

THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

CMS LISTENING SESSION:

HEALTH CARE DELIVERY SYSTEM REFORM

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LOCATION: The Westin St. Francis Hotel

335 Powell Street

San Francisco, CA 94102

REPORTED BY: Freddie Reppond

1 A P P E A R A N C E S

2 SPEAKERS:

3 David Sayen, CMS Regional Administrator

4 Dr. Donald Berwick, CMS Administrator

5 Dr. Richard Gilfillan, Acting Director, CMS
Center for Medicare & Medicaid Innovation

6
7 Melanie Bella, Director of Federal Coordinated
Healthcare Office

8 Herb Schultz, HHS Regional Director

9 COMMENTERS:

10 Fred Mayer, Pharmacists Planning Services

11 Dr. John Maa, UCSF Medical Center

12 Leslie Mikkelson, Prevention Institute

13 Elaine Wong Eakin, California Health Advocates

14 Wynne Grossman, Center for Oral Health

15 Melanie Balestra, California Association for Nurse
Practitioners; American College of Nurse
16 Practitioners

17 Dr. Dexter Louie, National Council of Asian and
Pacific Islander Physicians

18 Franco Herrera, San Francisco General Hospital

19 Jarbe Durant, Durant Management Corporation

20 Dr. Tom Bodenheimer, UCSF

21 Debbie Rogers, California Hospital Association

22 Hattie Hanley, Right-to-Care Initiative

23 Kathy Ochoa, SEIU-UHW

24 Adrienne Bousian, Planned Parenthood Shasta Pacific

25

1 A P P E A R A N C E S (Continued)

2 Dr. Dean Schillinger, UCSF, San Francisco General
3 Hospital

4 Dennis Robbins, National Research Network

5 David Grant, California Alliance for Retired
6 Americans

7 Dr. Bill Walker, Contra Costa Health Services
8 Carol Woltring, Center for Health Leadership and
9 Practice of the Public Health Institute

10 Michael Negrete, Pharmacy Foundation of California
11 Stephanie Berry, California Primary Care
12 Association

13 Dr. Bert Lubin, Children's Hospital Oakland
14 Joan Rothstein, California School Health Centers
15 Association

16 Terry Leach, University of California

17 Dr. Yoshi Laing, San Francisco General Hospital

18 Dr. Basil Khan, UCSF

19 Anne Hinton, Department of Aging Adult Services,
20 City and County of San Francisco

21 Joanne Handy, Aging Services of California

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1 P R O C E E D I N G S

2 [The meeting began at 9:13 a.m.]

3 MR. SAYEN: Good morning, everyone. Try that
4 again.

5 Good morning, everyone. You know, my name is
6 David Sayen; and I'm the regional administrator here at
7 CMS in San Francisco.

8 And originally I worked in our Philadelphia
9 regional office. And in the regional offices --
10 regional administrator's office in Philadelphia -- it
11 actually overlooks the back of Independence Hall, where
12 the Declaration of Independence was written. And
13 there's a little park that it overlooks, you know,
14 behind Independence Hall. And sometimes when I was
15 working on something challenging, I would go over there
16 instead, just to get outside. And sometimes I would
17 think about the Framers and how they sat in those same
18 places and thought about the things they were working
19 on.

20 And it strikes me today, as I looked at the
21 New York Times article today that reminded us how
22 President Reagan spoke out against socialized medicine
23 when the Medicare program began, I remembered that big
24 changes don't happen all at once. So when the Framers
25 wrote the Declaration of Independence, I imagine a lot

1 of people in the Colonies thought that they were crazy,
2 frightened. They probably thought these people were
3 the equivalent of domestic terrorists. You know,
4 almost a hundred years later you have the Emancipation
5 Proclamation. A lot of people didn't agree that
6 slavery should end; and it took a number of years for
7 that change to actually happen and a lot of bloodshed
8 as well. And then in the 1960s we had the Medicare
9 program. The American Medical Association was opposed
10 to it. Hospitals were opposed to having to integrate
11 in the South, that the law required; and it really took
12 quite a while to realize that promise of healthcare
13 security for our seniors, which is by no means
14 guaranteed. It continues to be a challenge for us
15 every day.

16 So here we are now with another, you know,
17 piece of legislation, another big step toward the
18 social justice goals that are embodied in providing
19 healthcare to everyone. But the passage and signing of
20 one piece of legislation is not the whole game by any
21 stretch. It's just one point on a continuum of points.

22 And so what we're here to talk about today is
23 a very important part of that, which is the
24 improvements, the innovation, the goals that are
25 embodied in the bill to create the kind of things we

1 need to create to really sustain what we are trying to
2 accomplish.

3 I think that -- and looking around the room,
4 knowing some of the brilliant people that are in this
5 room, we know the things that we need to do to solve
6 the problem of providing the care that everyone needs.
7 The trick is getting everyone to do them. So when we
8 think about how long it takes for a new innovation in
9 medicine, for example, to become the established
10 practice -- they say it's like 17 years -- that's the
11 problem that we're having. And what we're looking at
12 today is learning how can we make change happen faster
13 and get to where we need to go. And so we're looking
14 forward to hearing from you.

15 And we are very pleased to have three guests
16 from our leadership today that will be speaking to you
17 briefly and primarily listening.

18 The first is the administrator, Dr. Donald
19 Berwick, who was recently named administrator, who was
20 previously the chief executive officer at the Institute
21 for Healthcare Improvement and a clinical professor of
22 pediatrics and healthcare policy at the Harvard Medical
23 School.

24 I guess you're actually still a professor at
25 Harvard, though. You're off. I thought once you're a

1 professor, you're always a professor. Darn. No tenure
2 for you. Okay.

3 And then we also have Dr. Rich Gilfillan,
4 who's the acting director of the Center for Medicare
5 and Medicare Innovation at CMS, where he's working to
6 develop innovative programs to improve and update the
7 nation's healthcare delivery systems. He came here in
8 July of 2010, formerly the president and CEO of
9 Geisinger Health Plan and the executive vice-president
10 for system insurance there. And before that he was a
11 senior vice-president at Coventry Healthcare and before
12 that at Independence Blue Cross in my home town of
13 Philadelphia.

14 And then finally we have Melanie Bella,
15 recently appointed as the director of the Federal
16 Coordinated Healthcare Office at the Centers for
17 Medicare and Medicaid Services, an office that was
18 established by the Act to focus on the opportunities
19 for taking better care of the millions of people that
20 are eligible for both Medicare and Medicaid.
21 Previously she was the senior vice-president for policy
22 and operations at the Center for Healthcare Strategies,
23 where she worked on integrated care for complex
24 populations and people with multiple chronic
25 conditions, which, of course, is one of our biggest

1 challenges in Medicare and in Medicaid.

2 So, with that, I'll hand it over to Dr.
3 Berwick; and we'll have the three speakers; and then
4 we'll move to our listening session.

5 DR. BERWICK: Thanks, David.

6 Let me begin by expressing my thanks to David
7 and to Herb Schultz and my colleagues from the regional
8 office out here that made my visit here to San
9 Francisco so enjoyable already. And it's a pleasure to
10 get this -- to spend some time talking with all of you
11 about the possibilities that lie ahead of us. And
12 we're really interested in your input and comments and
13 we really do want to listen, as David said. So I'm not
14 going to talk very long. But I did want to set the
15 stage a little and then let Rick and Melanie make a few
16 opening remarks to give you the context.

17 So it's an important time in American
18 healthcare. We are at what feels to be a turning
19 point. The context is changing fast; and the energy
20 supplied by the new law, the Affordable Care Act, is
21 unprecedented. There's a tremendous amount of good news
22 in the Affordable Care Act around better coverage where
23 people need it, more security for beneficiaries -- both
24 current ones and those to whom care will now be
25 extended through various elements of the Affordable

1 Care Act. And I can spend a long talking about that,
2 but I want to move ahead to the purpose of today's
3 meeting.

4 The Affordable Care Act allows many Americans
5 who otherwise would not have security about their
6 healthcare coverage to have that security. It also
7 improves care in many ways, such as providing new
8 prevention benefits for current beneficiaries in both
9 Medicare and enhancements in Medicaid. But all of the
10 possibilities created by that law and by all of our
11 wish to have American healthcare reach everybody are
12 inhibited by the current problems of the healthcare
13 delivery system. And so, in addition to the coverage
14 agenda embedded in that act, there is another and
15 equally important agenda, which is to help healthcare
16 as a delivery system to become what it can become.

17 The current system is highly fragmented, as
18 many of you know. It doesn't give, especially, our
19 most vulnerable patients a fair shake in terms of
20 continuity of care and forms of efficiency and
21 effectiveness that keep them as healthy as they
22 possibly can be. We know about the deficiencies in the
23 way that our healthcare system is structured. Now the
24 stakes are higher because, in order to make access and
25 care sustainable for all Americans as we wish it to be,

1 we're going to have to invest as a nation in the
2 improvement of the delivery system itself.

3 The way I'm framing that at CMS with my
4 colleagues there is as a three-part aim, familiar from
5 my past, but very relevant today. It's an agenda for
6 improvement. The first is to improve care for
7 individuals. The Institute of Medicine in 2001 gave
8 us, in the "Crossing the Quality Chasm Report," a
9 framework for thinking about the dimensions for
10 improvement in the six aims for improvement in the
11 report. You're familiar, I'm sure, with many of these.

12 Safety: Improving the safety of patients in
13 care. So not getting injured by the care that's
14 supposed to help them.

15 Effectiveness: Aligning care better with
16 science so that people are absolutely guaranteed to get
17 all the care that can help them.

18 Patient-centeredness: To give -- turn over
19 to patients and families and communities the control --
20 the power to control their own destinies, to make
21 decisions that affect them, and to have us serve them
22 as guests and providers instead of just hosting
23 institutions.

24 Timeliness: The reduction of unwanted
25 delays.

1 Efficiency: The reduction of waste. Follow
2 a nurse through her day and you see it -- the hunter-
3 gatherer activity, the burdensome recording -- all of
4 the things layered into the life of a nurse, for
5 example, that denies him or her a chance to actually
6 have the contact with the patient they really want.
7 That's the lack of efficiency.

8 And equity: Closing racial and socioeconomic
9 gaps in health status.

10 The IOM said we need better care for
11 individuals in those dimensions: Safe, effective
12 patient-centered, timely, efficient, and equitable.

13 We're not there. Just three weeks ago, in
14 the New England Journal of Medicine, Chris Landrigan
15 and his colleagues reported on a study in North
16 Carolina, a state with a lot of activity and
17 improvement. But in ten hospitals tracked there, no
18 progress over the years 2002 to 2007 in the rates of
19 injuries to patients. And

20 I could make the same comments about all the
21 other dimensions of quality. So the first big aim:
22 Better care for individuals.

23 The second big aim is better health for
24 populations, because the events that lead us to have to
25 focus on care of individuals -- heart attacks and

1 injuries and strokes and diabetes and all -- many, many
2 cases traced to causal systems that lie way outside
3 healthcare. Only ten percent of the variation in
4 health is attributable to care. And unless we get
5 serious about upstream generators of those and really
6 get authentically serious about it, we'll continue to
7 deal with burdens that could be avoided. So the second
8 big aim is improvement of health for populations.

9 And the third and equally important component
10 of social need now is to do that: better care for
11 individuals, better health for populations while
12 reducing costs. Reducing costs through improvement --
13 not harming a hair on anyone's head, not by withholding
14 any care that people want and need, but by working very
15 hard on forms of improving the process and the delivery
16 that result in exactly what we want -- better care at
17 lower cost -- lower cost through improvement.

18 That three-part tool -- better care, better
19 health, and lower costs -- is the framework that I'm
20 bringing with my colleagues at CMS into our work every
21 day now. That's the kind of invention we need in our
22 country. The Affordable Care Act changes a lot that
23 will give us more will and more momentum toward those
24 goals, new forms of linkage of payment to measurements
25 of quality, for instance; supports to integration

1 through proper payment; and more.

2 But it's said in Africa that you don't make -
3 - that measuring -- weighing a pig doesn't make a pig
4 fatter. Just wanting to be better doesn't get us
5 there. Improvements of the type we are after -- better
6 care, better health, at lower costs through improvement
7 -- are change to change. And so it comes with the
8 territory of current American healthcare need and
9 policy to foster change and improvement in care --
10 improvement in the delivery of care itself, doing our
11 work differently.

12 We can call that healthcare delivery reform.
13 That's what it means. It means reworking our care
14 system altogether to have the ability to achieve higher
15 levels of performance on those three core social goals.

16 In the Affordable Care Act there are a number
17 of assets -- a number of resources -- that we can
18 harness to that goal for improvement through change --
19 better care, better health, and lower costs through
20 improvement through change. And that's what we're here
21 to discuss with you today.

22 One is the concept of an accountable care
23 organization. In the law there are a number of forms
24 of passive foster accountability for populations for
25 better care, better health, and lower costs through

1 improvement that weren't there before, including on a
2 fee-for-service side of Medicare -- A and B and D --
3 Medicare system. We're calling those accountable care
4 organizations -- and we are right now in our agency in
5 the process of writing a notice of proposed rule-making
6 that will appear probably in mid-January, which I hope
7 you'll all comment on, which is helping to give texture
8 and precision and more comprehensibility to the concept
9 of an accountable care organization. That's important.
10 We want to hear from you about that today.

11 But there are also two organizational
12 resources represented here by my colleagues Rick
13 Gilfillan and Melanie Bella. Rick heads the CMS
14 Innovation Center -- the Center for Medicare and
15 Medicaid Innovation, in the law -- quite a brilliant
16 component of something inventive and exciting for our
17 country, which Congress has set aside a substantial sum
18 -- \$10 billion over the next ten years -- for us to
19 establish and manage an innovation center whose role is
20 to foster and develop it all over the country of
21 improved and new forms of healthcare delivery -- better
22 delivery; and to spread the good news so that we find
23 or create a better delivery opportunity for better
24 care, better health, and lower costs through
25 improvement. We have the capacity to spread that

1 information and put it at the service of all of the
2 organizations and individuals out there that actually
3 want to make their care better.

4 Rick will be describing some of the agenda
5 that we're thinking about for that center. Melanie has
6 the Federal Coordinated Healthcare Office. I call it
7 the office of dual-eligibles, because that's where its
8 focus really is -- the 9.2 million people in our
9 country -- people eligible for both Medicare and
10 Medicaid who have especially onerous burdens through
11 their lives through disability or illness or other
12 factors that have caused them to become more
13 independent on us to help them through these journeys.

14 These 9.2 million Americans explain about, I
15 think, \$350 billion of our costs. They're -- 40
16 percent of the costs of state Medicaid budgets are
17 being devoted to these people. And they don't get a
18 fair shake. They get lost. They get dropped through
19 the slats. They're -- the systems that we built around
20 them are not well-coordinated. They don't work
21 together.

22 And Congress in its wisdom set up this
23 center, under Melanie's leadership, to cross the
24 bridges between Medicare and Medicaid and other
25 resources so that we can make much more sense for the

1 journeys and care of these 9.2 million people around
2 these concepts -- accountable-care organizations, the
3 Center for Medicare and Medicaid Innovation, and the
4 Federal Coordinated Healthcare Office.

5 We now want to hear from you. We're going
6 around the country in these listening sessions to get
7 feedback from you on your ideas. How should this work?
8 What should -- what do we need to know about you and
9 your context and your needs and your hopes that would
10 help us inform the next phase of standing up to these
11 very, very important efforts? Rick and Melanie and I
12 are very sensitive to the concept that one size is not
13 going to fit all here. We have a rich and textured
14 nation. There are variations among regions and
15 geography and demography and history and resources and
16 aims. And we want to hear about that, because in the
17 end I think it's going to be community by community and
18 area by area that's going to shape your own versions of
19 better care, better health, and lower cost through
20 improvement. And we need to be here to help you do
21 exactly that.

22 That said, I want to introduce -- I guess
23 Rick will fill in next. Rick is heading up the Center
24 for Medicare and Medicaid Innovation. You've heard
25 about his background. He's a terrific colleague and

1 he'll give you a little more precision on what we're
2 thinking.

3 DR. GILFILLAN: Thanks, Don. Thanks, David.
4 Thanks, Herb and Betsy and Nicole and the team that
5 have kind of come together to make this a whirlwind,
6 but a very enjoyable and very informative visit so far.

7 Let me just bring these slides up, if I
8 could.

9 Just like we planned it. Thanks, Darryl.

10 It really is a pleasure to be here. You
11 know, I must say I had great conversations last night.
12 And healthcare is local and the delivery systems are
13 local and the experience within healthcare systems is
14 very local and different. Of course, California is
15 close to unique, I think, when we start talking about
16 these new opportunities to redefine care. And so many
17 of the individuals and systems and people working in
18 your care systems over the last 25 years have really
19 set the stage for where we're headed. And we're
20 looking to you all -- and very mindfully -- of what we
21 can learn out here. And we learned a lot last night
22 from talking with folks.

23 I learned a lot this morning sitting down and
24 talking to folks in a local hospital. Two doctors and
25 a hospital administrator looked me in the eye, said,

1 You know, that 30-percent number that IOM talked about?
2 It's there to be gotten. The 30-percent waste in the
3 system -- the 30-percent better improvement, better
4 performance on the cost side -- is there to be gotten,
5 based on the recent experience that they've had in
6 putting into place new systems of care.

7 We should take a moment and reflect on that.
8 Thirty percent is what IOM estimated and what three
9 people in San Francisco told me this morning. It's
10 pretty remarkable when you think about it.

11 So three topics which Don has introduced.
12 And I just want to kind of ground us for a moment in
13 patients and the patient and the fact that at the end
14 of day what we're really talking about is redirecting
15 resources -- some of that 30 percent -- away from waste
16 and towards supporting people like Marie, who is
17 pictured here with her case manager. And her medical
18 home -- her primary care office was transformed into a
19 medical home where there are case managers assigned to
20 folks who could benefit from more intensive
21 coordination and support. Marie has a variety of
22 chronic illness. You can read her story on the New York
23 Times Website, where the story -- there's a slide set
24 and the audiotape of Marie and a nurse describing their
25 interaction.

1 So Marie before went to the hospital a lot,
2 went to the emergency room a lot, because she had
3 chronic obstructive pulmonary disease, a host of other
4 chronic illnesses. And when we put this nurse in her
5 office -- in the primary care office -- she suddenly
6 had someone who could actually work with her closely.
7 We put a hotline in so that nurse has had a line that
8 Marie can call directly to talk to about -- to talk to
9 the nurse about her problems with exacerbations,
10 questions about her medications. Her daughter can call
11 that phone number and talk directly to that nurse.

12 That support system doesn't exist today for
13 most people in Medicare. And yet most people on
14 Medicare can benefit dramatically from that kind of
15 support. And as Marie says here, as you can see, "The
16 idea of the program is to keep me healthy, keep me out
17 of the hospital, and keep costs down. I don't think I
18 would still be here without the program. It's been my
19 lifeline."

20 Health system transformation -- delivery
21 system reform -- is about taking those wasteful
22 resources and putting them in place to help people like
23 Marie and others who can benefit from that much closer
24 attention.

25 The mission, as Don has laid out, is for CMS

1 to be a constructive force and a trustworthy partner
2 for the continual improvement of health and healthcare
3 for all Americans. We know we cannot get meaningful
4 delivery system reform without working with folks --
5 other folks -- in communities to present a single or a
6 common approach for providers to want to have a
7 sensible environment within which to produce the kind
8 of care we're looking for. So it's a transition, as
9 Don mentioned, from a fragmented care system to a safe,
10 seamless, coordinated care system. The outcomes he's
11 mentioned already -- the three-part aim of better care,
12 better health, lower costs for the continuous
13 improvement.

14 The Center of Innovation -- if you think
15 about that for a moment, like, how do you get from
16 where we are today -- a fragmented care system to a
17 seamless-care system -- how do we get there, it
18 involves learning about new ways of delivering care and
19 learning about new ways to support providers in
20 delivering that care. And so, in a quite farsighted
21 way, the Affordable Care Act was -- established the
22 Center to test innovative payment and service delivery
23 models to reduce program expenditures while preserving
24 or enhancing the quality of care. Pretty direct focus
25 on the opportunity to improve the efficiency of the

1 system, as you can tell.

2 So we are interested in innovations in models
3 of care and models of payment that produce same
4 quality/lower costs. Occasionally we'll do some higher
5 quality/same costs. That's important and we can't
6 ignore it. It's important. It's not where we are
7 going to be doing most of our work. Where we're going
8 to be doing most of our work is in that realm where you
9 can improve quality and reduce costs. And we believe
10 firmly that the two go hand in hand.

11 We -- as Don mentioned, we're provided with
12 \$10 billion in funding over a ten-year period -- not
13 necessarily in the annual budget, but over ten years.
14 We were given a clear path forward and some freedom --
15 more freedom -- to operate than would normally have
16 been the case within prior demonstration or piloting
17 projects.

18 And, finally, there's a very interesting
19 twist to this. At the end of the day, if we find
20 models of care that take us from a fragmented care
21 experience to a seamless-care experience and we can
22 demonstrate that they result in lower program
23 expenditures -- that is, we are now paying providers in
24 a different way -- we can go to the Secretary and the
25 actuary -- the feedback from Medicare -- and if they

1 certify that indeed this is the case, that the costs
2 are lower, we can go to the Secretary and through
3 regulations, through rule-making, change Medicare's
4 fundamental ways of paying for services without having
5 to go back through Congress, which Kay knows is a
6 difficult thing to do. So that's kind of the big
7 change, if you will.

8 We now have the ability to think dynamically
9 about how CMS, through Medicare and Medicaid, can
10 interact with the delivery system and support the
11 delivery system in that new pursuit. So our mission at
12 the Center is to be a trustworthy partner to identify,
13 validate, and diffuse new models of care payment that
14 improve those three dimensions.

15 Okay. So we are really pretty tightly
16 focused. People say, Well, how can I talk to you about
17 models of care? We say, Think about patients. Think
18 about patient needs. Think about interventions that
19 address those needs in a way that's better than they
20 were before. Interventions like we talked about with
21 Marie and the nurse case manager. Interventions like
22 that -- that will make a difference. Tell us about a
23 population of those patients and tell us about how you
24 will measure and demonstrate movement on those three
25 dimensions of better health, better care, and better

1 costs.

2 And oftentimes we'll be talking about co-per-
3 month costs. Sometimes it will be a set below that.
4 We're going to be very focused and disciplined about
5 asking folks who are interested in doing these new
6 models to tell us that story and draw a tight
7 connection between the intervention, the patient, the
8 population, and the impact that they can see.

9 We'll focus on three levels. As Don
10 mentioned, we talked about the care model for
11 individual patients. How do you do the best OB care?
12 We'll talk about systems that coordinate care across
13 different sites -- ACOs, medical homes, and others --
14 which, no doubt, you guys out here in California will
15 tell us about and help us discover and test. And we'll
16 talk about interventions at the community of population
17 health level, where we can work with other parts of the
18 delivery system, other parts of public health, other
19 community initiatives, other parts of the federal
20 government addressing those fundamental determinants of
21 health of the population.

22 Here's a schematic of how we're thinking
23 about the Center. And we're interested in talking and
24 hearing from you all about ideas about how we should
25 interact and how we should operate, how we should think

1 about priorities, how we can best learn from you and
2 support you in this pursuit, which we think is a common
3 pursuit for all of us.

4 We'll have a diffusion learning system.
5 We're very interested and will invest significantly in
6 learning activities that will drive and support these -
7 - this new approach to care. We'll have teams of
8 people focused on those three levels looking for
9 innovations at those three levels. We know they will
10 cut across many -- will cut across those three levels.

11 But we're thinking very concretely; and our
12 business will be to constantly refocus on the patient,
13 where the patient is. And we will push resources. We
14 will push staff. We will push program to the patients,
15 to the delivery system out to you, not in Washington,
16 not consume them in Washington. So it's all about
17 getting that \$10 billion out to you to support what you
18 want to do in delivering on this new mission.

19 We'll have innovation cycle management. and
20 our goal here -- function. Our goal here is to be --
21 is to build an infrastructure nationally that supports
22 innovation specifically aimed at achieving the mission
23 and delivering the results we're after in those three
24 dimensions. And we'll be interested in supporting that
25 in all sorts of ways so that -- today there's great

1 innovation in medical devices, drugs -- lots of things
2 that support and benefit from a fragmented care system.
3 And think about us together building an infrastructure
4 where -- that supports innovation aimed at those
5 outcomes that Don described.

6 And finally we'll have a rapid-cycle
7 evaluation process. Think about our endpoint. The
8 actuary says this actually meets the criteria of saving
9 expenditures and improving quality. We can -- to
10 demonstrate that that's the case, we need to be able to
11 rapidly evaluate these models so we will have and be
12 building a rapid-cycle evaluation process.

13 Where are we today? We've opened our doors.
14 We're in the process of building a strategic and
15 operating plan. These outreach activities are a key
16 part of that. We want to help -- we want you to help
17 us think about how we should operate and what our goals
18 should be. We want to capture innovative ideas that
19 are out there today. And we have a Website,
20 innovations.cms.gov, where you can provide us -- you
21 can learn about what we're doing right now. And in
22 about two weeks you'll be able to, directly through
23 that site, give us suggestions, ideas. We're not at
24 the stage of accepting proposals yet. But we will be
25 there very shortly.

1 We are beginning our work; and we're working
2 across CMS; and we announced a couple of weeks ago four
3 new initiatives coming out of CMS aimed at taking us
4 from fragmented to that seamless-care environment. The
5 first is the multi-payer advanced primary care practice
6 model, where we will be working with states -- eight
7 states -- and supporting already existing medical home
8 programs by kind of doubling down with Medicare,
9 supporting what is already being supported by state
10 governments and private employers. We think that this
11 would result in us supporting approximately a thousand
12 medical homes across the country.

