Community Coalitions: Pursuing Better Quality Health Care One Locality at a Time
Alliance for Health Reform
April 15, 2011

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

[START RECORDING]

ED HOWARD: I wonder if we could get started. Oh my goodness, it's the voice of God. Everyone will be speaking with Centurion tones this afternoon. I'm Ed Howard at the Alliance for Health Reform. I'm going to move my microphone away from me a little bit. I assume you can hear me in the back, thank you.

Welcome all of you, on behalf of Senator Rockefeller and our board of directors although you may get a welcome on behalf of the board of directors from the board of directors to this program on how communities around the country are trying to improve the quality of health care that's delivered in those communities.

Now we know, based on the work of the Dartmouth Atlas folks and others that quality's uneven around the country in the United States. You may recall the Rand researchers who famously found that Americans get the right care about half the time maybe slightly more. What we don't often focus on is that quality varies substantially from community to community and even within the same community.

Now fortunately, stakeholders in dozens of communities around the nation have chosen to take action to improve quality locally by engaging in one or more collaborations. These collaboratives include purchasers and consumer organizations

and health plans and providers and everybody else relevant to the process.

There are several different initiatives, private and public, aimed at this goal of improving the quality of care being delivered in specific communities. Today, we take a closer look at some of those initiatives and see what lessons we might be able to learn from their experience.

You're going to hear about aligning forces for quality, which is a Robert Wood Johnson Foundation initiative, Chartered Value Exchanges sponsored by the Agency for Health Care Research and Quality and the Beacon Community Program that's run by the Office of the National Coordinator for Health Information Technology.

Fortunately our panelists and my co-moderator are well equipped to help us sort these various initiatives out and take a close look at the issues that they raise. Going back to that theme, our partner today in sponsoring the briefing is the Robert Wood Johnson Foundation, the nation's largest philanthropy devoted exclusively to health and health care.

We're pleased to have with us today to co-moderate Anne Weiss who's a Senior Program Officer at the Foundation and Director of its quality and equality team. Now just so everybody understands, Anne has done tours of duty in Washington both in the executive branch at OMB and here in the

Senate on the Finance Committee staff. She was a senior health official in New Jersey and thanks very much to Anne and Brian Quinn and their colleagues at the Foundation for supporting, helping put this program together. At this point, let me recognize Anne Weiss from the Robert Wood Johnson Foundation.

ANNE WEISS: Thank you so much and thanks to your team for putting together such a great program that's obviously attracted a lot of interest. I'm really thrilled to have a chance to be here to showcase and to learn more about efforts by the Robert Wood Johnson Foundation and others to improve the quality and equality of the care that Americans receive.

We heard a lot, in the last couple of years, about the problems facing Americans who don't have health insurance. We heard a lot about the soaring cost of health care. I don't think we always heard as much about the ways in which the system fails, those of us who do have health insurance but that is starting to change.

Earlier this week, the Foundation released the results of a national survey conducted by Bob Blendon at Harvard that showed that over half of Americans give the health care system a C or a D. Now I brought my 15-year-old son with me to Washington today. He's not in the room at the moment but if he were, he would tell you that in our house, a C or a D is not good enough [Laughter]. We attend to those problems and also

of course this week, we saw the launch of a major patient safety initiative by the Department of Health and Human Services very welcomed, very important. The issues of quality and equality and value are not for the Foundation just issues when they're in the headlines.

We're committed to improving health and health care for all Americans, helping people stay healthy and get the care that they need. So we've been investing in this area for years and it's pretty clear that as a nation, we're not really getting what we should be getting from an investment of $2.5 trillion a year. We have, compared to other developing countries, higher infant mortality rates, lower life expectancy and so on.

I think one of the problems is that health care quality is a very complicated problem. It's not one kind of problem so that makes it hard to talk about. We obviously have situations of underuse; situations where people are not getting care that the evidence tells us will keep them healthy or keep them from getting sicker.

We have overuse where people get services they don't need that simply expose them to potential harm like unnecessary imaging and those are problems as well. Then we have simply misuse situations where the health care system caused people harm or even kills them.

As Ed says, also of course the scope of the quality problem is also there in terms of who you are and where you live. We know that health care is delivered differently in different communities around the country and that people from different racial and ethnic backgrounds very often don't get the same level of care.

I think it's important to know that in every community you're going to hear about today and every community in the country, there are providers delivering high quality, state-of-the-art excellent care and there are those whose care simply falls short.

The way we pay for health care deserves some of the blame as well. We have both Medicare, public programs, and private insurance generally rewarding providers for delivering more care not for delivering better outcomes for their patients. We need to start flipping that around to reward value rather than volume.

The Foundation has been working for decades on different strategies to approach these problems of health care quality, disparities, and costs. We've done everything from support efforts to define and measure good quality to exploring new models for paying for performance, paying in a way that rewards good care to models that improve care for specific

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

conditions like diabetes or asthma but a couple things came out of that early work.

One was something that I think most people in this room live with every day, the reality that, when I worked in the Senate, we always used to say boy it's a big country out there. Health care looks really different in different communities around the country. The opportunities and the challenges, the delivery system, and the market all look very different.

So one approach was not going to work for every community. Also we just felt that given the scope and urgency of the problem, change was just not happening fast enough in a centrally managed way. So we decided to take a new approach, a fundamentally local community-based regional approach to improving health care. That became an initiative that's known today as aligning forces for quality. You're going to hear more about that initiative from several of our panelists today and also from our national program director, Dr. Robert Graham, who I'm thrilled is here next to me.

Our theory with aligning forces is that we're going to influence health care nationally by acting locally and that these 17 local laboratories will really serve as models and help propel the rest of the nation toward reform. So I'm looking forward to learning more, hearing more. Thank you very much for being here today.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

ED HOWARD: Alright, thank you very much Anne. Let me just do a little logistical business before we launch into the discussion. You obviously have a bunch of information in your packets that are important to this topic including the slides from our speakers and including biographical information about each of them that is greater than you're going to hear from me.

A couple of things, by the way, there is additional information, it's both listed on a sheet of paper in your kits and posted on our website at allhealth.org. When you go there, you're going to see something unusual. There's a link to an interactive map.

I have what they call a screenshot or something like that of it right here. It's a map of the United States with all of the major initiatives that you're going to hear discussed today on the map and when you roll your mouse over any of the places the little dots on that map, you'll see a short explanation of what goes on in that particular community and that project. You can follow up and get more information that way.

The other thing I wanted to make mention of, it's not in your packets, it wouldn't fit anyway but if you don't have access to *Health Affairs*, figure out a way to get it. The new issue is on a theme of the remaining quality problems. There are a number of relevant pieces in this issue that I think will

put some of the discussion you're going to hear today in an even broader perspective and our friends at the Robert Wood Johnson Foundation had something to do with putting that issue out as I understand it. So thanks to you for that as well.

There's a pod cast and a web cast of this briefing that'll be available on Monday. The Kaiser Family Foundation is the actor who allows that to happen. You can find the web cast on their website, kff.org, and in a few days after that, you'll be able to get a transcript on our website along with all the materials that we've discussed. There's a green question card you can use when we get to the Q&A portion of the program to get a question asked of our panelists and there are some microphones that you can use to ask the question in your own voice.

Now enough overheard, let's get to the program. We've assembled an incredibly knowledgeable group of panelists today with both national and community level experience. We'll get some presentations and then we'll save a lot of time to respond to your questions.

As Anne said, we're going to lead off today with Dr. Robert Graham who's newly installed as the Director of the Aligning Forces for Quality National Program Office, which is situated at George Washington University where he is also now a Research Professor of Health Policy. Bob, many of you may

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

know, has a wealth of experience in the executive branch, on the Hill, in academia, as head of the American Academy of Family Physicians.

In fact, AAFP if you go to their health policy briefings, they're conducted by the Robert Graham Center for Health Policy Studies in family medicine and primary care. So take note of that and all of that pales in insignificance to the fact that he is also the Chairman of the Board of the Alliance for Health Reform, the crowning jewel in his lifetime of great achievement. Bob, thanks for enduring the hyperbole and thanks for being with us today.

ROBERT GRAHAM: So now you understand why I got twice as much time as the rest of the speakers [Laughter]. Let me walk through just a quick overview of the Aligning Forces for Quality program that Anne has already given you a bit of an introduction to. I think I'm the guinea pig with the clicker. So let's see, it did work too well.

So basic definition, aligning forces for quality, one of the signature programs of the Robert Wood Johnson Foundation, really in terms of total investment of any of their programs, it is the single largest investment that they have made anticipated over an eight-year period and we are about halfway through that time, 17 communities that Anne mentioned and you can see here are the rough distribution across the

United States. There are some that are whole state communities, Maine, Wisconsin, Minnesota and then the rest are pretty much geographic areas or what you would term medical markets, a lot of diversity there, a lot of pluralism.

