THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

CMS LISTENING SESSION:

HEALTH CARE DELIVERY SYSTEM REFORM

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335 Powell Street

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REPORTED BY: Freddie Reppond

A P P E A R A N C E S

SPEAKERS:

David Sayen, CMS Regional Administrator

Dr. Donald Berwick, CMS Administrator

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

Melanie Bella, Director of Federal Coordinated Healthcare Office

Herb Schultz, HHS Regional Director

COMMENTERS:

Fred Mayer, Pharmacists Planning Services

Dr. John Maa, UCSF Medical Center

Leslie Mikkelson, Prevention Institute

Elaine Wong Eakin, California Health Advocates

Wynne Grossman, Center for Oral Health

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

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

Franco Herrera, San Francisco General Hospital

Jarbe Durant, Durant Management Corporation

Dr. Tom Bodenheimer, UCSF

Debbie Rogers, California Hospital Association

Hattie Hanley, Right-to-Care Initiative

Kathy Ochoa, SEIU-UHW

Adrienne Bousian, Planned Parenthood Shasta Pacific

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

Dr. Dean Schillinger, UCSF, San Francisco General Hospital

Dennis Robbins, National Research Network

David Grant, California Alliance for Retired Americans

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

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

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

Terry Leach, University of California

Dr. Yoshi Laing, San Francisco General Hospital

Dr. Basil Khan, UCSF

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

Joanne Handy, Aging Services of California

P R O C E E D I N G S

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

challenges in Medicare and in Medicaid.

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

DR. BERWICK: Thanks, David.

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

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

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

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

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

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

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

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

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

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

Timeliness: The reduction of unwanted delays.

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

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

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

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

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

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

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

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

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

through proper payment; and more.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Just like we planned it. Thanks, Darryl.

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

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

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

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

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

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

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

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

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

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

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

system, as you can tell.

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

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

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

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

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

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

costs.

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

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

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

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

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

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

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

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

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

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

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

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

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

integrate and coordinate care for that dual-eligible population.

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

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

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

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

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

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

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

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

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

MS. BELLA: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And so with that I reached out to our

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

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

So, with that, Herb Schultz.

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

I want to let everybody know that we have a

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

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

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

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

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

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

Fred Mayer.

FRED MAYER: Yes. My name is Fred Mayer.

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

because of drug interactions. Consumers like myself --

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

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

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

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

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

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

MR. SCHULTZ: Thank you, Fred.

Dr. Berwick or Dr. Gilfillan?

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

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

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

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

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

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

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

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

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

MR. SCHULTZ: Next.

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

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

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

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

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

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

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

So best wishes with the Center. Thank you.

MR. SCHULTZ: Thank you very much.

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

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

Thank you.

MR. SCHULTZ: Thank you.

Good morning.

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

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

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

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

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

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

MR. SCHULTZ: Thank you, Elaine.

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

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

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

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

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

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

Thank you.

MR. SCHULTZ: Thank you.

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

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

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

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

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

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

prove that they could be very good ACO managers.

Okay. Thank you.

MR. SCHULTZ: Thank you.

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

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

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

On provider HIT, I was just at the office of

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

Thank you for listening.

MR. SCHULTZ: Thank you very much.

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

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

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

providers and hospitals under the Affordable Care Act.

Thank you.

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

MR. SCHULTZ: Thank you.

Welcome.

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

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

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

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

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

JARV? DURANT: Thank you very much.

TOM BODENHEIMER: Good morning. I'm Tom

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

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

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

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

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

So thank you very much.

MR. SCHULTZ: Thank you.

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

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

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

TOM BODENHEIMER: Okay. Thank you.

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

Hello.

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

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

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

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

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

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

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

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

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

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

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

acknowledgment that we will need some flexibility.

And thank you very much for the opportunity.

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

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

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

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

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

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

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

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

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

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

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

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

MR. SCHULTZ: Thank you, Hattie.

Kathy.

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

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

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

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

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

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

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

MR. SCHULTZ: Good morning.

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

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

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

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

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

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

MR. SCHULTZ: Hello.

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

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

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

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

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

So my question, which is probably linked to

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

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

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

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

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

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

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

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

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

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

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

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

DEAN SCHILLINGER: Like a marriage.

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

DEAN SCHILLINGER: Thanks a lot.

MR. SCHULTZ: Good morning.

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

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

Thank you.

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

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

Good morning.

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

And the reason I'm here is talk about the

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

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

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

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

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

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

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

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

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

Thank you.

MR. SCHULTZ: Thank you, David.

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

Thank you.

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

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

MR. SCHULTZ: Hi, Billy.

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

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

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

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

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

to impact that.

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

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

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

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

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

Thank you.

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

Good morning.

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

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

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

goodness.

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

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

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

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

DR. BERWICK: Yes.

DR. GILFILLAN: Yes.

MR. SCHULTZ: Michael, good morning.

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

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

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

I want to speak on behalf of a lot of the

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

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

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

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

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

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

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

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

And I really wanted to just make a couple of

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

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

MR. SCHULTZ: Thank you.

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

Good morning.

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

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

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

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

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

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

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

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

today.

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

MR. SCHULTZ: Thank you.

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

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

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

Thanks so much.

MR. SCHULTZ: Thank you.

Good morning.

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

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

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

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

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

So Herb knows how to reach me.

MR. SAYEN: Where will the center be?

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

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

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

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

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

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

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

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

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

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

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

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

Thank you.

MR. SCHULTZ: Thank you very much.

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

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

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

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

Thanks.

MR. SCHULTZ: Thank you, very much.

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

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

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

DR. KHAN: No.

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

[Simultaneous speaking]

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

[Simultaneous speaking]

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

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

MR. SCHULTZ: Absolutely.

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

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

[Simultaneous speaking]

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

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

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

MR. SCHULTZ: Thank you, Walter.

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

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

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

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

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

MR. SCHULTZ: That's terrific.

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

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

Thank you.

JOANNE HANDY: Joanne Handy from Aging Services of California.

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

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

Thank you.

MR. SAYEN: Thank you.

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

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

Thank you again.

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

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

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

STATE OF CALIFORNIA)
COUNTY OF SAN FRANCISCO)

CERTIFICATE OF REPORTER

I, FREDDIE REPPOND, a duly authorized Shorthand Reporter and licensed Notary Public, do hereby certify that on the date indicated herein that the above proceedings were taken down by me in stenotype and thereafter transcribed into typewriting and that this transcript is a true record of the said proceedings. IN WITNESS WHEREOF I have hereunto set my hand on this 27th day of December, 2010.

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FREDDIE REPPOND

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