The Innovation Center: How Much Can It Improve Quality and Reduce Costs – and How Quickly?
Alliance for Health Reform
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ED HOWARD: Let me get started. I don't want to take any more time away from what I think you're going to find is an excellent program.

My name is Ed Howard, I'm with the Alliance for Health Reform and on behalf of Senator Rockefeller and our board of directors I want to welcome you to this program on the newly established Center for Medicare and Medicaid Innovation within HHS.

CMMI inevitably, or the Innovation Center, has a challenging agenda, in fact you might say it has a whole series of agenda items that are all aimed at identifying and testing and promoting innovative health care payment and service delivery models designed to enhance the quality of care and restrain costs.

Today we're going to take a look at how the Innovation Center is developing, how its agenda is being shaped, where it's putting early emphasis, where the barriers to innovation are showing up, in this early experience.

One of the key ideas to keep in mind is the balance that the Center is seeking between the creativity and entrepreneurial behavior that's needed to foster innovation in the first place and the accountability that's need to make sure

that billions of dollars of the federal tax payer money gets spent prudently.

We're pleased to have as our partner and co-sponsor in this briefing, The Commonwealth Fund. Joining me as co-moderator today is, as is often the case when the Fund has a co-moderator, somebody who actually knows about the subject that we're talking about here. Stu Guterman is the Fund's vice president for the Program on Payment and System Reform.

He's also the executive director of its Commission on High Performance Health System. He understands innovation, having directed CMS's office of Research, Development and Information for several years. So Stu, we're very pleased to have you in your position here.

STUART GUTERMAN: Thanks Ed. On behalf of The Commonwealth Fund I'm want to welcome you all here.

The issue of innovation is an extremely important one given the situation we face. The process of innovation is one we need to understand better in order to successfully address the issue. There are really two purposes to this session.

One is to offer some support and suggestion to the Innovation Center at CMS and another is to really raise some issues that need to be considered by the folks who are participating in and in the end will be evaluating the success

of the Innovation Center and the innovations that it develops and implements.

So I thought I'd take a couple of minutes to kind of lay out some of the basic issues and then hand over to the speakers who will be talking about these issues in more detail.

First a quote that I think really kind of encapsulates where we are in terms of needing innovation. President Roosevelt, when he was campaigning for his first term in office, said, "The Country needs, and unless I mistake its temper, the Country demands bold, persistent experimentation. It's common sense to take a method and try it but if it fails admit it frankly and try another. But above all try something."

I think that's pretty much the situation we're in now with regard to the health care system, both in terms of its performance and of course its cost. So I kind of use this quote from Roosevelt to set the tone for this session.

We're all familiar with the problems of the healthcare sector. We have fragmented care, we have a lack of coordination, we have variable quality across the country and we have high and rapidly growing costs. The goals of addressing and the strategies for addressing those problems have been widely discussed.

One of the pieces of that strategy is the Center for Medicare and Medicaid Innovation that was created in the Affordable Care Act and has already begun developing projects. I'm not going to spend a lot of time talking about the Center and the details of how the Center is supposed to be operated. We have others here who can talk about that and we can certainly discuss that.

There are a number of models that are innumerate in the law that the Innovation Center is tasked with developing and testing. Those are in the copy of my slides and I won't go into detail there either.

What I'd like to talk about to set the stage for the discussion, is the set of key considerations for successful development of pilot programs. One is multi-payer involvement. That is, Medicare, although it is has frequently been described as the 800-pound gorilla is still just one gorilla and it's just a piece of the program.

What we have frequently in our fragmented health care delivery system and fragmented health care financing system is a number of well-meaning organizations pulling for the same goal, but pulling in different directions and that doesn't help. So we need to have better coordination among multiple payers to try and develop successful initiatives.

We need to look for ideas everywhere we can and that means that as well as having great ideas that really wonderful people in Baltimore and in Washington can come up with, we need to look for ideas that have been developed in the private sector and in state and local levels. We need to have the federal government be willing to throw its weight behind some of those initiatives if they show promise of achieving our goals.

We need to consider an array of potential models. If you look at the most successful models of healthcare delivery in this country, you have to notice one thing and that is that all of those models are different from each other. One size does not fit all, indeed when we're thinking about improving the health care delivery system and we need to be able to consider an array of potential models.

We need to have flexibility in design and implementation of pilots. We need to pursue what I call, innovation with evidence development. That is, too often we think about a project and we think about whether it worked or didn't work, instead of what we can learn from all of the pilots that we try.

I think we need to change our outlook and really think about how we can make things successful by looking at them and figuring out how they can continuously be improved rather than

just make some kind of summative judgment about whether it succeeded or failed at everything we were trying to get accomplished.

We need to establish an infrastructure to support success. I'm an economist and I recognize the power of financial incentives, but that's not enough. We need to do everything we can to make sure that innovations are successful including providing the right financial incentives, but also providing the infrastructure to help support success. That includes the availability of information to folks who are trying to do things differently and the availability of shared services for delivery systems that are trying to deliver a population, as they provide them with the care that they need.

We need to have the Innovation Center be able to work with Med-Pac, Mac-Pac and feed into the Independent Payment Advisory Board deliberations. We need to bring everybody together on this because pilots won't work if they're individual lights in the darkness. They need to work by having everybody pull together to help them work.

We need to improve the process as well. More transparency in both the consideration and the operation and the evaluation of pilots is necessary to help the process be successful. We need to look carefully at the ways of identifying projects with the potential for success and we need

to be able to get those projects approved without the kinds of hurdles that are frequently faced in that process.

We need to take a careful look at how we evaluate projects, to make sure we're asking the right questions and that we have the right baseline that we're comparing them to. We need to have a good mechanism for translating pilots into policy. The Affordable Care Act provides a piece of that.

We need to have resource availability. The Innovation Center has $10 billion at its disposal over the next ten years. That's a good piece of change but remember that that's a small, tiny fraction of the amount of money that CMS spends every year. If you were told that a private company devoted .09-percent of its annual budget to R&D, you wouldn't be very impressed. Well that's about what $10 billion comes out to, over the next 10 years.

So you really have to be willing to go into this like it's an R&D initiative and really try to find things that work because otherwise we're stuck with a system that is crumbling beneath our feet.

So I end with another quote from Atul Gawande that basically says, we can do this if we work hard and really devote ourselves to it. The speakers who are sitting here around me are going to tell us how we can do this and provide some ideas about what needs to be done next.

ED HOWARD: Thank you Stu and I've never seen Atul Gawande summarized better, I want you to know.

In your packets a lot of good information, including a list of more information than there is in your packets. All of that stuff, or links to it, is on our website, allhealth.org. As of tomorrow sometime, you can check back exactly when, courtesy of the Kaiser Family Foundation, you'll be able to view a webcast of this briefing and in a few days on our website there will be a transcript available for you to take a look at.

At the appropriate time you'll have a chance to fill out green question cards and hold them up and have them asked on your behalf up here. So there are, if you're woman or man enough to try to get to them, places where you can ask your questions yourself. Then as many of you who have been to these before there is a blue evaluation form in your packet that we would be delighted if you would take the time to fill out and help us improve these programs.

Stu set the stage very well for what I believe is one of the best panels we've put together in a long time and the very first person on that panel is Marsha Gold.

Marsha is a senior fellow at Mathematical Policy Research here in town. Her specialty – and she is as broad gauged in her interests as this implies - her specialty is

health care delivery and financing, especially in managed care and public programs like Medicare and Medicaid. Other than that, she knows very little.

So we've asked her today to look at those broad gauged questions of how CMMI needs to go about its work. Marsha.

MARSHA GOLD: Thank you. What I want to do is present briefly the findings or key points from a paper that I and Dave Helms, who is former president of Academy Health, and Stu produced a couple of weeks ago.

The paper is based on a meeting that we convened with Academy Health and Commonwealth support of both researchers and policy makers, trying to anticipate what the analytical questions are that are going to be raised by the Innovation Center and how to answer them.

So we don't have answers to everything, but I think what we were able to do is at least point out some good practices that might help and areas where there are potential challenges that we all need to be aware of and try and address them.

So the Innovation Center is designed to figure out how we can improve organization and finance and then to scale up those projects and figure out what policy changes we need to make them.

So the three issues that we address are ones that seem to be important ones that analysis can benefit from, focusing on change that matters. That is, which innovations to test, how to set the agenda, documenting innovations to support effective learning and spread.

