The Alphabet Soup of Care Delivery Transformation

Alliance for Health Reform
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ED HOWARD: —can get started. I think that would be a good thing it being 12:17. My name's Ed Howard, I'm with the Alliance for Health Reform. I want to welcome you on behalf of Senator Rockefeller and our board of directors to this program about American's healthcare delivery system, its major shortcomings, what's being done to address them in both the public and private sectors and what seems to be working.

As we pointed out in announcing this program, a major shortcoming in the current system is fragmentation. Your primary care physician may be the last one to know what your cardiologist is doing or your radiologist or for that matter your pharmacist. Both the private sector and the public sector are addressing this fragmentation with strategies that collectively amount to that alphabet soup that we referred to in the title of the program ACOs and PCMHs and P4P and I'm learning even more obscure ones like CPCI and MCCD which are not roman numeral years that you have to worry about. Today we're going to try to sort out at least some of them for you and check their status.

We're pleased to have as a cosponsor and a partner in today's program WellPoint that is the operator of the Blue Cross Blue Shield plans in more than a dozen states covers what 1 in 9 Americans. It's a real pleasure to turn to WellPoint's

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Chief Medical Officer Dr. Sam Nussbaum who's going to help moderate today's discussion and get us started on the substantive conversation with an overview of where we are today. Sam.

SAMUEL NUSSBAUM, MD: Thank you. Thank you Ed and welcome everyone. WellPoint is delighted to help shine a light on those innovative areas in care coordination and delivery system change that are making a difference for care in our nation. It is a particular pleasure to work with Ed and the Alliance for health reform to make a difference to inform and sort of work in an arena that there's a lot of knowledge but we need to have data and information to support that.

What we do know is that our healthcare system has many challenges. Whether we look at the work from McKenzie World Global Institute or whether we look at the Commonwealth Fund, we do not rank high when it comes to quality, clinical performance, when it comes to longevity, when it comes to equity, when it comes to health. We do rank at the top and far at the top when it comes to cost. Why? We know there's variation in quality, safety, outcomes and cost in our nation. So much so that no matter what service we look at, we can find three, four, seven or 10-fold variation.

We know that increasing costs and technology are going hand in hand and this technology's breathtaking and it's

leading to healthier lives and in many instances cures of incurable disease, yet it's not always used in a way that leads to better outcomes and where the evidence is. We have an aging population with chronic illness. Ed said and talked about a fragmented healthcare system, shortages of primary care delivery and you see we have the perfect storm for what we have here which is costs that continue to rise, approaching 18, 19, 20-percent of the GDP over the years ahead. Healthcare costs for the individual and for employers and for government for CMS, for state governments that are taking away from our necessary infrastructure.

In fact, it's fascinating to me that when we look at healthcare and we say that the choices we make our behavioral patterns in life whether we smoke, what we eat, exercise as well as our genetics and our social circumstances so the social determinants of health and genetics account for about 85-percent of all premature death, most illness. Yet the healthcare we receive far less, 10 to 15-percent. What's interesting is, and somewhat stunning is that as we put more and more into direct healthcare services we starve education, we starve all of those areas that we need to have better health and better health outcome.

We also know that to manage cost we have to attack those areas where healthcare costs are so concentrated. Here's

some data from Medicare. You're going to see this again from Leeba. If we were to look at Medicare beneficiaries, 15-percent account for 75-percent of cost. These are individuals with complex illness, often with illness that can be far better managed. In the commercial side at WellPoint, 1 in 9 Americans, 1-percent of our membership drives 28-percent of cost and 5-percent drives 54-percent.

You have to approach this in two ways. You have to coordinate care, have secondary programs of preventing deterioration of health for that group. At the same time, we keep healthy people healthy and promote their healthy lifestyle. Those are basic elements that we're living with, but also there is excessive overuse and waste in the healthcare system.

There are different estimates of this. Some would say that 30 to 40-percent of all healthcare delivered doesn't lead to a better outcome, is not supported by science and therefore if we could remove it, it would be advantageous. Sort of, it is like fat and heavily marbled meat, meat that we shouldn't be eating, but that fat is very hard to dissect. You can see what some have believed that poor care coordination, unwarranted use of services, even fraud and abuse. What I think you will see from today's discussion is care coordination and the ability to improve those aspects of care can have a profound difference.

This is occurring in an environment, which is rapidly transforming. It used to be that insurers would provide financial support for programs and access. That's what really much of the last several years have been about, the insurance side, the access and the cost side of healthcare and healthcare reform. What's increasingly evident to most of us is that the delivery system needs to focus on driving higher quality, better health and lower cost.

It's a delivery system that's in flux. If we look at insurers, here we see Highmark and Humana, united health group and WellPoint insurers are getting into the delivery of healthcare services. If we were in Pittsburg, you'd see that Highmark has acquired the West Pen Allegheny system. Humana, a series of clinical sites in Concentra. United Health Group working with Monarch and other physician groups. WellPoint working and pleased with CareMore that you're going to hear more about.

At the same time this is happening, physicians are aligning with hospitals and delivery systems. There's been a velvet revolution of sorts where approximately 50-percent of America's physicians today are employed through a health system. When you think about how we can use what Atul Gawande and others are now calling big medicine, how can we use big medicine to have better outcomes of care?

We know from a January report of CBO when we actually look at how effective we have been and these are the Medicare demonstration projects that have looked at disease management and care coordination as well as value based payment. In an independent review of at least 10 demonstrations, most have been shown not to reduce spending. That doesn't mean they don't work if they could be enhanced. In fact if you look at those which have had a better outcome that's substantial, a direct interaction with patients and doctors and caregivers at the point of care, and there's a lot more of what might be termed feet on the street and facility based care for the most complex individuals.

These programs in of themselves are costly and that's where the investment was not shown in the CBO studies. From Leeba, Randy, and Arnie, we're going to be looking at this in some greater detail but what's clear is substantial change to payment and delivery is required to reduce spending and improve outcomes, substantial change. In fact, on Friday Health Affairs convened a meeting at the National Press Club. I don't know if some of you were there, where they had a thematic issue and the thematic issue was on payment innovation. If you get a chance, it may be valuable to look at a number of those papers because a lot of these were the early results from ACOs, medical homes and other programs.

Here's one example of where we can make a difference. Think about this, if you were a Medicare beneficiary and you're hospitalized, you have a 20-percent likelihood of being rehospitalized within 30 days. Much of that is a failure of care coordination. In fact, in some of the work that Steve Janx did several years ago, at least half of the Medicare beneficiaries did not even have follow up in that month, did not see a nurse, a doctor or others. There are ways of intervening by medication compliance, adherence, community resources, understanding discharge instructions that can absolutely make a difference along the way.

At WellPoint, we started several years ago to change the model of payment. We started with doctors and hospitals and we started at a very basic level. We said let's reward health outcomes, population health, higher quality through our payment systems. Last year we took this work called the Hospital Quality Improvement Initiatives or QHIP and we actually said that hospitals would not see more payment from us unless they succeeded on a series of 47 performance measures, and these measures were all about patient safety, clinical quality, clinical care and improved outcome.

As we talk about how these different payment models will work, it's going to be very dependent on the level of integration, sophistication and capability of each community,

of each market. This graph portraits that. It is pretty easy, relatively easy to do performance-based payment for hospitals and doctors even in a not highly coordinated, integrated model. When you start talking about patients that are medical homes, bundled payments and ultimately ACOs and other advanced delivery models, where you're paying either through capitated models or through budgeted models or through gain sharing, it's going to take an extraordinary degree of integration. Integration of information, integration of care points and importantly information given to patients to make better, wiser, healthier decisions for their care.