Ed and Anne have both spoken about the recognition that I think all of us have that health care in the United States is very complex. We don't have a single system. we have systems and to try to improve or make changes in a particular part of the health care system certainly helps to have national legislation, which provides an infrastructure but the way that plays out in a particular community varies according to the interest and to the players in that community.

This is what the Aligning Forces is trying to recognize and take advantage of. With those communities, we've got close to 13-percent of the total U.S. population, about 15-percent of all the primary care physicians and similarly, about 12-percent of all the U.S. hospitals. So the learnings that can come from these communities, we believe, will have transferability to other locations in the United States.

Albuquerque is very different than Humboldt County is very different than Minneapolis. So the way that they approach similar objectives may be very different but what each of them learns is probably transferable to other communities in the country that are very similar to them.

One of the ways that I think this developed and I was not obviously with the Foundation at the time that they decided to launch the program but if you just think back over the history of how issues in health policy have come to be focused on in the last 20 years, the first issue that we really paid a lot of attention to was cost. Everybody knows cost has been a problem since the late 70s, 80s, 90s.

One of the foci of the Clinton health reform is getting control of costs. Then in the late 90s and early 2000's with the Institute of Medicine report on patient safety, you saw an attention move towards quality. Ed's referred to Beth McGlynn's article that indicates that quality is highly uneven in the country.

When you put a focus of cost and quality together, what you essentially have is the equation for value. If you want high value care in the United States, you have to decrease costs, increase quality. That really is the experiment that we're looking at with the Aligning Forces for Quality community. In all of the interventions, what can we do to increase value, increase access, increase the patient experience?

Several different initiatives, one focuses on hospitals trying to reduce readmissions, improving patient flow, making it more efficient, empowering the nursing staff, and the

frontline staff to redesign their work processes so that patient care is of higher quality and safer, and specifically connecting data about race, ethnicity, and language so that you can look at whether or not the quality experience and outcomes for hospitalized patients is different based upon the demographic backgrounds.

In the ambulatory area, starting to look at what we can do to build an infrastructure so that there is sustainable quality improvement. All of us have had the experience of watching practices or health care system focus on a particular problem for a period of time and then you see that there is improvement. That's great, that's a good outcome. In many cases, you go back two years later when the funding's ended or when the CEO's changed or something else has happened, the quality measures are right back to where you started.

So one of the focus that we have is what can you do that makes a change in a positive way that's sustainable? Care coordination between all of the complex parts of the system and looking at the transitions of care, looking again as we did in the hospital area at equity and reduction of disparities, improving the patient's experience of care.

Those of you who also work or are familiar with the concept of patient-centered medical homes recognize that these are many of the same principles in patient-centered medical

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

home, which is trying to reform the ambulatory care experience for patients.

Consumer engagement, consumers have to be involved, have to be participating recognizing that chronic disease is as much of their responsibility as it is the health care system to be able to manage and maximize their health status. They have to be involved at all levels of our alliance decision making, integrating the consumer perspective and deciding what the relevant performance measures are that we will assess the progress of these communities, providing data to the consumer community and the public community so that they can make better decisions about where they seek care, the types of care, and the quality of care that they're getting.

Those of you who are tracking on the discussion about accountable care organizations and are looking at the NPRN that came out a couple of weeks ago see that there's a very important component in there for any entity that wants to be an accountable care organization, there's going to have to be a substantial amount of consumer involvement. We're just going into the third of what we anticipate will be four, two-year grant cycles in the AF4Q program.

So these 17 alliances between 2011 and 2013 will continue to focus on improving quality. All of them will go to publicly reporting set of performance measures so that the

individuals in the community know how things are going and can track on what the level of improvement is.

Payment reform is going to play out very differently in a number of communities. The Accountable Care Act is setting some things in motion looking at accountable care organizations. They're going to make some other changes. These alliances are going to have to manage and monitor that.

They may not be the ones that are driving payment reform but the way they are developing the information and providing the information to the multiple stakeholders is going to provide the forum wherein people can come and decide what is a more effective way to pay for health care services to get the outcomes that you want to have.

Consumers will continue to increase their involvement in decision making and the overall emphasis, as Anne has indicated, is efficiency, equality, and equity in health care. So it's just a snapshot. Seventeen communities is not the whole United States but there's a good geographic distribution, 13 to 15-percent of all of the U.S. population are within these communities.

I think the learnings that will come out of them and the types of projects that are ongoing will have implications for communities across the country. One of our challenges will be not only to make sure that these communities are successful

but how do we take the information about the ways in which they were successful and make that more broadly available to other communities that are starting down that same path? Thank you very much for the opportunity to be here.

ED HOWARD: Okay thank you very much Bob. Let me arm our next speaker with the clicker and introduce her. We're very pleased to welcome back actually Dr. Carolyn Clancy who's now served for eight years as Director of the Agency for Health Care Research and Quality and it's under Dr. Clancy's direction that AHRQ began issuing what is now an annual report on quality and health care disparities. She's held a number of academic posts, serves on important journal editorial boards, and among dozens of other duties at AHRQ, oversees the program of Chartered Value Exchanges. So Carolyn, thank you very much for being with us this afternoon.

CAROLYN CLANCY: Well thank you Ed and good afternoon everyone. It is really a pleasure to be here. For those of you who are thinking what is ARC, I'll just tell you we are an operating division of Health and Human Services. We've been around for a little over 20 years and we're a research agency but our mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans.

Now the only way research can do that is if the investments that we make in research on behalf of the taxpayers

actually are translated into tools that make it easier for people on the frontlines in local communities and so forth to provide the best care possible.

So I wanted to just take a moment and provide a slightly complimentary context to all of this. The Affordable Care Act has an incredible number of provisions around assessing and improving the quality and value of health care. It's always surprised me that that got less coverage than some other aspects but a very, very clear signal from policy makers that there's a lot of opportunities to improve care shall we say. One of these specific provisions actually directs HHS and Secretary Sibelius to submit to the Congress an annual strategy for health care quality.

Now for those of you who've been listening to this thinking there's so many different little detailed initiatives like strategy is not what came to mind, you have exactly the right idea. In fact, over the past 20 years or so, there have been many, many different types of initiatives and progress has been very incremental, evolutionary building on what we learn and so forth.

Now again, instructions from the Congress, we need to take that to a whole new level. So the opportunity and requirement for a national strategy was very, very welcome. So

you can't have a strategy until you can actually articulate aims.

So they are shown here. Better care, whenever and wherever someone enters health care, they should know that they're going to get seamless, reliable, high quality care. Whether that's in above average Minnesota or in Oklahoma, or fill in the blank, we should know that people not only get the best possible quality but that it's actually relatively easy to navigate. That last clause is where we have a little bit of trouble. I know this because I'm from a very large, extended family. No one else is in health or medicine, I get regular reports from the front about what is not working [Laughter].

The second aim refers to healthy people and healthy communities. You heard Dr. Graham talking about consumer engagement, something that we take very seriously at AHRQ. I will simply say that at the end of the day, of course, people don't get up every day so that they can have a positive experience in health care.

They get up to do their other lives, whether that's work, taking care of their families, whatever it is that they're doing, going to school, working on Capitol Hill. The health care system can't entirely direct what goes on in communities but it certainly can be a very powerful, positive force for addressing some of what we think of as the roots of

some particular illnesses and conditions especially chronic diseases. Then the third aim is affordable care and getting there by providing support and incentives for integrated care that reduces waste and therefore begins to put us on a path to making care more affordable for families, government, payers, and so forth.

So coming down from the lofty elevation of aims, are six priorities. You can't transition and change everything all at once. So the first priority speaks very directly to improving the safety of health care. I know that many members of Congress understand the safety issue probably better than they understand the quality issue. It's a what's wrong with this picture kind of question. Some of you are aware of the big initiative partnership that was just launched this week by HHS, the Partnership for Patients with a very strong focus on safety.

The second is ensuring that each person and family is engaged in partners in their care. Doesn't that sound nice? It's incredibly important, it's also pretty hard. We are now at a point where we can and do reliably report on patients' experience of care. I don't mean did you like the curtains?

I mean how often was your pain treated appropriately, did you have to wait to be seen? Did nurses and doctors

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

communicate with you in a way that you could understand but actually making it engagement is an actually bigger challenge.

A third aim is providing effective communication and coordination of care. When we say that all health care is local and I'll come back to reinforce that in a moment as well, a heart attack is a heart attack no matter where you are. It's not that we have different diseases and so forth. What has to be very local literally is the coordination so that what the primary care doc does when handing off to a cardiologist or to another specialist and then back again makes the whole journey for patients very seamless.

