SENATOR USIE RICHARDS (USVI): We are at the point of our agenda where we're going to have the third dialogue of the symposium on the subject matter, excuse me, how to build a successful accountable care organization, the patient-centered approach. And this is intended to have a brief discussion on a model of an Accountable Care Organization that aims to expand access to healthcare, provide higher quality of care while improving better health for populations and slower growth in the costs to improvement and effectiveness in care.

Now more importantly, it would lead us to discussing some innovative ways to holistic treatment of the individual one that is patient-centered, the patient-centered approach to care, and especially ACOs, the accountable care organization, which is an increasingly popular model that emphasize continuous, coordinated patient care. We are going to have three panelists who I believe have already joined us. So I would first like to call up Mr. Neil Pickett while I introduce him. He's the director of policy and planning in the Indiana University Health. He's also responsible for assessing the impact of changes in federal and state healthcare policy on the Indiana University health system. And additionally has had served as chief of staff of the Indiana University Health accountable care organization. Please welcome the former senior policy director in the office of Indiana under Governor Mitch Daniels, Mr. Neil Pickett. You could have a seat. We're going to introduce all your panelists up and we'll let you begin. Please welcome Mr. Pickett.

He will be followed and joined by Dr. Joseph Larosa who happens to be the chief medical officer for the St. Francis Health Network, which is the Franciscan Alliance, an Accountable Care Organization. They recently forged an agreement with the Centers for Medicare and Medicaid, known to most of us as CMS. And they did that with the intention of serving more patients while reducing Medicare costs. I think as recent as just late last year in December of 2011, the organization was the first in Indiana and one of only 32 nationally to be selected by Medicare to participate in a pioneer Accountable Care Organization model. Please welcome Dr. Larosa.

And our final panelist is Ms. Kiran Johal, and I hope I said that correctly, Kiran Johal, the assistant director for product development for the National Committee of Quality Assurance. It is a non-profit-based organization that is situated or located in Washington, DC. She has a vision to transform healthcare quality through measurement, transparency, and accountability. Prior to having that job, she joined the product development team. Ms. Johal worked with the committee's performance measurement team where she helped to establish performance measures. Please welcome Kiran Johal.

We are going to call to the podium our first panelist, and you can speak from here, if that's okay, Mr. Neil Pickett, welcome.

NEIL PICKETT: Good afternoon, it's a pleasure to be with you and thank you for being here in Indianapolis and thank you for what you do. I, as was indicated, I have the good fortune of working in state government for several years myself in the executive branch, but I have great appreciation and respect for the work and the effort and the challenges that all of you face as legislators, as partners in creating laws in the different states in which you live. So thank you for your service and thank you for being here today.

My goal is just to talk very briefly about the concept of accountable care and what IU Health is doing to move to a different care model that we think is, as been said, more patient-centric and more appropriate for the future. We think it's a model that is better for patients and better for providers, and frankly better for payers because we recognize that the increases in healthcare costs that have dominated the American healthcare system for many years are really not sustainable. We're getting to the point where both public payers, Medicare, Medicaid, and private payers are finding it increasingly difficult to pay for our services. The quality of those services is excellent and we work very hard and are committed to saving lives and improving health. But it comes at a very significant cost both for the individual and for society.

And we, let's see if I can make this work. Let's see, we basically believe -- and this is, you know, I can't speak for everyone at IU Health, but certainly in the leadership of IU Health that we need to move away from the current reimbursement model of healthcare, which is very much focused on fee-for-service, or a volume-based approach for care. So we get paid when we do more to people, when we have more patients come into our hospitals, when we do more tests on those patients, when we do more procedures, we're paid for that.

And I have a tremendous amount of respect for physicians and for colleagues, providers who sacrifice a great deal to care for patients. I'm not suggesting for a minute that there's any intentional effort to, you know, to do things that are inappropriate or to overcharge or overbill, but the nature of the incentives of the fee-for-service system are such that the whole entire process and the whole entire system is oriented toward volume, toward doing more. And we have to get away from that. We have to get away -- we have to move much more toward a concept of working within budgets, of taking responsibility for managing the health of a population of patients. We have to move to a situation where we're rewarded not for bringing people to our hospitals, but where possible to keeping them out of the

hospital. The hospital is the most expensive place to provide care. It's also dangerous. We want as few people in the hospital as possible. Now obviously you can't keep it -- obviously there are people who are there appropriately and need to be cared for in that setting, but we need to look for the most efficient, the most cost effective ways to provide care. And most of the time that's within -- that's in the community, that's -- or that's in a clinic or that's in the home even sometimes. It's certainly not in the expensive hospital setting. So we need to move to a point where we're incentivized as providers to keep people out of the hospital as opposed to bringing them in.

So the shorthand for this concept, this transition, from a volume-based to a value-based healthcare system is called accountable care. It's been around in the academic literature for some time. It has its origins -- it has many origins, like any good idea, it's got lots of parents. The Brookings Institution, Mark McClellan and Dartmouth, some experts at Dartmouth are known famously for kind of writing some seminal articles on the notion of accountable care. And most significantly, it was included in the Affordable Care Act as a possible alternative for Medicare.

So the Affordable Care Act permits legally providers to come together and to create Accountable Care Organizations that are able to share savings with Medicare. Previously, as I said, the only way Medicare worked is, you know, you submitted a bill as a provider and they paid you. We're now in a situation where we're essentially managing it toward a global budget. We're still billing Medicare, but they're basically kind of keeping track of the billings and they're counting that against a global budget that they've set for the populations that we're managing.

So it's much more about population management, much more about global budgeting than it has in the past. And again, the idea is to move the incentives toward efficiency and toward quality and to reward quality and efficiency as opposed to the volume of care. Whoops, sorry, I went the wrong way.

So some of the key concepts of accountable care are about trying to, as I said, trying to keep the patient well, trying to intervene in chronic disease as early as possible to prevent complications, to prevent the patient from having to come to the hospital.

Care management and coordination are essentially critical. One of the problems and one of the challenges of the fee-for-service system is again there are no incentives to cooperate among providers. There are no -- handoffs are very problematic--handoffs from the outpatient world to the hospital. When someone's discharged from the hospital and they go to a nursing home or even if they go back to

their own home, the handoffs are not good. The follow-up isn't always good. And sometimes that leads people to come back to the hospital which costs Medicare or Medicaid more money. So we're trying to avoid those kind of complications, those readmissions to the hospital.