13 We also are supporting and working closely
14 with our Medicaid colleagues on their health home state
15 plan option, where the federal government will
16 reimburse 90 percent of the costs for health homes that
17 are established by state Medicaid plans. But we also
18 announced directly out of the Center an initiative to
19 build medical homes in Federally Qualified Health
20 Centers. We expect that this will address about 500
21 FQHC sites.

22 And, finally, we are working closely with
23 Melanie in her office in a program she will describe
24 further that reaches out to the states and seeks
25 proposals from the states to new ways to better

1 integrate and coordinate care for that dual-eligible
2 population.

3 Partnership is central to all this. We know
4 that we need to present a rational environment for
5 folks in the delivery system so they're not being
6 pulled in this direction and that direction. We'd like
7 to talk about common metrics, common definitions of
8 success, and ultimately become a business model. In
9 that sense we're looking to partner with states,
10 payers, large employers, and providers to kind of help
11 build that common framework for us to think about the
12 new care system in. And the key point there is we want
13 to be operating and investing in an environment where
14 all patients are benefiting from these innovations.

15 Next steps: We're finishing up our business
16 plan. We'll be coming public more as we get out in the
17 next six weeks with that initial business plan. As I
18 mentioned, we'll have our Website up and be developing
19 online innovation communities and begin operating over
20 the next 60 days.

21 Let me just say a little bit about the shared
22 savings program. We are in rule-making for the ACO
23 shared savings program. It's going live January 2012.
24 We've had a lot of input already, conducted a lot of
25 listening sessions. We're interested in comments today

1 as well -- thoughts you may have. We just completed an
2 RFI process and received a great many comments and
3 suggestion from folks; and that closed a week ago.

4 A couple of principles about the -- as we're
5 thinking about ACOs. First and foremost, it's not
6 about financing primarily. It's about a new way to
7 deliver care. It's about getting to that point that we
8 described with Marie. It's about finding those new
9 ways to support providers in delivering that kind of
10 experience for patients.

11 There will be, as defined, multiple -- many
12 types -- of providing indices coming together, we
13 believe, to do ACOs. There's an essential requirement
14 in the legislation that we make sure that these
15 organizations are patient-, person-, people-centered.
16 And we're paying a great deal of attention to that.
17 We're interested in thoughts about how to make sure in
18 the rule-making process that we adequately address
19 that. There's a need to establish and to hold ACOs
20 accountable for meeting the quality threshold. And we
21 are taking that very seriously. And, again, I'd be
22 interested in people's thoughts about that.

23 We know that these are going to be data --
24 and need to be -- data-rich environments. We are --
25 we've had a lot of input already on the issue of what

1 data, how often, how detailed, et cetera. We're
2 interested in learning from you on that. And we know
3 that we need to be in a position -- or the ACOs need to
4 be delivering this seamless-care experience. And there
5 are prerequisites. If you think about it, if you think
6 about what does it mean to actually be able to say you
7 have a coordinated system where the patient has the
8 feeling that it's been engineered for them to provide
9 the seamless-care experience, what are the
10 prerequisites for that? Think about that and give us
11 suggestions, if you would, on that. And we know that
12 this needs to be a continuously learning system to meet
13 that three-part aim that we've talked about.

14 With that, I will turn the microphone over to
15 Melanie to talk about the dual-eligible program. Thank
16 you.

17 MS. BELLA: Thank you.

18 Good morning. I want to echo my thanks for
19 everyone in the region who's made this such a wonderful
20 visit for us. I'm going to be brief because we do want
21 to hear from you.

22 I guess I'll start off -- I just want to know
23 how many of you interact with someone who is eligible
24 for both Medicaid and Medicare? You care for them --
25 oh, okay. So for how many of you have we made that

1 easy? No hands. Sorry. I guess that's a trick
2 question. So our job is to change that. So when we
3 come back in six months or a year, gradually I'll hope
4 to see a few more of those hands going up.

5 And it's particularly relevant here. I mean
6 Don mentioned there's 9.2 million individuals who are
7 eligible for both programs. You have 1.1 million of
8 them in this state. Medi-Cal spends \$20 billion a year
9 -- Medi-Cal alone -- on the care of these folks. And so
10 it's incredibly relevant. And as we look at our little
11 score card and really push ourselves to move more of
12 these individuals into seamless systems of care, we
13 want you on this side. We want to move that number
14 into the score column that says, yes, these are people
15 who are experiencing a seamless journey; we are
16 improving care; we are improving health; and we are
17 lowering costs by virtue of that improvement.

18 So why are we focused on dual subsidy? It's
19 obvious; and it's even more obvious in California. The
20 beauty of your state is that you have a lot of assets
21 in place. You have -- you have different assets upon
22 which to build, whether it's case programs or special
23 needs plans. We have a lot of interest in the
24 comparable care organizations. And we hope that you
25 will think about how to broaden that concept to put the

1 launch of care piece in that and to think about the
2 blended funding stream. And you just have a lot of
3 innovation generally; and we really look forward to
4 working with you on that.

5 So let me tell you just a little bit about
6 this office. Around CMS halls we all kind of fondly
7 refer to ourselves as our number in the Affordable Care
8 Act. I'm 2602. Rich is 3021. But, nevertheless, 2602
9 -- really, I want to highlight just a few key things on
10 this slide.

11 The first important point in the first bullet
12 is access. We need to improve access to care for
13 people who are eligible for both programs. We don't do
14 a good job of that today.

15 The second is coordination. This is not
16 going to work if the states and the federal government
17 don't work together. And in large part the systems
18 that we're seeing today are driven by the separate
19 funding streams. It should be no surprise to us, both
20 programs work exactly as they were designed to work.
21 They were never pictured as serving over nine million
22 people when they were created. And so our job is to
23 think about the fact that they now do and how do we
24 make them work together from the perspective of an
25 individual.

1 The third point is we're looking for
2 innovation in delivery system design and payment
3 methods; and that's why we're excited to be able to
4 work with the Innovation Center and with all of you.

5 And last and very importantly is the
6 financial misalignment. There is way too much churning
7 of patients that goes on, driven by the incentives in
8 the system to do so. It's not good care and it's not
9 good use of our limited resources. And so we have a
10 real opportunity to change that.

11 So it is all about the individual. And
12 nowhere could this be more important than for these
13 folks that are complex patients in the system. When we
14 think about what we're going to be looking for in
15 designing these systems of care and working with
16 states, it's about what we expect the beneficiary to
17 receive. And our bar is high. When we think of fully
18 integrated care, it's everything that a person needs.
19 It's getting rid of the fragmentation. That means
20 primary care, acute care, behavioral health, and long-
21 term support and services. And we will drive toward
22 that. And we recognize every state won't be ready for
23 that on Day 1, but we need to see a plan for getting
24 there; because, otherwise, we're sort of just
25 meandering in this status quo.

1 The next thing, just to give you a brief --
2 again, brief -- description, our office is organized
3 into two main areas of business, if you will. The
4 first is program alignment. That is literally
5 cataloging every single place these two programs bump
6 up against each other and figuring out how many
7 beneficiaries it's impacting, what will be the
8 financial impact of fixing -- we call this our fix-it
9 list, by the way -- what would be required to fix it?
10 Would it be -- can we do it administratively? Does it
11 require regulation? Does it require statute? And then
12 we will prioritize this list and we'll make it very
13 public. It will be a living, breathing, transpiring
14 document that all of you will continue to give us input
15 into. And I'll tell you at the end how you can
16 continually give us input on this list.

17 And then the second area of activity is
18 around the models, demonstrations, and the analytics.
19 We will be actively testing new models of care and new
20 methods of financing that care. We also will be
21 committing to having a much stronger analytic
22 understanding of the population, particularly subsets
23 of the population, and teasing out so that that
24 understanding of who these folks are in this very, very
25 heterogeneous group really drives our thinking about

1 the care models, the financing mechanisms, and the
2 measurements. And it goes well beyond the over- and
3 under-65 group, but clearly there are important subsets
4 that we need to look at as we redesign systems of care.

5 So, quickly, what are we doing? We're
6 staffing up. We have a small but mighty team and we're
7 going to give this our best shot. We have established
8 coordinating committees within CMS and within HHS.
9 Sometimes I joke that instead of the Federal
10 Coordinated Healthcare Office we should be called the
11 Office of Translation and Interpretation because kind
12 of our phone is there and when Medicaid can't
13 understand why Medicaid is making them crazy, they can
14 call us and we interpret; and that's our job. That's
15 our job internally and that's our job externally. So
16 we very much want to play that role.

17 We -- external stakeholder outreach is really
18 important to us, so doing these things, but having
19 other mechanisms to sit down and get into real detail
20 with folks is very important, particularly as we work
21 on our fix-it list.

22 And, lastly, we're developing state profiles
23 -- again, to be more public, to get information out
24 there about who are these folks so that we begin to
25 have a much better understanding of who the subsets are

1 and what's driving their care needs and their costs.

2 So we have a little email box. That is the
3 acronym of our office. We also would be happy to have
4 people come up with more creative names than the
5 Federal Coordinated Healthcare Office. Certainly I do
6 not recommend you try it in an acronym, but please feel
7 free to use this email box. Send us anything and
8 everything, all the things that you would change if you
9 were us, all the things that drive you crazy about
10 working with these two separate programs. That's the
11 best to get in touch with us. But certainly we will be
12 creating opportunities along the way to get input.

13 So, with that, we just look forward to your
14 comments today. Thank you very much.

15 MR. SAYEN: Now, we get to the reason that
16 we're here. When I thought about the challenge of
17 hearing from so many people in a relatively brief
18 amount of time, I thought about who do I know that
19 really knows how to work with a group and have a
20 meeting be really successful? And I thought about --
21 we are focused very much at HHS on kind of being
22 boundary-less and working throughout the department and
23 CMS together to achieve the goals that we're trying to
24 do.

25 And so with that I reached out to our

1 regional director, who fortunately is on the same floor
2 and we work together a lot, Herb Schultz. We work
3 together a lot when we're in the office, which is very
4 rare. He spent the weekend running around Indian
5 country in Arizona and got back here just in time to do
6 this.

7 Herb previously was in Governor Davis's
8 cabinet as the Secretary of Labor. And then he also
9 served Governor Schwarzenegger as a senior adviser, did
10 a lot of work on the governor's healthcare effort.
11 Some of you may have met him when he did more than 1800
12 listening sessions all around the state. And he also
13 worked on the recovery bill efforts for the State of
14 California. And I guess it's been about six or seven
15 months now that he's been here as the regional
16 director, which is the Secretary's representative for
17 Region 9 at HHS. And so he is going to facilitate the
18 discussion so that we can hear from you and get some
19 ideas to get us started on innovation.

20 So, with that, Herb Schultz.

21 MR. SCHULTZ: Thank you. I can't ask for a
22 better partner than David and all of our colleagues at
23 CMS. And it's a real honor to have Don and Rick and
24 Melanie out here.

25 I want to let everybody know that we have a

1 phone, I think, with approximately a hundred people on
2 the phone. And the one thing that we all recognize in
3 Region 9 and recognize at headquarters is that we're
4 the largest region by geography and we're the largest
5 region by population. So we have folks from Arizona,
6 from Nevada, and from Hawaii on the phone.

7 So, Hawaii, hello. You got up at 6:00 a.m.
8 to do this call and thank you -- 6:00 am on Wednesday.

9 But I also want to say, as you know, we have
10 six Pacific jurisdictions, including three territories;
11 and we have representatives there. So right now, if
12 you just sort of centered on Guam and that region, that
13 part of the region it is about 4:00 o'clock in the
14 morning. And we do have people on the phone. And
15 that's 4:00 a.m. Thursday, because you've crossed the
16 date line. And that's how much they want to hear from
17 our colleagues and they want to express their views to
18 all of our colleagues sitting up here.

19 So it's a real pleasure to be here on behalf
20 of the Secretary. And I think, as this whole visit has
21 demonstrated, is the notion in this administration of
22 two things. One is one HHS. And we all work together
23 to cross-pollinate every day within internal, external,
24 as Melanie said so well. But, also, as a part of that
25 sort of one HHS, I think that the biggest thing that

1 the Secretary said to our ten regional directors,
2 myself included, when I started this position, is we
3 cannot be successful in the implementation of
4 healthcare reform or in any of the initiatives within
5 the Department of Health and Human Services or in this
6 administration, if we're not working with key external
7 stakeholders on the nongovernmental side. And this
8 department has always worked with state government and
9 some of the locals. But at the department level we've
10 learned from our colleagues at CMS and our colleagues
11 at HRSA and others and now, as you know, are reaching
12 out together to be able to come out to consumers,
13 labor, plans, providers, business, academics,
14 philanthropics, agents, brokers, and many others of you
15 that are in the room that we could name.

16 So I'm going to open it up. I'm going to ask
17 folks to, you know, state your name and what
18 organization you're with. And, given our timing, would
19 really appreciate folks' being, you know, coherent of
20 that and we'll move along the dialogue. So, with that,
21 let me open up.

22 Fred Mayer.

23 FRED MAYER: Yes. My name is Fred Mayer.

24 Dr. Berwick, your Harvard colleague Lucian
25 Leape had a study showing 107,000 deaths per year

1 because of drug interactions. Consumers like myself --

2 By the way, Fred Mayer, Pharmacists Planning
3 Services, nonprofit public health consumer pharmacy
4 organization, San Rafael, California -- forgot that.

5 Dr. Lucian Leape said 107,000 are dying
6 because of they're mixing up their drugs.

7 A couple of simple things that you could do
8 which doesn't take a lot of planning but from the
9 consumer aspect: Number one, two days ago there was a
10 death reported in the Washington Post about a
11 pharmacist mixing up a cancer drug for a blood-pressure
12 drug and the patient died. One of the things we could
13 do is on all prescription labels that are coming out
14 from CMS or Medicare or Medicaid is to put what the
15 medical indication is right on the label. In this
16 case, if it said one tablet daily for high blood
17 pressure versus one tablet daily for cancer, anybody
18 would have seen, well, this is the wrong thing. Nice
19 and simple. And that was suggestion No. 1.

20 Suggestion No. 2 is a question, I guess, for
21 Rick Gilfillan. Is -- Dr. Gilfillan, in light of the
22 evidence that pharmacists, medication therapy, MTM
23 services improve clinical and economic outcomes, what
24 would be your recommendation for how consumers and the
25 professional pharmacies should engage in the new CMS

1 Innovation Center? How do pharmacists work? Because
2 pharmacists are nowhere in this game plan. We don't
3 see pharmacists at all. And I am just wondering is
4 there any pharmacist at CMS? Is there anybody that we
5 could talk to? We have one pharmacist here at CMS,
6 Lucy Saldano, for the entire region of California,
7 Arizona, Fiji, et cetera, et cetera.

8 So there are three questions. And first is
9 the mixing up of drugs -- ICD-9 code unlabeled. Number
10 two, how do we work with the CMS Innovations Center?
11 And, number three, we need more than Lucy Saldano or
12 somebody at CMS to hear our problems. Thank you.

13 MR. SCHULTZ: Thank you, Fred.

14 Dr. Berwick or Dr. Gilfillan?

15 DR. BERWICK: I want to pick up on two points
16 that Fred said. And, remember, our purpose here is to
17 hear from you, so we're going to make a lot of notes
18 and get back to you rather than have too much of a --
19 trying to answer all the questions.

20 But, first of all, patient safety is a key
21 area. When we talk about being a major force for
22 improvement, it's very much on my mind that the kinds
23 of injuries that Fred was talking are occurring; and
24 not just in medications. They're all over the place,
25 even though we have many mechanisms, that we know that

1 pioneers have developed to make patient care safer --
2 medications, for example; blood pressure; ulcers; and
3 infections in hospitals. You'll see CMS move more and
4 more into that world of measuring, reporting, safety
5 issues, relating it to incentives; but, also, reaching
6 out to hospitals and clinics and physicians to help
7 them learn how to give safer care.

8 A lot of that is based in team-based
9 thinking. And I think as we stand up ACOs and medical
10 homes and other forms of care that can take
11 responsibility for people over time and space, you'll
12 see teams form. And I think pharmacists will be
13 central to those things.

14 DR. GILFILLAN: Yes. We have -- actually, we
15 have a pharmacist in our office, Fred. So his name is
16 John O'Brien; and he works in an aligned part of CMS,
17 but very much an important part of our team; although,
18 I need to be clear, he's not a full-time staff member
19 within the Center right now. He's bringing in that
20 perspective, though.

21 You know, we look to you, because we know
22 drugs are an important opportunity for folks to have
23 better health and to receive better care. And we need
24 to understand that better. So we are looking for you
25 all to come to us and say, Here's how we think we can

1 come together with patients, with other pharmacists,
2 with medical folks to make a difference. And we'll be
3 very interested in seeing proposals that get at that
4 point. So we are open to it, but we want to make sure
5 that we get you engaged in creatively thinking about
6 what the opportunity would be that we should think
7 about.

8 MR. SCHULTZ: And, Fred, as we've talked
9 about, there is a medication therapy management pilot
10 program in the ACA. Certainly we want your thoughts
11 and input on that.

12 FRED MAYER: Last thing is thanks for
13 inviting us, Herb. It's refreshing to have consumers
14 and activists coming to a meeting. This is very rare.
15 We haven't seen this in the last eight years. But
16 thank you.

17 MR. SCHULTZ: Next.

18 JOHN MAA: Good morning. My name is John
19 Maa. I'm an instructor at UCSF Medical Center. Thank
20 you for your wonderful leadership and your wonderful
21 presentations.

22 I just had a suggestion, ways of moving the
23 qualify improvement and pay-for-performance efforts
24 forward. The plenary speaker at the AHRQ innovations
25 conference this fall was Atul Gawande. And he told the

1 story that's repeated so often around this country of a
2 patient who suffers blunt abdominal trauma and
3 undergoes a splenectomy and gets discharged home, only
4 to return, perhaps while traveling abroad several
5 months or a few years later, in overwhelming sepsis and
6 renal failure requiring amputations -- extremity
7 amputations -- because someone forgot to give a
8 Pneumovax.

9 And I know that Atul and Malcolm Gladwell
10 have been really interested in the science of failure.
11 I spoke with Atul recently; and I suggested that,
12 rather than reporting what we perceive as good care,
13 what we really need to do is study these types of
14 failures.

15 One of my projects at the UCSF School of
16 Medicine is really to understand what is a poor-quality
17 teacher. And in my research I found it's very
18 interesting. It's not simply the opposite of what a
19 good teacher is.

20 And with regard to the pay-for-performance
21 movement, you could create a quality measure which
22 states, Give Pneumovax 95 percent of the time, or even
23 99 percent of the time. But you'll still have these
24 incidents like the one that Atul described in Boston
25 that had occurred, he said, in every single city in the

1 United States of America for varying different reasons.
2 And I think that much could be done to really move the
3 quality of improvement endeavor forward by really
4 studying these lines of failure.

5 So best wishes with the Center. Thank you.

6 MR. SCHULTZ: Thank you very much.

7 LESLIE MIKKELSON: Good morning. I'm Leslie
8 Mikkelson with Prevention Institute. And our
9 organization works nationally on really identifying
10 what are the quality approaches to population health.
11 And I so appreciate that that is one pillar of the work
12 that is moving forward. And we are working now with
13 the communities putting prevention to work grantees.
14 And I did see such an incredible opportunity to link
15 the encouragement of innovative models in delivering
16 primary care to this population health work.

17 And just as one practical starting point, I'm
18 wondering if there is an opportunity to put into the
19 criteria and the scoring of any kind of grant-making
20 that's done encouraging the link between these two
21 efforts because I think we can get the most ideally
22 outcome for the government investment in linking the
23 innovative care models to the innovative population
24 health models.

25 Thank you.

1 MR. SCHULTZ: Thank you.

2 Good morning.

3 ELAINE WONG EAKIN: Good morning. My name is
4 Elaine Wong Eakin. I'm with California Health
5 Advocates. I want to thank you for this listening
6 session and others around the country.

7 We'd like to ask the Federal Coordinated
8 Healthcare Office to look into and make sure that
9 beneficiaries who are dual-eligible have viable
10 choices. Currently in California dual-eligibles may
11 choose either a fee-for-service Medicare and Medi-Cal -
12 - that's what we call the Medicaid office program here
13 -- or a dual special needs plan, which is a type of
14 Medicare managed plan.

15 There are pros and cons to both choices.
16 With fee-for-service, the dual-eligible has to find
17 providers willing to accept both Medicare and Medi-Cal
18 and coordinate their own care in a fragmented system.
19 For the special needs plan, the dual-eligible may not
20 be able to access all Medi-Cal benefits, because
21 currently special needs plans are not required to
22 contract with state Medicaid programs and to create
23 financing or coordinate benefits from Medicare and
24 Medi-Cal. Even when special needs are required to
25 contract by 2013, we are concerned that dual-eligibles

1 may not know what their options are or what is the best
2 option for them.

3 Last month a Medi-Cal waiver for California
4 was approved; and that adds another wrinkle. The
5 waiver has a mandate to move seniors and people with
6 disabilities to managed care plans starting June 1st,
7 2011. The waiver specifically does not address how to
8 provide funding sources for Medicare and Medicaid or
9 how to coordinate benefits from both programs with
10 dual-eligibles. If seniors and people with
11 disabilities who have Medi-Cal are in a managed care
12 plan, what happens to them when they become eligible
13 for Medicare? Can they stay in the managed care plan or
14 do they have to choose a special needs plan? If they
15 cannot stay in the managed care plan and they must
16 choose a special needs plan, would they have choices?
17 What would -- would they have more than one special
18 needs plan to choose from? And if they are allowed to
19 choose between the Medi-Cal managed care plan and a
20 special needs plan, how will they be able to compare?

21 So these are just some questions that we
22 would like the Federal Coordinated Healthcare Office to
23 address concerning duals in California. Thank you.

24 MR. SCHULTZ: Thank you, Elaine.

25 WYNNE GROSSMAN. Hi. I'm Wynne Grossman; and

1 I'm with the Center for Oral Health in Oakland.

2 And I really appreciate the opportunity to
3 speak here. Dr. Berwick, I can really see that that
4 ground consistence thinking is coming through in your
5 plans and I appreciate that. And you talked about
6 going really upstream and doing some high-leverage
7 interventions.

8 And I would urge you to really consider what
9 could be done in oral health. Most of the time, we
10 feel like the ugly stepsister of healthcare. Nobody
11 pays too much attention to us. And there are so many
12 things that we know work and can prevent other diseases
13 and that are inexpensive and simple to do. We know
14 that providing dental visits to children by the age one
15 stops dental disease, can prevent dental disease from
16 occurring, and can prevent unnecessary surgeries; and
17 deaths like Diamonte Driver, who is a young man who
18 died in Washington -- or in Maryland -- a few years
19 ago. And it's very inexpensive. And yet there's
20 almost no funding and not much attention.

21 We talked about dual-eligibles; and yet
22 Medicare doesn't address oral health and in most states
23 Medicaid doesn't have dental benefits. We did in
24 California and there were in some other states. But
25 they're being cut as fast as they can be. So if

1 there's anything that you can do to really look at
2 these high-leverage, low-cost interventions, we would
3 really encourage you to do that.

4 Thank you.

5 MR. SCHULTZ: Thank you.

6 MELANIE BALESTRA: Hi. My name is Melanie
7 Balestra and I'm here on behalf of California
8 Association for Nurse Practitioners and the American
9 College of Nurse Practitioners. And I want to thank
10 you for letting me speak.

11 Multiple studies have demonstrated that care
12 provided by nurse practitioners epitomize the delivery
13 of high-quality, cost-effective primary care; and they
14 meet the National Commission for Quality Assurance
15 Medicare Payment Advisory Committee standards of care
16 for such entities as primary care and medical home.
17 The ACO models do not have to be confined to models
18 designed and led only by physicians and focused on
19 physician practices. Nurse practitioners have proved
20 that in primary care they can deliver quality care
21 equivalent to primary care physicians. Critical
22 provider responsible for enabling a organization to
23 meet specified quality performance standards and
24 qualify to share and savings are assured a central role
25 in leadership of the organizations.

1 And we believe these should also be -- nurse
2 practitioners should be included. Physicians do not
3 have the time to meet all patient needs. There simply
4 aren't enough of them to go around. NPs and advanced
5 practice nurses can assist and help meet these needs
6 effectively.

7 Another obstacle is payment. And we believe
8 that all services should be paid the same way, whether
9 a nurse practitioner delivers a service or a physician
10 delivers the service, because it's the same exact
11 service. They're doing the same thing.

12 The Institute of Medicine landmark report has
13 come out in 2010, which I'm sure you're sure of. And
14 the report's key messages include: Nurses should
15 practice to the full extent of their education and
16 training and nurses should be full-time partners with
17 physicians and other healthcare professionals.

18 I'd also like to stress, you know, having the
19 viability of small practices, not just allowing large
20 institutions to be ACOs. Patients should be able to
21 choose their own provider, whether they be a nurse
22 practitioner or a physician. They should have all
23 options present. And many NPs now already can function
24 -- I would say over 25 states in the United States have
25 NPs functioning independently. So I think that goes to

1 prove that they could be very good ACO managers.

2 Okay. Thank you.

3 MR. SCHULTZ: Thank you.

4 DEXTER LOUIE: Good morning. Thank you for
5 coming to listen. I'm Dexter Louie. I'm chair of the
6 National Council of Asian and Pacific Islander
7 Physicians. I'm a practicing physician. I've been
8 practicing right up the street here in Chinatown for
9 about 33 years, so I know about safety-net issues.

10 And that's largely my question. Asian
11 Pacific Islanders are a more-or-less overlooked
12 minority. And we are not all the model minorities,
13 because the majority are not. They're immigrants --
14 new immigrants -- and second generation. My father was
15 an immigrant.