The fourth aim speaks to effective prevention and treatment practices and we're going to start with cardiovascular disease because we've got terrifically good evidence. Our track record collectively of implementing and applying that evidence is not as good as it could be, again working with communities to promote wider use of best practices to enable healthy living and making quality of care more affordable for individuals through new delivery models.

Now again reinforcing this theme of all health care is local, when Ed Howard mentioned that we produced these annual reports on quality and disparities in care and wherever you are in the country, there's a very common reaction, which is oh boy I thought we were doing better than that. That's not very good

at all. Thank God it's not us. If the data and information is not very local specific to this community, it's kind of like watching a movie. It doesn't really have anything to do with our day jobs. So that's why I think it's incredibly important.

The other reason that it's very important is that around this whole challenge of coordinating care and trying to overcome the fragmentation so that people do have pretty seamless journeys, the assets and ecosystem of all these communities is very, very different. So we work very closely with a number of public/private partnerships and have had the privilege of working closely with the Robert Wood Johnson Foundation as well.

Now in 2007, we started a program of two dozen community quality collaboratives called Chartered Value Exchanges. The actual name has a very rich history but I won't bore you with that at all but similar to Aligning Forces for Quality, these communities have to include all stakeholders including consumers. They're committed to the mission of quality transparency and improvement. When you count it all up, it represents about a third, a little over a third of the U.S. population.

Now this is just a map and again what you can take from this map is we know how to make these maps and [Laughter] also

that what defines a community we left incredibly flexible for different communities.

So Louisiana, it is the entire state whereas Michigan has three different chartered value exchanges but that was their option. You'll be hearing from my colleague in Minnesota who's really done phenomenal work and so forth. There's a rich array of people.

So in some communities, there's a very strong relationship, for example, between practitioners, health care organizations, and the quality improvement organizations and those organizations are a big part of what's happening to improve quality. In other communities, that relationship is not so well developed. So you see a different sort of cast of specifics.

Now this is just a very, very busy map, which essentially says that there's a lot of activity here, Aligning Forces for Quality, Chartered Value Exchanges, Beacon Communities, you'll be hearing from one in Oklahoma. The point is at ARC, we recognize the incredible opportunity to actually learn from all of this local innovation.

It's been really a terrific pleasure and in our interest of being as frugal as possible with taxpayer dollars, we actually don't provide core support. Many of these communities do get core support from the Robert Wood Johnson

Foundation but we support a learning network and we think of the learning as by directional.

Now okay great, you're collecting all this data. Now what? A lot of the people who need to be part of the solution are not data geeks. In fact, they're a little scared of data. So what we are doing at ARC is actually making it very, very easy for them to take the information they collect and customize their own websites. You don't need to find somebody's whiz kid 10-year-old or hire a consultant. We're actually making the software available free of charge.

We're not telling them what quality is or what they ought to display. We're simply saying this is a tool for you to use. We are providing a fair amount of technical assistance including how do you make a report about all of this stuff? Clearly it's got to be a little more informative and compelling than a spreadsheet, which some of you have probably seen at one point or another with quality information.

We're also trying to think about, because many providers aren't necessarily thrilled by the opportunity to have their performance reported on but they want to know that it's fair. So we have a lot of depth and expertise and methods and we're trying to make sure that we can share that with relevant partners and so forth. We recently had a national summit on public reporting.

What is it that we ought to be public reporting? It is kind of early day. Sometimes I worry that we are actually giving people a little too much information like when a pilot tells you all about the specifics of the widget that's broken, who needs to know this right? You need to know when we're going to leave and so forth. So I think that there's still a great deal to learn.

I'll just close and say that we've been thrilled and look forward to continuing to learn from local innovations at those two specific challenges that we're addressing. One is trying to figure out how to keep up with all of that local innovation.

It's really very, very exciting and we create a lot of opportunities for that and the other that I think a couple of my colleagues may speak to is how do you transition from a fabulous success in one community to a place where you can spread that to other communities notwithstanding the fact that the communities themselves look quite different? So thank you for your attention, look forward to the discussion and Jim is next.

ED HOWARD: Alright. Thank you so much Carolyn. Would you pass that down to Jim? We turn next to James Chase. Jim's President of Minnesota Community Measurement, a non-profit

whose mission is to improve his community's health by publicly reporting on health care quality.

MCM grew out of discussion among several of the Minnesota health plans several years ago who agreed to develop a joint quality measurement project and today, Minnesota's one of the 17 AF4Q sites and MCM leads that initiative. We've asked Jim to give us a sense of what actually goes on at the community level in Minnesota to improve quality. We're very pleased to have you with us.

JAMES CHASE: Thank you everyone for having us here today to talk about this. Again I'm going to try to give a little perspective about what's been going on in Minnesota. Minnesota Community Measurement got started about seven years ago as was mentioned when some health plans came together and realized that they had data that they were using to measure their performance and sharing it with employers but they didn't have enough data in each plan to share it at a medical group level or a physician level where it could be used where the improvement really needed to go on.

So they agreed to come together and put their data together and provide measures for those provider groups so they could use it for the improvement process.

Minnesota already had in place some other collaboratives such as the Institute for Clinical Systems

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

Improvement where physicians and health plans and hospitals were working together around redesigning care to get better results. So this fit very well with that.

We put this into a multi-stakeholder collaborative that's been important since sometimes the physicians don't necessarily trust the health plans' data and health plans don't necessarily trust the physicians. So we all need to sit around the table and talk together about what's the best way to move this effort forward. We've grown quite a bit in this time to now having 18 measures. We started with just 34 groups that we were reporting on. Now we're statewide. We report on over 315 medical groups and 550 sites of care, about every provider in the state that participates with this.

We're using both data now from health plans but we also get data interestingly directly from the physicians themselves out of their, both electronic medical records or those that don't have that will sometimes audit their own data out of their paper records and give it to us for the results that we report because I guess one of our most important messages that I'll tell you a story about is that clinicians are really engaged in this information.

When we first started, we were worried that there would be pushback, people didn't want to be measured, but when people

find it useful and can really change the results for their patients, they get engaged in moving it forward.

We make our data public as well. We think that makes a big difference and we share it on a website called Minnesota Health Scores where we also provide information about how you can use this or what affects you with your diseases but our biggest impact so far has really been again in getting the provider groups engaged in the work that's going on. This is a chart I don't want to go into a lot of detail about, this is about our diabetes measure, but as you can tell from that, what's happening is things are improving.

We like to tell this story, it's not so much about the numbers with the measures but what gets people engaged is we know now for doing this for six years, we have seen for this measure, which is really important for the outcome for diabetic patients, we've seen it more than triple the number of patients who are achieving the five goals that we have for them. We know that means, in our state, more than 10,000 people who are now are achieving those levels that they weren't previously.

From research, we know that means hundreds of patients are avoiding those serious complications of strokes and amputations and heart attacks that come with that. That's what really gets our providers juiced about what's happening. So does anyone know what that's a picture of?

There’s got to be somebody—yes somebody here must be from Wisconsin or Minnesota, so this is cheese curds. I thought I would show this just as my favorite story of this year. Not only is cheese curds makes it harder to sometimes to do the vascular care measures when you’re trying to reduce cholesterol but actually it’s happened in a particular site and I wanted to tell this story about I got a call about a year ago from a physician in Ellsworth, Wisconsin.

So he’s a two-physician practice in a town that’s about an hour from Minnesota and we report on providers in the border communities as well who treat Minnesota patients. He gave me a call because he said they’ve been middle of the pack on the measures and that they were going to be number one next year. I kind of laughed because well again we have 300-and-some sites that we’re reporting this measure on.

The likelihood, even if you’re really good that you’re going to end up being number one is pretty low but he was a modest fellow and he wanted to share that with me. Sure enough about a few months ago, he called back and said we did it. I think we did it.

We’re going to be number one and I kind of paused, it’s interesting because again now that the providers are giving us data from our systems, they actually know what their scores are before we do but I did call my audit staff and say when you’re

doing the audit, check on this just because I always get a little nervous when somebody like Babe Ruth calls the shot [Laughter], sort of pointed and said they'd be number one but sure enough, these two little physician practice ended up being number one not in diabetes care but in our vascular care measure.

I thought this was a really important story for us because we often hear oh Minnesota, you have all these really big groups and all these famous organizations that have all the resources to make a difference in this and here's this little group that was able to be number one, so went out and visited with them and sat down, actually you could sit down at a little lunch table with the whole staff there and have some pizza and cheese curds and they shared sort of what made a difference for them.

