Imagining a World Without Low Value Care: What Will It Take?

October 21, 2019

Meeting Summary

This report summarizes discussions from an October 2019 summit: Imagining a World Without Low-Value Care: What Will It Take? The summit was convened by AcademyHealth, the ABIM Foundation, and the Donaghue Foundation, in collaboration with the Kaiser Permanente Center for Total Health and the Veterans Administration. This meeting summary was written by Timothy Timothy J. Lynch JD, Senior Director of Foundation Programs for the ABIM Foundation. Researchers, policy experts, practicing physicians, funders and other key stakeholders gathered in Washington, DC in October 2019 to plan a route to the ambitious goal of radically reducing low value care. The discussion focused both on the tools that could enable this change (e.g., measurement and data, effective interventions) and how health systems, physicians and others might decide to adopt them (e.g., culture change, alignment of incentives). By the end of the day, significant elements of a five-year agenda became clear.

Introduction

The leaders of sponsoring organizations began the meeting with opening remarks. Lisa Simpson, MB, BCh, MPH, FAAP, the President and CEO of Academy Health, provided background about the meeting and a definition of low value care: "services for which the potential for harm exceeds the possible benefit." Daniel Wolfson, MHSA, the Executive Vice President and Chief Operating Officer of the ABIM Foundation, reviewed the meeting goals and challenged participants not only to help develop recommendations for eliminating low value care, but to work to implement those recommendations when they returned to their institutions.

Measurement and Data

The meeting's first panelists explored measurement and data issues. Eve Kerr, MD, MPH, a professor at the University of Michigan Medical School, opened her presentation by talking about the patients she sees as a general internist at the Ann Arbor VA. She said that many who are there for a second opinion arrive with a stack of data, much of it generated from inappropriate tests. She said she sees in her patient panel both the opportunities and challenges involved in the effort to eliminate low value care.

Dr. Kerr said a major challenge is that many more performance measures address underuse than overuse. However, this disparity offers the opportunity to identify impactful targets for measures based on Choosing Wisely recommendations and the larger body of research about overuse. She recommended a systematic approach to identifying targets, including looking at performance gaps, the impact of decreasing the use of a service on quality and harm, as well as cost. Dr. Kerr also proposed balancing existing underuse performance measures with overuse measures, showing, for example, where screening should happen and where it should not. She also noted that measures are often driven by the availability of data, when they should be driven by clinical context.

Dr. Kerr said we cannot expect perfection from measures. In evaluating whether they are "good enough," she suggested considering unintended consequences of measure construction, including whether a measure might inadvertently incentivize underuse.

She also stressed the importance of not simply relying on claims data in measure construction, with a particular appeal for incorporating patient reported information and patient preferences. She said that claims data works best for tests and treatments that should never or rarely be performed, or should never be repeated. For areas where symptoms determine whether a test or treatment is appropriate, patient information is critical.

Finally, she said that while we typically use measures retrospectively, we should employ them more effectively to motivate future change and deliver better recommendations at the point of care.

Beth Bortz, the President and CEO of the Virginia Center for Health Innovation (VCHI), spoke about the statewide project VCHI is leading to reduce overutilization. The project includes 7,000 clinicians and focuses on seven measures with regular data sources that can be tracked over time, and is enabled by the state's all payer claims database. Ms. Bortz said they started with low hanging fruit – things that providers were getting wrong a lot.

"We start out assuming that everyone has the best intentions of providing good care," Ms. Bortz said. Participating clinicians receive quarterly utilization reports, and project leaders challenge them to come up with solutions to reduce unnecessary care. Ms. Bortz said that wide variations in utilization often stem from system failures. For example, she cited a physician who found his ordering rates for Vitamin D screening impossible to believe, until he learned that the test was included in a bundled lab at his system. Finally, Ms. Bortz said the project leaders were monitoring unintended consequences to make sure that necessary care was not being reduced.

Margaret O'Kane, MHSA, the President of the National Committee for Quality Assurance, spoke about how performance measurement can contribute to eliminating low value care. She called measurement a tool, not a strategy, and said showing physicians that they are outliers can achieve only limited good. To succeed, she said we need a health care system with properly aligned incentives and benefits design that prompts virtuous behavior, rather than a system in which high deductibles stand in the way of primary care and leave specialty care untouched. She said the re-engineering of care delivery is essential. She described our current reality as a care system with a foot in each canoe, divided between the old fee for service system and the new territory of value-based care.

