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Healthcare Delivery System Reform 12-13-2010

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WASHINGTON STATE HOSPITAL ASSOCIATION

CMS LISTENING SESSION:

HEALTHCARE DELIVERY SYSTEM REFORM

MEETING

December 13, 2010

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BE IT REMEMBERED THAT, pursuant to the Washington Rules of Civil Procedure, the CMS Listening Session was taken before Carmen L. Lundy, #2287, a Certified Court Reporter, and a Notary Public for the State of Washington, on December 13, 2010, commencing at the hour of 12:09 p.m., the proceedings being reported at 17620 International Boulevard, SeaTac, Washington.

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A P P E A R A N C E S

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3 JOHN HAMMARLAND, M.D.

4 SUSAN JOHNSON

5 DON BERWICK, M.D.

6 RICHARD GILFILLAN, M.D.

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1 CMS LISTENING SESSION MEETING

2 Monday, December 13, 2010

3 12:09 p.m.

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5 DR. HAMMARLAND: Well, good afternoon, all of you.

6 Welcome. Welcome.

7 This is a great opportunity for us today.

8 This is an important listening session on healthcare system
9 delivery reform sponsored by my agency, the Centers for
10 Medicare and Medicaid Services, or CMS, and the United States
11 Department of Health & Human Services. My name is John
12 Hammarland and I am the Regional Administrator for CMS based
13 here in Seattle.

14 We are incredibly excited to have CMS
15 administrator, Dr. Donald Berwick, with us today. We're
16 equally pleased that Don is joined by Dr. Richard Gilfillan,
17 who is the Acting Director of CMS's exciting new Center for
18 Medicare and Medicaid Innovations.

19 Before I introduce Don and Rick and tell you
20 a little bit about the purpose and the mechanics of today's
21 listening session, it's my pleasure to introduce my cohost,
22 Susan Johnson, the Regional Director of HHS who will provide
23 us with some opening remarks.

24 Susan Johnson was appointed in 2009 by
25 President Obama as the Regional Director of HHS, Region 10,

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1 serving Alaska, Idaho, Washington, and Oregon.

2 In this role, she serves as Secretary for
3 HHS's primary representative and key liaison to
4 constituencies in the region working with federal, state,
5 local, and tribal officials on a wide range of health and
6 social service issues.

7 For twelve years, she was the Regional Health
8 Administrator and Director of the King County Health Action
9 Plan. And I think quite a few of you in this room had
10 occasion to work with Susan during that time.

11 Before that, Susan was a member of the
12 Washington State Healthcare Policy Board. And, prior to
13 that, she was the State Governmental Relations Director for
14 the Service Employees International Union -- then, the
15 largest healthcare union in the AFL CIO.

16 My favorite part of Susan's bio is that she
17 loves the outdoors. And she's especially fond of one of my
18 favorite pastimes, fly fishing. Please welcome Susan
19 Johnson.

20 (Applause, applause.)

21 MS. JOHNSON: Anybody else here who likes fly
22 fishing? Yes. Well, we'll meet later over there.

23 Thank you very much, John, for the pleasure
24 of working with you this past year, and I welcome you all
25 today to this wonderful opportunity to share big thoughts and

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1 dreams in this room with harsh realities that I know we're
2 all facing.

3 Before I say a couple of other things, I want
4 to acknowledge that I believe we're joined today by some
5 representatives of Senator Patty Murray's office,
6 Senator Richard's office, also Congressman McDermott and
7 Congressman Inslee. And, if anyone else is here, please give
8 me a wave and we'll ask you to also introduce yourself.

9 UNIDENTIFIED WOMAN: --inaudible--

10 MS. JOHNSON: Thank you very much, Barbara.

11 We welcome you all to this opportunity to
12 hear both from our panelists, from Dr. Berwick and
13 Dr. Gilfillan, about the innovation center and also, for them
14 to hear from you about the best use that you all want to make
15 of this wonderful portal from here to our future.

16 It seems to me that within this region we
17 have no shortage of innovators; for two decades now at least
18 Washington and Oregon and other entities in the region have
19 led the way on transforming healthcare as we knew it to what
20 we know it and, still to go, what we want it to be. The
21 harsh realities now of state budget cuts and your own
22 difficulties getting from here to the future make this even
23 harder. And it seems that the transformation of what we're
24 doing is not just a luxury now but truly a necessity. So I
25 know that we have the triple A leading in our minds and our

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1 hearts, and we have the harsh realities certainly in
2 Washington of a special session just yesterday in the
3 forefront of our realities.

4 So, with that, I know that we will have a
5 great exchange today to hear from you, to share with you, and
6 to hear from our guests about the innovative center that will
7 be soon a reality for all of us to use. So, with that, thank
8 you very much for joining us and I look forward to the
9 discussion.

10 (Applause, applause.)

11 DR. HAMMARLAND: Thank you very much, Susan. And
12 thank you for your leadership at HHS here in this region.

13 All right. Now I am going to introduce you
14 to all of you.

15 You are quite a formidable representation of
16 healthcare in our region; consumers, clinicians, hospitals,
17 health systems, insurers and payers, government officials,
18 tribes and tribal leaders, social service agencies,
19 employers, academics, advocates, and thought leaders all; you
20 are the people that we need to hear from and engage with
21 today and moving forward.

22 All of us want the highest quality healthcare
23 system possible, and the Affordable Care Act allows the
24 public and private sectors to work together in new ways to
25 get closer to our goal.

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1 The purpose of today's listening session is
2 to hear from you on how CMS can best work with you to
3 undertake the important work of reforming the nation's
4 healthcare delivery system.

5 We're going to spotlight three areas of
6 interest that represent opportunities under the Affordable
7 Care Act:

8 One, the Accountable Care Organization,
9 Shared Savings Program.

10 Two, the CMS Innovation Center.

11 And, three, the Federal Coordinated
12 Healthcare Office.

13 Don and Rick will be sharing information
14 about these three areas and our priorities at CMS. They'll
15 be setting the table for you. And, then, we go in the
16 listening mode. And that's what these standup microphones
17 are for. We want you to give us your ideas, share thoughts
18 with us and with this collective.

19 We want to learn from you. We want this
20 entire community in this room and the communities and
21 organizations and constituencies you represent to be
22 energized by the conversation today and to help us with next
23 steps tomorrow.

24 It now gives me great pleasure to welcome to
25 Seattle and to introduce Dr. Donald Berwick, the

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1 Administrator of CMS. If our goal is to build a healthcare
2 system that keeps patients healthier and realizes its full
3 potential, there's no one who has more experience or is more
4 respected in the field than Don. In June, President Obama
5 named Dr. Berwick the Administrator for CMS. And, in this
6 role, Don oversees the Medicare, Medicaid, and the chip
7 programs. Taken all together, those programs provide
8 healthcare coverage to over a hundred million people, nearly
9 one in three Americans.

10 Before assuming leadership at CMS,
11 Dr. Berwick was President and Chief Executive Officer at the
12 Institute of Healthcare Improvement; clinical professor of
13 pediatrics and healthcare policy for Harvard Medical School,
14 and; professor of health policy and management at the Harvard
15 School of Public Health. He's also a pediatrician and has
16 served as adjunct staff for the Department of Medicine at
17 Boston's Childrens Hospital, and a consultant in pediatrics
18 at Massachusetts General Hospital.

19 It's really nice to have him at CMS. Please
20 welcome Don Berwick.

21 (Applause, applause.)

22 DR. DONALD BERWICK: Thank you so much, John and
23 Susan, and thank you for your leadership out in this
24 remarkable part of our country. It's really a pleasure to
25 get to be here again and, so many friends, I feel like I've

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1 actually arrived home instead of gone on a trip.

2 Rick and I are not here to speak very much;
3 we're here to listen. This is a chance to learn from you
4 about how you guide us in pursuing some of the initiatives
5 that now are in our hands, to try to achieve for the country
6 what we can around healthcare.

7 I'll just make a few introductory
8 stage-setting comments and then Rick will dig in a little
9 deeper on some of the things -- some of the questions we'd
10 like to ask you, but anything is fair game today.

11 The Affordable Care Act is the context for
12 our visit with you. It's the most significant piece of
13 healthcare legislation surely in our country for decades. A
14 very exciting piece of legislation. It has in it a primary
15 focus on extending coverage to people who otherwise would be
16 frightened they would lose it, and; giving benefits to people
17 who badly need those benefits like prevention, coverage for
18 medicine, for instance. And I won't delve into those
19 remarkable advances for our country in making care available
20 to people who would be frightened...

21 It is a fact, though, that whether or not we
22 did that piece of work to expand coverage, we would still
23 have in our hands a significant problem, which is that at the
24 moment the way the healthcare system is performing, we can't
25 sustain it in this current form; certainly not with this

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1 level of expanded coverage and certainly not with the kinds
2 of stress that both the federal and state governments and
3 private payers and employers -- we all, out-of-pocket, are
4 experiencing as costs rise out of our reach.

5 As I've gotten in the saddle at CMS, I
6 proposed there that we embrace the three aims that I've
7 referred to often in my prior life and still do now. And
8 those are the -- my attempt to define social need; that
9 anyone that cares about healthcare today should be rallying
10 for it in order to create the kind of care we want and need
11 for ourselves and for our children.

12 Those three goals are these:

13 Better care for individuals so that people in
14 care are getting the care they want -- at least all of the
15 care they want and need, exactly when and how they want and
16 need as defined by the Institute of Medicine back in its 2001
17 report across an equality category that would state care
18 that's effective that gives you exactly the care that will
19 help you, reliably; care that's patient-centered so the
20 patient is in the driver's seat; care that is timely so that
21 unwanted delay is engineered out of care; efficient so we can
22 reduce waste. Wasted time and ideas and resources that we
23 have bad -- we have a strong need for elsewhere, and; equity
24 so that we can close racial and socioeconomic disparities in
25 healthcare, and safe effective patient-centered timely

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1 efficient equitable care.

2 That's aim one, better care.

3 The second goal has to do with why we needed
4 care in the first place. And, as anyone who has studied it
5 even a little bit knows, most of the causes of the illnesses
6 we suffer from do not lie within healthcare's reach. Only
7 about 10 percent of the variation in health statuses is
8 purely healthcare; the rest is due to other things -- the
9 genetics, to some extent. They're also environmental, table
10 choices. The factors in society that give us the illnesses.
11 And those can be controlled but only if we invest in better
12 health, not just better healthcare.

13 So the second aim is better health.

14 The third goal is lower cost. Lower costs
15 through improvement, not by harming a hair on anyone's head
16 but lower costs by improving what we do. And it's the same
17 healthcare as any other sector of a society; doing things
18 right in general costs less than doing things wrong. So much
19 of our fragmented broken healthcare system today, not only
20 does it handle for the first two rules, health and
healthcare, but it also adds costs we don't need to pay.

