20/20 Cayman Islands National Healthcare Conference

Healthcare Economics: The Search for Quality and Affordability

The Ritz-Carlton, Grand Cayman, Cayman Islands

Saturday, 19 November 2011 -- 9:30a - 10:30a

The Quality Imperative: The Best Clinical Result at the Lowest Necessary Cost

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Intermountain Healthcare
Healing for life℠

Disclosures

Neither I, Brent C. James, nor any family members, have any relevant financial relationships to be discussed, directly or indirectly, referred to or illustrated with or without recognition within the presentation.

I have no financial relationships beyond my employment at Intermountain Healthcare.

Dr. Alan Morris, LDS Hospital, 1991

- ***NIH-funded randomized controlled trial***
  assessing an "artifical lung" vs. standard ventilator management for acute respiratory distress syndrome (ARDS)
- ***discovered large variations in ventilator settings***
  across and within expert pulmonologists
- ***created a protocol*** *for ventilator settings in the control arm of the trial*
- ***Implemented the protocol using Lean principles***
  Womack et al., 1990 - The Machine That Changed the World

Dr. Alan Morris, LDS Hospital, 1991

- ***Results:***
  survival (for ECMO entry criteria patients) improved from 9.5% to 44%
  costs fell by ~25% (from $160k to $120k)
  physician time fell by ~50%

- ***we generalized the concept: Shared Baseline protocols to standardize care*** *while encouraging clinicians to vary based on individual patient needs; and feeding back variation data in a "learning system"*

Shared Baseline protocols *(a form of Lean Production)*

A multidisciplinary team of health professionals:

1. ***Select a high priority care process***
2. ***Generate an evidence-based "best practice" guideline***
3. ***Blend the guideline into the flow of clinical work***
   - *staffing*
   - *training*
   - *supplies*
   - *physical layout*
   - *educational materials*
   - *measurement / information flow*
4. ***Use the guideline as a shared baseline, with clinicians free to vary based on individual patient needs***
5. ***Measure, learn from, and (over time) eliminate variation arising from professionals; retain variation arising from patients*** *("mass customization")*

Practical limitations on protocol use

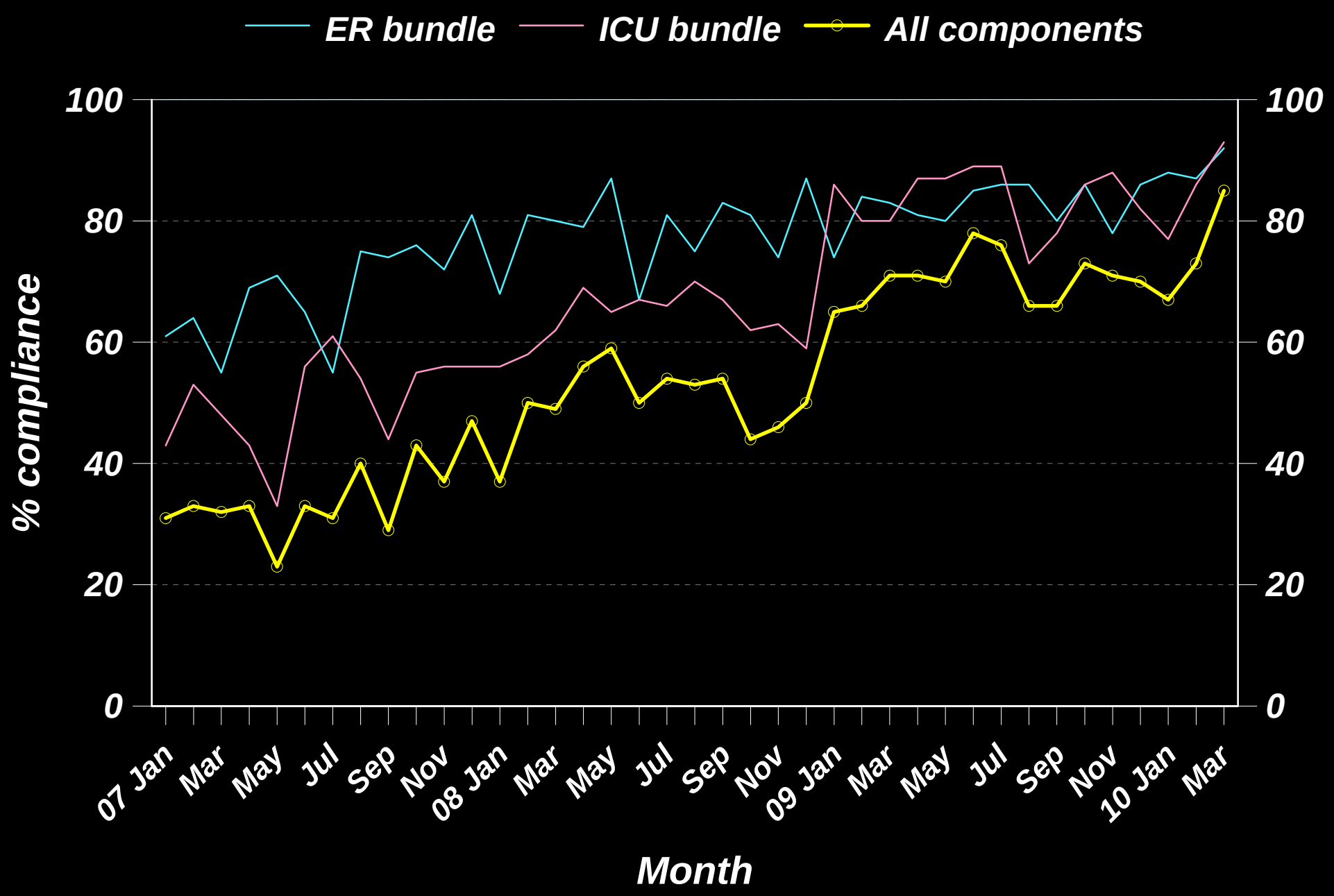
When abstract guidelines hit real patient care, experience clearly shows that *(with very rare exception)*

No protocol fits <u>every</u> patient;

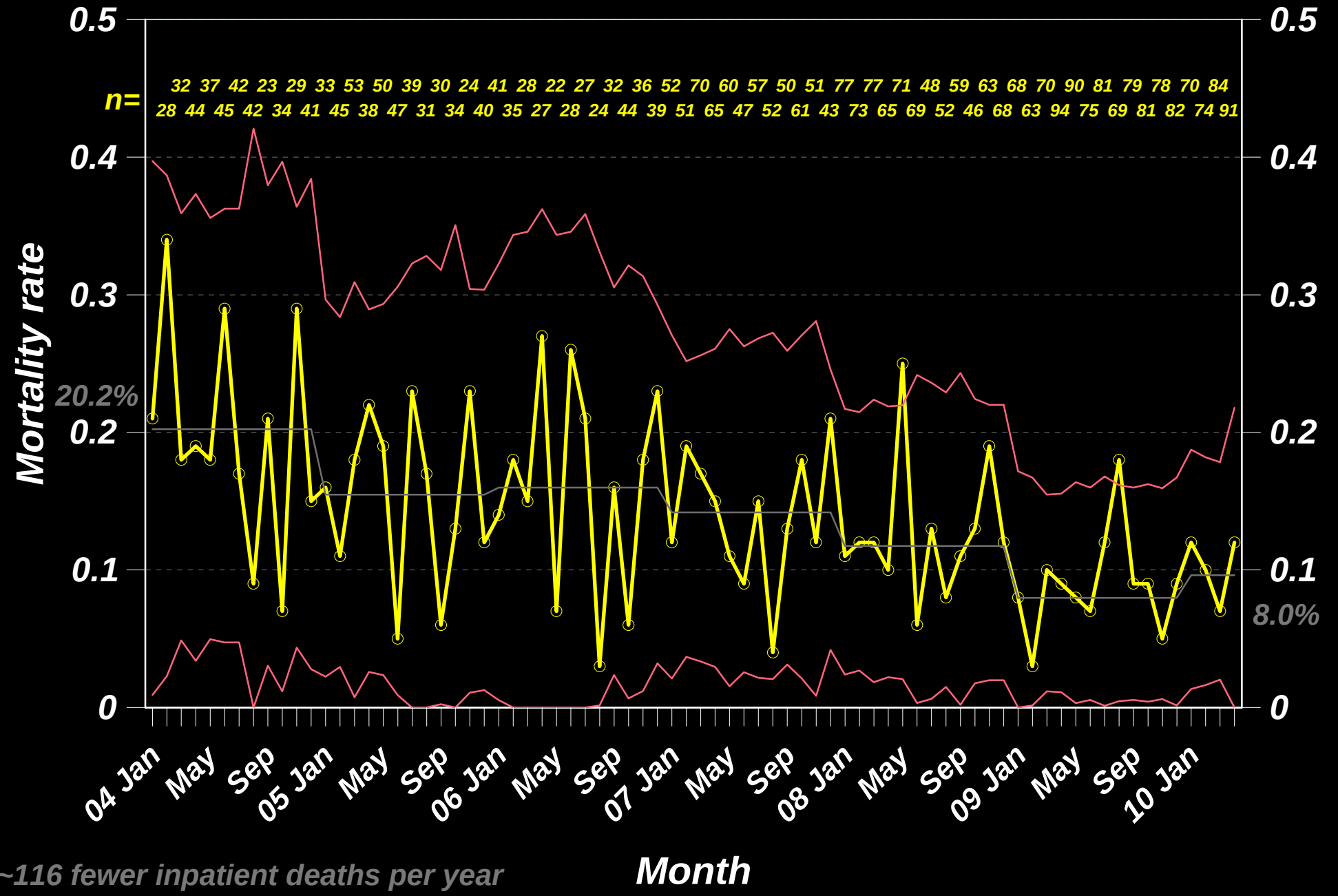
more important,

No protocol *(perfectly)* ***fits <u>any</u> patient.***

Sepsis bundle compliance



Sepsis mortality - ER-ICU transfers



~116 fewer inpatient deaths per year

Diabetes Patient Follow-Up Worksheet: All Patients

Report Period April-01-2008 to March-31-2009

Intermountain℠ Medical Group

Patients that need follow-up are those whose average Blood Pressure > 130/80, last A1c value was > 8.0, last LDL > 100, and/or Triglycerides >= 400, or any of the aforementioned tests were not performed during the reporting period. Please remember "credit" can be given to improve individual scores if patients are contacted by your office but are not compliant or lab information is incorrect.

