

***Redefining Health Care:  
Competition and Patient Value within Leading Organizations***  
**A NEHI Webinar with Professor Elizabeth Teisberg**  
**June 25, 2008**

**Valerie Fleishman, Executive Director, NEHI:** We have a terrific group of folks in the audience today and really true to NEHI, we have representatives from health care delivery, from medical schools, hospitals, primary care; we have suppliers, manufacturers, health IT companies, health plans, and others, and we're really anticipating a lively and interactive discussion.

So let's get started. We here at NEHI are just thrilled to be joined today by Professor Elizabeth Teisberg. Professor Teisberg is a professor of business at the University of Virginia's Darden School of Business and a true expert in innovation in healthcare, which is near and dear to NEHI's heart and mission. She's also co-author with Michael E. Porter of the book, *Redefining Healthcare* – a book that I'm sure many of you are familiar with and is really transforming the way people think about and practice healthcare to drive value competition and ultimately, better health across the healthcare system.

As many of you may recall, when *Redefining Healthcare* was first published, back in 2006, Michael Porter came and led a lively and productive discussion with our members around the concept of value-based competition. And our members were so excited by the ideas described in the book, that many of them wanted to know, right then and there, how to put the principles of value-based healthcare in practice with their own patients at their own health plans with employees, and in developing and selling their own products; they really wanted to know how to make it happen. And on the heels of that discussion, in 2006, we asked Elizabeth Teisberg to join NEHI as a Senior Fellow, so that she could continue her work on redefining healthcare, answering some of our members questions and identifying examples of how and where value-based healthcare is working today, what's making it work and what the results are.

Elizabeth's work has been a terrific tie-in to NEHI's mission of bringing value to patients through innovation in healthcare and we're delighted that she's here with us this afternoon to share with us her findings from her work over the past two years on creating a high-value healthcare system. She'll discuss with us what it takes to organize healthcare around patient value, which organizations are doing it well, and what the key success factors are. And then after her presentation, we'll open it up to all of you for a conversation and discussion. And with that now, I'll turn it over to Professor Elizabeth Teisberg; Elizabeth?

**Professor Elizabeth Teisberg:** Super. Okay, we can advance a slide. So first I want to say thank you, thank you to Valerie, and thank you to NEHI. I'm going to talk about a small fraction of a lot of work that we've been doing really over the last two years. And the truth is, NEHI's support has allowed us, me in particular, to do a lot more because it has directly reduced my teaching role here so I can focus my teaching on these ideas, rather than on having to do these and two other courses as well.

It's been tremendously helpful in keeping up with the momentum that has been developing and it just seems to keep building and building. Valerie asked me to talk for about 20 minutes. There's no way in 20 minutes I can tell you about everything that's been going on. So what I'll focus on, as Valerie said, is some of the work we've been doing to support organizations implementing these ideas and these activities.

So what I have on this slide (**slide two**) is, at the top, is some of what I'm going to talk about, some of the implementation work and the material for executive courses and advisory work that we've been doing. And then I won't talk as much about the papers, and the additional research projects, that we have going which are the list on the bottom part of this page. I will tell you, if there are things on those lines that you want to talk about, we've either got a few minutes in the Q&A, or you can reach me otherwise through NEHI or directly.

So we can move to the next one (**slide three**). As you know this work is about the transition to a high value health system and we talked before about what this means in terms of the characteristics of the system as it is and the characteristics of what a high-value health system would be. So where we've been focused on this is more on the question of: So what does this look like in practice and what insights emerge? How do organizations align strategy with value rather than with cost reduction and waste reduction? And how can financial success be aligned with patient success? So we've been looking more that those, you can turn, those questions.

(**Slide four**) So very broadly speaking, the guideposts for dramatic and ongoing improvements are redefining the goal to be explicitly about increasing value for patients, which means thinking about the organization and about innovation from a patient perspective and then redesigning delivery and care around full care cycles rather than around procedures or around portions of care cycles for the combinations of medical circumstances that people experience. So rather than around a piece view of the system, around care the way people actually experience it.

The third is actually results at the level at which value is created for patients cause what you make sure is going to improve, you want to be focused on things at the level at which value is actually created. And then finally, the last of these big ones is aligning reimbursement with restructured delivery and value. Which requires having taken some of the steps above. We often hear people say, well don't we need to wait for that to happen first? You can't really make that happen first, you need to be taking steps at least simultaneously. So that's a mouthful, you can go to the next slide. And in 20 minutes I can't give you detail on all, what I'll do is touch on each of these, as we go along with some notion of some of the cases and examples that we've been developing.