We want to reduce variation and improve the quality of outcomes using evidence-based standards. We want to control -- manage utilization to control the cost of care per individual. Again, making sure that we're held to quality standards, this is not about rationing care, this is not about denying care, this is not like the HMOs of the 1990s where the way you save money was to just say no. This is about -- but this is about asking the question, does that person with low back pain really have to have an MRI or can we manage, you know, with physical therapy or some kind of other medication treatment for a while and make sure that they -- see if they can get better that way. Don't start with the most expensive test. Start with the most conservative and the least expensive treatment and only go upward if really necessary.

Doing this depends a lot on investments in information technology and decision support to do analytics, to understand and identify patients who are at risk, to intervene with those patients much earlier, and to help those patients manage their disease effectively.

So then finally, I'm sorry, I keep going the wrong way. So in terms of what IU Health is doing, we're pretty much kind of trying to organize ourselves and trying to create processes that support this transition with the population we're managing. We also, the Franciscan ACO came before us, but we were selected in July to participate in the ACO program ourselves. We have about 15,000 lives that we're managing in Indianapolis and in the surrounding counties of Central Indiana. And we've just started the program, but we're basically trying to implement some of these processes to take responsibility for the care of this large population of Medicare patients. And we're doing so, again, to try to make sure we improve quality while figuring out ways to slow the growth or reduce the cost of care per person.

We're focusing on creating a primary care network and developing medical homes. Medical homes are a very important part of a strategy for accountable care. And it was mentioned, this is the idea of really trying to provide, as it says, a home for patients, not just having patients or physicians deal with patients reactively when they get sick, but being a source of kind of continual contact and information and assistance to them as you try to manage their illnesses over time.

A medical home has specially trained nurses and social workers who are designed to work with the physician in a team-based approach in order to, again, manage the care of patients who are sick. Medical home also implies greater access to physicians or their team through email, through extended hours, and through other forms of communication. So you don't have to just make an appointment and wait five days, there's much more kind of effective and regular interaction.

We've had some very significant early successes with the medical homes we've created. We found that the nurses in those homes are really having success in developing relationships with patients who are at risk and helping them deal with problems that they're having, and generally coordinating their care much more effectively than had been the case before.

We're also, again, focusing on trying to increase efficiency in our hospitals by reducing clinical variation, by sticking to evidence-based standards. And we're trying again, as I mentioned, to reduce inappropriate and unnecessary utilization of expensive services to make sure that those are targeted only on the people who really need them and not others where it's generally not necessary or wasteful.

So that's in a nutshell the concept of what we're trying to do. Again, just to summarize, it's basically -- you think of it very differently. You think -- think of Accountable Care Organization as taking responsibility for a population of patients and really being responsible for their overall care over the course of a year and to help them manage their illnesses much more, excuse me, effectively and in a much more coordinated fashion.

It's got tremendous promise. It's very new. We don't know yet whether it's going to work. We think it will and we have a lot of reasons for optimism about it, but you know, over the next few years we'll be seeing how well we do and how effective we are at implementing these systems and making it work. It's a big change for doctors. It's a big change for other providers. They're not used to managing this way. They're not used to this kind of system. Sometimes they're not used to working in teams. So it's a big change for doctors, and that takes time. But most of them are committed. And when you talk to them about this and when they see it start to work, they realize it really is much better for them and especially it's better for their patients. Let me stop there and let the other panelists make some comments and then we can open it up to any questions you might have. Thank you.

DR. JOSEPH LAROSA: Good afternoon, everyone. And we again welcome all of our visitors to Indianapolis. It was a pleasure having lunch with some folks from Pennsylvania and Maryland and Atlanta, Georgia. So again, welcome to Indianapolis. A little bit about me. I'm Joe Larosa and I started at

this gig by being an OB/GYN. I was a solo practice OB/GYN. I delivered one of Greg Taylor's kids. And a few years ago, I was delivering a set of twins and I had a very severe reaction at the hospital and overnight my career ended because I had a latex anaphylactic reaction. And my doctor said you really can't go back to the hospital. So there was an opening at St. Francis Hospital for the director of Medicaid, and as most people know, Medicaid is mostly involving babies and pregnant moms. At least in Indiana, the majority of a lot of Medicaid business surrounds the decisions of obstetricians. So St. Francis asked me to come on board, and it's been a real pleasure to kind of change my career midstream.

As Mr. Pickett just said in our -- and my introductory person, Franciscan Alliance was granted one of the pioneer ACOs back last December. And we've been kind of working really, really fast in 2012 to kind of get us up to speed learning really what's going to be the best way to make this thing work, what's going to be the best thing for the patients, which is the main thing. It's been a lot of fun.

You know, I'm a doctor, but medicine isn't great. We were even having a discussion at lunch about, you know, outrageous bills that hospitals charge and what doctors would charge for what seems like a five minutes' worth of work. It's very fragmented. We're not connected. We're not -- we do our thing. We deliver their babies. We do the surgeries. We admit the patients. And then we do the discharge summary. We kind of forget about things. We forget about the handoffs, as Mr. Pickett just said. The handoffs related to the patients leaving the hospital. And if they go to their home or to the nursing home or to some other facility, a friend's home, those handoffs are just not very good.

And so one of the things before we even applied for this ACO, we realized that St. Francis Hospital, and everybody thinks of St. Francis as just this little small hospital, but actually we're one of 14 hospitals across the state of Indiana and called Franciscan Alliance. But we realized that our sister hospitals, we weren't talking that well even with each other let alone even inside our own hospital. So we decided to start off with just getting some more IT backbone so that we -- the doctors could have access to labs, to radiology, et cetera and be on the same page. So that was our first step. We felt that we'd be a viable option for an ACO because of the ACO concept of communication. Again, that was what we were lacking. We put this IT system in about a year and a half before that and we felt very strong that our IT system was very excellent.