Provider Name (Provider ID) - Clinic Name

14 Patients That Need Follow-up

				SelectHealth Incentive Benchmark Goals:	50% to 90%			76% to 81%				85% to 90%		54% to 59%	
Total SelectHealth Patients - 21				SelectHealth Current Diabetes Performance:	100%			77%				92%		62%	
SelectHealth Patient Name	IDX MRN	Birthdate	Phone	Last Office Visit	Blood Pressure			Lipid Management				HGA1c		MicroAlbuminuria	
					Date	BP	<=130/80	Date	LDL †	HDL	Trig	Date	HGA1c	Date	MicroAlb ‡
				12/18/2006	12/18/2006	130/80	Yes	2/26/2007	105	50	227		Not Tested		Not Tested
Corrections															
				5/31/2007	5/31/2007	131/79	No	1/13/2007	99	30	230	5/31/2007	4.9		Not Tested
Corrections															
				5/11/2007	6/18/2007	108/59	Yes		74		236	1/16/2007	6.9		Not Tested
Corrections															
				5/3/2007	5/3/2007	131/73	No	12/13/2006	99	39	232	3/8/2007	NA		Not Tested
Corrections															
				3/15/2007	3/15/2007	131/83	No	Not Tested				12/14/2006	6.2		Not Tested
Corrections															
				10/2/2006	10/23/2006	131/80	No	10/2/2006	92	53	282	11/13/2006	6.8	10/2/2006	NEG
Corrections															
				6/4/2007	6/4/2007	111/63	Yes		23		115	6/4/2007	10.8		Nephropathy Tx
Corrections															
				2/16/2007	2/16/2007	144/74	No	8/23/2006	92	29	339	2/16/2007	5.9	8/23/2006	POS
Corrections															

Administrative (HEDIS) criteria for diabetes (at least 2 face-to-face contacts in an outpatient facility and an ICD-9-CM code 250.xx; or at least 1 inpatient stay and an ICD-9-CM code 250.xx; or at least 1 prescription for insulin or an oral hypoglycemic agent) in the current measurement period or prior measurement periods.

* Indicates a new patient on the list from last reporting period.

** Avg B/P measure is an average of the last three EMR recorded blood pressure results from home or clinic. Blood pressure data only available for physicians with access to Intermountain EMR.

□ Indicates a patient that has been noted in the EMR as having an in-control blood pressure within the last six months.

† Indicates a SelectHealth patient who has a pharmacy benefit, is over 40 years old with an LDL test above 100, and is not on a lipid lowering medication.

‡ Indicates a SelectHealth patient who has a pharmacy benefit, a positive microalbuminuria test and is not on ACEI or ARB medication.

11 July 2003

Patient Worksheet

v1.0.21

PATIENT NAME	SEX	DOB	MMI#	MRN#
TEST, A A	F	09/01/1964	545073664	545073664

Problems

Hypothyroidism
status post appendectomy
Diabetes mellitus type 2, insulin treated
Hypertension
Appendectomy
Coronary artery disease

Active Medications

1. - Digitoxin, 0.1mg, Tablet; 3 TABLET PO QD
2. - Entex LA (Guaifenesin/PPA HCl) 400-75mg, Tablet SA; 1 TABLET PO BID

Preventive Care

CV Risk	Pap Smear
5%*(1.4x)**	No Data

Clinical Laboratory Data

HgbA1c (<=7.0)		UA Protein		uAlb/Cr (<30)		24 Urine Albumin (<30)	
No Data	-	06/01/2001	Negative	No Data	-	No Data	-
		12/18/2000	Positive				
		11/06/2000	Negative				

Serum Cr		Serum K		Lipid Profile	LDL (<100)	Trig (<200)	HDL (>35)	CHOL (<200)
04/26/2003	1.1	04/26/2003	4.2	01/26/2003	107	93	50	176
10/25/2002	2.0	02/05/2003	6.0	04/06/2003	154	85	41	212
02/27/2002	1.6	10/25/2002	4.5	02/24/2003	149	151	41	220
10/03/2001	2.3	01/29/2002	6.1	02/06/2003	168	189	33	239

TC/HDL Ratio		HCT		hsCRP		Homocysteine		Fasting Glucose	
04/26/2003	3.5	02/05/2003	35.9 %	04/06/2003	0.6 mg/l	04/06/2003	6 mcmol/l	02/25/2003	127
04/06/2003	5.2	10/02/2002	37.7 %	02/24/2003	1.2 mg/l			12/19/2002	127
02/24/2003	5.4	08/23/2002	45.0 %					01/02/2002	127
02/06/2003	7.2	07/19/2002	29.9 %					12/20/2001	127

Clinic Data

Date	Weight	BMI (<25)	Weight Class	Blood Pressure (<130/80)		Heart Rate	
No Data	-	-	-	01/25/2001	145/74 mmHg	01/25/2001	86

Last foot exam: No Data -

Last dilated retinal exam: No Data -

Reminders

Preventive

* Predicted % Risk over 10 years of a cardiovascular event (MI, revascularization, CVA, death).
** Relative Risk over 10 years of a cardiovascular event compared to lowest risk category.
Pap and pelvic suggested every 3 years after three normal yearly Pap tests.
For Patients with known Cardiovascular Disease, Target LDL <100.
Blood Pressure measurement is suggested for adults every two years.
Suggested follow-up for missing data: - Pap Smear
Pneumovax suggested for all patients age 65 and above, and all patients over age 2 with systemic chronic disease.

Diabetes

Suggest repeat Urine Albumin Test more than (>) 1 year since last test.
Last ALT = 28 on 4/26/2003 & AST = 66 on 4/26/2003
Suggested follow-up for missing data: - HgbA1c - Dialated Retinal Exam - Foot Exam - Weight

Hypertension

ACE Inhibitors (ACEI) or if ACEI intolerant, Angiotensin II Receptor Blockers (ARBs) or the combination of ACEI or ARBS and Diuretics are the recommended initial drug therapy for patients who are diagnosed with hypertension in conjunction with Diabetes.

Problems and chronic conditions

Medication profile

Preventive care summary

Pertinent labs

Pertinent exams

Passive reminders organized by illness

General patient status information

Disease specific information

Diabetes Summary Report

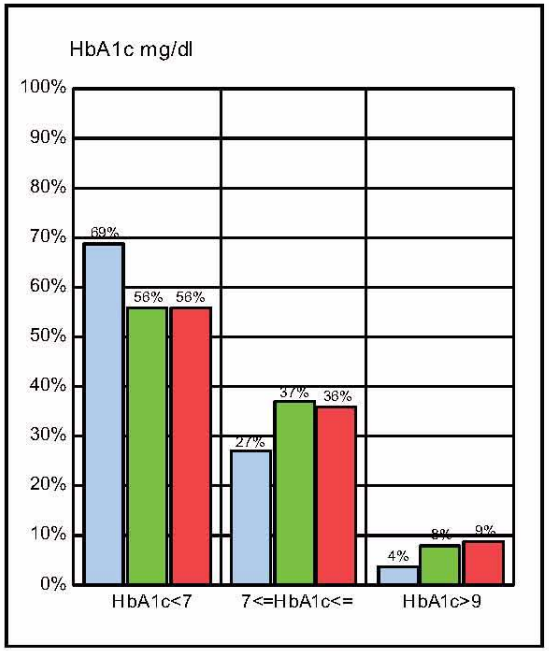
Provider: Towner, Steven (168)

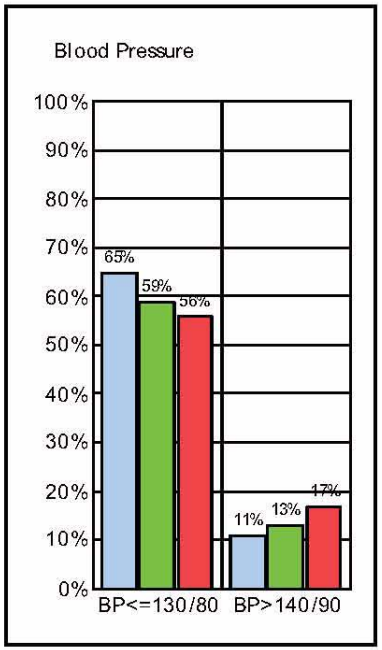
Period: Oct 2008 - Sep 2009

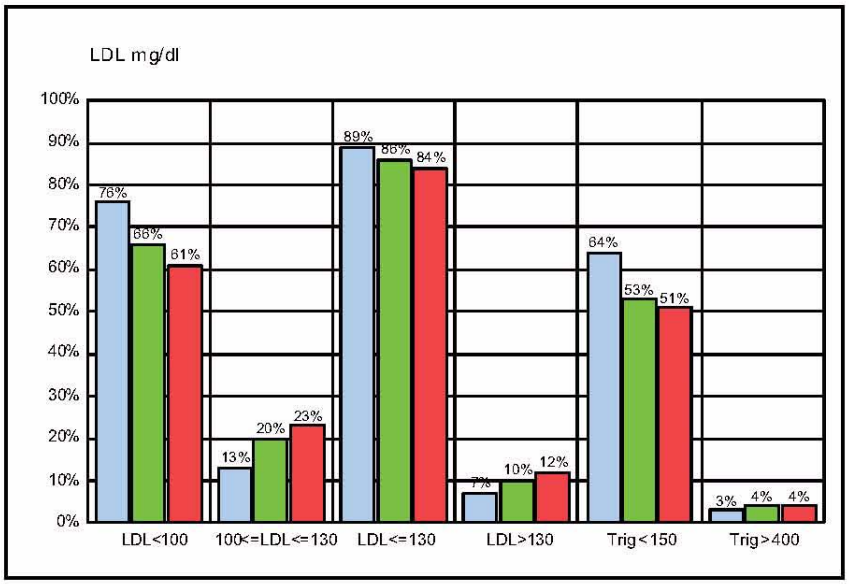
Patients Tested (Prop of Tot Pts%) - All Patients