(**Slide five**) So the first one, redefining the goal, thinking in terms of the patient centered, family centered care – we can go forward to the next one.

(**Slide six**) We're thinking in terms of patient-centered and family-centered care. The first thing to notice is that if we want to, even if you're thinking what we really want to do is achieve lower costs, the best way to do it is by achieving better health because it's less expensive to live in good health than in poor health. Particularly, when you're thinking across the full cycle it's easy to see. And we've talked, both Mike [Porter] and I, have talked to NEHI members about these

concepts but what the cases show, robustly, case after case seems to be that the successful organizations do think about reducing waste but they think about more than reducing waste. And they do worry about streamlining parts of a fragmented system, but they go beyond streamlining the parts. They are thinking about redefining across the care cycle, so across parts of care, parts of prevention and care delivery and long term management. They think across it in a broader way and about redesigning from a patient's perspective.

**(Slide seven)** What I'm going to take a minute on here, which I have talked to NEHI about before, is about the German Migraine, the West German Migraine Clinic, and you think about it. If you're thinking about innovation from the patient's perspective, what does that mean? The West German migraine care was a lot like it is in this country before they did this reorganization. The reorganization was designed by a health plan and a hospital working together on how to change it. And so, rather than having the patient have to schedule different visits with different specialists trying to figure out what's working and what's not, doing it sequentially, having it take a lot of time and a lot of frustration, particularly when somebody's in pain during the process.

They set it up so when you arrive at your first visit you see a multispecialty team. The team meets in person and figures out what's at the root. And so long story short, what goes on here is in the first six months of the new model, the percentage of patients that would miss six or more days of work from a single migraine episode went from 57% to 11%. Think about it from the employer's point of view, from the patient's point of view, from the health plan's point of view, from the clinician's point of view – a productivity improvement, huge pain reduction, a lot of efficiency built into this system by solving the problem much earlier, more efficiently. Let's move forward.

**(Slide eight)** I'm going to zip through the points here. The second one is the notion of redesigning around a full care cycle for medical conditions. And here I'll come back to everybody's favorite. When we said medical condition, we aren't physicians, we didn't define it the way physicians define it. We were talking about a set of interrelated medical circumstances, whatever set is best cared for in an integrated way.

**(Slide nine)** So when you're thinking about people with diabetes with hypertension – and in our view that is a medical condition, in fact, a number of other circumstances tied in with that as well. We have one of our cases addresses a group that has all the patients have at least four chronic diseases from the patient's perspective those co-occurring chronic diseases may be a medical condition not multiple conditions. The distinction we were making is CABG surgery is a procedure; that's not a condition, that's a procedure. So as we think about, go forward, as we think about medical conditions I talked to you before about integrated practice units and how thinking at the level of medical conditions drives a development of deeper expertise across the care cycle for co-occurring circumstances that are tightly interrelated.

**(Slide 10)** The issue is that today, most of what's referred to as integrated care isn't a team but a collection of fragmented services. Even in a good system this is how it tends to work. I drew a picture following the care for a particular patient – actually two patients. This is drawn around a patient with breast cancer, and if she first comes in to see a medical oncologist she'll go through

a series of appointments with a group of people – the surgical oncologist, the radiation oncologist, the labs, the imaging – she goes through a series of appointments where she moves around from one to another, and actually she’s making the appointments and there are delays between the appointments.

The clinicians involved in this are really hard working. They think of themselves as a team. They call each other during their kids’ soccer games, talk to each other on their cell phones on the way home from work. They see each other’s patients on Sundays when they’re in the hospitals. But they don’t really operate as a team. The next patient comes in – the one shown in that bluish line – and suppose she first sees the surgical oncologist. She is going to go through – even if she has the same set of circumstances – a different process, involving a lot of the same people, not all of the same people. The point is that although they’re all in the same box if you will – they share a payer or they share a hospital system – they don’t really learn and organize themselves as a team.

In practice, actually the caregivers, the judgments on which the care is based, the evidence on which it’s based differs, the outcomes differ but the clinicians, when you talk to them, don’t really know what the team’s results are. They don’t really know what they should compare to or how to compare one patient to another. They do have tumor boards – they meet once during the care and they don’t all meet as a team after the care to see how it went. There are a lot of pieces of what it would mean to learn as a team, to improve as a team, that are missing. They’re smart. They are well-informed and they work really hard. They assume they’ve done really well. But most aren’t doing really well. They’re not learning anywhere near as fast or with as much support, leverage and acceleration as they could.

