and a moral problem. So I think we're on the way to that.

I think it's still a very complex challenge. To give you an

idea of some of the projects that we're operating, the first thing we did was put together a claims database, which was an MDMPH student project. And it was initially focused on accidents and injuries, and we managed over the course of three years to get all of the raw claims data from all three hospitals.

And I'm sure many of you know, this is business intelligence to the hospitals, they don't want to let this out. We got the name, address, date of birth, date of admissions, all the ICD9 codes, charges, receipts; had no idea what we were doing, put in Excel, that didn't work; and access. And believe it or not, it still lives on two hard drives, locked in a metal box that's encrypted, password protected.

We use Microsoft Access, some very inexpensive linkage software, to link claims across the hospitals, and ArcView to map all of this. So it's about a $10,000 operation every year. I use a very smart 23-year-old to make lots of cool maps, graphs, and charts. So that's an Altair database, right, that's the Holy Grail of data that we all want.

So it's been really powerful to build strategies around. And one of the strategies, it was an incredible database for me to look at because my patients were in the database. And as my office, I'm making payroll every two weeks, and I'm having to draw down a line of credit, and I can't keep this thing going, and I'm looking in the database figuring out

where all the money is going, and the money was obviously not going to my office. As offices like mine are getting boarded up, the emergency rooms tripled in size in Camden, and the hospitals built new wings, massive expansions in the in-patient and acute care settings. And as I'm looking at the data, I'm seeing my patients going to the emergency room, the hospitals are getting payments of 150, 300, 500, 800, $1,000 for ER visits, and just realizing how distorted the marketplace of healthcare.

I came across the Dartmouth Atlas at one point, and the Dartmouth Atlas really spoke to me in Camden, which was that in the marketplace of healthcare, when we set a really high price for a certain set of services, we start to get too much of that at some point. And if we set a really low set of prices for my services in primary care, we won't get enough of that, and we'll begin to distort the marketplace, and that feels like what we've done in Camden.

If a patient needs a kidney transplant in Camden, I can get them evaluated immediately. If they need a basic appointment to control their blood pressure and control their diabetes, we could wait for weeks to months. And I think the way that you all should look at Camden, you know, in a poor community like Camden, we get to see all the stuff way before the rest of the country. Like foreclosure crisis, we've been there, done that. We had that 20 years ago. Primary care crisis, been there,

done that, you know. And I can tell you what happens in a primary care crisis, it's really ugly.

Our number one reason to go to the emergency room in Camden are head colds: 12,000 visits for head colds over a 5-year period. Number two is ear infection; number three, sore throat; number four, viral infection; number five, stomach virus. It's all primary care stuff.

The vast majority of those patients are insured patients. These are poor moms and kids sitting with their kids crying in the emergency room for six hours. They call and they can't get appointments. And I hear lots and lots of people say, well, poor people like to sit in the emergency room. Trust me, they don't like to sit in the emergency room.

High utilizers, they like to sit in the emergency room because their choice is either to be homeless or to sit in the emergency room. But poor moms and kids, if they had a better choice, they would take it. If they felt like they could call a phone number and the person on the other end of the phone knew them, was polite to them, maybe spoke in their language, they would probably call the number. If they felt like they could get appointments, they probably would go ahead and call and get those appointments.

The other projects that we're running, we've had a team, an outreach team tracking down the high cost, complex patients for the last

couple of years, and it's really been a root cause analysis. High utilizers are an incredible opportunity to find out what's broken in the delivery system. Each one of them are such a rich, contextual, complex story, and they have touched every institution in the city.

So we have worked through 1 case, then 2 cases, then 5, then 6, then 10 patients, 1 patient at a time. And it turns out that it's a really good way of bridging public health and clinical medicine, and that you can get clinicians to think up on the balcony in a much broader systems way by doing it in case-based learning and doing it one high utilizer at a time.

And those high utilizers really begin to challenge us as a system to rethink our basic assumptions, and I think that's been the greatest value locally in this. It's also built a lot of relationships between entities in ways that I wouldn't have imagined before.

The second major project is a classic medical home collaborative. We're using diabetes as the lens, but it's really transformative work in primary care offices. As anyone doing this work knows, this is hard, messy work. It's very challenging, particularly in an environment with Medicaid rates in offices that are struggling to stay open. We've had great luck using AmeriCorps volunteers. They're my favorite part of the work we're doing. These are really smart 22-year-old kids who

are very enthusiastic, have a lot of energy, and they turn out to be great practice change specialists. They're really good at helping practices implement electronic health records and do quality improvement projects, pull charts, make registries. They make great patient navigators, a lot of the things that the delivery system needs. We don't need, you know, super high training that a really smart kid out of college can do very well.

I'm proud to say that a lot of them are now going on to med school and nursing school. And I really feel like what I'll get back to in a couple minutes is that if we want to create new leaders in medicine, I think we're going to have to do it before they get to med school, that med school is a very damaging experience, as is residency.

And then the last major piece of our work has been to build an HIA. So we have a working HIA in Camden. It's got real time labs, radiology in hospitals to start summaries, streaming into a data warehouse from now four hospitals. We have legal access and technical access to all the underlying data so that we can build registries and we can also do real time alerts. So my goal within -- we're almost to this, in the next week or two, someone mentioned this earlier, I want to make sure that every provider has a list every day of who's currently in the hospital and who's been in the emergency room. That's going to drive everything. And I want to make sure that list has how many times they've been in the ER

over the last year, how many times they've been admitted, and how many times they have been to primary care offices, and also aggregate stats for their practice at the practice level.

The last and final thing we've done is to figure out a business model. I go up to the state of New Jersey and they say it's great what you're doing, you're kind of a one-off pilot, it's not replicable, we can't fix Medicaid around you. So we finally got fed up with that and we made friends with folks at the New Jersey Chamber of Commerce, who hired a lobbyist to help us fix this.

And, you know, watching all of the work that Brookings has been doing and Dartmouth has been doing around ACOs really felt like we could take this ACO model and kind of tweak it to make it more community-based. My big fear is that a hospital center like ACO is just going to be giving more money to the same system.

And, you know, the underpinnings of the model are that the average patient is loyal to the average doctor, is loyal to the average hospital, and that's true for the average patient, but all the costs are driven by outliers. And the problem is the outliers are highly mobile, particularly in an underserved community. So our data, we have data from Camden, Trenton, and Newark showing that the top 1 percent, 80 percent of them go from hospital to hospital, ER to ER, so they're incredibly mobile. And

the last thing we need in Camden is the Cooper ACO competing against the Lourdes ACO, competing against a Birch ACO, fighting over poor people.

That will work in the suburbs, it won't work in an underserved community. And not only that, but I don't think that the hospitals want to have my patients in Camden in their denominator. So it's really a win-win was to carve the city of Camden out and say let's do a different model here that's a collaborative model instead of a competitive model.

So we wrote legislation and we got it passed. It was a very painful process running around New Jersey for two years to do this. But our Republican legislative, you know, both Democrats and Republicans in the legislature supported it, broad bipartisan support, and our Republican governor signed it, as well. So it's law and we're in the middle of adopting regulations and kind of getting ready for this.

So I want to talk a little bit about some of the lessons I've learned about leadership in doing this work. I mean, it's a very intense level of collaboration locally that we've generated, and talk about some of the current deficits in our leadership model, and talk about how we're trying to either address this or how we found this within the Coalition. You know, many people have talked already about within the healthcare system, that we've got a very hierarchical model with clinicians at the

center. And, you know, I had this problem myself in my office. You know, I felt like I was going to, you know, be at the center of this office and do really good care, and I didn't do -- I didn't build a team. I was doing my own accounting, for instance, and, you know, I should have hired a bookkeeper. I needed a team to help me run this office.

So in the Coalition now, I've got a management team that's really an outstanding group of people, all of whom are not clinicians actually. I'm the only clinician in this five-person management team. And I sleep much better at night now, not feeling like the way to figure this out is on my shoulders, and also recognizing that I have incredible deficits. There's nothing about running from room to room to room for 12 years in a Medicaid office that in any way makes me good at running now a 25-person organization, that I really needed a management team and sort of letting go of control. So that was a personal lesson.

The other thing that we've really wrestled with a lot is that every project that I'm running, where I've got a really talented 23-, 24-year-old program assistant or project manager at the center of, and then I have a clinician that's just along for the ride, those projects run great. Every project where I've got a clinician who sort of thinks they know more than they really know and they want to insert themselves in the project management decisions, those projects are a complete mess.

And it took us a long time to figure that out. And now we've done something around decision-making rights. And, you know, there's some really good writing about decision-making rights and really dividing out what's a clinical decision from what's a project management decision. And I think 80 to 90 percent of this stuff is actually project management, not clinical decisions.

And most of the clinical decisions should be protocolized and standardized. So that's a pretty big realization. So I need my clinical directors or my clinicians who cost me way too much money, and I can't afford them, to stop running around holding meetings and project managing and getting into stuff they don't need to get into and just stick to helping me protocolize and standardize and then let our project managers do the project management.

And as we've gotten deeper, you know, we talk about this all the time now, is this a clinical decision or a project management decision, and, you know, really constraining the role of the clinicians. I never thought my job in this Coalition was to be constraining the role of clinicians, in that their leadership role was going to be a more constrained role, not a more expansive role, and that what I really needed were a whole new generation of project managers that were generalists who could manage clinicians.

And, you know, our organization now looks like a consulting firm. And as I look around the country at people really doing this work, you know, we all have to grow this new cadre of people that can have the confidence to stand up to clinicians and to project manage, and that all of the problems that we're having are like Henry Ford problems of figuring out how to standardize and protocolize so that we can customize and individualize, and that's a project management problem.

The other thing that we've learned about this sort of hierarchical model decision-making is our board makes decisions by consensus, which is a lot of work. So for nine years now, we've made all the decisions by consensus, and the most controversial one was we recently signed a contract with UnitedHealthcare. They're our second largest Medicaid payer. That's a shared savings contract, so it follows the structure of the legislation.

And I needed to get the vote of every board member, and some of my hospitals are nervous about going from our kind of cute kind of scaled -- cute little projects that are getting lots of attention to like now the numbers are getting bigger, and maybe we'll scale, and what's this going to do to our dish payments and our GME and all these sorts of stuff. But I really felt like I couldn't go forward in this until I had consensus, so, you know, really the need for thinking about consensus-based decision-

making.