22 So that brief part from me -- better care,
23 better health and lower cost for improvement -- informs all
24 of the strategies that my wonderful team at CMS and I are
25 tackling now as we try to get -- use the Affordable Care Act

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1 as a trampoline into the healthcare system that we want and
2 need.

3 We're not going to try to do this alone; we
4 can't do it alone. It has to be done in absolute full
5 partnership in the private sector, in all the states, and of
6 course with patients, and communities. Rick and I and our
7 colleagues are absolutely committed to CMS being a
8 trustworthy partner and a force to the continual improvement
9 of health and healthcare for all Americans. But that
10 partnership is key. And that's what brings Rick and me
11 across the country to meet with you today. We want to
12 partner. We want to understand what's on your minds, what
13 you need, and what ideas you have for us, and the context of
14 the opportunities that our country now has to get this right.

15 Healthcare reform -- delivery system reform,
16 which is the topic we're tackling here is at the heart of the
17 issue. If current systems aren't sustainable in the form
18 it's in, not with the expansion of coverage we saw, and
19 probably not even before that, then what is?

20 I'm always reminded of a story that I told
21 for many years, and probably half of you in the room have
22 heard this, but if you will kindly pretend you didn't, that
23 would be polite of you.

24 The story is about my now 24-year-old?
25 23-year-old? Approximately 24-year-old daughter, Becca.

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1 Don't tell her -- don't let that out of the room. I think
2 it's 24. Yeah. Becca -- we -- my wife lived out here in
3 Seattle for a few years and this had become our second city,
4 so we often were out here hiking. It became a real passion
5 for us. We were hiking a long trail one day with Becca, age
6 5. It was a 16-mile hike, frankly, and much too abusive to
7 be right. So she was slow and she wasn't making it back in
8 time to the car. So I, as a good father, I was yelling at
9 her. So I yelled, she cried. And I yelled and she cried.
10 And I yelled and she vomited.

11 So, Becca was moving along. It's getting
12 dark. Finally, she stopped on the trail -- true story --
13 this five-year-old girl turns around, looks me in the eye,
14 puts her hands on her hips and says: Daddy, telling me to
15 walk faster does not make me able to walk faster.

16 That became always the watch word for me in
17 my prior work. She was an expert; she knew that all
18 improvements -- you don't get improvement by exhorting an
19 existing system to do better. Now at whatever age she is,
20 she outpaces me.

21 So, improvement and change are linked to each
22 other. So when we talk about delivery system reform, we are
23 talking about change. We're discussing a question, which is:
24 What new form of healthcare delivery? Not the current one
25 cloaked. Not the current one exhorted or stressed or yelled

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1 at. Not the current one stabilized. But, a new one. What
2 other form of healthcare can we construct that's capable of
3 delivering the healthcare we want and need for ourselves and
4 our neighbors and our posterity?

5 That's the journey we're on. I won't call it
6 an expedition, national expedition, to find the care we
7 really want to give -- and working -- because this isn't
8 doing anything to anybody else. It's about doing for
9 ourselves what we ought to be doing for ourselves, including
10 those of us who want nothing more than to be able to deliver
11 exactly the care people want and need exactly when they want
12 it.

13 A lot of the innovation already exists. We
14 are seeing all over the country inspiring examples of
15 progress, many here in the Northwest, which show us a glimmer
16 of that new care, the care that will do the job correctly.

17 Now, the Affordable Care Act resources, we
18 have a kind of almost visionary investment in a series of
19 assets paired with the expansion of access and coverage to
20 care that's at the heart of the affordable care. Paired with
21 that is a support to a search process and the inventive
22 process. And it takes several forms. There are three we'd
23 like to talk with you about today, but any can be in play,
24 but:

25 The first is the concept of the Accountable

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1 Care Organization. That's a new term on the landscape the
2 past few years. Scholars have brought us that idea but it
3 now is getting traction. It's written in the law and it's in
4 the process of definition. We are currently writing the
5 Notice of Proposed Rulemaking that will be out in January.
6 Rick and I are involved as we try to shape the concept of the
7 report -- Accountable Care Organization -- into something
8 that you get your hands on. In fact, it's pluralistic; it
9 has enough different forms that it can work in many of the
10 environments around the country.

11 An Accountable Care Organization will help
12 ensure patients that they get the care they want and need
13 exactly when and how they want it -- immediately -- every
14 time, that is affordable.

15 At its heart is a transition from a
16 fragmented system to an integrated one in the context of
17 ordinary Medicare/Medicaid services; shared savings and other
18 supports to groups of care providers that want to come
19 together and take responsibility for attributing populations
20 of patients. They can do better for those people.

21 But that's one form of innovation with
22 Accountable Care Organization. Now, the -- those who are
23 performing will appear in January and you'll get a chance to
24 comment on it. But we're here to listen now because we can
25 take back ideas that you give us and map it into the plan

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1 that crosses to that first -- ambitious ideas.

2 Second, is the Federal Coordinated Care
3 Office. It was targeted by Congress to give us a resource to
4 really crack the nut around the care of not going to name
5 people dual eligibles, the neediest patients we have. These
6 are people who are often in conditions of both social and
7 physical need that make them extremely vulnerable. We have
8 to get their backs. They qualify for both Medicare and
9 Medicaid. They explain 40 percent of the state's Medicare
10 budgets in this country. And we don't do well right now.

11 Their care is fragmented beyond what they
12 really can deal with. They carry three identification cards;
13 there are different funding sources at play; different kinds
14 of benefit structure. But we're trying to rationalize that
15 care as a Coordinated Care Office headed by Melanie Vellot.

16 And the third, which Rick Gilfillan, my
17 colleague -- the CMS, Center for Medicare and Medicaid
18 Innovation. It's a big fat 10 billion dollars reserved by
19 Congress over the next ten years to invest and support, to
20 discovery and the spread of news, to be able to support very
21 old innovation on individual care, on integrated care, on
22 prevention beyond anything our country has actually invested
23 in before.

24 Rick is going to describe to you a little
25 more about these three resources, these three exciting

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1 components of the new law. But what we want your help with
2 today is to understand how we can help you help us shape that
3 agenda and other elements of the new context into something
4 that will really help you create that new healthcare system
5 that we so badly, badly need.

6 With that said, let me introduce Rick
7 Gilfillan, my colleague and Director for the Center for
8 Medicare and Medicaid Innovation. Rick is a long-standing
9 colleague of mine. He is an experienced healthcare
10 executive, worked at Geisinger System, and also is a
11 physician, skilled and committed. And I know that from
12 working with him directly. And I'm very proud to have Rick
13 as a colleague and introduce the plan for the today.

14 (Applause, applause.)

15 DR. RICHARD GILFILLAN: Thanks, Don. It's a
16 pleasure to be here, and it's an honor and appropriate to be
17 working in administration, and not to be forgotten. So
18 thanks very much for the opportunity to be here.

19 I'm going to step down, if I can. If this
20 works okay so that the slides -- the slides? The former
21 slides. Okay. Excuse me one minute while we deal with a
22 minor technical difficulty. There you go. Okay, I don't
23 need to be down here to see the slides because there's no
24 slides to see.

25 As Don pointed out, we're going to be talking

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1 about three, those three central topics and we're going to
2 start with the innovation centers, (unintelligible) federally
3 qualified for the Office of Coordinated Healthcare, talk
4 about dual eligible population.

5 We do want to learn a lot today. One of the
6 things I'd like to learn about is how we should have this
7 conversation nationally. Because, as Don pointed out, we're
8 interested in talking about improving health, improving care,
9 and reducing costs. And that, as we all know, that
10 reducing-costs conversation has been a difficult one and is
11 one kind of loaded with a lot of potential concerns in the
12 country.

13 So there's a lot of ways to think about and
14 talk about delivery system reform but my wife said, bring the
15 patient's voice into the room and start with the patient's
16 voice in the room. And so this is Marie; she's from a small
17 town in a rural state on the East Coast. And she's pictured
18 here with her dedicated case manager who works in the medical
19 home primary care practice that she has cared for. And Marie
20 has the usual constellation of chronic medical problems,
21 among them, chronic obstructive pulmonary disease and, hence,
22 the need for oxygen that you see here.

23 And Marie spent a lot of time going to the
24 emergency room and going to the hospital in prior years
25 before she was able to connect with a dedicated case manager

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1 pictured here. And that nurse has a hotline next to her desk
2 that's dedicated. Marie has that phone number; Marie's
3 family has that phone number. And when Marie has a problem,
4 she calls that number and talks to that nurse.

5 And, Marie says, the idea of the program is
6 to keep me healthy, keep me out of the hospital and keep
7 costs down; I don't think I would still be here without this
8 program; it has been my lifeline.

9 That's what delivery system reform is about.
10 It's about getting us to a position where we can make these
11 resources available to the people who need them. And take
12 ourselves from that fragmented system we've talked about to a
13 safe, seamless coordinated care system where we know we can
14 do the best thing for Marie and other folks.

15 And I wonder about -- and I'd like your input
16 on -- gee, if we had a national conversation talking about
17 Marie and talking about her family members who can also call
18 the nurse and know that even if you're in Florida that
19 someone is available to take care of them on the phone.

20 So, Question No. 1: How should we have this
21 conversation with the useful way of framing them? And I love
22 to see stories -- I know there are many of you in this room
23 who have stories that are similar to this that we could use
24 every time we have a conversation to begin and then with a
25 story about what a reformed process means for an individual

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1 patient. This is the CMS condition that Don mentioned; a
2 constructive force and trustworthy partner for continual
3 improvement of health and healthcare for all Americans.

4 From that fragment, a care system to the safe
5 seamless system we talked about; how do we measure success?
6 It's real clear. And we think about innovation, success is
7 defined as better health, better care, lower cost. And if
8 people say, well, how should we think about programs? You
9 want to think about what you might want to fund in the
10 innovation center. We say, think about a patient, think
11 about Marie, think about patients like that. Think about
12 those patients' needs.

13 Think about why those needs aren't being met
14 today; think about early interventions that can change and
15 address those needs and change their lives; think about the
16 measures of success across these three dimensions that that
17 intervention will provide, and; think about the population --
18 total population of people -- that are effected and that
19 these needs can be better met and packaged as a program. And
20 tell us about why we should join you as partner and a
21 supporter, if you will, or your efforts to make that -- those
22 differences in patients' lives.

23 That's the way we will think about being a
24 center of innovation. It's about innovating around
25 delivering these outcomes, working with providers and the

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1 delivery system in pursuit of those aims and, supporting you,
2 not in delivering fragmented care; not delivering IPPS and
3 OPS, not with RBI but with systems that support you as you
4 deliver that safe seamless experience with patients.