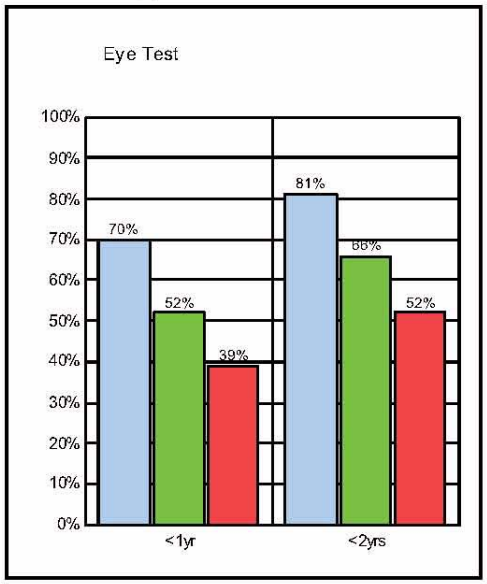
	Provider	Region	System
HbA1c	234(96%)	1,787(94%)	38,127(85%)
LDL	215(88%)	1,642(87%)	31,764(71%)
Eye Exam	37(70%)	182(52%)	5,448(39%)
Microalbuminuria	203(83%)	1,468(77%)	25,157(56%)
Blood Pressure	243(100%)	1,870(99%)	29,655(94%)
Total Patients	**244**	**1,897**	**44,705**

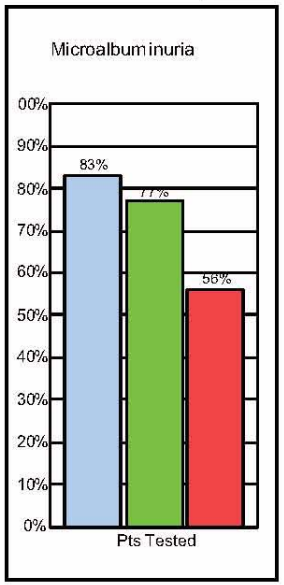
1. LDL measures represent two years ending in the chosen period. 2. Eye exam % calculated using SelectHealth patients only. 3.Includes spot microalbumin, 24 hour urine for protein and microalbumin/creatine ratio within the reporting period, or any history of treatment for nephropathy. 4.Measure is an average of the last three EMR recorded blood pressure results from home or clinic. Blood pressure data only available for physicians with access to Intermountain EMR.

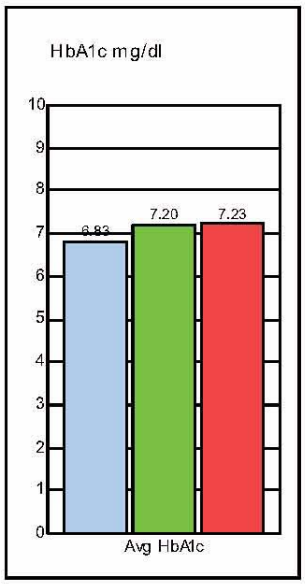












Intermountain Primary Care Clinical Programs: Adult Diabetes Medical Director Summary Report

Reporting Period: 01-Jul-08 To 30-Jun-09

Medical Director:

Intermountain Healthcare

Intermountain Medical Group

Family Medicine

Clinic Location	Diabetes Patient Count	Hemoglobin A1c Summary: 12 Months — Tested	Tested, result NA	Percentages based on only those with available A1c results: A1c<7.0	7.0<=A1c<=8.0	A1c>8.0	LDL Summary: 12 Months — Tested	Tested, result NA	Percentages based on only those with available LDL results: LDL<100	100<LDL<=130	LDL>130	Blood Pressure: BP Results If Available	BP In Control	MA: MA Tested
Clinic Name tain Taylorsville Clinic														
Provider Name														
SelectHealth	98	**88 (90%)**	1 (1%)	40 (46%)	26 (30%)	**21 (24%)**	**92 (94%)**	0 (0%)	**60 (65%)**	17 (18%)	14 (15%)	97 (99%)	**44 (45%)**	**67 (68%)**
All Other Payers	209	**184 (88%)**	4 (2%)	94 (52%)	29 (16%)	**57 (32%)**	**178 (85%)**	0 (0%)	**86 (48%)**	50 (28%)	31 (17%)	201 (96%)	**74 (37%)**	**110 (53%)**
Combined	307	**272 (89%)**	5 (2%)	134 (50%)	55 (21%)	**78 (29%)**	**270 (88%)**	0 (0%)	**146 (54%)**	67 (25%)	45 (17%)	298 (97%)	**118 (40%)**	**177 (58%)**
Family Medicine Summary:														
SelectHealth	98	88 (90%)	1 (1%)	40 (46%)	26 (30%)	21 (24%)	92 (94%)	0 (0%)	60 (65%)	17 (18%)	14 (15%)	97 (99%)	44 (45%)	67 (68%)
All Other Payers	209	--	--	--	--	--	--	--	86 (48%)	50 (28%)	31 (17%)	--	74 (37%)	--
Combined	307	272(89%)	5 (2%)	134 (50%)	55 (21%)	78 (29%)	270 (88%)	0 (0%)	146 (54%)	67 (25%)	45 (17%)	298 (97%)	118 (40%)	177(58%)

Intermountain Medical Group

Internal Medicine

Clinic Location	Diabetes Patient Count	Hemoglobin A1c Summary: 12 Months — Tested	Tested, result NA	Percentages based on only those with available A1c results: A1c<7.0	7.0<=A1c<=8.0	A1c>8.0	LDL Summary: 12 Months — Tested	Tested, result NA	Percentages based on only those with available LDL results: LDL<100	100<LDL<=130	LDL>130	Blood Pressure: BP Results If Available	BP In Control	MA: MA Tested
Clinic Name tain Holladay Clinic														
Provider Name														
SelectHealth	48	**48 (100%)**	0 (0%)	31 (65%)	6 (13%)	**11 (23%)**	**47 (98%)**	1 (2%)	**26 (57%)**	13 (28%)	6 (13%)	48 (100%)	**31 (65%)**	**31 (65%)**
All Other Payers	247	**240 (97%)**	0 (0%)	161 (67%)	49 (20%)	**30 (13%)**	**237 (96%)**	0 (0%)	**162 (68%)**	50 (21%)	21 (9%)	247 (100%)	**163 (66%)**	**165 (67%)**
Combined	295	**288 (98%)**	0 (0%)	192 (67%)	55 (19%)	**41 (14%)**	**284 (96%)**	1 (0%)	**188 (66%)**	63 (22%)	27 (10%)	295 (100%)	**194 (66%)**	**196 (66%)**
Internal Medicine Summary:														
SelectHealth	48	48 (100%)	0 (0%)	31 (65%)	6 (13%)	11 (23%)	47 (98%)	1 (2%)	26 (57%)	13 (28%)	6 (13%)	48 (100%)	31 (65%)	31 (65%)
All Other Payers	247	--	--	--	--	--	--	--	162 (68%)	50 (21%)	21 (9%)	--	163 (66%)	--
Combined	295	288(98%)	0 (0%)	192 (67%)	55 (19%)	41 (14%)	284 (96%)	1 (0%)	188 (66%)	63 (22%)	27 (10%)	295 (100%)	194 (66%)	196(66%)
Medical Director Summary:														
SelectHealth	146	136(93%)	1 (1%)	71 (53%)	32 (24%)	32 (24%)	139 (95%)	1 (1%)	86 (62%)	30 (22%)	20 (14%)	145 (99%)	75 (52%)	98(67%)
All Other Payers	456	424(93%)	4 (1%)	255 (61%)	78 (19%)	87 (21%)	415 (91%)	4 (1%)	248 (60%)	100 (24%)	52 (13%)	448 (98%)	237 (53%)	275(60%)
Combined	602	560(93%)	5 (1%)	326 (59%)	110 (20%)	119 (21%)	554 (92%)	1 (0%)	334 (60%)	130 (24%)	72 (13%)	593 (99%)	**237 (53%)**	373(62%)

IHC Primary Care System Goals and Managed Care Incentive Achievement Summary: Internal Medicine

Reporting Period: 01-Jan-04 To 31-Dec-04

Medical Director: Towner

1.) Diabetes, HbA1c Testing

The percent of patients with diabetes who had a HbA1c test within the last 12 months.

Your Achievement:	78%
System Goal:	80%
Managed Care Incentive Goal:	85%
Your Score in this area is:	**0%**

2.) Diabetes, LDL Testing

The percent of patients with diabetes who had a LDL test within the last 24 months.

Your Achievement:	94%
System Goal:	80%
Managed Care Incentive Goal:	85%
Your Score in this area is:	**100%**

3.) Urine Microalbuminuria Screen

Number of patients with diagnosis of diabetes who had appropriate urine screen in last 12 months.

Your Achievement:	72%
Goal:	45%
Managed Care Incentive Goal:	55%

Your Score in this area is: 100%

4.) Asthma Care

Percent of patients in your Internal Medicine Group with "higher risk asthma" who filled at least one prescription for a controller in the last year.