**(Slide 11)** The next is diabetes care – a typical structure. It’s complicated. There are a lot of things that go wrong for a patient with diabetes. And there are a lot of clinicians and social workers and educators involved in the process and as you look at care occurring around the country. Diabetes – we’ve done about four different cases right now and also working on international projects on outcome measurement. There are a tremendous amount of people involved and the process of getting it all coordinated is really complicated. We’ve had situations where we were working with doctors and gave them a chart and asked them to fill it out. In places where it was asking for referrals, they wrote in “various.” I said, “Why did you write ‘various’ in here?” and they said, “Well, it would take too much time to list out all the specialists this patient should see at this point.” You think, “Wow. If he can’t list them, how would I as a patient make appointments with all of them?”

**(Slide 12)** So this is a diagram of the initial care at the Joslin diabetes center which tries to organize it in a more coordinated, clinically integrated kind of way so that when the patient first comes in, they’ll see an endocrinologist and a nurse educator and an eye technician. And so with common exam rooms there is a lot less complexity about even just the initial appointments. And indeed if the eye tech discovers lesions on the eye, in the visit it’s possible for the patient to have the patient have the problem fixed before they leave the Joslin that day. So rather than spending a week or a month worrying about whether they might go blind, they’ll go knowing they were at risk but they’re not anymore. That’s a tremendous savings, not only in terms of waste reduction as it’s normally thought about but in terms of anguish. So we’re looking at various examples of

new models or improved models, steps toward more clinical integration in both chronic and acute care and things that combined elements of both.

One of the critical pieces of this is measuring results at the level that value is created for patients. The point here is not report cards. I know I've said that a million and a half times. But the idea is to drive improvement, to drive learning to enable clinical teams to work better, to share goals to help achieve better results and to help patients achieve better results. We're talking about enabling improvement.

**(Slide 13)** I've talked – I may have even used this particular slide with you. The idea is to get clinical teams to work better to get better results – to improve health and to improve health care.

**(Slide 14)** And we have now several frameworks that we're using with a variety of organizations to think about how do you think about the measures for your patients or your employees or your health plan members and how you weave those measures into the culture of your organization and how you help to change the culture of your organization to be more oriented toward health and full-cycle care using these measures. Move forward – I can come back to these in Q&A.

**(Slide 15)** This is a slide we developed to talk with groups about the different types of outcome measures that need to be considered to get that multi-attribute sense of what do we mean by a good outcome. So it's not just a matter of thinking about outcome versus process, or not even thinking about long-term outcomes – there is the issue of long-term, sustainable outcomes but there are also short-term outcomes, there are health indicators that tell you whether you're getting to good outcomes and then there are experience measures of were there errors, were there problems in the process or is there learning and enabling that's occurred during the process.

**(Slide 16)** This template has proved to be really powerful with a number of organizations – because either they want to focus on very few outcomes that occur after a very long period of time or they give you a list of 53 things when you say what do you want to measure, and you say 53 is a really big number, can we come up with a smaller set. Usually with this we come up with 10, 12 – a few things that give us a good place to start.

**(Slide 17)** The fourth one that I want to mention is aligning reimbursement with the restructured delivery and value so we're talking about team-based reimbursement, and people who've heard me talk know that I often push back on the reimbursement questions when they first come up and say we need to talk about something else first because often we hear people say first we need to get the reimburse system changed and then we will start to make adjustments. And you really just can't wait for it to happen that way. You have much more power in driving change and in creating change, even in the reimbursement system, if you're taking steps to create a different kind of driving improvement and value in the system – and then you can push more toward the team-based reimbursement. What we're seeing is where reimbursement changes seem to be beginning, they're occurring in parallel with changes made by the clinicians or provider organizations or by the employers in how they're thinking about care. So here we're looking at something that does need to come in order to get the value fully recognized but you don't need to wait for it to come first before you decide to take action. There's plenty of low-hanging fruit to be pursued now.

**(Slide 19)** So what push-back do leaders get as they start trying to push this change through their organizations? The usual ones. “We don’t do it that way!” Right. That’s why we’re thinking about change. You need to be thinking about doing it differently. The next one is “Wait, me first? Why should I move first? Don’t I have to wait for them – whoever ‘them’ is – to do something before I do anything?” There’s so much common ground to be gained by either yes, you first or sure, you working in conjunction with others who also benefit from these changes. Whether they’re your members or your employees or the health plan that’s administering your health benefits contracts or the health plan that’s paying for the patients that you’re serving. There are lots of people to work with. So, “do I have to first?” Yes.