16 So I guess the big ask is we need to provide
17 meaningful and coordinated outreach. It's not just for
18 the physician -- the safety-net physicians -- in these
19 communities, but also their patients, because there are
20 emotional issues here. There's cultural competence,
21 language access, even geographic access. If you look
22 in the Valley here in California you have Hmong
23 scattered up and down Highway 5. And you have
24 physicians who cannot communicate with them.

25 On provider HIT, I was just at the office of

1 the national coordinator; and it is so hard to bring
2 EHR, which is one of the requirements of the ACA --
3 hard to bring it to these solo physicians out in the
4 wilderness. They're just -- they don't have access.
5 They don't belong to an ACO. In fact, I would say most
6 minority physicians don't belong to organized medicine.
7 So they don't have access. So there is so much to do,
8 such a challenge.

9 Thank you for listening.

10 MR. SCHULTZ: Thank you very much.

11 FRANCO HERRERA: Good morning. My name is
12 Franco Herrera. I work for San Francisco General
13 Hospital, one of the implementing improvement nurses at
14 the hospital.

15 I believe without the knowledge, expertise,
16 and engagement -- the obvious contribution of nurses --
17 we are the single largest healthcare providers in
18 America -- hospitals will be unable to achieve the
19 triple aim you guys were talking about today -- better
20 care, better health, and lower costs; and for any
21 patients, not only Medicare-covered patients.

22 So based on the IOM Future of Nursing report,
23 I was wondering what the plans are for your agency to
24 guarantee the nurses' highly valued contribution is not
25 only rewarded but also incentivized as much as

1 providers and hospitals under the Affordable Care Act.

2 Thank you.

3 DR. BERWICK: Since there have been a couple
4 of questions about the nursing report, I'm well aware
5 of it. I keynoted the summit last week at which the
6 report was widely discussed with hundreds of people.
7 It's a very important report, taken quite seriously by
8 my colleagues in CMS. We're looking at the report for
9 indications for us that we can and should take action
10 on. I'm sure there will be consideration of the report
11 throughout the department. So we're really intending
12 to pursue that.

13 MR. SCHULTZ: Thank you.

14 Welcome.

15 Jarbe DURANT: Welcome. Thank you. My name
16 is Jarbe Durant. I'm president of a management
17 consulting firm that's putting together and developing
18 a coalition of a hundred primary care and family
19 clinics out of Los Angeles County. And, first of all,
20 I want to thank all of you for coming, because this is
21 so needed and it's very valuable to all of us here.

22 What my doctors are interested in, because
23 they have already been serving the underserved, so
24 forth and so on, how do they become or get some sort of
25 grant or become a pilot program or demonstration pilot

1 in Los Angeles County for some of the initiatives which
2 you have? So that's something that my people are
3 interested in.

4 DR. GILFILLAN: Jarbe, I think -- as I
5 mentioned, we're not quite at the point of accepting
6 proposals proposed. But keep an eye on our Website,
7 innovations.cms.gov. We'll have more information
8 coming as this -- as we move along. We'll be
9 interested in hearing from organizations like the ones
10 you described who are particularly interested in
11 serving -- delivering these new services in underserved
12 populations. And Melanie and I and our teams will be
13 working very closely together to look for opportunities
14 to support models of care that go at that, all the
15 issues you described. So I would keep an eye on that
16 site.

17 And at any point if -- we also have an open-
18 door policy where we're meeting with folks in our
19 offices in DC. We've heard from a lot of people. So
20 it wouldn't be -- might not be as prompt as we would
21 like, but we're available. And you can get us through
22 that -- calling our office as well. We can get you
23 that information subsequently.

24 JARV? DURANT: Thank you very much.

25 TOM BODENHEIMER: Good morning. I'm Tom

1 Bodenheimer. I'm at the department of family and
2 community medicine at UCSF and also at San Francisco
3 General Hospital.

4 I'd like to speak about the need for payment
5 reform for community health centers. As, of course,
6 you all know, community health centers are a very
7 vibrant and growing part of our healthcare system. And
8 they really rely on the augmented Medicaid payment to
9 survive. But the problem with the augmented payment is
10 that it really only pays for face-to-face visits by
11 MDs, NPs, and physician assistants.

12 We are trying very hard to make reforms in
13 the community health centers that are badly needed to
14 improve access to improved care to the population and
15 to reduce costs. So we are training medical assistants
16 to be panel managers to make sure that all patients
17 have all of their preventive and chronic care needs
18 done. We are training people to be health coaches, to
19 work with people with diabetes, hypertension,
20 hyperlipidemia. We need to have email visits and text
21 message visits with our patients so they don't always
22 have to come in if it's difficult for them to come in.
23 And, of course, we need our end-care managers for those
24 very complex patients that I think you've spoken about
25 before who have such high-cost and fragmented care.

1 We can't do any of those things without
2 payment reform, as I'm sure you all know. So hopefully
3 you will take a considerable amount of your efforts to
4 think about community health centers which are so
5 important.

6 Just one final thing is that, as -- community
7 health centers are really not at risk for reducing
8 hospitalizations and unnecessary emergency department
9 visits. And we feel like they should have some risk,
10 because if they don't have any risk for doing that,
11 then we'll continue to have -- they won't deal with the
12 cost part of these triple aims.

13 So thank you very much.

14 MR. SCHULTZ: Thank you.

15 DR. BERWICK: And, Tom, have you or any of
16 your colleagues documented a list of modernizations in
17 payment schemes for community health centers that would
18 be better aligned with the innovations in care you're
19 talking about?

20 TOM BODENEIMER: I think the National
21 Association of Community Health Centers and some other
22 people are working on things. But what we can do is
23 try to -- this was not a positive proposal. It was
24 just sort of a plea. But we could certainly put
25 together a positive proposal.

1 DR. BERWICK: Sure. I'd be interested in --
2 this is not outside the two centers -- but issues in
3 subregulatory, regulatory, and statutory changes that
4 you're implying would be needed. That would be very
5 helpful to get that input.

6 TOM BODENHEIMER: Okay. Thank you.

7 MR. SCHULTZ: Next -- and then for those of
8 you in the room, we are keeping the lights down just a
9 second more just in honor of our folks that are on the
10 phone from different parts of the country. No.
11 Seriously, we will have the lights up shortly. Sort of
12 noted sitting up here, gosh, it's a little dark.

13 Hello.

14 DEBBIE ROGERS: Thank you. I'm Debbie
15 Rogers. I represent the California Hospital
16 Association. And I wanted to thank you for the
17 opportunity. The fact that you're reaching out across
18 the country to hear from us and to hear about the
19 specific needs and interests that we have is really
20 terrific.

21 We continue to be inspired, Dr. Berwick, by
22 the big goals that you have for many, many years now
23 put out in front of healthcare providers to meet. And
24 we do reach and we do meet them. And certainly the
25 desire to have patient-centered care, that the patients

1 should be the center of the world and the reason why we
2 provide the care that we provide.

3 California hospitals have a long history of
4 providing integrated care. And we want to share with
5 you a little bit of our successes and some of the
6 challenges that we face. We're also detailing this in
7 a letter that will reach out to you this week or so.

8 We believe that successful integration and
9 care works best when there's an alignment between all
10 of the providers -- be they physicians, hospitals,
11 others that we work with -- where the mission and the
12 vision and the incentives are all going in that
13 patient-centered care direction. We know that this
14 takes capital investment and we know that IT --
15 information systems -- the ability to hand off care
16 between systems, between providers is vital. And we
17 know that when there's shared responsibility for the
18 management and the services to our patients, that's
19 when it works the best.

20 We also know that there are challenges in
21 integration, not the least of which would be the
22 funding alignment and funding for some of the capital
23 improvement mechanisms and for some of the coordination
24 that isn't currently funded under our current scheme.
25 We also know that there are legal barriers that prevent

1 full integration, be they anti-referral laws and those
2 sorts of things. And they will absolutely be detailed
3 in our letter to you.

4 The beneficiaries who are dual-eligible are
5 really some of our most vulnerable and some of our most
6 complicated patients that we care for. What's most
7 important is that they have the appropriate access to
8 the care that they need.

9 In a prior life I was an emergency department
10 nurse for many, many, many years; and I saw firsthand
11 the use of the emergency department for patients who
12 could not find access to Medicaid providers in the
13 community. And yet in a truly integrated system this
14 is really needed.

15 We also know that one of the hallmarks of
16 these programs is beneficiary choice. And so as we
17 look at how to best provide care for this population
18 and how to move them into integrated systems, we want
19 to be mindful of that beneficiary choice.

20 Really appreciate the remarks this morning
21 and the acknowledgment of the needed flexibility both
22 probably at the state level and at the local level.
23 Here in California we are so diverse in every possible
24 way that there could never a model that would work
25 everywhere. And appreciate the fact that there's an

1 acknowledgment that we will need some flexibility.

2 And thank you very much for the opportunity.

3 MR. SCHULTZ: Thanks, Debbie. And I can
4 attest that she is a trauma care nurse, because on my
5 first -- upon my appointment meeting that I went over
6 to the California Hospital Association I managed to
7 park, walk right into a cement thing, showed up
8 bleeding; and Duane Dauner, the CEO, drove me while
9 Debbie held my head together. And Sutter Health did a
10 very good job of keeping me together. So she really
11 should be back in nursing.

12 HATTIE HANLEY: Hi, I'm Hattie Hanley. And I
13 run a program for the State of California called the
14 Right-to-Care Initiative. I work for the California
15 Department of Managed Healthcare and UC Berkeley School
16 of Public Health Dean Steve Shortell.

17 And what we're trying to do is -- and I spoke
18 with you on the phone about this -- is spread best
19 practices in California into areas where there's really
20 clear scientific information that has not had good
21 uptake. So we are trying to prioritize those areas
22 using metrics -- HEDIS -- because that's what we have,
23 as imperfect as that is, to challenge the health plans
24 of California to get to the national 90th percentile of
25 performance, focusing in particular on proxies for good

1 managed care, which we see as control of high blood
2 pressure, control of LDL lipids, and control of blood
3 sugar.

4 So what we found is working with the 38
5 million people across California is a huge job. Herb
6 is the ultimate pro at this. But what we've decided to
7 do, thanks to a GO grant -- NIH GO grant -- with the
8 National, Heart, Lung and Blood Institute that supports
9 comparative effectiveness research is to do a
10 demonstration project in San Diego. So we are working
11 with the providers across, not just commercial managed
12 care where we have regulatory authority at the
13 Department of Managed Healthcare, but with the other
14 main providers there -- the Veterans Administration,
15 the Navy, the community clinics. And Herb is going to
16 help us synch up some of that with the grants that HHS
17 is doing on wellness. And one of the big challenges is
18 how do we synch up all the quality improvement efforts,
19 because there really are a lot of quality improvement
20 efforts and very impressive things going on here with
21 the California Quality Collaborative, the Integrated
22 Healthcare Association.

23 But I would just urge you, given what we have
24 found in the three years we've been doing this, to try
25 to focus on some metrics that are readily achievable

1 and that people focus on them and where we know it's
2 going make a huge difference, so we know by controlling
3 the blood pressure and the lipids, which are pretty
4 simple things.

5 And Arnie Milstein, who I'm sure you all
6 know, is wanting to focus there. We've got cheap
7 generics and we know how to manage these cases. So
8 let's see if we can get everybody to do it. And what
9 we've seen is some real improvement in three years
10 among the largest health plans and most integrated
11 groups in California.

12 Where we find the biggest challenge is with
13 the independent practice association model, which is
14 comprised of the onesy-twosy doctor practices. So we
15 have -- and I would love to just connect with you about
16 this and just try to think with you and your staff
17 about how we can take this wonderful moment in time
18 where you're bringing your awesome leadership that
19 everybody in this room I'm sure has been a fan of Dr.
20 Berwick, if they're here. It's such an exciting moment
21 for our nation and it may be a brief window of
22 opportunity where we can really leverage some big
23 change.

24 So I'm just hoping that you can help with
25 that spread of best practices quickly -- and it's not

1 that easy to do. We have no budget for it at the
2 state, so we're doing it all on grant funding. And
3 we're doing in one community because we just don't have
4 staff and we don't have the resources to try and do
5 that intensive effort across the provider.

6 Anyway, so we would welcome you to join us
7 for our demonstration project in San Diego. Thank you.

8 MR. SCHULTZ: Thank you, Hattie.

9 Kathy.

10 KATHY OCHOA: Good morning and welcome to
11 California. My name is Kathy Ochoa. And I'm here
12 representing Service Employees International Union,
13 United Healthcare Workers West. We're a two-million-
14 member union nationally, largest concentration of
15 healthcare workers on the West Coast and here in
16 California.

17 We are dedicated to healthcare justice, as
18 you will find as we work together. And we look forward
19 to the full implementation of the new healthcare law.
20 In order to achieve better care, better health, lower
21 costs and improve the delivery system, we have to be
22 mindful that we have to pay attention to the frontline
23 healthcare workforce and the role that they are going
24 to play in transforming our system. Systems are
25 designed, but it takes people to propel those systems.

1 And our union looks forward to figuring out what those
2 meaningful roles might be as we seek innovation
3 opportunity.

4 Right now UHW is working in a couple of areas
5 in San Joaquin and Santa Clara County and South Los
6 Angeles with teams of people who are looking at what
7 type of system delivery improvements we can create and
8 perhaps bring forward to the Innovation Center. We
9 would ask that as a metric you consider labor
10 management partnerships as foundational to the
11 successful outcomes of the goals that you have
12 articulated this morning. That's one thing.

13 We also would urge you to consider the types
14 of support that these innovations are going to need if
15 they are targeting safety-net systems or communities
16 that are the highest underserved communities that are
17 essentially deserts in terms of healthcare resources,
18 communities that lack access to supermarkets or to
19 green space. And a safety-net focus -- contemplating
20 that -- one that is built upon public and partnerships
21 is going to add another level of complexity, especially
22 when you consider an area as diverse and as large as
23 Los Angeles County.

24 We look forward to be full partners with you;
25 and on your next visit out would like to invite you to

1 a viewing tour of South Los Angeles. And I think that
2 would provide another way for you to measure this is
3 where we are and this is where we want to get. And
4 with your support, we believe we can get there. Thank
5 you.

6 MR. SCHULTZ: Good morning.

7 ADRIENNE BOUSIAN: Good morning. I'm
8 Adrienne Bousian. And I'm the vice president of public
9 affairs for Planned Parenthood Shasta Pacific. We have
10 17 counties in Northern California, including San
11 Francisco.

12 And I wanted to encourage that birth control
13 is covered under the Women's Health Amendment of the
14 Affordable Care Act. We know that HHS has directed the
15 Institute of Medicine to weigh in on this; and that's
16 happening right now. So this is very timely for me to
17 just make a few points on behalf of Planned Parenthood.

18 That fully covering birth control is a cost-
19 saving measure. Research from public health insurance
20 coverage shows that every dollar spent on
21 contraceptives saves \$3.74 in Medicaid spending in the
22 future. Better access to birth control is going to
23 lead to better pregnancy outcomes and reduce the
24 incidences of maternal and infant complications, which
25 are serious health problems that cost billions of

1 dollars a year. We know that in 1999, when the law
2 mandated federal contraceptive for federal employees,
3 that this did not increase costs for the federal
4 government, so it's cost-effective.

5 And, most importantly, birth control should
6 be covered, because the medical evidence is clear, when
7 women plan their pregnancies they're more likely to
8 seek prenatal care, improve their own health, and the
9 health of their children.

10 So thank you very much. And we are confident
11 that HHS will listen carefully to the Institute of
12 Medicine recommendations and include all preventive
13 healthcare for women. So thank you.

14 MR. SCHULTZ: Hello.

15 DEAN SCHILLINGER: My name is Dean
16 Schillinger. I'm a primary care physician at San
17 Francisco General Hospital and take care of a lot of
18 people with diabetes. And wearing another hat, I'm the
19 chief of the diabetes prevention control program for
20 the State of California.

21 And I was incredibly excited, Dr. Gilfillan,
22 to see the inclusion of public health innovation in one
23 of the missions of the new organization that you head.
24 As a clinician working in San Francisco General, which
25 has really been the home of a lot of innovation and

1 delivery for vulnerable populations, over the last few
2 years it's been a real pleasure for me to be able to,
3 on my one-on-one visits, see my patients' hemoglobin
4 A1Cs come down. As we initiate the registry, we're
5 seeing the blood pressures improve. Hopefully,
6 complication rates falling.

7 However, in the other three years, in my
8 other hat, California went from having one out of nine
9 adults having diabetes to now one out of eight -- and
10 almost one out of seven. I tell my kids, who are
11 learning math, you know, when I took the job it was one
12 out of nine and now it's one out of eight. Wow, Dad,
13 you're incredible. And as they're now sort of
14 approaching seventh grade and learning about ratios and
15 fractions, now I find myself saying, well, it would
16 have been one in seven had I not taken the job.

17 But, you know, these are really big issues
18 that are going to require significant innovation. And
19 as you know, the Centers for Disease Control and
20 Prevention provides very limited resource in the
21 chronic disease realm for states. For example, in
22 California we get a million dollars a year, arguably to
23 prevent and control diabetes for 3.7 million people
24 with diabetes.

25 So my question, which is probably linked to

1 one of the first questions from the Public Health
2 Institute, is what is the scope and scale of your
3 thinking and innovation in public health? Are we
4 talking about innovations in safety-net health systems
5 like San Francisco General Hospital, which do a good
6 job with the people who come? Or are we really talking
7 about some of the upstream opportunities, Don, that you
8 mentioned in some form of demonstration project,
9 because clearly, you know, the spigot is wide open.
10 And, you know, it's the big cost problem for us.

11 DR. BERWICK: Question, Dr. Schillinger. So,
12 with respect to diabetes and obesity as well, what's
13 your assessment of the degree of evidence we have? Is
14 it a spread problem -- we know we what to do and aren't
15 doing it? Or is this really a radical go back to
16 basics and figure out new patterns of managing --

17 DEAN SCHILLINGER: Are you talking about
18 clinical practice or are you talking about the
19 incidence of disease?

20 DR. BERWICK: Well, what you do, for
21 instance, in the clinical practice, what you do about
22 the overall analogy of it in the community level?

23 DEAN SCHILLINGER: I think in the clinical
24 practice, the state of the field is fairly advanced. I
25 think where a lot of me and my colleagues have focused

1 their efforts is on to how to make those advances
2 applicable to the underserved, vulnerable populations
3 who disproportionately have diabetes and how to bolster
4 the health system in which they receive their care.
5 And I think there's a lot of leverage there.

6 I think there needs to be, as health IT rolls
7 out, I think those advances are going to relate to how
8 we get the health IT benefits to the people who need it
9 the most. Literacy and language issues are going to be
10 incredibly important.

11 I think on the epidemiologic and public
12 health side -- you know, I mean I think we're talking
13 about -- thinking about the tobacco epidemic as the
14 model and really applying that in a serious way to
15 obesity and diabetes. And I think there are a number
16 of very good ideas, obviously related to diet -- you
17 know, sweetened beverages and sodium in our foods and
18 other things that could have small impacts at an
19 individual level but gigantic impacts nationally. Some
20 of the work done by my colleague at my center Kirsten
21 Bibbins-Domingo showed that modest reductions in sodium
22 content of processed foods -- modest -- to meet those
23 of, like, United Kingdom and Portugal would be on a par
24 with half of America stopping smoking or everybody
25 being on antihypertensive all the time with a hundred-

1 percent adherence. So I think those sorts of public
2 health interventions could be proven -- because a lot
3 of this is modeling work -- could be proven in
4 effectiveness trials to yield short-term fruit.

5 DR. GILFILLAN: Just to be clear, we urge you
6 to think about opportunities for us in the Innovation
7 Center to -- as we think about that population and
8 health opportunity, we recognize that that's -- at the
9 end of the day, that's where the biggest opportunity is
10 to make a difference in health. Given the work that we
11 need to do in our other -- those other levels -- what
12 we really look for is kind of two ways of thinking
13 about that.

14 And as one of the earlier speakers stated, I
15 think we'd like to find ways to kind of double-down on
16 the activities that we have in the care model and the
17 seamless-care systems in a way that gets at the
18 population. Also, the linkage there -- we'd like to
19 see opportunities to fund activities that link and that
20 have a strong piece of the population experience
21 addressed. Or we'd like to -- and/or we'd like to find
22 opportunities to kind of be synergistic with folks
23 doing primary work in that space and using the unique
24 capabilities that we have and some of the funding we
25 have to kind of be synergistic and make other efforts

1 more effective. So think about, if you would --

2 DEAN SCHILLINGER: Like a marriage.

3 DR. GILFILLAN: -- yeah, yeah, exactly,
4 because I think there's -- there's lots of people who
5 are primarily focused on that space; and what we want
6 to bring to it is the special capabilities that we have
7 to make those more effective. And we'd love to think
8 about focused efforts that are community-based that get
9 at some of these fundamental determinants of health,
10 particularly around diabetes and obesity.

11 DEAN SCHILLINGER: Thanks a lot.

12 MR. SCHULTZ: Good morning.

13 DENNIS ROBBINS: Hello. Dennis Robbins. I'm
14 with the National Research Network with the General
15 Patient Safety Healthcare Quality and a professor of
16 health policy at Pepperdine.

17 So I guess I'm going to ask more of a policy
18 question rather than a science question. Science data
19 and quality is obviously going to drive the change that
20 you want to make with your stewardship, your vision,
21 with your thoughtfulness. I wonder how you suggest we
22 might deal with the misunderstanding of the general
23 population and the public in terms of what you're
24 trying to achieve is really so wonderful for them to
25 misunderstand where it's going and what it's all about.

1 Thank you.

2 DR. BERWICK: There is a lot of
3 misunderstanding out, Professor Robbins, as you said.
4 And the -- but the logic is so compelling. And when I
5 see a patient and I have alternative ways to take care
6 of that patient, I really want the knowledge as to what
7 is better for the patient. And the whole arena of
8 investment in that kind of understanding, the
9 comparative effectiveness of the options you have, is
10 just in the interest of everyone. And I think we need
11 your voice and everyone's voice speaking up and
12 explaining how important it is that we work with
13 knowledge, as opposed to figures.

14 MR. SCHULTZ: We're coming up on about 20 of,
15 with 20 minutes. So I know a lot of people are in
16 line; and this is a listening session as well. So I
17 want to make sure that people are able to get comments
18 in to our panelists.

19 Good morning.

20 DAVID GRANT: Good morning, Herb. Good to
21 see you again. My name is David Grant. I'm here on
22 behalf of the California Alliance for Retired
23 Americans, which is California's largest senior
24 organization.

25 And the reason I'm here is talk about the

1 certainly missing 800-pound gorilla in the room, which
2 is the 4.4 million Medicare beneficiaries, the patients
3 and consumers who often do not have much of a voice or
4 a role in all the decision-making that goes on about
5 healthcare delivery systems. CARA has been a member
6 for the past four years of California Safe Hospital
7 Discharge Collaborative. And those of us who work with
8 seniors -- in my case for the past 30 years -- have
9 seen a lifetime career-long path where seniors have
10 been pushed out of hospitals unready to go home, ill-
11 prepared to cope, and then having a poor outcome. And
12 we've all complained, as with pitchforks in the outer
13 darkness, about this for decades.

14 Finally, in 2009, Jencks published a study
15 that it in fact was real and that one out of five
16 Medicare beneficiaries in California come back to the
17 hospitals in less than 30 days without seeing a
18 physician for the very same thing that put them there
19 in the first place.

20 So we've seen this issue now being
21 characterized as the "avoidable readmission problem,"
22 which I think tells you all you need to know about it.
23 That's the perspective as it's from the place where
24 they get admitted, not the place where they're not
25 living anymore. In other words, it's not the patient

1 who shouldn't be back there; it's why are they here.

2 So I wanted to talk about it just briefly.

3 What we've been doing to talk about this issue as
4 consumers to educate people that they don't need to go
5 home just the because hospital system DRG has run out;
6 to identify the fact that there ought to be better ways
7 that you people as the payers for this, through
8 Medicare and Medi-Cal, could insist that acute-care
9 hospitals provide discharge planning services; that
10 Medi-Cal, particularly in California, could much more
11 closely integrate the discharge process for dual-
12 eligibles with the community-based long-term care
13 support service system, which is the network that
14 should be taking care of them.

15 And our argument has had -- we've gone back
16 and forth on it. The most compelling feature we found
17 out, though, was the price tag. We had a meeting last
18 week with Herb to talk about this issue. We're going
19 to release a study in the new year that shows that in
20 California Medicare and Medi-Cal spend a month a
21 quarter of a billion dollars per day for avoidable
22 readmission care; and that if you took the 81,000
23 patients who come back to the hospital unfixed,
24 unhealed, unwell, and instead paid for discharge
25 planners to look after them, and if the discharge

1 planners only took two patients a day, you'd still have
2 \$170 million left over for lord knows what else.

3 So we'd argue that the poor outcomes that
4 people see, the increased costs and amount of money
5 that is spent on fruitless activities here should be
6 much more thoughtfully directed at the idea of
7 smoothing the transition of patients from the acute-
8 care facility back to home.

9 I've been very impressed that Dr. Gilfillan
10 is here and that the head of even the whole office is
11 going to be talking about exactly this sort of thing,
12 from what I saw from the slides. So we'd encourage you
13 to look at this as an idea consumers have an important
14 role in this process. The patients, the families, the
15 caregivers, and the community-based organizations which
16 are going to be providing them with the in-home support
17 services after they leave the acute-care facility. And
18 from a policy point of view you need to establish much
19 tighter linkages between the hospital staff, the
20 primary care physicians in the community, and then with
21 organizations which are going to provide this support
22 and transition home. So I encourage you all to think
23 about it and we'll certainly be looking at the Website
24 for proposal prospects.