Your Group Achievement	94%
Goal:	82%
Managed Care Incentive Goal:	87%

Your Score in this area is: 100%

5.) Clinical Learning Day

Your Score in this area is 100%

Attended a Clinical Learning Day Program in 2003 or 2004

Your Score for each of the above measures is computed as follows:
-100% if you exceed the Managed Care Incentive (MCI) goal
-0% if you are below the System Goal
-50%-100% sliding scale if you are between the System and MCI goals

Managed Care Incentive Summary

Your total score is computed using the following weighting:

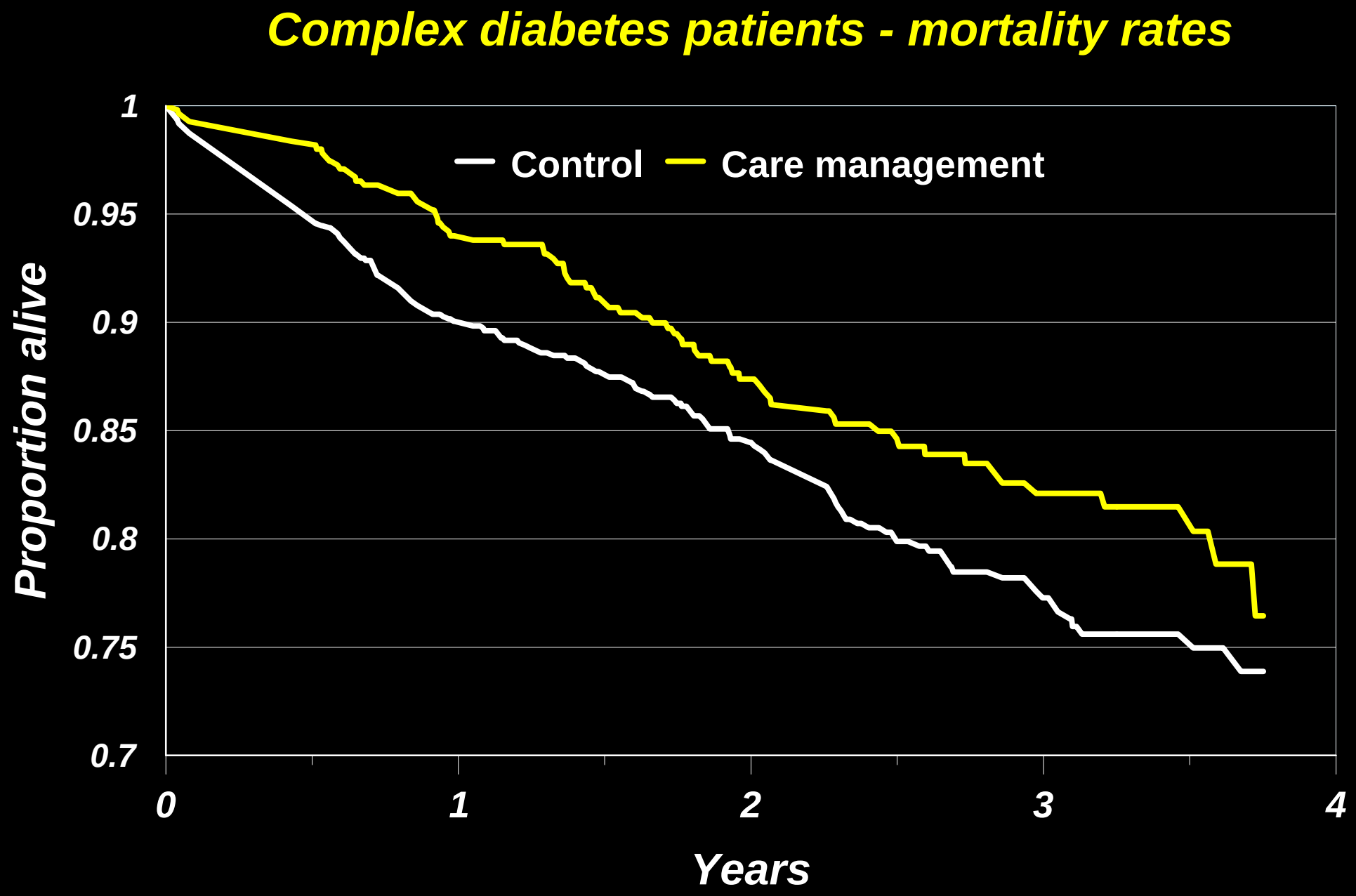
25% from Item 1 Diabetes (HbA1c Testing)
25% from Item 2 Diabetes (LDL Testing)
10% from Item 3 Urine Microalbuminuria Screen
15% from Item 4 Asthma Care
25% from Item 5 Attend Clinical Learning Day

Your Total Managed Care Incentive Score is: 75%

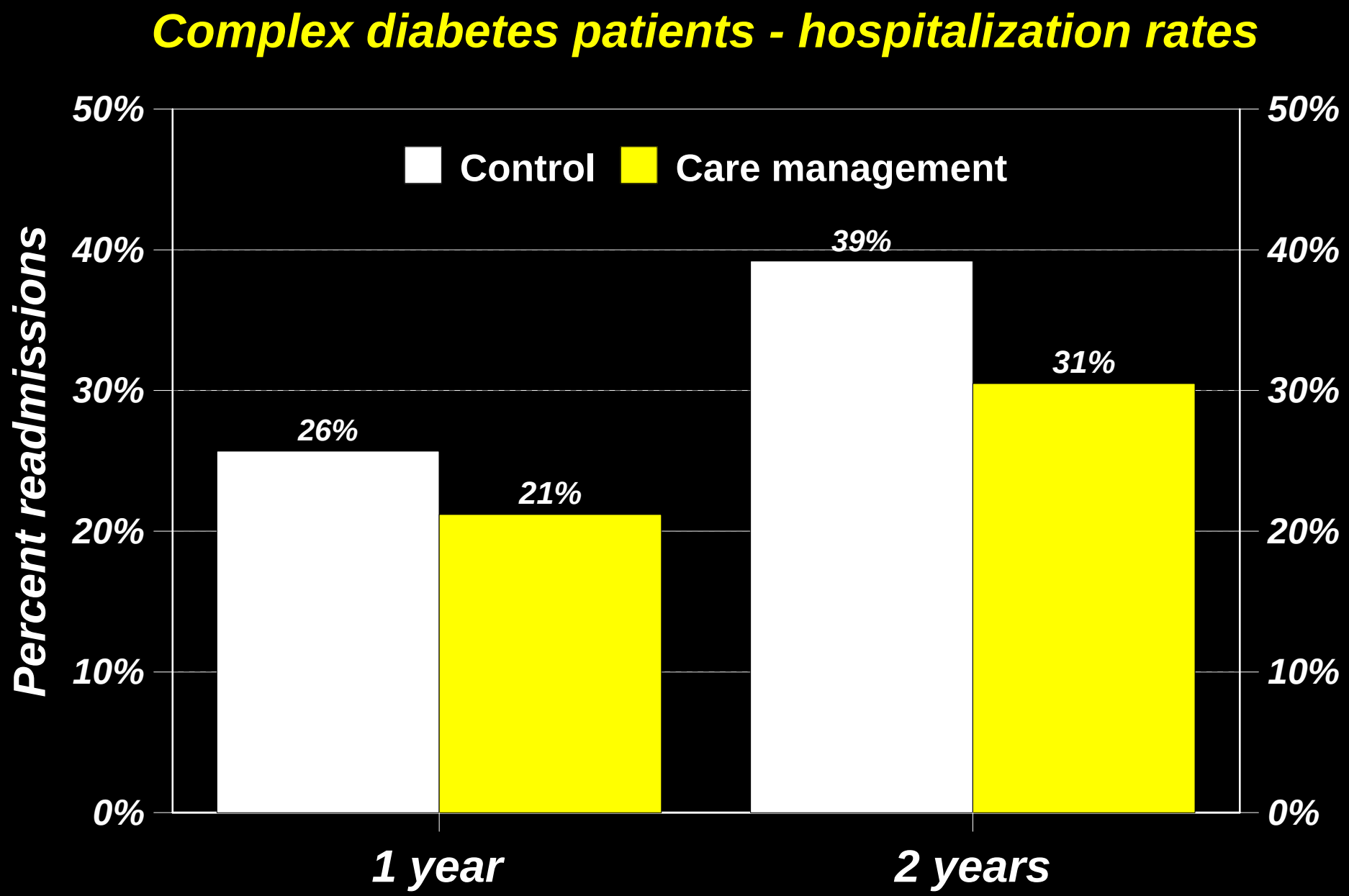
Please fax corrections to this report to: Steven Towner 355-3746

