



**Quality Care: Getting More Bang for the Buck?  
Alliance for Health Reform  
The Robert Wood Johnson Foundation  
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ED HOWARD: Alright. Why don't we try to get started here — sort of the voice of God. My name's Ed Howard, and I want to welcome you on behalf of Senator Rockefeller, Senator Blunt, the Board of Directors of the Alliance. This program examining how well the U.S. is doing in maximizing the value in healthcare that is the highest quality for the lowest possible price. We've gone through more than a dozen years since the Institute of Medicine issued a couple of reports on the quality of healthcare in America, made a lot of us choose our words more carefully when tempted to describe the U.S. healthcare system using superlative adjectives and adverbs. To err is human and crossing the quality chasm both laid out the extent of quality concerns and sort of the pathways to finding some of the solutions. And you may have heard there's widespread concern over healthcare costs as well. Despite the recent slowdown in the rate of increase, healthcare costs continue to consume about 18 percent of GDP compared to an average of about 9.5 percent in the OECD countries. The population is aging. Medicare enrollment is expected to grow by about 30 million between now and 2030. It's supposed to double in price—in spending, rather—between now and 2022. So, today they're going to try to bring this value formula, the quality and cost containment, into clearer focus. We're going to look at some of what's going on in the private and public sectors to pursue these twin goals.

And we're very pleased to have, as a partner today in sponsoring the briefing, the Robert Wood Johnson Foundation, which has been helping Americans enjoy healthier lives and get the care they need for now more than 40 years. And we're especially pleased to have with us today to co-moderate the program, Anne Weiss, who is a Senior Program Officer at RWJ where she directs the team for the Quality/Equality Healthcare Program, and if you peek at the biography sheet in your materials you'll see that she also spent some time not far from this dais working for the Senate Finance Committee and at OMP as well. So we're very pleased to have Anne Weiss with us today. Anne.

ANNE WEISS: Thank you so much. Thank you so much, Ed. Thank you. It's great to see everybody here. The Robert Wood Johnson Foundation where I work has been involved in the issues of quality and value of healthcare for many years and I think it's really interesting to think about this as a journey and talk about how the issues of quality of healthcare and the value of healthcare changed over time. At the beginning, I think we talked a lot about making sure that people got care that they need. So, was everybody getting their cancer screenings, their flu shots? Everybody here had a flu shot? Go get one, um, when this is over, go get one. And then we came to understand that it's just as serious a quality problem when the healthcare system delivers care that isn't needed, or even the wrong care; that these are not only quality problems but they contribute to the problem of high healthcare spending and that's a problem for government, it's a problem for business, and it's a problem for individuals and families in our country.

Also equally important, when it comes right down to it, it's so critical to think about the fact that quality really is in the eye of the beholder, too. Isn't it really important to stop and consider what's important to me when I get healthcare and what do I want for my

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family's healthcare? That's a really important perspective and one that people often don't stop to consider.

And finally, another thing we're going to talk about today that I think is, you know, a very important piece of the puzzle to keep in mind is well, how does the healthcare system have to change to achieve all these different visions of what healthcare quality and value really are, because it's a really complex enterprise. The system we have isn't working well for a lot of people including the people who are in it delivering the care every day, and if we want our care to be better quality and better value how do we have to change that system to meet our expectations.

It's complicated even to define and measure what we mean by quality and value let alone acting on the information that we got. So, over time we've gotten—the problem's gotten more complicated, even as our understanding of it has grown and I'm really delighted that we have the folks who are—the panel here with us today—that brings cutting edge expertise and a lot of wisdom born of many year's experience. I'm really looking forward to it and I thank you very much for having me here.

ED HOWARD: Great. Alright, thank you Anne. Let me do a little housekeeping. The packets of information that we'll give you, among other things, the slides that folks have put together and biographical information more generously apportioned than they'll get out of my mouth anyway in the time that we have. There'll be a webcast of this briefing available in a couple of days on our website at [allhealth.org](http://allhealth.org), and a few days after that a transcript as well. There are, actually now, digital copies of all the materials in your packets and more that we didn't want to kill trees to put in your hands, but you can check them out on our website. And we'd ask you, at the appropriate time, to fill out the green question cards, or go to one of the microphones when we get to the question and answer period, and there's a blue evaluation form that we would be deeply indebted to you for filling out before you leave so that we can improve these programs as we go along. If you're into Twitter, I think you can see a hash tag on the slide at health quality, and if I can work in a commercial here—it's just a brief one. I want to call your attention to the availability on our website of another resource; that is, the latest edition of—and I think I have the printed version here—our Source Book for Reporters, and our source book for reporters ain't just for reporters because it has a wealth of information about people who are experts, websites you can get more information about some upcoming questions that might be arising, and it covers the fourteen chapters that you see listed on the slide and we would commend it to you. There are also pertinent and recent newspaper stories from around the country having to do with the subject matter of each of them. Y, ah, en Espanol, tambien, on the website. How'd I do, Anna? Okay.

Let's get to the program. As Anne said, we have a terrific group of folks today. We're going to listen to some of what they have to say in some brief presentations and then we'll turn to an interchange among the panelists and the question and answers from you folks as well. And we've asked Dr. Don Detmer to start us off. Don's a professor of

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medical education at the University of Virginia Medical School. He's one of the country's leading experts on health information technology and health informatics. Today we've asked him to give us a little historical perspective on those seminal IOM reports I mentioned and the recommendations regarding quality of care in the United States that came out of them. He's eminently qualified for that task, having served on the IOM committees that issued both of those reports, and I should mention that Don worked diligently on the slides that were prepared and reproduced and put in your packets, so there isn't an exact match between what you'll see on the screen and what you'll see in the paper version in front of you, so don't get upset. It's on our website in the final version.

Don, thanks very much for being with us.

DON DETMER: Thank you, Ed, and thank you, Anne. And it's nice to be here. I appreciate it a lot. What I will be doing is covering largely the IOM perspective, but I also will be making a few personal perspectives and cover a little bit of history pretty quickly because I like to get up to where there IOM current thinking is about this.

Now, these are my conflicts of interest statement. I'm really here sort of representing Harvey Fineberg, the President of the IOM, as well as Mike McGinnis and Rob Saunders, who have been working very much in the Learning Health Care initiative. Curiously, I think somewhat curiously, Kathy Lohr, in a report in 1990, coined this definition with the committee work of quality, and has held up really amazingly well. I think just as a matter of in the handout of knowing a marker that when kind of the modern work, if you will, of quality from the IOM perspective started. And I think it's interesting to look at that. It talks about individuals and populations, outcomes, and current professional knowledge. And I think it's from those, some of those core concepts, that a lot of the subsequent development of what I currently call our modern, if you will, current framework which is still very robust and changing, currently fits.

There are four reports that really, I think, during the period from 1999 to 2000 were pretty much played also pretty key roles. You've already heard about the To Err is Human report and the Chasm Report, but there were a couple of prior reports; one, 1991 reissued '97 report on the Computer-based Patient Record, which ended up, obviously, being, I think, part of what led to high tech which is underpinning, along with, for the record, a report that really said how do we deal with security, confidentiality, and privacy, because that's got to be critical, this tech, if all of this is going to move forward. So, those reports, all of these reports I'm talking about, are still available at National Academy Press, so that's really nice. The Chasm Report, I think, one of its key markers was it laid out these criteria, the letters of which were reassembled into what's currently called STEEP, perhaps because it's a steep hill to climb to get out of that chasm. But in any event, it's safe, timely, efficient, effective, equitable, and patient-centered. And we were having a brief conversation among us at the table before we came up, of what patient-centeredness kind of means, and I think each of these terms has actually been

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pretty dynamic and I think have really framed a lot of the thinking since that report came out in 2000. All of this is seen from an informatics and an IT information communications infrastructure.

There is another little report that I think is pretty important. A summit that was held on competencies for health professionals going forward and it was in 2003. And again, it talked about going forward, if we're going to really get this chasm issue dealt with we really need to know what patient-centered care is, how to work in it, our disciplinary teams, particularly with the rise in chronic illness and aging populations. Evidence-based practice—important—continuous quality improvement and informatics making it as a formal kind of word for the first time in sort of the IOM lexicon of terminologies.