That is, how do you get feedback to know what's working so that you can make it work or try it out in more places? Balancing flexibility and speed with rigor in developing evidence to support policy change. That is, there's authority to make some major changes in Medicare and Medicaid, but also a need for evidence that's included in the act, and how do we find out whether something is indeed working and works?

So in terms of focusing on change and matters, Stu already mentioned, even though it's more money than you have and I have, and most of our friends have together, it really isn't that much money to have that much 10 million to test out all the changes for a system this broad. According to the legislation what they're looking for is an impact on some combination of quality and cost.

So you can do that by having large gains over a small population. That is, maybe targeted to people who use a lot of care, or you can have small gains over large populations. Maybe something preventative that helps a lot of people.

One thing I think we probably know, those of you from the Hill probably experience it every day, if there's money out there people are going to want to get it. One of the key challenges for people implementing this act, I think, is to figure out what they should fund and what they shouldn't fund and whether something is able to make change. Those are policy decisions not analytical decisions, but we can look at plausibility.

That is, if you look at what they're saying, does it make sense? From what we know, is there an ability of this to save a lot of money? Given what we know about how much a given thing costs, what are the likely savings and at least try and sort out whether something, even if it worked as it best could work, whether how high up on the priority scale it is. That can be potentially helpful in sorting through what I assume is a massive number of requests.

Second is documenting and learning from innovation. I mean there's a real problem and this happens a lot, even with a lot of studies. People look at whether it worked but we don't know what it is or how it worked.

So one of the goals, what's an innovation supposed to achieve? What are the metrics that we will know if it's successful? What's a logic model or just a simple way of looking at what is supposed to happen that's going to make that

outcome? In the setting in which it's happening, how does it work? Documenting that in the beginning and also looking at what was implemented versus what was intended.

In other words, something may not work but it may not be that the innovation was bad, it just may be that it never got implemented or it got implemented badly. You want to sort those out, because it it's not going to work that's one thing, but if it could work but we just need to figure out how to do it better, that's real room for improvement.

So that means a need for timely measurement and feedback to innovators on metrics that matter to them, feedback to CMS so that things can be improving and really working on understanding what we're testing and what's being learned and what's happening.

Because there will be a lot of things happening in a lot of places on different dimensions, I think it means that the Innovation Center probably is going to have to invest in shared metrics to support cross-site learning. If it's bottom up and top down, there's going to be some differences across the bottom up, and how do we decide what should be common across similar innovations and where there's going to be flexibility and how we measure differences in innovations, context and how we measure the common metric of success across similar things?

That's a difficult balancing act because everyone wants to be flexible to have bottom up stuff, but unless you have some commonality and way of comparing different locations, you can't figure out whether on a national scope this is likely to have a good effect or which places really are most hospitable to a given innovation.

This part no one will like, but it is the most probably commonly supported and deeply supported research finding we have from evaluation, which is that everything takes longer than expected and more so if the context is complex. No matter what Congress legislates, there's only so much those deadlines can do and even if CMS does everything perfectly, things take longer than we think. They can certainly take shorter than they have taken, but things take time. So I think having realistic expectations about what's reasonable is important.

Conversely, to get momentum in provider organizations, you have to get them up and running and nothing can stop that more, as you get everyone excited to start on X date and then all of a sudden there's some federal rule or state rule or an institution’s rule that says, wait, we have to solve this. So I think anticipating all those requirements and making sure that if people get momentum going things can go forward, become really important.

Now this is the area that I think is the biggest challenge for CMS and for the evaluation community, actually and maybe for the policy community as well. The way the legislation is written there's a lot more authority that CMS has to test innovation, to expand innovation, not go back to Congress but to make a program change the affects the broad Medicare/Medicaid. The actuary must certify that it won't add to program costs and the Secretary has to demonstrate the potential to improve quality. So there's a real question as to what should be the standard of evidence and I think it's worth thinking about that a little.

Historically there was a lot of focus on very well designed studies. They took a long time, you define your target population, you get one or more comparison groups that are similar, you get metrics from central data and you figure out if something works and it takes a long time to distinguish long-term effects from stable effects, from short-term effects.

The likely reality that we're going to be facing here is you're going to have 'national demonstrations', that is a lot of places are going to be testing things in slightly different ways, in slightly different organizations or even more than slightly different. You're going to have bottom up innovation with a lot of variation in detail. You're going to have a lot of things happening at once, so there isn't this

'hold everything constant and let's just keep these people separate and we'll figure out what works,' and a lot of desire for rapid feedback on whether things are going in the right direction, even though we might not know that right away.

So, pardon me for using Type 1 and Type 2 errors, I couldn't figure out how to get something short on here without this. Basically the challenges that you want to avoid moving too quickly versus too slowly with improvements. So, usually researchers focus on, 'well let's make sure it really works,' so we don't want to change things. On the other hand there can be things that are worth doing that never got done we don't want to change things so we're not sure if it works. On the other hand we know it works pretty badly now.

So, I think balancing those two efforts is really important and I think it may be valuable for those of you working on the Hill to realize that that's also what Congress does. I mean Congress has acted before evaluations are done, they've failed to act despite evaluations showing something was or wasn't successful clinically. Some of the competitive bidding stuff never got implemented because of political considerations. Some of the stuff that was proven to not work hasn't been implemented.

So what are our conclusions here? I think that it's important, and I think this was a lot of the thinking behind

the Innovation Center, if you look at history and what's been accepted, just demonstrating that you can make change. If a lot of providers and a lot of different places can make something work, that's going to be an important and powerful incentive. It's been very important historically in convincing Congress and convincing CMS that things are valuable.

We want to enhance the utility of pilots, by getting high quality evidence. We want to know what the pilot was and what was tested and where it was tested. We want to get consistent and timely measures of intended and unintended change. Do what we can to figure out that it was due to the innovation rather than anything else and give people in the private sector and in government enough information about context so we know whether an innovation is suitable in a different context.

So the ultimate challenge is, I credit Stu for this and I think everyone who I've talked to says it sort of captures it, what's the trade-off between rigor and rigor mortis? I mean we want to have some rigor, but we don't want to kill the patient or whatever.

So we want to distinguish useful initiatives to propagate from efforts that mainly preserve the status quo or are actually harmful. We want to avoid stifling innovation to improve system because no data are good enough and make some

appropriate trade-offs in thinking about that and looking at different stages and the risks and rewards. So there's more detail on those issues in the paper.

I know it sounds kind of dorky for a congressional presentation to talk about some methods issues, but there a means to an end and in some ways we've also been talking with the research community to help them understand the challenges that the policy makers are facing. I think together that cross communication can really help get some innovation in the way we look at things and evaluate them as well and hopefully provide the information that policy makers need to help make the Innovation Center successful.

ED HOWARD: Great, thanks very much Marsha. Next up is Dr. Paul Wallace. Dr. Wallace is director of the Center for Comparative Effectiveness Research at the Lewin Group, where he and his colleagues use comparative effectiveness research to improve effectiveness in the health care system, reasonably enough.

He brings to this discussion not only his skills as a researcher, but more than 20 years of experience at Kaiser-Permanente where he was a clinician, he was a medical director, a promoter of population-based care and head of Kaiser-Permanente's Care Management Institute. He's a board certified

hematologist and an internist. I feel safer already having him up here. Paul thanks for being with us.

DR. PAUL WALLACE: Well thanks Ed and I wanted to thank both you and Stu for the invitation to be here and participate today.

I think you've heard already from Marsha and from Stuart this is a big issue. There are a lot of dimensions, a lot of complexity and I particularly wanted to focus on an aspect that Marsha highlighted on her first slide that we want to focus on change that matters.

One of the challenges is going to be though, matters to whom and matters in what way? So I think it's important for us to think through that, because there are many, many different stakeholders as this goes forward.

So you heard that I did practice hematology and oncology for a long time. I guess I'm a recovering oncologist now. Though when I think back about practice, one of things that would have made my life a lot easier is if we could have just had all of the data organized and all of the information organized in a way that I could focus on the patient in front of me.

Unfortunately as a physician sometimes what focusing on the patient in front of you means is taking your hand off the door knob, actually sitting down for a second, staring the

patient in the eyes and telling them with absolute certainty what you think they should do, with the implicit indication that if they don't do it, they're an idiot. While that may be patient centered, I don't think that's personalized. One of our challenges going forward is to deliver personalized care that meets the needs of all the patients who we serve. In order to do that, I think it's important that we begin to listen and increasingly listen to the patient perspective.