They had implemented an electronic medical record. They'd been working with ICSI and had done some improvement processes but really made the difference for them was engaging the entire staff. It wasn't just what they could do with the two clinicians in the exam room.

It was everybody on the team participating, the lab tech, the receptionist, and everyone working together to try to improve the care for those patients. So that's why I think it's so important we talk about this being local. It's that

one step at a time that makes a difference in a lot of the results. There are some really important big system things that need to be done but it's also about engaging people locally and in the offices and improving the results.

Another quick story I want to tell you about is the experience we've had with depression care because I think this is a really important issue as well that it isn't just about having measurement that makes this happen. We need to be able to combine several different aspects to drive improvements. I'll actually move to that. This just shows here in this slide again don't need to worry about all the details of it but what we engaged in was we'd been working in depression care.

As you may know, in primary care, depression is a really difficult disease to work with. As you'll see in these numbers, very few patients are better after six or 12 months and the primary care physicians were very frustrated with that. It's very hard to treat by just seeing a patient once or twice a year in the office.

So groups came together to work with ICSI, the Institute for Clinical Systems Improvement, used an existing, proven care redesign that would improve the results for patients but we combined that with a new measure that we had. Previously, we were only working with medication compliance for depression care, did the doctor order a medication? Well that

isn’t what patients are really interested in. They’re not interested in whether they’re taking their drugs or not. They want to know if they’re going to be better. So we did a patient functional status measure. We asked patients how they’re feeling after six months and after 12 months of treatment and compared that to an initial assessment.

We had to get everybody in the community to agree to use a similar tool, it’s called the PHQ9, that was easy for patients to use and had been validated but we’re now able to tell what percentage of patients are doing better, which is what they care about after six and 12 months. This shows that those groups that implemented that new care system were able to get much better results for their patients. This is continuing in the community.

We measure everybody in the community on this so we can actually show, and this is also what motivates providers, when they see their neighbor’s doing better than them and there’s actually a care improvement process that they can adopt, you can start to get change to occur and get better outcomes for people but the other key component of this was it wasn’t just care redesign and measurement but also payment.

We worked with the health plans to bring together an enhanced payment for this because the problem for the primary care groups was they didn’t have, the reason why they did it

the way they did it before was the only way you got paid was to see a patient in the exam room. So we needed to do something different to help them do the other things in this care system such as call backs and working with the psychologists and so forth and psychiatrists that would make this work for those sites.

So it's been a really important opportunity for us to really get to this effort of not just having performance measurement but also working on care improvement, engaging patients in new ways and working forward on payment changes that Bob mentioned earlier that makes a difference to really help us hit that triple aim of cost, quality, and experience for patients and again would like to underline that it's so important to do this in a local community. I mean we need to have standardized measures across the country and we're working on that.

Our depression measure that I talked about has just been endorsed by the National Quality Forum as well as our diabetes measure that we use. Both of those can now be used in other market places. That's helpful but the work itself really has to happen in each community. You can't mandate that from Washington because it doesn't engage those individual clinicians and those individual patients that are the ones that

really make this all come together. So with that, I will close and turn it over to Ed.

ED HOWARD: Great, thanks very much Jim. Our final speaker is Dr. David Kendrick who's the CEO of My Health Access Network or Greater Tulsa, which is a Beacon community. My Health focuses on putting in place community-wide health IT infrastructure and the idea is to help improve quality and cost efficiency and population health in the greater Tulsa area. Dr. Kendrick practices internal medicine and pediatrics, holds a variety of posts in academic medicine, has a clear facility for managing and mastering software and other health IT mysteries. Once again, we've asked how to tell us a little bit about how the Tulsa project is pursuing its goals.

DAVID KENDRICK: Thank you very much Ed and thank you to everyone who's put this program on. I'm honored to be here and to get to share with you our experience. The nagging thought that I think everybody has in the back of their mind when they hear about what's going on in the very best communities in America is how do we translate to the rest. I'm going to tell you today, hopefully in pretty concrete fashion, how we've attempted to translate the lessons learned in other communities into our own community.

Now in case you haven't heard, our leadership from Oklahoma are not necessarily big fans of the Affordable Care Act.

So we have a bit of a different political milieu that we're working within but what I'm about to tell you about today has broad support from both sides of the aisle in Oklahoma and has been a real common ground where both parties in the state have come together to work on a common project to the extent that we have elected, informally elected officials serving in our leadership and governance. So that'll begin.

Some background on the Beacon opportunity first, to me this is one of those examples of good government because for a fraction of the high tech investment that was in the stimulus legislation, about $265 million, the ONC was able to get 142 communities to put together a proposal as complex and comprehensive as the one I'm about to tell you about.

That got a bunch of organization done that could've cost billions had it been rolled out as a comprehensive funded plan, so 17 communities were selected from that. It's a cooperative agreement program. So we have significant involvement with ONC and certainly we consider them to be a part of our team.

The objective is to demonstrate how health care IT can most effectively improve quality, produce cost efficiencies,

and improve population health. In May of 2010, our world changed in Tulsa but the work I'm about to tell you about began before that.

So here are the Beacon communities across the United States. You can see from the very furthest east to the very furthest west portions of the United States, there is representation and it's an incredible group. I've really enjoyed getting to know these folks and work with them on a regular basis.

So what is My Health Access Network? At its core, we're a nonprofit organization created by a grassroots community-driven effort of more than 50 organizations. I will tell you that the participants in this are as broad a coalition as I've ever been a part of. It's the University of Oklahoma and Oklahoma State University, which that's a very difficult mast to make in the first place.

It's the two largest payers in the state, private payers as well as Medicaid. We have all of the hospital systems, the largest physician groups, the Cherokee Nation, the Creek Nation, Indian Health Service, the VA, and many others involved actively in this project. So it's shared, as I say, widespread support.

We're focused on a common objective of improving the health in our community, and for the benefit of specifically

patients, employers, and providers. We have to keep our eye on that ball.

So we always start with a burning platform when we want to motivate action. So the Commonwealth Fund has been so kind as to give us such. You can see here our rankings as a state on the quality and effectiveness of our health care system, I always stress that, is near the bottom, near the bottom in 2007 and again in 2009. So this becomes our rallying cry. Again looking at a similar ranking our child health care system, we're no longer 50th.

We're 51st in that ranking. So we've used this, we call it our moment of Zen at the beginning of every meeting, to look at these outcomes, and to focus really on what's important rather than the bottom line of our individual communities. Our internal data and research work has shown that we have a 14-year difference in life expectancy between north and south Tulsa, just an incredible difference in a community, somewhat cosmopolitan community in this country.

So what are we going to do about that? This began not so long ago, just two years ago that this effort was launched. At that point, the Mayor, Kathy Taylor, hosted a summit on health care strategy for our community, 70 health care leaders from around the region were involved. My Health was created and we agreed to a charter.

Everybody signed the charter and basically that charter said we're going to stick together for the planning process. We didn't ask anybody to put money in yet. We asked them to stay at the table through the planning. The planning process we went through is somewhat instructive for communities. At least we found it very helpful and I know the two have been tried and tested in many other communities to this point.

We began with the clinicians, with the health care providers and asked them to sit together and decide what information they needed and in what settings to deliver high quality care. Then they handed off to a team of quality experts who decided what was needed to monitor and track the community's health.

Then it was handed to the business leaders, the CFOs to determine return on investment not just for the organization itself but for each of their individual organizations and to participate and then the privacy and security officers got involved and then last and least the technologists got involved to tell us what features and functions would be required in a system to support this kind of effort across the community.

So our focus objectives that emerged from that became a clear focus on improving cancer screening, increasing immunizations in our community, and then our sort of primary focus is improving care coordination because we have a highly

disparate health care system with great individual doctors and hospitals but almost no ability to work together across those business boundaries.

So I tend to think of this as our triple aim for our community and it essentially is our practical approach, which is first to aggregate our community's health data across business units so that we can begin to leverage it then in the green box to identify care opportunities, do data analysis and synthesis to identify those care opportunities and then to use and then to provide concrete tools that can be used to address those care gaps.

So obviously our intervention under the data gathering portion of this is health information exchange, standing up technology to support that. In our community, we have about 52 different electronic medical record systems and no two of them are connected to one another. The health information exchange then connects them by directionally and My Health is the governance for that entity. No single hospital, no single payer can control this governance because it will create obvious problems.

So My Health is a shared consortium of all of those groups. Then we put in specific tools for doing analysis and analytics. This is just an example of one of those that we're putting into place. This is a health care simulation that

continually runs in the background of our health information exchange and assesses risk of stroke, of heart attack, of cancer so that every time a patient presents for care, whether it's in their physician's office, the dentist's office, or the school nurse, right front and center on the screen is what this patient's risk of these primary outcomes is because we do not want to miss any opportunities to close a care gap. So that's a part of our interventions.