I'm reminded if we think of a race to value based care, now these are some pictures from the London Olympics and it's Sam Bolt as you can see winning. We don't expect this to be a sprint, this is a marathon. What we know is that there are certain tenants that are essential to win and principles for value based care, primary care, principal care is a central component. A commitment to medicine that makes a difference. Again, we still have to innovate and make sure we advance new technologies and treatments, but what we use in practice needs to be evidence based.

We want information more and more at the point of care to guide informed decision-making. We need to focus on health

not just healthcare, health and prevention. Risk reduction if you have chronic illness and above all coordination.

There are concerns along the way. Those concerns are will individuals tolerate more limited networks of care that can better coordinate care. How do we manage with the overuse of supply sensitive services? If you think of what hospitals have done, particularly hospitals, they've acquire not just primary care doctors but 50-percent of cardiologists, oncologists. These were rainmaker physicians who in fact drove revenue. How do you live in a world that was built to optimize fee for service revenue now at a time we're trying to optimize population management and more efficient services for the individual?

In addition there's been a payment shifting and cost shifting that's pretty profound. If we were to share openly and we do on our website in many instances what it costs in the private sector for the same services that CMS is buying, there's a vast difference. Often twice or more. We've shown some of that transparency and what it costs to get certain services, but a lot of that cost shifting needs to have new models going forward. How do you again take big medicine, which has historically been used to have leverage in contracting for the private sector and then convert that to a driving care and efficiency?

That's really what our day is about, and as I turn this back over to Ed, I want to say there's a lot that is very, very encouraging. You're going to hear experiments today. We're going to see that CMS, it's Center for Medicare and Medicaid Innovation I believe one of the jewels of healthcare reform is really building public private partnerships to test models for better care. Whether there's the multi-payer advanced primary care models or ACOs or this Ed your new initials CPCI where we're pleased to be working in three of the seven markets or Partnership for Patients Over Safety or the Innovation Challenge which as been awarded some very large grants for points of like.

There is a lot of innovation in public, private sector activity going on, but it will take a lot of not only innovation but also velocity for us to get there. Ideas that can be explored both across multiple payers but also having payers break out and test models when partnerships of the delivery system. That's the potential, that's what we're going to discuss today. That's what we are excited about getting your input and moving forward. Ed, let me turn this back to you to introduce our colleagues who are going to be leading this discussion.

ED HOWARD: Great, thanks very much Sam. I assume that that marathon can be done in under three hours you might say.

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SAMUEL NUSSBAUM, MD: You're not making that as a political statement give the discussions about marathon times are you?

ED HOWARD: I don't know what you mean. Before we introduce our panel I do want to just handle a couple of logistical items. You have a lot of good material in your packets. It's all also online at allhealth.org if you want to take a look at it later or share it with some of your colleagues. There will be a webcast available of this session on we hope Monday on kff.org, which is a service of the Kaiser Family Foundation. We appreciate their being willing to provide that.

On our website you'll find a transcript in about a week or so and there's also a longer list of materials that aren't in your packets that you can use for further research. There are green question cards that you can use. There are microphones you can come to ask questions when we get to that part of the program. My favorite part of the packet, the blue evaluation form which we would desperately love you to fill out before you leave so that we can improve these programs even more for you.

As Sam said, we have a terrific panel lined up and we're going to start with Randy Braun. Randal Braun is the Vice President and Director of Health Research at Mathematica

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Policy Research. He's done a ton of work in care coordination including a current evaluation of several care coordination projects for people with disabilities that he is working with HHS on. If you've looked at Medpac's 2012 report and you take a look at the care coordination chapter you'll see Randy Braun in the reference list in the back time and again. This is a guy everybody looks to for guidance in this area and we're very pleased to have you with us, Randy.

RANDALL BRAUN: Thank you Ed. Okay, I think this is on now. I have been working on care coordination for people with chronic illness for about 20 years now, so I'm going to talk today about what I think is the current state of knowledge about what works and what doesn't based on findings from federal demonstrations and the public papers. By what works I mean intervention that reduce the number of preventable hospitalizations by at least enough to cover the care coordination costs.

I'm going to focus on interventions and fee for service Medicare that still covers about three-fourths of all beneficiaries because that's where the credible and available evidence is. I'm going to talk about four things today, each very briefly. What do we know about effective care coordination? What characteristics have new CMS initiatives are likely to bring savings from Medicare? What can we do to

enhance the likelihood of success? Even the options that have some potential for success also have a high likelihood of failure unless we learn from the past 15 years of research. Finally, I'll say a little bit about what I see as the major barriers to success.

There are a lot of studies claiming very large effects of care coordination interventions but a lot of these studies are weak and unreliable. There is a solid body of rigorous studies and so here's what I think these studies tell us about which interventions do and don't produce real reductions in the need for expensive healthcare services and fee for service and Medicare.

I'll start with the CDO study from last January that Sam mentioned. It was written by a former colleague of mine Lyle Nelson who's a very careful, thoughtful researcher. It concludes there's very little evidence that fee for service based care coordination works based on 10 different studies involving over 30 programs, about half of which are telephonic disease management programs. It basically says most of them show no effects and even ones that do don't show large effects so the savings are likely to be minimal if they exist at all if we can't do better than that. Also found that value based purchasing programs tend not to generate savings.

The CBO studies are maybe a little too negative I think. The programs listed on this slide are rigorous studies that find significant favorable effects on hospitalizations, but importantly the effects are concentrated entirely among a high-risk subset of patients defined in various different ways. I won't go through all of the things on this slide due to time, but the first one I want to mention is the transitional care models, which Sam mentioned too. There's two models that were found to reduce the 30 day readmission rate of Medicare beneficiaries discharged from the hospital by about a third so that's pretty substantial savings.

There's the Medicare Coordinated Care demonstration that my colleagues and I published a paper in *JAMA* about in February of 2009. It had pretty discouraging results overall, only one of the 15 programs generated savings. A follow up study that we published in *Health Affairs* last June showed that four of the 11 programs that had enough enrollees to look at this subgroup reduced hospitalizations by about 15 per 100 beneficiaries per year and that was over a six-year follow up period, so every year for six years. Again, this was only for this high-risk subset of chronically ill beneficiaries.

I also thought from this I ought to highlight the Steve Counsel's GRACE model, which served low income seniors with multiple chronic illnesses and functional impairments using a

team based approach comprised of advanced practice nurses, geriatricians, the primary care physician, a social worker. That reduced hospitalizations and emergency room use but again only for a high-risk subgroup and the savings didn't occur until about the third year. One other thing that we know is the exclusively telephonic disease management programs don't seem to work at all, at least not in this fee for service setting.

Given that there are a lot of care coordination programs that failed but some that succeed what distinguishes the successful interventions from the unsuccessful ones? There are six common features that most of the successful programs we looked at and these other studies had exhibited as well, but very few of the unsuccessful programs had these features.

In successful programs care coordinators do the following. They had frequent face-to-face contact with patients. By that I mean about one a month for the first year at least. Care coordinators had strong report with patient's primary care physicians either through preexisting relationships, being located on the same medical campus or attending office visits with the patient. They used motivational interviewing, and other proven methods for actively engaging patients and educating them and overcoming

their personal barriers to adherence to medication and self-care recommendations.