A few years ago, we had a chance to do that. We were curious about how different constituencies think about value. So we sat down with groups of patients, with groups of consumers, groups of healthcare purchasers and groups of clinicians and asked them, when they think about value, what does their lens look like, as they view value?

What you'll see is they really helped us identify even then the triple aim, where clinicians when they think about value will tend to think about measures of quality performance; how well they delivered on certain kinds of services and how well they compare to their peers. The patient/consumer though frequently reflected on the care that they received through their experience in the care delivery process. Value to them was reflected by the care process. Finally folks who were paying for care, not surprisingly, tended to look at value primarily through the lens of affordability.

So I think the triple aim is an important organizing principle that can convene all of these perspectives. The other part to recall is, that it isn't just about how to convince all of these different constituencies that whatever we want to do is the correct thing, we also want to be able to look at these different constituencies as being resource and having perspectives that will give us guidance in thinking about how we actually developed programs.

So a successful deployment is going to mean a dialogue with all of the different major stakeholders so that we figure out what are the ambiguities, what are the places that we need to trade off, and how can we bring forward programs that will actually meet all of these different perspectives of value?

It gets a little more complex than that too, because when we think about spread, on one hand we tend to think about: how can we take an innovation and have it go from one location to another location? I think it's also important for us to remember that even if we take the perspective of the triple aim, how the triple aim plays out in different places will be significantly different.

It will reflect different biases, different organizational characteristics of the delivery system, different experience in the past with care and we could really create this model where at different parts of the healthcare

system, we'll have somewhat different or broader perspectives about thinking: what do we really mean by the triple aim?

There really isn't just one triple aim, there are a whole range of triple aims. At a policy or national level, we may have coalesced about a particular thinking around the triple aim, but that may not be durable as we go to more granular levels and particularly when we get down to the level of the patient and the provider.

So it's going to be critical for us to think, what do we really have in common at these different layers? It's also important to recognize this little guy here at the bottom. This would be the average patient seen by the average doctor, in the average health system with average healthcare coverage. If indeed that person exists, the challenges that we've focused a great deal of our research in the past, assuming that that person reflects everyone in this distribution. We've designed care, we've focused our research and we've communicated our results as if that person is the only one that matters.

Another challenge is: how do we think about the wider diversity? Well one step again is to go back and listen, what are the questions that are being asked at these different levels? At the policy level we ask, what works and what's the demonstration that things work? At the middle levels when we're running healthcare systems or as we're creating practices

or running hospitals, our question tends to be more around how can we make it work here? If we look at this from the patient or consumer perspective, our question will be yet again, fundamentally different, it's how does this impact me here and now?

All of those questions are correct. All really need to nest into the solutions that we bring forward, but also if you just imagine at the policy level, at the peak of this pyramid, if our policy's only reflect the perspective in a narrow range and just draw a line straight down from there, we may take care of our average patient in the average healthcare system, but we also haven't accommodated the diversity that we're also here to serve.

So our challenge is to think about how can we also serve the diversity. One way to begin thinking about this, is rather than necessarily mandating specific interventions or programs, to convene the discussion around what works around the logic that we hope can be spread.

So thinking about logic models may be a critical thing. Just as an example, if you examine the relationship between the patient and the healthcare system, there are various types of interventions. There are certain kinds of interventions that the healthcare system does to or for patients. You could argue that most of the prevention screening that we do are things

that we pretty much prescribe and do for the patient and we can do that with a high degree of confidence that it's correct.

There also are a range of activity's that can only be done successfully that involves collaboration between the patient and their family and the healthcare system. Examples of that would be things like care management or transitions in care from the hospital to home.

Finally, there are aspects of health that we're increasingly recognizing are solely dependent on the patient. The healthcare system may have a role in supporting the patient in creating more beneficial healthcare seeking behaviors and health behaviors, but the change needs to take place on the individual level. As a physician I can prescribe smoking cessation, but the cessation of tobacco use is dependent on the patient being able to change their own behavior.

While we think about models for how we can talk about, evaluate, and convey practices at these different levels, they're going to have some fundamental differences and they're going to have to fundamentally reflect the fact that these different logic models - the healthcare system, the payer and the patient - will have fundamentally different roles.

So one size isn't going to fit all, there are probably a finite number of sizes and we're going to have to figure out what those are. It's also going to very important for us to

figure out how we can orient our discussions so that we're not making absurd comparisons at things that really have substantially different underlying logic.

It's also important for us to recognize a problem that I think Marsha and Stuart have recognized before: it's the rigor, rigor mortis problem. When we're creating policies at the National level, obviously the stakes are very high and we need to insist on a particular level of rigor. So we'll tend to think about having very high degrees of confidence or in research speak, having the P value less than .05. When you're running a healthcare system you make hundreds of decisions a day, and there are very, very rare systems that you can make in running healthcare system that have a P value of less than .05.

If you're a patient who's transiting through the healthcare system or making value based decisions and the whole rest of our life, it's an extraordinary luxury to have decisions that have that degree of certainty.

So we also need to think about how can we support people and decision making in a real-life context? What does it mean for us to recognize that we won't always have that idealized degree of certainty and how can we accommodate the needs of patients at the same time, that we seek to accommodate the needs of the delivery system.

Well this is an example of how this plays out in a data based way in a healthcare delivery system, Kaiser-Permanente. So this is looking at new clinical technologies, largely medical devices that have been substantially examined by the American Research Enterprise and presented for broad application within a healthcare system.

So using a systematic process of looking at the evidence for these different innovations, when we looked at over a hundred of these, what we found is that it's actually quite rare to find compelling evidence in the literature that something doesn't work, which is sort of an indirect attribution of the intelligence of the people who publish these things. Because you don't get promoted by saying something doesn't work.

So the bias in what's actually published is not particularly surprising, but what's distressing is there actually are relatively modest number of interventions that have compelling evidence that says that they're medically appropriate for all patients. Most things fall into the grey, for any of the reasons that are shown in here.

The challenge of the health care system is, well how do you deal with the grey? Well one model of dealing with the grey would be just to say, stop here, don't jump off the cliff, don't go into the grey. We're just not going to pay for

anything that goes beyond that. The challenge is that that's not credible for the full distribution of patients and challenges.

An alternative is to say, if you're going to move into the grey be careful and be accountable and it also may be that we need to create new accountabilities going forward, for how we can track things in the grey, but not to prevent people from testing whether that's appropriate for a given patient.

Now, huge policy implications obviously because in the policy world we like to believe that things can be made black and white and our challenge going forward is going to be can we really rub out the grey or are we going to need to evolve ways to actually deal with the grey?

Well my bias is that we're going to need to evolve ways to deal with the grey. If they're going to include how we can use data and how we can use data over time and how we can learn and how we can progressively refine our understanding, this would be an example. This is a registry within Kaiser-Permanente that the orthopedists created to reflect their experience with joint replacement. It now reflects the experience of over a 100,000 joint replacements that's being used on a daily basis by clinicians to evaluate and modify their service.

For instance, they can ask a question, 'what's the appropriate joint prosthesis for a patient who has Diabetes?' and have around 10,000 people as a database that they can then use to examine that data in addition to looking at a whole population.

So going forward, when we think about are our opportunities to actually create a more enhanced dialogue. At the largest scale, the what works level, we need to figure out what's appropriate variation? What are those boundaries of the grey area and how do we tolerate that? What's the point we say, be careful, but what's the point we say, don't go there? We also have to rigorously think about do we want the world to be black and white? We need to have studies of the whole population or effectiveness studies that can translate into the middle scale of how do we actually make it work here?

Having things work at the practice level means that not every decision will be driven by a P value of less than .05. It's about testing widely and often, parallel processing but also having processes like the Innovation Center that can bring that information to a broad audience, but also being able to test rapidly, rapid cycle change.

Finally on the personal scale, it's about registries as I talked about before. It's going to be about increasingly capturing data directly from patients, not only about patient

experience with sickness, but also about patient functional status, how you're performing at work and what are your preferences and values, and finally the ability to leverage social medias, being actively experimented now. The key message though is that we'll need to balance experimental and observational methods.

So in conclusion I think that we have to respect perspectives. We have to respect perspectives because that will be how we communicate, but it's also again to recognize that the value of the perspectives in moving forward is it's also the greatest untapped resource for us to actually explore what works and how can we move it forward.

So, thanks very much.