The other thing I've learned, which is really an interesting learning point, was the absolute lack of compassion and empathy amongst many of my peers. As I've talked more and more about how to utilize a project, it has had really intense -- generated really intense reactions from some clinicians. And I'll have clinicians come up to me, and they're almost shaking, and they're like, if those high utilizers would just do what I told them to do, they'd all be fine. And, you know, all these words about compliance. And we've seen our patients yelled at a lot in the delivery system.

And it took me a long time to think, like, these are really pitiful people, I mean, they're struggling with unbelievable challenges. I mean, you know, no one wants to go 115 times to the emergency room. And in Trenton, we found someone that went 450 times in one year. I mean, these are really damaged, traumatized people. So, you know, why in the world would someone making 2-, $300,000 a year, living in a nice suburb, get so angry at these patients? Like what, you know, I finally realized it wasn't the patients, it was something about them, and really thinking about what's going on amongst my colleagues; what -- you know, that this model of the physician technician and the physician scientist as leader has in many ways really damaged us because it's truncated our

empathy for patients.

And, you know, we've begun to take physicians out with our team so they get to see what's going on in the community. And home visits are a great way of sort of breaking down some of these barriers.

And, you know, we talk a lot about adaptive leadership. We're beginning to talk about that internally. And I think there's going to be a huge hearts and minds change that my clinician colleagues are going to need to go through of throwing the word "compliance" out, of really rethinking what drives patient care, what drives change, and how non-linear people are, and, you know, I think we're going to have to elevate a new model of leadership.

Another learning point I've had in all of this was part of my role in the last 10 years has been to be an advisor for a student-run clinic. And it's actually a pretty complex organization. They do a whole lot of patient education activities. But student-run clinics are really interesting. It's about 50 students, they're all third year students, and they pick up 2 to 3 patients each and they're responsible for caring for that patient, soup to nuts. And the med school actually excuses them from whatever they're doing to go and scrub in, to go to the Board of Social Services, to go to the mammogram appointment, whatever the patient has going on.

They've adopted electronic health records. We have

clinicians that come and precept. And the patients get very, very attached. The students, they call for their own patients. And they have a whole leadership structure to run this. And they -- it's really interesting to walk into the office and watch what's going on, because they start yelling at each other, they get mad at each other. The patient -- the flow gets backed up and they're saying, you know, why is it getting so backed up, you're so slow, or this is going on. I mean, they fight for all the same reasons that we fight.

They have to develop a budget. They have a generic formula, and they order medications and they have to count the pills out. And what we've learned over time is that we used to have one person in each of the leadership spots within the organization, but inevitably we had lots of bad leaders and it would kind of mess up the organization.

And all of the leadership turns over every year in the organization. So we began to pair them up and have two leaders. And what we've seen in 10 years of doing this is that the quiet, reluctant leaders have, by and large, always been the best. They are mission-directed. And the loud, somewhat narcissistic and somewhat immature students who sometimes come directly through school and have a really -- they've always done really well in everything they've ever touched, but all the problems they've touched have been highly structured problems. It's a test, it's a paper.

And they get to the unstructured world, full of people and full of messy stuff and non-linear thinking, and they just can't handle it. And they try and overbear it, they try and control it, and it doesn't work.

And they tend to be a lot more men than women. So a lot of our best leaders in the student-run clinic have been women, and they have not viewed themselves as traditional leaders. They, you know, wouldn't see themselves on the track to be a chief or to be a CEO, but they've all been the best leaders. And that's been a sort of pretty profound realization on our part over time.

So the last thing we've learned is how important dissenting voices are, you know, particularly when you're engaging in such hard work. You know, our work is totally unstructured work. It's not like I open a book, as someone said earlier, and say how do you transform care in one of the poorest cities in the country, that we really have to make this up as we go, and that dissenting voices and uncomfortable discussions are very, very important. And one of the ways we've fostered that is by getting into high cost buildings and meeting high cost patients. So we went to the most expensive building in the city and teamed up with a church group that's called Camden Churches Organized for People. They are an old-school community organizing group that fight for better, safer schools, safer streets. And one of their main pastor's church is right next to this

high-cost building.

And we pulled residents in the building together, and I showed them all our data and said, you know, do you feel like you've got $12 million worth of care in the last 5 years? And they were appalled that anyone made that much money on such bad care.

And there's a major academic health center only five blocks away. And essentially good doctors and good hospitals are going to work every day delivering this really un-patient-centered and fragmented model, and we're just eliciting these crazy stories from patients and videotaping them, and eventually assembling this group into a leadership team.

We've taken them to CMS. We've taken them to Trenton, they helped to lobby for the legislation. We've had state officials come into the building. And then we had a retreat at a church, and it was really to make a covenant that we were going to promise one another to start behaving differently, that we were going to embrace a new clinical model, a new leadership model and have some hard discussions. And we went through all the data. My hospital CEO was there. We had state officials there. We had Medicaid HMO leaders there. We had patients, physicians, and eventually came to the conclusion, you know, and sort of promised one another that we all have to wake up in the morning and do something different, and that if we keep doing the same thing, it's not

going to work.

We literally hung the covenant on the wall and everyone signed it. And we made two concrete promises: one was to listen to the residents in the building and follow their leadership, and the other was to support the shared savings legislation, which everyone in the end did.

The outcome of the work in the building was, about 12 weeks ago, one of my board members, using our claims data, was able to build a business model for opening a clinic there. So we've opened a very small office in this very high-cost building. That's no grant money, it's privately funded, and it's sort of a great experiment.

My goal is to throw everything and the kitchen sink at this one building to see if I can bend the cost curve. So we've got a diabetic support group in there, a yoga class. Now, this clinic -- and we're just going to throw lots more stuff in there. We're going to do the same thing with our high-cost patients, throw everything and the kitchen sink and see if we can -- you know, 1 patient, 5 patients, 10, 100, and then the same thing with single primary care offices. We've spent a lot of time trying to figure out what it's going to take to bend the cost curve in a single office.

So I want to close up with just two final conclusions and not spend too much time on this. I'm sure many of you have heard of the model of servant leadership, which is really the model that has most

influenced me, and just close with a quote.

Robert Greenleaf was sort of the thinker behind this model. And he was -- he worked at AT&T back when it was Bell Telephone and really thought a lot about who the best leaders were at AT&T, and around the same time, in the ’70s, was watching all these failures at a national level, Vietnam, watching Watergate, really feeling like there was a leadership vacuum.

And what he said is that servant leaders -- servant first -- becoming a servant leader begins with the natural feeling that one wants to serve, to serve first. Then the conscious choice brings one to aspire to lead, and the person is sharply different from one who is leader first. The difference manifests itself in the care taken by the servant, first to make sure that other people’s highest priority needs are being served. And my goal in leading the Coalition is to make myself obsolete, and it’s to make my staff one day take over the organization. And he goes on to say the best test and difficult to administer is, do those served grow as persons? Do they, while being served, become healthier, wiser, freer, more autonomous, more likely to become servants? And what’s the effect on the least privileged in society, and will they benefit or at least not be further deprived?

So that’s been my touchstone as I’ve done our work in

Camden, and I think that that translates easily within a care/health setting, and we could use a lot more servant leadership in healthcare. So thank you very much.

MR. McCLELLAN: Jeff, thanks very much for a great perspective and recounting your experience. So I'd like to turn now to our other panelists, Barbara and then Elly, for some initial comments on this general theme of physician leadership at the community level, and then we're going to open it up to more discussion.

MS. TOBIAS: Great. Well, I'd like to thank Brookings Institution for being here. It is such a privilege to be here with clinical and thought leaders. And I'm really grateful for this experience. And I'd also like to thank Jeff. You know, the article, "Hot Spotters," I think was not only -- got national recognition and others to join the conversation, but it gave us as physicians talking points. And we had several discussions around Camden, New Jersey, and, you know, I think most of us said, duh, we know this. As clinicians, we know your patients, and it was terrific to have voice to that. You know, I think we're talking about changing culture. And I would argue that if I had all of your -- you know, for the physicians in the audience, if I had all of your personal statements that you wrote to apply to medical school, and as someone who's been on admissions boards for years, I've read many of them, I would argue that what you

talked about in your personal statement is exactly what you're talking about, servant leadership.

But, as you know, we get the stuffing knocked out of us. I think, though, that change is happening now, in answer to Kevin Schulman's point, why change now? It's happening now because we're returning to those values that are already internal.

All of the things that we're talking about, the CMI Initiatives, patient-centered activities, ACOs, accountability, responsibility, not letting patients drop through the cracks with transitions in care, that's something we know as clinicians have to happen. And when we are put into settings, residencies and our professional settings, the stuffing gets knocked out of us, because obviously the incentives aren't aligned.

So change is going to happen now because it's harkening back to something that we know is true to patient centered care. It's the right thing to do. So it's not new learned behavior. I want to just hit a quick bright spot in AF4Q lingo that's happening in Cincinnati. We have a multi-stakeholder collaborative by design. So we have payers, providers, plans, consumers, patients, all sitting at the table. And we have a public reporting site, Your Health Matters. And we have over 450 primary care docs voluntarily reporting their clinical outcomes data.

It's not claims data. They're going into their medical records

and they're reporting performance goals around diabetes, intravascular disease, and they will soon be reporting cancer screening rates, CHF. Patient experience will be on this, as well as hospital data.

Physicians and learners are motivated by data, as we've all heard. There is also the -- all of the cycle of grief and everything goes. When you first see your data, it's just as if someone died: there's denial, there's anger, there's bargaining. But when you have a trusted source, when you have a community collaborative presenting your data, not a payer, not a plan, and you have physicians guiding what measures are going to be reported, then you start to have trust, and that's what we're seeing in Cincinnati.

The difference between this, a physician portal, and some of the other things that are out there is, this is for the patients. So on Your Health Matters, we have content specifically for consumers and patients, to help them in their decision-making. And I think we start -- we have to start acknowledging the role that our patients have in their decisions, and not that they should take over the role of physicians. We don't want to just provide them data and have them in charge of their own healthcare. We really have to empower them with tools. So these are some of the tools that are happening now that I'm very proud of. I think we can talk more of that.

I also want to talk a little bit about paying it forward. What we can do as clinician leaders is mentor. And the question was asked earlier, what's the one thing you could change right now to foster more leadership? Mentor. Mentor students, mentor pre-med students, bring them to your offices, include them in these meetings, and show them why this is an exciting time to be in healthcare.