25 Thank you.

1 MR. SCHULTZ: Thank you, David.

2 DAVID GRANT: And if I can take two seconds
3 and make a pitch for the nation's only existing
4 universal healthcare system, Healthy San Francisco,
5 which I am a proud member of the Mayor's advisory
6 committee formed under manager Tangerine Brigham, who's
7 sitting right over there. We have 60,000 happy
8 customers receiving healthcare today that otherwise
9 wouldn't because San Francisco all by itself created
10 the system.

11 Thank you.

12 MR. SCHULTZ: Thank you. And Rick had an
13 opportunity this morning to meet with Tangerine.

14 DR. GILFILLAN: Yeah, it was great. And I
15 congratulate you on it. It was really inspiring. It's
16 great work.

17 MR. SCHULTZ: Hi, Billy.

18 BILL WALKER: Hi. I'm Bill Walker. I'm a
19 family practitioner boarded in geriatrics; and I'm also
20 health director and public health officer in Contra
21 Costa County across the Bay.

22 And my department, like many in public
23 hospital systems around the state right now, are really
24 grappling with our role in, No. 1, advancing the number
25 of people actually enrolled in care; and, No. 2, to

1 improve the quality of care and taking waste out of our
2 system.

3 And, first of all, I want to acknowledge
4 working with Dr. Berwick and CMS staff on the recently
5 negotiated Medi-Cal waiver, which is still in progress.
6 And I and my California Association of Public Hospital
7 colleagues around the state are grateful for the work
8 that we're doing with you and particularly for the
9 stretch goals and benchmarks that are part of that --
10 the innovation part of the waiver. The waiver, as you
11 also know, includes a significant expansion of medicaid
12 coverage equivalents as well as the healthcare coverage
13 initiative which would bring more uninsured into care
14 as a bridge to health reform in 2014.

15 But I want to also pick upon the efforts on
16 the triple aim. Now, we've been involved with the
17 triple aim now since its beginning in our department in
18 Contra Costa, working particularly on the issues of
19 patient experience and per capita cost, with our target
20 being ultimately the "Big P" -- the "P" for population
21 of our county in our case. And as we have acknowledged
22 earlier today in some of our comments, really only ten
23 percent of what we do in healthcare really affects the
24 "Big P" in terms of community health indicators. We
25 really have to get outside of our hospitals and clinics

1 to impact that.

2 And so I have basically two questions. One,
3 following the work of Dr. David Kindig, in terms of his
4 work with population health, he acknowledges that
5 that's where you have to go. And yet many of the
6 population-based interventions are as yet not evidence-
7 based. And so I would encourage the Center for
8 Innovation to really begin to focus on those
9 population-based evidence -- proven interventions that
10 we can effectively make.

11 But second is how do you pay for those
12 interventions in the community? And right now we are
13 entirely dependent for the most part on grants either
14 from the CDC, which are few and far between, actually,
15 for the kinds of interventions that have to be done.
16 And, No. 2, work more with foundations, particularly
17 the California Endowment having invested in 14
18 communities around our state. And one of those is in
19 our county.

20 But building on that, my dream would be that
21 as the triple aim advances and -- particularly in
22 highly managed care counties like our own, we have two
23 or three major health plans providing most of the care
24 in the region, that there could be incentives for those
25 health plans to invest in community-based innovations

1 from some of the cost savings from triple-aim work.

2 Now, right now that's voluntary. I'm in
3 conversation with health plans in our county about
4 that. But I would like to suggest that there perhaps be
5 developed CMS incentives in payment programs and in the
6 kinds of models that you set up that would drive some
7 of those savings on the healthcare side of the house in
8 the community health interventions. How you do that,
9 I'm not sure, but I think it really needs to be
10 calculated right now.

11 Thank you.

12 MR. SCHULTZ: Thank you. We look forward to
13 your help and we'll try to figure it out.

14 Good morning.

15 CAROL WOLTRING: Good morning. I'm Carol
16 Woltring. I direct the Center for Health Leadership
17 and Practice of the Public Health Institute, which is a
18 very large long-standing nonprofit organization in
19 Oakland that serves the California region, the country,
20 and do international work as well.

21 I have a point, an observation, and a
22 question. And I'll be quick.

23 First, the concept of a center for innovation
24 is fascinating and it's really needed. I just think
25 the whole concept of a center for innovation -- thank

1 goodness.

2 No. 2, when I looked at the slides, I was a
3 little concerned about the emphasis and the words that
4 were highlighted and bolded in the mission statement.
5 You emphasized patient care -- while improving quality
6 of patient care and reducing costs. There was no
7 bolded word there about the third major objective. I
8 believe the center. And that's improving population,
9 or community, health. I would really like to see that
10 bolded there.

11 I was concerned at first. And then I saw the
12 slide that did two things that really caught my
13 attention. One is over everything you have the concept
14 of a learning system, which I want to come back to.
15 But there was the community health -- the third leg of
16 the stool, so to speak, finally on slide six. So I'd
17 like to really encourage you to think about how to
18 emphasize that more in the purpose statement.

19 My question is around the learning system
20 concept. Knowing your background, I'm very glad that
21 you're emphasizing developing a learning system. We do
22 a lot of work on learning systems through our
23 leadership development -- organizational development,
24 learning communities, learning collaboratives. I
25 really think we need that for harvesting the learning

1 models. And I hope -- and my question is -- will you
2 be looking for partners to work with you to develop a
3 robust learning system? And would you be looking at
4 that both nationally and regionally? And, if so, I
5 think there are a number of us that would really like
6 to work with you.

7 DR. BERWICK: Yes.

8 DR. GILFILLAN: Yes.

9 MR. SCHULTZ: Michael, good morning.

10 MICHAEL NEGRETE: Good morning. My name is
11 Michael Negrete. I'm a pharmacist and CEO of the
12 Pharmacy Foundation of California, created by the
13 California Pharmacists Association in 1977 to improve
14 public health matters re.

15 Lated to pharmacy. We do that in a lot of
16 ways related to preventing medication errors,
17 specifically in the outpatient setting; and through
18 promoting the use of clinical pharmacy services and
19 Medicaid management services in the outpatient setting
20 as well.

21 I appreciate the opportunity to be here this
22 morning and the spirit of openness and inclusiveness
23 that you all are bringing. It's fantastic. That's
24 really what drove me to the microphone today.

25 I want to speak on behalf of a lot of the

1 partners that we have throughout the state and
2 throughout the country both in and out of pharmacy.
3 There's a lot of wonderful little organizations that
4 contribute a great deal to a lot of these demonstration
5 projects. The challenge is most of them aren't of the
6 size or scope that they're going to do their own
7 proposals. And unfortunately a lot of the
8 organizations who are doing proposals don't partner
9 with these folks, don't think about including them in
10 the proposals, don't think about partnering with them
11 when they roll out their projects and the proposal's
12 been accepted. And it's either because they don't know
13 about them or they don't know what they can bring to
14 the table or they just don't think of it when they're
15 putting the proposal together. And I am wondering if
16 there's an opportunity that you all can bring to -- I
17 don't know if it's like a match.com -- some kind of
18 infrastructure that would --

19 MR. SCHULTZ: I'm not dating you, Michael.

20 MICHAEL NEGRETE: That's fine. My wife
21 appreciates that.

22 I'm wondering if there's some infrastructure
23 that could be put in place where these smaller
24 organizations can make themselves known as who they are
25 and what they can bring to the table; and during the

1 proposal process the people who are proposing can be
2 referred to that site and say, Look at these resources
3 in your area. Partner with them. Include them in your
4 proposal when at all necessary and make that happen,
5 because I think they will really expand the
6 opportunities of what we can all do together.

7 DR. GILFILLAN: We were laughing because we
8 had that conversation last Thursday night about 9:30 as
9 we were putting the organization together. So that --
10 it's great to hear that suggestion that it would be
11 meaningful, because that's actually part of that. We
12 think that opportunity to build that national
13 innovation infrastructure is literally a Match.com for
14 people to come together. So if you have more specific
15 ideas about that, tell us. But we are interested to
16 hear more about it. Not now, but I'm sure we'll be
17 happy to hear it.

18 MR. SCHULTZ: Hi. We've got about 10
19 minutes. So that's why I'm --

20 STEPHANIE BERRY: Hi. I'm Stephanie Berry
21 with the California Primary Care Association. We're
22 the nonprofit statewide association that represents all
23 the community clinics and health centers in California.
24 And we have over 800 throughout the state.

25 And I really wanted to just make a couple of

1 comments about when you're thinking about the rule-
2 making for the ACOs. We really see clinics as natural
3 health homes. We think that we have a vital role to
4 play in this. And we feel that primary care really
5 should be the foundation of the ACO model and that any
6 shared savings should be reinvested for it to enhance
7 the health home model.

8 And, also, we really think that clinics
9 haven't really been identified as being qualified
10 providers in the ACO model. So we really hope that,
11 when you're proposing your rule, that you really keep
12 in mind the value that clinics and community health
13 centers can provide for that model.

14 MR. SCHULTZ: Thank you.

15 The line -- the woman in the back is the
16 last. Just so we know and we'll be giving you follow-up
17 information for people to continue to provide input to
18 CMS and the department.

19 Good morning.

20 BERT LUBIN: Good morning. I'll try to go
21 fast. I'm Bert Lubin; and I'm the CEO and president of
22 Children's Hospital in Oakland. I came to Children's
23 Hospital Oakland 37 years ago, starting in hematology
24 oncology and the research program; and one year ago
25 became the president and CEO. And I've learned a great

1 deal about healthcare in this year, being in a hospital
2 that now serves 70 percent Medicaid. It's -- every
3 year has gotten progressively more Medicaid because
4 people are unemployed and there's no place for them to
5 go. And access for Medicaid patients, even though all
6 the hospitals say they'll accept everybody, they're
7 not. They don't all accept everybody.

8 And I want to speak here for children. And I
9 know Dr. Berwick understands this, that this is our
10 future. And we haven't heard a lot about where
11 children fit into this. And they're not a strong
12 lobby; and they're not going to vote; and they're not
13 politically -- I mean they're politically moderately
14 powerful, but not very powerful.

15 So I'd like to make some suggestions.
16 Federally Qualified Health Centers. We're fortunate we
17 have one because of more foster care and homeless care
18 in the FQHC and we don't see adults in it. But all
19 children's hospitals could really benefit if they were
20 Federally Qualified Health Centers; they get reimbursed
21 at a level to take care of their subspecialty care.

22 We see 250,000-odd patients a year. We lose
23 50 to 60 million on subspecialty care for Medicaid
24 children -- for diabetes. We have a thousand children
25 with diabetes, a hundred new patients a year. Who pays

1 for the educator? Who pays for the nutritionist? Who
2 pays for the nurse coordinator? We only get ten cents
3 on the dollar of the cost that we charge, given this
4 state right now. So if we're going to look for the
5 future of health for our society, where children fit
6 into this is really critical.

7 And the other part is chronic illness in
8 children. We are doing better as pediatricians. Kids
9 are living that didn't live before, from heart disease,
10 cystic fibrosis, sickle cell, et cetera, et cetera.
11 There's no place for them to go when they leave the
12 children's hospital. There isn't another place in our
13 society that will pick them up and do the care that
14 they should receive. And I think in your planning of
15 thinking of our healthcare system we ought to really
16 think of some innovative ways to provide care for those
17 -- for those young adults who have diseases that start
18 in childhood.

19 And, lastly, we all know that socioeconomic
20 factors and environmental conditions, education are key
21 to health; and yet that is another system. And if we
22 ignore that, it's going to very unlikely that just
23 providing more healthcare is going to do anything but
24 provide more healthcare. It's not going to get at the
25 cause of all these things that we're dealing with

1 today.

2 So thanks, all of you, for listening. A word
3 for children and children's hospitals.

4 MR. SCHULTZ: Thank you.

5 JOANIE ROTHSTEIN: Hi. I'm Joanie Rothstein
6 with the California School Health Centers Association.
7 And I want to thank you for listening to our thoughts
8 today.

9 School-based health centers are about 2000
10 across the country and they serve kids and families
11 without regard for ability to pay. They are an
12 incredible access point, especially for kids who are
13 hard to see -- teenagers, youth that may be falling
14 through the cracks. They provide preventive, chronic
15 care, a lot of mental healthcare, some dental
16 healthcare. And as you are considering innovative
17 models of care, we really urge you to look at school-
18 based health centers. There are a variety of models --
19 some are FQHC satellites, some are county-run, some are
20 school district-run. But we really think that they can
21 be -- you know, medical homes all serve as access
22 points for medical homes and really want those kind of
23 alternative paths for kids to be seen. Really
24 concerned that rules are being made and some of the
25 pilot projects are being created, because they are

1 really a resource-proven outcomes in terms of keeping
2 kids in school, you know, for chronic diseases,
3 monitoring, and lowering costs for emergency rooms and
4 such. So we want to just keep that on your radar. And
5 we will certainly be looking at the Innovation Website,
6 as you said.

7 Thanks so much.

8 MR. SCHULTZ: Thank you.

9 Good morning.

10 TERRY LEACH: Good morning. Thank you so
11 much for the time. I'm Terry Leach. I'm the manager
12 of health policy for the University of California.
13 It's the office of the president. It includes the
14 medical schools and all of the academic medical centers
15 and the other professional schools, including the
16 schools of public health.

17 And I wanted to share with you -- well, first
18 of all, I wanted to thank you for taking the time to do
19 all that you're doing.

20 But I want to let you know that,
21 notwithstanding the competitive pressures we have in
22 California with the economy and the fact that 60
23 percent of our patient days reflect indigent patients
24 or Medi-Cal patients or patients on Medicare, we are
25 also seeing those Medi-Cal numbers going up. We also,

1 of course, have our tripartite mission that many of the
2 hospitals in our space do not have to educate the next
3 generation of providers; provide cutting-edge research;
4 and, of course, the most critical care -- we do 40
5 percent of the transplants.

6 We are so invested in your aims that we have
7 committed to creating a UC Center for Health Quality
8 and Innovation. And so we want you to know about that.
9 We -- you know, many people would this is not a good
10 time, with the economy. We feel it's the right time to
11 learn how to do more with less. And so I want to pass
12 that message on to you. Please work with us. Many of
13 our clinicians are here today. You're hearing from
14 them. They have national comments. We are pulling
15 them together.

16 So Herb knows how to reach me.

17 MR. SAYEN: Where will the center be?

18 MS. LEACH: The center is virtually located
19 in Oakland, where the office of the president is.
20 However, we have individuals, some of whom are in this
21 room, who will be from all five campuses and the
22 schools of public health. And we will rotate them our
23 -- really, what we want to do is create new generations
24 of innovators and rotate these fabulous people who've
25 been working on the national stage. But what we're

1 doing is not just for UC. We want to do it for all of
2 California and out.

3 One other point: I built up a lot of
4 frequent flyers miles over the last two years. I was
5 asked by the University of Minnesota to develop a
6 multidisciplinary health policy program for the school
7 of public health and was surprised, given the weather,
8 that they have the lowest childhood obesity rate. So
9 because I worked on childhood obesity in the
10 legislature here as a health consultant, I wanted to
11 figure out why in the world, given that weather, and
12 what we could learn from that in California.

13 And, you know, there's a lot to your point --
14 one of your points that only 10 percent is in the
15 chronic diseases that we're working with comes from the
16 healthcare system. And there's lot we can learn about
17 states that have invested in the parks and the trails
18 in a way that we really need to integrate our
19 professionals in urban planning. There is no house in
20 the Twin Cities that's more than six blocks from a
21 park.

22 And I can go into more detail later, but you
23 don't have the problem with the kids who can't get
24 outside because the bullets are flying. And it's
25 really important to understand, because when we study

1 geographic variations and contrast, let's say,
2 Minnesota and California, why do we have different
3 rates in certain chronic illnesses? There's some
4 underlying integral components that we should all know
5 about.

6 MR. SCHULTZ: Thank you, Terry. And we'll
7 follow up with you. I know -- we had our conversations
8 with folks.

9 And I want to let people know it's right on
10 11:00 and there's things -- we need to move. So, if
11 you at all possible -- I'm just going to ask folks to
12 state their name and a minute. And we're going to need
13 to time it. So that doesn't mean the end of your
14 input.

15 YOSHI LAING: Okay. My name is Yoshi Laing.
16 I'm a resident in family medicine at San Francisco
17 General Hospital here with some of my co-residents this
18 morning.

19 And I know this is an issue that you're
20 already working on, but I wanted to emphasize the
21 crisis in primary care physician supply. There's a
22 recent article by Jack Caldwell in Health Affairs
23 estimating 44,000 -- we will have a shortage of 44,000
24 by 2020. Recently having completed med school, I think
25 we'd agree that there are not enough medical students

1 interested in pursuing primary care. As well as I
2 would argue that residents in primary care training --
3 not many of them want to pursue a full-time career in
4 family medicine or primary care because of the demands
5 of the job.

6 So I think there's two main things that need
7 to be worked on. One is improving delivery of primary
8 care. So supporting panel management, nurse managers,
9 face-to-face as well as electronic phone encounters.
10 And then the second one is physician payment reform so
11 that medical students don't have to choose between
12 making half as much in primary care versus pursuing a
13 specialty career.

14 Thank you.

15 MR. SCHULTZ: Thank you very much.

16 BASIL KHAN: My name is Basil Khan. I'm also
17 a resident at UCSF in internal medicine.

18 Like Yoshi, I'd like to add for the point
19 about primary care. But I'm also thinking about the
20 role that residents play or young doctors have been
21 trained to play in health reform. I mean, obviously,
22 some of have the quality improvement curriculum; and
23 many of my co-residents from that class are here. Many
24 of us have advocated for health reform. And, you know,
25 many of us rotate through the hospital systems, like

1 the VA and academic center or county system, where we
2 really get an intimate look into the problems with the
3 system.

4 My comment is just, as you guys go forward
5 with delivery reform, is to engage the educational
6 community to really strategically think about what
7 we're training our young doctors to become so that they
8 actually have the competencies to work in new delivery
9 systems, to sort of be agents of change instead of to
10 react, and to really sort of get ahead of the curve and
11 begin thinking about these issues.

12 Thanks.

13 MR. SCHULTZ: Thank you, very much.

14 DR. GILFILLAN: Herb, just one quick point --
15 short.

16 You know, it just occurs to me, based on the
17 last two comments, that we have not -- not figured a
18 way -- we've not thought a who lot about a way of
19 getting input and perspective from you all who are kind
20 of, like, new to the whole thing. And seeing those
21 different places and -- you know, we'd love to hear
22 more about that and your thoughts.

23 DR. BERWICK: Are you organized as a group or
24 as a physician?

25 DR. KHAN: No.

1 MR. SCHULTZ: Well, Basil, we're going to
2 help you organize.

3 [Simultaneous speaking]

4 MR. SCHULTZ: We're going to have it in the
5 hospitals. We will do that. We will absolutely do
6 that.

7 [Simultaneous speaking]

8 UNIDENTIFIED SPEAKER: -- UCSF, not as a
9 resident. But I want to thank our residents because my
10 comments really builds on that.

11 And what I would propose is that the Center
12 for Innovation look at the NIH model, where they bring
13 in medical students and residents and fellows to expose
14 them to what -- I think for many of our colleagues and
15 residents, this is a foreign language that is spoken
16 here today. I think to the extent that we get nursing
17 and medicine and pharmacy students who can actually
18 spend time in Washington as well as at the state level
19 that would certainly enhance the ability to propagate
20 this model.

21 MR. SCHULTZ: Absolutely.

22 DR. GILFILLAN: I would tell you that the No.
23 1 advocate for doing exactly what was just said is
24 sitting to my right. So we'd be interested in
25 specifics about that.

1 MR. SCHULTZ: We'll get you to white-coat day
2 in Sacramento, Don.

3 [Simultaneous speaking]

4 UNIDENTIFIED SPEAKER: I wanted to come up
5 and just comment on something that I have not heard
6 expressed yet. And I think it's a little bit unique in
7 Northern California that we have such a strong presence
8 of large integrated groups like Kaiser and Sutter. And
9 these large integrated groups have the ability to do
10 their own payment reform. They have the ability to pay
11 doctors differently and provide the support that they
12 need to build the systems that we're talking about.
13 But a lot of the community hospitals who are critical
14 access hospitals, are important to the community, and
15 the community wants to keep and help them survive don't
16 have the payment reform in order to be able to do that.

17 I know you've mentioned this, but if you
18 could lay out a clear path for how a local community
19 can work with their doctors and get more resources to
20 finance it, to build the primary care access and
21 support systems and the patients that are in the
22 medical home, that's not here currently. I have a lot
23 of my clients who are spending a lot of money on trying
24 to support their primary care physicians by increasing
25 their salary or giving them more resources or, you

1 know, providing nursing standards and so forth. It's
2 all very expensive, but they're taking it out of their
3 pockets. And long-term hospitals can't do that. So the
4 payment has to -- we have this payment reform that
5 moves that money over. And I'd love to share examples
6 with them. That would be helpful.

7 MR. SCHULTZ: Thank you, Walter.

8 ANNE HINTON: Anne Hinton with the Department
9 of Aging Adult Services for the City and County of San
10 Francisco.

11 And, to be brief, in one minute, San
12 Francisco spent the last four years really working with
13 folks with chronic disease and severe disabilities to
14 create better outcomes for them living in the
15 community. We've done this through a number of
16 efforts. One of the major ones has been through
17 diversion and community integration program and also
18 through our triple-aim funding and transitional care
19 from the hospital to home.

20 I think through all of this work, plus others
21 that we've done, we're really seeing that it's when the
22 medical community and the social support community
23 comes together and that that partnership and the
24 ability to wrap around the services in a more complete
25 way that we're able to reduce some of the higher-end

1 costs at the same time plugging in things that are --
2 seem pretty simple and straightforward. Without the
3 money to do it, we can't do it.

4 So I thank you for the vehicles in which we
5 can share the data and the outcome information that we
6 have with you. And we will proceed to do that. Thank
7 you.

8 MR. SCHULTZ: That's terrific.

9 DR. BERWICK: And that first program you
10 mentioned -- you said it's diversion?

11 MS. HINTON: It's a diversion and community
12 integration program. So we have been working with
13 people who've been institutionalized for 10 or 15 years
14 and are back out in the community with medical and
15 social support needs.

16 Thank you.

17 JOANNE HANDY: Joanne Handy from Aging
18 Services of California.

19 I wanted to urge particularly the duals and
20 the innovations office to consider outside-in
21 approaches in addition to inside-out. What I mean is a
22 lot of the evidence-based practices have come from
23 hospitals out into the community. And I think
24 embedding those in senior living situations and
25 independent housing and senior residential places, a

1 lot of the chronic illness management models,
2 transition models, could really help to manage the
3 issues and reduce the cost. But I think they have to,
4 as Anne just said, have to be embedded in the community
5 where people live every day rather than in the three to
6 five days that they spend in acute-care hospitals.

7 Thank you.

8 MR. SAYEN: Thank you.

9 I'm going to turn it back over to David.
10 Thank you all for your very, very substantive comments.

11 MR. SAYEN: Thank you again. And I do want
12 to remind you that if you have further thoughts we're
13 interested in hearing about them. With respect to
14 Innovations, it's aco@cms.hhs.gov. And with respect to
15 the Medicaid and Medicare integration, it's
16 fchco@cms.hss.gov.

17 Thank you again.

18 DR. GILFILLAN: Hey, David. Let me just say
19 it's fchco for input on ACOs. And for Innovations,
20 it's innovations.cms.gov. Thank you.

21 MR. SAYEN: Maybe we should have stuck with
22 the numbers.

23 [Meeting ended at 11:08 a.m.]