Fourth, they found a way to consistently learn about hospitalizations while the patient was still there, so they could implement their timely comprehensive intervention they often return home with a good understanding of what they and their caregivers have to do to avoid a readmission.

The fifth thing that distinguishes these successful programs is they played an active role in communication making sure that patients communicated important information to physicians that they understood what they heard from providers and that primary care physicians received test results, referral findings and other key medical information from patients, other providers. Finally, they had reliable information about patient's medications and access to pharmacists or a medical director so that they could make sure that patients were on the right medications, weren't taking a mix of medications that was incompatible and that the patient wasn't overmedicated.

The question is does the ACA have provisions that suggests we're going to implement these lessons learned and achieve these elusive savings? Or are we just starting over from scratch with the newest idea on the block? There are a lot of payment reforms and practice reforms suggested in the

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ACA and a number of them have promise including the ones listed on this slide. Some of these are underway. There are two large patient centered medical home demonstrations, the CPCI one, which my colleagues and I are evaluating for CMS and the multi-paired advanced primary care practice demonstration. There is advanced payment ACOs with the pioneer program and a number of others like fully integrated care for dual eligible's and the independence at home program.

The success of these is going to depend greatly on whether they are implemented in ways that build on the lessons that we have learned about what actually does work. It doesn't matter if you call it an ACO or a medical home or fully integrated care. How you design, target and deliver the intervention to the high risk patients will determine whether it's going to save any money.

One option it does have evidence of saving but which I don't think is actually the best approach for people with chronic illnesses is bundled payments for episodes of illness, like 30 days after a hospital admission. It's a great idea for minimizing cost shifting, but what people with multiple chronic illnesses need is help to prevent the adverse health episode, not figure out how to get the care more cheaply from Medicare. It has potential for saving money but it's not the be all end all from the perspective of the beneficiaries.

What can we do to increase the likelihood that the ACA options will actually produce real savings for Medicare and taxpayers? You need to require that they have features that nearly all the successful past programs have found to be important. New demonstrations are pretty prescriptive so this might be happening. They need to focus on high risk patients. For example, medical home demonstrations are expected to provide a medical home for all beneficiaries, but the savings are going to depend almost entirely on what they do to coordinate care for the sickest 20-percent. They need to pay enough for these cases and not so much for the others to focus the program's attention on where it's needed, and that doesn't appear to be what CMS is doing.

We need to feed back timely information to programs and physician practices. They need to know how they're doing on both quality and cost efficiency so they can adapt. The new CMMI initiatives have this feedback built in. Fourth, these interventions should build in studies of operational issues. There are many, many unanswered questions about what assessment tools work best, which fall prevention program is the most effective, which motivational intervene techniques really are effective. Several demonstrations have built in learning collaborative so the participating programs or states can share what they're learning, so that's another positive sign.

Finally, while it looks like several of these new initiatives have promise, let's talk just for a minute about three factors that could pose a real barrier for the progress and the efforts to improve the lives and lower the cost of Medicare beneficiaries with chronic illnesses.

The first important barrier is excessive attention to rapid cycle learning. That's the mantra these days. We all want to learn quickly what works but quick answers are often wrong answers. I have two examples that I can tell you about where this would have occurred if we'd looked at only short-term effects. Some of the demonstrations have a two-year timeframe for programs to show savings or they can be terminated, so that's a potential risk.

Takes a program time to learn how to implement interventions effectively in their own environment and to build report with patients and providers. We can shorten that time relative to conventional demonstrations by looking at intermediate outcomes and using some new techniques or plan to do a study act approaches and sharing lessons. We're also developing interventions built on prior successes that could shorten the time to observed improvement.

It's important not to sacrifice rigor of evidence for speed. A quick but wrong answer will cost you far more than a slower but accurate assessment of an intervention and if an

ineffective program is implemented, you won't realize it's costing you more for years. Even worse might be the lost opportunity due to rejecting too quickly a program that does have real potential.

Second major barrier to saving money through care coordination or other AC interventions is the lack of political will. Failure to withstand pressure, special interests with deep pockets will fort attempts to save. It has happened many times in the past and it's something that has to be continually watched.

Finally the third barrier to controlling cost is lack of adequate information and incentive for providers to do the right thing. Physicians need data on quality and efficiency and payment to providers should be tied to both factors. More care isn't necessarily better care as we well know now. New initiatives from the CPCI and multi-peer advanced practice primary care practice demonstrations are providing shared savings and feedback so they're providing both the incentives and the information on quality and cost to participating practices. These programs are on the right track. The evidence suggests that you shouldn't expect large savings and we need to find cost effective ways to deliver care coordination. Thank you.

ED HOWARD: Thank you very much Randy. We are going to turn now to Dr. Arnold Milstein from Stanford Medical School where he directs Stanford's Clinical Excellence Research center. He's also the Medical Director of the Pacific Business Group on Health and does a great deal of work for Mercer. His experience with care coordination efforts is both wide and deep and I commend to you the *Health Affair's* article in your materials on Medical Homeruns which he is responsible for and which describes some program that are doing a good job of coordinating care. Arnie, thank you for being with us. You need to give it a second to pump up. It's good to have a lot of microphones.

ARNOLD MILSTEIN, MD: Thank you. As described in the introduction I've been looking at the same questions Randy's been looking at but through somewhat different lenses. I've led I guess two lives. First I've been a private sector advisor helping very large public and private purchasers identify and implement new ways of delivering care that generate more health with less money.

My work at Stanford Research Center is complementary to this. There having reflected on what successful innovators aimed at more health with less money have achieved at our research center. We then attempt to design and demonstrate new care models that will push America's price performance frontier

even further given the national urgency of transforming our health system into something that is a little bit more globally competitive then our current health system is.

I've labeled this learning from new leaders and the value of healthcare. Most of my good ideas come from taking a look at those who were succeeding, so think of my perspective as one of someone who's really a good listener to positive outliers. By the way, I'm going to boil all this down into three things.

First I'm going to digest the common ingredients of the care delivery innovations that is with all the tools available in the private sector we believe are generating more health with les money. Then I'm going to describe features of those that are able to take such care models and replicate them, get them to scale which is obviously a huge challenge for us nationally. Then I'm going to derive three key policy takeaways. My six years as a MedPAC commissioner trained me to think in this way. It took a while, but by about year three I figured it out.

Okay, let's go ahead with one of the commonalities again through a private sector lens looking at innovations serving the commercial sector and because many of the large employers have retiree health benefits. This also reflects what I observe looking at Medicare advantage plans. Though

I'll tread lightly on that because Leeba will go into that with much greater detail and personal knowledge.

I discern three primary commonalities among those delivery systems that do seem to be generating more health with less money. First they emotionally connect. They very easily connect meaning if it's 7:00 on Sunday night and you're a scared senior or an under 65 person with a severe chronic illness you don't get an answering service and a two hour phone call back, you get someone on the phone relatively quickly who knows about you and is part of your care team. An emotion connect is very important.

The programs that are successful are also focusing a theme that Randy hit upon, tend to be focusing on the most clinically unstable patient cortile among those over 65 and patient decile for these under 65. The reason is very simple, it's much easier to invest resources preventing expensive health crisis when the alternative is somebody who's going to spend a lot of money. As you begin to move down the curve in terms of how sick people are, it's very easy to overspend resources relative to any chance you have of preventing an expensive health crisis. That's my take on what I've observed and what I think is how it's one way of thinking about Randy's similar finding.