We also believed in our doctors. We believed in our system that we cared for our patients, which was the number one thing, and that's what we really strive to do is what's going to be the best thing for our patients. We had to sit a lot of people down and have a lot of meetings, lots of morning meetings, lots of evening meetings and say what are our -- and just look each other in the mirror -- in

each other's eyes, what are we doing good? But really what more importantly, what are we not doing so well and what's going to be the best way to do the best thing for our patients?

A lot of people have seen this slide before. Don Berwick is kind of the creator of -- one of the deliverers of the ACA. And Berwick used to work for the Centers for Medicare and Medicaid innovation. He's the chief executive officer for the Institute of Healthcare Improvement. But the three basic tenets of an ACO are number one, patient satisfaction. We want to make sure that the patients are happy. Number two, we want to make sure that they're getting quality care because a patient can be very happy, but not necessarily receiving quality of care. I mean, the patient may love their doctor and may love the hospital and they may love us so much that they keep coming to the emergency room every three days, but that doesn't mean that they're getting quality care.

And then the other thing is really how do we wrap our arms around the huge cost of medicine? We were heading -- I know you guys know the story, but they tell me that the Medicare Package A Trust Fund at the pace at we were going was going to be totally in deficit by 2020 as all these baby boomers are getting older and older and then utilizing services. And then also they're getting older. I mean, people are living longer. The fund was going to be out. So we had to wrap our arms around this thing.

Now I think the government did something very, very unique and interesting, and they said, you know what? I think it's a big problem. I mean, medicine is huge. It's so complex. Let's let these systems figure this out. And then if they figure it out, we'll split the money with them. And so I think that was a great idea whoever came up with that or maybe several people come up with that. But that's the idea of this pioneer ACO is that if systems can prove that they can save money, then they can share the savings. And so -- and the savings -- what we have decided to do with our savings is number one, help infrastructure changing our care management like Mr. Pickett said, really having a lot of people in the trenches and working really hard in people's homes and with discharges, et cetera, and also doctors' offices. But also sharing that money with our physicians that are really making a difference there.

In the very center of that is a patient-centered. And so that's what really this talk about, it's about what are we doing right for the patient? I mean, is -- we have to look at lots of things. We have to look at the population. There are populations of people that have high rates of diabetes. There are populations of various neighborhoods where everybody smokes cigarettes. There are areas of family histories where they're all clustered together, high rates of heart disease and heart failure. Focusing on communities, the patients that are in medical homes. But not only that, patient-centered medical neighborhoods where everyone's not only just talking with just the patient, but also the doctors that are

involved. And not only just the primary care doctors, but the subspecialists, the surgeons, even the ER doctors, et cetera. So everybody's on page with really serving those constituents.

Again, we talked about the triple aim and we'll go into that since we're kind of short on time. You're going to be hearing a lot about ACO contracting in the very near future. It started off with the government, with Medicare. And then actually St. Francis Franciscan Alliance is another ACO that -- it was just announced just a few weeks ago with American Health Network, which is a large network of primary care doctors across the State of Indiana. So between the two parties, we have about 58,000 lives in both of our ACOs. Now here's the interesting part of it, the insurance companies know that the hospitals, the delivery systems like IU and some other ones across the country, Monarch, et cetera, the insurance companies know that case management is the key. And as once hospitals develop these systems of really taking care of patients and really dealing with those handoffs, that those systems will be in place for all payers, that the Cignas of the world, Uniteds, Humanas, et cetera, are also dovetailing. So there's a lot of contracting out with systems and also insurance companies for ACOs for again, cost-sharings.

It's the same rubric. It's all about care management. It's all about taking care of the patient. It's all about making sure that we're really dealing into the social aspects of their lives, the behavior health of their lives because those aspects really come into play as far as health. And I think in the old rubrics where it was fee-for-service, it didn't really matter because we wanted to get the patient, you know, fixed. We wanted to get him well. But now, we want to make sure that they're well and don't even get to the hospitals. It's a totally different way of thinking.

Okay, Mr. Berwick mentioned and has had several articles about quality. But how do you make care safer? Well, the first thing is, you got to communicate. One doctor has to talk to another doctor or one case manager has to talk to another case manager. You just can't write it on a piece of paper. Those communications, those dialogues are so important for success. Another thing that Mr. Pickett mentioned also was that it's about evidence-based. I mean, we do -- doctors, we sometimes we think they're always the best way. And sometimes you think it's our way's the best way because we had a success with maybe just one patient, and that patient was happy. So we assume that everything was perfect. I used to be a surgeon, so I used to do some innovative things in surgery, and I could swear that, oh, my way, even though it's not in any textbooks, was the best way to do that. My patients are happy. My outcomes are really good.

But we have to go to the next level. We have to really look at what does the body of evidence say really works? And that makes my job very difficult because when you confront a physician and say, you know what? Yeah, you can order this really expensive PET scan, but there's really no evidence to say that that's really going to make a difference. And you're also maybe exposing those patients to radiation and some other problems. This is not good. And technology has really -- that's what's really driven up the cost of medicine is that the companies that make the new technology put it in the face of the physicians and the hospitals. The hospitals didn't want to compete with the other hospitals, so they want to buy the brand new equipment even though they just bought equipment two months ago, they want the brand new 60,000 CT slides for et cetera. It's all about the market share. But in the bottom line, the technology keeps driving up and driving up and driving up the cost. At some point, we got to say no. There's no evidence to show that that new PET scan's going to make it a world of difference as far as the health of this patient.

The other thing that we forget about is patient engagement. Think about it, when you're in a hospital, you're tired and you've been up all night with things, beep, beep, beep, all night long. Nurses coming in to check your vitals every, you know, couple hours or so. It's not a restful place. You may be recovering from surgery or from a stroke. But the old rubric was, you just kind of told the patient in the hospital, here's what you got to do and I'll see you in the office if you don't feel any better. Well, that doesn't work anymore. One of our strategies is we want to make sure that there's an advocate in the patient's room when the patients are awake and with it and well before they go home. We like to have a pharmacist in the room to kind of go over their medications, make sure they understand what's going on. We want to make sure that there's an advocate, that may be the patient's spouse, that may be the patient's neighbor, maybe the patient's cousin. Some of these patients live alone. It may simply just be the nurse in the hospital that then has pledged to this patient advocate once this patient leaves.