So with that, I'd like to kind of just end with one thought from one of my colleagues who's a physician leader, who's just been tapped to be the physician in charge of transformation for a large healthcare system. The leadership does not include physicians at the very top. And she was saying that they've decided they're going to be an ACO, and they want to just sort of snap their fingers and make that happen. She said she's sort of going between the sky is falling and the emperor has no clothes. We have to involve physicians in every step of the way to create accountability and responsibility and buy-in.

MR. McCLELLAN: Thanks very much. Elly.

MS. YOST: Thank you very much for being here. Thank you, doctors, it's an honor. I feel like the sole nurse, although I know I'm not. But I'm going to talk a little bit about nursing leadership and nurses need to be at the table, also.

Right now nurses are close to 3 million strong in the country,

they're growing. Advanced practice nurses right now are about 9 percent of that close to 3 million. And while what I've read is primary care physicians are not growing, advanced practice nurses are growing at about 9 percent a year.

So as we're talking about reform, I just want to put in there that the nursing population, and even though it's going to touch physicians, it's going to touch nurses and vice versa, and that we have to be working collaboratively.

You talked a little bit about physicians and the challenges of school and what it kind of punches out of you. And unfortunately, I think the nurses learn in nursing school that there is a built-in tension between physicians and nurses. Let's just put it aside. If it is, let's make it history and let's move forward together to serve clients.

And in Nurse-Family Partnership, which is in Camden, this is an evidence-based program, we have 30 years of evidence, we have 3 clinical trials, we've served the most vulnerable pregnant women, we've followed them through their pregnancy until the child is 2 years old. We're in 38 states, we're in 5 countries, and we have started this year serving 3 tribal nations.

And the approach in Nurse-Family Partnership is home visits every other week to support the mom. Our outcomes are that we want

this mom to have improved pregnancy, a healthy pregnancy. We want this child to have improved growth and development. And very importantly, we want to see this family at the end of the two years have a life plan to be financially sufficient ongoing.

And so I just want to read off to you some of our proven results. And these are from the clinical trials. Forty-eight percent reduction in child abuse and neglect, 56 percent reduction in emergency room visits for accidents and poisoning, a 32 percent reduction in subsequent pregnancies.

We don't ask moms to not get pregnant. We help them understand what close pregnancies mean to both their health and their family's economic self-sufficiency.

There's a 67 percent reduction in behavioral and intellectual problems at the child age 6. The clinical trial started in the '70s. These are longitudinal studies. We're still following the indexed children who are now in their thirties, because what we want to do is see if this is a generational change, and it is. This has been proven to be a generational shift in prevention and healthcare. Fifty-nine percent reduction in arrests at age 15. This is of the child. And an 83 percent increase in labor force participation. For every dollar that's invested in Nurse-Family Partnership, there's an over $5 return to society.

So what is our leadership model, I guess, if we want to talk a little bit about leadership? We embrace a reflective leadership model. We work with the nurses to make sure that when they're working with the clients, they are reflecting with the clients. They use a motivational interviewing approach to behavior in health change, meaning that nurses love to go in and tell you what to do. We love to go in and give -- push information at you. And what we do is, we bring all of the nurses together for education for a paradigm shift, that until the client wants to make the change, until the client believes it's important in her life and in her family's life, there will be no change. So we teach the nurses how to work with these very vulnerable clients to come to their own decision that they want to make this change.

Funding systems, is the BlueCross BlueShield gentleman still -- yes. BlueCross BlueShield is funding some of these implementation programs. They're being funded out of hospitals, they're being funded out of nursing schools, and then in five of the states actually it's a law that every eligible mom in that state will be offered an opportunity to enroll in Nurse-Family Partnership. It's 100 percent voluntary. The client has to be referred or she can self-refer or someone has to refer her, but it cannot be mandated by a core or by anyone else. The mom has to enroll voluntarily. I think that's it for Nurse-Family Partnership.

MR. McCLELLAN: Elly, thanks for that great perspective.

I would like to open up this discussion to comments from all of you, and I will have microphones around again. So hands up if a comment or question.

And maybe to start this off, you all touched, probably everybody in this room, with connecting back to why they got into the health profession in the first place, which was to serve and to make patients lives better. And it seems like a nice goal, but at this stage in our healthcare system with so much at stake financially and so much potential impact on peoples lives, having this focus and this leadership, this approach to leadership generally means going along with some new kinds of accountability, accountability for things like the overall results for patients and overall costs, and things like, Elly, you were just talking about, things like labor force participation and arrest rates. So that's a different kind of responsibility and maybe a little scary, too. How's that going?

MS. TOBIAS: You know, I think the way to move this forward is with data. And so just as the medical student is very quick to see whether they're above or below the mean on their test, when you have trusted, reliable data, physicians then are motivated to improve, and it has to be transparent, not just to the practice, but across systems, and

there has to be agreed upon performance measures.

Others talked about making sure that there's an even playing field there and that there's trust in methodology. Once you have data then, the payers can look at that, too, and then they can reasonably incentivize performance and other quality indicators.

You have to have physicians and other multi-stakeholders around the table to develop those. But I think that you can't move forward. You know, as a doc, of course, I used to say I'm a medical home. I looked at my patients in the eye, I provided warm, fuzzy treatment, you know, I even made extra calls that nobody knew about on the weekends, too. But unless I saw my data that maybe only 7 percent of my diabetic patients had A1Cs below 8, I didn't believe that I wasn't really performing up to standard. So I think we have to see our performance concretely before we can move forward.

MR. BRENNER: To go back to a point Richard made, what does good care look like, I don't think we really know what good care looks like yet. And the wonderful thing is that we have some examples out there that are evidence-based, so I think the Nurse-Family Partnership is -- and I would encourage you to go way beyond what you heard today and read deeply about it and to think about what it is. I've been very inspired by the model.

We also have Ryan White Clinics, which are for patients with HIV. They are a true medical home for HIV patients, because of the extra subsidy and the commitment and the patient engagement and the groups like Act Up and HIV activists. HIV patients get really good care in our country, they really get wraparound care, so that's the second model.

The third model is PACE programs. If you ever get a chance to visit a PACE program, they're really an amazing model for frail, elderly.

And the fourth model is a PACT team, which is a psychiatric hospital without walls. It's a very elite team that provide care in almost every state. It's an evidence-based model. It's the analog to the Nurse-Family Partnership with severely mentally ill, schizophrenics, and other types of patients.

So we have these pockets of care that I would say I bet a lot of people talking about accountable care organizations haven't even spent time reading about, visiting and looking at, that have been accountable care for 30 years, so, you know, with very rich data, with standardization, with protocolization, all the kinds of things we talk about. So, you know, so I'd like to see us do more to elevate what good care looks like, because when the system starts falling apart over the next couple of years, we're going to need to talk to the media and say, that's what good care looks like, and when you just do across-the-board price cuts, that's what bad

care looks like. And, you know, high deductible plans, you know, that's what bad care looks like, that results in bad care. So, you know, we're going to need to be really pointed in talking to the media about what good care looks like.

MS. YOST: And I want to add to that, to both of you, great points about data and what care looks like. In Nurse-Family Partnership, we do it twofold, so we look at our -- we have data constantly coming in. We look at the outcomes of our clients. But the other thing that we assess is the nurse based on her competencies, the supervisor based on her competencies, and the nurse consultant based on her competencies. Because it's one thing to see client data -- and we have client satisfaction surveys coming in. So it's one thing to see client outcomes, it's also something else to see other providers providing to their competency.

MR. McCLELLAN: Comments? Up here, Barbara. Go ahead.

SPEAKER: A quick comment. This was a remarkable presentation by all three of you and very inspiring. One of the parts that I think is the next step to make sure that programs like yours endure is the comment that Elly made about each $1 we spend here generates X-number of dollars.

And these programs are not going to have the infrastructure,

I would think, to create that kind of a business plan that we can then sell to the folks who control the revenue stream, but we need to start looking at what each of our processes, what does the medical home create, and how much does it save in downstream healthcare, and how much investment does it take to create that long-term return.

MR. McCLELLAN: Can you all say a little bit more about how you generate that evidence?

MS. YOST: Well, for Nurse-Family Partnership, it was a RAND evaluation. And people love to evaluate this program because it's so long and it's got so much evidence. The other thing that's important with that is bipartisan support has helped us go a long way.

MS. TOBIA: So the Health Collaborative in Cincinnati now has claims data from five different payers. Two of them have given us cost data. The case is to make a return on investment, a reason for patient-centered medical home, to be able to show ED visits and utilization and all of those things, too. But, you know, I think some of our other speakers spoke to the fear around disclosure of market share and allowable costs, and we're really struggling with that. We have very, very thoughtful business agreements with our payers around this claims data and it's a trust walk right now. We are being very careful on who we can release that data to. We'd like eventually to release it to the consumer.

It's their data.

And, you know, to your point, the payers know, they know that PCMH and these other models give them a return on investment. And so we've had Humana actually step up and say that any practice in Cincinnati that's an NCQA recognized PCMH will continue to give a per member per month incentive. They were part of our pilot and they've stepped out and said we have enough data right now to go on and so we're going to continue this.

United and Anthem are saying that we like the pilots that you started in Cincinnati, we're still a bit reluctant to spread this, but they have their own data, too. It will really make the case when we have aggregate data. Medicaid and CMS and others have spoken to that, as well.

MR. BRENNER: Access to the data isn't the only problem. Actually proving whether projects with high-cost patients or any bucket of costs saves money is really challenging. So there's, as many of you probably already know, there's something called regression of the mean. So if you take any high-cost thing, in fact, if you take any variable that's an outlier and just watch it, it tends to regress to the mean. So if you do nothing to a Camden high utilizer, statistically they will regress by one-third to one-half in their cost. So that makes it really challenging. And plus, when you're dealing with outliers, who do you match them to? So

you can do a randomized control trial, but, you know, each of these patients are so extreme that if you throw one into one group or the other, it can throw things off.

The other way to do it is something called propensity scoring, which is you use historic data to find matches. So we have all the data, we can do propensity scoring, but it can have pretty substantial confidence intervals of, you know, statistical significance.

Then the third way is sort of this actuarial smoothing, sort of looking at big enough numbers. But once you get to that big, you know, you've kind of smoothed all the data out and it's hard to look at individual variations.