5 The legislation, that's the purpose of the
6 center to test innovative payment and service delivery model
7 to reduce program expenditures while preserving or enhancing
8 the quality of care first. Pretty explicit. The Congress
9 expects us to help work with you all to bend the cost.

10 That's our No. 1 mission. We know we can do that; we believe
11 we can do that while improving care.

12 So one formulation is to provide better care
13 and lower costs. That's the home run; that's what we're
14 after. We know some initiatives may provide the same quality
15 but for a reduced cost. And we want to do that, too. That's
16 good.

17 We also know that occasionally we'll find
18 something where quality and outcomes and health and the care
19 are improved significantly. And maybe the story isn't as
20 strong as we'd like it to be; maybe we can't speak to it
21 exactly. We do know this: We can't live there; we can't
22 live in that space of much improved quality at the same cost.
23 And we know we can't live there if it's more cost. So we
24 need to think very concretely and specifically about cost and
25 quality together.

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1 Ten billion dollars in funding. It gives us
2 a clear path in many ways to do these new models of care.
3 And at the end of it -- and this is critical -- at the end of
4 our work looking at models, if we find that a model of care
5 does indeed improve quality, improve -- lower costs, we can
6 go to the Secretary and say, this is the way Medicare should
7 pay now. This is not the old fragmented way of paying. We
8 want to pay maybe a primary care practice, end up with per
9 member per funds so that they can have a nurse in the office
10 providing that kind of service.

11 So this is a very potent matter that did not
12 exist before; it's the ability to change fundamentally the
13 way CMS supports the delivery system without having to return
14 to Congress.

15 Our mission then is to be a trustworthy
16 partner with you to identify value and diffuse new models of
17 care plan that meet those triple A outcomes.

18 We're going to focus this on three levels,
19 we'd like to understand opportunities at the level of the
20 patient care model. How can we deliver the best OB care?
21 The best cabbage (CABG), for instance?

22 The second level, how we -- what are the best
23 models for delivery and coordinating care across different
24 locations? So, ACO's, medical homes. Other innovations in
25 that realm of coordinated care models.

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1 And, finally, how can we work with that
2 community population well? Probably, doubling down on some
3 of these other efforts or working with other community
4 providers. Because there are lots of people working in that
5 space. And we want to find ways to use our unique
6 capabilities to make other programs more effective in that
7 space.

8 These are the functional activities at the
9 center that we're thinking about right now. Key pieces. We
10 need diffusion and learning systems. And we will introduce
11 and work with you all to develop learning systems
12 capabilities that are far beyond what people have done in the
13 past. And we're thinking very actively about this now and
14 interested in your thoughts about how we might do that.

15 We're going to have parts of our organization
16 focused at these three levels. We're going to be actively
17 managing an intervention cycle. And, we want to work with
18 you to find new ways to develop a national innovation
19 infrastructure, support for innovators throughout the country
20 who are interested in not the latest medical technology or
21 not necessarily the latest drug, but how do we put all the
22 pieces together and innovate to deliver the outcomes that we
23 have talked about.

24 And the final piece of this, and I heard some
25 interesting stuff today about health group actually, how do

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1 we rapidly evaluate it? Because if you think about the work
2 we're doing, we want to find out as quickly as we can what
3 works better, confirm it, change the way we pay, and support
4 you in new ways to diffuse that. And, to do that, we need to
5 be able to evaluate these models very quickly. So rapid
6 cycle evaluation would be a key piece of what we do.

7 We just now opened our doors; we're about
8 three weeks old in terms of federal register notice. We're
9 working on a strategic operating plan now. We're out there
10 trying to capture new ideas about innovation priorities, how
11 we should operate. We want to hear from you on that today.

12 We have a website where you can learn a
13 little about what we're doing so far: Innovations.cms.gov.
14 But we're, most importantly, beginning our work -- we felt it
15 was important to get out there and start working with you all
16 in the delivery system around a variety of delivery systems.
17 These are the first four that CMS introduced a couple weeks
18 ago.

19 One: Multicare dealing with primary care
20 practice model and a PCP initiative. We're joining state-
21 based preexisting initiatives that are multiple care. This
22 niche will be to the creation of approximately 1,200 medical
23 homes nationally, or support the existence of 1,200 I should
24 say. And, we think, provide the kind of care systems we
25 sought for Marie for about a million Medicare beneficiaries.

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1 We also have Medicaid health home state plan
2 option where the federal government will match 90 percent of
3 funds sent by states on developing Medicaid-help homes.

4 We also announced an initiative to start
5 building medical homes in about 500 qualified health centers.
6 And we announced care models, the intent to develop with
7 states' care models that would address the dual eligible
8 population -- those eligible for both Medicare and Medicaid.
9 We'll be awarding contracts to a number of states as the
10 first phase to solicit from them their proposals for how they
11 would go about better managing the care for those folks.

12 As Don said, this is a partnership. We know
13 this. We know healthcare is local. We know providers need a
14 relatively simplified set of outcomes to be pursuing. And we
15 intend to work with you all to develop in a consistent
16 coordinated way a common approach in local markets so that
17 all patients can benefit.

18 Let me move on to the -- briefly -- on the
19 ACO Tiered-Savinas Program. It's Section 30-22 in the
20 statute. We are currently making, as Don mentioned, we --
21 this program will go live January 2012. We want to
22 emphasize, and you'll see this in the proposed rule, that
23 ACO's are not first and primarily a financing vehicle; they
24 are a new care model to deliver the kind of experienced care
25 we've talked about.

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1 There will be multiple types of providers who
2 will be in a position to play. Being patient-centered, we're
3 interested in ideas you may have about how we can develop
4 what criteria should be for you to meet the notion that was
5 in the bill that these ACO's needed to meet patient-centered
6 criterion. They also need to be a quality where you -- your
7 ideas talk back. We expect them to be very -- very data
8 rich. And we understand the need. And we'd like to hear
9 from you all about the need for data for this to be
10 successful in the sector.

11 And we expect these to be continuously
12 learning organizations. And, we expect to be facilitating
13 that learning in major ways as we get into the new year.

14 Finally, on the dual eligibles, as Don said,
15 almost 10 million individuals accounting for 40 percent of
16 Medicaid; almost 40 percent of all CMS spending is in this
17 population. Yet, they are cared for in ways that are
18 remarkably uncoordinated, unintegrated. Nonsensical would
19 probably be the most appropriate way to describe it. Because
20 there are dramatically different incentives operating for the
21 state and the federal government, leads to worst care for
22 patients, poor outcomes and more expense. It's a great
23 opportunity and we're interested in your ideas on this.

24 It's Section 2602 of the act. The purpose is
25 to improve quality, reduce costs and improve the beneficiary

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1 experience. And it's about defining new ways to coordinate
2 across state governments and the federal government, provide
3 entities, state governments, and; also, it's an opportunity
4 to do something at the beneficiary level to provide new
5 support mechanisms for beneficiaries to help them be more
6 responsible and be able to integrate the care better
7 themselves.

8 Melanie Vellot is the director of this
9 office. And Melanie is a former state Medicaid director.
10 She's a wonderfully, enthusiastic, knowledgeable, bright
11 person who is just totally focused on making the lives of
12 these patients better. She divvied up her department into
13 two areas; one, program alignment. That is, to find ways to
14 align the state and federal pieces of the program, and; two,
15 she's made great progress on getting a data center available
16 that actually gives a picture of this population that is not
17 readily available today. So she's worked hard to do that.
18 She's got about ten people now that are working in these two
19 areas of her organization.

20 We've established a number of coordinating
21 within HHS to get this done. We've reached out to
22 Medipac/Macpac to kind of begin the process of thinking this
23 through the national level, and is very interested in getting
24 any input from different states. And, I would say, we've
25 already had significant interest and input from the State of

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1 Washington. And maybe they'll be some of that referenced
2 today in the conversation.

3 So from Melanie -- questions, suggestions can
4 go directly to this website for the innovation center. The
5 website is innovations.cms.gov.

6 And, with that, I'd like to take one more
7 look at Marie and remind us it's about patients, and move on
8 to discussion. Thank you very much.

9 (Applause, applause.)

10 DR. HAMMARLAND: Thank you very much, Rick, and
11 thank you, Don.

12 All right, folks, as promised, we are now
13 going to go into the listening mode. We want you to utilize
14 the microphones that we have now in the center of the room.
15 And, if you can, we'd appreciate it if you could limit your
16 remarks to a few minutes because we want to be sure that we
17 can hear from everyone who wishes to contribute. And also,
18 when you come to the microphone, please let us know your name
19 and identify your affiliation -- a few more minutes, but it
20 won't take long.

21 MR. FLETCHER: Good afternoon -- (Pause due to A/V
22 technicality). We're technologically challenged in the state
23 of Washington.

24 I'm John Fletcher from Providence Health
25 Services. We have an incredibly successful program for dual

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1 eligibles, the Pace Program. And I'm kind of wondering if
2 anyone from CMS has envisioned how you might extrapolate the
3 success of the care for those with chronic conditions to the
4 broader population. And that works under a capitating model,
5 fortunately, but maybe unfortunately from a marketing
6 standpoint. But I'd just appreciate your thoughts on that.
7 Because it really is something Providence has been doing for
8 over a decade and has really served the elderly very, very
9 well.

10 DR. DONALD BERWICK: I can start the --- I can say
11 that the Pace Program is immensely interesting. I've visited
12 several Pace sites now. Melanie knows it well. We're using
13 it as a template for a lot of the work -- the dual eligibles.
14 The problem with Pace is making it scaleable. It's rooted in
15 geriatric expertise and there are a number of other features
16 that make it hard to replicate. But we're dedicated to
17 learning from that model. It's a tremendous success. In
18 fact, Rick, you're visiting on-lock, aren't you, when you --

19 DR. RICHARD GILFILLAN: I think later. Yes.

20 DR. DONALD BERWICK: -- in San Francisco.

21 DR. RICHARD GILFILLAN: And I think it's -- it
22 is -- there's some other programs we've seen that, again,
23 address very complicated populations where there are people
24 interested in what would be a capitated model for distinct
25 populations.

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1 So I think it's a -- we're going to learn a
2 lot from what was done at Pace and we're also the kind of a
3 -- the notion of somewhat niche populations that have great
4 opportunity to do a better job is going to be, probably, an
5 area of interest for us in the center.

6 MR. JOHNSON: David Johnson from Novus Behavioral
7 Healthcare Organization.

8 You know that one of your most expensive
9 populations in this area are people with serious and
10 persistent mental illnesses. And CMS has a history before
11 its late incarnation of doing all sorts of things to strangle
12 and discourage good things happening. And, particularly,
13 with people with mental illnesses. Historically, the
14 approach, the medical model approach, the pathology-based
15 approach to serving people with serious and persistent mental
16 illnesses gets it about a quarter right. There are things
17 that we can do with medications that make the difference.