Second common element is they use care coordination but not only care coordination but also team-based coordination in which you're in a very disciplined way always delegating down to the person who's the least expensive but most qualified to get the job done to get the job done. It's not all done by 160,000 dollar a year, at least in California with benefits, advanced practice nurse on the phone. A lot of it is done by well-trained medical assistants and so called community health workers who can do a lot of the work very well if they're carefully selected and trained in motivational interviewing and some of the techniques that Randy mentioned.

The key thing is to if you are going to invest in preventing expensive health crisis, to do it economically. That's one of the things that when I read Randy's report and the CBO report on those programs, it isn't like a lot of them did reduce hospitalizations and emergency room use, but they didn't. Most of them did not pay sufficient attention to the cost of the method they were using to achieve those reductions. The few that did that's who in my opinion got into the winner's circle in terms of better health outcomes and lower healthcare spending.

Last but not least and I'm just very controversial and I'm sure there's someone who will object to this in the audience but use conflict tolerant primary care physicians to

shield especially medically fragile patients from the unjustified optimism of medical specialists. I don't think that needs further elaboration.

Let's now turn to something that often isn't addressed which is once you have a winning approach either to a single disease or across a whole population, which is what I like to focus on. What do we know about those that are actually able to multiply their success across different geographies, that is spread these innovations quickly, because that's often been the rap against organizations like Kaiser that did in some cases struggle to move their model to other regions.

The ones that I succeed doing it happened to share three characteristics. I see, thank you Leeba. There we go. Number one; don't compromise what's known to work to accommodate local clinical norms. I mean this is often done. How is this couch, it's usually couched as allowing the locals to kind of reinvent the innovation. I don't think that works anywhere near as well as focusing in on a subset of people who are local who are willing to take the innovation as its working and replicate it and not have to substantially redesign it unless there're population factors that would allow that to make sense.

Secondly, relative to what most business people would say they overinvest in selecting, training, ongoing, and

coaching with quantified measures the staff in the new locations. They're not left and then a year later somebody goes the medical loss ratios and quality scores are dismal, I wonder what's going wrong. The ones who are doing it well pay attention to this.

Let me now move to a close. I'll talk a little bit more detail on implications for policy making if what we're after and I think we are after this, is to safely bend US healthcare spending trend not just for Medicare and Medicaid but across the board because we want America's workforce and America's employers to be globally competitive. We want much more money left over for states to fund K-12 eduction, to fund basic R&B and the other things that are essential to I think American prosperity.

Number one, I know this is not easy to do, but we have to think about how we can begin to harmonize public and private measurement of and financial rewards to all components to the health system. The thing that America struggle with right now is a splintered payer system. I don't think politically we're about to go to a single payer system tomorrow. The key then to preserving some competition in the payer market is to do more in policy making to encourage the private and public sector both measurements of doctors and hospitals and incentives for

doctors and hospitals to begin to harmonize better than they do.

There are some great examples of this. You know, when I was in MedPAC one of the things I originated and it actually got passed into law was this extremely unpopular idea in some circles of no longer allowing Medicare to pay extra for hospital acquired conditions. That was a great example of the kind of synergy that can be created between public and private payers. One of the reasons I was able to persuade the house speaker's staff, to Bill Thomas's staff to lead on this and get some Democrats to support it as well was that we had a great example Health Partners. One of the more progressive Minnesota health plans had made this policy work and the Minneapolis hospitals had accepted it much to their credit.

We used that as proof of concept then pushed it through, get it into law. Then once it's now in law, the beauty of it is that now private sector purchasers, the private insurers and the Medicaid agencies and plans are beginning to reinforce it. It's a great example of the kind of synergy that can occur. The question is can we do more from a policy making perspective to increase that synergy both in how doctors and hospitals are evaluated on value for money and the kind of rewards that they now benefit from.

Today if you look at where we're headed the rewards from the public purchasers Medicare and Medicaid are primary through better payments, payment reform. On the private sector side I think powered by the Cadillac tax you're going to see a different form of incentivization that's going to have to do with incentivizing enrollees in private sector health plans to tilt toward the more cost effective doctors and hospitals. This was part of the magic of the so called ACO success of the CalPERS for its under 65 population in the Sacramento area which is very well written up if you're interested in reading about it.

It also was central to the state of Minnesota employee health plan's big victory. They've had without any watering down to the benefits plan or changing their demographics, they've held annual per capita spending for those employees to below 3.5-percent and that's with epi4 adjusting for inflation. It's been a tremendous success. Then what they do it is not by begging doctors and hospitals to take a bundled price, which is really hard to do. It's one thing if you're Medicare you can set prices. On the private sector side, you can't do that, so they're incentivizing their enrollees to actually switch doctors, not easily done but they've made it work.

The second point is just keep the focus whether you're using prices or patient movement on rewarding healthcare

providers for higher value gain per dollar per capita. It doesn't have to be ae bundled price, but it is a bundled unit of value assessment. Last but not least, I do believe that in the end if we want to bend trend more quickly, we're better off rewarding superior value by encouraging economically and otherwise enrollees to tilt toward the more cost effective high quality doctors and hospitals. Why? You aren't giving back a substantial share of the savings in the form of I do not know what you would call it. It's called payment reform.

I do not want to too adversely characterize it because I do believe in care payment reform. Obviously, there are political considerations and I know that I was on MedPAC and pushing for doing more to incentivize Medicare fee for service enrollees to tilt toward the higher valued doctors and hospitals I was told that like many of my ideas, they indeed might work but they were termed political nonstarters. I hope we can begin to change that as the pressure to reduce spending trend in the US safely continues to build.

Obviously in the private sector side sometimes moving enrollees by incentives or other encouragements is very difficult if the kind of monopolization or oligopolization that is starting to occur in some markets further solidifies. There's no place to incentivize them, to go. Thank you.

ED HOWARD: Great. Thank you very much Arnie. Finally we're now going to hear from Leeba Lessin who's the President of CareMore Medical Enterprises, a Medicare advantage health plan and one of the exemplary programs that Dr. Milstein writes about in that *Health Affairs* article. She has an extensive background in managing care systems and has been with CareMore since 2006 so she has been there to experience CareMore's acquisition by WellPoint about a year ago. Leeba, thank you very much for being here today.

LEEBA LESSIN: Good morning, thank you. I'm always excited to talk about what we do. I think it's really cool. It's really different and it's really hard to do in 10 minutes, so I hope you'll bear with me.

ED HOWARD: How about 11.

LEEBA LESSIN: Yes, 11 minutes. Bear with me as we run through a description of our model. CareMore has its roots in a medical group. CareMore Medical Group in Los Angeles area who in the late 90s figured out that if they moved into being a Medicare Advantage Plan and could essentially assume responsibility for 100-percent of the Medicare dollar for its members rather than a fee for service payment for services that that capitation, that lump sum could become the fuel for reorganizing healthcare. In fact, that's exactly what has become the case over the last several years.

We have moved from roots in Downey and Whittier, California to being spread throughout five southern California counties, three northern California counties, Las Vegas, large parts of Arizona including Phoenix and Tucson and we're opening on the east coast. Come January we'll be in Richmond, Virginia and Brooklyn, New York. Our replication skills will clearly be tested.