ED HOWARD: Thank you Paul. Now we're going to hear from Dr. Timothy Ferris, who's an internist and a pediatrician and the medical director of the Physician's Organization of Mass General Hospital. Innovation in care delivery's only one of several areas of responsibility for him, as are efforts to improve the care of patients with multiple chronic conditions. He's just won a National Patient Safety Foundation award for a demonstration project that he directs to improve care for Medicare beneficiaries. So, from the front lines, Tim, thank you for being with us.

DR. TIMOTHY FERRIS: Thank you very much. Thank you for the invitation and I guess part of the perspective that I'm trying to bring here today is to think about, so I'm in the field, I'm innovating in the delivery of healthcare, how best can I work with CMMI to continue the cycle and support the innovations? I think you'll hear some echoes in my talk of some of the things you've heard already.

So the engaged doctor's dilemma. So healthcare costs are rising too rapidly, the engaged doctor knows that. Actually they're laying off people in my town in order to pay for the health benefits of the town employees. We've been through this before so I was around in the '90's when we went through this. Similar, although I would argue quite different in its scale and scope, but it feels very similar to doctors and so there's some healthy skepticism.

Physicians remain unsure of what reform will bring. It's a very important point that the impact of uncertainty in policy is very stifling, I think actually Marsha mentioned that and the longer uncertainty persists the more difficult I think it is to move forward.

So what is the engaged provider to do? Well the engaged provider, and I put this graphic up here, knows that they need to move from inpatient to outpatient encounters to episodes of illness and populations management. That is a

lifelong journey. It's going to take a long time but you can break that down into pieces and I'm going to try to do that a little bit today.

The other thing we have to do is figure out what we think works and, very similar to what Paul was just saying, and start moving forward with those and always think about improving and building improvement and innovation into the very nature of the structure of health delivery, all difficult tasks.

I'm going to spend a couple of minutes on this slide. So this is when we looked around at the evidence and thought what are all the things we need to do to move from transaction based healthcare to episode and population based healthcare? There are 20 cells on this slide and this is actually a full employment act for people like me, because there is nothing on this slide that's simple to do. These are 20 things that have been shown time and again, they've reached what is called saturation, meaning there really are very few people in the policy world who think that anything on this slide is a bad idea.

I'm going to go through a couple of them. These are innovations that have been around in the literature for a long time but it’s innovation not in the sense of coming up with a new idea. It's innovation in that you are adopting something

new within your organization and figuring out what it takes to make it work. That's a big part of what we're talking about here when you talk about innovation. Oftentimes people think of innovation only as a new technology or a new idea. Innovation also, as we've heard from several panelists, is the spread of existing ideas, the adoption and making it work within your organization, that's what I'm really focused on.

I'm focused on these 20 things. I'm going to talk about a couple of them, one high risk management, another electronic health records with decision support and order entry and a few others. You'll notice that access to care is critical to this framework and it's broken down as longitudinal or primary care, specialty care and hospital care. The design of care is actually what it is you're doing with patients in the actual moment of care.

There's a lot of measurement in this. There are business management types who summarize the literature of high performing organizations as having three characteristics; access to a lot of data and good use of that data, a front-line work force that is empowered to make decisions on their own and I'll come back to the third one.

So this is the Mass General Medicare Demonstration Project. I've been working with CMS on an innovation for the past six years now. This innovation has been highly

successful. What we did is we worked with CMS and their prior organization before CMMI, an organization called ORDI, which Stu is the director of, and based on the observation that a few patients here are responsible for a large majority of the costs, we use claim sets to identify those patients.

These are patients in a fee for service system so very similar to the whole ACO alignment model. The patients didn't need to sign up for anything here. We just provided care managers to them, very high risk patients, they really liked that experience and we have the data to show that.

What happened as a result? I'm not going to go through all of this, but we took the care managers, we had never had something like that in our primary care practices. It took us a lot of work to provide them the space, the management, we hadn't managed population managers in a fee for service system before. That was innovation on our part, though I think it's fair to say it wasn't innovation in that we didn't think of the idea. A lot of others, including those at Kaiser had been doing this decades ago.

What we did show though is we had very successful outcomes. We kept patients out of the hospital and we saved Medicare quite a bit of money, 7.1-percent annual net savings on the population that we managed. That's the kind of innovation that I think we're talking about here in the sense

that it's innovation in the delivery system on the adoption on of ideas that work and then making them work in your own local environment.

Here's another one; so this is work that we did using radiology order entry. So the curve here is the rate of rise of high cost imaging within our organization prior to the adoption of electronic order imaging. What we basically told all our doctors was, the only way you can order an MRI or a CT scan is using a computer that it forces you through a decision support process. When we fully adopted that technology, shown by this line here, this was the change in the rate of rise of high cost imaging within our organization.

This is the kind of innovation, so this took a long time. It took a long time to build the software, we're constantly tweaking the software and improving it, so this is a never ending story. It's the kind of thing where both innovation and evidence have come together to produce a nice result. This is available on the web and the website is available here.

This is one of my favorite websites. It's a website for data geeks. It's called Many Eyes, and it's a way of putting large data sets into a public domain and then using software to visualize all that data. So every cell in this graphic represents a measure of quality, at Mass General

Hospital. These are all measures of quality at the individual doctor level. You can see we have hospital-wide measures, we have surgical measures. Just to point out here, the orange color, those are the public measures, so that's what Medicare is measuring about us.

The white and the blue are what we are measuring about ourselves. This is a very data intensive process. We've been developing this for over 15 years. But the use of data to constantly monitor yourself and improve yourself is inherent to the innovation process and this is a way of visualizing all of our data.

These measures are actually available for anyone who wants to look at this website. This is publically available data.

One of those 20 cells is the use of incentives. So we have incentive programs. When we want our doctors to adopt something new or change their performance, we put a little money associated in their pay with that. This is just four examples of the decline in bacterial infections associated with increasing in hand washing.

We currently have financial incentives on our H-CAPS performance measures. Use of the electronic medical record, how long it takes for the doctors to get their notes into the electronic system and how long it takes our radiologists to

read films, which is now down to about 2 hours. So, the use of incentives with data is a very powerful and important piece of this.

What I've done here, very quickly is I've just highlighted the slides to show you that the 20 cells on this graphic are actually familiar to you, in the sense that there's already legislation or regulations that are specifically incenting pieces of this.

So you'll notice here the medical home, if I circled all these boxes and that's essentially what the medical home is. I circled these boxes and that's essentially the HITECH Act. I circled these boxes that's essentially meaningful use, these are all things that are all incented under meaningful use. I circled these boxes over here, that's the Partnership for Patients. Then finally something not out yet, but coming hopefully soon is our bundled payments. Bundled payments will incent the cells highlighted here.

So in closing you might not be surprised to hear me say that doing all this is going to take a while. I did produce a version of my 20 cell slide for my boss and he asked me how far along on each of these cells are we? I would say we're about 5-percent. So there's a long way to go. I'd say nationally that's probably about right.

How do we incent providers to do these things? Well besides all the things that we'd talked about here, one of the things that I like to bring up is our incentives around the relationships between payers and providers. There's a lot of regulations that providers deal with related to both commercial payers and government payers. And when I write gold card status, what I'm talking about here is let's get rid of some of that administrative and regulatory cost as an incentive to engage in these things.

I only talked about the engaged provider, but as Paul pointed out, we need the engaged patient to be part of this. Then finally just to reiterate I think what you've heard, there are two types of innovation, there's the adoption and innovation of ideas known to be effective, new processes. That's what I mostly talked about. Then there's the development and testing of new technology and new processes, not yet known to be effective. Thank you very much.

ED HOWARD: Alright, thank you very much Tim. You've just heard about engaged providers and engaged patients, now you have to get the viewpoint of an engaged government official.

PETER LEE: Thank you Ed, thanks Stuart, thanks Karen, both the Alliance and Commonwealth have really been incredibly important sort of founts of discussion around incredibly

important issues. I'd also like to thank Senator Rockefeller for hosting this.

It's really, when I look around the room, I know many of you, the Innovation Center is here because of a shared understanding that crosses the political spectrum, that crosses the spectrum of patients, physicians, employers, which is we have an imperative improving the health care system is one that we all share, that without having better tools between doctors and patients, in hospitals, in those clinical settings, we're all going to be up a creek without a paddle.

In many ways the Innovation Center is part of a broader context and I really appreciate Tim's last remarks, which is a place that I'll start with, which is to give you a reminder of context in terms of where the Innovation Center sits, is we do not believe that we are the fount of all innovation, believe it or not.