Then finally, some specific tools that we put into play to begin addressing those issues, this is something we layer on top. It's not enough just to have health information exchange, to have data flow from one place to another. You've got to support work flows. You've got to support clinicians in taking the right steps to close those gaps.

So we call this our community wide care coordination strategy. That is just as you get off the airplane and make your connection, you can look at the board and see the next place you're going to go, that's our vision for patients and for primary care providers in our community is that the entire plan is laid out and all the actors in that plan are understanding and accepting of what's going on including, of course, the patient.

So when we did research on this, which began more than 10 years ago, we evaluated many clinics in the community to

understand how care transitions were happening. What we discovered was rather frightening.

When referrals were initiated, either patients were being told you need to call your cardiologist and get a visit or there was some mish mash of faxes and phone calls going back and forth between these clinics. The problems were obvious. It was understaffed. There was no procedure in place to make sure this was standardized and there were really no quality metrics around that step so that it could be improved.

So we stepped back and say well how can we improve this process and we basically enacted this, which is when a referral begins, that referral is put on hold and doesn't leave the practice until the sending provider interacts with it and says this is really what my question is and what I'd like to get from you next level of care. Then there's a direct linkage made between the receiving end and sending end so that they can work together in an electronic environment to establish a shared care plan for this patient.

Then most of the time but not all the time, maybe as much as 65 or 70-poercent of the time, the specialist will say I do need to see this patient and when they say that, it goes automatically back into an electronic scheduling loop. So in this way, we created a program that not only allows us to have excellent data on patient transitions including down to the

minute and second that it took for that transition to be scheduled, for the patient to be notified and so on but also give us a learning feedback loop.

So primary care providers who have these electronic interactions with specialists learn every time about how to improve their own practice in their own clinics. So we see fewer unnecessary care transitions over time. We also see a strengthened relationship between the levels of care as they work together more.

ED HOWARD: Terrific. Thank you very much Dave. Let me just, if I can, we are now prepared to ask questions and prepared to make things clear that might not have been clear to you the first time around. There are green cards in your packets as I said and where are the microphones he said through 68-year-old eyes, in the back.

So you have to repair to the rear if you want to ask a question in person and if you do that, we would ask you to identify yourself and your institutional affiliation if you have one and to keep it as close, as concise as you possibly can. Let me just start us off by following up with something that Dave was talking about in establishing these electronic connections.

Nationwide, our percentage of wired physician practices, not nearly as good as hospital numbers, is not all

that impressive and I wonder what's it like in Tulsa and to what extent does the activity of the initiative depend on there being a full electronic exchange?

DAVID KENDRICK: Well we certainly struggle with that issue as do many communities but just to apply to be a Beacon community, you had to demonstrate that you had at least 25-percent adoption of electronic health records in your community. We had it on pretty good authority that we were going to have to have 40-percent even to apply.

So we did an in-depth research project and actually discovered that we were at about 42-percent because we have such a large presence of large health systems, VA, and Indian Health Service organizations, which all do have electronic health records but as I mention none of them are connected to one another. We still are paying a lot of attention to the remaining 16-percent and we work closely with our regional extension center.

I go out to rural clinics all the time with them to help them choose an electronic medical record system and I will tell you that I get lots of feedback from these rural practices and hospitals especially that they just don't have as many options as a bigger practice.

I mean there are EMR vendors that won't even come into Oklahoma because of the size of our practices. So the

relatively few choices we have, that we'll target smaller hospitals and practices, they're overburdened and they're not getting deployments done. So that's really our rate limiting step, at this point, I think as a vendor.

ED HOWARD: Anne?

ANNE WEISS: I want to jump in here. Is there anybody here from Cleveland? So definitely I think we all know that the access to electronic health records and technology vastly accelerates the potential to improve care and in our Cleveland community, you see that very much in the day-to-day made public where the gaps in care between people who were seen in practices without electronic records in places that are so stark that even if you think you know this issue already, it's chilling.

At the same time, one of the reasons that we wanted it to be on that map in so many different places is to make the case that no one tool or approach alone will solve the problem and that it's possible to make progress in many different kinds of markets including markets that don't have the privilege today of very high adoption of electronic health records. So it's not a closed club. We are seeing lots of improvement and lots of great stories to be told even in places that aren't at that level yet.

ED HOWARD: That actually raises the question of something that Jim Chase said about looking at paper records sometimes to get information from one place to another.

JAMES CHASE: Yes, interesting. When we started clinical data collection from sites, a third of our sites even in Minnesota, we're pretty far ahead in EMR adoption. A third of our sites were still on paper and actually did the extra work to collect the data that can be done, that has to be done if you don't have it electronic.

So we found that, again, with the Ellsworth story, it's interesting. They realized they had this EMR they had implemented. It helped them do a little bit better but it isn't just having that. It's necessary to improve but it's not sufficient to get everything done. It has to be other things that go with that that you, certainly the Beacon communities are learning that make the EMR and the interconnectivity so important.

ED HOWARD: Please go ahead.

DAVID KENDRICK: Just briefly Ed, I failed to mention that part of our strategy, as a Beacon community, was certainly we want all those clinics to adopt an electronic medical record that is certified and that can connect to us but we've set our systems up so that they can begin immediately gaining value from these technologies whether they have an electronic medical

record or not. So the two things I mentioned in my specific example are available to the clinicians today. They're using them whether they have an EMR or not.

ED HOWARD: Yes, why don't you go ahead.

MALE SPEAKER: I believe he was first.

ED HOWARD: Well how about that.

MALE SPEAKER: That doesn't happen in this room very often.

BOB GRISS: Bob Griss with the Institute of Social Medicine and Community Health. Most of the discussion so far has focused on improvements in clinical care as a way of improving quality and reducing costs but the topic is community coalitions and the introductory comments suggested that place really matters and there are lots of social and environmental determinants of poor health in different communities. That has a lot to do with the health outcomes that we see and that the health care system tries to respond to.

We have so much money in health care that it's not surprising that there's incredible fragmentation in the delivery system. We often pretend it's a good thing and we call it competitive but somehow it's extremely inefficient. The question that I have is how these community coalitions can address the social determinants of health at the community level and specifically whether it is possible that

infrastructures can be created at the community level so that inefficiencies in health care delivery can be reduced in a way that generates a surplus, which is then available for reallocation through the input of the community coalition to the priorities for health improvement at the community level.

Is that just a pipe dream that makes sense on paper but doesn't work politically or is there some possible with all these experiments that you referred to, are there some communities that are able to make more efficient the delivery system and redirect that surplus to social determinants of health?

ED HOWARD: Good question. Carolyn?

CAROLYN CLANCY: So Bob, in the spirit of walking before you run here, I guess the short answer to your question is yes and we'll leave it at that but [Laughter] to elaborate just a bit more, if there's one area where I think we need to get started on better connectivity between care delivery and community actors I'll say, that can be public health departments. It could be Verizon. It could be the motor vehicles organization.

I don't particularly care. People have worked with barber shops, churches, you name it but where we really, really need to start that right away is in improving care for people with chronic illnesses. We know how to count. We know how to

report the really good news, report cards, and transparency have made ordering the right tests. People are almost at 100-percent. This is pretty straightforward stuff but nonetheless we weren't there a few years ago.

When you look at short-term outcomes, so management of diabetes, management of cardiac risk factors, the top 10-percent of plans get it right just over 70-percent of the time, which if you think about it, is a pretty high failure rate. Now public health folks would say of course people have to live with the condition, manage their lifestyle, figure out how to get exercise, all that fun really easy stuff but most of the time, clinicians are pretty blind to who actually to reach out to. So I would say before getting to where you are and I'm not surprised that you're four steps ahead of where I can even fantasize right at the moment, that's one place where we can start to build that connectivity.

JAMES CHASE: Ed?

ED HOWARD: Yes Jim?

JAMES CHASE: I was going to add, I think it is an opportunity for us to have our collaborations get more involved in some of the social determinants of health. Part of what's fostering it in our community has been the opportunities, if we can call them that, related to accountable care organizations not from its structure and the way it's rolling out but as

we're moving to ask provide organizations to not get paid per service but to look at patient outcomes, they pretty quickly go to some of those social determinants of health and realize that if you're not dealing with the obesity, if you're not dealing with exercise, you're not dealing with smoking, you're going to end up with more patients that are going to be sicker.

You're not going to get paid for that. So our table has now started to bring in discussions. We have, for example, some statewide improvement projects that are looking at obesity and smoking in communities and the provider organizations in those communities want to be at the table now to discuss that because of the changes and the way they're going to be paid.