I will mention in my introductory comments about ourselves as well. With the advent of special needs plans and because of the models that you see here and will see in my comments, we moved aggressively into becoming a chronic care and institutional special needs plan in the early mid about 2006. That has been a significant enabler of the ability of CareMore to develop the chronic care programs that you'll hear about.

You saw this slide in Sam's presentation about the heavy concentration of Medicare spend. This is 2010 data, but the numbers are bearing themselves out for 2011 as well. That about 15-percent of Medicare beneficiaries consume 75-percent of healthcare costs. Anybody with any kind of structured thinking would say let's go after those costs. If we only go after what's actually happening in that sector it's not sufficient. We have to do a lot more work before people begin incurring these costs to ensure that the costs never occur.

In CareMore, for example, we spend more on healthy folks then the Medicare fee for service system does. We invest heavily in annual exams. We have proprietary and dedicated senior fitness centers that are very focused on a variety of muscular and other development that prevents onset of chronic disease. Everybody has an annual nutritional consult. We have significant behavioral health services, which are significant components to preventing chronic disease.

Once people are diagnosed with chronic disease, we spend much more on those folks in the early stages of their disease then are spent by the Medicare fee for service system. In large part seeing it as our responsibility to make sure that that disease does not take on the kinds of progressions that it might otherwise take on in unmanaged environments. For example, somebody with diabetes immediately moves into being at risk for kidney failure, eye failure, significant blood pressure related issues, cardiology issues, problems with feet, neuropathy, and amputations.

We see our job as not having those things progress for a diabetic and to keep them in an optimal state of control. As a result, we spend about half in this sector as the traditional fee for service population. Some of it is what we do. Actually once folks are in this most vulnerable state and the

level of care coordination that is applied, but a major portion of it is not having folks progress as in a complicated way.

There are so many things to understand about how CareMore does what we do. A fair amount of it just has to do with how we think. How we think informs what we do. For example, we think that healthcare is much more than clinical intervention. It's a combination of clinical, social, psychological, functional, pharmacological service. We see every one of our patients as a person with a need to have the sum total of these components of their overall health addressed.

Secondly, we think that clinical control is critical. We can't have 10 people giving advice to a family about what to do. We can't have eight doctors independently treating patients, we need clinical control. Thirdly and Arnie mentioned this, speedy deployment. We need to have the connection between our members need and our intervention happen in minutes not in hours, not in days, in minutes. I'll give you an example in congestive heart failure on that in a minute.

Arnie also mentioned the very critical need in our health sector to include non-physicians in patient care. CareMore employs physicians, but we also employ nurse practitioners, psychologists, social workers, physical therapists, nutritionists, respiratory therapist, and etcetera.

A team of non-physicians take over the primary management of chronic conditions and do all that prevention that I described on the first slide. Early intervention, you can see thematically that getting involvement into managing a disease at its earliest stages will prevent all of those long-term effects.

Finally and I don't think unimportantly we avoid fee for service whenever possible, at the most macro level we are not a fee for service provider. We are paid a lump sum by virtue of being in the Medicare Advantage Program from Medicare and we are responsible for 100-percent of our patient's care. As a consequence, we can decide that we're not going to pay a wound center for wound care. We're going to pay a certified wound nurse practitioner in someone's home. We can decide that a medical assistant is who is going to be paid to manage coumadin and not a doctor. We can decide that a patient can be seen twice a day, three times a day, four times a day even if Medicare guidelines only allow a once a day billing and so forth.

Being out of the fee for service rules if you will allows us to redefine clinical care in ways that allow us very rapid and very frequent interventions with our members. A key feature of CareMore system is what we call a CareMore Care Center. It's a physical location that becomes a medical home.

It is a place where primary care physicians refer members with chronic conditions, but it's also a place where we bring in members based on statistical variables. Anybody with a hemoglobin A1C over eight comes in whether the PCP refers them or not.

When I talk about clinical control, we don't call a PCP and say we noticed Mrs. Jones has a hemoglobin A1C over eight for six months now, is it okay with you if we do something about that. No, we read the data, we contact the patients. Of course, we're working with PCPs who know this is the game plan. The PCPs we work with are community PCPs. We do not hire our primary care physicians.

When I mention that we employ physicians, they are physicians that oversee the overall Care Coordination program and all of these interventions that I'm describing and then relatedly those physicians that are employed by CareMore we call them extensivists. They do all of CareMore's hospital work, all of CareMore's post-hospital work and all of the primary care for the frailest top one or two of our patients. The top 1 or 2-percent most at risk patients leave the traditional primary care system and are enveloped completely by CareMore extensivists.

It would literally take me an hour to describe to you what's on this page, but every circle here represents a

specific clinical program that has been developed by CareMore. About 70-percent of what is represented on this page would not be covered by Medicare. They are programs that have been able to grow up because we have the global payment from the Medicare Advantage Program.

These are all programs that are delivered in CareMore Care Centers by CareMore employed personnel. To the point of replication that Arnie made a few minutes ago, they all exist everywhere. These services that grew up in southern California and they're represented on this page, they are in Tucson, Arizona and Las Vegas, Nevada and they will be in Richmond, Virginia and they will be in Brooklyn, New York. They will be deployed identically to the way they are deployed in southern California.

One of Arnie's comments about not giving way to local community practice norms, I'll give you an example of the kind of courage that he was talking about as well. When we were looking to expand into Tucson a hospital that we wanted to work with owned a new beautifully built wound care center. They said we know in California you have nurse practitioners doing wound care, but we think if you're coming to Tucson, you should do the standard of care in the community and use our wound care center. Well we went back and forth, back and forth. We didn't want to use it. We finally went to them and said well,

we will use your wound care center if you take all downstream risk for amputations, fem-pop surgeries, the costs of a wheelchair for an amputated person, the cost of behavioral health from the amputated person and the ESRD costs for the amputated person. You can guess their answer.

The point is that to build a wound care center for the purpose of yes some community good but developing fees is very different than developing a wound care program for the purpose of never having someone in a wheelchair and never having them in an amputated state and ultimately on dialysis. Hopefully that tells you how we think.

You have in your packets several slides that go through CareMore's clinical programs and our specific interventions. I've mentioned wound care here and our diabetic wound care is 67-percent of the national average. You're 67-percent less likely to have a diabetic amputation if you're a CareMore member then if you're in the Medicare program. Every one of the interventions that you see on these pages take at least 50-percent of the cost and improve the quality by at least 50-percent for all of the conditions seen. Thank you.

ED HOWARD: Terrific, thank you very much Leeba. Let me just ask, you were talking about not consulting with the primary care physician when you have a situation where you think an intervention is needed. Does that mean that you are

very selective in the recruitment of primary care physicians in the first place or do you get a lot of pushback?

LEEBA LESSIN: Well, I would say that it's more of an evolving process. When we go to a community and we introduce ourselves to primary care physicians about half thinks it sounds awesome and half say those are my patients, you can't touch them. We start with a somewhat selected half. It isn't necessarily because we've been picky, it's because they've said okay, we like this program.

Over the course of two years, half of those initial PCPs will have left us because they find the program too intrusive. We will have gained about three times more PCPs who hear their patients say I'm leaving to CareMore because they take better care of me. Over a couple of years, our PCP group grows three-fold. One of my favorite statistics about us is when a PCP leaves us, 82-percent of their patients stay with us and say I'd rather be in CareMore than be with you which is radical for managed care.