Small Group Discussion on Data and Measurement

Participants divided into groups to define barriers to and opportunities for progress, consider important players and propose solutions.

Dr. Kerr said that the group worked toward an end goal of having easily accessible and routinely collected patient reported data in support of good measures. They called for measures that are relevant not only to care delivery but to health care more globally.

They described a variety of barriers, including regulatory and technological barriers to data integration, a lack of leadership, and financial issues (both who would pay for research and measure development and the continuing incentive to do more, not less). They also noted that acquiring data can burden patients and providers, and that issues around data validity can limit buy-in from clinicians and patients who doubt the evidence that underlies measures. Finally, they noted that no one in the health care system is communicating effectively about measures.

Areas for progress included the development of an infrastructure for All Payer Claims Databases and opportunities for transparency to facilitate public attention. The creation of common data models to facilitate the integration of clinical, EMR (electronic medical record) and claims data, in coordination with the patient advocate community and technology companies, offers another opportunity.

The group said that key players are patients, providers, purchasers, researchers, policymakers, data managers, and funders. They described the following as priority topics:

- Eliminating measures that aren't that valuable, actionable, or salient
- Harmonizing and standardizing data and measurement
- Developing patient-reported outcome and experience measures to gain information about symptoms and goal attainment
- Create a research agenda linked to actionability for stakeholders
- Develop better measures of harms
- Create agenda around all dimensions of health disparities

Effective Interventions

Carrie Colla, PhD, Assistant Professor at the Dartmouth Institute for Health Policy and Clinical Practice, began this session with an overview of her research on the effectiveness of interventions to reduce low value care. She cited patient-side interventions such as cost sharing, value-based insurance design (VBID), patient education and provider report cards. Clinician-side interventions included pay for performance, prior authorization, risk-sharing arrangements, clinical decision support (CDS), education and feedback.

Dr. Colla noted that in her 2016 systematic review ("**Interventions Aimed at Reducing Use of Low-Value Health Services: A Systematic Review**"), which analyzed studies published through 2015, the interventions that had the best evidence of effectiveness included CDS, education and multicomponent interventions. Successful multicomponent interventions were most common in hospital settings.

She said that there have been nearly 2,000 articles on interventions to reduce low value care since 2015, with about half of those focused on provider report cards. She highlighted a set of findings from those articles:

- CDS: displaying information to clinicians about the price to the patient of a particular test doesn't reduce imaging rates
- Patient cost sharing: increased medication adherence associated with VBID; high deductible health plans reduce appropriate use
- Patient education: patient knowledge of and attitudes toward clinical guidelines are low; brief written decision support unlikely to change patient intentions regarding low value screening
- Clinician education: precommitment led to small but unsustained reductions in low value care
- Insurer restrictions: payer utilization review reduced low value care for back pain, costs and disability claims
- Multicomponent interventions effective to reduce opioid use, C-Sections

Christopher Kolker, MD, Medical Director at United Community and Family Services (UCFS) Healthcare, spoke about how patient-directed posters were surprisingly successful in engaging patients in his Connecticut system. He said UCFS also educated its clinicians about Choosing Wisely.

Ellen Albritton, JD, Senior Policy Analyst at Families USA, provided a patient perspective. She suggested that patients and consumers want relief not only from high prices, but also from a system they feel does not listen to them or have their best interests at heart. She said that avoiding low value care doesn't always resonate with patients, who may think the effort mainly affects the financial health of clinicians and insurers. She suggested a few approaches that could motivate consumers, such as appealing to health equity and stressing the long-term risks to the system if the problem of low value care is not addressed. Ms. Albritton said it would be useful for researchers to study particular high value and low value services for women, people of color, and people with disabilities, rather than focusing on the "mythical average."

Shannon Brownlee, MSc, Senior Vice President at the Lown Institute, said that we do a poor job of collecting data about harm, making it difficult to understand how much harm overuse causes and to define whether a test or treatment is an example of low value care. Dr. Colla responded that harm is difficult to quantify but that we would benefit from more systematic patient-reported outcomes about harm.

Small Group Discussion on Effective Interventions

Dr. Colla said the group had agreed on an end goal of ongoing improvement in research paired with the political will to implement, scale and sustain interventions to reduce low value care, sparking a movement among all key stakeholders.