We don't think it comes from Washington, we don't think it comes even from Baltimore. Innovation however is something that is central to a lot of parts of HHS today. It's central to what was in the Affordable Care Act in terms of changing incentives in many, many places.

It's embedded deeply in what we're seeing happen in virtually every community across the country where private payers and states are going directionally in the same way.

Saying we have to change our healthcare system to move away from being one that is about volume, that is about unit delivery, and Tim actually had this in his slides, to one that rewards value, to one that changes the dynamics, changes the incentives and creates the tools so we bend to that cost curve in a way that is patient centered.

In thinking about where the Innovation Center fits, again we aren't the only answer. Think about us in the context of HITECH. The payments under the Recovery Act, which are kicking in this year, that are providing a huge incentive for physicians, for hospitals to put in place electronic healthcare records that are going to be the platform for doing the better performance measurement, better information systems that we need to actually reform care.

Think also about what's in the Affordable Care Act in terms of value based payment. Tim referred to the Partnership for Patients. I'm going to talk about that in a moment but the incentive changes in the Affordable Care Act, are themselves innovations going in the direction of trying to foster better quality care in very, very big ways.

In 2015, the average hospital in America will have somewhere in the neighborhood of 9-percent of their Medicare payments in play for different elements that are looking at the quality and the value of the care they're providing, okay.

Some of that is going to be for adoption of electronic health records, some is going to be for their reduction of healthcare required infections. Some is going to be for admissions. Some is for broader measures about patient responsiveness. Over 9-percent of Medicare payments is more than the average hospitals margins in total, okay.

If you look back three or four years, Medicare had virtually no money on the table. We started that money on the table for pay for reporting, but moving over a pretty short period of time, to having 10-percent, almost, of Medicare payments in play for value, is a game changer.

So I just want to frame some of the context. The Innovation Center is part of a broader effort, private sector, throughout HHS, etcetera, to move payments and support delivery reform.

You've had a great set of introductory remarks and I feel like I could say, well let's go to questions, because across the panelists they've touched on a lot of what we're about. What I'd like to do is talk some about the principles that we're operating under at the Innovation Center. Some about our setting up our infrastructure, which you've heard about, a little bit about where we're placing some of our initial bets and then something about evaluation.

So first in terms of the principles that we're operated under. The legislation lays a lot of this out and you've heard about it in terms of we are supposed to be testing new models of care delivery and those that work we're supposed to be helping take those to scale. It's a really big deal. The Secretary has the authority with a review by the Office of the Actuary that an innovation that we've tested is at least cost neutral if not lowering costs and at least quality neutral if not improving quality, to take initiatives to scale and implement them nationally. That is a huge deal.

Now I want to let you know that three part aim that you heard referred to, the three part aim is: one are we delivering better healthcare, two, are we delivering better health and promoting population health and three are we reducing costs through improvement. Now, when we look at our aims we are constantly looking at the trifecta, in the sense that we're looking at initiatives that will lower costs through improvement while improving quality.

Now if others want to improve quality and increase costs god bless, go to town, that's not the Innovation Center. We're looking at the three part aim and all at once.

Second principle, we are, in terms of Paul noted, what do we mean and what are we looking at? What are our goals and from what perspective? We're starting from the perspective of

the patient, of the family, from the bedside. How is this going to touch the lives of patients throughout America?

Third principle though is that we recognize that healthcare is local. What happens in Iowa is different than downtown New York City and so how to make sure that we have national action that is framed by local implementation that is different in different communities, is critical.

Fourth is the need for alignment. You've heard about this, again I feel like I'm echoing some of the prior speakers, but the issues of aligning our efforts, with not just states. I think it's really critical that our name, the Center for Medicare and Medicaid Innovation, our charge is to partner with states to help states deliver more cost effective, quality care for Medicaid beneficiaries, for CHIP beneficiaries, is absolutely critical. So we are looking at how do we partner with states, but also how do we partner with private payers.

In virtually every one of our initiatives, if you look at whether it’s the request for proposal, etcetera, you'll see embedded in them, reflection of that principle.

Finally the balance of our sense of the need for urgency with the need for deliberative, thoughtful action and you've heard this framed as the balance of rigor versus rigor mortis. So we feel deeply the sense of urgency.

We also know that much of the change we need to support won't happen overnight. It's going to take some time to play out. We need to have a portfolio that reflects both of those sensibilities.

So where are we at the Innovation Center? We are in the process of setting up the infrastructure that you've heard Marsha and other note we need. What was the Office of Researched and Demonstration Programs, is now part of the Innovation Center. We've been blessed with a very rich staff at CMS who really know how to evaluate programs and they're now part of the broader center.

We've also been bringing in people from the outside and a handful of them, I'm not going to run through all of them, but we're organized in three domains. One is around care models, sort of the one on one patient care. The woman who's running that is Belinda Rutledge who was the CEO of a hospital in North Carolina, understands the issues of sort of patient care in rural settings and she's teamed up with someone at CMS who knows how to get things through Medicare.

Seamless coordinated care, Rich Baron, a physician from Philadelphia, who's been living and breathing medical homes for the last 15 years, is running that area help and get up and running ACL's other coordinated care issues.

The third area of focus is population, community health. Not a traditional area for CMS to look at, it's one of our three pillars. We've had on loan from the Office of the Assistant Secretary Dr. Anant Parekh who is helping us frame our initial steps in that area.

The other two areas of infrastructure is rapid cycle evaluation. We've recently been joined by Will Shrank from Harvard to run that program working hand in hand with Renee Mentnech, a long-term CMS person who is great. Finally a focus on learning and diffusion, Joe McCannon, who used to be at IHI and helped launch the 100,000 Life campaign, and has helped stand up the program called Partnership for Patients is running that area.

Across the board, we're looking at setting up an infrastructure that is based on this not being a one year play. That it's going to take time. We're needing to build that infrastructure.

So our process, and I've actually heard some comments that I need to sort of take issue with across the panel, is we are not a funder. We don't see ourselves as yet a new foundation. We're a partner with other payers, we're a partner with providers to set up ways to pay differently with Medicare, with Medicaid, to support new care delivery. We are getting hundreds of ideas across the transom, at our website of folks

knocking on our door, saying they've got an idea, they've got a model, do this.

Our modus operandi is not to say: give us a proposal, we'll give you money. It's rather, bring the best ideas forward, and we're also casting the net. We're looking at what Med-Pac's recommended. We're looking at Mac-Pac, we're looking at IOM, looking at the Commonwealth's Commission on High Performance. Just say, what are the best ideas out there and our standard modus operandi is to turn those into competitive RFPs to give everyone an equal playing field, to sort of step up and then test different pilots. That's our standard mode and we've been running out there in a number of areas and it's anchored in.

Also, I mean love this panel, is you heard the issue of action model. The term we use in our shop is theory of action. Is for any model out there, we're frame it, what is the theory of action? Who's changing what and on what pace to impact patients in what ways? So we're framing all of our tests by looking at theory of action.

So I know I'm running out of time but I'll go a little bit over if you don't mind. Big bets, let me note the four places we're placing big bets out of the gate. The first is around reinforcing and supporting primary care. When we launched in November, we noted the Innovation Center was going

to be part of supporting the multi-payer primary care initiative in eight states. For those that aren't familiar with it, in many ways it's a model of how the Innovation Center is seeking to engage local communities, because it was saying in these eight states, Medicare wants to be a partner with private payers and with Medicaid to support medical home models so a practice has common aligned incentives across all the payers.

So it's not that 7-percent of you that happen to be the Aetna beneficiaries or that 32-percent which happen to be Medicare. It's rather all the payers aligned with common measures, common payments so a practice can reform what they're doing. We've also launched a range of other initiatives support primary care, Medicaid Health Homes, federally qualified health centers, advanced practice primary care settings, and this is an area that's a big bet.

Second big bet is around care coordination. You'll notice these obviously are Venn diagram, they overlap, but we've been working very closely throughout CMS in launching the shared saving program. You've probably heard that this is actually not out and final yet, but what has been out, announced by the Innovation Center, is that there will be pioneer ACOs, pioneer accountable care organizations.

Those organizations, physician based or hospital based, that are ready to go further and faster in terms of taking on risk and then totally coordinating care for their population. Beyond just supporting pioneer ACOs we've announced that we're going to be looking at for some of the shared savings participants having advanced payment. We heard and CMS heard as part of the shared savings comments, that physician anchored practices were worried about having the resources to become accountable care organizations.