18 But we have found that some of the most
19 healing things that we can do, and there are things that make
20 people healthiest and most independent, has to do with the
21 supports we bring forth; safe pieces of affordable housing or
22 helping people get jobs and keep jobs, or dealing effectively
23 with a crisis system that efficiently involuntarily commits
24 and then brings people back into better places to be.

25 We have all sorts of evidence-based best

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1 practices and emerging practices that have been very
2 effective that, because of adherence to coding and a focus on
3 fee-for-service and not paying enough attention to what since
4 has been discovered and have made us not as effective as we
5 can.

6 So, my hope is that when -- as you would roll
7 out what you're doing, and we're very much excited about the
8 integration of primary healthcare model organization partners
9 with neighborhood health and very pleased what we're able to
10 do with them on our campus and having us on their campus,
11 but; as we look to Accountable Care Organization(s), I hope
12 that we're able to structure what will allow for
13 organizations that do housing and employment supports and the
14 incredible healing work that happens through peer support
15 specialists in working with people in mental illness where
16 all of that in tandem with primary healthcare educations and
17 so on.

18 If integration simply ends up being that
19 there are social workers and psychologists at the primary
20 healthcare clinic, you're not going to get that network of
21 vocation, housing, peer support services, psycho education
22 and so on. And that's so important.

23 So I'm hoping you'll keep that in mind.

24 MR. MOORE: Hi. Gordon Moore from Ideal Medical
25 Practice. It's a nonprofit working with small private-firm

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1 industry.

2 There's a lot of evidence that supports that
3 the foundation of a high-performing health stands on
4 effective primary care. And, primary care, if you look at
5 the 1978 WHO definition, it's based on simple rules; be the
6 first point of access for care, provide for relationships at
7 the time, provide comprehensive services and care
8 coordination.

9 Please note, these simple rules can be easily
10 measured from the aggregate series of care from need.

11 Patients can very easily and very accurately identify whether
12 or not a practice has these attributes, and, in what degree.

13 I've been working with solo and small
14 practices and lots of others from around the country. And
15 I'm frustrated by a systematic bias against small practices
16 in the United States. We're shutting out 78 percent of the
17 practices in the U.S. that are five positions or smaller. A
18 lot of these medical demonstration projects say that unless
19 you have a significant number of patients in your practice,
20 you can't participate.

21 In Farmington, Maine, Jean Antigen, she's a
22 solo physician, has for three years in a row, zero
23 preventable hospitalizations for her Medicaid population.
24 She stands out in the state but she can't get in the door.
25 That's wrong. We need to solve this problem. There are ways

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1 to measure. There are ways to get granularity of measurement
2 down to the individual position level. But we have to be
3 flexible in how we understand measurement in this attribution
4 of behavior at even small practice level. It is possible.
5 But we have to get out of the mindset that the plethora of
6 metrics is the only way to that end. Those are excellent
7 metrics but they don't have granularity. Preventables don't
8 have granularity.

9 So I'm hoping, especially the center for
10 innovation, you begin to think about different measurement
11 modes and think about actively recruiting and engaging small
12 practice representatives so that you can hear that voice. We
13 cannot afford to shut them out. And I don't think you want
14 to just see them all consumed by large systems, because not
15 all large systems treat them well if we look back into the
16 experience of the 1990s.

17 UNIDENTIFIED SPEAKER: Tom --

18 DR. RICHARD GILFILLAN: Could I just -- you know,
19 we are very conscious of the -- you know, kind of a
20 distribution of care and where it's given. And we're not
21 looking to reinforce biases. So, if there are specific ideas
22 you have at some point about how programs, you know, we
23 should be instituting or metrics that you think would be
24 helpful and would give us a reasonable belief about what's
25 actually -- or insights into what's happening as practiced,

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1 we certainly would be open to receiving the information. And
2 we have had a pretty open-door policy in terms of talking to
3 people. So if there's an organization that you'd like to
4 have us talk with at some point, we'd be happy to do that.

5 MR. MOORE: What's the mode of communication for
6 that?

7 DR. RICHARD GILFILLAN: The website,
8 innovations.cms.gov. And you can try Richard.Gilfillan@
9 cms.hhs.gov as well.

10 MR. SAIGER: I'm Tom Saiger, Medical Director for
11 the University of Washington Medical Center. My comments are
12 a little bit along the same lines as the prior speaker. What
13 I'd like to suggest is the importance of the role of CMS at
14 the center for innovations in developing metrics and other
15 infrastructure that will help support the alignment of
16 organizations both within the organization and across the
17 communities in meeting a triple A.

18 A number of us in this room were at IHI last
19 week and we heard Rokawanda (phonetic) talk about the state
20 of metrics, you know, in proper quirks, are exceeding the
21 state of metrics in health reports in this country.

22 We know that if turnaround time from
23 measurement from something occurring to a report of
24 measurement being a tremendously long time, and, that any
25 attempts we make to improve are going to be lagged. Any

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1 change, we're going to tell what we did so that both handle
2 robust metrics, that will help us assess the health of our
3 population, the quality of the care that we're providing; the
4 patient experience and cost will be useful to all of us
5 across the country. Metrics that can be -- we share across
6 organizations as well as within the organization to help
7 drive collaboration.

8 And then, finally, just a comment for the
9 number of people that I've heard mention that the Puget Sound
10 and Washington are a unique -- in some ways, a laboratory for
11 working on healthcare reform. We have a lot of people who
12 are used to collaborating and a lot of good leadership in the
13 state. And I think there's as much opportunity here in this
14 area as anywhere to do some innovative work around healthcare
15 reform. So thank you for again for being here.

16 DR. RICHARD GILFILLAN: You know, we should note
17 that I think this -- the topic of metrics for ACO's has been
18 one that we've spent a lot of time on. Almost more than
19 anything else. And we are really interested in finding that
20 next generation. We've talked a lot about functional
21 outcomes that our patients' perceptions of their outcomes as
22 maybe being more -- more important in something that we
23 should be developing further. We're interested in hearing
24 from the industry. And we'd love to see people in the
25 industry come together and propose kind of the next

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1 generation of metrics that really get at outcomes in a way
2 that, up to date, we have not been able to do a very good job
3 with. So we're very interested in hearing from you all on
4 it.

5 MR. WALKER: Good afternoon. My name is Roy
6 Walker and I work for the Olympic Area Agency on Aging. And
7 I represent the thirteen Area Agencies on Aging in Washington
8 state. And I appreciate having been invited to participate
9 in your listening session today.

10 I just am hoping to see the openness of --
11 for the opportunity of working with local partners in the
12 aging network. In Washington state, triple A's have been
13 extremely innovative, particularly, focusing on those
14 high-cost dual eligible claims as we support them in their
15 home. And, I think one of the key things that we can offer
16 all of you, as partners, is realtime information about the
17 consumer's condition in the setting that they're in most of
18 the time, in their home.

19 In Washington state, the Area Agencies on
20 Aging have been very involved in the outcomes -- programs,
21 including a recently piloted chronic care management program
22 for Medicaid high-cost clients and providing supports to them
23 for active engagement and accessing services at the right
24 time and the right quantity.

25 So I'd just like to remind folks that you

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1 have built-in community partners available to you and the
2 triple A's in Washington state. And thank you again for this
3 opportunity.

4 DR. DONALD BERWICK: Right. When you think about
5 partnering at the community level, who are some of the --
6 what are some of the organizations or types of things we
7 should keep in mind but look for partnering opportunities?

8 MR. WALKER: On our side or on your side?

9 DR. DONALD BERWICK: On your side.

10 MR. WALKER: Well, the Area Agencies on Aging have
11 care managers and many of them are nurse care managers. And
12 we're doing home visits to people, and we're helping to
13 manage the community-based long-term care system with help
14 from the pilot Medicaid long-term care system. Dually
15 eligibles -- not only older people but younger adults with
16 disabilities as well. And, as I said, we've been piloting a
17 chronic care management for a number of years here and five
18 triple A's, and I think we're able and ready to continue to
19 partner and develop in these activities. And I'm very
20 proud to -- one of my heroes, Dr. Pearson, from Bellingham.
21 And they're working on care transition models, shared care
22 plans and many other consumer engagement strategies.

23 From my point of view, the biggest untapped
24 resource in our network are consumers themselves. And when
25 we can engage those consumers to understand their healthcare,

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1 how to communicate and coordinate with their healthcare
2 delivery system, I think we'll get those three aims you're
3 looking for.

4 MR. KILO: Thank you. Chuck Kilo, Oregon Health &
5 Science University. Oregon is a small state to the south of
6 here, but we're well represented in the audience. Thank you
7 for having us.

8 One can imagine when Dr. Fisher was initially
9 contemplating the Accountable Care Organization, he was
10 asking himself that very untenable question: How can the
11 United States look more like Sweden where healthcare is
12 actually accountable to its entire community? And they've
13 delivered, as you know, at the county level. And if one
14 thinks about that, the advantages that they have is that they
15 cover everybody; they're accountable to the entire community.
16 And, because of that, because they're distributing resources
17 throughout the county, they could have rational decision
18 making. And we don't have any of those things, including
19 rational decision making.

20 So you can see that perhaps Dr. Fisher was
21 asking himself, how do we create language that would help us
22 get there, and thus comes the Accountable Care Organization.
23 But everything has unintended consequences.

24 And one of the challenges we have now is that
25 instead of us being accountable to the entire community,

1 we're being allowed to find the community that we want to
2 take accountability for, which means that there's going to be
3 a lot of people that nobody wants to take accountability for.

4 So there will be a lot of people for whom
5 nobody really wants, presumably, if you allow us to define
6 who our communities are. And that's going to -- that,
7 indefinitely, would lead to a lot of challenges.

8 So I'm curious about your thoughts about
9 how -- what might we do to make sure that we get everybody
10 into an ACO so it's not just specific to an urban area? The
11 rural areas, it's hard to hide from the population you're
12 supposedly serving. But in urban areas it sort of ends. And
13 so how do we fit into those three principles where we get
14 everybody covered, we're accountable to the entire community,
15 not just to those people that we want to serve? And, then,
16 we have rational decision making when we have, particularly
17 in urban areas, these big health systems, their primary
18 objective is to kill everybody else -- all the other health
19 systems. So that creates a level of dysfunction, and I'm
20 wondering if the ACO is really going to help us get out of
21 that dysfunction. So I'm just curious about your thoughts.

22 DR. RICHARD GILFILLAN: It would be nice to have
23 some people accountable for a significant segment of the
24 population, No. 1. I think we'd all recognize the challenges
25 of difficult populations and the business realities that

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1 exist today. And I think the way we think about it is, it's
2 kind of a dynamic process that will take place as things --
3 as I think the system transitions. It would be great if
4 system leaders said, you know, we're over here and we're
5 going to seamless care; in five years, we'll be there; we'll
6 be doing state, you know, seamless coordinated care and we're
7 ready to get there. The business realities are what they are
8 and that's not -- that transition is not a given, so.