So our science I think, you know, needs to advance on this. And we're part of the grant with the Record State Center for Health Policy to help us use our data to kind of figure this out. We just hired a Ph.D. inside of our organization to figure this out, but it's really hard. So even once they get the data, going the next step, as CMS is finding out, you know, the 5,000 number they set for Medicare, you know, has a pretty huge confidence interval about, you know, ensuring that you didn't just have noise, showing you saved money or cost money, but, you know, getting to a real number. So I think we're just at the beginning of this, and I'm not an expert in it. I only know enough to know that we don't know yet

what we're doing.

MS. POPLIN: Hi. I'm Dr. Caroline Poplin. I'm an internist, a board-certified internist, and not a leader, I'm a worker bee. I spent 15 years seeing patients. And one of the things that's distressing when you talk about lack of empathy with patients is that primary care providers are under a lot of pressure, we have to meet performance requirements, we have to meet productivity requirements, and nobody ever asks us what we think the problem is and what we would like to see to fix it. They just propose a solution that, you know, it sounds pretty good, it works at Geisinger and it works at Kaiser.

The people making these decisions generally don't see patients at all, or they're in very protected academic practices where they do some turns on the floor and they do a couple of resident clinics, and that's what they think practice looks like. I'm surprised that you didn't know that your diabetics weren't doing well. I knew how my diabetics were doing, who was doing well and who wasn't doing well and why.

MR. McCLELLAN: So is the question is there -- how to get more reforms driven by clinicians in actual practice?

MS. POPLIN: Yeah. You're talking about leadership and I think one of the attributes of leadership should be talking to the people who actually do the work.

MS. TOBIAS: And let me just say, I work and still do see patients, but also was at Lincoln Heights Health Center, first FQHC to be NCQA recognized. But we have no EMR. So my comment was really, I didn't know how my patients were doing in a population. And population health isn't something that we teach our med students either. I knew who came to see me, I knew when they came to see me, but I didn't know overall how my patients were doing as a group.

And I want to also just make a plug for Lincoln Heights, too. The medical director of Lincoln Heights, Bernie Lenchitz, is really a physician champion around this transparency. He's the first one at our medical meeting to offer to show his specific data, because he'll say it, overall his data is the worst. And so by stepping up and saying look at my dashboard, he creates atmosphere for the other docs to feel comfortable around this transparency. I agree, we need street credibility, and we have to have physicians who are seeing patients to be part of the solution.

MR. BRENNER: I agree 100 percent with you, we need more front-line providers. You know, up until two years ago I was a front-line provider and had to make a choice. And, you know, I think most of my comments were directed at really needing to flip the power hierarchy in the medicine and the need to take more front-line providers and elevate them up into CMO and CEO and, you know, higher level positions, because the

people getting up to those jobs right now are not primary care providers. They don't have a holistic view, and it's not clear what their purpose is to get into those jobs, whether it's to make more income, whether it's to serve a community purpose, to be a servant leader, or to serve their own needs. So I agree 100 percent.

MS. YOST: I agree with you, and I want to add to that, if you don't mind. We have to hear from the patient, the client, the consumer, the customer, whatever in your world of healthcare you call this person. They're who we're trying to serve. And where is their voice? So I just want to add that to it.

MR. McCLELLAN: Any final thoughts on how to do that? I mean, one of the things that's striking about these community-based initiatives is that they do try to put patients front and center and outcomes that matter to patients, like how well family is doing or whether people are actually able to go on and live their lives, often in very difficult environments, put that front and center. And I think that's one of the things that has driven a lot of your work out of the traditional ways of delivering care. Are there any further lessons on how to promote that perspective effectively in emerging healthcare organizations as part of this healthcare reform effort?

MS. TOBIAS: Yeah, I think that we're recognizing how

powerful consumer engagement truly is and how we as physicians can help patients become more activated. We all want to work with an empowered patient, that's the dream, and so there are lots of tools out there that we as physicians can help to direct our patients to around that.

We also need to make them part of the leadership. And there's challenges around consumer engagement, but I know that there are very progressive -- Robert Wood Johnson is recognizing this, Aligning Forces for Quality, in making consumers part of the solution, activating them so that they can be effective in these meetings. You can't just have somebody come off the street and tell their story, but they need to be part of this discussion.

MR. BRENNER: There's failed ways to do it that are very interesting. If anyone knows about the Federally Qualified Health Center's governance model, they have 51 percent consumers. And I've worked in NFQHC, some of you may be familiar, it works rarely. Most of the time it doesn't work. Because in a poor community, it's not necessarily -- the 51 percent consumers on the board aren't necessarily people who can sit on boards and hold the board leadership accountable, they're sort of handpicked. So we have a lot of phony models of patient leadership, at least in poor underserved communities, where people are plucked out and put in positions where they're not really being leaders. So in our

organization, the two seats, they are CCOP members.

The Camden Churches Organized for People has two seats that are for community members, but the staff from CCOP come to all the meetings, and they meet beforehand with the residents, they meet afterwards to debrief. I will go and sit down with them sometimes. And now they ask really hard questions, because we've taught them claims data. They know how doctors get paid, they know about the whole deal.

So I think patient engagement is telling the truth, and the truth is, telling people why the doctor is running for the door handle in 10 minutes, why they got thrown out of the hospital, why no one translated, why, you know, 12,000 people in Camden went to the ER for head colds and the ER has tripled in size. We need to pull aside and explain the money and the power, you know. So engagement isn't just the patient being health literate in a room, it's being able to stand on the balcony and get what's really going on.

MS. YOST: Every one of us in this room touches a patient or a client, whatever we want to call them, so if we just listen for the intent of hearing what they have to say and hear it with respect, I think we can represent patients, too.

MR. McCLELLAN: I'd like to thank our panel for an excellent discussion. Thank you all very much. (Applause)

MR. SENNETT: Well, good afternoon. I'm Cary Sennett, I'm a Fellow at Brookings and Managing Director at the Engelberg Center for Healthcare Reform, and I have the privilege of moderating today's final panel, which is on building clinical leadership.

It's been a pretty full day and difficult to boil it down to a couple or three basic things. But I think that there probably are three themes that have emerged fairly clearly for me. First of all, clinical leadership is important, really important. Second, it doesn't just happen, it's not something that's intrinsic. And finally, if we're going to accelerate meaningful healthcare reform, we need to do something about the problem of not enough people who are skilled clinical leaders.

So this panel is going to tell us how to do that. It's going to help us understand how organizations that face the challenge of needing clinical leaders to transform have solved that. And it is build intentionally, a broad range of expertise, but individuals from four different kinds of organizations so that we can get a sense of how this problem is solved in different types of organizations with different types of resources available. Patrick Conway, Chief Medical Officer, CMS, is going to kick us off and talk to us about how the government or how CMS at least solves the problem of developing clinical leaders, people like himself, like Rich

Barron, who bring the clinical perspective to the policies of very, very, very influential organization in healthcare.

And then we'll have three folks from provider organizations, delivery systems, different sizes, beginning with Don Casey, who's Chief Medical Officer at Atlantic Health, a system comprised of two hospitals, Maureen White, Senior Nursing Executive at North Shore-Long Island Jewish Health System, a really market dominant organization in New York, and then Jack Cochran, Executive Director of The Permanente Federation, a very large national system. Their full bios are available to you, so my brief introductions, and if I could ask Doctor Conway to begin.

MR. CONWAY: Sure, I'll definitely start. So I'm Patrick Conway, Chief Medical Officer and Director of the Office of Clinical Standards and Quality at CMS. I'm not sure I can actually answer the question, but I'll give you some thoughts. So first I'm going to talk a little bit about CMS and policy leadership, a little bit about delivery system leadership from my previous role, and then maybe some ideas about how we might foster.

So first, in terms of the policy arena, and we have several folks who work with me in the room, so you can check me if this is true, everything I say. As clinicians, we bring front line knowledge to healthcare and how policy decisions are likely to play out. For myself and my

background, to give you a little bit of context, I've gone in and out of government. I also have training from McKenzie Consulting, which I often apply currently and an RWJ Clinical Scholars Program, so a number of formal development opportunities which I'll come back to.

And our policy role at CMS, especially under the leader of the current administrator, Doctor Brobeck, we highly value clinical leadership. Notice I said clinical leadership, not physician leadership, much broader than just physician leadership.

And I think in my office, the Office of Clinical Standards and Quality, we have a huge number of clinicians we believe that bring that front line knowledge. How do we do that? We try to recruit them. A number of the people in the room are actually newly recruited to CMS.

We can't offer you –- we can offer you low pay, lots of hours, but the opportunity to create change in America, so we try to be honest about that. And then we try to develop their careers. So I've been in academic environments on a number of occasions. I think mentorship and career development is incredibly critical. By the way, I think government historically does it relatively poorly. So we're trying to create an environment that's career development oriented. I think we still have work to do there. And then we try to leverage that, both clinician leadership within CMS and then outside of CMS.

I like to tell people, because I sign off on all the physician adjustments, so I can't tell you all the clinicians, but I can tell you there's approximately 50 clinicians in all of CMS, that includes the regions.

Half of them are in my office. Guess what, with 50 physicians, you cannot cover the spectrum of care in America, so we need to leverage physicians and clinicians from outside of our organization, as well.

The last point I'll make on the sort of policy realm is, I feel relatively strongly that clinicians who go into policy roles should maintain clinical practice if at all possible. I had two requests when I took this job. And you can ask Doctor Berwick about this. I think the first question I asked him was, can I still work clinically, and I will not sign that I'm taking the job until I have ethics approval that I can do so. I do as a volunteer on the weekends. I think it's credibly important for me, it keeps me grounded, and it keeps me in contact with patients, which is why we do this work.

I'm briefly going to talk about a couple of things we're doing broadly with the delivery system, if that's all right. Because we think clinical leadership is important, we've announced a couple programs that I think are relevant here. One, Innovation Center Advisor's Program. The first round closed November 15th. I can't tell you how many applications we got, but it was a lot. And it's basically how can the Innovation Center in

CMS get what I would call a front line army of clinicians, including clinician leaders, to engage with us on changing on the healthcare system.

I often say in Baltimore that we can't actually change healthcare from Baltimore, we can set up the incentives, we can create the right environment, we can be a catalyst for change, but in the reality, and I've written about this in JAMA and a few other places, the front line of care is where care changes.

I love the comment, I think she left the room now, from the primary care clinician. I think, you know, that front line at the end of the day interaction between the patient and clinician is where change occurs.