Now, to bring us from 2006 up to the present, there have been some additional things that are built on those and I mentioned the Learning Health Care system, and I think this concept has really quite—has been quite robust and has spawned a whole variety of studies looking at it from a variety of perspectives of how does that learning occur and it's across all of the players. It's across the patients, the communities in terms of public health, as well as individual patients, as well as providers and various health professionals, and so forth. So it's a learning health care system that requires a structure that allows learning to occur. And that's as important, probably, as anything else. Bill Stead, who's also the report with Lynn on Computational Technology for Effective Healthcare, talked about how we kind of do this inside organizations using robust information infrastructures. And then the National Research Council, a recent study called *Toward Precision Medicine*, and basically what we're saying here is sometimes called Personal Medicine, but that's a little confusing because what you're talking in precision medicine you're really talking about my genome and my snips of my proteomics, not just necessarily them more broadly. And that, I think, at the end of this talk I'll hit a couple of those things, because that's very promising work.

And then, probably the thing I'll spend the most time on and use slides from that report, is *Best Care at Lower Cost*. And this report just recently came out and I think is the path to a continuously learning health care system in the country. And this is a little hard to see, all these names, but it's a very good—it's like most of the studies. Mark Smith chaired it. Good representation across a lot of domains from Art Levin, for example, a consumer perspective, and Paul Tang from IT and so forth, I think, really a very strong group of people across the ranges of knowledge bases that fits into this.

So, there are three major areas where they say why now, why talk about this at this point? First, some quality shortfalls, second, unsustainable costs and waste in the system, and then, increasing complexity. And toward that end they have pulled together some slides that show, on the quality side, for example, 20 percent of patients reported that test results weren't available, or transferred from one place to another; a quarter of patients said that tests had to be redone because information wasn't available. So that was seen as one of the problems, whereas in other industries, on online banking, for example, this is really a

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model that we can lean on. And in another quality sense, in terms of how well the system's partnering with patients, less than half patients reported receiving clear information on their benefits and tradeoffs at treatment for their conditions, and less than half of patients were satisfied with their level of control in medical decision making. And I think there are, again, other industry examples where this is handled better.

The actual report talks about more of these in greater depth and I'm just going to hit the high points of a lot of this. Talking about unsustainable costs, overall healthcare costs, as we know, are really astonishingly high and keep climbing, although that's mitigated somewhat. But the point is, compared to the general economy it's grown faster than the economy in 31 of the last 40 years, and also, compared to wages, it's been also a challenging issue. And I think the conclusion—and I added this to the slide, it wasn't part of the original on the website—but, I think this is clearly not sustainable and it's potentially obviously capable of sinking both the U.S. and the global economy if it's somehow not managed better and to illustrate that this gives you some idea. Other prices had grown as quickly as healthcare costs since 1945, a dozen eggs would cost you \$55, and a dozen oranges \$134. Well. That ain't gonna work. And if you look at some of the assessments of where our wasted expenditures are, they're from a whole variety of categories. Missed prevention opportunities, unnecessary services, as Anne mentioned, inefficiently delivered services, prices that are too high, excess administrative costs and fraud also is a challenge. These numbers vary somewhat depending on who's doing the work, but I think everybody agrees there's a lot in there, and there are a lot of opportunity costs that, if we could just deal with that, could go a long way to helping us on a whole variety of important issues. Waste could pay the entire nation's infrastructure costs for one and a half years for roads, railways, water, telecom, and so forth. It's outlined in there.

So, the point was, the report was saying we can take advantage of a lot of things that have developed. Computing power, connectivity, improvements in organizational capabilities and collaboration among patient and clinician teams. And obviously we're talking about a vision that involves clinicians, patients, communities working with care, evidence, and science in a continuous way of improving things. And the recommendations came down to a digital infrastructure, data utilities, clinical decision support, financial incentives—and we'll be hearing more about that from others—performance transparency, and well, leadership. And obviously, if you're talking about a more patient-centered care, community links, care continuity, and optimized operations, we'll be discussing some more of those here.

So, I think going forward, I think the vision from now to say 2020 is for a continuous learning healthcare system, very active citizens, patients, and communities with precision, personalized medicine as the genome costs continue to drop and proteomics and translational bioinformatics can tend to move us forward, and some of that is even looking at the social determinants of health, which I think is critical.

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So, on the digital infrastructure, when I think what we're really talking about, I'm going to end with some comments about what I see is where the knowledge generation side of this is really critical. As we look at this, we are entering an era of what's called big data, although nobody exactly defines what big enough is big, but at least we clearly are dealing with volumes of data that's critical. The issue is, it's not just big data but what kind of a data ecosystem is that living in, and how is it serving the various needs, then, of these communities of interest and need to, in fact, create this kind of getting them what they need when they need it as they need it and making it better over time. And I think the issue, of course, comes down at the service level for value-based payment in terms of financing, obviously, safe quality care, professional accountability and credentialing, which my colleagues the rights in the middle of at the moment, and then, of course, obviously the science of diagnostic drug developments and so forth.

The point is, is that data quality is going to be evolving and how do we capture registries and data management across the various needs of the players and systems to do this. A set of different kinds of records are going to be critical. And I think the first of the top of these shows how, right now, are systems which could actually serve a lot of joint needs with the same data coming out of electronic health records don't—that connectivity's not there. And also, the standards in such a way that they can help that aren't really there. So what we'd like to see is the bottom part of that, which really has this connectivity going where it is, and that involves, obviously, the development of some key standards.

So, to improve the data movement is a challenge as well. We have a lot of regulations in place that don't allow us to move the data as much as we need to, and that is part of a challenge. And there's been some past reports from the IOM and others that actually current policy is not, maybe intentionally, but is causing almost all kinds of research to suffer. There have been a lot of reports recently to try to move this in addition to the better care at lower cost that we really need to look at our rates. I think the interesting issue is, as Faulkner said, the past is not dead. It's not even past. I think as things are moving along we still are kind of being dragged by some of our challenges.

This is a picture of Atul Butte, who, if you haven't gone to his website you might want to—the little fellow up in the top corner there is a little boy in Milwaukee who was actually the first person saved because his human genome was cracked and he had a bone marrow transplant. He was actually having multiple bowel surgeries and was really headed downhill. So the point is, even in individuals with not as much knowledge as you'd think we'd need to do something like that were doing this. And I think what we know is that having free access to good data, secure, but it's really becoming critical, and if we can get longitudinal, identifiable, personal health data on larger populations that's even better because the human genome has gotten more complicated as human populations have grown.

So the age of precision medicine really is at hand. I think a lot of cures and preventions are within reach and boy, do we need cures. I think, halfway technologies really are, in

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fact, part of where our costs are coming from and I think it is time for us to actually walk the talk. We're saying the right things on these regulations and re-looking at them, but I think it's time to really do it.

To learn more about the report, obviously, here's the website. I really thank you for the attention and I apologize for running through this so fast. If you have any questions or comments feel free to email me and I again, apologize for switching a few of the slides there, but I just wanted to make a couple more points. Thanks a lot.

ED HOWARD: Great. Thank you, Don. And we're going to get a chance to get into some of the things you were not able to do much in depth, I'm sure, as we go through the program.

We're going to turn now to Dr. Richard Baron. He's just taken over as the CEO of the American Board of Internal Medicine and the ABIM Foundation. For many years he was practicing general internal medicine and geriatrics. I'm always glad to see a geriatrician on the panel. And more recently he directed work on seamless care models for CMS's Center on Medicare and Medicaid Innovation. Today he's going to tell us about one of the prominent projects of ABIM called Choosing Wisely. Choosing Wisely is a physician-shaped, evidence-based approach to discouraging ineffective treatments. It's gotten a lot of attention and has a lot of dynamism to it and I'm, frankly, interested in getting the latest information about it, and thank you for coming to tell us about it.

DR. RICHARD BARON: Well, thanks so much, and thanks to Anne and the Robert Wood Johnson Foundation, which has provided additional support for Choosing Wisely, as I'll talk about in a minute. I want to also thank my team, John Held and Leslie Tucker, who are here, and Dan Wilson, who's been one of the major architects of Choosing Wisely, and my predecessor, Chris Cassel. I think I came into an initiative that really had a lot of legs, and I want—I'm really thrilled to talk to you about it today.

The proposition I'm going to put out, knowing who's in the audience, looking at the list of all of you who are here, is to think about the idea of activating professionalism as a core part of regulatory strategy. And when I'm done talking about Choosing Wisely I think you'll have a better appreciation for what I mean by that, for some of the potentials of doing that, and for some of the ways, I think, as we move forward and try to get the most effective healthcare for the least cost, this is going to be a critical part of it.