Employed

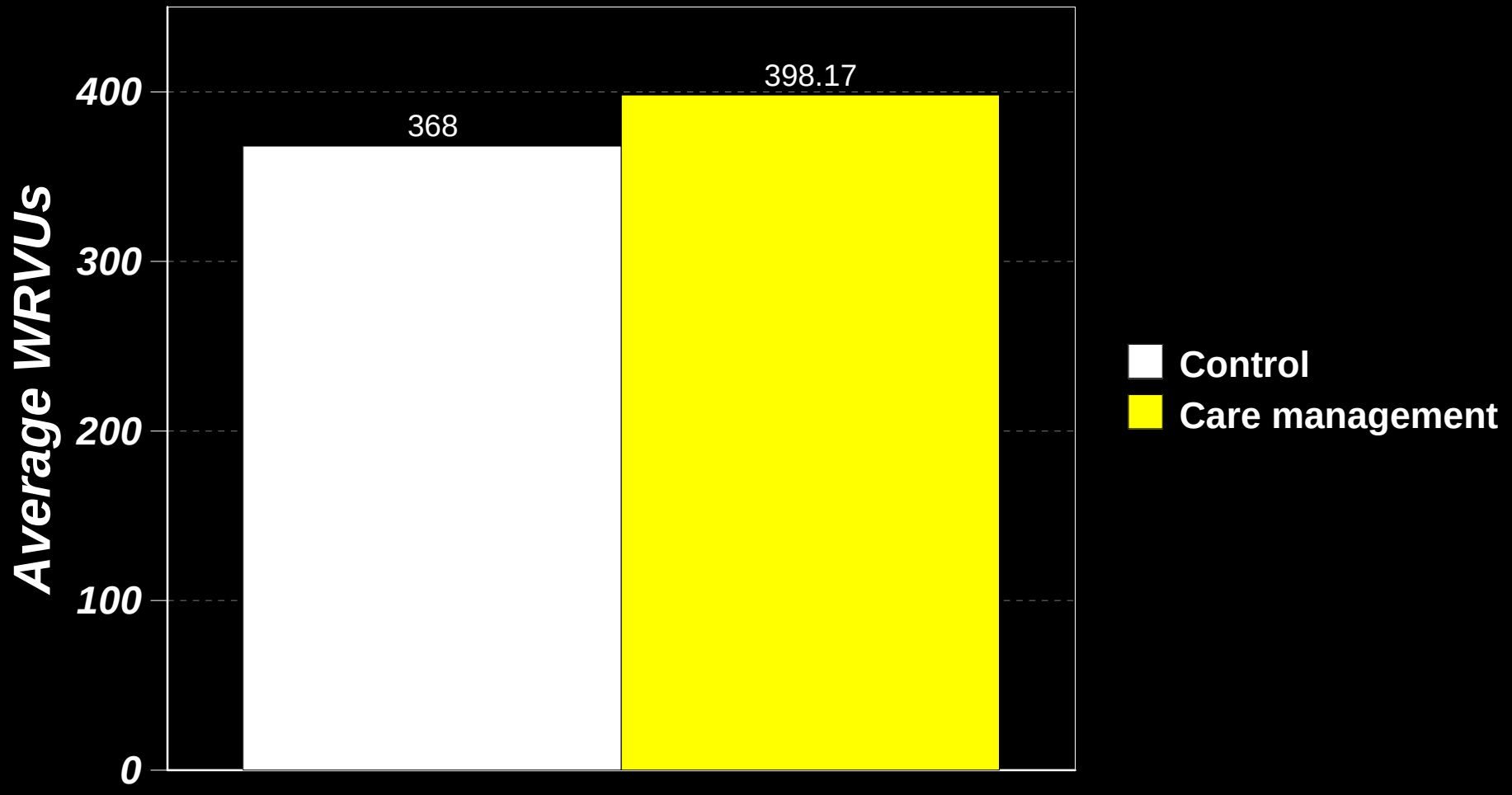
CPM with clinic care managers



CPM with clinic care managers



Physician productivity *(WRVUs - work relative value units)*



Physicians with embedded care management support were significantly (8%) more productive than controls

Of the 4 measurement tools shown,

which was most effective in driving change?

1. ***Action lists*** *(tools to move from episodic to continuous care)*

2. ***Patient worksheets*** *(targets of opportunity - embedded, evidence based reminders at every point of contact)*

3. ***Comparative outcomes*** *(what is possible, who to ask)*

4. ***Financial incentives*** *(see:* Drive *by Daniel Pink; intrinsic vs extrinsic motivators)*

Only one pertinent question:

Assume that front-line clinicians are
- *as smart you are*
- *as dedicated to patients as you are*
- *as hard-working as you are*
- *as motivated as you are*
- *are the only ones with fundamental knowledge of how the front-line process actually works;*

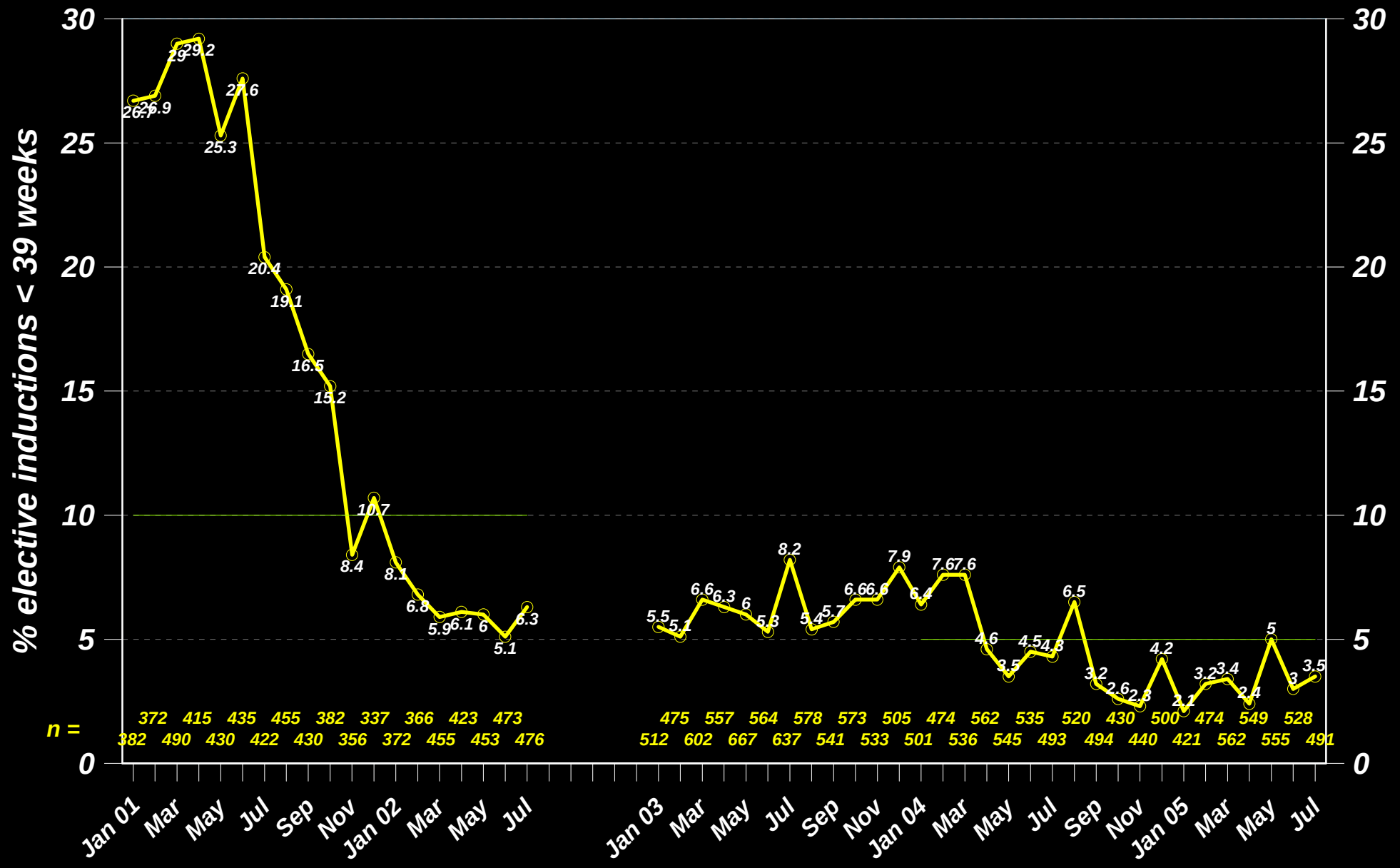
But they usually don't control the systems that set the context within which they work ...

How will your proposed intervention

make it easier for them to do it right?