24

25

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<p>_____</p> <p>\$</p> <p>\$10 14:18 21:12 24:17</p> <p>\$170 74:2</p> <p>\$20 30:8</p> <p>\$3.74 64:21</p> <p>\$350 15:15</p> <p>_____</p> <p>1</p> <p>1 32:23 39:19 75:24 93:23</p> <p>1.1 30:7</p> <p>10 82:18 89:14 96:13</p> <p>10:04 1:10</p> <p>107,000 38:25 39:5</p> <p>11:00 90:10</p> <p>11:08 97:23</p> <p>14 77:17</p> <p>15 1:9 96:13</p> <p>17 6:10 64:10</p> <p>1800 36:11</p> <p>1960s 5:8</p> <p>1977 80:13</p> <p>1999 65:1</p> <p>1st 46:6</p> <p>_____</p> <p>2</p> <p>2 39:20 75:25 77:16 79:2</p> <p>20 71:14,15</p> <p>2000 86:9</p> <p>2001 10:7</p> <p>2002 11:18</p> <p>2007 11:18</p> <p>2009 72:14</p> <p>2010 1:9 7:8 49:13</p>	<p>98:14</p> <p>2011 46:7</p> <p>2012 27:23</p> <p>2013 45:25</p> <p>2014 76:14</p> <p>2020 90:24</p> <p>25 17:18 49:24</p> <p>250,000-odd 84:22</p> <p>2602 31:8</p> <p>27th 98:14</p> <p>_____</p> <p>3</p> <p>3.7 66:23</p> <p>30 18:15 72:8,17</p> <p>3021 31:8</p> <p>30-percent 18:1,2,3</p> <p>33 50:9</p> <p>335 1:13</p> <p>37 83:23</p> <p>38 60:4</p> <p>_____</p> <p>4</p> <p>4.4 72:2</p> <p>4:00 37:13,15</p> <p>40 15:15 88:4</p> <p>44,000 90:23</p> <p>_____</p> <p>5</p> <p>5 50:23</p> <p>50 84:23</p> <p>500 26:20</p> <p>_____</p> <p>6</p> <p>6:00 37:7,8</p> <p>60 27:20 84:23 87:22</p>	<p>60,000 75:7</p> <p>_____</p> <p>7</p> <p>70 84:2</p> <p>_____</p> <p>8</p> <p>800 82:24</p> <p>800-pound 72:1</p> <p>81,000 73:22</p> <p>_____</p> <p>9</p> <p>9 36:17 37:3</p> <p>9.2 15:8,14 16:1 30:6</p> <p>9:13 4:2</p> <p>9:30 82:8</p> <p>90 26:16</p> <p>90th 59:24</p> <p>94102 1:14</p> <p>95 43:22</p> <p>99 43:23</p> <p>_____</p> <p>A</p> <p>a.m 1:10 4:2 37:7,15 97:23</p> <p>A1Cs 66:4</p> <p>abdominal 43:2</p> <p>ability 13:14 22:8 57:15 86:11 93:19 94:9,10 95:24</p> <p>able 25:10,22 29:6 32:3 38:12 45:20 46:20 49:20 66:2 71:17 94:16 95:25</p> <p>abroad 43:4</p> <p>absolutely 10:16 58:2 93:5,21</p>	<p>ACA 42:10 51:2</p> <p>academic 87:14 92:1</p> <p>academics 38:13</p> <p>accept 45:17 84:6,7</p> <p>accepted 81:12</p> <p>accepting 25:24 53:5</p> <p>access 9:24 31:12 45:20 50:21 51:4,7 54:14 58:7,12 63:18 64:22 84:5 86:12,21 94:14,20</p> <p>accomplish 6:2</p> <p>accountability 13:24</p> <p>accountable 13:22 14:3,9 28:20</p> <p>accountable-care 16:2</p> <p>achievable 60:25</p> <p>achieve 13:14 35:23 51:18 62:20 70:24</p> <p>achieving 24:22</p> <p>acknowledge 76:3</p> <p>acknowledged 76:21</p> <p>acknowledges 77:4</p> <p>acknowledgment 58:21 59:1</p> <p>ACO 27:22 48:17 50:1 51:5 83:5,10</p> <p>aco@cms.hhs.gov 97:14</p> <p>ACOs 23:13 28:5,13,19 29:3</p>
---	---	--	---

<p>41:9 49:20 83:2 97:19</p> <p>acronym 35:3,6</p> <p>across 23:12 24:10 26:2,12 56:17 60:5,11 62:5 75:21 86:10</p> <p>act 7:18 8:20,22 9:1,4,14 12:22 13:16 20:21 31:8 52:1 64:14</p> <p>acting 2:5 7:4</p> <p>action 52:9</p> <p>actively 33:19</p> <p>activists 42:14</p> <p>activities 24:6 25:15 69:16,19 74:5</p> <p>activity 11:3,16 33:17</p> <p>actually 4:11 5:7 6:24 11:5 15:2 19:6 25:8 29:6 41:14 75:25 77:14 82:11 92:8 93:17</p> <p>actuary 21:25 25:8</p> <p>acute 32:20 74:7</p> <p>acute-care 73:8 74:17 97:6</p> <p>add 63:21 91:18</p> <p>addition 9:13 96:21</p> <p>address 22:19 26:20 28:18 46:7,23 47:22</p> <p>addressed 69:21</p> <p>addressing 23:20</p> <p>adds 46:4</p>	<p>adequately 28:18</p> <p>adherence 69:1</p> <p>administration 37:21 38:6 60:14</p> <p>administratively 33:10</p> <p>administrator 2:3,4 4:6 6:18,19 17:25</p> <p>administrator's 4:10</p> <p>admitted 72:24</p> <p>Adrienne 2:24 64:7,8</p> <p>Adult 3:15 95:9</p> <p>adults 66:9 84:18 85:17</p> <p>advanced 26:5 49:4 67:24</p> <p>advances 68:1,7 77:21</p> <p>advancing 75:24</p> <p>adviser 36:9</p> <p>advisory 48:15 75:5</p> <p>advocate 93:23</p> <p>advocated 91:24</p> <p>Advocates 2:13 45:5</p> <p>affairs 64:9 90:22</p> <p>affect 10:21</p> <p>affects 76:23</p> <p>Affordable 8:20,22,25 9:4 12:22 13:16 20:21 31:7 52:1 64:14</p> <p>Africa 13:2</p>	<p>against 4:22 33:6</p> <p>age 47:14</p> <p>agency 14:4 51:23</p> <p>agenda 9:14,15 10:5 15:4</p> <p>agents 38:14 92:9</p> <p>Aging 3:15,16 95:9 96:17</p> <p>ago 11:13 26:2 28:3 39:9 47:19 83:23,24</p> <p>ahead 8:11 9:2 92:10</p> <p>AHRQ 42:24</p> <p>aim 10:4 11:21,23 12:8 20:11 29:13 51:19 76:16,17 77:21</p> <p>aimed 24:22 25:4 26:3</p> <p>aims 10:10 16:16 55:12 88:6</p> <p>aligned 41:16 55:18</p> <p>Aligning 10:15</p> <p>alignment 33:4 57:9,22</p> <p>Alliance 3:4 71:22</p> <p>allowed 46:18</p> <p>allowing 49:19</p> <p>allows 9:4</p> <p>alone 30:9</p> <p>already 8:9 20:11 26:7,9 27:24 28:25 49:23 52:23 90:20</p> <p>alternative 71:5 86:23</p> <p>altogether 13:14</p>	<p>am 37:8 40:3 75:5 81:15</p> <p>Amendment 64:13</p> <p>America 44:1 51:18 68:24</p> <p>American 2:15 5:9 8:17 9:11 13:8 48:8</p> <p>Americans 3:5 9:4,25 15:14 20:3 71:23</p> <p>among 16:14 61:10</p> <p>amount 8:21 35:18 55:3 74:4</p> <p>amputations 43:6,7</p> <p>analogy 67:22</p> <p>analytic 33:21</p> <p>analytics 33:18</p> <p>and/or 69:21</p> <p>Angeles 52:19 53:1 63:6,23 64:1</p> <p>Anne 3:15 95:8 97:4</p> <p>announced 26:2,18</p> <p>annual 21:13</p> <p>answer 40:19</p> <p>antihypertensive 68:25</p> <p>anti-referral 58:1</p> <p>anybody 39:17 40:4</p> <p>anymore 72:25</p> <p>anyone's 12:13</p> <p>anything 35:7 48:1 85:23</p> <p>Anyway 62:6</p> <p>appear 14:6</p> <p>applicable 68:2</p>
---	--	---	---

<p>applying 68:14 appointed 7:15 appointment 59:5 appreciate 38:19 44:11 47:2,5 58:20,25 80:21 appreciates 81:21 approach 20:6 24:7 approaches 44:10 96:21 approaching 66:14 appropriate 58:7 approved 46:4 approximately 26:11 37:1 area 16:18 33:17 40:21 63:22 82:3 areas 33:3 59:19,21 63:4 arena 71:7 aren't 49:4 67:14 81:5 arguably 66:22 argue 74:3 91:2 argument 73:15 Arizona 36:5 37:5 40:7 Arnie 61:5 article 4:21 90:22 articulated 63:12 Asian 2:17 50:6,10 aside 14:17 aspect 39:9 assessment 67:13 assets 13:17 30:20,21</p>	<p>assigned 18:19 assist 49:5 assistants 54:11,15 association 2:15,21 3:9,11 5:9 48:8 55:21 56:16 59:6 60:22 61:13 76:6 80:13 82:21,22 86:6 Assurance 48:14 assured 48:24 attacks 11:25 attention 19:24 28:16 47:11,20 62:22 79:13 attest 59:4 attributable 12:4 Atul 42:25 43:9,11,24 audiotape 18:24 augmented 54:8,9 authentically 12:6 authority 60:12 authorized 98:7 available 53:21 avoidable 72:21 73:21 avoided 12:7 aware 52:4 away 18:15 awesome 61:18</p> <hr/> <p style="text-align: center;">B</p> <hr/> <p>background 16:25 79:20 badly 54:13 Balestra 2:15</p>	<p>48:6,7 bar 32:17 barriers 57:25 based 18:5 41:8 51:22 77:7 86:18 92:16 basically 77:2 basics 67:16 Basil 3:14 91:16 93:1 Bay 75:21 beauty 30:20 became 83:25 become 6:9 9:16 15:12 27:8 46:12 52:24,25 92:7 begin 8:6 27:19 34:24 77:8 92:11 beginning 26:1 76:17 behalf 37:19 48:7 64:17 71:22 80:25 behavioral 32:20 behind 4:14 believe 21:9 28:13 49:1,7 51:15 57:8 64:4 79:8 Bella 2:6 7:14 14:13 29:17 belong 51:5,6 benchmarks 76:9 beneficiaries 8:23 9:8 33:7 45:9 58:4 72:2,16 beneficiary 32:16 58:16,19 benefit 18:20</p>	<p>19:14,23 25:2 84:19 benefiting 27:14 benefits 9:8 45:20,23 46:9 47:23 68:8 Berkeley 59:15 Berry 3:8 82:20 Bert 3:10 83:20,21 Berwick 2:4 6:19 8:3,5 38:24 40:14,15 47:3 52:3 55:15 56:1,21 61:20 67:11,20 71:2 76:4 80:7 84:9 92:23 96:9 best 23:11 24:1 34:7 35:11 44:5 46:1 57:9,19 58:17 59:18 61:25 Betsy 17:4 better 7:19 8:22 10:15 11:10,22,23 12:10,11,16,18 13:4,5,6,19,25 14:21,23,24 15:3 16:19 18:3 20:11,12 22:19,25 26:25 34:25 36:22 41:23,24 51:19,20 55:18 62:20 64:22,23 71:7 73:6 85:8 95:14 beverages 68:17 beyond 34:2 Bibbins-Domingo</p>
--	--	---	--

<p>68:21 biggest 7:25 37:25 61:12 69:9 bill 3:6 5:25 36:13 75:18 billion 14:18 15:15 21:12 24:17 30:8 73:21 billions 64:25 Billy 75:17 birth 64:12,18,22 65:5 bit 27:21 31:5 57:5 94:6 bleeding 59:8 blended 31:2 blocks 89:20 blood 39:16 41:2 60:1,2,8 61:3 66:5 blood-pressure 39:11 bloodshed 5:7 Blue 7:12 blunt 43:2 boarded 75:19 BODENEIMER 55:20 Bodenheimer 2:20 53:25 54:1 56:6 bolded 79:4,7,10 bolster 68:3 Boston 43:24 boundary-less 35:22 Bousian 2:24 64:7,8 box 35:2,7</p>	<p>breathing 33:13 bridge 76:14 bridges 15:24 brief 29:20 33:1,2 35:17 61:21 95:11 briefly 6:17 73:2 Brigham 75:6 brilliant 6:4 14:15 bring 17:7 51:1,3 63:8 70:6 76:13 81:13,16,25 93:12 bringing 12:20 41:19 61:18 80:23 broaden 30:25 brokers 38:14 budget 21:13 62:1 budgets 15:16 build 24:21 26:19 27:11 30:22 82:12 94:12,20 building 25:3,12,14 77:20 builds 93:10 built 15:19 63:20 89:3 bullet 31:11 bullets 89:24 bump 33:5 burdens 12:7 15:10 burdensome 11:3 business 24:12 27:8,15,17 33:3 38:13</p> <hr/> <p style="text-align: center;">C</p>	<p>CA 1:14 cabinet 36:8 calculated 78:10 Caldwell 90:22 California 2:13,15,21 3:4,8,10,12,16 17:14 23:14 30:19 36:14 39:4 40:6 45:4,10 46:3,23 47:24 48:7 50:22 56:15 57:3 58:23 59:6,13,14,19,24 60:5,21 61:11 62:11,16 64:10 65:20 66:8,22 71:22 72:6,16 73:10,20 76:6 77:17 78:19 80:12,13 82:21,23 86:6 87:12,22 89:2,12 90:2 94:7 96:18 98:1 California's 71:23 campuses 88:21 cancer 39:11,17 capabilities 69:24 70:6 capacity 14:25 capita 76:19 capital 57:14,22 capture 25:18 CARA 72:5 card 30:11 care 1:7 3:8 6:6 7:19,23 8:20,22,24 9:1,4,7,20,25</p>	<p>10:6,13,15,17 11:10,22,25 12:4,10,14,16,18, 22 13:6,9,10,13,16,1 9,22,25 14:3,9,24 15:3 16:1,19 17:16,18 18:6,18 19:5 20:8,9,10,11,16,1 8,20,21,24 21:3,20 22:13,17,25 23:10,11,12 24:7 25:2 26:5 27:1,12 28:7 29:24 30:9,12,16,24 31:1,7,12 32:8,15,18,20 33:19,20 34:1,4 35:1 41:1,7,10,23 43:12 44:16,23 45:18 46:6,11,13,15,19 48:11,13,15,16,2 0,21 51:20 52:1,18 53:14 54:14,17,25 55:18 56:25 57:2,4,9,13,15 58:6,8,17 59:4 60:1,12 62:20 64:14 65:8,16,17 68:4 69:16 71:5 73:12,14,22 74:8,20 75:25 76:1,13 77:22,23 79:5,6 82:21 83:4 84:17,21,23 85:13,16 86:15,17 88:4 90:21 91:1,2,4,8,12,19 94:20,24 95:18 career 91:3,13</p>
---	---	--	--

<p>career-long 72:9 carefully 65:11 caregivers 74:15 Carol 3:6 78:15 Carolina 11:16 case 18:17,19 21:16 22:1,21 25:10 30:22 39:16 72:8 76:21 cases 12:2 61:7 cataloging 33:5 caught 79:12 causal 12:2 cause 85:25 caused 15:12 CDC 77:14 cell 85:10 cement 59:7 center 2:5,11,14 3:6 7:4,22 14:14,19 15:5,23 16:3,23 20:14,22 22:12 23:23 26:18 32:4 40:1,10 41:19 42:19 44:5 47:1 57:1 63:8 68:20 69:7 77:7 78:16,23,25 79:8 88:7,17,18 92:1 93:11 centered 37:12 centers 1:5 3:10 7:16 26:20 54:5,6,13 55:4,7,17,21 56:2 66:19 82:23 83:13 84:16,20 86:6,9,18 87:14</p>	<p>central 27:3 41:13 48:24 cents 85:2 CEO 7:8 59:8 80:11 83:21,25 certain 90:3 certainly 35:5,11 42:10 55:24 56:24 72:1 74:23 87:5 93:19 CERTIFICATE 98:4 certify 22:1 98:8 cetera 29:1 40:7 85:10 chair 50:5 challenge 5:14 35:16 51:8 59:23 61:12 81:5 challenges 8:1 57:6,20 60:17 challenging 4:15 chance 11:5 change 5:7 6:12 13:7,9,18,20 22:3,7 30:2 32:10 35:8 61:23 70:19 92:9 changes 4:24 12:22 56:3 changing 8:19 characterized 72:21 charge 85:3 Chasm 10:8 cheap 61:6 chief 6:20 65:19 childhood 85:18</p>	<p>89:8,9 children 47:14 65:9 84:8,11,24 85:5,8 86:3 children's 3:10 83:22 84:19 85:12 86:3 Chinatown 50:8 choice 58:16,19 choices 45:10,15 46:16 choose 45:11 46:14,16,18,19 49:21 91:11 Chris 11:14 chronic 7:24 18:22 19:3,4 54:17 66:21 85:7 86:14 87:2 89:15 90:3 95:13 97:1 churning 32:6 Cities 89:20 city 3:15 43:25 95:9 Clara 63:5 class 91:23 clear 21:14 41:18 59:20 65:6 69:5 94:18 clearly 34:3 67:9 clients 94:23 clinical 6:21 39:23 67:18,21,23 80:18 clinician 65:24 clinicians 88:13 clinics 41:6 52:19 60:15 76:25 82:23 83:2,8,12</p>	<p>close 17:15 closed 28:3 closely 19:6 26:13,22 53:13 73:11 closer 19:23 Closing 11:8 CMS 1:5,6 2:3,4,5 4:7 7:5 10:3 12:20 14:13 19:25 22:9 26:2,3 31:6 34:8 35:23 36:23 38:10 39:14,25 40:4,5,10,12 41:3,16 52:8 76:4 78:5 83:18 coaches 54:18 coalition 52:18 Coast 62:15 code 40:9 coherent 38:19 Collaborative 60:21 72:7 collaboratives 79:24 colleague 16:25 38:24 68:20 colleagues 8:7 10:4 11:15 12:20 14:12 26:14 36:22 37:17,18 38:10 52:8 55:16 67:25 76:7 93:14 College 2:15 48:9 Colonies 5:1 column 30:14 comes 13:7 89:15 95:23</p>
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<p>coming 26:3 27:16 28:12 39:13 42:14 47:4 50:5 52:20 53:8 71:14</p> <p>comment 14:7 92:4 94:5</p> <p>COMMENTERS 2:9</p> <p>comments 8:12 11:20 27:25 28:2 35:14 71:17 76:22 83:1 88:14 92:17 93:10 97:10</p> <p>commercial 60:11</p> <p>Commission 48:14</p> <p>committed 88:7</p> <p>committee 48:15 75:6</p> <p>committees 34:8</p> <p>committing 33:21</p> <p>common 20:6 24:2 27:7,11</p> <p>communicate 50:24</p> <p>communities 10:19 20:5 27:19 44:13 50:19 63:15,16,18 77:18 79:24</p> <p>community 16:17 23:16,19 54:2,5,6,13 55:4,6,17,21 58:13 60:15 62:3 67:22 74:20 76:24 77:12 78:8 79:9,15 82:23 83:12 92:6 94:13,14,15,18 95:15,17,22 96:11,14,23 97:4</p>	<p>community-based 70:8 73:12 74:15 77:25</p> <p>comparable 30:24</p> <p>comparative 60:9 71:9</p> <p>compare 46:20</p> <p>compelling 71:4 73:16</p> <p>competence 50:20</p> <p>competencies 92:8</p> <p>competitive 87:21</p> <p>complained 72:12</p> <p>complete 95:24</p> <p>completed 28:1 90:24</p> <p>complex 7:23 32:13 54:24</p> <p>complexity 63:21</p> <p>complicated 58:6</p> <p>complication 66:6</p> <p>complications 64:24</p> <p>component 12:9 14:16</p> <p>components 90:4</p> <p>comprehensibility 14:8</p> <p>comprised 61:14</p> <p>concentration 62:14</p> <p>concept 13:22 14:8 16:12 30:25 78:23,25 79:13,20</p> <p>concepts 16:2</p> <p>concerned 45:25</p>	<p>79:3,11 86:24</p> <p>concerning 46:23</p> <p>concretely 24:11</p> <p>conditions 7:25 85:20</p> <p>conducted 27:24</p> <p>conference 42:25</p> <p>confident 65:10</p> <p>confined 48:17</p> <p>congratulate 75:15</p> <p>Congress 14:17 15:22 22:5</p> <p>connect 61:15</p> <p>connection 23:7</p> <p>cons 45:15</p> <p>consider 47:8 63:9,13,22 96:20</p> <p>considerable 55:3</p> <p>consideration 52:10</p> <p>considering 86:16</p> <p>consistence 47:4</p> <p>constantly 24:12</p> <p>constructive 20:1</p> <p>consultant 89:10</p> <p>consulting 52:17</p> <p>consume 24:16</p> <p>consumer 39:3,9</p> <p>consumers 38:12 39:1,24 42:13 72:3 73:4 74:13</p> <p>contact 11:6</p> <p>contemplating 63:19</p> <p>content 68:22</p> <p>context 8:16,19</p>	<p>16:9</p> <p>continual 20:2</p> <p>continually 33:16</p> <p>continue 12:6 33:14 55:11 56:21 83:17</p> <p>Continued 3:1</p> <p>continues 5:14</p> <p>continuity 9:20</p> <p>continuous 20:12</p> <p>continuously 29:12</p> <p>continuum 5:21</p> <p>Contra 3:6 75:20 76:18</p> <p>contraceptive 65:2</p> <p>contraceptives 64:21</p> <p>contract 45:22,25</p> <p>contrast 90:1</p> <p>contribute 81:4</p> <p>contribution 51:16,24</p> <p>control 10:19,20 60:1,2 64:12,18,22 65:5,19 66:19,23</p> <p>controlling 61:2</p> <p>conversation 78:3 82:8</p> <p>conversations 17:11 90:7</p> <p>coordinate 23:12 27:1 45:18,23 46:9</p> <p>coordinated 2:6 7:16 15:6 16:4 20:10 29:7 34:10 35:5 45:7 46:22</p>
---	--	---	--

<p>50:17 coordinating 34:8 coordination 18:21 31:15 57:23 coordinator 51:1 85:2 cope 72:11 co-per 23:2 core 13:15 co-residents 90:17 91:23 Corporation 2:19 cost 12:17 16:19 18:4 55:12 64:18,25 67:10 76:19 78:1 85:3 97:3 Costa 3:6 75:21 76:18 cost-effective 48:13 65:4 costs 12:12,19 13:6,19,25 14:24 15:15,16 19:17 20:12 21:4,5,9 22:1 23:1,3 26:16 30:17 35:1 51:20 54:15 62:21 65:3 74:4 79:6 87:3 96:1 Council 2:17 50:6 counties 64:10 77:22 country 12:22 14:17,20 15:9 16:6 26:12 36:5 43:1 45:6 56:10,18 78:19 81:2 86:10 county 3:15 52:19</p>	<p>53:1 63:5,23 75:21 76:21 77:19 78:3 92:1 95:9 98:2 county-run 86:19 couple 26:2 28:4 39:7 52:3 63:4 82:25 course 7:25 17:14 54:5,23 88:1,4 Coventry 7:11 coverage 8:22 9:6,13 64:20 76:12 covered 64:13 65:6 covering 64:18 cracks 86:14 crazy 5:1 34:13 35:9 create 5:25 6:1 14:23 43:21 45:22 63:7 88:23 95:14 created 9:10 31:22 75:9 80:12 86:25 creating 35:12 88:7 creative 35:4 creatively 42:5 crisis 90:21 criteria 25:8 44:19 critical 48:21 85:6 88:4 94:13 cross 7:12 15:23 crossed 37:15 Crossing 10:8 cross-pollinate 37:23 cultural 50:20</p>	<p>current 8:24 9:8,12,17 13:8 57:24 currently 45:10,21 57:24 94:22 curriculum 91:22 curve 92:10 customers 75:8 cut 24:10 47:25 cutting-edge 88:3 cycle 24:19 cystic 85:10</p> <hr/> <p style="text-align: center;">D</p> <hr/> <p>Dad 66:12 daily 39:16,17 dark 56:12 darkness 72:13 Darn 7:1 Darryl 17:9 data 28:23 29:1 70:18 96:5 data-rich 28:24 date 1:9 37:16 98:9 dating 81:19 daughter 19:10 Dauner 59:8 David 2:3 3:4 4:6 8:5,6,13 17:3 36:22 71:20,21 75:1,2 77:3 97:9,18 Davis's 36:7 day 5:15 11:2 12:21 18:14 21:19 32:23 37:23 69:9 73:21 74:1 94:1 97:5 98:14</p>	<p>days 27:20 39:9 72:17 87:23 97:6 DC 53:19 deal 12:7 28:16 55:11 70:22 81:4 84:1 dealing 85:25 Dean 3:2 59:16 65:15 67:17,23 70:2,11 death 39:10 deaths 38:25 47:17 Debbie 2:21 56:14 59:3,9 decades 72:13 December 1:9 98:14 decided 60:6 decision-making 72:4 decisions 10:21 Declaration 4:12,25 dedicated 62:17 deficiencies 9:22 defined 28:11 definitions 27:7 degree 67:13 delays 10:25 deliver 28:7 48:20 delivering 20:18,20 24:18,23 28:9 29:4 44:15 53:11 delivers 49:9,10 delivery 1:7 7:7 9:13,16 10:2 12:15 13:10,12 14:21,22,23</p>
---	--	---	---