The work in Choosing Wisely is based on this thing called the Charter on Professionalism which was created by some internal medicine organizations in 2001 and 2002. And it basically was meant to be a code of ethics for physicians in the 21st century. I must say, I was pretty skeptical of it. I was on the board at that time and I thought, you know, one more code of ethics, more or less, like, so what. Who reads those things anyway? But there was a call out of a series of commitments that you see listed on this slide. Some of them are very familiar—professional competence, honesty with patients—but there was

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at least one that was really quite unfamiliar and this involved a just distribution of finite resources. And part of how we got to Choosing Wisely was the ABIM Foundation saying very explicitly, as we look across these aspects of professionalism, which ones are in the most trouble? And the thought was, the one that might need the most help is figuring out how to help physicians and patients talk together about a wise distribution of resources.

This slide is the different version of the pie graph that Don showed you. It is something that we have from Don Berwick, and it basically is meant to say that there are many components of waste and so we're not going to find a silver bullet. Nothing that we're going to get as a country is going to be one thing. And I think it's a useful frame for thinking about the different ways of attacking the problem.

There was a study in JAMA that was really pretty disappointing a month ago about the views of U.S. physicians on who they thought was most responsible for controlling healthcare costs. And for those of you who can't read from where you are, top of the list, number 1, trial lawyers. Which is pretty stunning when you think about it, or whatever you want to say about defensive medicine, if you're in this room you know enough health policy that if we did hang all of the lawyers we probably would still not solve this problem. One of the more disappointing things was that only 36 percent of them thought that practicing physicians had major responsibility. But the good news in that was only 15 percent of them thought that practicing physicians had no responsibility. And that 50 percent is arguably a huge opportunity area for us to engage practicing physicians in caring about managing total cost of care and avoiding waste.

Choosing Wisely is really founded in, believe it or not, a \$10,000 grant, maybe \$20—I'm sorry. I've been corrected on this—to the National Physicians Alliance. And they came up with the idea of where we have this guideline development process in healthcare. We've got a bunch of experts in a room to look at the evidence to say what's the right way to talk about, to treat Hepatitis C, and then come up with a set of standards, and they get out there and they drive practice. And the thought was, well, what if we put them in a room and said, What are we doing too much of, that we know we have evidence we're doing too much of? And we presented that as a list of five things, and tried to raise the profile of those things as things that we know are being done more than they should be. It's not that they should never be done, but they're being done more than they should be, could we focus attention on that? And this was combined with the Foundation investment in, frankly, market research of what were words you could use and couldn't use in talking about resources and ways and stewardship with physicians and with patients? And out of this comes Choosing Wisely where the focus of the initiative is to help physicians and patients engage in conversations. And I really want to stress that. Like, people ask us all the time, well, can you show it really works? And I'm going to say that the goal was to try to foster these conversations and I think we have ample evidence that there's a lot more of these conversations happening around the country than there were before. We're leaving it to others to demonstrate actual impact—people closer to the data.

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The components of the campaign are the messengers and collaborators, primarily, at this point, it's up to 58 specialty societies. The communication of the messages, which had a lot to do with a partnership with Consumer Reports, consumer organizations, and the ABIM Foundation also oversaw some of the communication aspects, and really trying to activate people in a concrete way. Now, I know many of you in the room are policy makers and, as Anne said, I spent a couple years at the Innovation Center, it's real easy to talk about changing the payment system. It's really hard to do it and I don't have any magic insights on that, but I do want to share with you one slide. This is what the guidelines were for the societies preparing Choosing Wisely recommendations: Pick something that's in your purview and control; Don't talk about what somebody else ought to be doing; Pick something that's done a lot for which there's a significant cost; Pick something for which there's general evidence to support each of the recommendations that you made; and, The process you use needs to be transparent. Folks, that's the anatomy of Choosing Wisely. Okay, that is the policy framework in which Choosing Wisely happens.

And, as I now talk about the scope of the initiative, these are the various partners, the first wave of Choosing Wisely recommendations came out in April 2012. It was nine societies. They were a little afraid to get out there on that thin ice, but by February of 2013, we had a bunch more. We were worried that we were sort of overwhelming the media. A major thing we heard back was, we can't cover all those recommendations. So when we had another 30 plus lists coming out in the fall of 2013 and early 2014, we're now doing that on a weekly basis to try to create a drum beat. And that's the list of the other 30. But there's a series of consumer groups who are engaged and, again, this is a conversation. This is not meant to be you must not, and again, we're often invited into partnerships with payers or with government—can we hard code this stuff? And our view on that is that this is about activating professionalism—that's where we're trying to stand and we're looking, we think there's plenty of real estate to be gained here on that ground.

And out of this come very user-friendly designed reports, documents, and we're hearing about people hard coding this, including these documents in their EHR's so they can give them to patients as part of encounters. They can, again, the goal was to support conversations and we're hearing about people hard coding the recommendations into EHR's and using them to trigger decision alert systems. We'll see how much of an impact that actually winds up having. Don is more familiar than I am with the literature about decision support, but I think that the idea is it's a set of tools that people are using to have these conversations.

And then we get various kinds of more in depth things about how do you talk about this? Well, to the extent that this was about stimulating a conversation, this is just a sampling of who's been covering Choosing Wisely and Chris Cassel, when she learned that Vogue was going to come and interview her, the only disappointment was it was not a cover shoot and we had a lot of grief about that, but that's how it goes. It's also been in a fair

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amount of peer review journals, and of course, we have a wonderful endorsement from Don Berwick describing it as a game changer in healthcare reform.

And, as I said earlier, we got support from the Robert Wood Johnson Foundation to come up with 21 local grantees to try to implement this on the ground. They're doing everything from iPhone apps for appropriateness of echocardiograms to engaging patients in practices in Maine to help the doctors get better at talking to their patients about these issues. So, we're trying to get more local, but the campaign is way beyond our ability to support it and we regard that as a victory.

You know, I think that this is the situation we're trying to deal with. Your labs are back—they show a serious overuse of unnecessary and inappropriate tests and procedures. The number that the IOM is putting out there is 30 percent of what we're doing in healthcare may be waste, if waste is defined as things that are done that don't benefit actual patients.

If you want more information about Choosing Wisely these are some web links, but the thought that I'm going to leave you with is what's happening right now is we're transforming from a fee-for-service payment system to a different form of payment. We're all trying to get there as fast as we can, whether it's global payments and ACO's, whether it's advanced models of primary care with upside-downside risk, whether it's bundled payment, but they represent a different incentive structure for physicians. Physicians don't think of themselves as responding to incentives, they think of themselves as taking care of patients. But their opportunities for doing what they do are driven, a lot, by the payment system in which they function. I think one of the things we need the most right now in these new payment systems is a values-congruent professional compass so that doctors can feel like they're doing the right thing for their patients and not just trying to make the bottom line numbers for a CFO or the publicly traded stockholders or make the business people look good. And I think what's driven the adoption of Choosing Wisely is a need for ways that doctors and patients can be on the same page about reducing inappropriate resource use and we have so much that we're doing that's inappropriate we don't need to be talking about rationing, and as we talk about avoiding harm, and as we talk about appropriateness, we can have very different conversations. Choosing Wisely is starting to outline a professionally driven road map for how to have those conversations.

I look forward to questions as we move on, and thanks for the opportunity to be here.

ED HOWARD: Great. Thanks very much, Rich. And as both Dr. Detmer and Dr. Baron have emphasized, we're talking about conversations between physicians and patients and that's why it's so important that our next panelist is with us. Jennifer Sweeney is the Director of Consumer Engagement and Community Outreach with the National Partnership for Women and Families. Now, one of the most important components of healthcare quality, as you've heard, is the degree of involvement by patients and their

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families. Jennifer and the Partnership work with all the stakeholders to improve healthcare quality, including the degree of patient and family centeredness, and that's what we've asked her to talk about today. So, thanks for being with us and we're looking forward to your comments, Jennifer.