The Innovation Center is looking at and we received very rich comments on the need to provide advanced payment support to some ACOs so that they can participate in shared saving program.

The third thing we're doing in this area is supporting accelerated learning. We've already hosted a learning session for people that say, I think I might want to be an ACO, how do I do it? Now I know there's a big industry out there amongst the consultancy world, but we wanted to make sure there's a level playing field in terms of data, information and resources.

So we're hosting a series of trainings around the country. We've already had one in Minneapolis that had over 250 individuals from physician based organizations, hospital based organizations, that have said we want to become an ACO.

How do we do it, what data do we need, and how can we be supported? So those are three tracks around care coordination.

Next big bet and I really can't reinforce what Tim was noting strongly enough, innovation is not just about finding new things; innovation is about adoption. The Partnership for Patients is an initiative that says, how can we, as a nation, come together to make dramatic reductions in preventable hospital acquired conditions and reducing readmissions?

Now, the Partnership for Patients is not a hospital incentive program. Those incentives are in play in a big way in the Affordable Care Act. I noted earlier there's going to be phenomenally large changes in payment. What the Partnership for Patients is though is a major bet from the Innovation Center saying, there are hospitals - there are many hospitals - that have shown we can reduce ventilator associate pneumonia by 80-percent. We can reduce, for instance, pressure ulcers by 80-percent. What hasn't happened is the spread of those innovations.

This is an investment in learning how to spread what's known to work and to support hospitals that want to change their practice with tools, but also with aligned effort with the private sector. We have virtually every major health plan saying, we want to align with these efforts, send common signals to the market that we're going to reward hospitals that

put in place change, theory of alignment. We're working with hospitals to actually give them the boots on the ground to put in place change. So that third bet is around supporting innovation and adoption.

The fourth major bet is one that related to again partnering with states on a target population, those that are dually eligible.

If you look at that Willy Sutton remark of 'where's the money,' in both Medicare and Medicaid the money and the need for better care is amongst the dually eligible individuals, those that have both Medicare and Medicaid. Those individuals are also, because our incentives are so misaligned, the individuals who are today least likely to be getting coordinated care. The incentives between how Medicaid pays and how Medicare pays go crosswise. If Medicaid is responsible for the nursing homes, is Medicare responsible for the acute care? The issues of supporting incentives that are aligned have not been well addressed.

The Innovation Center is part of a number of initiatives to try to address that in fundamental ways. We funded awards to 15 states to develop programs to address their duals. We're now going to be getting their proposals back for how those states can, in innovative ways, address their dual populations.

Just last week the Secretary announced a state Medicaid letter that called on states to come forward and partner with Medicare to do managed care effectively for those dual populations. In some cases this is going to require three-way agreements; a state, Medicare and a managed care organization going to take capitated payments. Also we're looking at how to deal with people that are still in fee for service. How can states undertake a responsibility such as they can win, instead of it being a lose, lose situation. That states can win if they reduce total costs for those populations.

Finally, in the area of duals we announced the program for residents of skilled nursing facilities. To how to keep people in skilled nursing facilities and not be ping ponging back and in and out of hospitals with huge waste and huge cost in harm to patients.

So those are some of our big bets. We'll have other bets you'll be hearing about in the months to come but all of this is framed by a process that is really anchored around rapid cycle evaluation. You've heard from people that know this well and I celebrate Marsha's willingness to be dorky with us. The dorkiness of getting evaluation right is phenomenally important. You've heard a lot of the challenges of how we're going to need to wrestle with issues of what does rapid cycle evaluation mean.

I'll fly a couple things about what it means for us and again the issue that Marsha noted, the 'contaminated comparison groups'. The real world out there is a mucky real world and the Innovation Center's charge is to be living in that reality of not living in a pretense of academic purity, and I say all due respect to my friends in academia.

So a couple of things we're wrestling with and will be working with as we implement pilots. First is, as part of the evaluation and part of the monitoring, is we will be taking the lessons immediately to modify and improve what we're testing.

Now a cleaner thing to say is, you say here's your model, you say we're going to now run this out for four years and we're then done and we'll test it. As opposed to saying, if we've got 15 sites and five are doing great, we're going to try to immediately learn what they are doing and give that information to the other 10 sites, okay. That complicates our work.

We'll be tracking it, we'll be doing real time monitoring, but taking evaluation on a real time monitoring but taking evaluation on a real time basis to modify and improve is something we'll be doing.

At the same time, we're going to be setting up markers for our initiatives to, in essence to have a kill switch, to terminate programs. So it's not a matter of saying, this is a

five year program, we're going to run to the end of five years. We're going to say, if our goal is to show at least a for example, 2-percent reduction and we aren't hitting that 18-months in, we've told folks ahead of time, we'll terminate programs, okay.

Third issue though is scaling up. We're going to be looking at an evaluation of what are the learning's to take initiatives to scale and this means two things. In some cases it means our initiatives will be small because there's not enough evidence there to test to scale. In others, we want to test things at a large enough scale that we can say, to the Office of Actuary, to the Secretary, this is good enough to go. We want to implement this. We think this should be implemented across the entire Medicare program, the entire Medicaid program and be a lesson that we think can be instructive to other payers out there.

I think critically the Innovation Center sees our role as not only being, let's get to the Secretary and implement something across Medicare, but let's take our lessons such that private payers, that providers out in the community can say, we see that this works, we want to follow that example, we want to learn from it and we want to implement it as well.

So, when we think about scale up, it's not just the big lever that the Affordable Care Act gives the Secretary, but

it's as important that we're learning and sharing our learning's in a very transparent way so those other payers we're partnering with can say, you know we're going to do this too. So those other gorilla's, so to speak, aren't the only ones that are looking to Medicare to act, that are joining us in acting to transform the health care delivery system.

So with that, I think you've heard the challenge that we have before us. We welcome the work that this panel has done. The paper we've already been looking at. Our evaluation team is looking at it.

We believe that we both have to be dorky and nimble at the same time and I look forward to your questions.

ED HOWARD: It sounded a lot more nimble to me Peter than dorkiness, but I'm just a poor country lawyer what do I know, with a bunch of very qualified researchers and practitioners up here? Now you get a chance to join the conversation. Remind you that you have a chance to write your question on a green card in your packets and hold it up and I note that there are two microphones, near the rear of the room, one on each side that you can use to ask your question orally.

If you do that, I ask you to both be brief and to identify yourself. Let me start, if I can, Peter by following up on something we've heard a couple of times. Marsha mentioned it and others did as well; the difference between and

the need to do both ground up development and top down development. I wonder if you could say a few words about as you put your portfolio together, how much of it is likely to be local and intense and how much of it is likely to be National with 15 sites the way you were describing?

PETER LEE: Yes. The truth yes is, is we will be doing a combination of what I call ground up of issuing RFAs saying here's the broad problem, here's the issue, but we want to hear your solutions. It's going to be different in different communities.

We will also though be having initiatives that are more 'top down'. They're saying we've had very well developed examples of a solution. We want to test that solution in 15 sites. So when we think about that it really is a well framed way to think about it.

If you think about, in many ways the Multi-payer Advanced Practice Primary Care, you'll note I try to speak in sentences and words not in acronyms, but also known as the MAPCP program, the eight state program. We didn't say, states you must do it this way. States came in differently; Pennsylvania is different than Vermont. I think that's part of what we're going to be testing and trying to assess so it's going to be absolutely a mix of the two.

ED HOWARD: Thank you. Yes.

BOB ROEHR: Bob Roehr with *British Medical Journal*. Two questions; first of all, despite all of the gleam of high tech of medicine when it comes to studies, it really is still a cottage industry, where everyone uses their own standards and procedures and operations, even if you look at the cacophony of EHRs there. What is going to be done to try and standardize things enough so that you actually can compare studies?

ED HOWARD: Marsha and then Paul.

MARSHA GOLD: I mean some of this, you have to recognize these innovations are done at different levels and some of what we're talking about isn't specifying how care will be given to particular patients. It's trying to say, how do we reorganize the way providers practice or the way they're paid, so that they can make better decisions and be rewarded for those decisions? So I don't know if that reassures you a little because it means that the decision of what particular care gets given is still between the provider, the patient and whatever system they're in.

I think one of the things that is important to capture, and I'll let him talk about what will be done because he's the one who has better authority for that, I think what is important to capture from an analytical perspective is what's the same and what's different?