A managed care mantra has always been you have to have the member's PCP to attract the member. We have been able to prove that if you give the member things they really need and their PCP isn't on board, they will make the change.

ED HOWARD: Good. Let me invite you now to join the conversation. As I pointed out there are some microphones that

you could use to ask a question orally. There are green question cards that you can put your question onto. If you'll raise your hand with card in hand, it will be brought forward. Also, want to invite Sam to chime in with questions and observations for our panelists or ab initio. Give you a chance to intervene at the moment. There we are. I would ask that you keep the questions as brief as you can and identify yourself.

CAROLINE POPLIN, MD: I'm Doctor Caroline Poplin. I'm a primary care physician. The first thing I want to say is I'm not sure Randy's presentation made it into the microphone. If you could check when you do your thing on the website. I think you were reading from something. If you could put what you were reading from on the website that would be terrific.

He said important things that no one else has said such as not running the change process too fast. If you look at the IOM report that came out on Friday, that's exactly what they're proposing. My comment, and that's really what it is most of the things involving care coordination are things primary care physicians or at least internists like me are supposed to be doing already. We're supposed to know if we sent a patient out for a referral what the consultant said. If you ignore what the consultant said or you don't find out what it was, that could be malpractice.

If insurers or Medicare would risk adjust the patients so that we got more money for seeing a more complex patient and less money for seeing a healthy person with a cold, and insurance I think you would get a lot of what you want with a very simple change so you don't have to restructure everything. You could do this now with fee for service in Medicare using the RBRVS system and it would be easy.

It's something I think you should consider because many doctors want to do the right thing and want to take comprehensive care of their patients, but they can't because the system pays them the same amount for an 85-year-old person with six chronic conditions and dementia as it does for a healthy person with a straightforward hypertension.

ED HOWARD: Responses to the comment. By the way, I'm told that Randy's comments were picked up by the recording if not by the PA system. You ought to be able to listen to that more closely if you missed some part of it today. Arnie.

ARNOLD MILSTEIN, MD: Yes, two comments. Number one is this issue of pace of change. I think keeping the pace of change slow makes a lot of sense through the lens of current healthcare providers. I'm not so sure it makes sense if one reflects on the opportunity cost to the country of slower progress on more health with less money.

Second point having to do with are primary care physicians capable of doing this if we had a more sensible payment system or a way for rewarding them. I think many are. I don't think at the level of sophistication of what I observed when I went to see CareMore. If you're interested in a third opinion about this, David Ruben, the Chair of Geriatrics at UCLA who found my Medical Homeruns Positive Characterization of CareMore which was only a half an hour where he was located to be literally beyond belief. It took a three person UCLA sophisticated clinical team onsite at CareMore for four days to dig into it to find what's really going on. I encourage you to read his editorial in *Geriatrics*.

What his conclusion was is that what the kind of I'll call it systems based medicine that CareMore has perfected; systems based medicine with I'll call it the human touch. In a sense of human psychology was something that American physicians particularly in relation to clinically unstable patients ought to be dreaming about and participating in and I think he was saying that for his own practice as well.

CAROLINE POPLIN, MD: Rapid change makes sense when you're very sure that the change is a positive one. If you're not sure having us all employed by HMOs or ACOs we may end up in a place that we don't want to end up in.

SAMUEL NUSSBAUM, MD: If I may add just one final comment because WellPoint is experimenting in both models, the proven model of CareMore. When you see this in operation you can see that quality improving by 50-percent in the whole set of domains and lower costs, 20-percent lower costs, that's really hard for primary care physicians to replicate. As you know because you were at the health affairs briefing on Friday, we also showed examples and some were multi-payer including Medicaid and some were single payer WellPoint Anthem. Programs where patients that are medical homes also achieved very strong results with lower healthcare costs, with better quality, with reduced hospitalizations in ER and better outcomes.

For this one to 5-percent to 15-percent of the population go back into your office and that of your colleagues, do you have those teams, those pit crews, those extraordinary capabilities to take care of the people with multiple illnesses, to take care of those wounds and to prevent the imputation. Again, I'm not to get in a debate about it, but most physicians don't have that extraordinary capability with a lot of nurse clinicians and others supporting patients in their social environment in their home.

CAROLINE POPLIN, MD: No, because we're not paid enough to take care of them, we're paid the same for everybody.

ED HOWARD: Okay, I have a question for Leeba Lessin. How do you plan to maintain the additional services, the annual nutritional counseling and social workers etcetera when health reform cuts to Medicare Advantage go into effect? In other words, will reform undercut the innovations that you've instituted?

LEEBA LESSIN: Well, there's a lot of components to that question. I think the two high level ones are the cuts to the Medicare Advantage program, which is at least to 100-percent in most counties and to 95-percent of Medicare in many counties, urban counties. The second component is the changes in the way the benefit calculations and the 85-percent NCR rules, MLR rules.

In CareMore's case, actually we will not be challenged in that regard because we would require the revenue cut to get to 85-percent MCR. I mentioned that we were taking 20, 30, 40-percent out of healthcare costs. That had us functioning at a very, very low MCR even with all those services included and healthcare costs and even with patients having zero copayment.

ED HOWARD: No, I just wanted to make sure everybody knew that you were using MCR and you also said the MLR has the loss—

LEEBA LESSIN: Interchangeable.

ED HOWARD: —ratio that we've heard so much about that was part of the Affordable Care Act.

LEEBA LESSIN: Good.

ED HOWARD: I'm sorry.

LEEBA LESSIN: In our case, actually, we're able to absorb the revenue reductions and in some cases, we're still going to be challenged to hit the MLR. We're going to have to find more benefits to offer to our members. What I'm concerned about over time actually is less about those formulas then about increasing definitions of what can be considered a benefit. I mentioned the freedom that we've had in considering multiple visits a day a benefit considering a lot of home based service is a benefit. There's been change in CMS policy in reducing what can be offered to members as benefits. I think that is actually a bigger challenge then the revenue challenge.

Randal Braun: Leeba, what's the rationale for that that the CMS gives. Once they capitate plan, why do they care so much about whether you give more service?

LEEBA LESSIN: Well, certain types of services they're quite happy for us to give more, but there are a lot of policy disagreements about what's a healthcare service versus a social service. Medicare is seen as a payment for medical services and so when we move into more social support services that we think are actually aiding healthcare even though they are

aiding healthcare if they're a social service there's an objection.

ED HOWARD: Isn't there a selection question as well that if you're paying for health club memberships as you mentioned that you're going to end up with a lower risk profile?

LEEBA LESSIN: Well actually health club memberships is one of the ones they encourage. The special needs programs for those of you that aren't familiar with chronic care special needs plans, more than half of our membership is in chronic care special needs plans. To be in those plans you have to be ill. A fair amount of our discussion has been this is not about cherry picking. This is about saving healthcare dollars by applying things that might not traditionally be healthcare in order to prevent future healthcare expense.

ED HOWARD: Arnie, do you want to try it with a new mic.

ARNOLD MILSTEIN, MD: There we go. Yes, I'd like to speak in support of what Leeba's talking about. I mean when I do on site visits at so-called positive outlier health systems, those that are generating more health and incurring less per capita spending this flexibility to address social threats to medical stability is critically important.