The other program I'll mention is the Partnership for Patients. Once again, in a Don Berwick mantra, you know, a campaign oriented about engaging clinicians and change, creating incentives to eliminate patient harm over time in this country. So I think we think of clinician leadership both internally and how we can foster it externally. I will close, because I do like to adhere to my ten minutes, I'll close with a couple thoughts, if you will, on how we might foster further clinician leadership. One, I think multi disciplinary training is important. You know, I benefited from an RWJ Clinical Scholars Program, as I mentioned, some business training earlier in my life, health economics, public health, QI training.

We took Don Berwick to Cincinnati Children's, where I was a Vice President in Outcomes Performance and director of a hospital medicine division and we showed him a QI scholar we trained, and he said, why can't you scale this to everywhere in America, and it was a classic Don moment, I'm like that's a great question, why can't we do that. So we're working on that.

But I think it was a great example where that sort of cross cutting training that enables clinicians to be true change agents, understand improvement, understand system redesign. In this country, I think we have not enough opportunity there.

I also think we have a number of fellowship opportunities. I was a White House Fellow at one point. Barb Tobias I know was an RWJ Health Policy Fellow. I think we need to encourage broad application for those kinds of fellowships and foster more of them. I honestly think the White House Fellow is a great example. They pick, you know, 12 to 15 people a year, that's not enough. How do we think about, you know, creating those kind of opportunities to get into government much more broadly?

The third thing, I was just at the RWJ Clinical Scholars meeting, so I can't say this enough, the traditional academic path is fine and okay, but it's not for everyone. I met with like 25 physicians who

seemingly didn't actually want to go into academics right away, but we're going to anyway just because that's what they had seen and heard.

I think we have to let people know that academics is a great path. I've been in academics in other times, but there's multiple paths to change and we need to enable people to realize that.

The other thing I think is, take some risks. I've applied for many jobs, it's arguable whether I was qualified to be selected. I've also applied for jobs that have a high risk of failure. I think in clinicians, we are sometimes risk adverse in our thinking and mentalities. I think we need to think about how we enable clinicians to take risks.

I'll end with two points. I practiced in a delivery system where we took responsibility for the whole population in our region. So we did things like, we're going to drive down infant mortality in this whole region even though we'll actively lose our delivery system money. We had the benefit of a CEO and a leadership structure that allowed us to do that. I think more delivery systems in America need that kind of clinician leadership. We're going to try to set up the incentives in the federal government to make the right thing to do, the thing that also pays you money. But I also think it's still the right thing to do. So –- and this goes back to our policy realm.

My second day on the job, there was a decision about this

patient is first. Other people know we always go back to relentless focus on what is best for patient. We have guiding principals for OCSQ. We went around the table with the decision where everybody said, no, we shouldn't do this, no, we shouldn't do this. The person right before me, she said, Patrick, if you say this, you want to do this. By the way, you will get sued. And I said I still think we should do this, it's the right thing for patients.

The person after me was Don Berwick, who agreed. We ended up going forward with that decision. But I think it's a great example where, you know, and recently on a panel somebody said, well, weren't you worried about getting sued, I don't actually care.

So I think, you know, the relentless focus on, you know, what is right for patients and enabling clinicians to make those kind of decisions, I think we have to create an environment where we empower clinicians to do that. And the last point, we have to do these types of jobs. This job is painful in many, many ways. I made the decision with my family, it was a joint decision, but we have to get clinicians that are willing to sort of jump off that cliff with you, if you will, and take a servant leadership role and serve in those roles. So thank you.

MR. SENNETT: Don.

MR. CASEY: Thank you. I appreciate the chance to be

here. I want to also congratulate Mark and Brookings for their announcement today. Presumably the output of this session helps inform where you're going, and so what I'd like to do is address the notion of clinical leadership from the perspective of the health system executive, with the understanding that I did spend 20 years as a primary care physician.

I think I calculated I practiced in every environment except the present system so far. So I bring that perspective, as well, and want you to understand that even though it's not in my bio.

I've been struggling with the notion that physicians are trained in medical school to be natural leaders. And I might argue the point based upon what I just witnessed here with Patrick's inspiration and others today. Jeff Brenner is a friend of mine, as well, but there are many others, that physicians actually have a natural instinct to leadership. Nurses to, too. And that relates to what problem they're trying to solve. If they're trying to solve bureaucratic problems, admittedly they're not trained for that, but if they're trying to solve important patient care problems, and they really mean it, stand back. So somehow or another what we have to do is help them learn how to discover that that could be translated into a leadership moment for them.

The other thing is that leadership is a spectrum, and, you

know, it can be an avocation or a vocation, but it can also occur in the moment. And I can tell you, I go through my day as Chief Medical Officer of a large system now that incidentally just added one more hospital, and I am constantly keeping my eyes and ears open for leadership moments that occur right in front of my eyes with, again, passionate clinicians who are attempting to sort of break out of the shell of the stereotype of what they do all day.

So it's, in part, my job to capitalize on those moments and to also nurture as many people along as I can in that evolution, whether it be a small project or taking on a new, big responsibility.

So what I'm going to do, and hopefully this will be helpful, is to describe a framework for thinking about leadership and give you the understanding that I approach my job using all of these concepts, and it isn't like a one size fits all. So everything I'm going to talk about relates to what I do as a leader and what I do as a leader developer. I want to say that, first of all, it takes time and it takes clear interest to take the lead, and so that's important. We talked a lot about payment, but we haven't talked about time. Frankly, I think physician leaders care a lot more about time than they do payment, and that's really important, and that may be initially one's own time. I think that's how I got into this is through my own time, not because someone was paying me to do it.

I think the other component of leadership is, it's hard initially to get other people to follow you, and that, again, is the definition of leadership. It takes a leader and it also takes people to follow the leader, and that's really what leadership is.

And sometimes in the beginning, that isn't easy to do, especially when you're toying with new ideas that you think may create inspiration to get other people behind you. And some or another I think one of my roles is to not – is to help people who are trying to do that not get discouraged, especially when their ideas don't take shape right away.

It's especially true when physicians get in front of non-physicians, and I mean non-clinicians. I mean having a physician address a group of physicians around a clinical issue takes an entirely different skill set than having them get up in front of a lay board and explain why it's important to do X, Y and Z from a clinical improvement standpoint. You think it would be easy, but it's not, and it is something that needs to be learned. I think, too, that working together to measurably improve care outcomes is the natural driving force that we've been talking about today that will bring leaders together to make the changes that we're looking for.

I think there are technical skills, and I think we should pay mind to developing those. Again, I agree that, in most instances, it doesn't require a business degree, but I believe that things like just the notion of –-

we've talked a lot about data and measures, but just the design of the accountability, whether that be a contractual relationship with a group of physicians in terms of how they're paid, or an organization that evaluates itself against national standards for the purpose of improvement is really, really important and is not something you just make up, it takes a lot of experience to do this well.

Clearly, you need more than just a working knowledge of performance measurement and performance evaluations, the other part of this. We talk about measures, but we don't talk about actually how we use them to evaluate care, to evaluate performance, and that's, again, a very important part of this. It takes feedback skills and it takes managing conflict.

I talked about the performance measurement part, but I do think that negotiation expertise, and I mean that more broadly in terms of say the Harvard Negotiation Project that Elliot Fisher's dad led is another important domain of learning how to navigate with groups. Physicians are notoriously passionate when you get them in a room and try to get them to agree on one thing. And, again, no one is ever wrong, it's just that sometimes we end up letting the perfect be the enemy of the good, and we have to have skills to at least make some progress in this regard.

I think that how effective governance works is also really not

something that you learn naturally, it's got to be experienced. Jeff was talking about dealing with boards at the community level, that's in and of itself a challenge. But these things, again, you don't teach through a lecture.

And then health policy payment and regulations, I think the average clinician doesn't really understand how the payment system at least is supposed to work. They understand bits and pieces of how it doesn't work. But at least having that insight would be helpful.

I have four quick slides that I'm going to go through which I hope will help. I think – and this is, again, something that I'm not going to ask you to read verbatim. But I do think that when you look at at least a health system's perspective, you have to evaluate that health system from the standpoint of what the moving parts are.

Geisinger has a health plan. Eliott Lazar has a medical school. We have none of the above. And I also think that, you know, some organizations like Kaiser have largely employed physicians. We have largely self-employed physicians. So the dynamics of how you develop the clinical leadership program has to be cross matched with what the moving parts are, because it will look in some cases similar, but in some cases, very, very different in terms of how you organize the clinical leadership approach. And then this business of quality and safety

improvement is important.

There are a number of factors that relate to quality improvement that I think also need to be looked at. And if you take any organization and use these nine pieces, I think that that can be, as well, kind of a strengths and weaknesses perspective in terms of how we get to defining what the leadership should focus on first, because depending on the organization, there may be, for example, a board that's involved as opposed to a board that's not involved, or administrative leadership that is either supportive or doesn't care that much about the clinical improvement processes.

Those will change the dynamics of how we make leaders effective, clinical leaders effective, so keeping that in mind is important. My favorite picture when I talk to physicians is this slide which I stole shamelessly from the late Everett Rogers and his book, *The Diffusion of Innovation*. And this is a book that if you haven't read it, it's critical to understand. I always ask, in a room of 200 physicians, I put this up and I ask physicians to raise their hand if they're above average, how many physicians are above average, and you see like two or three go up, and then all of a sudden no one –- it's interesting, no one raises their hand, and that's because, depending on the issue, we're good at some things and we're not so good at others. And so that's one part of this.

The second part of this is that leaders can actually emerge from anywhere along the spectrum. Some who may be the most curmudgeon actually are the most thoughtful in terms of needing to just be convinced about one or two things, and all of a sudden turn into the early adopters of leadership. I've seen this happen time and time again, whereas some people are so out at the cutting edge that they can't really take on much responsibility.

So I think this is -– I can use this five different ways to discuss leadership. These are just two of the ways that I look at it. Ultimately, you're going to lead a group that's going to have this distribution and so you're going to have to figure out where to put your time and energy in terms of making the change, generally in the early adopter and early majority.

And then the last part is, you know, we talked a lot about standardization and protocolization, and I just leave you with this comment from Floyd Loop, who's the past CEO of the Cleveland Clinic who wrote a book on physician leadership. And I like this quote because I think it's important and does emphasize what we've been saying about information, and that is, don't start with the notion that doctors don't understand how to do the right thing, provide them with information, hopefully make that as meaningful as possible, and then make every attempt to actually let them

be the deciders of how they want to move things. We've heard that time and time again.