The barriers they recognized included a lack of evidence for outcomes, outdated payment structures, time constraints, and a lack of shared values and leadership.

The group saw opportunities in prioritizing collaborative multi-stakeholder efforts, in payment alignment through interventions such as VBID, CDS and patient-reported outcome measures, and in initiatives that can scale and spread, such as projects in large health systems.

The group said national and local employer groups were good places to start, and also mentioned payers such as the Centers for Medicare & Medicaid Services (CMS), clinicians and administrators at health systems, patient and advocacy groups, regional health collaboratives, medical journalists and funders.

They described priority topics that included:

- improving research about and understanding of how we communicate and engage with patients and consumers, including how we communicate:
  - about harms,
  - with members of groups that have reason to distrust our system
  - with complex patients who have high service usage
- improved research in areas where there is still ambiguity about whether something is a low-value service
- placing all of this in a systems framework that does not depend on improved individual decision-making to eliminate low value care

Culture Change

Dhruv Khullar, MD, MPP, Assistant Professor at the Weill Cornell Department of Healthcare Policy and Research, spoke about the importance of culture change in the effort to eliminate low value care. He offered a variety of definitions of culture, including:

- A set of shared values and norms by which an organization operates
- A consistent, observable pattern of thinking and behavior
- An organization's collective story about who and what they are

He noted that systematic reviews have shown that a positive organizational culture is associated with positive patient outcomes. Developing such a culture, though, requires vision and leadership.

Dr. Khullar offered the Leadership Saves Lives (LSL) program as a case study. Motivated by disparities among hospitals in how they treated heart attacks, the program, which was led by Leslie Curry, PhD, a senior research scientist in health policy and management at the Yale School of Public Health, sought to train clinical leaders from 10 hospitals to change their institutions' culture. Each hospital developed a guiding coalition that included 15 members who were involved in treating patients who had myocardial infarctions (MI). The LSL program supported the coalitions through an annual meeting, workshops, and other programming.

Six of the 10 hospitals experienced significant culture change, particularly in creating a learning environment and the involvement of senior management. Their use of evidence-based strategies for treating MI increased, and they achieved large reductions in mortality rates. The predictors of successful culture change included the professional diversity of the coalition members, authentic participation in the program, and better conflict management.

Dr. Khullar concluded by saying that culture change has both tangible and intangible benefits, that it is difficult but possible, and that it requires strong leadership, clear vision, authentic participation and diverse coalitions.

Vivek Garg, MD, MBA, the Chief Medical Officer at CareMore Health, said that CareMore focuses on the concept that "change happens at the speed of trust." He said the baseline they are seeking to change is that patients are unclear about their care and even about procedures they are about to undergo. The health care system makes it difficult to change this, with bifurcated care provided by primary care physicians and specialists and a lack of time for physicians to spend with patients and develop relationships. CareMore reduced physicians' daily patient load to enable 30-45 minute visits and a better focus on care coordination. Dr. Garg said that clinicians at CareMore talk explicitly with patients about the harm of unnecessary care, in pursuit of their mission of delivering high value care to the most vulnerable patients with humanity and integrity.

Tara Montgomery, the Founder and Principal of Civic Health Partners, said that addressing the "culture barrier" is essential to improving value in health care. She said that her experience at Consumer Reports taught her that storytelling really makes a difference in culture change. She stressed finding ways to bring people into the room who feel left behind. She also emphasized the importance of leadership and psychological safety. Finally, she noted the potential negative impact of the larger societal culture of mistrust and the rise of medical misinformation on public trust in the effort to eliminate low value care.

Small Group Discussion on Culture Change

This group described structural, technical, financial, historical and psychological barriers to the desired end goal of culture changes that enable the elimination of low value care. They included the failure of leadership to model change, the difficulty of measuring culture, the expectation that doctors should be "doing something" rather than watchfully waiting, and a fear of uncertainty.

They described opportunities for achieving buy-in from senior leaders and recruiting clinician champions; focusing on 'easy wins' to gain attention; aligning payment models in support of the change we want to see; more effectively educating patients about the benefits of eliminating low value care; providing actionable and transparent data and rapid cycle feedback to clinicians; and increasing transparency around how health care stakeholders make decisions.