JENNIFER SWEENEY: Thank you, Ed, and thank you Anne and the Robert Wood Johnson Foundation. Just checking—Zack are you going to forward my slides for me? Great. Thanks. If you could go to the next slide. So first, a little bit about the National Partnership. We are a consumer organization located here in Washington and we have a long history of working at the legislative, policy, and grassroots levels on healthcare issues. We have an extensive healthcare portfolio ranging from access to care to health information technology, to performance measurement and public reporting. At the National Partnership I run a campaign called the Campaign for Better Care and for about the last three years now we have been working to build partnerships between healthcare providers and patients and families in an effort to redesign care delivery to be more patient and family centered.

Next slide. So, as I was preparing for this presentation, it occurred to me that we probably should sort of take a step back and think about whether or not advocates and consumers actually think about healthcare with a value lens. Is this even on their radar screen? And sort of with the caveat that these are not monolithic groups. I think there's a great diversity of interest and concerns within both the advocacy community and the patient and consumer community. So, a little bit of what I'm going to be talking about is in generalities, but it's based on the work that we've done at the National Partnership.

So, our experience with the advocacy community is that advocates do, both state-based and national advocates, do understand the connections between cost and quality. They understand that our payment system has historically driven our healthcare costs, our unsustainable healthcare costs, and it's for that reason that the National Partnership and our coalition partners often will advocate for performance measurement and public reporting, and for value-based purchasing, and for changes in our healthcare system. So, I think I can answer my own question there and say that advocates do look at healthcare with value in mind.

I think it's different, though, for the patients and consumers and the general public. Our experience has been that really they don't conflate the terms healthcare and value in any way, shape, or form and this is probably not surprising to you all, but I'll just share with you a couple of the reasons why we think that is. One is that typically consumers have been insulated from the bulk of healthcare costs if they have employer-sponsored health insurance; two, there's almost no information available to consumers on cost and pricing in healthcare so how could we possibly think about value when we don't even know how much things cost or what the prices are within healthcare? I think three, a lot of the research shows that the general consumer public has absolutely no idea about the quality deficiencies within our healthcare system. And I think there's a lot of misperceptions out

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there around things like, you know, more care is better, which is why, I think, campaigns like Choosing Wisely are so important. So, I think the bottom line is that while the advocacy community is very tuned into these issues, we have a lot of work to do to raise awareness among consumers and patients. Next slide.

So I'm going to share with you some of the strategies that I would recommend we think about as we raise awareness with patients and consumers about healthcare and value. First, I think it's important to understand what it is patients and families value in healthcare and what they've told us is they value things like communication, access to their healthcare providers, care coordination, and their overall experiences with healthcare, and of course, outcomes as well. So I think when we talk about value we need to be careful not to sort of front load things like costs and efficiency because what we hear from patients and families is that really concerns them and they think that what we're talking about is trying to limit their treatment options.

I also think, though, that if we sort of focus our energy as a society on trying to address some of the priorities that consumers have told us about we will, in fact, get to that value that we're all seeking in healthcare. Second, I think we need to give patients and families compelling information that they can use, and I think the quality performance reports that are coming out of the Aligning Forces for Quality Communities, which the Robert Wood Johnson Foundation supports, as well as Choosing Wisely, are two really good examples of information geared toward consumers that can help them raise awareness and then also make well informed decisions.

And then I think, thirdly, it's important to use trusted messengers when we're talking about getting more value from our healthcare system with patients and consumers. The research shows that the most trusted sources of information when it comes to healthcare are consumer groups and clinicians, so it's important to use them as conduits when we're talking about these issues. Next slide.

So, those strategies that I just shared are ones in which patients are really sort of the recipients of care with the goal being changing their behavior. But I think another really important strategy to think about when we're driving to work getting more value out of our system is working, partnering with patients and families to redesign the system. I think tapping into their unique perspectives, their experiences, is really going to get us the value that we need. And I actually think that there are some legislative and policy mechanisms for doing all of that. So, I'll share with you a couple of experiences that we've had at the National Partnership. When the Affordable Care Act was being drafted, my colleagues and I advocated for patient-centered criteria in the program requirements for new models of care—things like accountable care organizations, primary care, the comprehensive primary care initiative, partnership for patients. We did that because what we believed was that by focusing on patient priorities, things like communication. We all know that communication is key to reducing things like hospital acquired, or hospital readmissions, that we would, in fact, enhance value. We also supported regulations that

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include patients and consumer advocates in the governing bodies of these new delivery models because we know that they, meaning the consumer advocates and the patients, can help the system understand what changes need to be made in order to get that better value. So, for example, what is it that patients need to stay out of the emergency department—another huge driver of cost in our system? And then another thing that we've been doing is providing extensive feedback to CMS as they're developing evaluation methods for these models, making sure that they take into account the priorities and interests of patients and families. Next slide, please.

So, I think our first speaker did a really great job of sort of outlining some of the goals that we all have within our healthcare system. These are sort of mom and apple pie, I mean, who's going to argue with them, really? I think the issue is sort of that maybe all of the stakeholders have slightly different strategies for how to get to our goals, and I think it's important to recognize that the history of our healthcare system is one in which we all, meaning all the other stakeholders, do things to and for patients and not with them. And I would really encourage you to think about, as we're driving toward that value within our healthcare system, that we tap into this unique resource of patients and families and their perspectives to really get to that value, and really that's where my organization is doing our work today in building these partnerships between patients and their healthcare providers to understand what it is they need from the system. Next slide, please.

So, I'll close with some things that I think all of you, legislative and policy folks, can do to get us closer to a value-based system. First, I'd encourage you to learn more about what I'll call the healthcare quality movement or enterprise. There's actually a huge healthcare quality movement or enterprise out there. I mean, if you're not familiar with groups like the National Quality Forum that has a multi-stakeholder consensus process for endorsing performance measures, I encourage you to get to know these groups because really, they are a huge locus of activity for driving value in our healthcare system. Second, I would advise you to get to know some of the new models that are being piloted in states and communities around the country. My colleagues and I have had the privilege of working with the pioneer ACO's and with the Comprehensive Primary Care initiative, and with Partnership for Patients, and they're doing tremendous work. And, as you can see, they're in many communities and states around the country and if you're working with a House member or with a Senate member it's likely that these projects are happening in your community, so I encourage you to learn more about them. I also think it's important for all of you to communicate with your constituents and reinforce some of the messages around value that I shared earlier. Don't lead with the cost issues or your efficiencies or things like that, talk about the goals of new delivery models and how we are working toward care coordination and better communication and partnership with patients and families.

And then finally, if you are with a Hill office and you're in the position of drafting legislation aimed at getting more value from healthcare, I'd really encourage you not to

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overlook this key stakeholder of patients and consumer advocates and make sure they're built into the process from beginning all the way through to evaluation.

So, thank you and I look forward to questions and comments.

ED HOWARD: Great. Thank you, Jennifer. Our final speaker is somebody we've called on pretty often to share his insights with our audience: Dr. Robert Berenson. Bob's a board certified internist, currently an Institute Fellow at the Urban Institute. He just finished a term on Medpac, including a couple of years as vice chair, and Bob has accepted the job of describing the challenges in measuring and rewarding quality improvement in healthcare, particularly physicians. But he is not short of an informed opinion, and we're delighted to have you with us.

DR. ROBERT BERENSON: It's a pleasure to be here and I also want to thank the Robert Wood Johnson Foundation who keeps supporting me all through my career, most recently a paper which is in one of the handouts that I co-authored with Peter Pronovost and Harlen Krumholz, trying to take a comprehensive look at where we are with performance measurement, and then made a number of recommendations which I'll get to in my short presentation.

I'm talking about value-based payment aspiration meets reality, and I will start by saying, as you all know, sitting in a Senate room, there's not a lot of agreement between Republicans and Democrats on what we should do about our healthcare system, but about one of the few areas of agreement is that we need to move to value-based payment from volume-based payment, and it's an aspiration that I think we all share. What I'm going to do in my nine minutes is talk a little bit about the reality of trying to achieve that aspiration. And I'm going to start by discussing what I think is a disagreement, actually, mostly unacknowledged over the role of measurement in value-based payment. For some, value-based payment literally means measuring quality and cost that's directly measuring and rewarding value where value is considered to be quality over cost—getting a bigger bang for the buck means the quality improves while the cost is managed or comes down. And so, in a sense, it's a robust form of pay for performance. For others, and I put myself in this camp, value-based payment means using payment methods with a higher demonstrated or, in some cases, hypothesized relationship to desired cost outcomes in using measures more opportunistically; for example, to measure quality in areas of concern under a particular payment approach. Most discussed payment methods and most that are in the current demonstrations and the Medicare Shared Savings program, are really primarily changing the incentives to do more—rewarding more prudent care that's largely about cost. But, at the same time, quality is factored into that so that organizations don't have an incentive to underserve or, in some cases, can achieve certain things that are under their control. But I don't believe either approach we're really paying for outcomes. I think we're a long way from paying for outcomes. This often gets shortened like, that value-based payment is paying for outcomes. I think we've got a ways to go before we can get there. So, I think we need to be doing this but let's be careful about not

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over promising. I think that's an issue we've seen in recent days—some of the concerns about over promising. I think we want to be a little more clear-eyed about what we are doing with value-based payment.