So the ultimate challenge is, how do you provide good information. And, you know, we've got lots of sources, but I think what I'm hearing is, we've got a lot of data dysfunction out there right now, as well. So those are my final comments.

I just want to leave you with two mantras that I give to every physician leader or every new person who's enthusiastic, and that is, I quote Yogi Bear because I now live in New Jersey, the first is, when you come to a fork in the road, take it, and the second is, if you don't know where you're going, any road will get you there. So thank you.

MR. SENNETT: Maureen.

MS. WHITE: Thank you very much. I also want to thank you for the opportunity to come and present some of the work of the North Shore-LIJ Health System. I've been quite impressed, as most people would imagine, about the presentations today, very thought provoking and inspiring. The North Shore-LIJ Health System is a 15 hospital health system situated in New York, primarily on Long Island, but we extend from Lenox Hospital in New York City to South Side Hospital in Suffolk County. So we cover most of the five boroughs of New York City. We are a very large – we are the largest health system, integrated health system in our

region. So we do have, you know, a tremendous amount of spread.

We capture of the more than six million patients in our collective catch men areas, we capture about 35 percent of that market. We have in-patient hospitals, as well as home care hospice care, long term care, you know, the full spectrum. We start with our conception laboratory, say we can care for you even before even thought of until you die. And we have a psychiatric hospital so you can have a little breakdown in between.

You know, when we as a health system, we're fairly young, although we're in our teenage years now. The health system, we came together in our present form back in 1999, so we're entering our 14th year as a health system.

And early on in our coming together as an integrated health system, we realized the vital importance of clinical leadership, whether you speak in its – the narrow sense that it's just physician leaders or whether you speak in its broader sense, as was brought up that clinical leadership is, you know, any clinician who delivers care to a patient or a patient population. So, you know, when we talk about clinical leadership, it's the physicians, it's the nurses, it's the allied health professionals all along the way.

And we realized that in bringing together these 15 very

diverse hospitals, some large quaternary hospitals, tertiary care hospitals, two small 150 bed community hospitals in our rural areas, that, you know, we had certainly many different cultures.

And every hospital we went into, they always said to us, we're different, we're special. And we treat each of these hospitals as if they are special. But what we realized early on was, we needed to change the culture. And so the question was, how are we going to change the culture in a reasonable amount of time because we saw that healthcare was changing so fast and so rapidly.

And the CEO, Michael Dowling, felt very strongly that the best way for us to change the culture was through education. And many hospitals at that time felt that, you know, education, yeah, it's nice to have education, but it's like wasted money, you know, you'll get reimbursed for that, you know, unless it's medical education, which we do a lot of. We have very large residency programs. But our philosophy was, in talking about leaders and whether you're physician leaders or clinical leaders or nurse leaders, you know, where is the leadership going to come to help us through these transitions as healthcare changes? And we believed at that time, and we continue to believe healthcare is changing faster than we perhaps have the ability to change with it. But we didn't want to be on the back end of the change, we wanted to be at least towards the front in

leading those changes.

And so the question for us was, where will we find these leaders, and it became very clear to us, the leaders were within our organization. So, you know, I guess it goes to that old question, are leaders born or are they made. We believe leaders are born, they just don't know it. Some do, but not all of them do.

We believe that everybody has the ability to lead if they are prepared and if we give them the tools to lead and if we help them through those transitions of what leadership really means.

And so it was decided, back in 2004, that we would create our own corporate university within the health system. What started out in 2004 as 5,000 square feet of a couple of classrooms and a, you know, at that time it wasn't so developed, you know, simulation mannequins, has now flourished here in 2011 to a 45,000 square foot Center for Learning and Innovation, which incorporates our Patient Safety Institute. The Patient Safety Institute is a high fidelity simulation learning laboratory. And we don't use this high fidelity simulation laboratory just for, you know, residents to, you know, practice assessment skills or for the nurses to learn new techniques or whatever, we use it to see how the groups will interact together.

See, we believe, along with the ION, that the ION report on

core competencies that will be needed for healthcare providers are the future, that if we don't embrace those, we will not be able to improve the quality and safety of our patients and our healthcare environments, you know, those core competencies of patient eccentricness, looking at working together in interdisciplinary teams, employing evidence based practices, you know, utilizing quality improvement methodologies and the utilization of clinical information systems.

So in our corporate university, we provide programs for what we believe to be our future clinical leaders. And we don't go based on title, we don't go based on years of experience, we don't go on specialty, we go based on attributes, the things that we see in our physicians that we think will make great transformational leaders, that they have the right attitude towards healthcare and what healthcare is about, they care about the patient openly, not just secretly, that they, you know, are always advocating for doing the right thing regardless of the cost, leaders who are willing to change, who really embrace change, and people who can work well together with other team members and not over shadow other team members. So this corporate university has become, you know, one of our vehicles of educating what we believe the future leaders to be, because we don't believe that the people who are currently in the work force, of course the country, with few exceptions, you know, there's a percentage

of people, whether it be physicians or nurses or allied health professionals of people in government or whatever who truly understand what it's going to take to transform healthcare to make it what it needs to be in order to provide the level of care that we need to provide to this ever growing population of people who are requiring care.

And so in looking at our corporate university, as I've indicated, you know, we put almost all of our employees, not just our clinicians, but all of our employees we put through this program to be able to see and to assess do they have the leadership qualities that we're looking for and can we elevate them up.

Many of the people who go through here are part of our succession planning list or high potential list, people who have been identified as great team players, people who can do project management, who understand the scope and the breadth of the work that we need to do, and so, you know, that's where we're at. You know, in 2008 we had some quality issues like many organizations did, and we said, you know, we just can't keep saying, you know, we'll do plan, do check act and it's going to change, we really have to change the culture. So the organization in its totality decided to embrace the tenants of Team Steps. Team Steps, as many of you know, is a program that was initiated through the Department of Defense and supported in its rollout with AHRQ.

And Team Step stands for strategies and tools for enhancing performance and patient safety. And we put all of our employees through the Team Step's program so that we were all speaking the same language, that we do expect, when you're talking about team work and talking about patient safety, that everybody is going to speak up.

So we believe very strongly that the more people we have focusing on the patient and quality of care, the better the quality of care will be, the more efficient the delivery of care will be, and the greater capabilities we will have to provide more care to more patients within our communities.

And it's not just about the bottom line, because as I've indicated, having a corporate university is very expensive. We estimate that we spend in excess, and this is a very conservative number, $15 million a year, unfunded, taken out of the bottom line of the organization, in training and in education and in developing those future leaders to what we believe the healthcare systems will need those leaders to be able to function, too. So $15 million a year. And we went into it not thinking, because the Board of Trustees said, okay, if we do this, what's the return on investment. And Michael Dowling stood up there and said there might not be one. Intuitively, I believe that if we invest in the development of our future leaders and in our employees, there will be an investment, but I

can't stand here before you today and tell you what that return will be. So I'm going to couch my bets and tell you there will be no return, it's just $15 million we won't see anymore.

And the Board was intrigued by it, his honesty, and said, you know, let's do it. I'm happy to tell you that we've estimated that since -– through the evolution of the Center for Learning and Innovation in developing our future leaders, our current leaders and our future leaders, that we've estimated that in the last 18 months to two years, we have saved or reduced our costs and expenditures, improved the quality of care, which has netted in $100 million savings to our health system.

So when you talk about, you know, what's the value and what's the return on investment, sometimes you don't always know what the return is, but when you look at the results and are you doing the right thing for the patient, then you know that, regardless of what the return is, that it was a worthwhile thing to do.

MR. SENNETT: Maureen, thank you. Jack.

MR. COCHRAN: Well, good afternoon. There was a lot of sort of talk earlier about are we talking about clinician leadership, physician leadership, and I think the answer is, we're talking about clinician leadership. My particular area of responsibility is physician leadership, however. And so I do think that it's not more important, but

physicians have a disproportionate impact on how high the bar is raised in an organization. You can have great leaders around us, and if we're not willing to be part of the future, it doesn't go as well.

So I'm just going to talk about sort of three things. First of all, choices that we might make as leaders, and I would amplify what was spoken about in Camden, so the choices we may choose to make are not. Secondly, physicians moving from the industrial age into the information age of healthcare and what does that look like, how do we lead them, and what does it take for them to make that journey. And lastly talk about investment, talk about investment in healthcare.

So choices in leadership, I did not want to choose a leadership path. I dreamed when I applied to medical school to be a clinician. I loved doing what I did. But I got frustrated, and I got angry, and I got upset with things that were not fair, were not going well, and I thought I could either choose to sit on the sidelines and let this happen, or document all the things that other people were doing wrong, or I could step in and try to make a difference. So why is this important? It's bad in Camden, but around this country, the fabric of the American dream is at risk, and healthcare is right in the middle of it, and the healthcare issues are right in the middle of it.

And as physicians, we've got it made in many ways, and

we've got to understand that our job to be a doctor as we applied to medical school is a voluntary act. The role of patient is an involuntary act. Nobody wakes up in the morning and says, you know, it's been a while, but I think I'll try that out.

So I'm going to show a couple of slides. And I want you to notice the difference in the slides between a cognitive specialist and a surgeon, okay. The cognitive specialist has facts and detail, I have drawings and pictures.

So, first of all, choices that we make in leadership, it's a rough world out there. One of my favorite quotes is from the Polio researcher, Jonas Sulk, who says our greatest responsibility is to be good ancestors. So what are we going to leave behind? Are we going to leave behind a system where I wouldn't want my grandson to become a nurse because it's such a rocky profession? Or we try to talk to people about, I hope your primary care career is sustainable. What a ridiculously low bar for these bright people that are going to go into this great profession. Why don't we make primary care desirable and relative and interesting and vibrant? That's our bar. A bar is not sustainability.

So anybody ever sat on the sidelines and just resisted change and said as soon as the federal government, you know, fixes the funding, then I'll get in the game, everything is going to be okay once they

fix that? That's the role of victim.

The problem was that if you're a physician and you're a victim, the patient has lost a voice. Patients encounter the healthcare system physically, socially, psychologically, financially. At times we need to be their teachers, at times we need to be their healers, their fiduciaries, their caregivers. We need to help them through this. And every time we say, sorry, that's not my responsibility, somebody else has to make it their responsibility.