And then “What? Measures? I don’t want report cards. I don’t want you measuring me. Isn’t this just yet another form of administering control? As soon as they start measuring won’t this go through the same process that HMOs went through? We’ll have to go through the same process that pay for performance went through. Isn’t it all going to become administrative control? No. Not if you have a different cultural attitude about it from the beginning. It needs to be there to enable the changes, not to judge the participants. And then the other one is, “Show me the ROI. If you can prove to me that this has a positive ROI then I’ll do it.” Sometimes you have to try it to see the ROI. But one of the things we’re seeing is that places where people are really measuring the ROI, some of them are stunningly high; some of them are stunningly low. The ones that are returning the really low are the places where the reimbursement is just plain backward for the returns. I saw a really neat presentation by the CEO of Baylor Health recently where he showed how you can tell which ones are going to be positive and which ones are going to be negative by thinking about how the reimbursement system works. It illustrated how much low-hanging fruit you could find to demonstrate to people how much value it creates and have your talking points, your leverage, for helping people to move forward in implementing projects with appropriate reimbursement so that good health care is rewarded with good financial results as well.

**(Slide 20)** So we’ve been developing new cases – we’ve got about 12 now and another half dozen in the works – that enable us to do courses and workshops. We did our first course last January and taught it several times since then, and we now have the ability to do workshops from different perspectives as well, to help enable the transformation in care delivery organizations, in health plans, with employers.

Actually one of the things I’m currently most excited about, probably because I’m waist deep in it at this point, is the work we’re doing on employer initiatives. We have a new paper coming on that, looking at not just the work employers are doing to enable health, but also how people are thinking about improving care as well – so improving health, health benefits and health care. And there is leverage for employers in all three places. In spite of the conversations about employers getting out of health care, there are tremendous opportunities for employers to accelerate the right kind of change. And there’s a risk in just getting in – when employers say they just want to get out of health care – that they assume that someone else will make the necessary transformations. So there’s a bunch of exciting work going on there as we’re looking at what are employers doing who are not in the health sector, and then what are employers who are also within the health sector doing in their role as employers. This page tells you some of the

things that are addressed in cases that are already finished, cases that are already developed. So in courses we're delivering for business students, for medical students, for public health students, but also for executives and in executive workshops. I won't walk through these topics unless you want to ask questions about them but I'm happy to talk to people individually about them or the courses in general if people want to follow up beyond the call.

What you'll see here – there are two things. One is that as we work through the cases there is a handful of insights that come through very robustly In case after case about what it means to move to a team structure, what it means to move to a broader definition of the care cycle including developing and maintaining health as well as providing care. And what it means to provide true clinical integration of care. The other things that comes through screamingly in many of the cases is that these themes – these issues – require a shift at their strategic level.

So when you think about strategy and you say how do you know a good strategy – there are three ways you recognize when someone has a good strategy. You recognize it because a good strategy develops unique value – either develops value uniquely or develops value that other people don't develop – so there's a unique component. The second thing is that good strategy feels like a cause. It sort of pulses in an organization and then the third is a consistency through the organization that you can feel with a good strategy.

So in order to get the kind of shift that's required here, you have to drive a shift not only in what you're trying to do but in how. So in both the vision and the culture. And so there are themes that come up over and over again about enabling these changes in organizations. And it comes up whether you're studying AIDS care in Rwanda or care of multiple chronic illnesses in Massachusetts. Or care for head and neck cancer in Texas or care for large systems of employees in a company that operates throughout the nation -- so we're definitely seeing themes.

I can leave it there.

**VF:** Terrific. Thank you so much, Elizabeth. Really terrific presentation and so exciting to hear about the progress you've made and the examples you've found in bringing value-based health care to life at different types of organizations. And seeing as we have different types of organizations sitting around the table or the computer and the phone in this case, we would love to hear questions, thoughts and reactions from you at this time.