9 But the interesting thing to me is that some
10 of the people have been most progressive, have actually been
11 people -- in coming and talking to us -- have been people
12 from safety net situations. And I say doctors and clinics
13 and hospitals and health systems.

14 So, I think there's -- you know, I think it
15 feels like out there, there's a lot of energy in a lot of
16 places. And it's not like it's -- I mean, a lot of it is
17 coming from that area, at least in urban areas. And I think
18 we need to be -- the important thing for us is to crack
19 opportunities -- different opportunities that different kinds
20 of organizations can place themselves within to get at
21 those -- every population or as many populations as possible.

22 So maybe it's because some people find
23 themselves in those kinds of institutions that are more --
24 more mission driven? We're actually hearing from them more.
25 And so I'm optimistic that if we can -- if they can put

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1 together proposals, we can do some very interesting things to
2 get at accountable care for populations that might, on the
3 surface, might not be the obvious ones. And I hope, along
4 the way, that we find ways to create a sense of dynamist --
5 dynamic kind of attention in the industry so that other
6 institutions that might not find themselves so compelled to
7 go there would find that it might be in their business
8 interest to do it.

9 MS. LAIRD: I'm Sue Laird for Enumclaw -- trustee
10 in the hospital there in the Franciscan system out of Tacoma,
11 and I'm an R.N. who has worked most of my career in public
12 health.

13 Now, I'm really interested in the case
14 management side of this, however, coming from a rural area I
15 look at how are sole providers or small groups going to
16 afford a case manager? Well, I worked in Oklahoma in the
17 '70s, and that's what we did in public health. The local
18 doctor would call and say, I sent Mrs. so-and-so home from
19 the hospital, these are the problems, would you please go out
20 and make sure all is going well?

21 Not every patient in a practice is going to
22 need case management; why not look at consolidating the case
23 management program into either a public health function or a
24 visiting nurse-type function, so that all of the providers in
25 the area, especially outside of the large urban areas, could

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1 refer to this entity, whichever way you decide to do it?
2 That would also have the social services, the housing
3 resources that we have traditionally covered in public health
4 but now have seemed to have gone by the wayside -- we've lost
5 the funding for public health. But I think maybe if you
6 consolidate some of these resources in another -- in a
7 separate area, it might be more do-able for the rural areas
8 or the smaller practices in the urban areas. Thank you.

9 MR. SECORD: I'm Mark Secord with Neighborhood
10 Community Healthcare Center in Seattle.

11 One of Washington State's basic distinctions
12 is that we're in the top three states in the country in terms
13 of having the largest percentage of the state's population
14 seen in community health centers. It's 11 percent in the
15 state of Washington. So we have a very well-developed system
16 here.

17 For one, I am glad to see on the list of high
18 priorities, the idea of fostering medical homes in the FQAC.
19 So that's great.

20 I'd encourage you to change your language.
21 We, in the community health center movement, talked about
22 healthcare homes, and I think you're aware of that. We have
23 got to include -- offer what is often the forgotten
24 stepchild: Oral health. Dental care as part of that. Last
25 time I checked, the mouth is connected to the rest of the

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1 body. And there's growing evidence that diseases like
2 diabetes are exacerbated by oral health problems, infection
3 of the mouth. Really beg that question.

4 But it is more and, as my colleague David
5 Johnson from Novus talked about, is really knitting together
6 the work of community mental health agencies and community
7 health centers. Which brings me to a point about the
8 reimbursement way that we're paid.

9 We watched, last year, the unfolding of a
10 Greek tragedy, literally, as mid year last year -- really at
11 CMS's insistence, we lost our per-member per-month payment
12 system, as FQAC's, and moved to a per-visit reimbursement
13 system that is in place in most of the country.

14 Don, I only wished that you'd been here a
15 year ago because I have a feeling that you wouldn't have
16 stood for it.

17 So, my hope is that we can both change the
18 language and get back to a more sensible form of payment and
19 take advantage of the power that exists in health centers.

20 DR. RICHARD GILFILLAN: Thank you.

21 MR. MOSELEY: I'm Randal Moseley, and I'm the
22 Quality Director for Wenatchee Valley Medical Center. We're
23 a group practice of about 200 providers with a rural health
24 network in north central Washington.

25 We're very excited as a group about the winds

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1 of change that are going. But our recent experience with CMS
2 really also makes us very hesitant and concerned. We
3 partnered with CMS for a demonstration project for an in-home
4 monitoring system that was extremely successful and we were
5 enthused about that. But the contracting process to deal
6 with that was just incredibly complicated and left us, I
7 think, with some significant misunderstandings. And we ended
8 up basically with about 20 percent of the gain sharing that
9 we were led to expect in the beginning of the project.

10 So, you know, my plea is not for us,
11 personally, but in general I think if we're going to proceed
12 with projects of innovation, that CMS clearly needs to have a
13 more transparent and precise contracting system. Better
14 follow-through with these kinds of payments and partnerships.

15 DR. HAMMARLAND: Thank you.

16 MR. MURRY: Hi. My name is Charles Murry. I'm a
17 family doctor and I've worked in the Seattle area in
18 Washington for the last 20 years. And I wanted to say, I
19 really appreciate you being here today. My comments are
20 about health improvement more than just healthcare
21 improvement. And I have three points that I wanted to make
22 about what would improve health because, as we all know,
23 we're ranked about 41st in the world in health -- health
24 outcomes. And we'd like to go closer -- since we've spent so
25 much money -- to the top 10.

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1 Now, three ways that we could do that:
2 Number One: Primary care, primary care,
3 primary care. We know outcomes are much better. And there's
4 lower costs if we emphasize primary care.

5 One of the reasons the CHC's do well for a
6 difficult patient population -- whv Group Health does so
7 well -- is because they have a high primary care for the
8 specialty ratio. And we know that England has -- 75 percent
9 of their physicians are primary care. And, here, it's like
10 10 percent.

11 And so money going towards the pipeline to
12 increase the number of primary care physicians is really
13 important. And, along those lines, as long as people have a
14 health insurance, which I know we've passed the law and I
15 hope we continue to have that, that will protect everyone so
16 people can get into primary care, including the uninsured.

17 My second point is: We also all here know
18 that the most important outcome for the health in this
19 country isn't what we do in medical care but in public
20 health. We've known that for the last century -- we have
21 reports. Public health is crucial. So, if we look at the
22 obesity epidemic, we know that medicine -- we know that the
23 obesity surgery, bariatric surgery, is not going to do it.
24 It's going to take public health.

25 So, I know that it's not up to CMS to do that

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1 corner, but I think we should restructure so that public
2 health gets a much larger pie, a lot more money as well as
3 power to influence how we do things in the health of this
4 country. It's very important if we're going to improve
5 health outcomes, go to the top 10 in the next 10 years.

6 And, third, I'm thinking more of the date we
7 go the regional way of approaching medical care. If we can
8 have a regional, that is, kind of styloid, where we can have
9 the entire region work together to use evidence across
10 organizations instead of us competing to try and get money,
11 if we can -- if the financial incentives could be that we all
12 do well if we follow the best evidence, we would all do
13 better (unintelligible) as compared, physically, we see the
14 darkness. Dr. Atlas also proved that, of course, health
15 outcomes would be better if we emphasized evidence
16 regionally. But there is a way that we can put -- have
17 financial incentives so that in this area the Swedishes and
18 the Group Healths can actually work together to collaborate.

19 And I know we do well in this area but with
20 lower costs and health outcomes. But, actually, in my
21 experience, I see a lot of differentiation between areas.
22 And I can tell you, privately, that all the crazy stuff that
23 I hear that some docs are doing -- it's very expensive. And
24 we can -- and it's not improving health outcomes.

25 So if you do those three things the next 10

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1 years, trust me, we'll be in the top 10.

2 MS. EDLUND: Hi. I'm Tina Edlund. I'm the Deputy
3 Director for the Oregon Health Authority.

4 The Oregon Health Authority was just created
5 last year as part of Oregon's overall health reforms. This
6 is something you may all know and we've been working on this
7 for some time now in that state down south.

8 We have a \$3.5 billion budget shortfall --
9 revenue shortfall. We also have a new governor who is
10 impatient to change the healthcare delivery system in this
11 state. So a real sense of urgency. So I have three points:

12 One, I hesitate to -- after Dr. Berlick's
13 story, I hesitate. But, the first one is flexibility. I
14 actually think that the table is set here. That's really
15 exciting for us. We definitely have some plans and can use
16 that flexibility.

17 The second one is for speed. When we put our
18 plans together and we come forward to you, if we could
19 actually get responses quickly and be able to implement on a
20 fairly rapid cycle, that would be really helpful to us.

21 And, then, the third one is the data. When
22 we look at what we can do around duals and triples in the
23 state, and we think there is huge opportunity there, we don't
24 have a good picture; we don't have any window into the
25 Medicare side of the spin and to actually do that analysis

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1 and see what kind of progress we can make in those dollar
2 amounts. We really do use the data. So, thank you.

3 MR. JACKSON: Hi. I'm Aaron Jackson at the
4 University of Washington, School of Public Health, and I want
5 to thank you for holding this session.

6 At the risk of being one of these people that
7 I hate that will stand up and say some stuff that seems
8 totally irrelevant to the topic at hand, I want to talk to
9 two elephants in the room; one, actually, you just heard
10 about. Sort of rhetorical, but you didn't talk about the
11 importance of health improvement or improving the health of
12 populations and the ability to acknowledge the relatively
13 limited role of medical care in that. So, I mean, I think
14 you have to -- to speak the truth that, really, if we wanted
15 to improve the health of Americans we'd try to find a way of
16 pulling \$5 or \$800 billion out of the Medicare system and put
17 it in education, which we know has a lot more to do with
18 health.

19 I know that is -- I'll accept that that's
20 sort of a rhetorical comment, but my second one is not so
21 rhetorical.

22 The other elephant in this room, I think, is
23 that the Accountable Care Act and your role of really what
24 you're here about is the role of innovation and promoting
25 innovation in the healthcare system.

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1 But, you know, if we look back over the last
2 60 years, if all it took was more innovation, we would surely
3 have what some people still mythologize about the best
4 healthcare system in the world. We have been innovating for
5 certainly as long as I have been involved in this business.
6 This room is full of innovators. Truly, it's full of
7 innovators. But innovation does not transform the healthcare
8 system. And, you know, the one ingredient we're not going to
9 get -- and I'm not just dreaming here -- that we're going to
10 get that limitation on the amount of resources going into
11 this hemorrhaging system.