Just a brief vignette to illustrate, I talked to an RN who was part of one of these exceptionally cost effective health systems getting great patient experience and quality scores and asked her if she could sort of elaborate on why the ability to provide social support services, what was so important. She related the following vignette, which has really stayed with me.

She said that they have one patient in their practice that is essentially a relatively frail older women in her mid 80s who's managing and not easily so to care for her severely demented husband and all that you could imagine what that's like to do it at 85 years old. One Sunday night I guess about a year ago she called up and said I know that I'm always supposed to call you before I call the ambulance, but I'm calling the ambulance. The nurse coordinator said well what are the circumstances. She said he's been really tough, and then this afternoon, this is Sunday, my disposal backed up. She said I can't wash the dishes, they're piling up, and it is just too much.

The nurse coordinator said give me 30 minutes. The nurse coordinator went out to the house, sized up the situation, got under the sink, and fixed the disposal no ambulance call. That's the kind of whatever it takes psychology that doesn't differentiate between social services

and traditionally defined medical services. That's the kind of flexibility that we need to give our care teams, physician supervised.

SAMUEL NUSSBAUM, MD: Let me take on the next question that you've asked. It's really a comment, but also asked to comment. One area that hasn't been touched today is the role of patients and consumers in care delivery transformation, not only engaging them. We've talked a lot about engaging them in their care, but the next level up in actually helping redesign care in the delivery process. We know patients and particularly families for older individuals can provide valuable input on what's going well and what could have been better in support quality improvement cost reduction.

If you could comment and perhaps Leeba you can maybe begin because you have a community model and how you've used the input from others. Then particularly Arnie as you've seen some of the homeruns in others how families can make a difference in promoting and ideas for improvement.

LEEBA LESSIN: Inputs from others, individuals 75 years and older typically rely on another person to aid them with their healthcare. In our case, we have a program we call Healthy Start within a first 30 days of a member's enrollment with CareMore they come in for an hour and a half full physical, psychological, functional cognitive exam. We

encourage them to bring their family, a family member or caregiver with them.

About 70-percent do which astonished us. Then a fair amount of what we do upon exit is we do surveys but one of them is to the family members about what we could be doing that supported of them most effectively. The most robust body of information that we've gotten back is from family members who have their relative with some form of dementia. They're just lost. Is it a little bit of memory? Is it a lot of memory? Is it always going to get worse? Is it going to stay? Lots of different advice from lots of different clinicians.

We have a family caregiver dementia management program that's both online and in person that grew up out of all of this feedback from families. It's the kind of feedback that wouldn't have been able to come from the members themselves for obvious reasons. As we all know, where we're headed with dementia in this country and what it's going to do to the Medicare tab. If you haven't studied that, read some of the articles about that. The key to changing the curve there is not better clinical intervention, although that can be some of the curve. It's about the family and how the family and other caregivers can support.

ARNOLD MILSTEIN, MD: The Medical Home Runs article that's in your packet at one of the practices that I thought

qualified was just to maybe address your question back was a three doctor primary care practice. They don't think they can ultimately rise to the level of in terms of systemization and performance as CareMore. They did an extremely good job and were substantially reducing American healthcare spending and improving quality.

When I went on site to visit with a nurse and a clinical team one of the things I noticed is that the examining rooms were about twice as large as anything I'd ever seen before. I said to the primary care doctor, what is the story here. He said it's really important to make plenty of room so the family member can come in, particularly with patients over 50 years old. He said what goes on, and he was dealing with a lower middle class and blue-collar population. He's saying in these populations' people they want to please the doctor. They regard the doctor as sort of a higher social standing, and you just don't want to say to the doctor, your pills aren't working, your recommended diet tastes like cardboard. I'd never do it in a million years. You don’t say those things.

He said the reason I have plenty of room in the waiting room and plenty of chairs is I want the family here because when the patients finish telling me the socially acceptable story, I don't rush them out. I turn to the family members and say is there anything that you think is important for me to

know we haven't had a chance to cover yet. He said, and that's where the gold comes out. That's where I have a prayer of knowing what's actually going on in the home as opposed to the story that the patient told me to appeal to my ego and to prevent them from seeming ungrateful based on all my unrealistic recommendations to them.

ED HOWARD: Good point. Yes, go right ahead.

LISA SUMMERS: Thank you. I'm Lisa Summers with the American Nurse's Association. Before I ask my question, I have to say we've done a lot of talking over the years about the holistic training of nursing and how important it is but I don't think I've ever talked about garbage disposal repair. I appreciate that story.

My question is for Dr. Milstein. I think I may have missed it if you addressed it, or if you didn't address it. I was really intrigued by the third bullet on your replicating success after initial proof of concepts slide; assure power balance between collaborative clinicians and methodical managers. I was wondering if you could just expand on that and talk a little bit more about that.

ARNOLD MILSTEIN, MD: Sure, in most healthcare delivery systems the doctor is king or queen. They're in charge because they're regarded as having the most sophisticated knowledge. Succeeding in preventing health crisis and helping patients

feel confident enough that they don't have to run to get a lot of additional specialist opinions and the hopes of finding some medical magician. That tremendously depends on the brain that's leading the care team not being 100-percent the physician's brain.

The most successful teams that I see are the physician and a professional manager be it a nurse or an MBA are coequals. One has the training in sort of the system skill and systems control tools. The other has the clinical expertise and you need both.

One of the things I did in my positive outlier study is I went to unlock which is one of the few PACE programs nationally that patients love quality scores are great and actually generate a positive margin. I said to the person who'd put it all together Jennie Chin Hansen a nurse and one of my fellow MedPAC commissioners. I said, well why did this work, how come so many PACE programs went under? Why did your work? Why did your patients love it? Why are all of your quality scores so good?

She said we were doing a lot of things and I really wasn't sure what it was, so we brought in a team from Wharton to figure it out for us. She said it boiled down to three things. One of the three things was it went even a little bit further than my statement. It wasn't that the doctor and the

manager were coequal; it was generally avoiding having the physician be the head of a team. That requires management skills, skills in which most physicians are not trained. The Wharton team felt that part of the magic and success of the PACE program was actually using a professional manager advised by a physician rather than a physician to lead the team.

I think maybe that was their experience. I think when I went on site to CareMore what I found was really a coequal team, professional manager and a physician. For some patient categories, I think a nurse or other healthcare professional would have been equally valuable.

ED HOWARD: Leeba.

LEEBA LESSIN: If I could add to that, there are overly simplistically two legs to the stool. What's the right thing to do and how do you make sure that's what happens all the time? Our clinical leadership can tell us what the right thing to do is and our management leadership, which we have a bunch of engineers, which I love. It's their job to make sure it happens all the time.

I often sit in airplanes and marvel at all those little switches that have to get switched and all the little touch points with the tower that has to happen. They have to happen every single time in the same sequence in the same way. The argument I get sometimes when I make this analogy is well

aren't you then just turning medicine into cookbook medicine, not patient friendly etcetera? That's where we go back to the clinician to say use your judgment. It's a very symbiotic involvement but there shouldn't be a reason that a physician doesn't want a wound taken care of and healed.

The clinical folks say here's how we're going to go about healing our wounds. The management folks say here's how we're going to make sure it happens that way every time. We're going to seek out the times it didn't happen and find out why it didn't and put in control systems to make sure that it does. That's management's job. Management's job is not accounting, although there is some accounting and it's not IT although there's some IT. It's making sure it happens all the time.

ED HOWARD: Yes.