This group's priority audience would be clinicians and system leaders. Their primary levers for change would include communication and storytelling and the use of universal concepts like trust and reforming the payment system. They stressed the importance of diversity and inclusion, and ensuring meaningful patient involvement. They also called for flattening the hierarchy within the medical system, including a call for more leadership from residents. Key partners would include employers, payers, unions, and community leaders.

Alignment of Financial Incentives

Kevin Volpp, MD, PhD, Distinguished Professor of Medical Ethics and Health Policy at the University of Pennsylvania, provided an overview of what we know about using provider payment as a tool to move from volume toward value. He said that although there have been bright spots, such as the use of bundled payment for surgical procedures, financial incentives have only delivered modest savings thus far. He offered a number of reasons for that, including:

- The continuing incentive for even physicians in accountable care organizations to generate RVUs (relative value units) due to internal budgeting pressure
- The small size and complex formulas of most performance incentives
- A lack of attention to behavioral biases in design, such as the lack of immediate feedback and the need to hit high thresholds to receive rewards rather than being rewarded for improvement

He suggested increasing the salience of incentives by providing them directly to physicians, applying them to fewer measures for a meaningful percent of income (e.g., 10 percent), rewarding physicians for improving rather than hitting a set target, and employing social comparisons and recognition. He also proposed an appropriateness modifier that would adjust payment, including downside risk, based on a physician's use of unnecessary care.

Kate Goodrich, MD, MHS, the Director and Chief Medical Officer of the Center for Clinical Standards and Quality at the Centers for Medicare & Medicaid Services (CMS), said she sees low value care

as a quality and safety issue, and believes that addressing it requires fundamentally changing the payment system. She said payers need to put resources and time into working together to structure and align incentives and to select a core set of measures worthy of focus.

Dr. Goodrich also said that clinicians want to provide high value care and do not always know when they are providing low value care. She said that CMS is thinking about resources it can provide to help systems and clinicians take on risk and move away from fee for service.

Michael Thompson, the President and CEO of the National Alliance of Healthcare Purchaser Coalitions (NAHPC), said that employers have not seen meaningful reductions in waste in recent decades, and suggested that fundamental change is required, primarily in payment. He said that NAHPC is focused on advanced primary care and episodes of care bundles. He listed five principles behind their episodes of care work:

- Creating common episode definitions among employers
- Improving quality and appropriateness of care, not just saving money
- Double sided risk
- Warrantied performance: employers should not pay twice for the same health service
- Relevance for patients, purchasers and providers

Mai Pham, MD, MPH, Vice President, Provider Alignment Solutions at Anthem, said she agreed that innovative designs can be undermined if they are installed on top of underlying signals that provide incentives for low value/high margin services even in a capitated environment. Richard Baron, MD, the President and CEO of the American Board of Internal Medicine and the ABIM Foundation, asked the panelists for any examples of institutions that have creatively addressed this disconnect. Dr. Goodrich said that CMS was currently digging into the data from its recently concluded Transforming Clinical Practice Initiative, and was hoping to find such examples.

Small Group Discussion on Alignment of Financial Incentives

This group worked toward a goal of evidence-based and rigorously tested payment incentives and benefit designs, which would be accompanied by nonfinancial incentives. They expressed wariness about incentives that have unintended consequences such as cherry picking.

The barriers they mentioned included a lack of political and institutional leadership, the complexity of the current system, uncertain interactions between financial and nonfinancial incentives, and limited understanding of the effectiveness of existing incentives.

The group saw opportunities for meaningful research and evaluation of what works, for more effectively using incentives to address social determinants of health, and for capturing innovations in the states and working to align multi-stakeholder organizations, government and employers.

The priority topics and populations they highlighted included:

- Evidence: there are hundreds of approaches, and few are being evaluated in any meaningful way. A systematic assessment of the evidence is critical.
- High utilizing providers: it would be useful to understand providers who are doing well and doing poorly, and why.
- Alignment of payer and provider incentives
- Determining how a trend toward a complicated system of incentives does not disproportionately harm entities that care for vulnerable populations
- High-risk patients: focus on continuity of care outside the hospital and appropriate sites of care

The group agreed that a wide array of actors need to be involved in an effort to use incentives more effectively. The top five were payers, patients, employers, clinicians, and elected officials.