12 But, I'm really curious about what CMS will
13 do differently; how it will not only promote, disseminate and
14 encourage innovation in a way that overcomes the incessant
15 self-interest that a two-and-a-half trillion dollar a year
16 system creates. And it's two-and-a-half billion dollars of
17 the King County profits. And it's very difficult to overcome
18 that, regardless of how much we put into great ideas.

19 I'm really curious and interested to hear
20 what the new ideas at CMS will have to get over that hump.
21 Thanks.

22 DR. DONALD BERWICK: Aaron, before you leave, so
23 can you answer your own question for a minute, so --

24 MR. JACKSON: You know a lot and --

25 DR. DONALD BERWICK: Rick and I both know that the

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1 innovation center has got to attend to the spread of
2 knowledge, and that adoption is not just creating the new
3 knowledge; what should we do about that?

4 MR. JACKSON: Well, you know, the only mechanism
5 that -- TRE was here, I don't know, a month-and-a-half ago,
6 talking his book and -- I'm sure you've read it, it's a great
7 book. But the one pointed thing he said in answer to a
8 question about this business of innovation, he said, you
9 know, look, if we limit the amount of money going into the
10 system people will start innovating, figuring out how to do
11 more better with less.

12 Okay, so we're not going to do that -- at
13 least in the next few years. But if there's some analog of
14 limiting the resources available to the system -- I don't
15 know what it is, I really don't know what it is -- but if
16 there's some way for you to create sort of the feeling, the
17 sense of limited resources rather than what we have now which
18 is, you know, ever-increasing, ever-hemorrhaging system. I
19 really don't know what it is. I'm not -- I just don't have a
20 great idea. But it seems to me that that's the direction
21 that you have to go. And I think if that means somehow
22 unifying the purchasing activities of Medicare/Medicaid, the
23 VA -- you know, whatever it is -- to really create sort of a
24 monolith or a mammoth purchasing strategy from the federal
25 government. Maybe that's the way to do it. But some analog

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1 of that limited resource I think is what they have to create.

2 (Unintelligible - (unrelated to meeting))

3 MR NEFF: My name is John Neff, I'm a pediatrician
4 at -- I've been affiliated with Seattle Children's Hospital
5 for a long time. And, pediatrics -- somewhat of a unique
6 situation heavily dependent upon Medicaid so that the
7 pressure to be able to show improved costs, to be able to
8 improve services, is really very tightly within a bind. And,
9 then, of course the feeling that they're squeezing from the
10 dual eligibles at the other end.

11 The main focus, the group that I've been
12 interested in is the children with long-lasting chronic
13 conditions. Not asthma or even some of the mild mental
14 health but children that have a condition that may well be
15 lifelong. And those children consume an enormous amount of
16 the resources that are devoted to children and are
17 concentrated at Children's Hospital.

18 We're now trying to do innovative efforts to
19 go out and work with health plans to work with them in
20 figuring out care management programs that would, in a sense,
21 decrease costs. But when you're in that, and I'd love your
22 thoughts on this, our outcome measures are very strictly
23 limited. It's really, how do you improve costs? Which is do
24 you decrease emergency use in the hospital, which is valid,
25 and hospital duties? And that one should be able to show

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1 over a period.

2 But there's a much, much greater dimension of
3 quality of costs in improved care with this population. And
4 I would love to be able to hook our information up so that we
5 could see measured improved school attendance factors, school
6 attendance and, also, improved employment. It's very clear
7 that when you have a mother and father working very hard to
8 take care of a child with so much of their resources going
9 into that, they're severely limited in terms of that,
10 employment capabilities in the country.

11 The other area -- just terrible -- is
12 transition to adult services. It's like, for these children,
13 they're going over a cliff. And so you may feel that in all
14 of those systems in the pediatric care model, but once you
15 get them to develop adult care, it's like redoing the whole
16 thing again.

17 So, I think -- and I think there are other
18 outcome measures that really show the benefit to society, but
19 we have a breakaway from just those simple ones we all look
20 for, the use of the emergency room and in-patient.

21 DR. RICHARD GILFILLAN: John, again, we're
22 interested in specific programs that may address the
23 population that you're talking about. So I would urge you to
24 think very concretely about a way of approaching us with a
25 proposal that might say, you know, this is the population and

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1 here are the interventions we think can make a difference and
2 we'll -- you'll see the results in the following areas.

3 So, we're interested. We're not going to be
4 able to think -- we're looking out to all of you to have the
5 best thoughts about how to kind of get at particularly some
6 of these very specialized and small number but large-impact
7 clinical conditions.

8 MR. NEFF: Thanks.

9 MR. KINTNER: Bill Kintner, family doctor from
10 Port Angeles, Olympic Family Center. I have a request and a
11 question both related to geographical maldistribution of
12 patients. Through no fault of the four -- you up front -- I
13 think it's the fault of Congress, for those of us in the
14 Northwest and everybody in this room has suffered under
15 greatly lesser Medicare coverage of our patients in terms of
16 knowledge and, in this case, throughout the country. I think
17 that it's true in the rural counties in Washington and
18 Oregon, almost universally, are in the lower 10 percent --
19 lowest 10 percent of Medicare benefits to our citizens.

20 So, I know that's not the fault of you four
21 up front, but can you please take to Congress the message
22 that their geographic or maldistribution of traditional
23 Medicare and the reimbursements stifle us and
24 disincentive-ize the nation? I think the reason -- at least
25 part, are the members' fault, is that traditionally in the

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1 Northwest (unintelligible) and patients largely take care of
2 themselves. But it's not fair and it's not fair to those
3 patients.

4 The second question actually related to that.
5 I didn't expect to ask this but I saw your slide there: How
6 is it that there are up to eight states -- I saw the slide --
7 that are involved in the medical home funding demonstration
8 projects? Did I not see that all of those are east of the
9 Mississippi with the partial exception of Minnesota? How is
10 it that none of them are from the West?

11 DR. DONALD BERWICK: Let me deal with the
12 geographic variation first. There's a lot known, as you say,
13 about variation in payment based on the current models we're
14 using -- the Geographic Practice Cost Index, gypsy. Congress
15 has mandated that we look at that. In the meantime, there
16 are mitigating rules, as you know, in the Affordable Care
17 Act, in prior legislation, to minimize the downside in rural
18 areas. People are very worried about that, a lot of
19 congressmen and senators.

20 We have a Institute of Medicine Report, one
21 that is due in May which is taking a whole other look at the
22 basing of those cost-input parameters to see if we can get a
23 more accurate reading on what practice costs actually look
24 like. And we may not have it correct now; we may be able to
25 correct it, depending on what the IOM reports, we will be

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1 able to put the new knowledge into the rulemaking for
2 payments starting next year. So that's good news.

3 There's a longer term Medicare study -- IOM
4 study -- funded in the law, a three-year study of geographic
5 variation, overall in outcomes and costs, building on the
6 controversies that are out there -- around -- with Atlas and
7 others. Unfortunately, that study is going to take some
8 time. But I've been talking with the IOM about ways to get
9 early information so they can begin to do more accurate
10 basing of the actual costs.

11 Do you want to comment on the --

12 DR. RICHARD GILFILLAN: Yeah. On the MAPCP. This
13 is an activity that's actually going to come out of the
14 traditional ORDI group at CMS that has done evaluations in
15 the past. It was underway for a long time. The solicitation
16 had been done. The evaluation package for the applications
17 had been done, and the selection process. And there were
18 actually a number of states that you would have thought would
19 have been kind of right there. And I think it was more a
20 function of who in the state decided to apply. And so it was
21 surprising both from a geographic standpoint and also some
22 usual suspects who you would have thought would have been
23 there.

24 So we're going to continue working, continue
25 looking for opportunities to make sure we get a good

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1 selection of medical home models to get started, or to
2 support and to evaluate so that we're sure that we're -- we
3 come up with the right answer at the end of the day about
4 which -- what the right medical home model is -- or models
5 are so that we can take the opportunity to maybe support them
6 more directly through that program regulation process that I
7 described. So it's not over yet but, hopefully, it will be
8 more expansive next time around.

9 DR. DONALD BERWICK: I took a very strong personal
10 interest in this once I arrived and looked at all the
11 applications. And we did expand that. It was supposed to be
12 six states but we went to eight states but, as Rick said, I
13 hope we can revisit this, so.

14 MR. PIERSON: I'm Marc Pierson, Whatcom County
15 Peace Health.

16 I want to suggest what I think may be one of
17 the most highly-leveraged innovations we could work on, and
18 that is: Governance. The community watch-out for limited
19 resources.

20 I'm pretty sure that the government's models
21 we have out there, they are not going to work. Eleanor
22 Austin has spent most of her life and got a Nobel Prize for
23 sort of documenting how communities have been able to do
24 this. And I think a lot people would think that's too Harry
25 Caray. We need to replace this broken fad, fetishness, as

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1 others have pointed out. But some innovation is going to
2 increase the cost. This issue, someone brought up, how can a
3 small practice play a game with the big practice? I think
4 Eleanor Austin gives us some ideas about this and so forth,
5 and there are eight simple rules. And I really think that's
6 going to be the cheapest, perhaps biggest payoff that we
7 could improve in playing -- figuring out how to do this.

8 DR. RICHARD GILFILLAN: You know, that's a very
9 interesting suggestion. And as the conversations have -- or
10 the questions and comments have gone around here, that
11 thought came to mind. The real interesting question is,
12 okay, here we are in Seattle, in Washington state and, you
13 know, we're -- folks have collaborated a lot and worked in a
14 very progressive way around a lot of care delivery
15 approaches. And if that's the solution -- or if that's an
16 important part of the solution, it would be great to see an
17 opportunity to evaluate a community coming together and
18 looking at that. Looking at the total span, looking at the
19 commercial, Medicare/Medicaid, other payers spend in the
20 community and say something like, we are changing the rules
21 of governance for those of us who are part of this community
22 in a way that -- because that is so -- we'd sure like to be
23 part of an initiative that gets at that. What better place
24 than right here in Washington?

25 DR. DONALD BERWICK: If even a single community in

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1 the country, one household per region, took that seriously
2 and built the all-payer regime that would allow the three
3 aims -- better care, better health, and lower cost -- to
4 really, really be there and measure over time, not just
5 starting where they are, that would be groundbreaking to the
6 country.

7 MS. ROWE: Good afternoon. My name is Cheryl
8 Rowe, I'm the Executive Director for the American Indian
9 Health Commission in Washington State.

10 And, as you're thinking about these
11 innovations, I think we'd -- we would like to encourage you
12 to really take a look at those tribal health delivery systems
13 that are already in place so that, by design, they are -- you
14 can look at those systems' medical homes. And they're very
15 innovative because of serious underpinnings of the Indian
16 health service. (Unintelligible.) Tribes have become very
17 creative in financing in how to provide services to their
18 people.