In other words, if people are trying to do a given thing, like a medical home we, we know from different ways that there are different dimensions you can talk about a medical home. How do we know which ones were in place and which ones were not in specific sites? So at least we have information to describe it to people and they'll know.

The other thing is how do we capture some characteristics of the patients that were involved in that demonstration? How do we capture some ways of the settings and the markets in which those things worked? So we can at least describe the diversity, try and look at relationships, and a combination of CMS deciding whether there are certain conditions that are required before something can go forward, but any given organization or provider can look at this and say, does this make sense to me. Now, how you get that data is not easy but from an analytical perspective that's where we think it has to go. I'll leave you with the how.

DR. PAUL WALLACE: I guess the point I'd make is to think about where are there the fewest barriers and the most gain from doing things the same. I would argue that's around how we measure and coming up with common measurements, thinking about what are the factors that feed into a measurement. Because having common measurements allows you to then convene a conversation about how did you achieve that and how did I

achieve that; where if the measurement systems are different then it just ends up being babble. So if I had one thing where I could wish that we would have consistency it would be how we create measure definitions.

The second part of that is I think that as we can do that, and I think that there's a reasonable track record now if you begin to look at NQF and think about how that's helped us with things like meaningful use; is that once you've actually begun to centralize on something, other things can fall in place.

So it's been easier to think about what are the measures we might use in meaningful use by virtue of the fact that there's an agreement around measure definitions.

So that would be my suggestion about a place to start.

STUART GUTERMAN: Peter if I can jump in just for a second here. I wanted to mention that we've been recognizing the issues you've raised, I think they are extremely important issues and they're kind of two dimensions along which action can be taken.

One is, colleagues of mine at the Fund have pulled together a consortium of evaluators of medical home models with just the purpose of kind of aligning the way these models are evaluated and the kind of data that get produced so that you can do some comparisons of different approaches to try to get

at the same objectives. We're working on the same kind of thing for the ACO model as well.

The other dimension is facilitating communication between the health services research community evaluators and the actuary evaluators. The Office of the Actuary is going to have a very big part in what the Secretary can do to spread innovations and I think we want to try and align the standards of evidence for judging whether innovations are successful and ready for spread across the different folks with different perspectives on that issue.

So we're going to try to facilitate communication on that line too.

ED HOWARD: Peter?

PETER LEE: I'd underscore the note of alignment and it's not just within the Innovation Center. We're absolutely using common measures across different initiatives, but also those sync up with what CMS is doing, with what meaningful use is doing. So, if you're in those cottages, you aren't getting 19 questions and I think per Stuart's note, it's also syncing up with what the private sector is doing.

So we'd need to have a common set of measures, that's certainly what we're driving towards.

ED HOWARD: Can I ask any of the panelists, when the Office of the Actuary makes the judgment about cost savings

over time or at least cost neutrality, is there a timeline like a CBO 10 year budget window that they have to use?

PETER LEE: No.

ED HOWARD: There you have it.

PETER LEE: I mean the legislation says the Office of the Actuary needs to look at, is this a cost reducing or cost neutral and that's how it's defined. I'm sure the Office of the Actuary will provide a time frame.

We however, and I think this is an important note back to the rigor versus rigor mortis, is that one of the things the legislation specifically provides is that the Innovation Center, in doing our testing, does not need to be budget neutral right out of the gate. I mean that's a recognition that there's thin evidence for some of what we're doing. That's why we're testing things, but when it comes to the Office of the Actuary saying this is having a positive financial impact, it's not defined, but it'll certainly be something that we'll be working with them to define as it goes forward.

ED HOWARD: Okay.

BOB ROEHR: Could I have a follow up there. Within this context of trying to simply identify what works and what doesn't, in the outpatient setting, probably the most important factor is adherence and right now we basically, largely rely

upon what the patient says they did, which we know is notoriously inaccurate.

What can be done and what is going to be done in terms of identifying better measures of adherence and better measures of evaluating adherence.

ED HOWARD: Questions that also arise in the ACO context. Anybody? Stuart?

STUART GUTERMAN: Well one thing, the Commission on a High Performance Health System put out a report on ACOs and addressed this issue or kind of a related issue. There's an issue of attribution and how you manage patients when they have free choice to go anywhere they want and clearly also want to have free choice to adhere to your recommendations or not. There are two ways to go about that.

One is that the Commission recommended that CMS look at different ways to kind of share savings with patients as well as providers to get them to kind of buy into the need to manage care better for themselves as well to listen to their providers.

The other is actually a phrase that Karen Davis told me somebody mentioned at a meeting is, 'the best fence is a good pasture,' which means basically if you present a recommendation for treatment in a way where the patient understands that it's

the best thing for them, that they're much more likely to adhere to that recommendation.

MARSHA GOLD: Just briefly, I mean that's what logic models and theory's of action are about. I mean that patient adherence will be more relevant for some things than others and presumably when thinking it through, if you find out that that's a big part about of whether you're successful then thinking about how you measure that or know what's going on, or will influence it, has to be an important part of how operators think about what they're designing.

So, there's a lot of issues as you get into subunits as to how you get data, how you do that. Fuzzy logic results in garbage, so.

ED HOWARD: That's almost as good as the best fence is a good pasture. Paul?

DR. PAUL WALLACE: So, I think it's also important to ask whether the intervention that we're asking the patient to adhere to is adhere-able. When you actually look at things through the patient perspective, there's an awful lot of unnatural acts that we expect patients to do, like taking meds four times a day.

So, I think there's a lot of opportunity for innovation to think not only about spread and the nature of the innovation, but also to think about, is this something you

could expect a reasonable person to be successful with? I'm not sure that we've put many things to that test frankly.

ED HOWARD: Yes, you've been patient.

NATHAN DANSKEY: Nathan Danskey, HIV Medicine Association. Medicaid and Medicare pays for a large percentage of conditions, diseases that we do not have to face in the United States, CDC calls them the six winnable battles. Naturally I'm going to talk about HIV is one of them. Medicaid pays for 40-percent of people who have HIV, pays for their care. So I'm wondering what CMMI is doing to focus on any of those winnable battles in the United States, how they're organizing or strategizing around them. If I can aside for Dr. Wallace, there's a study HBTN-052, which mentioned that if we treat people early enough who have HIV, they're 96-percent less likely to infect someone else and it had a P value of .01, that's pretty good. I'll take my answer at my seat so I can take some notes, thank you.

DR. PAUL WALLACE: That's a great question. This is one of the great examples I think of where there's incredibly important lessons to be learned from different conditions and the community based response to AIDS and HIV it's been sort of a popular thing to talk about hot spotters and complex populations where we have some models that you can actually have lessons that can be learned or taken to other conditions

that have multiple conditions that relate to them, which HIV often does.

Now in the near term, when I think of what we're doing right now is, we have not launched yet any condition specific initiatives. Rather when you look at what we're doing with the duals, many of those people with HIV are in states which now will have better aligned incentives to do coordinated initiatives with those dual populations.

As we partner with states, looking at their Medicaid populations, similarly we'll have the states and encourage them to come forward and do initiatives with us. Similarly when we look at accountable care organizations, medical homes, we will be holding to account for how they respond to different particular conditions and treatments.

One of the questions that we're wrestling with quite honestly is sequencing how many of our big bets should be population wide versus rifle shot approaches, so to speak, for condition specific and whether that's HIV or cancer or renal failure, etcetera and it's one of the things we're looking at today.

So, I look both at we're doing big bets and looking where we might make more specific bets in the future.

ED HOWARD: Okay, speaking of specific, we have a very specific question directed to Dr. Ferris. I will try to

translate as I read. For the value based purchasing evaluation score CMS puts a lot of weight on the patient satisfaction measure, 30-percent. Is that too much or have your experiences show that those patient satisfaction incentives work well? Did I translate it well?

DR. TIM FERRIS: Yes, I think you translated right. I don't know the answer to that. It's one of those areas where I think the jury is out.

Certainly we are, at my hospital, we're focusing a lot on our HCAP scores, that was the scores that were being referred to here and frankly we found them very difficult to move but the fact that we are focusing on them very intensively is only good news for the patients that we care for.

So, while I could maybe argue, oh it should be 20-percent they're weighted too high. Maybe, but the fact that they're in there is very important and I don’t think that I would get in the job of quibbling with what the level of importance is attributed to them financially.

ED HOWARD: Peter?