Now, very briefly, in two slides I'm going to review the experience of pay for performance. It's called in congressional and CMS parlance, value-based purchasing. One of the major initiatives was the Premier Hospital Quality Incentive Demonstration Project, which actually is the largest hospital pay-for-performance anywhere in the world. This program took place over six years from about 2003 to 2009. It mostly used process measures for five conditions, and the process measures, for example, aspirin and beta-blocker use in acute myocardial infarction. And initially it was a tournament model, meaning that only the top performers were eligible for bonuses in the top two deciles. Now, years really, after some declared this approach a success, academic studies ultimately found that the voluntarily enrolled 261 premier hospitals initially performed better but the differential with all the other hospitals was not sustained. But, in fact, all the hospitals wound up doing quite well, so there's something that's being called a 'ceiling effect', I mean, most hospitals are now well above 90 percent on these process measures. But here's the concern. Studies have now shown, and I think they've been pretty well done, that the performance on and the improvement on these process measures don't predict outcomes. They're not largely responsible for better outcomes, so you're improving process measures, and the question is: what we really want to know is, do outcomes for patients improve? And it turns out that process measures do not capture the decisive role of hospital culture, leadership, management, which has been shown to have more influence on outcomes than a few process measures of evidence-based care. So we have a large enterprise underway to improve performance. Now CMS, to their credit, is evolving the program to have much greater focus on outcomes, on patient experience, and on efficiency measures, and interestingly, Premier has gone on to organize a very broad collaborative effort to improve quality and safety across even more than the 260 hospitals which emphasizes executive commitment, sound measurement, collaboration, knowledge transfer, transparency, and that's probably having much more positive impact than sort of measuring and rewarding.

CMS, for their part, is also promoting broader collaborative efforts. You've already heard a little bit about the Partnership for Patients, which is focusing on decreasing re-admissions and reducing hours in harms in hospitals. Again, it's a collaborative effort with practitioners and hospitals, a different approach from just putting measures out and hoping you get a response.

On the physician side, I would say physician value-based purchasing is even more challenging than hospitals. Behavioral economists have started weighing in on raising the potential of what they describe as crowd out of intrinsic motivation through professionals who manage complex situations and solve problems. So, it could well be that a professional's response to pay-for-performance incentives may be different from an

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organization's. I assume most of you remember corporations are people, my friend. I'm not sure that organizations are people, but we need to figure that out.

What is generally not appreciated in pay-for-performance approaches in Medicare is that the economics of a medical practice is very different from a hospital. Hospital margins are a few percent, one percent or two percent at the margin is a really big deal. For physicians, overhead is about 50 to 60 percent, the rest is sort of take home or re-investment in the practice, so you don't get the same physician interest with one or two percent. But I think, even more importantly, with PQRS and another of your handouts, I deal with this one, the physician value modifier. I think physicians don't respect the PQRS for their importance or validity. Many of marginal importance do not reflect the core of what they do for patients. In that handout I have examples of the kinds of measures in PQRS which, I think, make the case. And I think it's important to recognize that after six years, less than 30 percent of physicians actually participate in PQRS.

So, let me just start closing down. Here's where I think public policy has gone astray on performance measure and reporting; and that is, what we measure is considered important and what we don't or can't measure is marginalized or ignored altogether. There's a quote that is usually attributed to Albert Einstein, which would be great if Albert Einstein actually said it. I've actually looked it up and it's a guy named William Bruce Cameron, who was a sociologist from the 60s: Not everything that can be counted counts and not everything that counts can be counted. So policy makers, I would say, don't think very much about diagnosis errors, which are increasingly being recognized. Wherever you look you find about 10 to 15 percent of patients are being misdiagnosed or undiagnosed or diagnosed much too late. Inappropriate overuse of discretionary services—that's what Choosing Wisely is about, but it's only been in the last year that that's hit the policy stream. And then, care for patients with multi morbidity, and we don't, you know, patients with multiple chronic conditions and functional impairments, there was this fabulous article about a decade ago by Boyd et al. which demonstrate that if you actually measure based on the measures we use for individual diseases you would—and follow practice guidelines—you'd be killing the patient because we don't have good quality guidelines or measures for patients with multiple conditions.

So, let me finish very briefly. I'm over time now and I'll just go through these very quickly. Here's where I think we can get back on track and I guess what I'm suggesting is we're off track a little bit by overemphasizing measurement for the sake of measurement in some situations. I think we need to move decisively from measuring processes to measuring outcomes, including patient reported outcomes as they come online. Again, CMS is moving in this direction for hospitals. It is much more difficult to do this for individual physicians, if not impossible. Use quality measures more strategically to solve problems, not as ends in themselves. Increasingly measure at the level of the organization, not the individual, with one exception. Patient experience surveys can be measured at the level of the individual and you don't need nearly the same *N*, the same number to have statistical validity that you do for clinical measures. So I think that's the

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level of the individual. I know patients want to know about their individual doctor and I think we could do a pretty good job, a better job actually, at identifying unacceptable behavior, outlier behavior, but to try to sort of measure between good and a little better than good, I think, can't be done at the individual level on a national basis. Use patient experience as a core outcome, not as an instrumental thing that gets us better clinical measures but because it should be considered an outcome in and of itself, whatever that does for those other measures. Measure and incentivize improvement more than comparative performance. Get organizations to improve and do away with this sort of tournament model. It makes it a lot easier technically to not have to do the sophisticated risk adjustment that is required for comparative performance. Use measurement to promote rapid learning systems and collaboration amongst organizations, invest in the basic science of measurement development with an emphasis on anticipating unintended adverse consequences. And I recommended a paper that's in your packet by Larry Casalino, which he wrote in 1999 but could've been written yesterday for its relevance to unintended consequences if you do this wrong. And then the final one is considered tasking a single entity with defining standards for measuring and reporting quality and cost data to improve validity and comparability of publicly reported data.

There was recently an article done jointly between the Washingtonian and Kaiser Health News which basically found that, in measures of hospitals in this area, leapfrog joint commission and health grades had no common hospitals. They all had different hospitals as the better ones. If you'd listen to the radio driving around, I tend to listen to the news station, it would seem that every hospital in this area is in the top 50 according to somebody. I don't know. I think the public has to be very confused right now about all of these publicly reported measures and it would be nice if we had some standardization. And with that, I'll stop. Thanks a lot.

ED HOWARD: Thank you, Bob. I have to repeat a conversation I had a couple weeks ago with Jim Talen, who's a member of the Alliance Board and runs the United Hospital Fund, which is the think tank for New York City hospitals, and he has said, based on the ratings system that Bob described, that 75 of the country's 50 best hospitals were in New York. [Laughter.]

We all get a chance to weigh in now, and I would encourage our panelists to challenge something they've said, or if they want to add something that was triggered by something they heard after they spoke, they should be able to do that. You have green question cards that you can write upon and Dexter Williams, or one of our other staffers, will snatch it from you and bring it forward, and there are microphones to which you can repair to ask your question orally. If you do so, I would ask you to identify yourself and keep your question as brief as you can so we can get through as many questions as we can. Seeing no immediate jump in on the panel we'll go to the microphone. Yes. Go ahead.