19 So, as you do these, I'm just hoping that
20 you'll be inclusive with tribal health organizations in the
21 effort.

22 MS. SMITH: Hi. My name is Jeanene Smith, I'm
23 from the state of Oregon, Office of Health Policy, the health
24 authority. And, in your request for ideas about the
25 Accountable Care Organization, I want you to look at what

1 Oregon has done in its usual public process, developed
2 patient-centered primary care home standards reform. We
3 recently just updated it with a look at from children as well
4 as adults. And I think one of the things that emerged from
5 our discussions was how to change the language that's
6 patient-centered.

7 So one of the first things we did was, we
8 took the six attributes, what we thought it should be,
9 because we felt the NCQA definitions were more a process
10 checklist, and we really wanted outcomes that really change
11 the culture inside the clinics. And what came out, you know,
12 instead of saying the third next available appointment means
13 access means be there when my family needs you to be there
14 for us. It says maybe help me be -- I am the most important
15 partner of the medical team and how can you help me and my
16 family do that?

17 So we revised sort of the key elements to get
18 us to think that way and to really apply the thinking about
19 it from the patient perspective. I think those could be
20 applied to overall Accountable Care Organization perspective
21 if you think about all the things you want in a
22 patient-centered primary care home. That's exactly what you
23 want that entity, the ACO, to be able to provide for those
24 patients.

25 So maybe if you could mirror that language up

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1 from the clinical site and the surrounding health community
2 needs that need to partner with public health and social
3 services; to achieve it all the way up, I think would be the
4 most effective decision to achieve that new language coming
5 down as a definition for accountable care.

6 DR. DONALD BERWICK: Jean (sic), is this written
7 up?

8 MS. SMITH: Yes. I can send it to you.

9 DR. DONALD BERWICK: Would you, please?

10 MS. SMITH: And Susan has it as well.

11 DR. DONALD BERWICK: Thank you.

12 MR. MARTIN: I'd like to draw your attention to an
13 infrastructure that already exists in rural communities.

14 My name is Tom Martin, I'm the Superintendent
15 of the Lincoln County Health Hospital District in Eastern
16 Washington. We operate a critical access hospital and three
17 rural health clinics. We also operate emergency ambulance
18 service, a nursing home, and we partner very closely in a
19 structured way with public health.

20 Reality is that in these rural communities
21 you already have the infrastructure for a medical home.
22 Primary care base.

23 In Washington state, we've got a history of
24 working collaboratively among the rural hospitals to look and
25 measure the quality of care. The issue has always been, do

1 we have statistically significant data? And, many rural
2 communities, we just don't have the numbers. However, we can
3 demonstrate that we do have best practices, scientifically-
4 proven methods of practice of the medicine. And that's, I
5 think, an option for us to be able to demonstrate quality.
6 If someone comes through our emergency room and we apply the
7 best practices, then the outcome should follow. I think
8 that's a way that we can actually demonstrate quality to our
9 populations rather than being hampered by the
10 statistical-significance issue.

11 The other aspect in Washington state is that
12 we have been very effective in working together as a
13 community of hospitals, small and large. We've implemented
14 some emergency protocols with the help of the Department of
15 Health, looking at trauma for cardiac and stroke. And we've
16 been able to achieve some pretty significant integration of
17 care between the rural communities and the urban communities,
18 coordinating care of our emergency rooms into those cath labs
19 in the large urban areas.

20 So my point is that I think we already have
21 an infrastructure that's already been put into place. The
22 policy at CMS, it says we need to have an infrastructure
23 rural community's support for quality of life. And the State
24 even sanctioned that community. The cost base for those
25 resources are extremely important. We can certainly

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1 demonstrate that we can maintain the quality of care and we
2 can maintain the status of people's health. We can do that
3 in a primary care-based organization.

4 We can also manage the referral process to
5 assure that we're making appropriate referral so the
6 utilization of the specialty and critical level of care is
7 being used appropriately.

8 So I think we have a good structure that we
9 can bring forward -- demonstrate to CMS that you already have
10 good partners in rural communities that can actually achieve
11 efficiency, patient safety and all of the six goals that have
12 been identified.

13 DR. DONALD BERWICK: What's your organization?

14 MR. MARTIN: We are Lincoln County Public Health.

15 DR. DONALD BERWICK: Lincoln?

16 MR. MARTIN: Lincoln County Public Health --
17 excuse me -- Public Hospital District Organization. And we
18 work together in Eastern Washington, Critical Access Hospital
19 Network, that is going to be coming forward with a proposal
20 to CMS that will integrate all of what we just talked about
21 as far as the pieces that are in both communities. So I
22 wanted to give you a head's up of something that will be
23 coming forth from that.

24 The other point I want to make is that we
25 also have an organization that's unique on the national

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1 scene, that is, the Rural Healthcare Quality Network. It is
2 an organization that represents all of the critical access
3 hospitals in the state of Washington. And we work on a
4 collaborative basis to identify safety issues, quality
5 issues. We're looking at the stemi programs, the stroke
6 program, and making sure that protocols are applied in all of
7 our rural communities.

8 So the point is that I think you already have
9 an infrastructure that you can achieve what you're after.
10 And in the rural communities. We just need some flexibility
11 in how we measure how we make those benefits.

12 DR. RICHARD GILFILLAN: We'll look forward to
13 seeing that.

14 MS. SMITH: Laura Smith, Washington Dental Service
15 Foundation.

16 As you approach ways to integrate healthcare
17 services and address the reputation that's out there, I think
18 you have an unprecedented opportunity to put the mouth back
19 in the body. Better care, better health. The evidence is
20 that you won't get there without good oral health.

21 We have worked a number of years here in
22 Washington to include the delivery of preventable oral health
23 services through Well Child Checks. And we're making
24 progress with that.

25 We're working nationally to increase the oral

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1 health education that happens during healthcare
2 professionals' education. We really think the fact that oral
3 health, for the most part, and oral disease, is preventable.
4 This means that there's some real opportunities to lower
5 cost. Most people really are surprised when they find out
6 how much dental care is delivered in operating rooms and
7 emergency rooms.

8 So I really would second Mark Secord's
9 admission to really think about how oral health can be
10 included in county care organizations and as you think about
11 innovations. Thank you.

12 MS. GOODWIN: Thank you. My name is Dawn Goodwin
13 and I represent two organizations today; I'm in charge of
14 operations for a large home health and hospice agency in
15 Eastern Washington, Family Home Care & Hospice. I'm also the
16 current President of the Home Care Association of Washington.

17 And, I would just like to remind you all that
18 you already have a solid element in place and, that is, the
19 Medicare home health benefit. So while I'm very encouraged
20 to hear about the care organizations and the like, but I
21 think what's missing is a discussion about home health within
22 those organizations. So I would encourage you to remember
23 that home health is here and has been around since inception
24 of the Medicare benefit. We are a outcome data-rich
25 organization and we've always been patient-centered.

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1 So I would just encourage you to do home
2 health, any sort of innovations that may develop down the
3 pike. So, thank you.

4 DR. RICHARD GILFILLAN: Just to be clear, most of
5 the ACO work is kind of anticipating -- ACO activity -- we're
6 anticipating the opportunity to use current -- some current
7 Medicare reimbursement mechanism. So there's -- the
8 expectation is that those benefits will be an important part
9 of ACO's meeting their mission.

10 MS. JACKSON: I'm Joyce Jackson, CEO, Northwest
11 Kidney Centers.

12 I'd like to talk about what you termed
13 earlier, perhaps a niche operation. People with kidney
14 failure. Because of a law that passed in 1972, this is an
15 almost universal entitlement under Medicare if you have
16 kidney failure. So it's a population that represents point
17 six percent of Medicare beneficiaries but six percent of the
18 Medicare budget. So something that I think, we all have high
19 interest in improving health and lowering costs.

20 For the center of innovation, I really
21 encourage you to consider innovative projects relating to the
22 ESRD dialysis population. There's an epidemic of kidney
23 disease due to diabetes and high blood pressure, for the most
24 part. So we've got an increasing number of people facing the
25 need for these intense services. But because of payment

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1 policy, for instance, there have been a lack of innovation;
2 in fact, for 30 years our field has hardly changed at all.
3 An example is home dialysis.

4 We now know, through research, that people
5 who have treatment in their home five, six or seven times a
6 week instead of coming to a center three days a week --
7 actually have improved outcomes and lower hospitalization
8 costs. But because Part B is where we're paid for and Part A
9 is hospital, we've been prevented from really innovating in
10 that area.

11 So I really encourage the center for
12 innovation in recognizing 40 percent of our patients are dual
13 eligibles as well to consider ESRD-related projects. We'd
14 love to work with you. Thank you.

15 DR. DONALD BERWICK: Joyce, any other innovations
16 besides home health -- home dialysis that you just -- popped
17 in mind?

18 MS. JACKSON: Well, the new bundling payment
19 system that goes into effect next month is also part of --
20 brings with it the quality incentive pay system. Like "P,"
21 which I believe is the first pay-for-performance system
22 within pay-for-service Medicare. I think that's a very good
23 innovation, and it's forcing us all to think about what are
24 the most key measures of outcomes that we should be monitored
25 by and, in fact, pay based on -- and I think more is to come

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1 in that area. And I applaud CMS for moving us forward in
2 that area.

3 DR. DON BERWICK: Thanks, Joyce.

4 DR. HAMMARLAND: This is my way of signaling that
5 we'll have to draw this to a close in a little while. So
6 we'll take those who are standing in line and anybody who
7 just zips up right now to get in line, and then we'll have to
8 close out.

9 MS. SOSNE: Thank you. My name is Diane Sosne and
10 I'm a Registered Nurse, and I am President of SEIU Healthcare
11 1199 Northwest. And, two points.

12 The first is -- at first I want to say, we
13 really appreciate the opportunity to have a forum like this.
14 And it's great to see you taking notes, so we appreciate
15 that.

16 I wanted to tag on to something Aaron Jackson
17 said and the colleague from Oregon regarding the State's
18 budget deficits and what we're seeing as a result. And I'm
19 sure this is not anything you don't know, but we're actually
20 seeing, because of these cuts, a dismantling of some of the
21 innovations and a sliding backwards. So when cuts -- whether
22 it be mental health, behavioral health, internal, child,
23 public health, we're just seeing money poured into a deep
24 black hole. And so if there is a big CMS idea, this is a
25 time that would be really important to think about an

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1 initiative related to what's happening to the states.

2 The second has to do with work force. And,
3 when I think about the large number of unemployed in this
4 country in our state, what happened in the last election
5 around the top issue being jobs for people, I think about how
6 can CMS put resources into helping get unemployed trained as
7 healthcare workers, outreach workers, community health
8 workers, educators, and how we -- and how you could help
9 really drive mobilizing an army of registered nurses and
10 these other types of innovative workers into communities.
11 Not just into existing healthcare system as we know it on a
12 regional and state basis.