We want to make sure they understand. So that's one thing that we've done, and it's been very, very successful. The other thing that we're doing is that we're sending out a home nurse to every one of our discharges. Not the newborn babies and that kind of thing, but everybody that's our Medicare patients. They all get a home nurse within 36 hours from the time that they leave the hospital. We sit them out on the kitchen table and we say, let's get all the medicines out. I want them right here on this kitchen table. What's the old stuff? They already have their new stuff that's in that bag that are all labeled and they're going to put -- let's get your pill pack out and let's start -- let's dive through this and we're going to throw away that old medicine and we're going to start from scratch today. We used a lot

of telehealth so that the patients can have their blood pressure monitored at home, their weights checked for CHF and the glucose sticks, et cetera, for diabetes. And then we have case managers that then take over from there, where they call the patients periodically and maybe even visit them in their home. And then lastly, we like to promote prevention with population management.

So this is what we've done. You know, kind of a summary of my discussions as far as the IT being at the top, patient-centered being in the middle, and we talked about the other aspects of population management, case management, and medical homes, et cetera. So thanks for your time.

KIRAN JOHAL: Okay, so good afternoon, everyone, and I wanted to echo the sentiments of my colleagues on the panel here and thank you for your hospitality today and welcoming me to join in this discussion. It's been informative and I've learned just as much as hopefully I can impart information to you today.

So I'll also be talking about Accountable Care Organizations, surprise. Our role in NCQA, as alluded to a little bit earlier, we're a 5013C non-profit organization dedicated towards improving the quality of healthcare. And our mission and driven agenda really is to improve the quality of healthcare through transparency. And the way that we do that is through a number of means. So quality measures, quality measures that show improvement in outcomes. We heard a little bit earlier about stroke and diabetes, recognizing physicians who have made great strides with their populations. We also accredit health plans, so thinking about the exchanges in the discussion earlier today. How do we know that health plans coming forward are really offering the types of services that are going to improve patient-centeredness, patient safety, and better health outcomes for all? And also we have programs for multicultural healthcare and disease management.

So really again, proving to be, hopefully, a good housekeeping seal that folks can look to, legislators, the public, and consumers can see that if the NCQA seal is associated with the program, that it means that they meet a very basic set of criteria to be what is thought to be the gold standard in that area.

So we do have a program for Accountable Care Organizations. And part of our development process as we come to create these programs involves consensus building. So we bring into a large room a number of experts. So folks such as Dr. Larosa, Mr. Pickett, folks from CMS, folks from local government, folks from the federal government, payers, employers, and the consumers. So all of the folks that would comprise an ACO, or be the ones who are on the delivery end, or be the ones paying for

the care. And through this process, what we do is we use consensus building to create a set of standards against these basic set of criteria and define, for our program, what an ACO is going to look like.

The two programs that were just discussed a little bit earlier, their ACOs, I believe are shared savings or pioneer ACOs, so they work primarily with the Medicare population. And our program really extends more towards the commercial population. So we understand in some ways we're a little bit ahead of the curve ball here. We have to give times for organizations to get up to speed. I heard some great presentations right now just thinking about the infrastructure that goes into place. But -- and these gentlemen did a great job presenting that, but please don't be fooled. That takes a lot of manpower, a lot of effort, and a lot of dedication. So I think that what they're doing is truly wonderful. And what I'm about to speak to is hopefully where a lot of organizations can move towards the steps they can take to become an ACO, and when you're looking at the public to what an ACO should look like, what it might be.

So one of the first steps that we did was to define what an ACO is. So in our world, an ACO is a provider-based organization that's accountable for both quality and costs of the care for the defined population. And as we heard Dr. Berwick, his triple aim at CMS and IHI, again, another cornerstone of our definition. But we also would like to see that the organization is aligning the incentives. So we heard that there's -- there can be rewards based on performance, so the quality and outcomes of the patient. Are your patients getting healthier as opposed to sicker? And also, are you saving money? Is this a good use of your capital and expenditures to make sure that you're taking care of the folks that really need it?

And again, the overall goal is for us to be improving the triple aim of healthcare. I think we're all on the same page about that here. Improving their experience of care, improving the care of the population, and also reducing the overall cost of cares so care is affordable.

We have in our office a little joke. What is an ACO? An ACO can take on many shapes and sizes. There are a lot of types of organizations out there right now associated with healthcare. You have HMOs, you have PPOs, you have POSs, managed care, all sorts of acronyms that we like to spit out in the healthcare industry. But ACOs are truly unique because they can take on a number of shapes and sizes. Right now, they are the unicorn of healthcare. A hospital could be an ACO. An integrated delivery system could be an ACO. A group of physicians can form an ACO. So you can see here, these are just some examples of what eligible entities for our program might look like.

And the goal of our program, again, is to set a basic set of standards that an ACO should meet but not be overly prescriptive. We don't want to stifle the innovation that's out there. We see all of these innovative practices that happen at the regional level and understand that every region is different. Care that should be delivered in Indiana might be a little different than care in Georgia or care in Pennsylvania, depending on your population and your needs. So what we're trying to do again is to be able to provide a framework so that folks can see that there is a basic set of national standards that can be met. So the unicorn is -- it's difficult, but I think that's the beauty of the ACO, is that an ACO can be any type of organization. And these are just a number of examples here.

There is one minimum criteria we have, and that's just to make sure our measurements, so the data that we're collecting and saying and giving our seal to that this is a good ACO actually is statistically valid. And that's that the ACO needs to serve at least 5,000 patients. And this is in line with the work that the statisticians and health economists at CMS have done for their shared-savings program and what's in the ACA as well.

Our program evaluates a total of seven key areas, which span from things like structure and operation. So does your ACO have a governing board? Does that governing board potentially include members of the community? Is it just a number of executives holed up in a room or are you getting input from the consumers and the stakeholders? And alternatively, are you also having appropriate guidance from the folks who really should be providing it to you?

The second area is access to needed providers. And this is where a little bit of that regional difference comes into play. If you're operating in a state like Montana where you may not see a provider for -- more than one provider in 250 miles. Is there telemedicine available? Is there a way for your patient or your population to be able to get the care they need when they need it?