I'll start by asking you a question, Elizabeth. I don't know if Ranch Kimball is on the phone or not – he is president and CEO of the Joslin Diabetes Center. And I know, Elizabeth, Ranch has had several discussions with us and we're obviously quite familiar with the model of care that they provide, and I was just hoping that you could elaborate a little on this issue of the chicken and the egg. They're clearly an org that has been putting this new model in place because they believe it's the right thing to do and their outcomes are certainly among the best in the country. But when you talk to Ranch and talk to folks at the Joslin they will be the first to tell you that they're not being paid in full for the services they provide – and I can't remember what the number is, it's 60 cents on the dollar or 75 cents on the dollar or 80 cents on the dollar or something of that order – and so they're in the position of raising funds from other sources to cover their costs to provide the care they want to provide. And so they're clearly an organization

out there doing this despite the reimbursement side of it not being there yet and I'm just wondering what your thoughts are as you've been going around the country and talking to folks how you see people addressing this issue of the chicken and egg.

**ET:** I am in the process of working with the Joslin and so I'm at a point where I can't yet talk about my work with them because we don't have approval on the release other than the two slides I showed you, so I can't say too much about the Joslin. But I can speak to diabetes since I have four cases on diabetes other than the Joslin. It's easy for me to say that yes, the Joslin is providing excellent care and when we have the outcome data to demonstrate that certainly we will – certainly they have a lot of people living for a long time in good health. Ranch may comment on that aspect.

But as far as payment for diabetes and new models for that, there are several evolving reimbursement models for diabetes that would help places that are providing excellent care to be better reimbursed for it, and there are a number of major employers very interested in participating, in making those models come to reality and widespread use faster. Some of the employers we're working with are doing things like creating on-site clinics, interestingly not staffed by doctors but by diabetes educators, to try and get some of the early stage education care and important word engagement – so they're not talking about informing people, they're talking about engaging people in caring for their own health and so there are some of those sorts of initiatives going on. The employers that are engaged in that are very interested in changing the way payment is done for diabetes care because employers are not interested in paying for more and more acute care. They're interested in preventing the need to pay for that care, in making their employees healthy and at work.

So there's a big change in perspective that happens when you think about the services from the perspective of the patient and the employer rather than thinking about them just as the revenue line for acute care centers. And there's room for a different model there that would help take some pressure off the system. One of the themes that comes up there that come up in many areas of care is that there are an amazing number of new roles for people who are not doctors or nurses but who are educators or coordinators who have a role in helping to get the care to be full cycle, the patient to be not just compliant but engaged and in getting the system to work more as a clinically integrated and health integrated system rather than just focusing on being a payment integrated system. If Ranch is there he can comment on things about the Joslin that I know are true but didn't have permission to say.

**VF:** And this is Valerie, I didn't mean to put you on the spot about the Joslin. I don't think he's here. Is there another question?

**AM:** This is Andrew MacKnight from Thermo Fisher, I'm calling in from Center Valley, Pennsylvania. I'm curious about your perspective on the development of products. How does a value-based system such as the one you've been describing impact organizations that are developing – whether they're drugs or devices or other products to be used in the system – what sort of pointers or insights should be provided to that side of the equation?

**ET:** Thanks Andrew. Cool question. The first obvious thing is that when you read the newspapers the common impression is that the drug and device companies try to sell to everyone with a bellybutton rather than trying to sell to the people who would most benefit, for whom most value is created. Those are very different perspectives on what does it mean to create value to be successful. So if you think about it from the perspective of how do our products or services create the most value – for whom do they create the most value – and then how do we expand that value, how do we make it even better, it provides different emphasis on innovation, on strategic direction. It also has some implications for how you work with the clinicians and others in your supply chain whom you’re working with for the patients.

One of the most fun projects on that line that I’ve been working on is with Novo Nordisk and their work on measuring outcomes worldwide on diabetes. They’ve developed what they call a barometer which is multiple attributes, multiple outcome measures that is now being used in 21 countries to think about what are the outcomes, shorter term and longer term and some of it is process measures and some of it’s experience measures – they’ve got a variety of things in the mix. But they’re working on measuring outcomes for diabetes care.

As you start getting measures there’s a way to share insights about what’s working and how, and what are the circumstances for the processes that support what’s working. And that’s in fairly early stages but it’s a really cool effort. The mission is to reduce the disease burden of diabetes – and diabetes if you could – but certainly to stem the pandemic. And so rather than thinking about or having the goal be how to sell the most product, the goal there is explicitly how to reduce the problems from the disease. And we’re getting some really interesting stuff as you compare what’s going on in Sweden to what’s going on in Italy to what’s going on in Mexico to what’s going on in various parts of the U.S. and sharing of insights. And then there’s also sharing of insights about how to get patients more fully engaged so that they spend less of their lives as patients, more of their life engaged in other parts of their life. But it’s more of a change in – it’s not inconsistent with the perspectives before, but a shift in emphasis.