ED HOWARD: Bob?

ROBERT GRAHAM: Just a quick add-on to that, my suspicion is and you had a two-part question, my suspicion is that what you will see in these communities and go to the map, I think that Jim showed, there's not just 17, there's 40 or some, is that the multi-stakeholder entities in those communities are really the leaders around which conversations are taking place that would not have taken place three or four years ago.

I'll use an example since I'm in Cincinnati, we have a group, which oversees the aligning forces for quality grant but now we have another group, which is community-wide with a

variety of other stakeholders starting to look at issues of school health, the city health department, the local United Way, don't have the schools themselves involved. So I think that's a platform on which those conversations start to spread.

Now your second question is the toughest one and that is if we do a real good job and we start improving quality and saving money, how does that money get redistributed? Well because our system now is made up of a variety of different funding streams, if you do a real good job on your Medicaid population, you may have the opportunity for redistributing funding. If you do a real good job on the population that is covered by one of the commercial insurers that redistribution is not really available to the community. So I think your second question is a really much more tough one.

DAVID KENDRICK: So the way this becomes reality in our community in Tulsa is that we've positioned the work we're doing as a support tool for a very generous philanthropic community. Our philanthropic community is involved in, organizations in our community that are involved in philanthropy have a wide array of projects from Educare to neighborhood revitalization, etc. and they are in desperate need of outcome measures and independent ways of measuring the effects of the money that they put in the community.

So we've positioned what we're doing as a tool that they can use to begin to measure the effects of other programs they fund. So we become the quality improvement loop I guess you'd say for community revitalization and those other projects.

ED HOWARD: Yes, go ahead.

JIM THOMPSON: Good afternoon. My name is Jim Thompson. I'm a former HHS employee and a retired employee and I serve on two or three advisory boards and committees in the District of Columbia. Dr. Graham and any others on the committee, could you illustrate how the hospital quality network reduces hospital admissions in areas related to cardiovascular disease, strokes, diabetes, or asthma, or an asthma?

This question relates to slide six on page three of your handout there. I know that these kinds of things are important for a lot of people so if you could illustrate a couple unique ways that the hospital quality network reduces hospital admissions in those areas?

ROBERT GRAHAM: I can answer in general and since I'm just coming on to being involved in the program and probably has some, much better examples in mind of the, but I think your specific question is admissions. I think a lot of what the hospital quality network is looking at is readmissions and so

that’s a question of when the patient is ready to leave the hospital, how good is that transaction handled? Do they understand their new medications?

Do they understand the lifestyle changes? Is a contact made with the primary care physician to make sure that they know they’re being discharged? That may get back into the information exchange. Is there a follow-up with that individual in the primary care space to make sure that they are being maintained in the way that they should because so many of the readmissions are never seen by anyone in the primary care space between their two hospitalizations. So sort of in a general area, I think those are some of the strategies that specific hospitals are looking at and Anne, you probably got better case studies.

ANNE WEISS: That’s exactly right and somebody observed to me before this sessions started and I thought it was such a smart thing to say that to really understand problems of care coordination and readmission, you can’t fix those problems only in the hospital and you can’t fix them only in the community. I think that’s one of the hardest things we’re all going to have to contend with.

The work that we built on that fed this hospital quality network was work that began with looking at the role of nursing and the critical role of nursing, the problem in

hospitals of nurses been drawn increasingly into administrative tasks and away from the bedside and one of the collateral benefits of re-engineering care in hospitals to allow nurses to focus more on care at the bedside was the ability to create smoother, more patient-centered care transitions.

So that's the kind of work we've done previously that feeds these networks and I think the creation of a community-wide alliance that brings ambulatory and hospital care together holds a lot of potential for that as well.

ED HOWARD: Very good. Yes, so let me just say before we go, JoAnn if you will forebear for a second, I neglected to mention that in your packets, there is a blue evaluation form, which before you leave, you would do us a great favor if you would fill out your suggestions about topics and speakers and how we can make these programs better are very useful to us. Yes, I'm sorry. Go right ahead.

JOANN MANN: That's okay. That was important before anybody bolts. I'm Joann Mann and I had a set of ideas that are difficult to converge that I wanted to have this group think about publicly with me for a minute. The community coalitions that you've been working with in the QIO program and I assume they're much the same in the Aligning Forces for Quality have been really dynamic and very exciting endeavors and making some headway.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

So it looks like something really worth investing in but the country has quite an unsettled terrain between whether we are going to mostly work with competition and trying to keep every care system in D.C. at each other's throats and thereby somehow manage to get both quality and efficiency or whether we're going to allow or encourage competition.

Certainly the two competing images of how we're going to run our budget illuminate some of that but probably the ACO regulations are especially troubling with the pretty stark threat of the anti-trust issues coming at the end of the ACO stuff.

I had been selling the idea to communities that you get started on something like care transitions and you get the nursing homes and the home care agencies and the United Way agencies and the hospitals beginning to talk to each other and learning how to talk to each other and you make some real gains and then you move into 3026 funding or something like that and find a way to have some income that supports that endeavor and you move toward an integrated system with shared savings.

As Bob Graham was just saying, the ACO offers you the opportunity maybe that you'll get some shared savings and you use that to manage the community coalition.

Now for most of the communities I'm working with, that's been simply removed. There's no way you can make this

run at less than 50-percent of the market share. FTC and DOJ seem to be thinking in terms of services in an acute care frame that the service you buy in a cardiology service is something that happened in the hospital.

It's a surgery or it's a what's it. It had a time limit around it. If you went to what Carolyn was talking about and the challenge of chronic care, maybe if we think in terms of the what's it that we're buying being something like the rest of your life living with COPD or the rest of your life living as a 96-year-old with 17 illnesses and that what we would do is to monetize and purchase those sorts of services rather than a heart thing here and a lung thing there and a skin thing here and thinking of it as loaves of bread that can easily be competed over, we could compete over whole chains of services or we could move it into a public utility mode and try to have government really take a hand in it but I don't think that these community coalitions can persist in the current uncertain environment.

I mean there'll undoubtedly be a dozen that will but as a general way to solve things for the country, there has to be a way in which to establish the coalition, fund it, and give it some authority. When you work in Scandinavia, that's automatic.

The county council does it but here we don't even have authority to have all the hospitals in D.C. sit down and meet and decide how they're going to use Provenge. So everybody's going to run up a huge bill and they're all going to compete their way to the trough and feed themselves. We're still going to have a zero rate of information moving from hospital to clinic. It seems that they would have to simultaneously solve the competition anti-trust problem, the continuity of care problem, and the how-to build a coalition authority problem and failing to solve any one of them means the community coalitions are going to be dead on the vine. Help me.

ED HOWARD: let me add one other dimension to this and that is what do you guys do when the ONC money or the Robert Wood Johnson money runs out? We had a telephone conference call in which Carolyn distinguished her network from the others we were discussing by pointing out that the other entities got money from the entity that was running the initiative whereas you get technical assistance from AHRQ. Yes Jim?

JAMES CHASE: You had a lot of issues there but the one I wanted to address is the compete versus collaborate and what can we do to foster that? I think especially in the environment where we know part of the thinking around accountable care organizations, we're going to change the payment system and then wa-la, everything's going to be better.

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

What we're finding and having some experience in this is it's really hard work and people need to figure this out. I mean individual clinicians need help in trying to get a better value out there for their patients but I think what we found is I think it's a rare community where providers really want to compete on quality that they're not willing to share with each other best practices around quality.

So I think that's a step that collaboratives can help foster because they really want to find ways just like the airline industry, Delta's not going to say gee we crashed less than United. That doesn't sound very good. They work together around safety issues. I think provider organizations want to do that.

The interesting thing will be are we going to work together well in cost reduction because that gets much closer and you have a different set of people that have to talk about that in the organizations. It's generally the finance suite not the clinicians' suite. So we're going to have to use some of the same tools that we've had around how to collaborate in communities to foster that more and make it work.

I think some communities that will be more effective than others. I agree with you, there needs to be some attention paid to how do we make sure that this kind of

collaboration versus competition works well in all communities in the country and not just in a few.

DAVID KENDRICK: For our community, dead on the vine was sort of a harsh term but our approach has been, from the beginning, to focus on sustainability because, as I said, we began before the Beacon opportunity was there. The Beacon opportunity, as we discuss it in our board meetings, simply allowed us to put our foot on the accelerator. It didn't change our plan.

We didn't change our direction. We're just doing it faster. So we're going to be asking them to pay a little faster for the services they're getting but we've done a very comprehensive job of making sure the CFOs and the other financial folks in the community are on board with the direction we're going.