PETER LEE: I'm going to take that as a question also to the Innovation Center, which is regardless of the percentage, this is back to having a common measured framework across all our initiatives, patient experience is going to be a central element of everything we measure. So, we can then

quibble is that 30-percent or is it 40-percent, but whether we're talking about initiatives that are about ACOs or medical homes or duals at every single one will have that. It's back to having a common measurement frame from our perspective, a patient experience measurement is absolutely critical.

So where we have a standardized measure set, whether it's clinical and group caps or in HCAPs we're going to look to that and not have one offs but it's going to be certainly a piece that we'll certainly be looking at.

ED HOWARD: Go ahead Stu.

STUART GUTERMAN: If I can add one comment. We're talking about innovations here today, but there's a challenge to the health care delivery system I think regardless of what innovations or whether any innovations take place and that is to change the way it interacts with patients.

All too often the health care delivery system seems to have the attitude that the patients are there for them as opposed to that they're there for the patients. I think that needs to change regardless of what other innovations we put in place in terms of payment and delivery.

ED HOWARD: Yes, go right ahead.

KATHLEEN SHEEHAN: Hi, Kathleen Sheehan with the Visiting Nurses Association. There's been a lot of discussion today about hospitals and doctors, but I just wanted to put on

your radar home health. If you're discharged from the hospital, you get a discharge note. If you go to see your physician, he gives you orders about what do to, but home health nurses actually go into the home, work with the patient, work with the families and actually do the educational process, involved in helping to people to stay out of institutional care.

Home health agencies, I represent the non-profits, are particularly focused on dual eligible's and chronic care conditions. We haven't seen too much yet coming out of CMMI that would really be focused on home health but both patients and States want to see patients who are able to go home, to be able to go home.

So I guess my question is, how are we going to, as we look at these innovations really look at where home health can be more helpful to patients and to payers with regard to transforming our system?

ED HOWARD: Peter?

PETER LEE: Thank you for the question. Oh, I didn't mention, but I will mention as one of the initiatives that's part of the Partnership for Patients is sort of a two-track. It's a very significant investment from the Innovation Center in terms of producing hospital required conditions, but an equally large investment under the Affordable Care Act, $500

million to support better care transitions which is in many ways going to be about how to have better home health. How to have that hand off from exit from hospital to be handed off smoothly to someone going home, so that's a major investment area.

The other place that we're looking at is, how do you build this into other initiatives? So when we think about what does it mean to be an accountable care organization, that's not a place, it's a process of accountability for a population to ensure that people get the right care in the right setting, which is very, very often going to be their homes.

So it's, I think, more initiate that we look at we may have initiatives that are specific to home health, but more importantly when we think about medical homes, accountable care organizations, other initiatives, is how to make sure that right setting starts with the one that is most patient sensitive, which is most often the home.

So we'll certainly be looking at that throughout our initiatives.

ED HOWARD: Okay, let me just take a second to remind people we have less than 10 minutes left and I'd like you, as you listen to these last questions and answers to fill out a blue evaluation form and help us make the next briefing even better, if you can imagine that. Yes.

SUZANNE MINTZ: Suzanne Mintz, National Caregivers Association.

Within the Affordable Care Act, within the Innovation Center, there are actually 15 sections that mention family care givers, five of them relate to measurement. It has been my experience so far that those are, and will continue to fall by the wayside unless somebody champions them.

Family caregivers are providing 80-percent of all the care for persons with chronic illnesses and disabilities, and we, with the patient, are the only people who are currently consistent across all care settings. So, obviously the role of the family care giver in chronic illness care is huge and I'm here to say, I don't want to get a little bit about family care givers that's in ACA lost because of lack of inattention.

ED HOWARD: I guess it's worth noting for the record that AARP's new report that quantifies the amount of money represented by that uncompensated care in the hundreds of billions of dollars a year. Now does someone have a comment?

PETER LEE: I mean I hear that as a comment not a question. I agree, it's an area that we are centrally concerned about. When I noted our principals about its both patient and family centered care as a core starting point principle, how we look at all our initiatives. It's not a

sideline, it's really a center point of how we're trying to design our programs.

SUZANNE MENZ: Now I understand that it's a center point, what I'm saying is, nobody is championing the inclusion of the family care components into any of the programs, the demos and pilots that are happening. So somebody at CMS, at the Innovation Center, needs to look at that, needs to champion it, so that they are included. There's been a new CAPS for the medical homes, it's all patient and I was told there's just no time for family care givers. I'm saying make it.

PETER LEE: Okay, thank you.

ED HOWARD: Tim Ferris has a comment.

DR. TIM FERRIS: Well just that both your comment and the last comment when we're innovating around the 20 cells that I put up there, about 10 of them couldn't be successful if either nurses, visiting nurses or family care givers weren't tightly involved in the process.

So in our care coordination demo's, in much of the work that we're doing they're there and there may be an issue of the naming and the calling them out as being there, but we couldn't be successful in what we do in care coordination. More than 50-percent of our interactions with our patients in our care coordination demo are with, not our patients, but our patients care givers. So they're right there at the forefront of any

innovation that's going to be coordinating care for any one of a number of high risk patients, so thank you.

ED HOWARD: We've got a question here, raises an interesting aspect of this discussion; when the appropriate clinical practice is known, for example, the questioner says, radiology benefit management within fee for service Medicare, is it appropriate to mandate practitioner compliance through some sort of prior authorization? Whether this is innovation or not, I'm not quite sure.

DR. TIM FERRIS: Well on that note the state of Minnesota I believe, if I have my facts correct, actually did mandate that providers order high cost imaging through a decision support system.

So, there's precedence at least as far as I understand it for this. I think there are certain interventions that have been shown repeatedly and wide-spread and therefore start to become, from a policy perspective, where one would look at all of one's levers. I think mandating something is a lever that you want to restrict for circumstances where you know that the benefits dramatically outweigh the risks and specifically the costs.

In the case of much of the HITECH Act and other legislative efforts, the place of incentives before going to regulation. So just how we do it in my hospital, we generally

incent the doctors to adopt something. We get them 80-percent adopted roughly and then we mandate it, so that we get over the hurdles of adoption.

So I consider mandating something generally on a just managing change basis, something that you do for the last 10 or 20-percent, rather than something that you do out of the gate for both political and just change management issues.

ED HOWARD: Marsha and then Paul.

MARSHA GOLD: Yes, if I can just. I think there's a real dilemma that CMS has that I think policy makers can help. Obviously there are a lot of things we don't have that strong evidence and then it's hard to tell, but then sometimes we have strong evidence and what can or should the government do to tell providers how to practice?

If it doesn't do anything with evidence then it may not be encouraging efficient care, and I like your way of putting it. What do you do first? You use incentives, you use mandates as a last cause, but sometimes people have tried to do the right thing and the press is all over it. You're denying X person their right to Y and this is a bad thing.

I think there's a dialogue that has to go on with the American people that the policy makers and the Congressional people need to support, which unfortunately I think neither party does often enough. Which is, what should we do, what

shouldn't we do? Don't always assume more is better. We have to figure out how to figure out how to be more judicious yet help people.

It becomes very difficult for the government to figure out how to use the knowledge that we have and my sense is that until we get better about talking about these things, in a rational way that takes everyone's judgments into account, it's going to be hard to use some of the evidence that we have.

ED HOWARD: Paul?

DR. PAUL WALLACE: One way I would think about it is, that if you think of a continuum where something is safe, something is risky and something is reckless, that we want to restrict the use of mandates to things that we as a society judge are reckless. We want to think about in areas of risk, how can we manage it using other tools.

It doesn't mean that will work every time but I think we have to be very cautious in how we jump ahead and I think we also have to be very cautious about assuming that if a mandate works in one situation, we should more broadly apply it. Because the opportunity cost is, we won't do more things that are creative and scalable.

So I think that mandates probably do have a place in the portfolio but we ought to be very careful about how we use them.

ED HOWARD: Well I believe that is, and a very sagacious one, the last word in discussion. Thank you very much Paul. I want to thank all of you for asking some good questions and staying with the discussion. Remind you as you listen to me blabber on here for another 45 seconds that we'd love to have you fill out your blue evaluation form.

Thanks very much to our colleagues at The Commonwealth Fund, both for Stu's very active and positive participation and the support and co-sponsorship and helping to fashion this program in the first place.

I would ask you to join me in thanking our panel for a very thoughtful discussion about very tough subject.

[END RECORDING]