13 And, you know, I was thinking the other day
14 that if we, hypothetically, could think about, let's just say
15 Washington state, where we have -- roughly we're going to hit
16 one in six unemployed -- I mean uninsured -- in just a short
17 fifth year, if we could do some kind of pilot where we could
18 deploy a lot of healthcare workers regionally or statewide
19 and say we're going to show results in six or twelve months;
20 we're going to have everybody screened on this; we're going
21 to have everybody immunized on this; we're going to do
22 education on nutrition and smoking cessation; we're going to
23 do something really big on diabetes and prediabetics that --
24 again, I really like the idea that you've talked about and
25 showed in your slides about how can we really move the dial.

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1 Thank you.

2 JEFF GROSHONG: Thank you. My name is Jeff
3 Groshong. I'm a pharmacist and work with the Washington
4 State Pharmacy Association as their CEO.

5 I just wanted to thank you for this
6 opportunity to speak at this forum and I really urge you to
7 consider the role that the current infrastructure within
8 pharmacy settings has to offer. And there's
9 differentiation -- I speak to pharmacists but the pharmacist
10 within those settings, whether it's in a community setting,
11 within the hospital setting and coming from the like --
12 currently, I have a skill set that is typically not
13 underutilized or up -- really not utilized. And that's in
14 the area of medication management.

15 We know that there is a tremendous amount of
16 resources put into medications and therapy, yet there's no
17 support for the quality and the outcomes of the appropriate
18 use. Non-appearance costs us \$290 billion annually by some
19 reports. If you know that there is a huge issue with regard
20 to the perfect storm, then these are patients.

21 When we are in the care of patients, when
22 they're with us, we do a pretty good job taking care of them,
23 and then they go home. And when they go home they decide not
24 to take their meds. They read on the Internet
25 (unintelligible), they have poor health literacy or language

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1 barriers. They've got 300,000 over-the-counter products to
2 work around, and they may have four or five doctors reported
3 by a pharmacist working with this.

4 So the work that's been done regarding heart
5 disease medications, therapy management is a step in the
6 right direction. I certainly think and hope that you'll
7 consider where pharmacists within the Accountable Care
8 Organization will fit -- and the medical homes. That is
9 crucial, I believe, and I think it is something that might
10 not be considered. And the reason I think that is,
11 currently, the services provided by the pharmacists are
12 uncompensated for. The product is what these contracts and
13 the pharmacies are based on. And, without that service
14 model, and the services are central, then we have an industry
15 where chronic disease stage will continue to cause the
16 biggest money drain in our system. And pharmacists are
17 perfectly trained to help with that.

18 So I'm hopeful that in this effort to have
19 better health, better care and lower costs, that it utilizes
20 the role that the pharmacists could play to help manage that.
21 Thank you.

22 DR. HAMMARLAND: We're down to the final five.

23 MS. BUELTER: I'm Madeline Buelter, Chief Executive
24 and the Vice President of Operations at the Seattle Cancer
25 Care Alliance. And I would just like to state that I would

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1 hope that within this healthcare discussion is the role of
2 the drug companies come to play because they are a huge part
3 of costs for cancer care. And how do you look at ratcheting
4 down those costs without looking at the cost of drugs?
5 Especially cancer. Thank you.

6 MS. MOODY: My name is Robin Moody with the Oregon
7 Hospital Association.

8 And, in Oregon, we have one of the highest
9 penetration rates of Medicare advantage products that
10 approaches 40 percent. There's been some concern and
11 consternation about whether Medicare-managed patients will be
12 eligible and able to enroll in the ACO's and Shared Savings
13 Programs.

14 So if you haven't made that decision, you
15 know, we're hoping that Medicare advantage patients will be
16 able to be in those products.

17 Secondarily, both Oregon and Washington has
18 eluded to today -- are low cost states. We tend to be, you
19 know, very efficient on the hospital side. And so, you know,
20 it is somewhat of a concern, I guess, that some of the costs
21 that you might be able to bring out of higher cost systems
22 might not be available to a lot of those needs. When you
23 look at other states -- might not be available. Because I
24 think, you know, CMS took a big step forward with the value
25 purchasing and may want to, you know, consider that as you

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1 construct the payment models or the shared savings models for
2 ACO, keeping in mind that there are people that come in on a
3 lower benchmark, such the healthcare quality coalition has
4 submitted comments' fees. So, some suggestions and I would
5 encourage you to take a look at those. Thanks.

6 DR. RICHARD GILFILLAN: Thank you. Just one quick
7 point on the ACO's and the MA plans, and there's certainly
8 nothing that would limit MA plans from being able to pursue
9 contracts with ACO's, and; we are interested in looking for
10 opportunities to get as much -- kind of momentum behind a
11 particular model as we can, and get multiple payers involved
12 for ACO's, medical homes -- whatever -- in the issues we're
13 pursuing.

14 MS. JOHNSON: My name is Carrie Johnson. I'm a
15 home health hospice and community education programs manager.
16 I have two comments.

17 One, that you have really good chronic
18 disease case management and cardiac rehab, pulmonary rehab,
19 and diabetes education done by nurses right now. And I'd
20 encourage you to strengthen that, if possible. And we added
21 a chronic disease exercise program that goes for years after
22 their initial episode. And that's been a really positive
23 self-pay program that I think is really good in communities.

24 The other thing, and I haven't heard it and I
25 guess I was a little surprised is that, it's because of

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1 hospice work but it's not in hospice that I think primary
2 care and other providers need to be educated about how to
3 have that conversation with people when care is futile and
4 we're spending thousands -- millions of dollars on care that
5 doesn't give quality and it really doesn't allow people to
6 end their life with dignity.

7 DR. HAMMARLAND: Thank you.

8 MR. VIGDOR: Greg Vigdor, Washington Health
9 Foundation, healthy state and nation campaign.

10 We've been innovated on a number of concepts
11 in our campaign for about the past six years. I think the
12 one I'm most intrigued with -- because, actually, I work in a
13 health home. The use of that term predated a lot of the
14 applications right now. I think in terms of innovation, the
15 one thing that strikes me to listen to this conversation --
16 that I don't think has come out -- has been the importance of
17 relationships that we've found when we talk to people about
18 how to form, broadly speaking, health homes.

19 And I think what we've found is the truth,
20 that most people, and probably an awful lot of people, their
21 primary health relationship is not with the medical
22 community, not with the physician, but with their spouse,
23 family member or friend, or someone who they met online
24 because they came down with some disease they didn't know
25 anything about.

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1 And what we've found that's really active in
2 health homes in the way we were doing things -- really it's
3 important just to reach -- reach into those relationships and
4 somehow try. I know that CMS mostly pays people -- we're not
5 suggesting that you do that. But I think somehow working
6 with the provider community to help make sure those
7 relationships thrive rather than be hindered would be an
8 important innovation to consider somewhere in this platform
9 of work that you're doing.

10 DR. JOHN HAMMARLAND: All right.

11 DR. RICHARD GILFILLAN: Thank you.

12 MR. FISHER: Thank you. My name is Mark Fisher,
13 Olympic Community Center. I want to just ask the question of
14 the role of the innovation center and what service they can
15 provide to us who want to use it.

16 I want to mention a problem that I think that
17 may resonate with many people in the room, particularly,
18 providers. I work in a semi rural community. And I've
19 actually accumulated, personally, sort of a difficult series
20 of complex patients over the last year-and-a-half, where
21 there's been substantial ball-drops in transfers from
22 tertiary medical center back to their care in the community.
23 And I've looked at myself in the mirror many times and
24 thought that issue, to see what I could do on my end to try
25 to help that issue. By the way, these case names that I'm

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1 referring to come from all the amazing superior medical
2 centers that you've heard many people represent today.

3 My question is: In this era where we're all
4 on a different trajectory for EMR's, we have disparate
5 communication systems -- is there a role in this
6 public/private process that you're talking about this morning
7 for establishing some type of standard communication or
8 continuity that may help a region until the blooper-Alice
9 (phonetic) enterprise, EMR, becomes a reality?

10 DR. RICHARD GILFILLAN: That's a great, great
11 point I think. A couple things; one, we are very interested
12 in the whole issue of care transition as much as the nation
13 has gotten very interested the industry has gotten interested
14 in care transitions over the past three or four years it
15 seems like. It seemed like it was a blind spot for all of
16 us.

17 So we are going to be very interested in
18 looking at readmissions and opportunities to improve the way
19 we do care transitions, and opportunities to improve patient
20 safety in hospitals which would include, we think, that
21 transition. So that is going to be a major area of focus and
22 interest for us in the near future I think.

23 I know systems I've seen in the past have
24 had -- provided access, or tertiary systems can provide
25 access to rural physicians or doctors who are not necessarily

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1 on the medical staff. And I'd be interested in a proposal or
2 in an initiative that maybe looks at somehow doing that in
3 pursuit of improving transitions as we get into doing some of
4 the transitions of care work that we see coming up.

5 DR. JOHN HAMMARLAND: Thank you. Well, you
6 know, when you throw a party you're always afraid folks won't
7 show up. I think, given the guests that we have here today,
8 given the criticality of these topics and given the
9 commitment of the people in this room, you folks definitely
10 showed up. You taught us -- you inspired us. And we thank
11 you very much for joining us today.

12 If you did not have a chance to give your
13 comment to us, this is just the beginning of the
14 conversation; you can reach us at aco. -- aco@cms.hhs.gov.
15 That's if you want to give comments about ACO's. And with
16 respect to duals, fchco@cms.hhs.gov. Those are the two ways.

17 You can also get ahold of me, my office is
18 right here in Seattle; I'll make sure I get the comments back
19 East. And, as Rick mentioned earlier, the innovation has its
20 own website at: www.innovations.cms.gov. They've got
21 information, and it's also a portal into CMS.

22 To my cohost, Susan, thank you so much for
23 joining today and giving your leadership.

24 Let's, once again, thank Don and Rick for
25 coming to Seattle.

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1 (Applause, applause.)

2 They set the table very well for us here in this
3 community. Thank all of you for your participation today and
4 for the hard work that I know is to come. We really
5 appreciate your engagement. Thank you all for coming.

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1 CERTIFICATE OF NOTARY PUBLIC

2

3 I, Carmen L. Lundy, do hereby certify that pursuant
4 to the Rules of Civil Procedure, the witness named herein
5 appeared before me at the time and place set forth in the
6 caption herein; that at the said time and place, I reported
7 in stenotype all testimony adduced and other oral
8 proceedings had in the foregoing matter; and that the
9 foregoing transcript pages constitute a full, true and
10 correct record of such testimony adduced and oral proceeding
11 had and of the whole thereof.

12

13 IN WITNESS HEREOF, I have hereunto set my hand this
14 22nd day of December, 2010.

15

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19

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21 Carmen L. Lundy

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23

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25

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