The first two CEO's I ever worked with in hospitals weren't doctors or nurses, they were Roman Catholic sisters and they were as good a CEO as I've ever known. They're probably also as good a healer as I've ever known. So your educational background is relevant, but it's neither a barrier or a guarantee. Or we could react. We can get a little better at what we're doing. We can create some improvements and some reactions. But where this country needs to go is to –- moving into the information age of healthcare, which I'm going to talk about, how do we use information, and how do we create a coalition of people, not just Kaiser Permanente. Heaven knows we've got 8.9 million members and 16,000 physicians, that's a big N of people that can potentially learn. But we're not big enough. We need to learn from you, we need to learn from other organizations, and that's how we create a learning coalition over

time.

So what does the industrial age of medicine look like? Well, a lot of guys that looks like me. Now, I know some of you in the room have no idea who Marcus Welby was, I apologize to you. He used to be a TV doctor and he looked like a lot of us, kind of old and gray and white, and that's what the physician was.

The physician was the center of the universe, it was one patient at a time, you went to the doctor's office, they knew about the patient in front of them, they were good medical homes because they kept track of things and they didn't use extenders.

The new age, it's Marshall Wellbite Marshall Wellbite comes to the information age with a sense of accountability for a panel and a population, believes in transparency, wants an EMR before you hire her, she doesn't want to say are you going to pull an end some day, I'm used to being computerized, I want to be computerized, believes in team care, a very different skill set for physicians, to take this complexity of medical information, the boomers who are coming in, and all the needs for managing a population using team care.

Jeffrey talked about, bring me some young 23 year olds who are bright. We need to invest in physician leadership, but we must not make them tokens, we must make them relevant and in the center of

things where they can actually be impactful and not just bring a degree and a little bit of hope and moving care out of the doctor's office.

So it wasn't that many years ago that we went to banks and we cashed checks and we got money, and then the banks – and that's where the information, the power and the customer went. And then they moved to the ATM machine and the information, the product and the power moved there. And now they've gone mobile, and that's what's happened.

What's happened in air travel? We've gone from airplane tickets, we've gone to more virtual tickets imprinted, we've gone mobile, and the same thing is happening with books. So where is healthcare in that information age? Where is our mobility and our connection with mobile applications to patients, where is that going? And the beauty of it is, it's not just wealthy people that have cell phones, cell phones are a pervasive societal asset. So lastly in the area of investment, I think that we as a large organization with a significant history of investment of physician leadership, my day job, I'm a chief executive of my day job and it involves a lot of formal leadership training myself with people and mentoring, so I don't hand it off to somebody who says you changed these people into leaders, I do a lot of that myself.

We ask physicians to be involved in clinical quality, we ask

them to be interested in and involved in resource stewardship, IT technology systems development and deployment, drug formulary research and even public policy.

And I will copy your learning with one of these information technology.

I was the President of the Medical Group in Colorado and we had an old IBM system we were replacing with an Epic system. We needed to do it in four and a half weeks, 850 doctors, 17 clinics, 5,000 employees, four and a half weeks. And we actually followed your lead. We didn't know about you and your lead. But what we did is, we spent an extensive amount of time sharing context, bottom up, top down, just sharing context so that this group of people understood why we needed to change and where it was best for us to go, and there was no way to shortcut that.

Secondly, we invested in training and support so they didn't go in half armed into this battle of trying to change out a system in four and a half weeks. Third of all, we got very clear, we said because this old system is falling apart, we have to have this done in four and a half weeks, crystal clear, and then we went to the early adopters and we said, okay, you guys are ready, we will provide you with support and backfill. My entire leadership team was trained as trainers, which is an unusual thing to do. I would recommend it, but I'm not sure I won't also do that.

And then after the early adopter clinic, the social networking, and this was actually before there was as much Facebook and all that, but the buzz in the region was so much more compelling than anything I could say because their peers were saying, this things is really good, this really works.

So we took those super user, early adopters two days later to the next clinic, and over the next four weeks and two days, we deployed the entire thing. But it was investment up front with context sharing and why providing enough support, being very clear on where we were going, and then really getting the early adopters. And what you saw was, the change was fast, but it didn't come from going fast, it came from momentum, it came from momentum which got better and better over time, so some leadership lessons.

MR. SENNETT: Thank you, Jack. Thank you all. So I have a lot of questions, but I think the most important thing is that we answer, the panel answer the questions that are important to you. So are there questions from folks in the audience, questions or comments?

SPEAKER: How did you find the right people to lead your training into your university?

MS. WHITE: Well, we used a variety of different methods. Number one, we partnered with Harvard University School of Public

Health to help us with some aspects of it. We went to outside industry, Jet Blue and, you know, Toyota and different groups to talk to them about how they did their leadership training. And some of our people who we hired for the Center for Learning, you know, went through their training courses, as well.

And we chose clinicians who we felt worth leaders in the organization and well respected, again, not because of their years of experience or their titles, but because they showed what – they exhibited transformational skills that we all said, I would follow that person.

And, you know, I think it is very true that, you know, an organization can go far, but you'll never go as far as you absolutely need to go without physician buy-in and physician leadership. It is intrical to healthcare and it should never have been short changed, and, you know, we can all discuss the reasons why it may have been or whatever, but it is absolutely important. So, you know, I think it is about, you know, a lot of people, you know, as indicated, you know, it's pulling out the leader from within. And we were surprised the numbers of people when we had our first program and identified certain individuals who aren't the chairman or the chiefs of the department, who, I can step up, too, well, go ahead, step up, we're waiting for you.

So we went to outside industry to look to see what outside

industry was doing, we just didn't rely solely on healthcare to help us to identify who the core people of trainer should be.

MR. SENNETT: Greg.

SPEAKER: I'm always amazed at as leaders get to certain stages, they often lose their sort of learning training mentality, and one of the ways I think to overcome that that I was intrigued with was Atul Gawande's article on coaching, and that maybe you're never too experienced or never too far along to have thoughtful, reflective feedback on your -– I think it's where leaders sometimes go astray and forget what they should be doing, and that's the sort of continuous learning.

I'm just curious as to how you think about that and whether you incorporated that into your own or other senior executive or senior leadership training.

MR. CASEY: I can speak to that. We actually do go through a regular phase of coaching that is not just coming in and chatting, but actually getting 360's and, you know, all that stuff. But then what's important for us in the next phase is to translate what we've learned in terms of the people that we're influencing. So the next phase of that is to then mentor and supervise using the techniques that we've learned through whatever the last phase of this was to try to bring that out.

And we haven't done it as much with physicians, although

we're starting to do that. And I'm spending a lot more time, you know, in that realm. We have a different model than North Shore. We have the buy model. We don't build. So I use a variety of organizations externally for physicians specifically to help them.

There are pros and cons to having internal versus external groups, but we use, you know, name and ACPE and (inaudible) Health, a variety of organizations like that to bring this more experiential.

Ultimately, I was reading Coach Kay's book last night. I had no idea he was breaking Bobby Knight's record as a disclaimer because I'm not a Duke fan, but it's a great book. If you haven't read this book, I think it's very relevant to today. And he says when it comes to training development, he's so cogent about this, he says that in training and development, you hear, you forget, you see, you remember, you do, you understand. So somehow or another we have to move from in a classroom to actually turning this into action. That's what we try to translate in this sort of feedback mentorship in terms of not just tell me more about myself, but do something active to see if you can learn something.

MR. CONWAY: I mean just real briefly. So I think it's a critical concept. I think, you know, you named it. I think that coaching our group directors and deputies in OCS, we have about 400 people who

literally have over 200 years of experience. So I view my role as coaching, enthusiastic and asking questions. So, you know, why couldn't we do this, what about this.

I mean, we literally had a room structured around like a hierarchy of like T at the top of the table. I can tell people more if you want that. We've sort of restructured that dynamic.

And then the 360 feedback I'd say we're still working on. So I constantly ask for feedback, which people will talk about, and I still struggle with it. I think it's hard for people to really feel comfortable giving that honesty back. So I think it's always a work in progress. And maybe I haven't learned to give up coaching yet, but hopefully I'll keep doing it.

MR. COCHRAN: A couple things. First of all, I heard the word descent earlier, and it's one of the cornerstones I think for learning. And if I don't create an environment on my team that they will provide me with descent and that's my fault. Descent is an extremely valuable tool, because most of us don't wake up in the morning and say, you know, I think I'm going to go do a mediocre job today, and sometimes we do a mediocre job. But if somebody doesn't have the humanity to say, Jack, you really screwed that up, if somebody doesn't care enough about me to say, boy, you really – that talk you gave at Brookings, that was lame, because I assumed I was okay.

And so if I don't have a team that has enough – that cares enough about me to give me that descent, then shame on me for that environment.

The other two things that we do is, I do two different kinds of book clubs. I have a book club with my team that we do once or twice a year, and then a book club with the other regional medical directors. And we'll pick some book that's about leadership typically and then we'll talk about it. And then we have sort of changed leadership conundrum talks around, okay, we're having this issue, how do you manage it as a very formal time period during our organized meetings, sort of a co-mentoring group.

MR. SENNETT: Tom.

MR. JAMES: Yes, Tom James. I have not thought about this particular issue, so I hope I can frame the question correctly. There are cultures in various companies that are more or less receptive to integration of technical people into leadership. You look at the chemical industries, you look at the airline industries, often you don't see true leaders coming out of those because they're considered to be technocrats.

Clinicians often fall into that realm. They're either considered to be scientific or too wishy washy, and the culture doesn't

allow it. But there's other companies that do embrace that concept and bring them in. Can we demonstrate that there is, in fact, an ROI for the bringing in of clinicians into leadership roles in one organization versus another?

MR. SENNETT: Actually, Maureen, if you don't mind being the first to respond to that, because I think you've commented that at this point there's no evidence of ROI, but I guess part of the question is, well, how are you looking at that, and I think that relates to Tom. So –-

MS. WHITE: Well, you know, I think that there –- when we went into it, I think my comment was that when we went into it, we didn't expect an ROI, that wasn't the reason we were going into it. We saw that, looking forward, that we believed there to be a gap in leadership, and the leadership that we felt would be needed in the future. What we have found was that by developing those leaders, there is an ROI, and, you know, as I've indicated, by getting physicians more engaged and taking, you know, more active leadership roles in, you know, a variety of different committees and initiatives, that we have throughout the health system in a multi- disciplinary, interdisciplinary fashion with nursing and other allied health professionals, that the ROI was that we were able to bend our cost curve, you know, by $100 million.