**AM:** Thank you, very interesting.

**VF:** Elizabeth, I know when you had met with our team several months ago you had talked pretty extensively about what they’re doing at the Cleveland Clinic. I know we don’t have a lot of time left but I thought maybe touching on some of what they’ve done there, because soup to nuts it’s a pretty interesting model and how they’ve gone about it is pretty interesting as well.

**ET:** Yes, the Cleveland Clinic has a number of interesting initiatives going simultaneously. They have announced they’re restructuring the entire organization so we’re talking 35,000 people from a patient perspective. So from the perspective of what we would think about as integrated practice units. So they’ve started with some particular areas and are moving along that learning process of what does it mean to restructure in this way.

In the early efforts, some of the things you’ve seen is that as you bring together a multi-disciplinary team around a set of patient circumstances, you enable the change in part by having the team rethink, “How do we know when we have good outcomes?” And when you pull together a multi-disciplinary team you get a different set of answers than you get when you have

the surgeons sitting together or the medical team in an area sitting together or the physical therapists sitting separately. So they've had to start with meetings that discuss what success is for the team, they've also found that by thinking in terms of the team having a pool from which reimbursement for the whole team happens is enabling, that's easier with a staff model – but almost half of the Cleveland Clinic physicians are not staff so they're having to bridge to a non-staff model as well on that. But so they're going through those – that's part of the transformation we talked about.

Another part of the transformation we talked about has to do with information systems and how they're using their information systems to enable a team to coordinate and learn together faster. One of the things that comes up in the Cleveland Clinic's multi-disciplinary groups that we've seen in some of the groups we've worked with in diabetes, in various kinds of cancer, we've seen it in groups for AIDS care, and in multiple chronic diseases, is that when you start pulling together these multi-disciplinary teams no longer divided along the standard lines of organization, the standard medical specialty lines, the research jumps faster in ways that teams didn't expect. They find that because they're asking a different set of questions – or they're asking questions from different perspectives or they're sharing different hypotheses about the answers – that the research agenda – what we hear over and over again is that our research agenda, our research insights – jumped forward faster than we expected. And they say it with an enthusiasm and a surprise that is stunning. You'll hear it from physicians that will say, "I work at a really great community hospital system and then I worked at this leading center in New York and now I'm working in this multi-disciplinary group at M.D. Anderson [Cancer Center] and I really thought that the other organizations I worked at were fantastic, but I didn't understand how much faster I could learn and we could learn. But I'm learning that much faster now." And so that's been a really interesting part of it that participants aren't expecting.

**VF:** Right, I know we were really impressed when you had talked to us about what they're doing soup to nuts, and about how the teams there are developing their own performance metrics and defining it themselves and then holding themselves to it.

**ET:** Yes – when the team gets together and defines what is success, what are the outcomes we want to measure ourselves by – and that's an interesting one, because if you watch, the clinic has these outcome measure booklets, they're on the web and they're published and sent out and you see a real evolution in those – some are much more sophisticated than others. And having made a commitment to measuring and publishing outcomes it's a really bold move to restructure your teams and ask them to look at it again and ask what really should we be measuring because people are watching your progress on these outcomes measures and you "risk" looking like you're backing up.

But it's the right thing to do, it's the right way to learn faster, to ask that question again, what should we be measuring and how do we know if we are doing well. And one of the really cool things about that is the Cleveland Clinic also has a different kind of geographic expansion going on where they have Cleveland Clinic-salaried people in, I think, seven states at this point who are working in particular areas of care but train with and share outcome measures with and rotate through the Cleveland Clinic so that they're accelerating the dissemination of knowledge from the Cleveland Clinic to other places.

And again sharing these outcome metrics, so that if what it means to do really well is held to a common standard and if you can't do it really well then you try to get those patients to somewhere that can do those patient services better. And so it's a bold geographic expansion strategy as well. So we talk about a lot of aspects – if there are other aspects you'd like me to bring up I will.

**VF:** I think, regrettably, we're bumping up to our end time and I want to be respectful of people's time. I really want to thank you on behalf of all of us at NEHI and those of us in the audience as well for your terrific presentation. If anyone has questions feel free to contact us – we'd be more than happy to follow up.

Finally I just want to thank Elizabeth for her fabulous work over the past two years as a senior fellow at NEHI and it's been so wonderful having you be part of the team, and you've given us some terrific ideas on where we can continue to work through our members to drive change in health care. Thank you to everyone who participated.

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