Creating and Sustaining a Transformative Change

The afternoon session began with presentations from two speakers who have worked on creating and sustaining efforts to eliminate low value care. Adam Elshaug, PhD, MPH, Professor of Health Policy at the University of Sydney, said that we understand drivers of unnecessary care, including cognitive biases, perverse incentives, media hype, fear of uncertainty and of litigation, and power imbalances between clinicians and patients. We are less clear, however, about the interaction between these drivers, and which interactions compound the problem more.

He described the effort to eliminate low value care as a funnel. The largest group of clinicians can be persuaded by making it easier for them to eliminate low value care, an additional cohort by making it normative, another by making it rewarding, and the remainder by making it required.

Pamela Johnson, MD, Vice Chair of Quality and Safety, Department of Radiology at Johns Hopkins Medicine, discussed the need for multiple stakeholders to engage to reduce health care costs, with each doing "what only they can do." What physicians can do, she said, is to change the care they deliver to a patient, with the recognition that they are accountable for at least half of the waste in the system.

At Johns Hopkins, Dr. Johnson said leaders have sought to improve care by facilitating evidence-based practice, using clinical pathways and guidelines to make sure that tests and treatments are appropriate. She discussed the barrier of entrenched clinician ordering and prescribing behavior, using as an example how half of academic medical centers are still treating chest pain in the emergency department by using tests that decade-old research showed were unnecessary.

To combat this, physicians at Johns Hopkins started the Things We Do for No Reason project to eliminate tests and treatments that add no value, saving more than $7 million in unnecessary care between 2017-19. They created their own guidelines and included them in the electronic medical record. "If physicians design something themselves, they're more likely to be engaged," Dr. Johnson said. To be successful, she said it was also important to understand the biggest burdens to patients.

Inspired by this work, Johns Hopkins led the creation of the High Value Practice Academic Alliance, which 100 partners in the US and a few outside it have joined. Members must commit to implement one high-value quality improvement project, which must improve patient safety while reducing costs. The American Hospital Association has joined, expanding the alliance's reach beyond teaching hospitals.

Dr. Simpson noted that research published by a particular academic medical center often fails to change behavior even within that academic medical center. Dr. Kerr said the University of Michigan has focused on this challenge, which ultimately comes down to funding. Dr. Johnson said that Johns Hopkins has funded her project to propel guidelines across the system, and that it is difficult to find external funding for that purpose.

Conclusion: Setting an Agenda

The meeting closed with a panel whose members each offered their views about the most important priorities moving forward.

Dr. Volpp commented that the U.S. leads the world in health care spending but stands 36th in life expectancy. He suggested five main opportunities to address both:

- Building more and better evidence about what works
- Joint ventures among payers, providers and social agencies to design interventions that can then be evaluated
- Employers stepping up their pressure for better health without increased spending
- Working with state elected officials, who could seek Medicaid waivers to experiment with new initiatives
- Work with EMR manufacturers to reduce overuse through order sets in their software

Dr. Kerr's priorities were:

- Moving our focus beyond individual health systems to the broader community
- Align incentives across all systems of care and at all levels, with participation from industry, government, specialty societies, employers and payers
- Commitment from leaders at all levels
- Keeping patients front and center, which will restore joy in medicine for clinicians
- Measure, test and evaluate where we have problems and what works in fixing them; continue to develop better measures and evaluation methods

Dr. Khullar proposed the following priorities:

- Research and Data: Develop measures focused on overuse, and integrate social, clinical and EMR data into measures
- Culture change: The average clinician and patient still do not view the elimination of low value care as a major priority; we need concerted efforts to raise the profile of the issue.
- Understanding patients better: Patients want relief from a system that doesn't listen to them. We should frame discussions of low value care around health promotion and be able to explain why it matters for patients.
- Payment reform: We need to work toward financial models that make it easy to do the right thing; when organizations are losing revenue, progress is a challenge.
- Find champions and the right messengers

Finally, Gwen Darien, Executive Vice President of Patient Advocacy and Engagement at the National Patient Advocate Foundation proposed:

- Assuming good intentions among clinicians, patients and other stakeholders
- Develop a consensus of what value means
- Eliminating disparities by increasing high value care
- Enhance bidirectional trust between patients and physicians
- Change public health messages to emphasize high value care

Summit: Imagining a World Without Low-Value Care: What Will It Take?