The third area is the patient-centered primary care. And this is really based on the patient-centered medical home concept. And I think all three of us have thrown around the PCMH concept a little bit, and I can stop to define it for a second. So what a patient-centered medical home really is, is your primary care physician acting to coordinate your care, provide the services you need in a timely manner, do some of the things that Dr. Larosa was talking about on follow-up. And I think both of their organizations had mentioned it and they're doing a great job with that as well. So the PCMH, in our mind, is central to an ACO. There's a connection between the two. So the medical home and then also thinking larger to that medical neighborhood. So what's the role of the specialists? What are the role of

the hospitals? How can the health plan out by providing the claims data and making sure that utilization is being monitored? That's an area of interest as well.

The fourth area is the care management. And really what care management is speaking to is the IT systems. So do you have the management systems necessary to take care of your population? Do you offer electronic prescribing? Do you have different ways for folks to access their medical records? How can they see your hospital directory? How can they see a list of their physicians? Again, some basic things and also some not so basic things for organizations to move towards and be able to provide information that can really manage the care of their patients.

The fifth area is the care coordination and transitions. Talked a little bit about earlier the need for care coordination and following up with folks after they leave the hospital. I'm sure if you keep up with the meeting and you all are legislators, so you're at the pulse of those current events, but you know that there have been some changes in the readmissions rules for hospitals and the reimbursements from CMS. And there's penalties associated with it, and you won't get your payment if you have individuals who are readmitted frequently to your organization.

So really care coordination is central to improving that quality of care both from the financial perspective but also from the quality of care. We don't want to see patients going back to the hospital readmitted having issues with their medication reconciliation. And again, I think both of these gentlemen have shared some really great examples of ways on the ground level that their organizations have been moving forward to mitigate these problems and to improve the quality of care.

The sixth area is the patient rights and responsibilities. So here's where we speak a bit more to the actual rights and responsibilities of the consumer. As a consumer or a patient, how do I know what the ACO should be providing to me? Let's be honest, most folks out there, if they get a letter that says you've been enrolled in an ACO, they'll say, hmm, what's an ACO? That's an interesting term. But I think what our standards are trying to do is help to share that information with folks so they can understand and truly get a grasp on the care that they can receive and what their expectations should look like. And in relation and in converse also that the ACO can expect that the patient to be engaged and to be hopeful and optimistic about their care and moving it in a positive manner hopefully to help get them back on their feet or take care of their chronic conditions. So really, just making sure that there is clear communication and expectations are out there. And that also touches a little bit on the HIPAA piece as well because like any organization that's maintaining healthcare data, we want to make sure that that data is kept in a way where it's not going to be compromised or shared with folks it shouldn't.

And the last area is the performance reporting and quality improvement. And this is where some of the research, Elliott Fisher and the folks at Dartmouth and Mark McClellan at Brookings Institution have done that's actually pretty cool. They think that the crux of an ACO and what makes it so special and so wonderful is the fact that you can measure the outcomes because you're working in a system where information is being shared and you should have complete data capture on your population. So that means if I pull a file on me, Kiran Johal, as a patient, I should know where I've been in my ACO. I can see and I can track with my physicians what tests they've ordered. And you can truly get a picture of my health and understand what I'm doing to either help make myself better or what I'm doing with my physician to work together to improve my health.

So the performance reporting really is unique. In the CMS program, they require for their Medicare population the reporting of 33 performance measures. For our NCQA program, it's about 40 measures. And the difference is with CMS, their population, again, is Medicare, so it's geared towards 65 and over. Our population is for Medicare-Medicaid, so those mothers and babies, and also for the commercial population, so the working. So really what we're trying to do is get data and information and performance measures on that so we can start to build a repository of data and as consumers, as the public, you can go to our website and see, okay, this ACO scores in the 90th percentile for diabetes prevention, for making sure that their patients are screened for LDL, that they're getting the foot checkups and they're going to the eye doctor as well.

So I wanted to say first of all that we are assessing these core capabilities that we think will improve the likelihood of success for these ACOs, and we are being agnostic because again, we understand ACOs are just in the development phase right now. For a lot of the organizations, what I'm mentioning right now is a few years off. I think that some of the gentlemen up here in the work that they're sharing, they truly are pioneer, the pioneer ACO is an apt term for the work that they're doing. So I don't think that we can expect to see these types of outcomes or changes in the way care is delivered overnight, but I think that it's something that the organization, the industry is really striving for and moving towards. And it's a great thing.

So we do have a PCMH recognition program, so that's recognizing the provider, as I said, to make sure they're doing the things like having access to office hours, they're coordinating care, and they're really serving to be that home base for their patients, to make sure they get the care they need.

And this slide here really just demonstrates what some of those capabilities might look like because to some folks out there, they say, well what's the difference between an ACO and a PCMH?

Well really the ACO is a higher level, it's thinking at a much broader spectrum about what's happening at the system and how it's being integrated. The PCMH is thinking more at the patient level, what's happening to my patient? How are they being treated? Making sure their day-to-day outcomes are better. The ACO is not concerned with that. They are the ones who are making sure that the network is there for those physicians to improve their quality of care. This is just an example here.

So again, as I said, our program that we have is different population than the shared savings pilot and the pioneer pilot right now, but we do offer three levels of accreditation. So the first level is for organizations that really are starting to become an ACO. They're in that transformation stage. They're metamorphosing. They're changing and they're growing and they're becoming an ACO and they're meeting what we believe to be the baseline capabilities for an ACO. And we do have a point structure, so our program you can score a total of a hundred points. So to be a level one, you need to score 50 points in the program.

We have a level two, so this is for these well-established organizations that really have been ahead of the curve and really thought through becoming an ACO and are dedicated to the cause. And this demonstrates that they have the capabilities to be an ACO. And they have to score 70 points as well as report on a few key capabilities, one of those is those performance measures.

And then we have a third level, and these are for organizations that have been reporting their performance measures to state collaboratives, have been working within their region to really improve the quality of their healthcare and have been doing that performance measurement and been doing those improvement activities for a while. So these are for folks who receive the 70 points and also show performance against that triple aim.