<p>17:12 19:20 20:4,22 22:10,11 23:18 24:15 27:5 32:2 48:12 62:21 63:7 66:1 72:5 91:7 92:5,8</p> <p>demands 91:4</p> <p>demography 16:15</p> <p>demonstrate 21:22 22:24 25:10</p> <p>demonstrated 37:21 48:11</p> <p>demonstration 21:16 52:25 60:10 62:7 67:8 81:4</p> <p>demonstrations 33:18</p> <p>denies 11:5</p> <p>Dennis 3:3 70:13</p> <p>dental 47:14,15,23 86:15</p> <p>department 3:15 35:22 38:5,8,9 52:11 54:1 55:8 58:9,11 59:15 60:13 75:22 76:17 83:18 95:8</p> <p>dependent 77:13</p> <p>describe 26:23</p> <p>described 25:5 28:8 43:24 53:10,15</p> <p>describing 15:4 18:24</p> <p>description 33:2</p> <p>deserts 63:17</p> <p>design 32:2</p> <p>designed 31:20 48:18 62:25</p>	<p>designing 32:15</p> <p>desire 56:25</p> <p>destinies 10:20</p> <p>detail 34:19 89:22</p> <p>detailed 29:1 58:2</p> <p>detailing 57:6</p> <p>determinants 23:20 70:9</p> <p>develop 7:6 14:20 80:2 89:5</p> <p>developed 41:1 78:5</p> <p>developing 27:18 34:22 52:17 79:21</p> <p>development 79:23</p> <p>devices 25:1</p> <p>devoted 15:17</p> <p>Dexter 2:17 50:4,5</p> <p>diabetes 12:1 54:19 65:18,19 66:9,23,24 67:12 68:3,15 70:10 84:24,25</p> <p>dialogue 38:20</p> <p>Diamonte 47:17</p> <p>died 39:12 47:18</p> <p>Diego 60:10 62:7</p> <p>diet 68:16</p> <p>difference 22:22 42:2 61:2 69:10</p> <p>different 17:14 21:24 23:13 30:21 44:1 56:10 90:2 92:21</p> <p>differently 13:11 94:11</p>	<p>difficult 22:6 54:22</p> <p>diffuse 22:13</p> <p>diffusion 24:4</p> <p>dimensions 10:9 11:11,21 22:14,25 24:24</p> <p>direct 20:24 78:16</p> <p>directed 64:14 74:6</p> <p>direction 27:6 57:13</p> <p>directly 19:8,11 25:22 26:18</p> <p>director 2:5,6,8 7:4,15 36:1,16 75:20</p> <p>directors 38:1</p> <p>disabilities 46:6,11 95:13</p> <p>disability 15:11</p> <p>discharge 72:7 73:9,11,24,25</p> <p>discharged 43:3</p> <p>disciplined 23:4</p> <p>discover 23:15</p> <p>discuss 13:21</p> <p>discussed 52:6</p> <p>discussion 36:18</p> <p>disease 19:3 47:15 66:19,21 67:19 85:9 95:13</p> <p>diseases 47:12 85:17 87:2 89:15</p> <p>disproportionately 68:3</p> <p>district-run 86:20</p> <p>diverse 58:23 63:22</p> <p>diversion 95:17</p>	<p>96:10,11</p> <p>doctor 61:14</p> <p>doctors 17:24 52:22 91:20 92:7 94:11,19</p> <p>document 33:14</p> <p>documented 55:16</p> <p>dollar 64:20 85:3</p> <p>dollars 65:1 66:22 73:21</p> <p>domestic 5:3</p> <p>Don 17:3 18:11 19:25 20:9 21:11 23:9 25:5 30:6 36:23 67:7 94:2</p> <p>Donald 2:4 6:18</p> <p>done 44:2,20 47:9 54:18 68:20 77:15 95:15,21</p> <p>door 53:18</p> <p>doors 25:13</p> <p>double-down 69:15</p> <p>doubling 26:8</p> <p>doubt 23:14</p> <p>Dr 2:4,5,11,17,20 3:2,6,10,13,14 6:18 7:3 8:2,5 17:3 38:24 39:5,21 40:14,15 41:14 47:3 52:3 53:4 55:15 56:1,21 61:19 65:21 67:11,20 69:5 70:3 71:2 74:9 75:14 76:4 77:3 80:7,8 82:7 84:9 92:14,23,25 93:22 96:9 97:18</p> <p>dramatically 19:14</p>
---	---	---	---

<p>draw 23:6 dream 77:20 DRG 73:5 drive 24:6 32:21 35:9 70:19 78:6 driven 31:18 32:7 Driver 47:17 drives 33:25 driving 35:1 dropped 15:18 drove 59:8 80:24 drug 39:1,11,12 drugs 25:1 39:6 40:9 41:22 dual 30:18 45:13 73:11 dual-eligible 27:1 29:15 45:9,16,19 58:4 dual-eligibles 15:7 45:10,25 46:10 47:21 duals 46:23 96:19 Duane 59:8 duly 98:7 Durant 2:19 52:15,16 53:24 during 81:25 dying 39:5 dynamically 22:8</p> <hr/> <p style="text-align: center;">E</p> <hr/> <p>Eakin 2:13 45:3,4 earlier 69:14 76:22 easy 30:1 62:1 echo 29:18 economic 39:23</p>	<p>economy 87:22 88:10 educate 73:4 88:2 education 49:15 85:20 educational 92:5 educator 85:1 effective 11:11 70:1,7 effectively 49:6 77:10 effectiveness 9:21 10:15 60:9 69:4 71:9 efficiency 20:25 efficiency 9:20 11:1,7 efficient 11:12 effort 36:10 62:5 efforts 16:11 36:13 42:23 44:21 55:3 60:18,20 68:1 69:25 70:8 76:15 95:16 EHR 51:2 eight 26:6 42:15 66:9,12 either 45:11 77:13 81:12 Elaine 2:13 45:3,4 46:24 electronic 91:9 elements 8:25 eligible 7:20 15:9 29:23 30:7 31:13 46:12 eligibles 73:12 else 74:2</p>	<p>email 35:2,7 54:20 Emancipation 5:4 embedded 9:14 97:4 embedding 96:24 embodied 5:18,25 emergency 19:2 55:8 58:9,11 87:3 emotional 50:20 emphasis 79:3 emphasize 79:18 90:20 emphasized 79:5 emphasizing 79:21 employees 62:12 65:2 employers 26:10 27:10 enabling 48:22 encounters 91:9 encourage 48:3 64:12 74:12,22 77:7 79:17 encouragement 44:15 encouraging 44:20 end-care 54:23 endeavor 44:3 Endowment 77:17 endpoint 25:7 energy 8:19 engage 39:25 92:5 engaged 42:5 engagement 51:16 engineered 29:8 England 11:14</p>	<p>enhance 83:6 93:19 enhancements 9:9 enhancing 20:24 enjoyable 8:9 17:6 enrolled 75:25 entire 40:6 entirely 77:13 entities 48:16 environment 20:7 26:4 27:4,13 environmental 85:20 environments 28:24 epidemic 68:13 epidemiologic 68:11 epitomize 48:12 equally 9:15 12:9 equitable 11:12 equity 11:8 equivalent 5:3 48:21 equivalents 76:12 errors 80:16 especially 9:18 15:10 63:21 86:12 essential 28:13 essentially 63:17 establish 14:19 28:19 74:18 established 6:9 7:18 20:21 26:17 34:7 estimated 18:8 estimating 90:23</p>
--	--	--	---

<p>et 29:1 40:7 85:10 evaluate 25:11 evaluation 25:7,12 events 11:24 everybody 9:11 36:25 61:8,19 68:24 84:6,7 everyone 4:3,5 5:19 6:6,7 29:19 71:10 everyone's 71:11 everything 32:18 35:8 79:13 everywhere 58:25 evidence 39:22 65:6 67:13 77:6,9 evidence-based 96:22 exacerbations 19:9 exact 49:10 exactly 12:16 16:21 31:20 70:3 74:11 93:23 example 6:9 11:5 41:2 66:21 examples 95:5 excited 32:3 65:21 exciting 14:16 61:20 executive 6:20 7:9 exist 19:12 existing 26:7 75:3 expand 82:5 expansion 76:11 expect 26:20 32:16 expenditures 20:23 21:23 25:9</p>	<p>expensive 95:2 experience 17:13 18:5 21:21 28:10 29:4,9 69:20 76:19 experiencing 30:15 expertise 51:15 explain 15:14 explaining 71:12 expose 93:13 express 37:17 expressed 94:6 expressing 8:6 extended 8:25 extent 49:15 93:16 external 34:17 37:23 38:6 externally 34:15 extremity 43:6 eye 17:25 53:6,15</p> <hr/> <p style="text-align: center;">F</p> <hr/> <p>fabulous 88:24 face 57:6 face-to-face 54:10 91:9 facilitate 36:17 facility 74:8,17 fact 18:13 31:23 51:5 56:17 58:25 72:15 73:6 87:22 factors 15:12 85:20 failure 43:6,10 44:4 failures 43:14 fair 9:19 15:18 fairly 67:24</p>	<p>fall 42:25 falling 66:6 86:13 familiar 10:4,11 families 10:19 74:14 86:10 family 52:18 54:1 75:19 90:16 91:4 fan 61:19 fantastic 80:23 farsighted 20:20 fascinating 78:24 fast 8:19 47:25 83:21 faster 6:12 father 50:14 fatter 13:4 fchco 97:19 fchco@cms.hss.go v 97:16 feature 73:16 federal 2:6 7:15 15:6 16:4 23:19 26:15 31:16 34:9 35:5 45:7 46:22 65:2,3 Federally 26:19 84:16,20 feedback 16:7 21:25 fee-for-service 14:2 45:11,16 feel 35:6 47:10 55:9 83:4 88:10 feeling 29:8 feels 8:18 fellows 93:13 fibrosis 85:10</p>	<p>field 67:24 figure 67:16 78:13 89:11 figured 92:17 figures 71:13 figuring 33:6 63:1 Fiji 40:7 fill 16:23 final 55:6 finally 7:14 21:18 25:6 26:22 72:14 79:16 finance 94:20 financial 32:6 33:8 financing 28:6 33:20 34:1 45:23 finding 28:8 fine 81:20 finishing 27:15 firm 52:17 firmly 21:10 first 6:18 10:6 11:21 26:5 28:5 31:11 33:4 40:8,20 52:19 59:5 67:1 72:19 76:3 78:23 79:11 87:17 96:9 firsthand 58:10 fit 16:13 84:11 85:5 five 72:15 88:21 97:6 fix 33:9 fixing 33:8 fix-it 33:8 34:21 flexibility 58:21 59:1</p>
--	--	--	---

<p>floor 36:1 flyers 89:4 flying 89:24 focus 7:18 11:25 15:8 20:24 23:9 60:25 61:1,6 63:19 77:8 focused 22:16 23:4 24:8 30:18 35:21 48:18 67:25 70:5,8 focusing 59:25 folks 17:22,24 18:20 20:4,5 23:5 27:5 28:3 30:9 32:13 33:24 34:20,24 37:5 38:17,19 41:22 42:2 53:18 56:9 69:22 81:9 90:8,11 95:13 follow-up 83:16 fondly 31:6 foods 68:17,22 force 20:1 40:21 foreign 93:15 foremost 28:5 forgot 39:4 43:7 form 41:12 67:8 formed 75:6 formerly 7:8 forms 9:20 12:15,24 13:23 14:21 41:10 forth 52:24 73:16 95:1 fortunate 84:16 fortunately 36:1</p>	<p>forward 6:14 21:14 31:3 35:13 42:24 44:3,12 62:18 63:1,8,24 78:12 92:4 foster 13:9,24 14:20 84:17 foundation 3:8 80:12 83:5 foundational 63:10 foundations 77:16 FQHC 26:21 84:18 86:19 fractions 66:15 fragmentation 32:19 fragmented 9:17 20:9,16 21:20 25:2 26:4 45:18 54:25 Framers 4:17,24 framework 10:9 12:19 27:11 framing 10:3 Francis 1:12 Francisco 1:14 2:18 3:2,13,15 4:7 8:9 18:9 51:12 54:2 64:11 65:17,24 67:5 75:4,9 90:16 95:10,12 98:2 Franco 2:18 51:11,12 Fred 2:10 38:22,23 39:2 40:13,16,23 41:15 42:8,12 Freddie 1:16 98:7,19 free 35:7</p>	<p>freedom 21:14,15 frequent 89:4 frightened 5:2 front 56:23 frontline 62:22 fruit 69:4 fruitless 74:5 full 49:15 58:1 62:19 63:24 full-time 41:18 49:16 91:3 fully 32:17 64:18 function 24:20 49:23 functioning 49:25 fund 69:19 fundamental 22:4 23:20 70:9 funded 57:24 funding 21:12 31:2,19 46:8 47:20 57:22 62:2 69:24 95:18 future 51:22 64:22 84:10 85:5 <hr/> G <hr/> game 5:20 40:2 gaps 11:9 gatherer 11:3 Gawande 42:25 Geisinger 7:9 general 2:18 3:2,13 51:12 54:3 65:17,24 67:5 70:14,22 90:17 generally 31:3 generation 50:14</p>	<p>88:3 generations 88:23 generators 12:5 generics 61:7 geographic 50:21 90:1 geography 16:15 37:4 geriatrics 75:19 gets 43:3 69:17 getting 6:7 10:13 24:17 28:7 32:19,23 92:19 gigantic 68:19 Gilfillan 2:5 7:3 14:13 17:3 39:21 40:14 41:14 53:4 65:21 69:5 70:3 74:9 75:14 80:8 82:7 92:14 93:22 97:18 given 21:14 38:18 60:23 69:10 85:3 89:7,11 giving 83:16 94:25 glad 79:20 Gladwell 43:9 goal 13:18 24:20 goals 5:18,24 12:24 13:15 25:17 35:23 56:22 63:11 76:9 gone 73:15 goodness 79:1 gorilla 72:1 gosh 56:12 gotten 18:2,4 84:3 government 23:20</p>
---	--	---	--

26:15 31:16 38:8 44:22 65:4	92:4	headed 17:19	38:4 45:8 46:22 47:10 49:17
governments 26:10	<hr/> H <hr/>	heading 16:23	51:17 54:7 56:23
Governor 36:7,9	hair 12:13	headquarters 37:3	59:15 60:13,22
governor's 36:10	half 68:24 91:12	heads 14:13	62:13,15,17,19,2 3 63:17 65:13
grade 66:14	Hall 4:11,14	health 1:7 2:13,14 3:6,7,10 7:9	70:15 72:5 75:4,8 76:12,23 78:7
gradually 30:3	hallmarks 58:15	11:9,23	84:1 85:15,23,24
grant 3:4 52:25 60:7 62:2 71:20,21 75:2	halls 31:6	12:4,8,11,19	86:15,16 89:16
grantees 44:13	hand 8:2 21:10 57:15 98:13	13:6,19,25 14:24	healthy 9:21 19:16 75:4
grant-making 44:19	hands 30:1,4	16:19 19:20	hear 14:10 16:5,16 29:21 36:18
grants 60:16 77:13	Handy 3:16 96:17	20:2,12 22:25	37:16 40:12,17 56:18
grappling 75:24	Hanley 2:22 59:12	23:17,18,21	82:10,16,17 92:21
grateful 76:7	happen 4:24 5:7 6:12 82:4	26:14,16,19	heard 16:24 53:19 84:10 94:5
great 17:11 24:25 28:2,16 75:14,16 81:4 82:10 83:25	happens 46:12	30:16 32:20 38:5	hearing 6:14 23:24 35:17 53:9 88:13 97:13
green 63:19	happy 35:3 75:7 82:17	39:3 41:23	heart 11:25 60:8 85:9
Grossman 2:14 46:25	hard 12:15 51:1,3 54:12 86:13	44:10,16,24 45:4	HEDIS 59:22
ground 18:12 47:4	harming 12:13	47:1,9,22 51:20	held 59:9
group 33:25 34:3 35:19 92:23	harness 13:18	54:5,6,13,18	he'll 17:1
groups 61:11 94:8,9	Harvard 6:22,25 38:24	55:4,7,17,21	hello 37:7 56:13 65:14 70:13
growing 54:7	harvesting 79:25	59:9,16,23 61:10	help 9:15 10:14,17 15:13 16:10,20 19:22 23:15 25:16 27:10 41:6 49:5 60:16 61:24 78:13 93:2 94:15 97:2
Guam 37:12	hat 65:18 66:8	62:20	helpful 56:5 95:6
guarantee 51:24	Hattie 2:22 59:12 62:8	64:13,19,25	helping 14:7
guaranteed 5:14 10:16	haven't 42:15 83:9 84:10	65:8,9,22	hematology 83:23
guess 6:24 16:22 29:22 30:1 36:14 39:20 50:16 70:17	having 5:10 6:11 22:4 33:21 34:18 49:18 66:8,9 72:11 77:17 90:24	67:1,3,4	
guests 6:15 10:22	Hawaii 37:6,7	68:4,6,8,12	
guys 23:14 51:19	head 12:13 59:9 65:23 74:10	69:2,8,10 70:9,16	
		75:20 76:14,24	
		77:4,23,25	
		78:3,8,16,17	
		79:9,15 80:14	
		82:23 83:3,7,12	
		84:16,20 85:5,21	
		86:6,9,18	
		87:12,16 88:7,22	
		89:6,7,10 90:22	
		91:21,24	
		healthcare 2:7 5:12,19 6:21,22 7:7,11,16,22 8:18 9:6,11,12,15,23 12:3 13:8,12 14:21 15:6 16:4 17:12,13 20:2 34:10 35:5 36:10	

<p>hemoglobin 66:3 Herb 2:8 8:7 17:4 36:2,7,20 42:13 60:5,15 71:20 73:18 88:16 92:14 hereby 98:8 herein 98:9 Here's 23:22 41:25 hereunto 98:13 Herrera 2:18 51:11,12 he's 7:5 16:25 20:10 36:15 41:18,19 heterogeneous 33:25 Hey 97:18 HHS 2:8 34:8 35:21 36:17 37:22,25 60:16 64:14 65:11 Hi 46:25 48:6 59:12 75:17,18 82:18,20 86:5 high 32:17 39:16 60:1 high-cost 54:25 higher 9:24 13:14 21:4 higher-end 95:25 highest 63:16 high-leverage 47:6 48:2 highlight 31:9 highlighted 79:4 highly 9:17 51:24 77:22</p>	<p>high-quality 48:13 Highway 50:23 Hinton 3:15 95:8 96:11 history 16:15 57:3 HIT 50:25 Hmong 50:22 hold 28:19 home 7:12 18:18,19 26:7,14 43:3 48:16 65:25 72:10 73:5 74:8,22 83:7 94:22 95:19 homeless 84:17 homes 23:13 26:12,16,19 41:10 83:3 86:21,22 honor 36:23 56:9 hope 14:6 30:3,24 80:1 83:10 hopefully 55:2 66:5 hopes 16:9 hoping 61:24 hospital 2:18,21 3:2,10,13 17:24,25 19:1,17 51:13,14 54:3 56:15 59:6 65:17 67:5 72:6 73:5,23 74:19 75:23 76:6 83:22,23 84:1 85:12 90:17 91:25 95:19 hospitalizations 55:8 hospitals 5:10 11:17 41:3,6 51:18 52:1</p>	<p>57:3,10 72:10,17 73:9 76:25 84:6,19 86:3 88:2 93:5 94:13,14 95:3 96:23 97:6 host 19:3 hosting 10:22 Hotel 1:12 hotline 19:7 house 78:7 89:19 housing 96:25 HRSA 38:11 huge 60:5 61:2 Human 38:5 hundred 5:4 37:1 52:18 68:25 84:25 hundreds 52:6 hunter 11:2 hyperlipidemia 54:20 hypertension 54:19 <hr/> I <hr/> ICD-9 40:9 I'd 28:21 49:18 54:4 56:1 79:16 84:15 91:18 95:5 idea 19:16 74:6,13 ideally 44:21 ideas 16:7 23:24 25:18,23 36:19 68:16 82:15 identified 83:9 identify 22:12 73:6 identifying 44:9 ignore 21:6 85:22</p>	<p>ill 72:10 I'll 8:2 29:22 30:3 33:15 78:22 83:20 illness 15:11 18:22 85:7 97:1 illnesses 19:4 90:3 I'm 4:6 8:13 10:3,11 12:19 29:20 31:8 38:16 42:19 44:7,17 45:4 46:25 47:1 48:7 49:13 50:5,7 52:4,10,16 53:25 54:1 55:2 56:14 59:12 61:5,19,24 62:11 64:7,8 65:16,18 70:13,17 71:21,25 75:18,19 78:2,9,15 79:20 80:11 81:19,22 82:16,19,20 83:21 86:5 87:11 90:11,16 91:16,19 97:9 imagine 4:25 immigrant 50:15 immigrants 50:13,14 impact 23:8 33:8 77:1 impacting 33:7 impacts 68:18,19 imperfect 59:23 implementation 38:3 62:19 implementing 51:13</p>
---	---	---	---

<p>implying 56:4</p> <p>important 5:23 8:17 9:15 12:9 14:9 16:11 21:5,6 31:11 32:12 34:3,18,20 41:17,22 52:7 55:5 58:7 68:10 71:12 74:13 89:25 94:14</p> <p>importantly 32:5 65:5</p> <p>impressed 74:9</p> <p>impressive 60:20</p> <p>improve 7:6 10:6 20:25 21:9 22:14 31:12 39:23 54:14 62:21 65:8 66:5 76:1 80:13</p> <p>improved 14:21 54:14</p> <p>improvement 6:21 10:2,6,10 11:17 12:8,12,17 13:6,9,10,18,20 14:1,25 16:20 18:3 20:2,13 30:17 40:22 42:23 44:3 51:13 57:23 60:18,19 61:9 91:22</p> <p>improvements 5:24 13:5 63:7</p> <p>improves 9:7</p> <p>improving 10:12 12:15 25:9 30:16 79:5,8 91:7</p> <p>incentives 32:7 41:5 57:12 77:24 78:5</p> <p>incentivized 51:25</p>	<p>incidence 67:19</p> <p>incidences 64:24</p> <p>incidents 43:24</p> <p>include 49:14 65:12 82:3</p> <p>included 38:2 49:2</p> <p>includes 76:11 87:13</p> <p>including 14:1 37:10 64:10 81:9 87:15</p> <p>inclusion 65:22</p> <p>inclusiveness 80:22</p> <p>increase 65:3</p> <p>increased 74:4</p> <p>increasing 94:24</p> <p>incredible 44:14 66:13 86:12</p> <p>incredibly 30:10 65:21 68:10</p> <p>indeed 22:1</p> <p>Independence 4:11,12,14,25 7:12</p> <p>independent 15:13 61:13 96:25</p> <p>independently 49:25</p> <p>Indian 36:4</p> <p>indicated 98:9</p> <p>indication 39:15</p> <p>indications 52:9</p> <p>indicators 76:24</p> <p>indices 28:12</p> <p>indigent 87:23</p> <p>individual 23:11</p>	<p>31:25 32:11 68:19</p> <p>individuals 10:7 11:11,22,25 12:11 15:2 17:17 30:6,12 88:20</p> <p>inexpensive 47:13,19</p> <p>infant 64:24</p> <p>infections 41:3</p> <p>inform 16:10</p> <p>information 15:1 34:23 53:7,23 57:15 59:20 83:17 96:5</p> <p>informative 17:6</p> <p>infrastructure 24:21 25:3 81:18,22 82:13</p> <p>inhibited 9:12</p> <p>in-home 74:16</p> <p>initial 27:17</p> <p>initiate 66:4</p> <p>initiative 2:22 26:18 59:14 76:13</p> <p>initiatives 23:19 26:3 38:4 53:1</p> <p>injured 10:13</p> <p>injuries 11:19 12:1 40:23</p> <p>innovation 2:5 5:24 6:8 7:5 14:14,15,19 16:3,24 20:14 24:19,22 25:1,4 27:19 31:3 32:2,4 36:19 40:1 63:2,8 65:22,25 66:18 67:3 69:6 76:10</p>	<p>77:8 78:23,25 82:13 87:5 88:8 93:12</p> <p>innovations 21:2 24:9 27:14 40:10 42:24 55:18 63:14 67:4 77:25 96:20 97:14,19</p> <p>innovations.cms.gov v 25:20 53:7 97:20</p> <p>innovative 7:6 20:22 25:18 44:15,23 85:16 86:16</p> <p>innovators 88:24</p> <p>input 8:12 27:24 28:25 33:14,16 35:12 42:11 56:5 83:17 90:14 92:19 97:19</p> <p>inside-out 96:21</p> <p>insist 73:8</p> <p>inspired 56:21</p> <p>inspiring 75:15</p> <p>instance 12:25 67:21</p> <p>instead 4:16 10:22 34:9 73:24 92:9</p> <p>Institute 2:12 3:7 6:20 10:7 44:8 49:12 60:8 64:15 65:11 67:2 78:17</p> <p>institutionalized 96:13</p> <p>institutions 10:23 49:20</p> <p>instructor 42:19</p> <p>insurance 7:10 64:19</p>
---	--	--	---

<p>integral 90:4</p> <p>integrate 5:10 27:1 73:11 89:18</p> <p>integrated 7:23 32:18 57:4 58:13,18 60:21 61:10 94:8,9</p> <p>integration 12:25 57:8,21 58:1 95:17 96:12 97:15</p> <p>intending 52:11</p> <p>intensive 18:20 62:5</p> <p>interact 22:10 23:25 29:23</p> <p>interaction 18:25</p> <p>interactions 39:1</p> <p>interest 30:23 71:10</p> <p>interested 8:12 21:2 23:5,23 24:5,24 27:25 28:17,22 29:2 42:3 43:10 52:22 53:3,9,10 56:1 82:15 91:1 93:24 97:13</p> <p>interesting 21:18 43:18</p> <p>interests 56:19</p> <p>internal 37:23 91:17</p> <p>internally 34:15</p> <p>international 62:12 78:20</p> <p>interpret 34:14</p> <p>Interpretation 34:11</p>	<p>intervention 23:7</p> <p>interventions 22:18,20,21 23:16 47:7 48:2 69:2 77:6,9,12,15 78:8</p> <p>intimate 92:2</p> <p>introduce 16:22</p> <p>introduced 18:11</p> <p>invention 12:21</p> <p>inventive 14:16</p> <p>invest 10:1 24:5 77:25</p> <p>invested 77:17 88:6 89:17</p> <p>investing 27:13</p> <p>investment 44:22 57:14 71:8</p> <p>invite 63:25</p> <p>inviting 42:13</p> <p>involved 76:16</p> <p>involves 20:18</p> <p>IOM 11:10 18:1,8 51:22</p> <p>Islander 2:17 50:6</p> <p>Islanders 50:11</p> <p>isn't 57:24 85:12</p> <p>issue 28:25 72:20 73:3,18 90:19</p> <p>issues 41:5 50:9,20 53:15 56:2 66:17 68:9 76:18 92:11 97:3</p> <p>it's 5:21 6:10 8:9,17 10:5 13:2 16:17 18:2,9 19:18 20:8 21:6 24:16 27:23 28:5,6,7,8 29:8</p>	<p>30:5,10,18,19,22 32:8,16,18,19 33:7 36:14,23 37:19 40:22 42:13 43:17,18 47:19 49:10 50:17 52:7,21 54:22 56:12 61:1,20,25 65:4 66:2,12 67:10 70:25 72:23,25 73:1 75:15 78:24 80:23 81:12,17 82:10 84:2 85:22,24 87:13 88:10 89:24 90:9 94:6 95:1,21 96:10,11 97:14,15,19,20</p> <p>I've 50:7 74:9 83:25</p> <hr/> <p style="text-align: center;">J</p> <hr/> <p>Jack 90:22</p> <p>January 27:23</p> <p>Jarbe 2:19 52:15,16 53:4</p> <p>JARV 53:24</p> <p>Jencks 72:14</p> <p>Joan 3:10</p> <p>Joanie 86:5</p> <p>Joanne 3:16 96:17</p> <p>Joaquin 63:5</p> <p>job 30:2 31:14,22 34:14,15 59:10 60:5 66:11,16 67:6 91:5</p> <p>John 2:11 41:16 42:18</p> <p>join 62:6</p>	<p>joke 34:9</p> <p>Journal 11:14</p> <p>journey 30:15</p> <p>journeys 15:13 16:1</p> <p>July 7:8</p> <p>June 46:6</p> <p>jurisdictions 37:10</p> <p>justice 5:18 62:17</p> <hr/> <p style="text-align: center;">K</p> <hr/> <p>Kaiser 94:8</p> <p>Kathy 2:23 62:9,10,11</p> <p>Kay 22:5</p> <p>key 25:15 27:12 31:9 38:6 40:20 49:14 85:20</p> <p>keynoted 52:5</p> <p>Khan 3:14 91:16 92:25</p> <p>kids 66:10 85:8 86:10,12,23 87:2 89:23</p> <p>Kindig 77:3</p> <p>kinds 40:22 77:15 78:6</p> <p>Kingdom 68:23</p> <p>Kirsten 68:20</p> <p>knowledge 51:15 71:6,13</p> <p>known 81:24</p> <hr/> <p style="text-align: center;">L</p> <hr/> <p>label 39:15</p> <p>labels 39:13</p> <p>labor 36:8 38:13 63:9</p>
---	--	--	---