Convened by AcademyHealth, the ABIM Foundation, and the Donaghue Foundation, in collaboration with the Kaiser Permanente Center for Total Health and the Veterans Administration

October 21, 2019
9:00am – 5:00pm ET
KP Center for Total Health
700 Second St. NE; Washington, DC 20002

Agenda

Background

Stakeholders across healthcare, policy, and research are working to advance research, policy and practice efforts to tackle low-value care. The question before us is: What next? Where are the gaps in knowledge that we need to fill? What are the barriers to future progress?

Summit Goals

- Highlight the state of the field of low-value care research and showcase recent progress;
- Define an agenda for the next five years; and
- Support increased multi-stakeholder collaboration and community-building.

Objectives

Focus on the following areas:

- measurement and data;
- evidence of effective interventions;
- culture change; and
- alignment of financial incentives.

Format

The day will use a blend of brief presentations and reactions on each of the four topics above followed by general discussion and then rotating workgroup discussions in a world café format. Time is allocated for reporting out on all four topic areas from the workgroup exercise. We will end the day with open mic contributions kicked off by four speakers.

9:00-9:30 **Breakfast and Registration**

9:30-9:40 **Welcome and Overview of the Day**
Lisa Simpson, AcademyHealth; Daniel Wolfson, ABIM Foundation; and Nancy Yedlin, Donaghue Foundation

Focus of the Morning: What Do We Know About What to Do?
Moderator: Lynne Garner, Donaghue Foundation

9:45-10:15 **Measurement and Data**
Speaker: Eve Kerr, University of Michigan

Reactors
- Margaret O'Kane, National Committee for Quality Assurance
- Beth Bortz, Virginia Center for Health Innovation

– Audience Discussion

10:20-10:50 **What Works to Reduce Low-Value Care (evidence on interventions)**
Speaker: Carrie Colla, The Dartmouth Institute for Health Policy and Clinical Practice
Reactors
- Christopher Kolker, United Community and Family Services (UCFS) Healthcare
- Ellen Albritton, Families USA

– Audience Discussion

10:50-11:00 **Introduction to Groups**
Daniel Wolfson, ABIM Foundation

11:00-11:15 **Break**

11:15-12:15 **World Café - Working Group Session**
Four workgroups focus on Measurement and Data: The session will begin with a large group discussion that includes all four workgroups to explore the desired end state for this topic. The large group will then break into four workgroups around the room where each workgroup rotates through a set of four strategic thinking questions respectively, focused on: barriers, opportunities, key players, and priority topics/populations.

Four workgroups focus on What Works to Reduce Low-Value Care: The session will begin with a large group discussion that includes all four workgroups to explore the desired end state for this topic. The large group will then break into four workgroups around the room where each workgroup rotates through a set of four strategic thinking questions respectively, focused on: barriers, opportunities, key players, and priority topics/populations.

12:15-12:35 **Report Out - Moderator: David Atkins, Veteran's Administration**
Facilitators from Measurement and Data share key points
Facilitators from What Works to Reduce Low-Value Care share key points

12:35-1:05 **Lunch (get food and sit)**

1:05-1:40 **Keynote – How to Create and Sustain Transformational Change - Moderator: Murray Ross, Kaiser Permanente**
Adam Elshaug, USC-Brookings Schaeffer Initiative for Health Policy
Pamela Johnson, Johns Hopkins Medicine
Audience Discussion

Focus of the Afternoon: What Needs to Happen to Facilitate Change? -
Moderator: Daniel Wolfson, ABIM Foundation

1:40-2:10 **Culture Change**
Speaker: Dhruv Khullar, Weill Cornell Department of Healthcare Policy and Research

Reactors
- Vivek Garg, CareMore Health
- Tara Montgomery, Civic Health Partners

– Audience Discussion

2:15-2:45 **Alignment of Financial Incentives (motivations)**

Speaker: Kevin Volpp, University of Pennsylvania

Reactors

- Kate Goodrich, Centers for Medicare & Medicaid Services
- Michael Thompson, National Alliance of Healthcare Purchaser Coalitions

– Audience Discussion

2:45-3:00 **Break**

3:00-4:00 **World Café - Working Group Session**

Four workgroups focus on Culture Change: The session will follow the same format as the morning.
Four workgroups focus on Alignment of Financial Incentives: The session will follow the same format as the morning.