So a number of organizations in Minnesota, so in Minnesota they have community measures where organizations are compared one against each other and they have benchmarks and thresholds. In California, they have the Integrated Healthcare Association program where organizations are rewarded financially, based on the outcomes of their performance measures. So these are really some of those progressive states that are out there. And we see also a number of states moving to form these measurement collaboratives, again, so they can demonstrate that they are really doing what needs to happen out there to move the industry forward. And I know there are a number of organizations out there and a number of states that are looking at this. And there was a Robert Wood Johnson program called Aligning Forces for Quality, and that program outlines some of the work that a lot of the states are doing to get their measurement collaboratives off the ground.

So that's the end of my comments. I wanted to, again, thank everyone for coming. And I'm slightly in a difficult position because again these two gentlemen have done a great job explaining the work that they're doing on the ground level. I haven't started an ACO. I've only talked to folks who are in the process of doing so. But again, thank you for allowing me to come speak with you today.

SENATOR USIE RICHARDS: We do want to thank the presenters, but before we take on any other questions, I don't know if Dr. Larosa misread the fact that I stood up when he was speaking and you did not get the opportunity to speak on your very last slide. But we're going to have it up and you could use the microphone there to at least expound on it and then we'll take some questions. Put the button on. You got it.

DR. JOSEPH LAROSA: Thank you, Senator. I have to admit, when you did stand up, I thought it was like the high sign, Dr. Joe, you're talking way too much, my friend. So yeah, just real quickly, I think we hit most of the points here. It really is all about integration though. I mean, IT is at the top and then we go with the population management, which I mentioned about. We get a lot of reports based on the Medicare spend on what our patients are costing Medicare so then we can then stratify that out to really see, you know, which is our patients are the sickest of the sick and the not so sick and level it all out. We got the case management we talked about, medical home, Kiran mentioned. And then again, the integration. So that was really everything, so thank you, Senator, for that time.

SENATOR USIE RICHARDS: Thank you. And we are going to entertain questions. Anyone that would like ask a question could come to the microphone, but I do want to begin that process and start with Mr. Pickett. I've listened to your presentation as you're quite aware the audience that you're speaking to are state legislators and we represent a large constituency of individuals that we could categorize as being underserved, uninsured, or underinsured. And a lot of the presentation made by the panel focus on these subject matters of continuity, quality, quantity, costs. And I suspect from where we sit as state legislators, one of the important topics or concerns that we would have is the subject matter of accessibility and availability. What does that have to do with our constituents dealing with the proposed Accountable Care Organizations? Could you at least speak on that matter?

NEIL PICKETT: That's a very fair question and a very good one. There are two answers, one may you not like and the other I hope you'll like a little more.

SENATOR USIE RICHARDS: Well, we can't like or not like it if you don't speak into the microphone so we could hear what it is.

DR. NEIL PICKETT: Okay, I'm sorry. So there are two answers. The ACO itself, the Accountable Care Organization itself, doesn't really say much about access to care. It does in the sense of, as both Dr. Larosa and I have said it, it does in the terms of making the medical home perhaps more accessible and hopefully improving care handoffs and care coordination. But in terms of the literal question of, you know, of getting access to the care network, I think that's really more a matter of which populations are covered by the ACO. Right now, the experiment that both of our organizations are involved in have to do with Medicare. There is a provision in the Accountable Care Organization that allows for the creation of ACOs for Medicaid patients. I'm not aware of any rules yet that have been issued on that. It's been delayed and I don't know of any ACOs that are currently underway for Medicaid populations. But that would be an important step, I think, in terms of bringing the ACO concept to, you know, to an underserved population because obviously Medicare represents both patients who do have access to insurance. Over time, over time -- you might find over time, the ACO concept will start to include all patients in a certain population. And again, the global budgeting will be set in a way that will be responsible for managing the care of that population in a sense whatever their particular insurance payer might be. But we're not there yet.

And I think it's important that, on the one hand, you appreciate the fact that we have to learn how to do this. And these ACOs in Medicare are an experiment in a sense, a pilot project. Learning how to do it. But at the same time, I could certainly respect your impatience and your insistence that this concept also be spread as quickly as possible to include patient populations that don't have access to insurance.

SENATOR USIE RICHARDS: Dr. Larosa, if I could just get you to follow up and Delegate Nathan-Pulliam you can come to the microphone. And I just want to make sure I understood Mr. Pickett correctly or thoroughly. The implication that I got from your statement is ACOs are, in your experiment and for those of us particular legislators like us that have these large constituencies who are underserved, uninsured, who are underinsured, and don't have appropriate access to quality services that should be available that this is something that ACOs would not be involved in but be looked at sometime further down the road. Is that a proper interpretation?

NEIL PICKETT: That would be my opinion. I'm welcome -- I'd welcome the views of the other panelists, but yes.

SENATOR USIE RICHARDS: Okay, do you have an opinion, Dr. Larosa?

DR. JOSEPH LAROSA: Well, I would say that, you know, we kind of started our model of our ACO with our care management with our Medicaid population anyway. We did a lot of projects with ER frequent fliers, with patients that were coming -- that were having basically easy access but so and trying to dive into the social aspects and the behavioral aspects, didn't spend a lot of time. So I think that it's going to carry over. I really do that the ACO concept of the care management is really the key -- it's the glue, that is the glue here.

SENATOR USIE RICHARDS: Of course. Ms. Johal.

KIRAN JOHAL: Okay, I just wanted to piggyback on the comments from Mr. Pickett that I would agree that at the state level right now, there haven't been any legislation come forward or any regulations that have said that they're going to be Medicaid ACOs, but there are a number of states that I think that are toying with the idea and thinking about it. I think part of what makes it difficult is the transient nature at times of the Medicaid population. You can't necessarily measure the in and out, the frequency, and the care that's being delivered there. I think so once we can find or once CMS can think of a way to start measuring that, just like there's a shared-savings for Medicare population right now that they'll potentially move forward and think of ways of maybe to work with states for the Medicaid population as well.

SENATOR USIE RICHARDS: Go right ahead.

NEIL PICKETT: Sorry, but really quickly I do want to emphasize too though that IU health is not unaware of its obligations in this area, that the ACO concept is only part, you know, of what we do. We support and we're affiliated with a federal qualified health center here in Indianapolis, Health Net, and we obviously also are a safety net, we have safety net hospitals at a number of our hospitals in our system. So we certainly are committed to providing care for all people regardless of their ability to pay in our institutions. But in terms of the specific ACO, I think my answer still stands.