<p>lack 11:7 63:18 laid 19:25 Laing 3:13 90:15 landmark 49:12 Landrigan 11:14 language 50:21 68:9 93:15 large 27:10 31:17 49:19 63:22 78:18 94:8,9 largely 50:10 largest 37:4 51:17 61:10 62:14 71:23 last 17:11,18,21 32:5 42:12,15 46:3 52:5 66:1 73:17 82:8 83:16 89:4 92:17 95:12 lastly 34:22 85:19 Lated 80:15 later 5:4 43:5 89:22 laughing 82:7 launch 31:1 law 5:11 8:20 9:10 13:23 14:15 62:19 65:1 laws 58:1 lay 94:18 layered 11:4 LDL 60:2 Leach 3:12 87:10,11 88:18 lead 11:24 64:23 leadership 3:6 6:16 15:23 42:20 48:25 61:18 78:16 79:23</p>	<p>Leape 38:25 39:5 learn 17:21 24:1 25:21 41:7 88:11 89:12,16 learned 17:21,23 38:10 83:25 learning 6:12 20:18,19 24:4,6 29:2,12 66:11,14 79:14,19,21,22,2 4,25 80:3 least 57:21 leave 74:17 85:11 led 48:18 leg 79:15 legal 57:25 legislation 5:17,20 28:14 legislature 89:10 Leslie 2:12 44:7 less 72:17 88:11 let's 61:8 90:1 letter 57:7 58:3 letting 48:10 level 23:17 38:9 58:22 63:21 67:22 68:19 84:21 93:18 levels 13:15 23:9 24:8,9,10 69:11 leverage 61:22 68:5 licensed 98:8 lie 8:11 12:2 life 11:4 58:9 lifeline 19:19 lifetime 72:9 light 39:21</p>	<p>lights 56:8,11 likely 65:7 limited 32:9 66:20 line 19:7 37:16 71:16 83:15 lines 44:4 link 44:14,20 69:19 linkage 12:24 69:18 linkages 74:19 linked 66:25 linking 44:22 lipids 60:2 61:3 list 33:9,12,16 34:21 55:16 listen 8:13 50:5 65:11 listening 1:6 6:17 8:4 16:6 27:25 36:12 45:5 51:9 71:16 86:2,7 Literacy 68:9 literally 33:4 82:13 little 4:13 8:15 17:1 27:21 30:10 31:5 35:2 56:12 57:5 79:3 81:3 94:6 live 27:23 85:9 97:5 lives 15:11 living 33:13 72:25 85:9 95:14 96:24 lobby 84:12 local 17:12,13,14,24 58:22 94:18 locals 38:9 located 88:18</p>	<p>LOCATION 1:12 logic 71:4 long 6:8 8:14 9:1 32:20 57:3 long-standing 78:18 long-term 73:12 95:3 lord 74:2 Los 52:19 53:1 63:5,23 64:1 lose 84:22 lost 15:18 lot 4:25 5:5,7 11:16 12:22 17:21,23 19:1,2 27:24 28:25 30:20,23 31:2 36:2,3,10 39:8 40:17 41:8 53:19 60:19 65:17,25 67:25 68:5 69:2 70:11 71:2,15 79:22 80:15,25 81:3,4,7 84:10 86:15 89:3,13,16 92:18 94:13,22,23 96:22 97:1 lots 25:1 70:4 Louie 2:17 50:4,5 love 61:15 70:7 92:21 95:5 low-cost 48:2 lower 12:17,19 13:6,19,25 14:24 16:19 20:12 21:22 22:2 51:20 62:20 lowering 30:17 87:3 lowest 89:8</p>
--	---	---	--

<p>Lubin 3:10 83:20,21</p> <p>Lucian 38:24 39:5</p> <p>Lucy 40:6,11</p> <p>Lung 60:8</p> <hr/> <p style="text-align: center;">M</p> <hr/> <p>Maa 2:11 42:18,19</p> <p>main 33:3 60:14 91:6</p> <p>major 40:21 77:23 79:7 95:16</p> <p>majority 50:13</p> <p>Malcolm 43:9</p> <p>man 47:17</p> <p>manage 14:19 61:7 97:2</p> <p>managed 45:14 46:6,11,13,15,19 59:6,15 60:1,11,13 77:22</p> <p>management 2:19 24:19 42:9 52:16 57:18 63:10 80:19 91:8 97:1</p> <p>manager 18:17 22:21 75:6 87:11</p> <p>managers 18:19 50:1 54:16,23 91:8</p> <p>managing 67:16</p> <p>mandate 46:5</p> <p>mandated 65:2</p> <p>Marie 18:16,21,24 19:1,8,15,23 22:21 28:8</p> <p>marriage 70:2</p> <p>Maryland 47:18</p> <p>match.com 81:17</p>	<p>82:13</p> <p>maternal 64:24</p> <p>math 66:11</p> <p>matters 80:14</p> <p>may 28:1 36:11 45:10,19 46:1 61:21 86:13</p> <p>Maybe 97:21</p> <p>Mayer 2:10 38:22,23 39:2 42:12</p> <p>Mayor's 75:5</p> <p>MDs 54:11</p> <p>mean 29:6 30:5 68:12 84:13 90:13 91:21 96:21</p> <p>meandering 32:25</p> <p>meaningful 20:3 50:17 63:2 82:11</p> <p>means 5:13 13:13 32:19</p> <p>measure 22:24 43:21 64:2,19</p> <p>measurements 12:24 34:2</p> <p>measuring 13:3 41:4</p> <p>mechanisms 34:1,19 40:25 57:23</p> <p>med 90:24</p> <p>medicaid 1:5 2:5 7:17,20 8:1 9:9 14:15 15:10,16,24 16:3,24 22:9 26:14,17 29:24 34:12,13 39:14</p>	<p>45:12,22 46:8 47:23 54:8 58:12 64:21 76:11 80:19 84:2,3,5,23 97:15</p> <p>medical 2:11 5:9 6:22 18:17,19 23:13 25:1 26:7,12,19 39:15 41:9 42:2,19 48:16 54:15 65:6 86:21,22 87:14 90:25 91:11 93:13 94:22 95:22 96:14</p> <p>Medi-Cal 30:8,9 45:11,17,20,24 46:3,11,19 73:8,10,20 76:5 87:24,25</p> <p>Medicare 1:5 2:5 4:23 5:8 7:4,5,17,20 8:1 9:9 14:2,3,14 15:9,24 16:3,24 19:13,14 21:25 22:9 26:8 29:24 39:14 45:11,14,17,23 46:8,13 47:22 48:15 72:2,16 73:8,20 87:24 97:15</p> <p>Medicare-covered 51:21</p> <p>Medicare's 22:3</p> <p>medication 39:22 42:9 80:16</p> <p>medications 19:10 40:24 41:2</p> <p>medicine 4:22 6:9 10:7 11:14 43:16 49:12 51:6 54:2</p>	<p>64:15 65:12 90:16 91:4,17 93:17</p> <p>meet 29:12 48:14,23 49:3,5 56:23,24 68:22 75:13</p> <p>meeting 4:2 9:3 28:20 35:20 42:14 53:18 59:5 73:17 97:23</p> <p>meets 25:8</p> <p>Melanie 2:6,15 7:14 8:15 14:13 15:5 16:11 26:23 29:15 36:24 37:24 48:6 53:12</p> <p>Melanie's 15:23</p> <p>member 41:18 62:14 72:5 75:5</p> <p>mental 86:15</p> <p>mentioned 20:9,11 21:11 23:10 27:18 30:6 53:5 67:8 94:17 96:10</p> <p>message 54:21 88:12</p> <p>messages 49:14</p> <p>met 36:11</p> <p>methods 32:3 33:20</p> <p>metric 63:9</p> <p>metrics 27:7 59:22 60:25</p> <p>Michael 3:8 80:9,10,11 81:19,20</p> <p>microphone 29:14 80:24</p> <p>mid-January 14:6</p>
---	--	---	---

<p>mighty 34:6 Mikkelson 2:12 44:7,8 miles 89:4 million 15:8,14 16:1 30:6,7 31:21 60:5 66:22,23 72:2 74:2 84:23 millions 7:19 Milstein 61:5 mind 40:22 83:12 mindful 58:19 62:22 mindfully 17:20 Minnesota 89:5 90:2 minorities 50:12 minority 50:12 51:6 minute 90:12 95:11 minutes 71:15 82:19 misalignment 32:6 missing 72:1 mission 19:25 22:11 24:18,22 57:11 79:4 88:1 missions 65:23 misunderstand 70:25 misunderstanding 70:22 71:3 mixing 39:6,11 40:9 model 23:10 26:6 27:8 50:12 58:24 61:13 68:14 69:16 83:5,7,10,13 93:12,20</p>	<p>modeling 69:3 models 20:23 21:2,3,20 22:13,17 23:6 25:11 33:18,19 34:1 44:15,23,24 48:17 53:14 78:6 80:1 86:17,18 97:1,2 moderately 84:13 modernizations 55:16 modest 68:21,22 moment 18:7,12 20:15 61:17,20 momentum 12:23 money 74:4 94:23 95:5 96:3 monitoring 87:3 month 23:3 46:3 73:20 months 30:3 36:15 43:5 more-or-less 50:11 morning 4:3,5 17:23 18:9 29:18 37:14 42:18 44:7 45:2,3 50:4 51:11 53:25 58:20 62:10 63:12 64:6,7 70:12 71:19,20 75:13 78:14,15 80:9,10,22 83:19,20 87:9,10 90:18 move 8:4 9:2 30:11,13 38:20 41:3 44:2 46:5 53:8 58:18 90:10 movement 22:24</p>	<p>43:21 moves 95:5 moving 42:22 44:12 MTM 39:22 multidisciplinary 89:6 multi-payer 26:5 multiple 7:24 28:11 48:11 myself 38:2 39:1 66:15 <hr style="width: 20%; margin: 0 auto;"/> N <hr style="width: 20%; margin: 0 auto;"/> nation 10:1 16:14 61:21 national 2:17 3:3 48:14 50:6 51:1 55:20 59:24 60:8 70:14 82:12 88:14,25 nationally 24:21 44:9 62:14 68:19 80:4 nation's 7:7 75:3 natural 83:2 Navy 60:15 necessarily 21:13 necessary 82:4 negotiated 76:5 Negrete 3:8 80:10,11 81:20 network 3:3 70:14 73:13 Nevada 37:6 nevertheless 31:8 news 8:21 14:22 Nice 39:18 Nicole 17:4</p>	<p>night 17:11,21 82:8 NIH 60:7 93:12 nine 31:21 66:8,12 Nobody 47:10 nongovernmental 38:7 nonprofit 39:3 78:18 82:22 normally 21:15 North 11:15 Northern 64:10 94:7 Notary 98:8 noted 56:12 notes 40:17 notice 14:5 notion 37:21 notwithstanding 87:21 nowhere 32:12 40:2 NPs 49:4,23,25 54:11 nurse 2:15 11:2,4 18:24 19:4,7,9,11 22:21 48:8,9,12,19 49:1,9,21 58:10 59:4 85:2 91:8 nurses 49:5,14,16 51:13,16,24 nursing 51:22 52:4 59:11 93:16 95:1 nutritionist 85:1 <hr style="width: 20%; margin: 0 auto;"/> O <hr style="width: 20%; margin: 0 auto;"/> Oakland 3:10 47:1 78:19 83:22,23 88:19</p>
--	--	--	--

<p>OB 23:11 obesity 67:12 68:15 70:10 89:8,9 objective 79:7 O'Brien 41:16 observation 78:21 obstacle 49:7 obstructive 19:3 obvious 30:19 51:16 obviously 68:16 70:19 91:21 Occasionally 21:4 occurred 43:25 occurring 40:23 47:16 occurs 92:16 Ochoa 2:23 62:10,11 o'clock 37:13 office 2:7 4:9,10 7:16,17 8:8 15:6,7 16:4 18:18 19:5 26:23 31:6 33:2 34:10,11 35:3,5 36:3 41:15 45:8,12 46:22 50:25 53:22 74:10 87:13 88:19 96:20 officer 6:20 75:20 offices 4:9 53:19 oftentimes 23:2 oh 29:25 okay 7:2 22:15 29:25 50:2 56:6 90:15 oncology 83:24</p>	<p>one-on-one 66:3 onerous 15:10 ones 8:24 53:9 95:16 onesy-twosy 61:14 online 27:19 open 38:16,21 42:4 53:17 67:9 opened 25:13 opening 8:16 openness 80:22 operate 21:15 23:25 25:17 operating 25:15 27:13,19 operations 7:22 opportunities 7:18 17:16 35:12 53:13 67:7 69:6,19,22 82:6 opportunity 14:23 20:25 32:10 41:22 42:6 44:14,18 47:2 56:17 59:2 61:22 63:3 69:8,9 75:13 80:21 81:16 82:12 opposed 5:9,10 71:13 opposite 43:18 option 26:15 46:2 options 46:1 49:23 71:9 oral 2:14 47:1,9,22 order 9:24 62:20 94:16 organization 13:23 14:9 38:18 39:4</p>	<p>44:9 48:22 65:23 71:24 78:18 82:9 organizational 14:11 79:23 organizations 14:4 15:2 16:2 28:15 30:24 48:25 53:9 74:15,21 81:3,8,24 organize 93:2 organized 33:2 51:6 92:23 originally 4:8 others 19:23 23:13 38:11,14 45:6 57:11 95:20 otherwise 9:5 32:24 75:8 ought 73:6 85:15 ourselves 30:11 31:7 outcome 44:22 72:11 96:5 outcomes 20:10 25:5 39:23 63:11 64:23 74:3 87:1 95:14 outer 72:12 outpatient 80:17,19 outreach 25:15 34:17 50:17 outside 4:16 12:2 56:2 76:25 89:24 outside-in 96:20 overall 67:22 overlooked 50:11 overlooks 4:11,13 overwhelming 43:5</p>	<p style="text-align: center;"><u>P</u></p> <p>Pacific 2:17,24 37:10 50:6,11 64:9 paid 49:8 73:24 panel 54:16 91:8 panelists 71:18 par 68:23 Parenthood 2:24 64:9,17 park 4:13 59:7 89:21 parks 89:17 particular 59:25 particularly 30:5 33:22 34:20 53:10 70:10 73:10 76:8,18 77:16,21 96:19 partner 20:1 22:12 27:9 36:22 81:8 82:3 partnering 81:10 partners 49:16 63:24 80:2 81:1 partnership 27:3 95:23 partnerships 63:10,20 pass 88:11 passage 5:19 passive 13:24 past 10:5 72:6,8 path 21:14 72:9 94:18 paths 86:23 patient 11:6 18:13 22:18 23:7</p>
---	---	---	---

24:12,13 28:15 29:7 39:12 40:20 41:1 43:2 49:3 70:15 71:5,6,7 72:25 76:19 79:5,6 87:23 patient-centered 11:12 56:25 57:13 Patient-centeredness 10:18 patients 9:19 10:12,19 11:19 18:13 22:17,23 23:11 24:14 27:14 28:10 32:7,13 42:1 49:20 50:19 51:21 54:16,21,24 56:25 57:18 58:6,11 66:3 72:2 73:23 74:1,7,14 84:5,22,25 87:23,24 94:21 patterns 67:16 pay 62:22 77:11 86:11 94:10 payers 27:10 73:7 pay-for-performance 42:23 43:20 paying 21:23 22:4 28:16 payment 12:24 13:1 20:22 21:3 22:13 32:2 48:15 49:7 54:4,8,9 55:2,17 78:5 91:10 94:10,16 95:4	pays 47:11 54:10 84:25 85:1,2 pediatricians 85:8 pediatrics 6:22 people 5:1,2,5 6:4 7:19,24 8:23 10:16 12:14 15:8,9,17 16:1 17:17 18:9,16 19:13,22 22:16 24:8 30:14 31:13,22 35:4,17 37:1,14 41:11 46:5,10 52:6 53:2,19 54:18,19 55:22 60:5 61:1 62:25 63:6 65:18 66:23 67:6 68:8 70:4 71:15,17 73:4,7 74:4 75:25 82:1,14 83:17 84:4 88:9,24 90:9 96:13 97:5 people-centered 28:15 people's 28:22 Pepperdine 70:16 per 38:25 73:21 76:19 perceive 43:12 percent 12:3 15:16 18:8,15 26:16 43:22,23 69:1 76:23 84:2 87:23 88:5 89:14 percentile 59:24 performance 13:15 18:4 48:23 59:25 perhaps 43:4 63:8 78:4 period 21:12	person 28:15 32:18 perspective 31:24 41:20 72:23 92:19 pharmacies 39:25 pharmacist 39:11 40:4,5 41:15 80:11 pharmacists 2:10 39:2,22 40:1,2,3 41:12 42:1 80:13 pharmacy 3:8 39:3 80:12,15,18 81:2 93:17 phase 16:10 Philadelphia 4:8,10 7:13 philanthropics 38:14 phone 19:11 34:12 37:1,2,6,14 56:10 59:18 91:9 physician 48:19 49:9,22 50:7,18 54:11 65:16 72:18 90:21 91:10 92:24 physicians 2:17 41:6 48:18,21 49:2,17 50:7,18,24 51:3,6 57:10 74:20 94:24 pick 40:15 76:15 85:13 pictured 18:17 31:21 piece 5:17,20 31:1 69:20 pig 13:3	pillar 44:11 pilot 42:9 52:25 86:25 piloting 21:16 pioneers 41:1 pitch 75:3 pitchforks 72:12 places 4:18 92:21 96:25 plan 7:9 25:15 26:15 27:16,17 32:23 40:2 45:13,14,19 46:12,13,14,15,1 6,18,19,20 65:7 planned 2:24 17:9 64:9,17 planners 73:25 74:1 planning 2:10 39:2,8 73:9 85:14 89:19 plans 26:17 30:23 38:13 45:21 46:6 47:5 51:23 59:23 61:10 77:23,25 78:3 play 34:16 62:24 83:4 91:20,21 plea 55:24 please 35:6 88:12 pleased 6:15 pleasure 8:9 17:10 37:19 66:2 plenary 42:24 plugging 96:1 plus 95:20 Pneumovax
--	--	---	--

<p>43:8,22 pockets 95:3 point 5:21 8:19 27:12 28:7 31:11 32:1 42:4 44:17 53:5,17 74:18 78:21 86:12 89:3,13 91:18 92:14 points 5:21 40:15 64:17 86:22 89:14 policy 6:22 7:21 13:9 53:18 70:16,17 74:18 87:12 89:6 politically 84:13 poor 72:11 74:3 poor-quality 43:16 population 22:23 23:8,16,21 27:2 33:22,23 37:5 44:10,16,23 54:14 58:17 69:7,18,20 70:23 76:20 77:4 79:8 population-based 77:6,9 populations 7:24 11:24 12:8,11 13:24 53:12 66:1 68:2 Portugal 68:23 position 29:3 38:2 positive 55:23,25 possibilities 8:11 9:10 possible 58:23 90:11 possibly 9:22</p>	<p>Post 39:10 Powell 1:13 power 10:20 powerful 84:14 practical 44:17 practice 3:7 6:10 26:5 49:5,15 61:13 67:18,21,24 78:17 practices 48:19 49:19 59:19 61:14,25 96:22 practicing 50:7,8 practitioner 49:9,22 75:19 practitioners 2:15,16 48:8,9,12,19 49:2 precision 14:8 17:1 pregnancies 65:7 pregnancy 64:23 prenatal 65:8 prepared 72:11 prerequisites 29:5,10 prescription 39:13 presence 94:7 present 20:5 27:4 49:23 presentations 42:21 preserving 20:23 president 4:22 7:8 52:16 64:8 83:21,25 87:13 88:19 pressure 39:17</p>	<p>41:2 60:2 61:3 pressures 66:5 87:21 pretty 18:10 20:24 22:15 61:3 96:2 prevent 47:12,15,16 57:25 66:23 preventing 80:16 prevention 2:12 9:8 44:8,13 65:19 66:20 preventive 54:17 65:12 86:14 previously 6:20 7:21 36:7 price 73:17 primarily 6:17 28:6 70:5 primary 3:8 18:18 19:5 26:5 32:20 44:16 48:13,16,20,21 52:18 65:16 69:23 74:20 82:21 83:4 90:21 91:1,2,4,7,12,19 94:20,24 principles 28:4 prior 21:16 58:9 priorities 24:1 prioritize 33:12 59:21 private 26:10 pro 60:6 probably 5:2 14:6 58:22 66:25 problem 6:6,11 54:9 67:10,14</p>	<p>72:21 89:23 problems 9:12 19:9 40:12 64:25 92:2 proceed 96:6 proceedings 98:10,12 process 12:15 14:5 25:7,12,14 28:2,18 73:11 74:14 82:1 processed 68:22 Proclamation 5:5 produce 20:7 21:3 professional 39:25 87:15 professionals 49:17 89:19 professor 6:21,24 7:1 70:15 71:3 profiles 34:22 program 4:23 5:9 19:16,18 20:23 21:22 24:14 26:23 27:22,23 29:15 33:4 42:10 45:12 52:25 59:13 65:19 83:24 89:6 95:17 96:9,12 programs 7:6 26:8 30:7,22 31:13,20 33:5 35:10 45:22 46:9 58:16 78:5 progress 11:18 76:5 progressively 84:3 project 60:10 62:7 67:8 projects 21:17 43:15 81:5,11</p>
--	---	--	--

<p>86:25 promise 5:12 promoting 80:18 prompt 53:20 propagate 93:19 propel 62:25 proper 13:1 proposal 55:23,25 74:24 81:15 82:1,4 proposals 25:24 26:25 42:3 53:6 81:7,8,10 proposal's 81:11 propose 93:11 proposed 14:5 53:6 proposing 82:1 83:11 pros 45:15 prospects 74:24 proud 75:5 prove 50:1 proved 48:19 proven 69:2,3 77:9 provide 25:20 29:8 46:8 50:16 57:2 58:17 64:2 73:9 74:21 83:13,17 85:16,24 86:14 88:3 94:11 provided 21:11 48:12 provider 48:22 49:21 50:25 62:5 providers 10:22 20:6,19 21:23 27:10 28:9 38:13 45:17 51:17 52:1</p>	<p>56:23 57:10,16 58:12 60:11,14 83:10 88:3 provides 66:20 providing 5:18 6:6 9:7 28:12 47:14 57:4 74:16 77:23 85:23 95:1 proxies 59:25 public 3:7 23:18 27:16 33:13 34:23 39:3 59:16 63:20 64:8,19 65:22 67:1,3 68:11 69:1 70:23 75:20,22 76:6 78:17 80:14 87:16 88:22 89:7 98:8 published 72:14 pulled 27:6 pulling 88:14 pulmonary 19:3 purpose 9:2 40:16 79:18 pursue 52:12 91:3 pursuing 91:1,12 pursuit 22:11 24:2,3 push 24:13,14 30:11 pushed 72:10 putting 18:6 19:22 44:13 52:17 81:15 82:9</p> <hr/> <p style="text-align: center;">Q</p> <hr/> <p>qualified 26:19 83:9 84:16,20</p>	<p>qualify 42:23 48:24 quality 10:8 11:21 12:25 20:24 21:9 25:9 28:20 43:21 44:3,10 48:14,20,23 60:18,19,21 70:15,19 76:1 79:5 88:7 91:22 quality/lower 21:4 quality/same 21:5 quarter 73:21 question 30:2 39:20 50:10 66:25 67:11 70:18 78:22 79:19 80:1 questions 19:10 40:8,19 46:21 52:4 67:1 77:2 quick 78:22 92:14 quickly 34:5 61:25 quite 5:12 14:15 20:20 52:7 53:5 quo 32:25</p> <hr/> <p style="text-align: center;">R</p> <hr/> <p>racial 11:8 radar 87:4 radical 67:15 Rafael 39:4 rapid-cycle 25:6,12 rapidly 25:11 rare 36:4 42:14 rate 89:8 rates 11:18 66:6 90:3 rather 40:18 43:12 70:18 97:5</p>	<p>rational 27:4 ratios 66:14 re 80:14 reach 9:11 56:24 57:7 88:16 reached 35:25 reaches 26:24 reaching 38:11 41:5 56:17 react 92:10 readily 60:25 readmission 72:21 73:22 ready 32:22 Reagan 4:22 real 32:10 34:19 36:23 37:19 61:9 66:2 72:15 realize 5:12 really 5:11 6:1 8:12,13 11:6 12:5 15:8 17:10,18 18:14 22:15 30:11 31:3,9 33:25 34:17 35:19,20 38:19 43:10,13,16 44:2,3,9 47:2,3,6,8 48:1,3 52:11 54:8,10 55:7 56:19 58:5,14,20 59:10,19 60:19 61:22 65:25 66:17 67:6,15 68:14 69:12 70:24 71:6 75:15,23 76:22,23,25 77:8 78:9,24 79:9,12,17,25</p>
--	--	--	--