SPEAKER: I'm Dr. Caroline Poplin, I'm a primary care physician. An article that I wrote for the *Archives of Internal Medicine* in 2000 was quoted, was cited in Crossing the

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Quality Chasm. I think the frustration that physicians feel—oh. I should say one more thing, and that is that I agree almost entirely with Dr. Berenson for once. I think the frustration that physicians feel is that we're being told what to do, that no one is asking us what we think would help improve our practice. Toyota was a good model for process improvement several decades ago and the way they improved their process and built quality into their cars was to consult the people on the factory floor and consult the people who were selling because they knew what customers wanted and they knew best how the process worked. We've looked at all these problems and not asked why do we have them, and maybe if we fixed the reason we'll get a better outcome instead of just saying well here it is. This is what we're going to do to change it. I would make one suggestion as an example, and that is we need to pay more for thinking and talking and less for procedures, and I don't mean primary care. I mean, we want the cardiologist to spend more time with the patient and less time in the cath lab. Choosing Wisely and shared decision making is all wonderful, but you can't do it in a 15 minute appointment, particularly if it's an important problem, and particularly if the patient has several problems. So that's the way we ought to be thinking and you ought to ask us. One more thing, since the ABIM guy is here, I'm supposed to certify—recertify next year. I'll be 67. That looks like a nightmare. I don't think it—I recertified in 2004. I thought it had nothing whatever to do with the way I practiced. I don't understand why doctors who don't practice are grading my practice when I do practice. I should be grading them, they shouldn't be grading me. It's an opportunity so I had to take it. Thank you.

ED HOWARD: Well there are few things there for folks to respond to. How about that ABIM guy. Can you start us?

RICHARD BARON: Sure. On the last point I will say that ABIM has changed its governance coincident with changing its CEO and we now have community practicing physician's requirement on all of our boards, and a requirement for patient or caregivers on all of our boards, and a requirement for a member of the interim professional healthcare team, so we're definitely moving in that direction. But getting back to the theme of today, I think one of the things that's going to happen with global payment that's pretty interesting from the policymaker point of view, is that a lot of the locus of control is going to shift from the payer policy world to the provider world, and I know the pioneer program, one-third of the pioneers are going to get global payment for all of their imputed Part A and Part B expenses next year. And that means that the people who are making a lot of the decisions that the doctor was complaining about are actually us—on the delivery system side, not any more on the policy side. And conversations about how to allocate resources within institutions need to start to shift to how do we meet the needs of our patients better and physicians are going to need to participate in those conversations at the point at which the financial game changes and it's no longer if we get to value over volume then we need different bookkeeping systems and stuff like that. So the point I would make to the policy people is it might be a good time to start looking at the kind of structural aspects of healthcare enterprises with which you interact. Jennifer gave an example of, they advocated very strongly for being part of the governance of the

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new payment model systems. I wouldn't overlook those opportunities. I wouldn't overlook opportunities for pure review committees within these organizations to review inappropriate care. I think there are a lot of ways to activate healthcare institutions to take on some of these responsibilities closer to the ground.

ED HOWARD: Don?

DON DETMER: And I thank you for the comment. I was also a little surprised you didn't mention meaningful use as well. Since you didn't, I will for you. But I think it's getting a lot of attention, too, and I think, again, well intentioned efforts by well intentioned people. I don't think there's any question about that, period. But I think it's another area where we obviously have outstripped the capacity to assimilate what is coming online, and some people have been doing it, like yourself, where you practiced for 16 years with these systems, you know how to do it. But to try to force feed that and such is a real challenge. So, on the other hand, you hate to penalize the early adopters as well, at the same time, you do need to bring people along. So, some of these are transition challenges, too. But I hear your pain and I think it is definitely real out there and it's pretty substantial both on maintenance and certification and meaningful use.

ED HOWARD: Bob Berenson.

ROBERT BERENSON: Just a couple of comments on the topic of does anybody consult with practicing physicians, I mean, there are specialty societies, some of whom are represented in this room, who are talking to policy makers all the time. We could have a different conversation of how well they represent their membership, but they're certainly part of that discussion. A number of the demonstrations that Medicare is doing through the Innovation Center have qualitative aspects to them. I've just finished two site visits in Minneapolis and Pennsylvania talking to practicing physicians about their experience in the multi-payer events primary care demonstration, and that feedback is going to CMS. So I don't think people are quite oblivious to the need to talk to practicing physicians. I agree with you. I don't think it's always been done as well as it might, but it's not been ignored. On your point, which I agree with, which is that we pay too much for procedures and not enough for time, it depends on which physician you're talking to about whether they agree with that or not. And happily, from my perspective, the draft legislation on the SGR repeal actually addresses how those relative values are set and contemplates a modified approach that might base the evaluations more on empirical data rather than on judgment by the RUC, I think that if it can be operationalized—and that's a challenge—that would be an improvement. So I don't think the kinds of concerns you raised are being ignored altogether.

ED HOWARD: And, Rich, I know that you said that each of the societies had its own procedure for coming up with its list of five things to talk about, but presumably, some of them involve their members.

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RICHARD BARON: Oh, absolutely. I think that they involve their members lots of ways, as many people have observed, somebody's expense is somebody else's revenue and Choosing Wisely recommendations often focus on doing less of something that may be quite remunerative for a clinician. And the willingness of specialty societies to step up and using the member-driven and committee process identify opportunities there and come up with recommendations, I think speaks of, see a change in the landscape. I think that most physicians realize the same thing you realize, and certainly healthcare leaders realize this. We have an unsustainable system. It's going to have to change. It's not going to change on a dime, and I think lots of people are trying to get out in front of that, and that creates a lot of policy partnership opportunities.

ED HOWARD: Okay. Why don't you go ahead, sir.

NICK BLOOM: Hello. My name's Nick Bloom from the Centers for Medicare and Medicaid services. I just want to say at the outset that the views I express are my own and not those of the agency. I do very much appreciate the time all of you have given. It was just wonderful to hear all the different perspectives. I wanted to speak to some of the issues that Dr. Berenson and Miss Sweeney spoke to, especially with regard to the evaluation metrics that are being developed and re-thought out through consensus building entities and for upwards of more than a decade we've been reporting along some lines of quality metrics. And I was wondering, as we look toward the future and understand the role that the quality initiatives play in the value-based purchasing program, as well as the fact that, you know, we don't want to step on any toes, have too many cooks in the kitchen, you know, we really recognize the value—some of the efforts that Dr. Baron reflected at the sort of the local level, what role should Medicare play in promulgating evaluation metrics, paying based on performance, to the extent that, you know, we don't want to regulate the practice of medicine, you know, how far is too far, and what is the most appropriate role to be played by Medicare in going forward?

ED HOWARD: Bob, before you answer that, let me complicate it by quoting a related query from one of our card questioners: What entity should be responsible for developing measures, collecting data, reporting data? CMS, NQF, IHI, somebody else? And should there be an entity?

ROBERT BERENSON: Well, first, in your response to Medicare's role, I think Medicare is the largest payer in the country. It has a natural desire to, and obligation, in fact, to try to get better accountability for the substantial amount of spending it does. I mean, here are the three major purposes of public reporting, that's one of them. Second is to promote quality improvement activities amongst organizations, and three is to provide information for beneficiaries or citizens to make choices. I don't think they're all equally do-able and sometimes there's an occasional conflict between those. I have concerns, right now, and in fact, it's not CMS's problem. The Congress has told CMS that they are doing a value modifier for physicians and so CMS sort of is between a rock and a hard place. I think they have creatively focused on starting with medical groups where the data

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is more valid, and I think that's right. But ultimately the law says you've got to go and by 2017 every physician will have a value modifier placed on them. I don't know what you get to do if the law's telling you've got to do it. I think it's a bad idea because I don't think we have, for most specialties, good measures. And so, I think I would prefer, frankly, to have CMS have a little more autonomy in this area and be able to show more discretion about using measures and pay for performance where there's a strong case that they are valid and important and to use other techniques to improve quality where we don't have good measurement. And so, I think, for example, using readmissions as a measure and then a partnership for patients to promote activities and to collaborate with hospitals to decrease readmission rates is exactly the right kind of thing that a large payer should be doing there. The measurement is being used. There's even some controversy over something that sounds straightforward, which is a readmission rate. You know, it should be easy to calculate a readmission rate but it's turning out that at least some suggestions that are if you reduce readmissions you reduce admissions, so you might be doing a great job and your rate doesn't change at all because you've reduced both the numerator and the denominator. So, even something that simple is tricky, but it makes sense to proceed and that's proceeding, and that's solving a problem. My concern with some of the other sort of pay for performance measures are, it seems like we're measuring for the sake of measuring and that consumers aren't really using the information, so why don't we move on and do something different, I guess. So, it's a longer answer, but that's what I would say.