Now I'll tell you in terms of compete versus collaborate, we one, maybe two organizations in our community that are going to try to stand up an ACO. They've been planning for this for months if not years behind the scenes. What we've done to support that because we were aware of it is to choose our technologies and the place where we would put our technologies very carefully. We had to provide the things that they could not do as a single health system to set themselves up as an ACO.

For example, our health information exchange is really two major concepts. The first is the basic wires that connect everybody. We bought the most plain, vanilla ability to connect everybody with basic wiring. Then we made sure that that platform would allow us to use, anybody here have an iPhone? Anybody ever use the app store?

So we use the same concept in our health information exchange. That is that the health information exchange is a common data store for the whole community but the applications that people choose to run on that highway, so to speak, are chosen by those organizations. So they have the ability to choose one or the other tools for care management, one or the other tools for even EHR or care transitions.

That allows them to compete in a way because they can make decisions about their environments but they're all able to share equally in the pool of patient data that helps them do a better job. So in that way, we sort of think of ourselves as an ACO enabler because no single hospital system would be willing to take risk on a population if they knew that that population could go out anywhere else and get care on their nickel, essentially on their bonus, and not be made aware of it. So our ACO enabler model is to make those health systems aware of where their patients are moving around the community.

ED HOWARD: Okay. Anne, you want to pluck a few from the cards?

ANNE WEISS: This question comes up frequently and it's a good one. Aligning Forces for Quality, why are there three states and the rest are counties or individual cities? That's largely self-determined. We ask markets to come to us and tell us about what the rate level of aggregation was to bring together the people who give care, the people who get care, and the people who pay for care and in some places, in Maine and Wisconsin, in Minnesota, Jim talked a lot about things have been going on in that state for many years.

They're really able to deliver that at a statewide collaboration level but it's not the case in other states. In Ohio, we have two communities. In Michigan, we have two communities. So that's a situation where those stakeholders feel their collaborative relationships really come together at a metropolitan or a multi-county area. Interestingly, we start, our project in Oregon began in Willamette Valley some years ago and that group has now grown in influence to the extent that they are going to become a statewide effort. So sometimes that happens over time as well.

ED HOWARD: So yes, go ahead and this one I guess would be directed at Dr. Graham and maybe Anne can chime in as well. Strike that. Let me try David Kendrick and the question is to

what extent is My Health or its participating providers working with the regional extension centers? You had mentioned in your presentation that you do have a relationship.

DAVID KENDRICK: Well yes, we view the regional extension center as a critical partner because they have the boots on the ground in these clinics. They have relationships with all of the clinics in the region, certainly the focused eligible providers. Now we're helping them actually to expand into the specialty practices as they grow. So they're really a part of our team.

In fact, I've got a couple of text messages in the last 10 minutes from one of them. So it's very much a partnership that we work with them and they're critical to our implementation and we are to theirs. Can I just add one thing to that very quickly?

We also are working with our community college, which has one of the health care IT training grants. So they've actually put members of our Beacon leadership on their board to guide their curriculum because we know what skills we need in the community to help implement.

That's been a great partnership as well because they've turned out their first class and we picked up some of those folks and made them a part of our process. So at least that end of it seems to be working pretty well for us.

ED HOWARD: You did such a good job with that question that we got another question directed to you. The questioner would like to know how much time specialists, in general, in the Tulsa area spend responding to questions that are really primary care physician-type questions. Are they reimbursed any sort of way in the system? How do you avoid, in that context, obstructing the flow of patients?

DAVID KENDRICK: Great question and those are all these sort of operational questions you have to ask if you want to stand something up like this. As I say, we started more than 10 years ago on this work and learned some very good, hard lessons along the way. The first rollout of the system was put in place with the message to specialists, hey if you provide good service to primary care providers, you're going to get the referral business here.

It's not required that you turn anything away. In fact, the specialist controls the decision about whether to see the patient or not but the time the consultation comes to them, the primary care provider has decided to send the patient, has decided to seek help.

So when we first rolled it out, it was an utter and complete success with primary care providers. Hundreds signed up overnight and very few specialists would actually respond to

the cases. So we learned that there had to be a payment in place for these cases.

Then when we put a payment in place, we had an overnight success on the specialist side and in a particular setting, and it's a small payment. I mean it's just a hey we value your time, its worth, you at 11:00 at night logging in and handling this case. From the time perspective, it takes between two and four minutes for a specialist to triage a case, which is a fraction of the time spent delivering the care in an actual office visit.

The specialists themselves will, before we even began this work, would tell us between 25 and 45-percent of the work that came to their practice was essentially primary care with stuff that a primary care provider could do with really minimal guidance. That's what prompted us to begin the work in the first place.

We've seen as high as 52-percent, now this is real data based on the use of the system over 10 years, as high as 52-percent of the time and as low as 20, 18, 19-percent of the time depending on specialty, the particular questions, and so on.

So it's definitely a truism that there's unnecessary utilization along specialists but if you think about it, somebody who's trained to do orthopedic surgery doesn't want to

spend three days in their clinic to get two days in the operating room doing the workups.

What they'd rather do is let a primary care provider help them with the coagulation screening and all the things that have to be done before the surgery and let the primary care provider provide that and then get to spend three days in the operating room instead. We use the term in Oklahoma practice at the top of your license and that's really what we're trying to do here.

ED HOWARD: I wonder whether, at the regional level or nationally, there's any way to figure out whether from community, whether the ratio of specialists to primary care physicians has anything to do with the willingness of the specialists to enter into those kinds of arrangements. We end up with too many orthopedic surgeons perhaps.

ROBERT GRAHAM: Well there certainly is some pretty good evidence from the Dartmouth Group about the variations and concentration of specialists and primary care physicians and quality outcomes. I don't know that they have ever gone into those communities and tried to assess specialists' attitudes about what their preference of workload is.

So one level, I think we do know that the proportion of types of physicians in a given community has a lot to do with access to primary care services and outcomes on specific

measures. What the specialty and primary care culture happens to be in those communities, whether that's reacting to that proportion or driving those percentages, don't know.

Certainly our community is, I think we have the fewest number of primary care providers per capita in the United States. So if you want to take that as an extreme, we're certainly that extreme.

ANNE WEISS: Bob I understand that there's a question from the audience about measures. Can you talk just a little bit about that?

ROBERT GRAHAM: This is a very interesting question. What performance measures is the AF4Q initiative using? What, if any overlap with NQF measures, are these being used by various CMS or those being used by various CMS programs? So I looked at that question and I looked at the bottom left hand side of the card where you check off Congress or Congressional agency, national organization, news organization, the questioner checked off other. So I'm going to say policy wonk. Any time you have to explain the question to the audience, you know you're really getting in deep.

The performance measures that are used by most of the alliances are NQF-endorsed. That is the desire. That's sort of the gold standard. National Quality Forum is an organization based here in Washington, again a

multistakeholder, not-for-profit organization that serves as an adjudicator of a variety of measures and tries to come to a conclusion about which ones are valid and useful. So those are the measures that the alliances try to use. It's not 100-percent in every community.

In any community, you may have a particular measure that that community's been using for a long time or the plans or the provider community really likes but the general sense is yes, there's a high degree of convergence with the measures that you'll see in AF4Q with NQF. The question about various CMS programs I'm not familiar enough with all of the CMS programs to know what measures they're using but I think they too are trying to get an overlap with NQF measures.

ED HOWARD: Freshly arrived question to the panel. I guess this is immediately directed at Jim and David but further responses could be useful too. Do patients, in your circumstances, have electronic access to their health records and if so, is there any data on and a correlation between that access and health outcomes? If not, can you comment on some best practices to engage patients while they are outside of the care environment? Dr. Kendrick do you want to try it?

JAMES CHASE: I'm not an expert in that question around what we call more the patient health record as opposed to

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

having it housed at the provider office. Many of our sites have started to use that.

It doesn't have as big an uptake as they had expected but it certainly is one method to get patients more engaged in their own care, which we know is an important correlation to getting better outcomes. I think another thing that's important about that may be again, we're looking at trying to find ways to get more information from patients about their outcomes. So we're going to see a lot more requests for patients, what we call patient functional status information that we can use for both the improvement process and also accountability.

I think even in the payment systems the best payment systems, we're hypothesizing, are not going to be based service to service but based on something that the patients are valuing as far as outcomes themselves and the best outcomes may be what they think they have received. The challenge with that is always is it reliable?

We always get pushback that when you're hearing from the patients or using data from their own health record, is it reliable for the clinician to use. So I think it's still out there as a question. I'd be interested to see if some kind of market like Oklahoma City or Tulsa, excuse me, how you—

DAVID KENDRICK: Yes, those are fighting words.

JAMES CHASE: Sorry [Laughter].