Now, we're a $6 billion organization, so you say, well, it's not

so bad, but it's a start and we're seeing the fruits of those labors. Because I think when you're looking at change in a culture, it takes a long time. It's not as easy as putting somebody into a class and say, oh, good, you have a certificate, now you're a leader, it's putting them into real life situations and testing what they learned and helping them, mentoring them, coaching them through those experiences to see, you know, did they learn, do they need more development, and how do we help to support them through that so they feel more empowered the next time that they go, not as afraid to say I'm not going in there again, they threw me out the last time, no, let's figure out what went right and what went wrong, how we could do it differently, how we're going to support one another.

So I think that there is an ROI on, you know, education and developing the future leaders. And I think the enthusiasm in the organization which has been highlighted by many of the panelists is just contagious, I mean it's just infectious throughout the organization, that people see people who they've worked with their whole careers and never thought they had these leadership abilities within them and are just so impressed like I want to do that, too, they seem so happy in what they do, and I think that goes a long way in helping to change the culture into one of saying we can be different, you know, it's not the same old healthcare where it takes 17 years to make any change no matter how large or small.

MR. SENNETT: I'm going to actually, Tom, in the interest of time, I'm going to take the panel chair's prerogative and ask the last question, because it's a very important one, Don, and something that you actually teed up. As you all know, Patrick, I guess you weren't here this morning, but Mark McClellan announced today funding from the Richard Merkin Foundation to support Brookings Engelberg Center Initiative in this area.

So in one sentence, or two, what's the most important thing that we could do, what's the most important thing that needs to happen in order to solve this problem of, we don't have enough people who have the skills that are needed at this critical time in healthcare? One or two sentences. I'm looking for a volunteer to start.

SPEAKER: How much money do you have? Just kidding.

MR. SENNETT: Jack.

MR. COCHRAN: I would say to try to deeply and quickly understand what is going on right now that's working and to learn as much from that as a starting point.

MR. CASEY: I would say one of the things I skipped over in terms of essentials is program evaluation. And so I think whether it's Maureen, whether it's Atlanta, California, whether it's CMS or Kaiser, we have to get real intention about the structure evaluation, and that has

different dimensions.

I mean financial is one, but obviously there are behavioral inputs, as well. So I would hope that maybe we can create that, and ultimately, I think the learning, sharing environment is the most powerful thing that especially physicians and nurses respond to.

MR. SENNETT: I'd offer the two of you a chance to comment.

MR. CONWAY: Go ahead.

MS. WHITE: I would absolutely agree with what's been said. I think that we have to look to see what is going on across the country now. There are great practices, you know, across the country and great organizations and I think it may be a culmination of all of those and it may morph into an even greater initiative than any of us could have ever imagined at this point.

MR. SENNETT: Patrick.

MR. CONWAY: So I'd do two things, first I'd understand sort of best practices and what might be applied. And then secondly, and probably more importantly, I'd think about the idea of fostering a collaborative around organizations that want to drive clinician leadership and how they could learn and collaborate together to drive clinician leadership.

MR. SENNETT: Well, I want to thank the panelists. I want to call out two things from this panel that I think are particularly important. First I want to acknowledge that this is the first time I've heard one person quote both Yogi Bear and Coach K. But the other is, probably what resonated most with me and may have resonated most with others, and certainly with messages that we've heard from others, are two of the examples of leadership that the panelists provided.

Patrick, your comment early on that a hard decision and we made the decision even thought we might be sued because it was the right thing; and Maureen, your CEO's commitment to make an investment in education and clinical leadership development no matter what it cost because it was the right thing.

So I think it probably reminds us again and a theme that's emerged today is, leaders are people who are committed to the best that the profession stands for in healthcare, about serving the patient, and we need to find people like that, and we need to support them. So maybe that's the most important tick way. Thank you all for your participation. Thank you.

MR. MCCLELLAN: I'd like to thank all of our panelists and all of you for joining us today. And for those of you who have been here for the whole day, as you've seen, we've covered a lot of ground, a pretty

intensive set of topics, but a lot to discuss.

I'm going to just wrap this up quickly mainly by telling you where we're planning to go next with this effort. And one of the main things that I think we're going to keep doing is holding events like this one to get good ideas on the table and to help with that process of sharing experiences. It was so prominently mentioned on the last panel and so effectively illustrated through all of the earlier discussions today.

Jeff Brenner said that we're at an inflection point in healthcare leadership. And Jeff was talking about, in his usual very getting out there way, the need for some fundamental changes in who was becoming leaders and why, and that reflects back to some -– the fact that we're at I think an inflection point in the whole way that healthcare is delivered and financed, whereas we started out this morning talking about some of the challenges with cost, some of the frustrations with quality of care and all the opportunities to do better, it's really calling out for new kinds of clinician leadership, working closely with patients around this kind of vision of serving leadership or patient centered care or something that connects better with what patients want and spending the resources on a healthcare system as effectively as possible.

And today, as well, we had one of the images to go along with this. I think Tom put up on his slides was tilting at the windmill, and

as Gene said, at least it looked like an optimistic Don Quixote there.

My hope is that we're no longer just tilting at a windmill here, but that this opportunity to get to much more effective care is for extremely challenging reasons becoming more of -– not just a possibility, but a necessity.

Many of you talked about how the past approaches to try, and policy reform to try to address rising costs and access, squeezing down prices, trying to expand coverage in traditional ways to fill the gaps just wasn't getting the job accomplished, and to find an approach that would work, that could be supported by the American public, it's going to have to have clinician leadership.

So with that in mind, we thought that it would be helpful to bring together a range of different perspectives to talk about how to overcome all these challenges. And what I think you heard today was a broad range of settings and circumstances for public and privately insured patients, for people with means and people who are much more vulnerable in urban settings of care, in rural areas, in large integrated systems and in smaller -– in small practices, group practices and community care. In primary care and in specialties, there are a lot of very promising things going on. But by no means have we secured their establishment throughout our healthcare system, and by no means do we

have the policies in the environment in place and the leadership development in place to support that happening quickly or reliably.

We took away a number of ideas from today. I'm not going to try to summarize them all here, but I did want to mention a few points that we will be following up on as part of this initiative.

First, all of the stress or many of the stress are the importance of sharing experiences more effectively across these different kinds of settings and these different starting points for effective reform. And they are quite different starting points. As many of you pointed out, what needs to happen next or what seems to be most promising in small practices or in rural areas may be quite different from what's most promising in urban areas or for larger integrated groups.

Fortunately, there's some strong foundations to build of for this shared learning. Barbara mentioned an effort that she's already started with a number of smaller cancer practices from around the county, sharing experiences, sharing data, identifying some best practices and promising ways forward.

Jack has been working with Cap, which is doing some similar kinds of activities around leadership and around, Cary, for larger integrated groups. We've been doing some work already with ACO implementation, our ACO learning network with Dartmouth. But clearly

there's some gaps and clearly there's some opportunities to build on these existing efforts, and we will be following up on that.

The second area that came up often is the need for data and meaningful measures, actionable measures based on the data. So this is something that many of you felt is very important for clinician support of reform efforts, and it's something where the possibilities are there for improving data flow.

As you heard Rich Baron talk about the new opportunities for getting data from CMS as part of their accountable care, bundled payment, medical home and other initiatives, and more opportunities to do so from private payers, as well, they're involved in care, and more opportunities to match that up with increasingly sophisticated electronic systems, registries and the like. You hear about ACC and others talking about those systems. And we had a sort of side conversation about how, you know, if you talk to the payers, they always say, well, if we can just get the data integrated from the clinical systems, it's so much better than what we have, or the people in the clinical systems say, oh, we just get the data from the payer, they're so much better, more complete than what we have.

Clearly, there's some opportunities to put those two together, to identify some best ways of doing it so it's not such a big administrative burden, something many of you stressed.

You know, there's no sort of automatic CPT coding system, an automatic way of making these data flows happen smoothly, and that needs to change. And I think there's some good ideas from today and our related activities on data infrastructure that can help make that change.

Related to that are better methods for using these data to construct meaningful measure that can help drive the intended improvements in care and support the leadership that we want, and along with that, better capacity for evaluation, an extremely challenging set of issues, but one which is going to be essential for these efforts to succeed.

A third area that we emphasized more in the morning than in the afternoon I think that's underlying a lot of this is that as part of this initiative, we are going to continue doing some serious work on payment reform in the Medicare program. The CSR system is clearly not sustainable. You heard from the members of Congress who were here this that they expect something to happen to change it, at least in the short term. If there had been hope that with this round of the SCR debate, that we would get out of the vicious cycle of just trying to boost up the payment rates a bit every year or two and not really doing anything to solve or support the underlying changes in care that physician leadership supported by a better payment system could drive.

And you heard from them that they are going to be looking

for either a transition period or some additional opportunities building on the kinds of pilot programs that Rich Baron talked about in Medicare, and what I think that's going to mean is that there will be some other options available in the near future for physicians who are ready to move to something else as part of their efforts in leading care reform, and I think we'll try to make sure that that happens sooner rather than later, and it can work for all the different types of care delivery situations that we've heard about today.

Fourth, a very important theme, important especially for economists like me to remember, is that it's not just about payment. There was a lot of discussion about the need for support for adaptive change in other ways at this critical time. That includes leadership opportunities and skills, but also paying attention to other policy issues. Anti-trust policy came up today, policies around benefit design and reforms that can promote patient engagement, other steps to put patients more at the center of reform, community based efforts, all important there, as well, so we will try to make sure that these other issues fit in, as well.

And then finally we concluded the day, not that we ever really left it, but we concluded the day with a big emphasis on models for supporting the development of the kinds of clinical leadership that we need to meet all these challenges, to make sure that this is an inflection

point upward, and to drive effective change in our healthcare system as quickly as possible.

Many of you emphasize the importance of leadership processes here, sharing and developing a common context, notions like fair processes, as well as new steps for meaningful involvement or practicing providers, sort of turning the leadership, the nature of leadership around a bit, as Jeff said, and much more involvement of patients or consumers in effective ways, too.

There will be some further work that you'll see from us on all of these issues and others. Coming up soon are going to be some more interactions between us and many of the physician and nursing, other health professional leadership organizations on this effort, as well as more upcoming events and materials available from this conference, too. There will be some lab resources available. And I hope you'll also keep an eye out for further announcements from us about our future activities as part of this new Merkin Initiative on clinical leadership.

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I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

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