You wanted me to talk about who the entity that should do this. NQF may be the right entity. It doesn't have the authority right now to establish standards for measurements. It reviews what's presented to it. Many of the measures that hospitals use to claim that they're in the top 50 never get presented to NQF, so I don't have a strong position on whether NQF is the right entity. It might be. I think it's probably not a government agency. I think it would be better to be something like NQF, a quasi government, whatever its sort of legal characteristics are, but not in one of the line agencies like CMS.

ED HOWARD: Don Detmer.

DON DETMER: My comment isn't to—it's just to add to what Bob said. I agree with those comments. I was on the committee that recently, an MRC study that gave CMS advice on what to do relative to their technology and information infrastructure. And one of the things that's really our problem as well in this space is it's all driven off of paper-based thinking pretty much. The value interface with informatics is just really rudimentary at best except a few places that are really working at it. And that's a consideration that just must be kept in mind if we are, in fact, going to get the payoff from the high tech investments and so forth. So, I think part of the challenge is that you've got to have some of that capacity in house. And CMS, right now, is really shy on that kind of expertise in house. You can't really shop it out and it's not IT. It's really understanding health and healthcare and being able to walk that business of putting things into a computer and bringing it out with the same meaning and that's a real challenge. So,

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you can get to the quality metrics, but they have to be done so that they make sense with that kind of a mind set. And I think that's something that it really still sounds like in the pretty early days.

**JENNIFER SWEENEY:** The question of who should sort of create and develop these measures—I mean, I think one of the things to point out, sort of talking about that healthcare quality enterprise, is there are private companies around the country who are creating these measures and making a lot of money, you know, on them. So going back to taking away, you know, one person's, I don't know what is the phrase again, I can't remember, but one person's waste is another person's income. I mean, I think if we do go in that direction there are going to be a lot of companies who are saying, wait a minute. You're taking away, you know, a huge amount of money for us. So and I don't think the NQF is the entity that should be developing measures. I don't know that they have that expertise. Certainly they're very good at the multi stakeholder consensus process, but for me, that's taking on a whole new range of activities that I think we have enough to work on right now without figuring out how to develop these new measures in a different way.

**ROBERT BERENSON:** I just wanted to clarify. I think that entity needs to establish standards for measures. It doesn't need to establish—they shouldn't establish the measures. A lot of those measures from, you know, the private organizations are non-transparent about how they came up with them. They're black boxes and so my notion, and I would say Peter Pronovost on our team was the one who's most impassioned about this, and he's written about it, is the idea that there would be a set of standards that the measures would meet that the public could have some confidence, that what they're hearing in the TV ads meets some basic standards. So, that's what we have in mind. It's just an initial idea and I think the goal is to get that into the discussion.

**BRUCE STUART:** Bruce Stuart, University of Maryland, Baltimore. This is for Bob Berenson. You've told us about some of the concerns in terms of developing the best quality metrics for pay for performance. My question relates to another way in which quality might be improved, and that's specifically through the CMS star's rating program, which is focused primarily on moving market to organizations that are able to obtain a high star rating. Of course, the quality of the metrics also is an issue there. But it would really turn this title around from quality care, more buck for the bank, and I wonder if you might comment on that.

**ROBERT BERENSON:** So, you're talking about whether, I mean, specifically whether we can sort of roll things up into a star rating, in other words, the usefulness of doing that for both pay for performance and beneficiary choice? Well, I have mixed feelings about it. On the one hand I'd be interested in Jennifer's views of this. It's certainly easier to know how five stars compares to three stars. I've got concerns about missing the details when you sort of wind up just with some stars. And I know the one part in Medicare that's mostly based—that mostly uses the star ratings is Medicare Advantage Plans and everybody seems to think it's a great system, though all the plans seem—well, not all the

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plans seem like to like it, but many of the plans seem to like it. My concern is that if you actually look at the plans that are four and half and five stars they all seem to be in certain geographic areas, like Massachusetts, like Minnesota, like places like that. And so my question is, are we measuring the plans or are we measuring sort of the underlying delivery systems. I'm very impressed by a plan in Tallahassee, I think it is, which gets four and five stars, but its underlying delivery system is not getting those kinds of high marks. So I'm wondering whether we're actually in some ways misleading in that particular instance without providing sort of that nuance of where does it come from. In the area of, let's say, hospital stars, I'm aware of literature suggesting that performance in one clinical area doesn't predict the performance in other clinical areas, and that you need to know your hospital's performance on a specific condition. Ideally, that performance would be outcome measures like 30-day mortality or complication rates. I'd be worried about losing that kind of nuance of it varies by condition if you roll it all up into this is a 4-star hospital. So, I think we've got to find a balance between user acceptability and usefulness versus sort of missing the details that are really important. Jennifer, do you have comments?

JENNIFER SWEENEY: I would agree. I think one of the biggest challenges with these reports is in some cases we've lost consumers along the way. There's very little differentiation. They're really hard to understand, so, you know, they've sort of given up. I think the Aligning Forces for Quality, their reports have improved over time, and because they're region-based, consumers do seek them out more than others. But, you know, I think we haven't cracked the nut on how to get this information to consumers in a way that they will find it useful and that they will, in fact, use it.

ED HOWARD: I should say, by the way, that the fellow running Aligning Forces for Quality, national program office, is none other than Dr. Robert Graham, who is the chairman of the board of the Alliance for Health Reform. Yes. Go right ahead.

SPEAKER: Hi. I'm Julie, with the College of American Pathologists and I have a question, and this really comes from our experience with both PQRs and the BBM and then looking at the various SGR replacement proposals. There really seems to be attention between the desire of policy makers to move to team-paced care and on the physician side measuring each physician, physician by physician. And most of the schemes seem to be heavily based on what office-based physicians do, where I represent diagnostic physicians and there's this great desire to move to ultimate patient outcomes. But if you're a pathologist, you're delivering the results of a biopsy or directing labs, and so those things just don't work. So I wonder if you could talk about that mismatch between the fact that we're measuring physician by physician on whatever measures we can come up with given the limitations of the existing system, and the desire to move to team-based care. Thanks.

RICHARD BARON: I think that's a terrific question and I think it gets at what you could almost call a category error in a fee for service payment system that what we're

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trying to buy is some discreet service. And I don't care whether it's a path lab interpretation or an MRI, or a physician visit, ultimately, from a patient point of view, those are as relevant to the objective that the patient had in encountering the medical system as is the quality of the tire on the airplane that I land in when I'm going from Philadelphia to wherever. But we have embedded that in the payment system. I think one of the most interesting opportunities—and amplify it with PQRS, and I think that's Bob's point about the few number of individual physicians, the cognitive frame was individual physicians are responsible for quality, let's drive their payment connected with quality. But the reality is that physicians are players in complex systems and contribute to those systems in different ways. And I think, from a policy point of view, as we move away from that fee-for-service system towards something that—and I agree with Bob, we're a long way from outcome-based payment—but if you ask Jennifer to give you a list of things that patients want when they encounter the delivery system and make a list of that on one side and what we pay for on the other, there's going to be almost no congruence. And I'm not talking about incentives or the two percent for value. I'm talking about basic procurement, like who wants an MRI? Who wants a path interpretation? Nobody wants that. They want that in the process of something more complicated, so I think you're making a very good point.

ED HOWARD: Yes, Don.

DON DETMER: I'd just like to tail on that a moment because I think these are such complex systems that I think that was part of where it comes back to Peter Pronovost's comment about standards because I think when we talk about that big data is that fairly too fast visually showed about, actually if you could show those ways for the right community to get the right information for their circumstances and it ends up becoming very complicated, but that, unfortunately, is what we're dealing with. We're dealing with complexity which was one of the huge points of the Better Care Lower Cost issue is that these are the realities. And unless we face and deal with those realities we're not going to get there. And I think there was an oil minister from Arabia said the reason we gave up the Stone Age wasn't because we ran out of stones. I mean, I think we have a way of getting to a better deal, but we've got to obviously answer that and get there.

ROBERT BERENSON: I guess my brief comment would be that pathologist is exactly one of my examples of where we don't have PQRS measures that I think, that measure the core activity of what we want clinical pathologists to do is to do correct interpretations of specimens, of biopsies, etcetera. We don't have a way to measure that in real time yet we want every, I think we want accountability so it seems to me that's where we want a hospital, ideally a hospital part of an ACO or contracting with an ACO and that there's somebody on the clinical side who cares about the performance of those pathologists. And so, that's exactly the kind of example of where we're not going to have a national measure.