<p>80:5,24 82:5,25 83:2,4,8,9,10,11 84:19 85:6,15 86:17,20,22,23 87:1 88:23 89:18,25 92:2,6,10 93:10 95:12,21 97:2</p> <p>realm 21:8 66:21</p> <p>reason 35:15 57:1 71:25</p> <p>reasons 44:1</p> <p>receive 32:17 41:23 68:4 85:14</p> <p>received 28:2</p> <p>receiving 75:8</p> <p>recent 18:5 90:22</p> <p>recently 6:19 7:15 43:11 76:4 90:24</p> <p>recognize 32:22 37:2,3 69:8</p> <p>recommend 35:6</p> <p>recommendation 39:24</p> <p>recommendations 65:12</p> <p>record 98:12</p> <p>recording 11:3</p> <p>recovery 36:13</p> <p>redefine 17:16</p> <p>redesign 34:4</p> <p>redirecting 18:14</p> <p>reduce 20:23 21:9 54:15 64:23 95:25 97:3</p> <p>reducing 12:12 55:7 79:6</p> <p>reduction 10:24</p>	<p>11:1</p> <p>reductions 68:21</p> <p>refer 31:7</p> <p>referred 82:2</p> <p>reflect 18:7 87:23</p> <p>refocus 24:12</p> <p>reform 1:7 13:12 19:21 20:4 38:4 54:5 55:2 76:14 91:10,21,24 92:5 94:10,16 95:4</p> <p>reforms 54:12</p> <p>refreshing 42:13</p> <p>regard 43:20 86:11</p> <p>region 29:19 36:17 37:3,4,5,12,13 40:6 77:24 78:19</p> <p>regional 2:3,8 4:6,9,10 8:7 36:1,15 38:1</p> <p>regionally 80:4</p> <p>regions 16:14</p> <p>registry 66:4</p> <p>regulation 33:11</p> <p>regulations 22:3</p> <p>regulatory 56:3 60:12</p> <p>reimburse 26:16</p> <p>reimbursed 84:20</p> <p>reinvested 83:6</p> <p>relate 68:7</p> <p>related 68:16 80:16</p> <p>relating 41:5</p> <p>relatively 35:17</p> <p>release 73:19</p> <p>relevant 10:5 30:5,10</p>	<p>rely 54:8</p> <p>remarkable 18:10</p> <p>remarks 8:16 58:20</p> <p>remember 40:16</p> <p>remembered 4:23</p> <p>remind 97:12</p> <p>reminded 4:21</p> <p>renal 43:6</p> <p>repeated 43:1</p> <p>report 10:8,11 49:12 51:22 52:4,6,7,8,10</p> <p>reported 1:16 11:15 39:10</p> <p>Reporter 98:4,8</p> <p>reporting 41:4 43:12</p> <p>report's 49:14</p> <p>Reppond 1:16 98:7,19</p> <p>represent 56:15</p> <p>representative 36:16</p> <p>representatives 37:11</p> <p>represented 14:12</p> <p>representing 62:12</p> <p>represents 82:22</p> <p>require 33:11 66:18</p> <p>required 5:11 33:9 45:21,24</p> <p>requirement 28:13</p> <p>requirements 51:2</p> <p>requiring 43:6</p> <p>research 3:3 43:17 60:9 64:19 70:14 83:24 88:3</p>	<p>resident 90:16 91:17 93:9</p> <p>residential 96:25</p> <p>residents 91:2,20 93:9,13,15</p> <p>resource 66:20</p> <p>resource-proven 87:1</p> <p>resources 13:17 14:12 15:25 16:15 18:15 19:22 24:13 32:9 62:4 63:17 82:2 94:19,25</p> <p>respect 67:12 97:13,14</p> <p>responsibility 41:11 57:17</p> <p>responsible 48:22</p> <p>result 12:16 21:22 26:11</p> <p>results 24:23</p> <p>Retired 3:4 71:22</p> <p>return 43:4</p> <p>rewarded 51:25</p> <p>reworking 13:13</p> <p>RFI 28:2</p> <p>rich 7:3 16:13 31:8</p> <p>Richard 2:5</p> <p>Rick 8:15 14:12,13 15:4 16:11,23 36:23 39:21 75:12</p> <p>rid 32:19</p> <p>Right-to-Care 2:22 59:14</p> <p>risk 55:7,9,10</p> <p>Robbins 3:3 70:13</p>
--	--	---	---

<p>71:3 robust 80:3 Rogers 2:21 56:14,15 role 14:19 34:16 48:24 62:23 72:4 74:14 75:24 83:3 91:20 roles 63:2 roll 81:11 rolls 68:6 room 6:3,5 19:2 38:15 56:8 61:19 72:1 88:21 rooms 87:3 rotate 88:22,24 91:25 Rothstein 3:10 86:5 rule 83:1,11 rule-making 14:5 22:3 27:22 28:18 rules 86:24 run 59:13 73:5 running 36:4</p> <hr/> <p style="text-align: center;">S</p> <hr/> <p>Sacramento 94:2 safe 11:11 20:9 72:6 safer 41:1,7 safety 10:12 40:20 41:4 70:15 safety-net 50:9,18 63:15,19 67:4 salary 94:25 Saldano 40:6,11 San 1:14 2:18</p>	<p>3:2,13,15 4:7 8:8 18:9 39:4 51:12 54:2 60:10 62:7 63:5 64:10 65:16,24 67:5 75:4,9 90:16 95:9,11 98:2 Santa 63:5 sat 4:17 satellites 86:19 saves 64:21 saving 25:8 64:19 savings 27:22,23 48:24 78:1,7 83:6 saw 58:10 74:12 79:11 Sayen 2:3 4:3,6 35:15 88:17 97:8,11,21 scale 67:2 scattered 50:23 schematic 23:22 scheme 57:24 schemes 55:17 Schillinger 3:2 65:15,16 67:11,17,23 70:2,11 school 3:10 6:23 43:15 59:15 86:6,17,20 87:2 89:6 90:24 School-based 86:9 schools 87:14,15,16 88:22 Schultz 2:8 8:7 36:2,20,21 40:13 42:8,17 44:6 45:1</p>	<p>46:24 48:5 50:3 51:10 52:13 55:14 56:7 59:3 62:8 64:6 65:14 70:12 71:14 75:1,12,17 78:12 80:9 81:19 82:18 83:14 86:4 87:8 90:6 91:15 92:13 93:1,4,21 94:1 95:7 96:8 Schwarzenegger 36:9 science 10:16 43:10 70:18 scientific 59:20 scope 67:2 81:6 score 30:11,14 scoring 44:19 seamless 20:10 30:12,15 seamless-care 20:17 21:21 26:4 29:4,9 69:17 second 11:23 12:7 31:15 33:17 50:14 56:9 77:11 91:10 seconds 75:2 Secretary 21:24 22:2 36:8 37:20 38:1 Secretary's 36:16 security 5:13 8:23 9:5,6 seeing 31:18 42:3 66:5 72:17 87:25 92:20 95:21 seek 63:2 65:8 seeks 26:24</p>	<p>seem 96:2 seen 39:18 42:15 61:9 72:9,20 86:23 SEIU-UHW 2:23 Send 35:7 senior 7:11,21 36:9 71:23 96:24,25 seniors 5:13 46:5,10 72:8,9 sense 15:25 27:9 sensible 20:7 sensitive 16:12 separate 31:18 35:10 sepsis 43:5 serious 12:5,6 64:25 68:14 seriously 28:21 52:7 56:11 serve 10:21 86:10,21 served 36:9 serves 78:19 84:2 service 15:1 20:22 49:9,10,11 62:12 73:13 services 1:5 2:10 3:6,15,16 7:17 22:4 32:21 38:5 39:3,23 49:8 53:11 57:18 73:9 74:17 80:18,19 95:9,24 96:18 serving 31:21 52:23 53:11 session 1:6 8:4 45:6 71:16 sessions 16:6 27:25</p>
---	--	---	--

<p>36:12 setting 80:17,19 seven 36:14 66:10,16 seventh 66:14 several 43:4 severe 95:13 shake 9:19 15:18 shape 16:18 share 48:24 57:4 87:17 95:5 96:5 shared 27:21,23 57:17 83:6 Shasta 2:24 64:9 short 92:15 shortage 90:23 Shortell 59:16 Shorthand 98:7 shortly 25:25 56:11 short-term 69:4 shot 34:7 showed 59:7 68:21 showing 38:25 shows 64:20 73:19 sickle 85:10 significant 66:18 76:11 significantly 24:5 signing 5:19 simple 39:7,19 47:13 61:4 96:2 simply 43:18 49:3 Simultaneous 93:3,7 94:3 single 20:5 33:5 43:25 51:17</p>	<p>sit 34:19 site 25:23 53:16 82:2 sites 23:13 26:21 sitting 17:23 37:18 56:12 75:7 93:24 situations 96:24 six 10:10 27:17 30:3 36:14 37:10 79:16 89:20 size 16:12 81:6 slats 15:19 slavery 5:6 slide 18:23 31:10 79:12,16 slides 17:7 74:12 79:2 small 34:6 49:19 68:18 smaller 81:23 smoking 68:24 smoothing 74:7 social 5:18 12:10 13:15 95:22 96:15 socialized 4:22 society 85:5,13 socioeconomic 11:8 85:19 sodium 68:17,21 solo 51:3 solve 6:5 somebody 40:12 someone 19:6 29:23 43:7 Sorry 30:1 sort 32:24 37:12,25</p>	<p>52:24 55:24 56:11 66:13 74:11 92:9,10 sorts 24:25 58:2 69:1 sources 46:8 South 5:11 63:5 64:1 space 41:11 63:19 69:23 70:5 88:2 speak 47:3 48:10 54:4 79:16 80:25 84:8 speaker 42:24 93:8 94:4 speakers 2:2 8:3 69:14 speaking 6:16 71:11 93:3,7 94:3 special 30:22 45:13,19,21,24 46:14,16,17,20 70:6 specialty 91:13 specific 56:19 82:14 specifically 24:22 46:7 80:17 specifics 93:25 specified 48:23 spend 8:10 9:1 73:20 93:18 97:6 spending 64:21 94:23 spends 30:8 spent 36:4 64:20 74:5 95:12 spigot 67:9</p>	<p>spirit 80:22 splenectomy 43:3 spoke 4:22 43:11 59:17 spoken 54:24 93:15 spread 14:22,25 59:18 61:25 67:14 St 1:12 staff 24:14 41:18 61:16 62:4 74:19 76:4 staffing 34:6 stage 8:15 17:19 25:24 88:25 stakeholder 34:17 stakeholders 38:7 stakes 9:24 stand 41:9 standards 48:15,23 95:1 standing 16:10 start 17:15 29:22 85:17 started 36:19 38:2 starting 44:17 46:6 83:23 state 11:16 15:16 26:9,14,17 30:8,20 32:22 34:22 36:12,13 38:8,17 45:22 58:22 59:13 62:2 65:20 67:24 75:23 76:7 77:18 81:1 82:24 85:4 90:12 93:18 98:1 stated 69:14</p>
--	--	---	---

<p>statement 79:4,18 states 26:6,7,24,25 27:9 31:16 32:16 43:22 44:1 47:22,24 49:24 66:21 89:17 statewide 82:22 status 11:9 32:25 statute 33:11 statutory 56:3 stay 46:13,15 stereotype 98:10 step 5:17 Stephanie 3:8 82:20 steps 27:15 stepsister 47:10 Steve 59:16 stewardship 70:20 stool 79:16 stopping 68:24 stops 47:15 story 18:22,23 23:6 43:1 straightforward 96:2 strategic 25:14 strategically 92:6 Strategies 7:22 stream 31:2 streams 31:19 street 1:13 50:8 stress 49:18 stretch 5:21 76:9 strikes 4:20 strokes 12:1</p>	<p>strong 69:20 84:11 94:7 stronger 33:21 structured 9:23 stuck 97:21 students 90:25 91:11 93:13,17 studies 48:11 studying 44:4 subregulatory 56:3 subsequently 53:23 subsets 33:22 34:3,25 subsidy 30:18 subspecialty 84:21,23 substantial 14:17 substantive 97:10 success 27:8 successes 57:5 successful 35:20 38:3 57:8 63:11 suddenly 19:5 suffers 43:2 sugar 60:3 suggest 70:21 78:4 suggested 43:11 suggestion 28:3 39:19,20 42:22 82:10 suggestions 25:23 29:11 84:15 sum 14:17 summit 52:5 supermarkets 63:18</p>	<p>supplied 8:20 supply 90:21 support 18:21 19:12,15 20:19 22:10 24:2,6,17 25:2 28:9 32:21 53:14 63:14 64:4 73:13 74:16,21 94:11,21,24 95:22 96:15 supported 26:9 supporting 18:16 24:24 26:7,9,11,13 91:8 supports 12:25 24:21 25:4 60:8 supposed 10:14 sure 10:11 28:14,17 42:4 45:8 49:13 52:10 54:16 55:2 56:1 61:5,19 71:17 78:9 82:16 surgeries 47:16 surprise 31:19 surprised 89:7 survive 54:9 94:15 sustain 6:1 sustainable 9:25 Sutter 59:9 94:8 sweetened 68:17 synch 60:16,18 synergistic 69:22,25 system 1:7 7:10 9:13,16,17,23 10:2 13:14 14:3 18:3 19:12,20,21 20:4,9,10,16,17</p>	<p>21:1 22:10,11 23:18 24:4,15 25:2 27:5,12 29:7,12 32:2,8,13 45:18 54:7 58:13 62:21,24 63:7 68:4 73:5,13 75:4,10 76:2 79:14,19,21 80:3 85:15,21 89:16 92:1,3 systems 7:7 12:2 15:19 17:12,13,17,18 18:6 23:12 30:12 31:17 32:15 34:4 57:15,16 58:18 62:24,25 63:15 67:4 69:17 72:5 75:23 79:22 91:25 92:9 94:12,21</p> <hr/> <p style="text-align: center;">T</p> <hr/> <p>table 81:14,25 tablet 39:16,17 tag 73:17 taking 7:19 19:21 26:3 28:21 73:14 76:1 87:18 95:2 talk 5:22 8:14 19:8,11 22:16 23:12,16 27:7 29:15 40:5,21 71:25 73:2,3,18 talked 18:1 22:20 23:10 29:13 42:8 47:5,21 talking 8:10 9:1 17:15,22,24 18:14 23:2,23 40:23 51:19 55:19</p>
--	---	--	---

<p>67:4,6,17,18 68:12 74:11 94:12 Tangerine 75:6,13 target 76:19 targeting 63:15 teacher 43:17,19 team 17:4 34:6 41:17 team-based 41:8 teams 24:7 41:12 53:12 63:6 teasing 33:23 teenagers 86:13 ten 11:17 12:3 14:18 21:13 38:1 76:22 85:2 tenure 7:1 ten-year 21:12 term 32:21 terms 9:19 63:17 70:23 76:24 77:3 87:1 terrific 16:25 56:20 96:8 territories 37:10 territory 13:8 terrorists 5:3 Terry 3:12 87:10,11 90:6 test 20:22 23:15 testing 33:19 text 54:20 texture 14:7 textured 16:13 thank 29:15,17 35:14 36:21 37:8</p>	<p>40:12,13 42:16,19 44:5,6,25 45:1,5 46:23,24 48:4,5,9 50:2,3,4 51:9,10 52:2,13,15,20 53:24 55:13,14 56:6,14,16 59:2 62:7,8 64:4 65:10,13 71:1 74:25 75:1,11,12 78:11,12,25 83:14 86:4,7 87:8,10,18 90:6 91:14,15 92:13 93:9 95:7 96:4,6,16 97:7,8,10,11,17,2 0 thanks 8:5,6 17:3,4,9 29:18 42:12 59:3 60:7 70:11 86:2 87:7 92:12 that's 6:10 10:13 11:7 12:21 13:13,20 14:9 15:7 16:18 21:5 22:6,19 25:10 30:1 32:3 34:14,15 35:10 37:15,16 43:1 44:20 45:12 50:10 52:17 53:2 57:18 59:22 63:12 64:15 69:8,9 72:23 77:5 78:2 79:8 80:23 81:20 82:11,19 89:20 94:22 96:8 themselves 81:24 therapy 39:22 42:9 thereafter 98:11</p>	<p>there's 4:13 8:21 18:23 21:18 24:25 28:13,19 30:6 47:19 48:1 50:20 57:9,17 58:25 59:19 68:5 70:4 81:3,16,22 84:4 85:11 89:13,16 90:3,10,21 91:6 they'll 84:6 they're 15:15,19 27:5 39:6 40:24 47:25 49:11 50:13 51:4 61:20 65:7 66:13 72:24 81:6,14 84:6,11,12,13 95:2 they've 18:5 third 12:9 32:1 79:7,15 Thirty 18:8 thoughtfully 74:6 thoughtfulness 70:21 thoughts 28:1,17,22 42:10 86:7 92:22 97:12 thousand 26:11 84:24 three-part 10:4 12:18 20:11 29:13 threshold 28:20 throughout 35:22 52:11 81:1,2 82:24 Thursday 37:15 82:8</p>	<p>tight 23:6 tighter 74:19 tightly 22:15 Timeliness 10:24 timely 11:12 64:16 tobacco 68:13 today 4:20,21 5:22 6:12,16 10:5 13:21 14:10 19:12 20:16 24:25 25:13,19 27:25 31:14,18 35:14 51:19 75:8 76:22 80:24 86:1,8 88:13 93:16 today's 9:2 Tom 2:20 53:25 55:15,20 56:6 tool 12:18 topics 18:11 touch 35:11 tour 64:1 toward 5:17 12:23 32:21 towards 18:16 town 7:12 traced 12:2 tracked 11:17 trails 89:17 trained 91:21 training 49:16 54:15,18 91:2 92:7 transcribed 98:11 transcript 98:12 transformation</p>
---	---	--	---

<p>19:20 transformed 18:18 transforming 62:24 transition 20:8 74:7,22 97:2 transitional 95:18 Translation 34:11 transpiring 33:13 transplants 88:5 trauma 43:2 59:4 traveling 43:4 tremendous 8:21 trials 69:4 trick 6:7 30:1 tripartite 88:1 triple 51:19 55:12 76:16,17 77:21 triple-aim 78:1 95:18 true 98:12 truly 58:13 trustworthy 20:1 22:12 try 4:3 35:6 55:23 60:24 61:16 62:4 78:13 83:20 trying 6:1 35:23 40:19 54:12 59:17,21 70:24 94:23 turn 10:18 29:14 97:9 turning 8:18 Twin 89:20 twist 21:19 two-million 62:13 type 13:5 45:13</p>	<p>63:7 types 28:12 43:13 63:13 typewriting 98:11 <hr/> U <hr/> UC 59:15 88:7 89:1 UCSF 2:11,20 3:2,14 42:19 43:15 54:2 91:17 93:8 ugly 47:10 UHW 63:4 ulcers 41:2 ultimate 60:6 ultimately 27:8 76:20 unable 51:18 under-65 34:3 undergoes 43:3 underlying 90:4 underserved 52:23 53:11 63:16 68:2 understand 34:13 41:24 43:16 89:25 understanding 33:22,24 34:25 71:8 understands 84:9 unemployed 84:4 unfixed 73:23 unfortunately 81:7 unhealed 73:24 UNIDENTIFIED 93:8 94:4 uninsured 76:13</p>	<p>union 62:12,14 63:1 unique 17:15 69:23 94:6 United 44:1 49:24 62:13 68:23 universal 75:4 University 3:12 87:12 89:5 unlabeled 40:9 unless 12:4 unlikely 85:22 unnecessary 47:16 55:8 unprecedented 8:21 unready 72:10 unwanted 10:24 unwell 73:24 update 7:6 upon 30:21 59:5 63:20 76:15 upstream 12:5 47:6 67:7 uptake 59:21 urban 89:19 urge 47:8 60:23 63:13 69:5 86:17 96:19 <hr/> V <hr/> VA 92:1 validate 22:13 Valley 50:22 valuable 52:21 value 83:12 valued 51:24 variation 12:3</p>	<p>variations 16:14 90:1 variety 18:21 86:18 various 8:25 varying 44:1 vehicles 96:4 versions 16:18 versus 39:17 91:12 Veterans 60:14 viability 49:19 viable 45:9 vibrant 54:7 vice 64:8 vice-president 7:9,11,21 view 74:18 viewing 64:1 views 37:17 virtually 88:18 virtue 30:17 vision 57:12 70:20 visit 8:8 17:6 29:20 37:20 63:25 visits 47:14 54:10,20,21 55:9 66:3 vital 57:16 83:3 voice 71:11 72:3 voluntary 78:2 vote 84:12 vulnerable 9:19 58:5 66:1 68:2 <hr/> W <hr/> waiver 46:3,5,7 76:5,10</p>
---	--	---	---

<p>walk 59:7 Walker 3:6 75:18 Walter 95:7 Washington 24:15,16 39:10 47:18 93:18 waste 11:1 18:2,15 76:1 wasteful 19:21 ways 9:7 20:18,19 22:4 24:25 26:25 28:9 42:22 69:12,15 71:5 73:6 80:16 85:16 wearing 65:18 weather 89:7,11 Website 18:23 25:19 27:18 53:6 74:23 87:5 we'd 27:6 45:7 69:15,18,21 70:7 74:3,12 90:25 92:21 93:24 Wednesday 37:8 week 28:3 52:5 57:7 73:18 weekend 36:4 weeks 11:13 25:22 26:2 27:17 weigh 64:15 weighing 13:3 welcome 52:14,15 62:6,10 we'll 8:3,4 12:6 21:4 23:2,9,12,15 24:4,7,19,24 25:6 27:16,18 33:12 38:20 42:2 53:7,8 55:11 74:23</p>	<p>78:13 82:16 83:16 90:6 94:1 well-coordinated 15:20 wellness 60:17 we're 5:22 6:11,13 8:12 10:1 11:13 13:20 14:3 15:5 16:5 17:1,19 18:14 20:8 21:7,11 23:4,22,23 24:5,11,23 25:14,21,23 26:1 27:9,15,25 28:4,16,17 29:1 31:18 32:1,3,14,24 34:5,6,22 35:16,23 36:3 37:3,4 38:6 40:17 52:8,11 53:5,18,21 57:6 59:17 62:2,3,13 66:4 68:12 71:14 73:18 76:8 82:21 84:16 85:4,25 88:25 89:15 90:12 92:7 93:1,4 94:12 95:21,25 97:12 West 62:13,15 Westin 1:12 we've 25:13 27:24 28:25 29:13 38:9 42:8 53:19 60:6,24 61:6,9 72:12,20 73:3,15 76:16 82:18 92:18 95:15,21 WHEREOF 98:13 whether 30:22</p>	<p>49:8,21 whirlwind 17:5 white-coat 94:1 whole 5:20 37:20 71:7 74:10 78:25 92:20 whom 8:24 88:20 who's 7:4 29:19 75:6 whose 14:19 who've 88:24 96:13 wide 67:9 widely 52:6 wife 81:20 wilderness 51:4 willing 45:17 window 61:21 wisdom 15:22 wish 9:11,25 wishes 44:5 withholding 12:13 WITNESS 98:13 Woltring 3:6 78:15,16 woman 83:15 women 65:7,13 Women's 64:13 wonder 70:21 wonderful 29:19 42:20 61:17 70:24 81:3 wondering 40:3 44:18 51:23 81:15,22 Wong 2:13 45:3,4 work 12:20 13:11 15:20 16:7 19:6</p>	<p>21:7,8 23:17 26:1 31:16,17,20,24 32:4 34:20 35:19 36:2,10 37:22 40:1,10 44:11,13,16 47:12 51:12 54:19 57:11 58:24 59:14 62:18 68:20 69:3,10,23 71:12 72:7 75:16 76:7 77:3,4,16 78:1,20 79:22 80:2,6 88:12 92:8 94:19 95:20 worked 4:8 7:23 36:13 38:8 89:9 91:7 workers 62:13,15 workforce 62:23 working 4:15,18 7:5 12:14 17:17 20:4 26:1,6,13,22 31:4 32:15 35:10,22 38:6 44:12 53:13 55:22 60:4,10 63:4 65:24 76:4,18 88:25 89:15 90:20 95:12 96:12 works 41:16 44:9 57:9,19 world 41:4 57:1 89:11 Wow 66:12 wrap 95:24 wrinkle 46:4 writing 14:5 written 4:12</p>
--	---	--	---

<p>wrong 39:18</p> <p>wrote 4:25</p> <p>Wynne 2:14 46:25</p> <hr/> <p>Y</p> <hr/> <p>yet 19:13 25:24 47:19,21 58:13 77:5,6 85:21 94:6</p> <p>yield 69:4</p> <p>York 4:21 18:22</p> <p>Yoshi 3:13 90:15 91:18</p> <p>you'll 14:7 25:22 41:3,11 43:23</p> <p>young 47:17 85:17 91:20 92:7</p> <p>youth 86:13</p> <p>you've 16:24 37:15 54:24 94:17</p>			
---	--	--	--