4:00-4:20 **Report Out - Moderator: Leslie Tucker, ABIM Foundation**

Facilitators from Culture Change share key points

Facilitators from Alignment of Financial Incentives share key points

4:20-5:00 **Closing - Focus on the Future: Setting an Agenda (open mic)**

Moderator: Richard Baron, ABIM Foundation
Speakers will kick-off with lightning reflections on “What is the future agenda?”

- Eve Kerr, University of Michigan
- Dhruv Khullar, Weill Cornell Department of Healthcare Policy and Research
- Kevin Volpp, University of Pennsylvania
- Gwen Darien, National Patient Advocate Foundation - 3 minutes

Open mic: What is the future agenda?

Participants

Bill Adams
Consultant
Baby Boomers for Balanced Health Care

Ellen Albritton, JD
Senior Policy Analyst
Families USA

Paul Armstrong
Research Assistant
AcademyHealth

David Atkins, MD, MPH
Director of HSR&D
Veterans Health Administration

Eric Barbanel, MD
Practicing Internist
Crystal Run Healthcare

Richard Baron, MD
President and CEO
ABIM Foundation

Mary Barton, MD
Vice President
National Committee for Quality Assurance (NCQA)

Kate Berry, MPP
SVP; Clinical
American Health Insurance Plans (AHIP)

Arlene Bierman, MD, MS
Director of Center for Evidence and Practice Improvement
Agency for Healthcare Research and Quality (AHRQ)

Beth Bortz, MPP
President and CEO
Virginia Center for Health Innovation

Marc Boutin, JD
CEO
National Health Council

Danielle Brooks, JD
Director, Health Equity
AmeriHealth Caritas

Shannon Brownlee, MSc
Senior Vice President
Lown Institute

Michael Budros, MPP, MPH
Senior Policy Analyst
VBID Health

Helen Burstin, MD, MPH, FACP
Executive Vice President and CEO
Council of Medical Specialty Societies

Al Charbonneau, MA
Executive Director
Rhode Island Business Group on Health

Alyna Chien, MD, MS
Assistant Professor of Pediatrics
Harvard Medical School

Steven Clauser, PhD, MPA
Director, Healthcare Delivery and Disparities Research Program
PCORI

Betsy Cliff, PhD
Assistant Professor
University of Illinois at Chicago

Carrie Colla, PhD
Assistant Professor
Dartmouth Institute for Health Policy and Clinical Practice

Ceci Connolly
President and CEO
Alliance of Community Health Plans

Elizabeth Cope, PhD, MPH
Senior Director of Public and Population Health
AcademyHealth

Gwen Darien
Executive Vice President, Patient Advocacy and Engagement
National Patient Advocate Foundation

Robert Dressler, MD, MBA
Quality and Safety Officer, Academic and Medical Affairs
Christiana Care

Adam Elshaug, PhD, MPH
Professor of Health Policy
The University of Sydney and Brookings Institution

Vivek Garg, MD, MBA
Chief Medical Officer
CareMore Health

Lynne Garner, PhD
President & Trustee
Donaghue Foundation

Karen George, MD, MPH
Senior Fellow, Women's Health Policy
Institue for Medical Innovation

Roshni Ghosh, MD, MPH
Vice President and Chief Medical Information Officer
Premier, Inc.

Kate Goodrich, MD, MHS
Director and Chief Medical Officer
Center for Clinical Standards and Quality, Centers for Medicare & Medicaid Services

Paul Grady, MBA
Principal
Alera Group

Reshma Gupta, MD, MSHPM
Co-Director
Costs of Care

Emma Hoo,
Director of Value-Based Purchasing
Pacific Business Group on Health

Pamela Johnson, MD
Vice Chair of Quality and Safety, Department of Radiology
Johns Hopkins Medicine

Hunter Kellett, MPA
Director of Payment Reform
Arnold Ventures

Eve Kerr, MD, MPH
Professor
VA Ann Arbor Healthcare System and University of Michigan

Marya Khan, MPH
Senior Manager
AcademyHealth

Dhruv Khullar, MD, MPP
Physician and Assistant Professor
Weill Cornell Department of Healthcare Policy and Research

Tracey Koehlmoos, PhD
Professor
Uniformed Services University of the Health Sciences

Christopher Kolker, MD
Medical Director
United Community and Family Services (UCFS) Healthcare

Debbie Korenstein, MD
Director of Clinical Effectiveness and Chief, General Medicine Service
Sloan Kettering