DAVID KENDRICK: In our community and practicing clinicians always struggle with how to present the results of a visit and the data back to patients in a way that is effective and productive and helps the patient understand without creating unnecessary concern. So that underlies our approach to this.

It hopefully is not as paternalistic as it sounds but the approach we take is to make sure that the technology we put into place is the capability of sharing data with the patients but we're going to take a little bit longer time with it before we roll out that data in a comprehensive way. You all may be aware and you're probably participating in health plans or with doctors' offices who have patient portals and you can go there. If you request a prescription refill or a visit, that kind of functionality we want to provide right away.

So we intentionally purchased the platform that lets us connect to one of the free, there're really two big free patient health record systems in the country and it lets us connect to those not just for purposes of getting results out to the patient but also getting patient questions and patient-fed data in.

I don't know if you've looked but if you look at either. I'll just say Google or Microsoft on their sites, they

both now offer devices, they don't sell them themselves but reference devices sold by major pharmacy chains in this country that are already enabled for gathering data and plugging it in and uploading it to the patient health record.

Well as a clinician, that's incredibly helpful to have data fed from a $30 glucometer or a $50 blood pressure monitor at home to me so that I can now begin to do what I think is really the vision we have to get to in health care, which is more widgets less time.

We've got to deliver more units of care for less time in order to get enough care delivered to this country for fewer dollars. So with that in mind, if I have a data feed between visits of blood glucoses, of blood pressures, etc., I can make adjustments in care without having to turn the crank on an office visit. That will drive a lot of efficiencies in our system.

So yes, it's an important part of our strategy. We're still really trying to decide the best way to present the results to patients so that we can reassure and give the appropriate level of concern to them but I think it's critical that the patient be involved and patients are helping to guide that. We have a patient panel that's helping to decide what to do with that information.

ANNE WEISS: So just to inspire your patient panel, one of the tings that I can share is that the Robert Wood Johnson Foundations has separately funded an initiative that's known as Open Notes. Open Notes is designed to look at that sort of scary thing about taking what's the doctor rates in your chart and putting it out there for you to see. That is quite a transition.

If we have more time, I'd tell you a story about what happened once when I looked in my own chart and I didn't really like what I saw. The Open Notes project is a group of providers that are working on a system that physicians in the delivery systems are comfortable with and patients are as well for making all the information in the chart immediately and completely accessible to the patients.

It takes culture change. It takes behavior change. It takes trust. It takes a whole new set of institutional practices and systems but definitely something that I think is a direction that many of us feel it seems right, feels right. So more to come from the Open Notes project.

ED HOWARD: Very good. Time for one more question. I have it. I'm going to ask you, in the meantime, to listen to my question while you fill out the evaluation form, that's right. It was triggered by something that Anne said when she

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

was first speaking to you and I'm paraphrasing here but something like you learn locally and apply nationally.

You have a bunch of folks who really have a national view in our audience and I wonder if I could ask any of the panelists and Anne as well to chime in on it. What the kind of lessons that you would like to see learned as a result of these community initiatives and what you are learning that you think is really important. Bob?

ROBERT GRAHAM: I'll start off. I think the lesson I'm seeing thus far is that because health care is so complicated and has so many financial interests and institutional interests associated with it that if you're really going to have a successful approach in a given community to making change, it has to be multistakeholder. The entity, which is the convener for that really has to be a non-interest, which is why you see all of our communities are basically not-for-profit organizations.

You need to have that neutral ground where people can come discover that they do have overlapping concerns even though they may have business or professional differences outside of the room, they have overlapping concerns and can agree that yes, there are some things that we can do together and then you start doing a few things together.

They may be small things and you discover that you have some success and there's positive feedback. Then that group can become more expansive and maybe talk about questions and think about issues that they couldn't have done together two or three years before.

So I think it's common ground, neutral ground, but everyone in the community has to be involved because if you get a relatively small cadre of folks in the community saying well this would be good and we're going to make the change, somebody out there looks at that change as being a loss to them. They will resist you and then you're just back into that dialectic that you have so much of the time.

ED HOWARD: Good, Jim?

JAMES CHASE: I certainly agree with that. another thing I would add is one thing we've learned that alignment across the community really helps especially in the measurement and improvement focuses having multiple payers participate in that and do things in a similar way and collaborate has been very helpful. That's a challenge and we kick that up to a national level.

We do know that having Medicare participate with us locally is really important because it's such a big piece of the funding and attention that local providers have. We need to find a way as we move forward with implementing Medicare

accountable care organizations and other things to make sure that it's responsive to local needs.

Our discussion here about how that's how we're going to make change happen, get the redesign that we need to happen, to get the better value for patients is going to happen at the local level. We need Medicare to be able to participate and the trick there is doing it in a way so it's consistent across the country but isn't just one size fits all.

ED HOWARD: Great.

DAVID KENDRICK: So you guys took mine, which was the alignment of pay sources and their perspective on this. That is so critical. If you're working in a physician practice and we all recognize that this pen in my hand spends about 80-percent of the health care dollars because I'm writing orders for things that happen in other facilities. I'm writing orders for patients to fill in the pharmacy. This has to be a point of our focus.

What we have to deal with is that the patients who come to see me, I treat everybody exactly the same way but they have very different pay sources and very different rules for each of those organizations that we must deal with so that I have a whole back office staff focused on dealing with that.

So when we try to implement innovations, I think the highway of health care improvement is littered with failed

projects that fail to account for the fact that Medicaid is only 10-percent of this doctor's practice. So that doctor's practice is not going to substantially change the way they do things for that 10-percent slice.

We've got to have interventions, whether they're technology or programmatic that cut across or able to cut across a practice setting because that's where we're doing the work, what we're thinking about the work flows, and not limit them to a particular pay source. I think that's probably the one biggest struggle we have in our Beacon community is it doesn't come with a component with aligning the payers.

So I spend probably 30-percent of my time trying to get private payers aligned with Medicaid, aligned with, would be nice, aligned with Medicare to support these interventions because, as I very clearly described, if we don't have a payment for a particular transaction we know to be of value, we don't have any improvement.

ED HOWARD: Anne, do you want to chime in?

JOHN STENT: Ed, can I ask a question?

ED HOWARD: A quick one with a quick answer if possible. How's that? Identify yourself.

JOHN STENT: Okay. I'm John Stent. I've spent most of my career in health care and the last 15 years as a CEO or

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

administrator in rural community hospitals and I applaud you for what you're doing.

My biggest concern is the small communities, 1,000 population that's 50 miles from the next critical access hospital, that's 300 miles from a medical center that has a nurse practitioner taking care of all the patients and of those thousands, you and I know that there's heart problems. There's different disease issues that need to be taken care of by a specialist and most of that time, they're taking care of in a community. How are we going to roll out what you're doing in bigger towns and cities to the outlying communities that also need good quality health care?

ED HOWARD: Very good question.

ANNE WEISS: Again, we set out to do our work in many different kinds of communities and while I don't think we have any communities that you would call frontier communities exactly, we have for example, in Humboldt County, California, pretty remote, pretty hard to get to. There's one major hospital. You can put all the dots in one room. Some of the logic is the same everywhere, measuring, supporting improvement, engaging consumers.

Those are things that have to happen from the smallest to the largest communities. There may be technologies that make it easier to do in more remote areas. Minnesota obviously

has remote areas. Oklahoma is not a heavily metropolitan market as well.

The Foundation supports something known as Project ATCO, which is a very innovative use of distance learning to supervise specialty care, remote specialty care. So there are lots of technical ways about it that folks have to share but in many ways, I think the basic dynamics are not that different.

ED HOWARD: Okay. No, go ahead.

DAVID KENDRICK: So just really quickly, we do have the critical access hospitals and rural HQFCs as a part of our program. They're really critical to the mix. We use the term virtual integrated delivery network to sort of indicate that now these groups can leverage what they're really good at and what services they have in the community but then be connected to a larger entity that maybe has the cath lab and some things uniquely that they don't.

Our vision there is by creating a tighter connection between say the primary care and the local care in these rural areas with the specialists and the tertiary care in the urban areas, the patients can stay at home as much as possible because their providers have closer, 24/7 support from higher levels of care. If a move needs to be made, it can be made quickly and effectively. So that's a really important part of our strategy.

ED HOWARD: Terrific. Well we've come to the end of our time. You've been very patient with us in a very wide ranging discussion. I want to thank you for that.

I want to thank our friends at the Robert Wood Johnson Foundation both for their support and co-sponsorship of this briefing and really Anne's participation in the shaping of and the availability of such good panelists across the board [Applause] and thank them. Thank you very much for helping to thank our panel [Applause] for this discussion and we're adjourned.

[END RECORDING]

[1] The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.