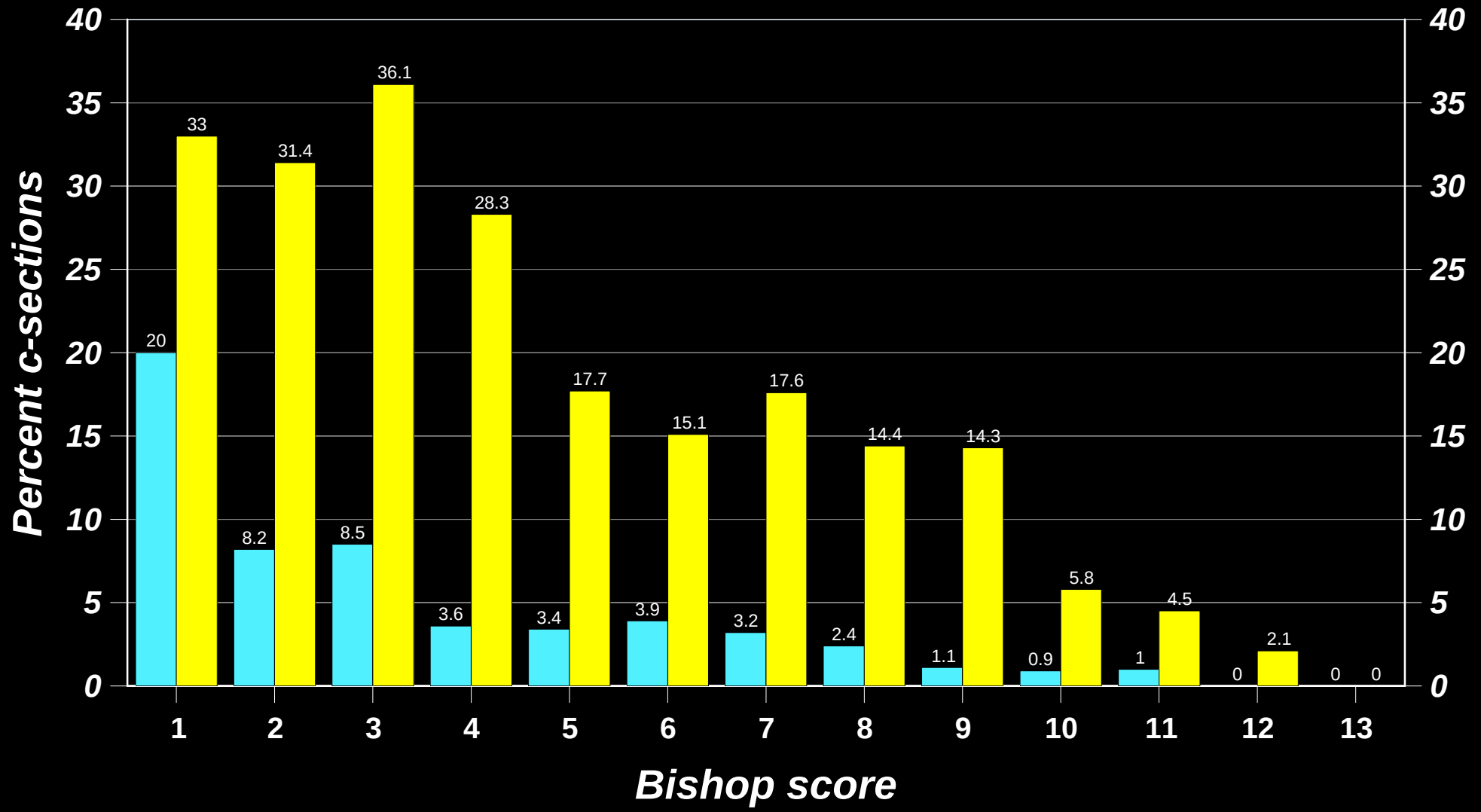
NICU admits by weeks gestation

Elective inductions < 39 weeks



Unplanned c-section rates

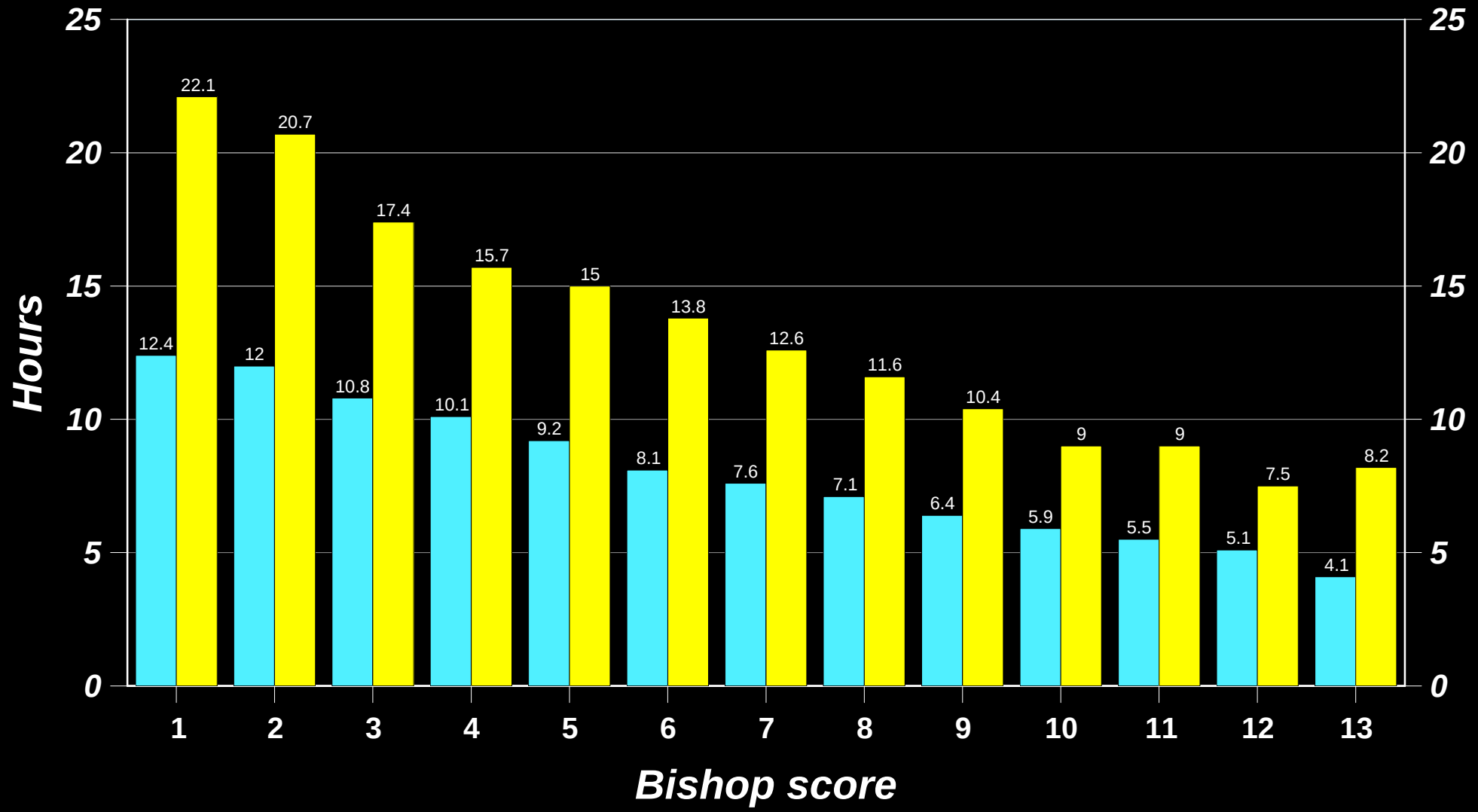
Electively induced patients by Bishop score, Jan 2002 - Aug 2003



n												
Multips	10	49	130	274	567	856	1114	1266	1062	737	415	86	19
Primips	18	35	61	99	164	278	375	487	453	346	179	47	7

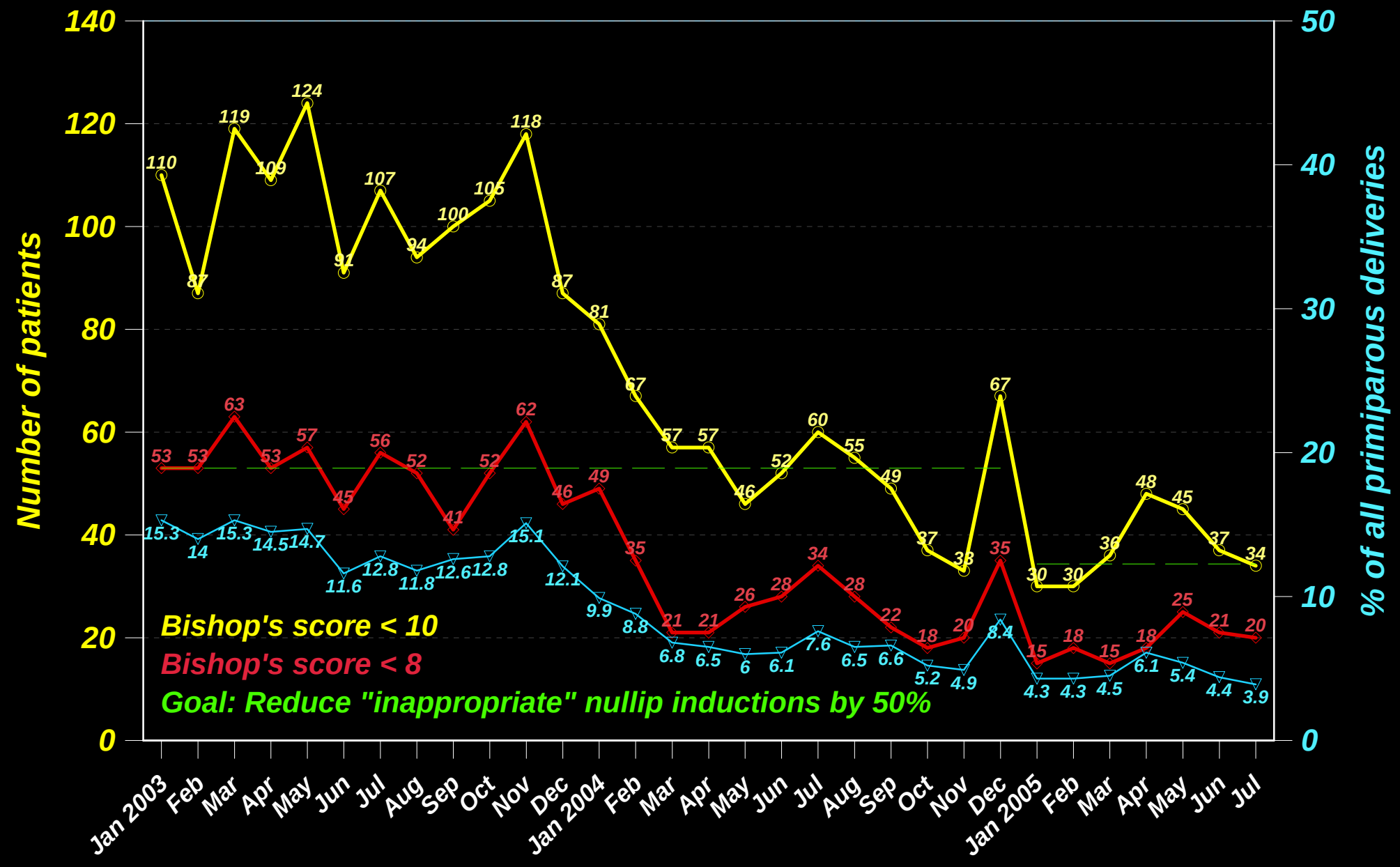
Average hours in labor & delivery

Electively induced patients by Bishop score, Jan 2002 - Aug 2003



n	1	2	3	4	5	6	7	8	9	10	11	12	13
Multips	10	49	130	274	567	856	1114	1266	1062	737	415	86	19
Primips	18	35	61	99	164	278	375	487	453	346	179	47	7