SENATOR USIE RICHARDS: Okay, and you're getting me into trouble because all these folks want to ask a question. But you took the opportunity to point out that the Indiana University is also a FQAC, or affiliated with one and so now you're quite familiar with the population that we're speaking of.

NEIL PICKETT: Yes, and in fact they are part of our ACO.

SENATOR USIE RICHARDS: Okay. Delegate Shirley Nathan-Pulliam from Maryland, our second vice chair.

DELEGATE SHIRLEY NATHAN-PULLIAM (MD): Yeah, Delegate Shirley Nathan-Pulliam from Maryland. I just wanted to say to all three of you, excellent presentation. What I wanted to ask, however, in Maryland we have already launched our pilot program, and our pilot program is named the Maryland Patient-Centered Medical Home pilot program and Accountable Care Organization. But one of the things that we have done is that and I personally amended the legislation when it was passed to make sure it addressed racial and ethnic disparities and cultural competence care, and how are you going to be able to get those providers, make sure that the patient-centered medical home is properly diversified? And how are you going to be able to make sure you have providers and patients in that particular center? And luckily for us, we have two institutions, Johns Hopkins University and University of Maryland School of Public Health. And what they have done, we have worked with them to the University of Maryland in setting up the criteria for the cultural competence component of the medical home. And Johns Hopkins School of Public Health, Bloomberg School of Public Health, have developed some measurable criteria to measure cultural competence. You're not just using lip service, but you actually can be measured. And NCQA that I notice you have there and also JCO is going to be looking at those areas to make sure. So I just wanted to make sure I had your thoughts about that in the development of those patient-centered medical home.

And finally to share with you that we have Medicaid, we have five insurance, large insurance companies, and let's see. We have a group. We have five large commercial insurance Medicaid and some self-funded employers that are already involved in our medical home.

SENATOR USIE RICHARDS: Thank you. Anyone with any questions?

DELEGATE SHIRLEY NATHAN-PULLIAM: I just wanted -- I'm asking them if they've thought about how whether or not they in fact addressed those areas.

SENATOR USIE RICHARDS: No disrespect intended, I thought you was giving them information of what exists in the state of Maryland. But does any one of the panelists want to respond to her commentary?

DR. JOSEPH LAROSA: We have definitely take that into account as far as our case managers. We have a very diverse group of case managers. It's a little bit harder I think for diverse providers sometimes and because I think IU has a little bit stronger ability for that because they have the medical school. We at Franciscan Alliance, being a not-for-profit situation still, that's a little bit more challenging. You brought up a great point that I do think we will need to have cultural competency for providers. I think our

hospital is very culturally competent. But the physician providers, physician extenders, I think it brings up a good point for me to take back to my institution. So thank you.

NEIL PICKETT: Yeah, I would just say that this is an important priority for IU Health, that we do work closely with the school of medicine to develop such competencies and to implement them, we have a simulation center that we use to train both medical students, residents, and also practicing doctors and nurses on how to engage and interact with patients in a variety of different settings and patients from a variety of different backgrounds and experiences. So that is an important component, but I think you're very appropriately raising it is something also which we need to be held accountable for. It ought to be, and I believe it is to some extent, it is part of the application, Medicaid asked us to indicate how we would deal with these questions of cultural competence and we provided a plan for them and we need to be held accountable as Medicare reviews our performance over the next few years.

SENATOR USIE RICHARDS: Thank you.

REPRESENTATIVE JOE GIBBONS (FL): Joe Gibbons, State of Florida, state representative. The whole idea I'm getting from this is that we want to deal with cost containment and quality care. So I haven't heard anything where there's a component that deals with treating wellness rather than sickness because, as we all know, if we want to contain our costs, and we got -- if we catch the -- it's more expensive on the sickness part than the wellness part. So where in this medical home model is there some piece that deals with, you know, a reward for dealing with, especially with insurance companies dealing with wellness rather than sickness if in fact we truly want to contain costs?

DR. JOSEPH LAROSA: Well, I think that with the 33 measures for the Medicare ACO, I mean, preventive care is, I think, six or seven measures, maybe even eight. I can't remember what exactly. But the way that that starts is that the physicians will get their report cards and so they'll know how many patients are delayed with getting say, their mammograms or their pap smears or their annual exams, colonoscopies, et cetera.

What we are doing is we then send a list out to the doctors, oh my gosh, you know, these patients in your panel are behind on their mammograms or are behind on their getting their annual lipids, et cetera. So that will be our strategy is just constant dialogue with the physicians, giving them their list, their lists of patients that are -- the non-compliant or just maybe they forgot to even order the tests. That will be our strategy at St. Francis.

REPRESENTATIVE JOE GIBBONS: So then there's an outreach component then?

DR. JOSEPH LAROSA: Yes, oh yes, there is a -- they get a monthly report card of this particular list as of this point is behind, so please get those tests done. The case managers for the complex cases, there's another -- an extension arm of the physician offices where they can then remind Sally, Sue, you know what? I was looking on your list, it looks like you are behind on getting your mammogram. Let's get that done tomorrow. I'll call Dr. whoever, and we'll make sure that that is ordered for you. Everything is all -- having that IT component is so important because when the doctor pulls up that screen on their patient screen, there's best practice alerts. We have that already now. And so they can see that this person is behind with their services. So if they come in for, say, a broken toenail or whatever or sore throat, they know that they're behind in those other services. And it's getting the staff involved and engaged and having that all before them.

What we -- another one of our strategies with the financial stuff with the savings is that we plan on incentivizing office staff members to make sure that those medical assistants are getting and checking for their diabetic foot exams and making sure that those patients are caught up. So they'll have the incentivized also. I mean, that's our strategy. Again, we don't know if it's going to work or not. We may lose our shirt over it, but we think it's going to work.

REPRESENTATIVE JOE GIBBONS: You may lose your shirt but you'll save a lot of lives.

DR. JOSEPH LAROSA: We hope so, thanks.