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I was testifying a few years ago on the House side and a member asked me, well, I mean, she told a story about a mis-radiology diagnosis of somebody in her family and when was Medicare going to be able to not pay a claim for a misdiagnosis, and it just—my response was you don't want to go there. You don't want to go to what CMS would have to do, you want CMS to get the clinical records and then follow up to make sure? No. You want somebody in that community who cares about the quality of the people they are contracting with, the credentialing and then follow up on performance, and that's where the locus of responsibility should be and as a reason for all of its growing pains and potential problems, I'm a believer in ACOs, that we want to sort of have some medical director out there who's caring about that their radiologists and pathologists are doing their jobs because we can't measure that in Baltimore.

ED HOWARD: You've been very patient. I just wanted to say we have about ten minutes left here and Anne and I are sitting on about 27—

ANNE WEISS: Really good questions.

ED HOWARD: —good questions. So if it's absolutely imperative you get it asked, you might not want to take the chance that we picked the right one from the stack and go a microphone in the little time we have left, and use these last few minutes, if you would, to pull out the evaluation form and jot down your feedback to us. Yes, ma'am. Go right ahead.

LORI MIHALICH-LEVIN: Great. Thank you. My name is Lori Mihalich-Levin and I'm with the Association of American Medical Colleges. I'm thinking about the next generation of physicians and other health professionals that we're training right now. I was wondering if all the panelists could speak briefly to what role you believe trainees can and should play in addressing some of the problems and issues you were talking about this morning, and specifically whether you had any advice on how to engage the residents and other trainees in the process of developing solutions.

DON DETMER: Yes. A few years ago, actually, I was President and CEO of the American Medical Informatics Association, and we were actually trying to develop a curriculum of attitudes, skills, and a knowledge bases related to these skill sets at the Institute of Medicine that I flagged, working in teams, continuous quality improvement, patient-centered care and so forth, and obviously part of the way of doing that is to, I think, have a common core curriculum of certain of those things that actually the students learn collectively if we're going to expect them to work in teams. I think they need to actually start doing some of that socializing and working together as they do. Not easy to do. Not easy to do. But I think some of that is, at least, my one comment relative to it. Thank you.

RICHARD BARON: I would say that a state-of-the-art medical school today would never operate without the best MRI machine it could get, and yet they are operating with

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antiquated payment models. And there are new payment models out there and medical schools and health centers at academic customers have been slow to embrace them. And as a result they are training people in an environment where all the institutional alignment is going in a direction that will not serve them all for the future. So I think moving aggressively into the new payment world at the academic health center level, and then engaging trainees the same way everybody else is going to have to be engaged, what does it look like to be successful here?

JENNIFER SWEENEY: I would say I would encourage the trainees to be focused on communication. Those communication skills are really important to the patients they'll be serving. I think things like shared decision making, learning what it is, why it's important, and how to do it effectively. Motivational interviewing, again, is, I think also something, a very important skill and will be useful to the trainees interacting with patients and families. And then, I think, and this is a much heavier [Unintelligible], so I recognize that, but I think my organization is really interested in seeing a culture shift in which, again, you know, clinicians are doing things to and for patients but instead, really working with them and partnering with them and viewing them as an asset in the whole process of healthcare. So, you know, helping us with that culture shift would be something else we'd be interested in.

ROBERT BERENSON: Very briefly, just to say one thing, it would be nice if physicians—I might go back to Rich's survey where physicians sort of want to think it's everybody else's problem—it would be nice if the culture of teaching sort of deemphasized the notion of physicians as victims, which I think is all too prevalent, and emphasize that physicians can be a major part of the change and to get it right. They're partly victims because, for the most part, they've had it good, and now everything is changing around them and there's a little too much victimhood and not enough being part of the change.

ED HOWARD: Bob, are you moving to the mic?

BOB GRISS: Bob Griss with the Institute of Social Medicine and Community Health. The presentations started with looking, the IOM perspective focused on where all of the medical dollars are going, but I didn't see any address—focus on prevention. There was mention of social determinance of health, but that was not part of the 750 billion dollar potential savings. And I'm thinking that we're not really paying attention to all of the options at getting quality care. Don Berwick, among his many good quotes, is that our system is ideally designed to maximize profits in healthcare, and it does that far better than any other system in the world—twice as good as any other country in the industrialized world. When we narrow our focus on how we can improve the efficiency and effectiveness of the medical care system I think we're ignoring how savings in medical care can be redirected more profitably to those social determinants of health. And that is often what we mean by population health and yet we haven't focused on it here. When we talk about consumers we're talking about communication of consumers

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with healthcare professionals, we're not talking about consumers as citizens in a society that is ultimately determining where resources are going to medical care versus other services that ultimately impact on population health. So I say that, not because I'm trying to introduce a different topic, I'm trying to uncover a narrow topic that really deserves to be addressed more directly.

ED HOWARD: Anne, do you want—

DON DETMER: It's a perfect setup for one of my comments because actually Bill Stead is just heading into a new study for the IOM looking exactly at that, and also working with the National Committee on Violent Health Statistics to start looking exactly at that. So I think, you know, it is coming. And the other piece that I was going to comment, is that I think we're also ignoring when we talk about citizens' health on the health side, is what's also starting to be available. There's a lot of bad stuff on the Internet but there's also some really good stuff on the Internet too, and some of those things are helping people manage their own health, totally outside of quote healthcare as we talk about it. It's called health that they're owning and doing. And I think it's a very excellent point. I'm really glad you raised it.

ANNE WEISS: I just want to add that I think it is a great question, to remind all of us that, you know, really what we all have is the shared goal of health, right? We want to live in a culture of health. A good strong healthcare is part of that, but that's not all we want. You know, it's funny that we heard a lot of conversation here today about measures and measurement and that is where a discussion usually starts, so I am very happy. I actually can think of three separate IOM studies and efforts that are focused very specifically on capturing sort of universal measures that look at all the factors that drive a healthy culture, including but not only the healthcare system. So, I think there's an increasing emphasis on understanding what the drivers of health are, and healthcare is part of that. It's an important part, but that there are many other facts that we need to look at at the community level to accomplish that. The National Quality Forum has launched a population health measurement initiative. I think there's growing understanding out there of the fact that these things are interconnected. They've been siloed, you know, sort of over here is the world of public health and prevention, over here is the world of fixing the healthcare system. But they really belong together and I'm thrilled that you raised it because I think that ought to be in the middle of every one of the conversations like this that we have.

ED HOWARD: Yes. Go ahead.

ROBERT BERENSON: Very briefly, I think what you've raised is sort of another unacknowledged difference in how people sort of their vision of an accountable care—population-based accountable care. Some sort of have a concept of the community taking responsibility for population and others more grounded in our current health system are viewing sort of competing ACO's who are responsible for a designated population of

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people, not for the community, and it is figuring out that connection between the community and the governance structures of the community, whether that's the formal government or something else, and ideally, ACO's that are doing a good job on behalf of taking care of personal health—I know Joanne Lynn at Altarum is now thinking a lot about this topic and other people are but, for the most part, it hasn't gotten sort of these two different visions haven't sort of talked to each other. I don't know how visions talk to each other, but why not? [Laughter.]

ANNE WEISS: I mean, I think we want to see those visions talk to each other.

JENNIFER SWEENEY: And I think one of the reasons we fought for the inclusion of consumers in the governance of these new models is for that very reason. We wanted them to be able to come to the table and be a part of the discussions of prioritization and allocation of resources. So that's exactly what our goals were, and are.

ED HOWARD: Well, that's a very good set of comments on which to bring this discussion to at least a stop, if not a close. A couple of quick things, and my apologies to those of you who took the time to write, as Anne said, some very good questions that we didn't get to, and we don't really have a mechanism to conjure up this panel for another hour and make them respond off the dais, but we really appreciate your involvement. Second, a reminder about evaluations, we really would like you to do it. And third, another very brief commercial—it's a related topic on which we are conducting a briefing. I think in this room on Monday looking at referencing pricing as a way of reshaping the payment mechanism which, if you couple it with some other reforms, may have an impact on what we've been talking about today as well.

I want to thank our colleagues at the Robert Wood Johnson Foundation, and particularly Anne for her contribution to making this flow very nicely. Thank you for asking good questions in all forms, and I ask you to help me thank the panel for an incredibly good discussion of an incredibly difficult topic. [Applause.]

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