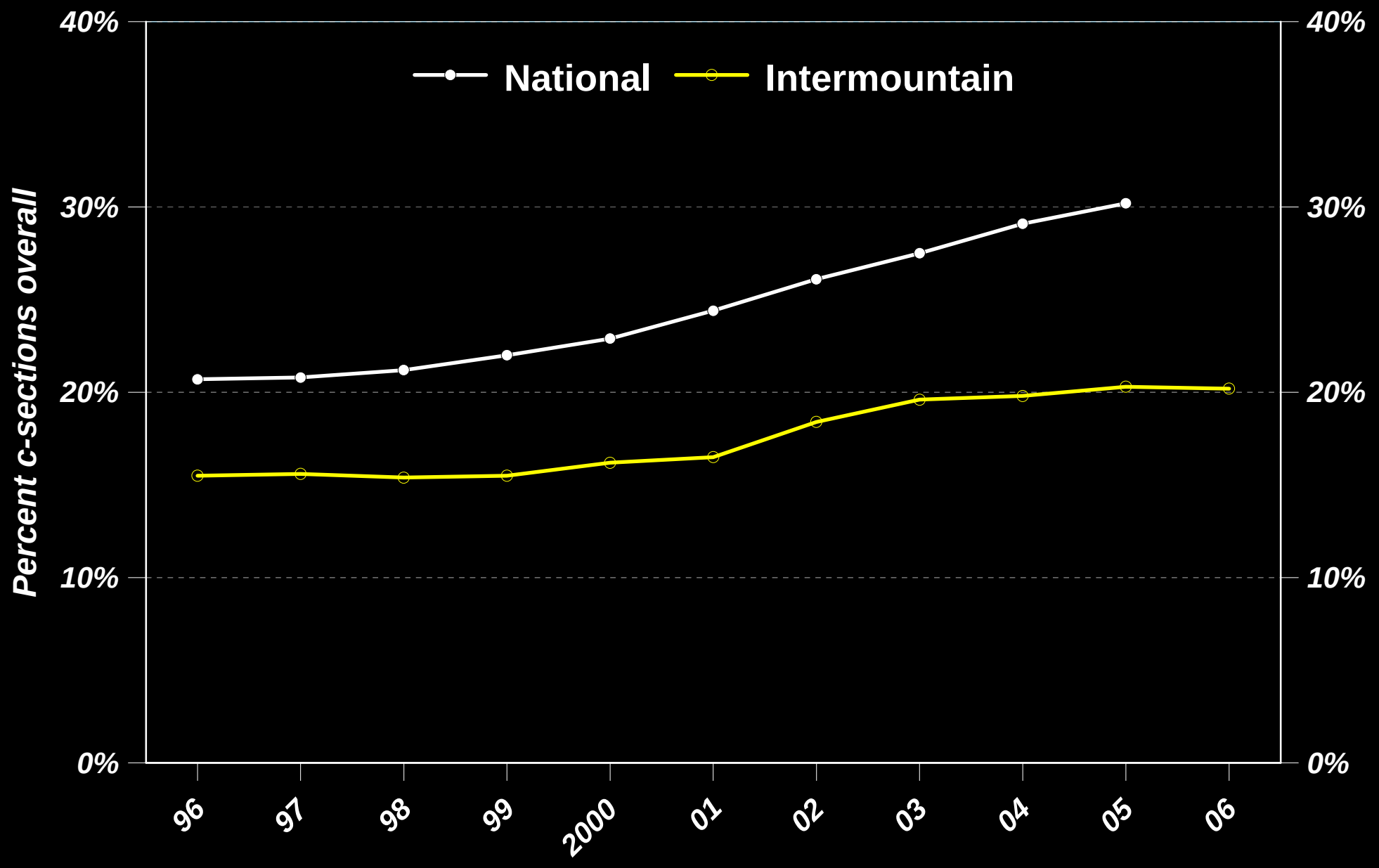
Primiparous elective inductions



Elective induction: length of labor

(note: includes all elective inductions)

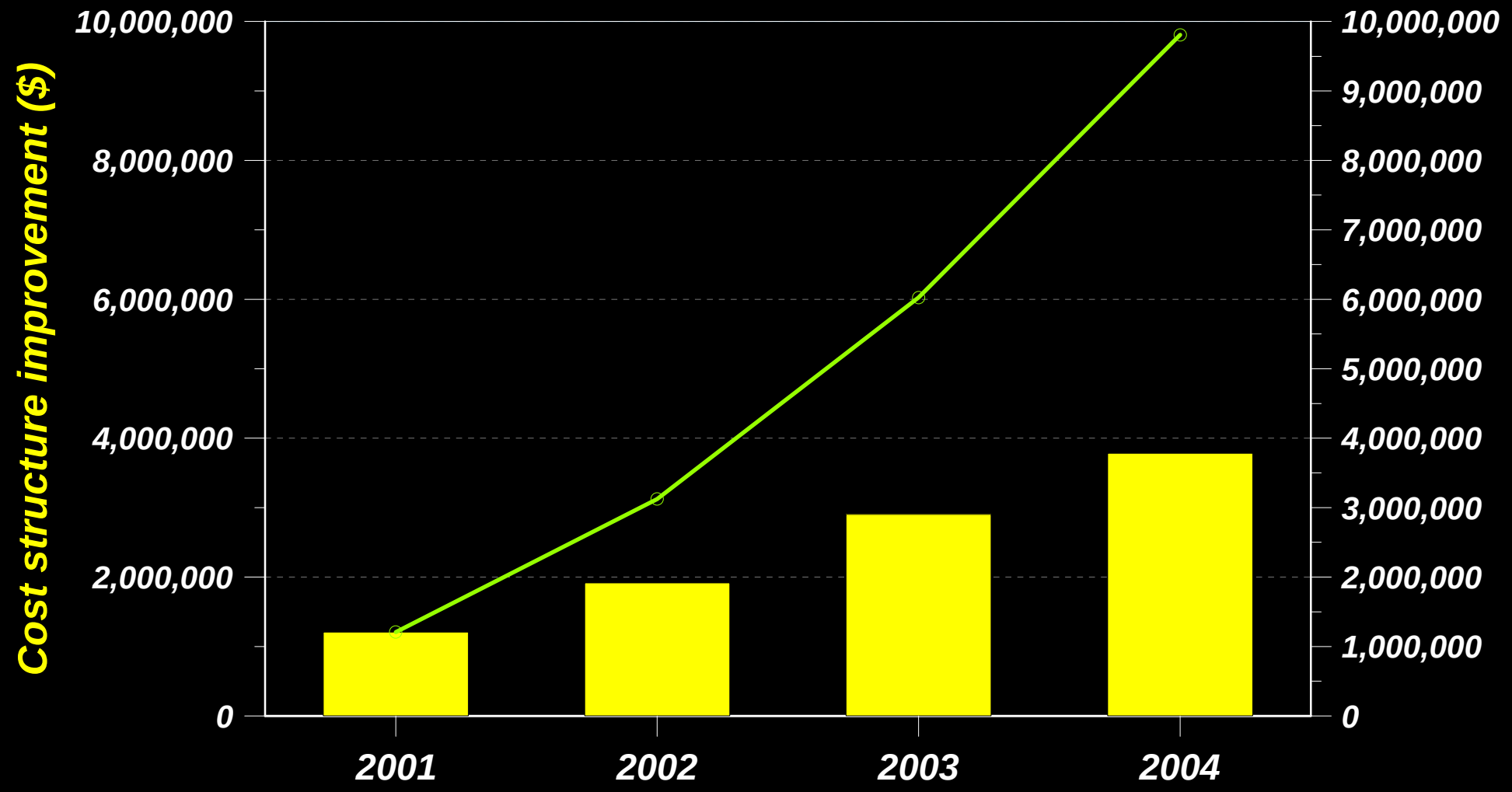
Overall c-section rate



Quality-based cost improvement

Combined maternal and neonatal variable cost

Deliveries without complications resulting in normal newborns
Actual - expected cost, based on year-end 2000 with PPI inflation



Deming: Quality controls costs

	Quality	Cost	Forum	Potential Savings
Waste:				
Quality waste	↑	↓	*internal*	*25-40%*
Inefficiency waste	–	↓	*internal*	*> 50%*
Cost-benefit	↑	↑	*society*	*(none)*

50+% of all resource expenditures in hospitals is quality-associated waste:

- *recovering from preventable foul-ups*
- *building unusable products*
- *providing unnecessary treatments*
- *simple inefficiency*

Andersen, C. 1991
James BC *et al*., 2006

Rough estimate: more than 80% of all cost saving opportunities lie on the clinical side of the line

Nested waste analysis

1. Population Level

(a) Supply-induced overuse *- no benefit to patient; should never have been done* **14%**

(b) Preference-induced overuse *- if given a fair choice, patients opt out* *(left out)*

2. Episode / Microsystem (process) Level

(a) Preventable patient safety events *(left out)*

(b) Evidence-based best process implementation *(left out)*

3. Patient Level

(a) Non-value adding front-line work **35%**

(b) Administrative efficiencies *- including regulatory mandates* *(left out)*

Effective, efficient care

- everything that works, but only what works;
- at the lowest necessary cost; with
- no unnecessary delays;
- no unnecessary risk or pain;
- under the patient's full understanding and control;
- to all in need;
- good this time, but better next time.

Shared savings? *(2008 data)*

	Per Case	
	Cost	NOI
Normal delivery:	**<1.00>**	**303**
Unplanned c-section:	**<2.05>**	**648**

Aim: *reduce unplanned c-sections by 2 percentage points*
(6.25% to 4.25%; more than 670 fewer c-sections per year)