SENATOR USIE RICHARDS: Any other questions? Let me ask the final question before I do give a wrap up, and I think it's only fair in my mind that we get some sort of response from you, Ms. Johal, as a non-profit-based organization and understanding one of the objectives is doing measurement relative to the provisional care. Given the comparisons that you've made with PPOs, HMOs--all these exist in acronyms and abbreviations--what do you foresee as measurement tools that came out of what can come out of a ACO in regards to the providing of care within a particular jurisdictions and states that we may serve in?

KIRAN JOHAL: So I think there are a number of performance measures that are out there to be considered. I think Dr. Larosa just mentioned the 33 that are put forward for the Medicare shared savings program and the emphasis on prevention. Our measure set also focuses on prevention again, not just for the 65 and older population, but in general. So getting at some of those concepts of wellness. So screenings, colon cancer screenings, breast cancer screenings, Chlamydia screenings, all of that preventive care, LDL, cholesterol, making sure that the organization really is measuring.

I don't know that it will have a number of data sets immediately. I think it's going to take some time to build that data as these infrastructures are being built. But I think the goal is to one day -- right now we have a health plan report card right now that's out there. So if you want to see how your health plan ranks on our performance measures, you can do that. And I think the goal is to, again, use our set of performance measures for an ACO where there's a report card for the ACOs. And you can see how they perform in these key areas. And I think that's really the end game for us as a nonprofit where we're trying to go with ACO and ACO measurement. I believe in our materials I had provided a fact sheet which gives an overview of our perspective on ACOs and also white paper that discusses some of the research that we've done, the folks that we worked with and some of their work on ACOs and gives a primer on ACO.

And I think what we're trying to do at this point is really raise awareness about ACOs, raise awareness about measurement and the importance of forming that infrastructure and the importance of having a nationally standardized set of criteria to measure ACOs on.

SENATOR USIE RICHARDS: Thank you. Could you give a round of applause to Mr. Pickett, Dr. Larosa, and Ms. Johal. We want to thank you for being here, sharing your ideas. We want to thank the participating members, those who are listening via our live stream for participation and listening. And we want to thank the participants for sharing their questions. We appreciate you being here. Thank you very much.

We are going to wrap up with the President of NBCSL Representative, Barbara Ballard. And I do want to say that we would hope that this encounter and the discussion of all three dialogues would have served as a foundation for us to begin to think on some of the activities that should be addressed in making policy within our state legislatures and hopefully it is something that you could take back home with you. Please welcome to the microphone our President, Representative Barbara Ballard. And I'll take that one task off of her shoulder and remind everyone to complete their evaluation sheets so that we could leave it behind with the staff before you leave.

And I've been given another task, and to remind you as soon as the president is finished, we're going to have the photo right here, so please don't leave. Thank you and enjoy the rest of your day.

REPRESENTATIVE BARBARA BALLARD: Thank you, and I do have our chairperson to thank. But since he's standing here, give him a round of applause right now. Thank you. Thank you. I'll make this quickly for us. I will simply say thank you all for participating in this symposium. And I want to thank all of our panelists, our speakers, and our presenters on a job well done.

A special thanks go to our online audience who joined us via webcast. And I hope they enjoyed the presentation as well. We gather here to continue a dialogue on black health, one that started 19 years ago and will continue, God willing, for many more.

Over the course of these 19 years, the world has changed, our communities have changed, and America has changed. We now live in a world full of hope and opportunity, and this carries over into our personal health, medical advancements, and cutting edge technology across the globe, have led to the possibility of healthier lifestyles and better outcomes for patients.

Today we learned a lot. Last night, we started with our heart. We found that our heart controls all of us. We found that our heart makes us feel bad, sick, makes everything better for us. I want to take this opportunity to give a special thanks to our moderators, Dr. Virginia Caine and Senator Usie Richards. And I prompt that last night by saying, he stepped in as our new chair. And I think he did an outstanding job. Thank you again.

I'll say that because you've guided us on our journey helping us to stay the course efficiently and orderly. I want to thank Eli Lilly and Nate Miles for allowing us to have such an enriching experience. And we share the same goal, and that goal is to ensure that all Americans can live a long and healthy life with access to quality healthcare services and products.

I also want to thank Chairwoman Vanessa Summers. She took care of every detail. And you may -- and I think many of you noticed last night, she came rushing in, but she had been to a candidates' forum, but she wanted to come to say welcome, I am here, and I will see you tomorrow. And I found out when somebody needed hot water, she was running for the hot water as well as providing an outstanding lunch for all of us, and all of that takes work.

I would be terribly remiss if I did not acknowledge our NBCSL staff. Lakimba DeSadier Walker for taking -- not even Walker -- Desadier -- for taking care of every detail that needed to be done and a special thank you. And I want her to step forward, Ajenai, I want her to step forward, because Ajenai takes care of every single detail here. And I want to say thank you very much for our program and also to the rest of the staff that were present today and our photographer, be nice to her because she's always around with her camera.

We must remember to work together to break down barriers and remove the disparities that exist by collective and bold leadership. This symposium has provided us with recommendations to forge stronger partnerships with our HBCUs, with other legislatures, the federal government, and the private

sector. We have learned more about how to help our communities access insurance coverage. We have learned that in order to truly care for patients, we must coordinate their care and ensure it is accountable, accessible, and efficient. When it comes to raising our health status through medical innovation, treatment, and delivery, which was part of our theme, there is no shortcut to achievement. One of America's greatest innovators of all time, George Washington Carver, once said, "Where there is no vision, there is no hope." Let me tell you, and I think you all know it, NBCSL has vision.

The National Black Caucus of State Legislators has vision that extends beyond this generation and into the next. And through this dialogue, we assert our hope. When you have past leaders come back to attend your meetings, encourage you on, the organization is doing something right. And we thank Lois DeBerry. Give a round of applause.

I think we have had an outstanding evening and a day. And I hope we take back with us the courage to make changes because there's a move to keep things where they were, and make them worse. And we cannot allow that to happen. That has to be our promise. That has to be our legacy. Other people had to fight, they did, and they achieved. And I think it's our time now to fight and protect what was given to us and to make sure we leave it for others. Thank you so very much for today. Remember the picture up front. We will board the buses after that and we have a reception back at the Weston. Have a good day.