Sarah Krug, MS
CEO
Cancer101

Jeff Kullgren, MD, MPH, MS
Assistant Professor, Department of Internal Medicine
University of Michigan and VA Ann Arbor Healthcare System

Danielle Lloyd, MPH
SVP, Market Innovations & Quality
American Health Insurance Plans (AHIP)

Tim Lynch, JD
Senior Director of Foundation Programs
ABIM Foundation

Matt Maciejewski, PhD
Professor and Research Career Scientist
Duke University Medical Center and Durham VA Medical Center

Katie Martin, MPA
Professor and Research Career Scientist
Health Cost Containment Institute

Shannon McMahon, MPA
Executive Director Medicaid Policy
Kaiser Permanente

David Meltzer, MD, PhD
Chief, Section of Hospital Medicine
University of Chicago

Mark Miller, PhD
Executive Vice President
Arnold Ventures

Penny Mohr, MA
Senior Advisor
PCORI

Tara Montgomery
Founder and Principal
Civic Health Partners

Dan Morgan, MD, MS
Professor of Epidemiology and Infectious Disease
University of Maryland Baltimore

Darilyn Moyer, MD, FACP
Executive Vice President and CEO
American College of Physicians

Amol Navathe, MD, PhD
Assistant Professor
University of Pennsylvania

Margaret O'Kane, MHSA
President
National Committee for Quality Assurance (NCQA)

Monica O'Reilly-Jacob, PhD, RN, FNP-BC
Assistant Professor of Nursing
Boston College

Orestis Panagiotou, MD, PhD
Assistant Professor
Brown University

Susan Perez, PhD, MPH
Assistant Professor
California State University, Sacramento

Mai Pham, MD, MPH
Vice President, Provider Alignment Solutions
Anthem Inc.

Caroline Picher, MPH
Policy Analyst
National Governors Association Center for Best Practices

Eva Powell, MSW
Senior Manager, Quality Programs
Alliance of Community Health Plans

Louise Probst, RN
Executive Director Medicaid Policy
St. Louis Area Business Health Coalition

Lynn Quincy, MA
Director
Altarum

Kelly Rand, MA, CPH
Program Officer
ABIM Foundation

Carmen Reyes,
Director of Community Relations and Outreach
UCLA

Eugene Rich, MD
Senior Fellow
Mathematica

Meredith Roberts, MPH
Executive Director, Oregon
Comagine Health

Deborah Roseman, MPH
Principal Project Specialist
America's Essential Hospitals

Murray Ross, PhD
Vice President
Kaiser Permanente

Sameer Saini, MD, MS
Acting Director and Associate Professor
VA Center for Clinical Management Research / University of Michigan

Catherine Sarkisian, MD, MSHS
Professor and Staff Physician
UCLA

Lucy Savitz, PhD, MBA
Vice President, Health Research
Kaiser Permanente Northwest

Richard Shonk, MD
Chief Medical Officer
The Health Collaborative

Lisa Simpson, MB, BCh, MPH, FAAP
President and CEO
AcademyHealth

Daisy Smith, MD
Vice President, Clinical Programs
American College of Physicians

Denise Smith, MBA, CHW, PN
Research Associate and Projects Manager
UConn Health Disparities Institute

Christopher Stanley, MD, MBA
Chief Population Health Officer
Sutter Health

Scott Sussman, MD
Senior Medical Director, Clinical Operations
Yale New Haven Heallth

Michael Thompson
President and CEO
National Alliance of Healthcare Purchaser Coalitions

Leslie Tucker, MPH
Consultant
ABIM Foundation

Janice Tufte
Patient Partner
Hassanah Consulting

Marianne Udow-Phillips, MHSA
Founding Executive Director
Center for Health Care Research and Transformation

Ryan Vega, MD
Diffusion of Excellence Lead
Veterans Adiministration

Navin Vij, MD, MSHP
Senior Clinical Investigator
Cristiana Care Health System

Kevin Volpp, MD, PhD
Distinguished Professor, Medical Ethics and Health Policy
University of Pennsylvania

Scott Weingarten, MD, MPH
Consultant and CEO
Cedars-Sinai Health System

Kimberly Westrich, MA
Vice President;,Health Services Research
National Pharmaceutical Council

Daniel Wolfson, MHSA
Executive Vice President and COO
ABIM Foundation

Nancy Yedlin, MPH
Vice President
Donaghu Medical Research Foundation