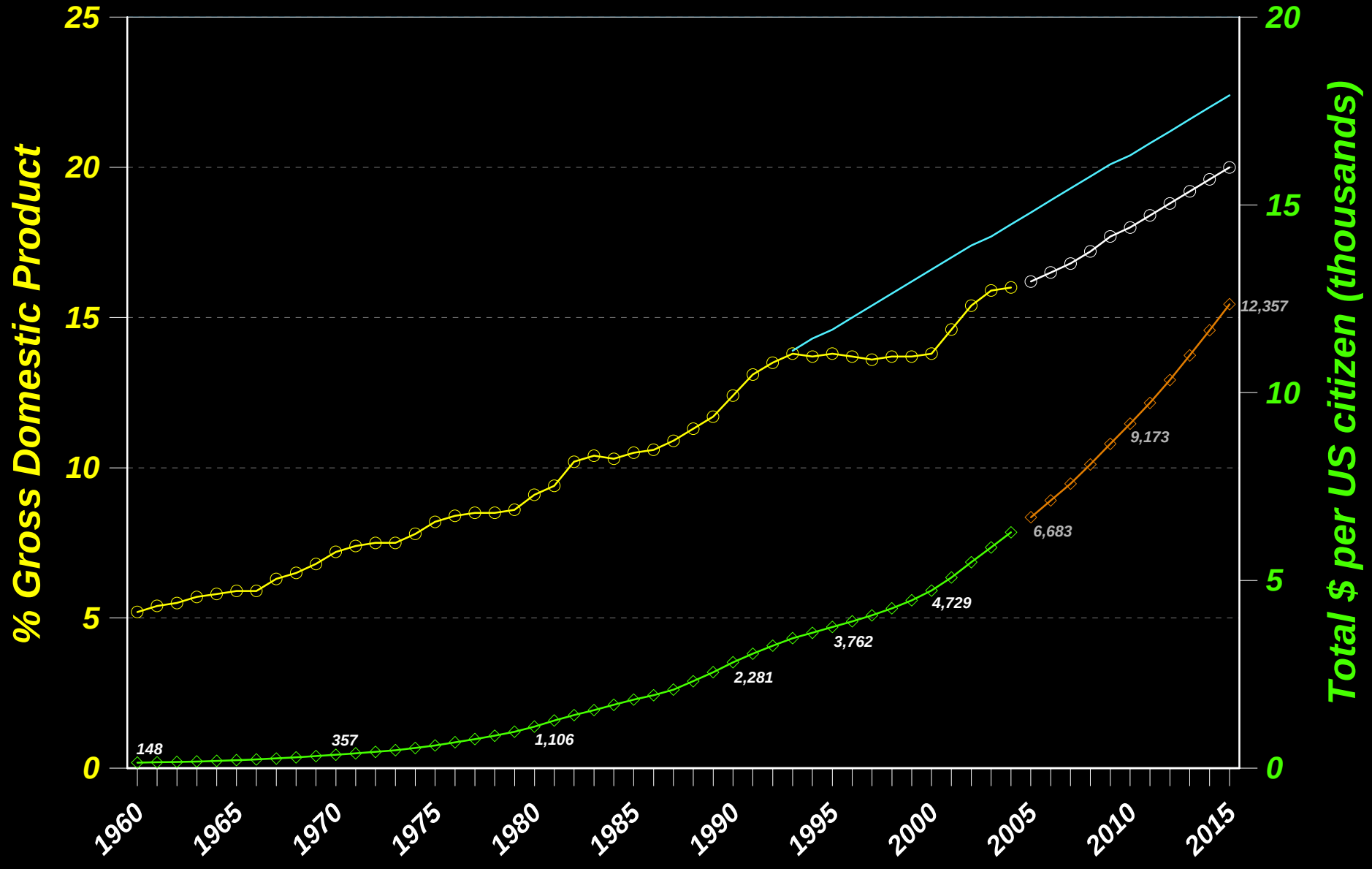
Reduced cost:	**1,991,860**
Reduced revenue *(insurance payments)**:***	**2,216,800**
Reduced NOI:	**224,940**
Reduced contribution to margin:	**1,370,222**

(2008 data)

Current payment mechanisms

- ***Actively incent overutilization:*** *do more, get paid more - even when there is no health benefit*
- ***I am paid to harm my patients*** *(paid more for complications)*
- ***Actively disincents innovation that reduces costs through better quality*** *(a key success factor for the rest of the U.S. economy)*
- ***Very strong, deep, wide evidence showing exactly this effect throughout U.S. healthcare***

Bending the cost curve



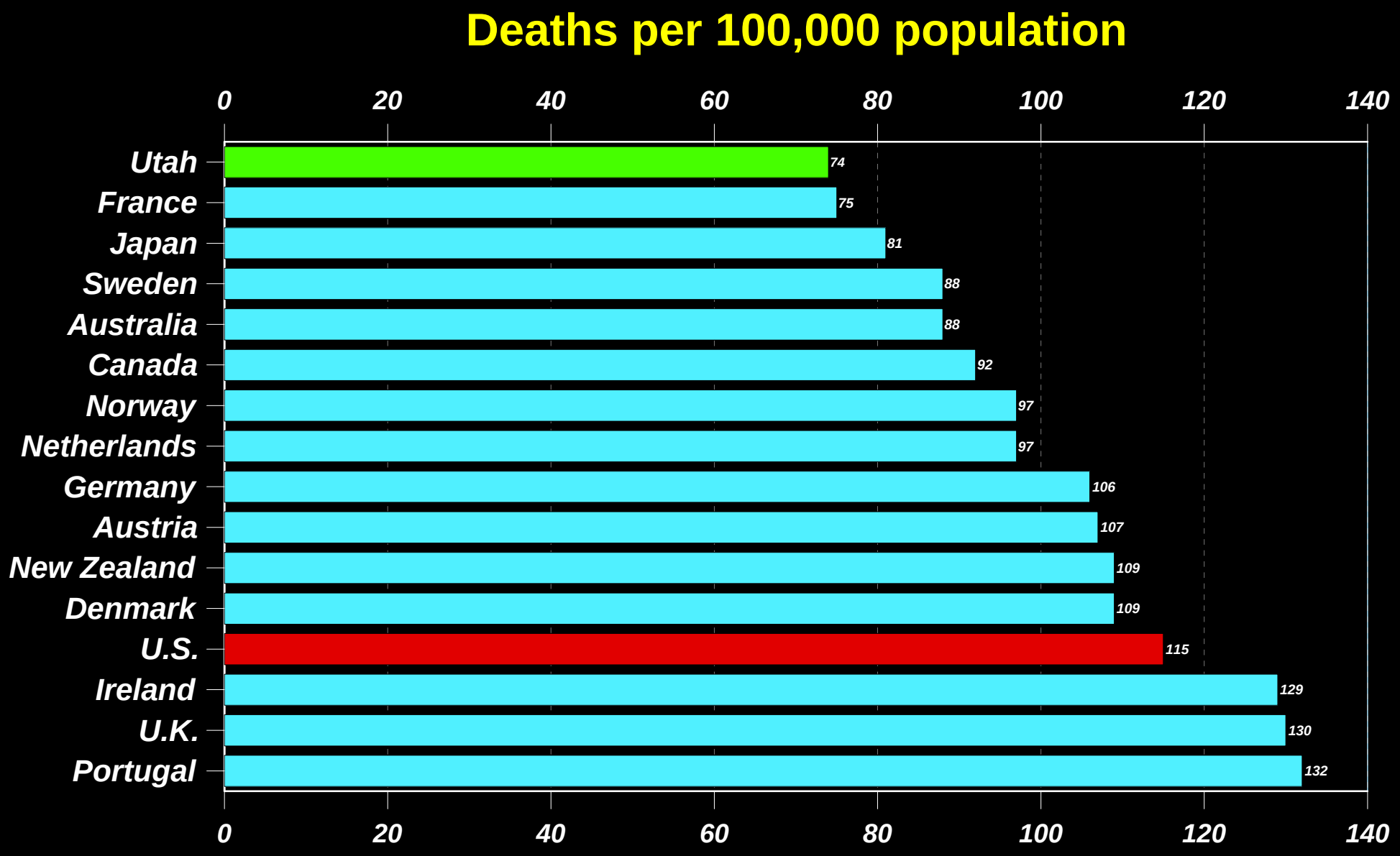
Capitation makes a comeback

1. ***ACOs, AMHs: sophisticated forms of capitation***
   - *provider at (financial) risk: bundled payment, chronic disease capitation, etc. … but with*
   - *better data systems (quality measaurement) and better risk adjustment*

2. ***Represent "managed care at the bedside"***
   - *managed care the only method that has "bent the cost curve"*
   - *shifts control / accountability from insurers to care delivery groups*

3. ***More than 80% of cost saving opportunities live on the clinical side***

Mortality amenable to health care



Source: World Health Organization, Nolte and McKee, Rutgers Center for State Health Policy Standardized for age (1998)
Utah from 2003, normalized for general US change from 1998

The Wall Street Journal

Perverse Incentives in Health Care

April 5, 2007

John C. Goodman, President, National Center for Policy Analysis

Research at Dartmouth Medical School suggests that if everyone in America went to the Mayo Clinic, our annual health-care bill would be 25% lower (more than $500 billion!), and the average quality of care would improve. If everyone got care at Intermountain Healthcare in Salt Lake City, our healthcare costs would be lowered by one-third.

Of course, not everyone can get treatment at Mayo or Intermountain. But why are these examples of efficient, high-quality care not being replicated all across the country? The answer is that high-quality, low-cost care is not financially rewarding. Indeed, the opposite is true. Hospitals and doctors can make more money providing inefficient, mediocre care.

Wells Fargo inflation summary, 1988-2006

December 2006

WELLS FARGO

COST OF LIVING INDEX

	Wasatch Front			National			
	Index Mar. 1988=100	% Change 6 Mos.*	(Non-Seas. Adj.) 1 Mo. Prior	Index Mar. 1988=100	% Change 6 Mos.*	(Non-Seas. Adj.) 1 Mo. Prior	(Seas. Adj.) 1 Mo. Prior
All Categories	**154.6**	**-0.1%**	**0.2%**	**173.4**	**2.7%**	**0.1%**	**0.5%**
Housing	182.8	2.7	0.1	175.6	3.8	0.1	0.4
Transportation	120.2	-11.4	-1.4	163.9	0.8	0.9	1.8
Health Care	157.4	0.1	-0.1	249.5	3.9	0.0	0.1
Food at Home	201.2	3.3	3.1	170.6	1.8	0.0	-0.3
Clothing	113.2	-1.6	0.6	102.9	0.2	-2.5	0.6
Food Away	162.2	0.0	0.0	168.7	3.2	0.3	0.3
Utilities	128.7	-1.0	0.0	175.4	3.1	1.1	1.2
Recreation	139.1**	5.8	0.0	109.8†	1.3	-0.4	-0.3
Education & Comm.	124.6**	5.6	0.0	116.2†	2.5	-0.1	0.2
Other Goods & Svcs.	104.3**	0.0	0.0	243.3	2.6	0.7	0.8

*Last six-month percentage change compared with same period one year ago.
**(Feb. 1998=100 base)

National Data Source: U.S. Bureau of Labor Statistics
†(Dec. 1997=100 base)

"Better has no limit" *(an old Yiddish proverb)*

- ***The professions passed the tipping point roughly 9 years ago; accelerating rapidly***
- ***Similar major change in care delivery operations***
- ***Tightly linked to better internal data*** *(true transparency)*
- ***Often called "Organized Care:" Health care as an organized system focused around patient need*** *(not built around physicians or technology; "patient-centered care")*
- ***Financial incentives*** *(payment)* ***aligned to appropriate patient-centered professional goals = provider "at risk" payment*** *(ACOs; AMH, bundled payment)*
- ***Key operational idea: Don't wait for Washington***