MIKE MILLMAN: Mike Millman from Assistant Secretary of Planning and Evaluation and HHS. Can you say more about how CareMore deals with the situation in which a patient has multiple specialists and it's not necessarily an inpatient episode? They are seeing a neurologist for their Parkinson's and somebody else for their depression; cardiologist and often they are kind of complex interactions in those sorts of treatment protocols. Since there's so many unique combinations of chronic diseases in this fragile Medicare population. How

do you deal with this sort of interaction among the specialists and control what's going on there?

LEEBA LESSIN: Good question. Again, simplistically there's two answers. One is when all of those specialist interactions are needed and when all those specialist interactions are not needed. I mentioned our Healthy Start program where we bring in patients in their first 30 days of enrollment with us. Part of that process is to look all of the physicians they're seeing, all of the medications they are seeing, interview them about why they're seeing them.

Often patients say I don't know, they told me to come back. I don't know. Rarely can a patient articulate an ongoing long-term stream of care with a physician. If there is a patient that has a lot of that, then the person conducting the Healthy Start exam includes the extensivists that I mentioned. It's a CareMore employed internist who gets involved directly in the patients' case, calls the primary care physicians so that they know who all the physicians are that are seeing the patient and together they try to make sort of a rationalization out of it, the PCP does this. Explain to the patient why they may no longer need a neurologist. We sent you there once two years ago for the following reason. You really don't need it any more.

In the case of when that care is needed, it once again kind of comes back to the extensivist. One of the data scans that we run is any member seeing more than four physicians. Any member that pops up, we take out anesthesiology, radiology but any member that pops up into that scan, the extensivist reviews the case with the primary care physician.

Primaries that have been with us for a long time start doing that scan themselves. We have a tool we call Patient Quick View. It's not an EMR, but it's an aggregation of all the data we have on a patient that can be accessed from any IPad or home PC or in the office. It includes one of the tabs as a list of all the physicians a patient has seen in the last 90 days.

PCPs often use that when members come in for a visit. That among other screens they'll pop it up and say well I see you went to a cardiologist, why did you go? Then with a new patient, it's unraveling some of those relationships. With an ongoing existing patient, it's a matter of the extensivist and the primary care physician keeping in touch about it. We do have sort of a traditional UM authorization kind of thing, but that tends to be more for procedures and diagnostics. It's really more human interaction.

MIKE MILLMAN: It doesn't quite really get at the issue of sort of reconciling conflicting complex genuine interactions [interposing].

LEEBA LESSIN: Right, that is the role of the extensivist. When I say the extensivist gets involved, I'd say our extensivists have four to five conference calls a day each that are getting all of those specialists on the phone and saying we have patient XYZ, what are you doing, what are you doing, what are you doing? Could you stop doing that? It's a little mini round, grand rounds on a patient. Those happen several times a day on the most complex patients. We obviously can't do that for every single patient. For the less complex situations the extensivist and PCP [interposing].

MIKE MILLMAN: What proportion of patients are in that?

LEEBA LESSIN: About 3-percent of patients are in that live rounds kind of thing.

SAMUEL NUSSBAUM, MD: Okay. Do you want to do this one?

ED HOWARD: Yes, go ahead.

SAMUEL NUSSBAUM, MD: If I may Mike on your question, because I think you're raising something so vitally important and I'm going beyond CareMore to what happens today in the ACOs or integrated delivery systems where you have predominately specialists taking care of these complex individuals. It's I

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think a great example of where all of the deep knowledge of science and technology and capability and everything that we who are specialists have learned over our careers that missing element of course is the care coordination, the handoffs. In fact, one would think that the ACO integrated care model could deliver exceptional results for these patients with great need.

There are some examples, Mass General had a demonstration project and others, but hat is the hallmark of those at least as I know them is they almost all have that quarterback. Sometimes nursing team, but primary doctors who really keeps in close contact with those very capable specialists.

There's another question here we have that relates to the involvement of others and other domains and that's behavioral health. It's for Arnie and Leeba. Do you believe managed behavioral care carve outs have to be eliminated, says gradually eliminated, in order to end our bifurcated healthcare system and allow for comprehensive whole health coordinated integrated care. We know that carve outs have existed for several decades and continue to exist in behavioral health.

ARNOLD MILSTEIN, MD: Behavior health carve outs began to thrive for a reason. The reason was that they were measured through the lens of purchasers and patients measures of value.

They were generating as far as anyone could measure as good outcomes for a lot lower cost.

That being said, for the reasons I commented earlier that is an integrated approach to the patient makes so much more sense when and if there's an alternative in the community that actually is capable of and is taking accountability for cost quality and is doing that by embracing the patient's behavioral, physical, social and emotional needs. Then by all means we're much better off with at that point terminating the behavioral health carve out.

Often, if you look at what happens, what's going on with mainstream American patients they're at least as well off with a behavioral health carve out. Hopefully as America's delivery system evolves and the kind of care that Leeba describes becomes more prevalent the carved out behavioral health programs will be a piece of American medical history.

ED HOWARD: I have a question for Randy that arises out of something that Leeba presented. There was a conscious effort in the CareMore experience to catch things before they got expensive. In other words, to direct resources toward people who weren't in Sam's 54-percent from the 5-percent of folks?

You talked about the importance of targeting in predicting the success of the various models that you've been

looking at. I wonder if there's any inconsistency here that people need to deal with.

RANDAL BRAUN: Yes, that's a good question. I don't know, can you hear in the back better now if I get my face right into this microphone here?

Well, it's really hard to find evidence. Everybody would really like to say you must be able to do something a little less intensive and a little less expensive for the people that aren't quite at that most severe level yet. As Arnie said, it's hard not to overspend for that group and still generate some savings. It may be that we're not looking out far enough. You need a five year because they're not at such high risk of short-term hospitalization so there's not that much to save in this short run. It may just be a failure of not having looked at long enough yet in any studies.

Again, that's driven in part by this pressure to get results quickly. You have to find something that saves money right away so that those two things are a little bit at odds there. I think it would be great to be able to find something that slows down that trajectory into the more serious end of the spectrum of costs for the people with chronic illnesses. It's hard to find interventions that do work at least in fee for service. Maybe within a managed care plan where you have a

lot more control over who does what and when that it's better able to find something that does pay off.

ED HOWARD: Leeba, you want to add to that.

LEEBA LESSIN: Yes, my opinion is it's virtually impossible to find things that pay off big in today's fee for service model. To pay off big interventions that are not currently paid for have to be applied for one. Secondly, the investment has to be for a longer-term future. It's investment in resources now to avoid expense four years from now or five years from now or six years from now.

It's hard in budgets to agree to increase budgets to pay for services on the [inaudible]. That's what prepayment does. I agree with Randy's comment that in a fee for service system it would be very hard to get the same magnitude of change. I think there's lots of incremental change, but the same magnitude of change I don't think is possible.

SAMUEL NUSSBAUM, MD: It strikes me as we bring this discussion to a close and thank you all for attending is that Arnie has given us a message and Leeba has, and Randy also and that is that these proven models what work really can't have a lot of modification to see their sustained success. Yet, how many of us have said that all healthcare is local? Not only is healthcare local as you look at delivery systems you're seeing they evolve differently.

Most of our major metropolitan areas have three hospital or health systems that have now as I mentioned earlier acquire doctors. To me one of the interesting themes as we close is how much sort of variation in delivery shall we have? How do we accept best practices? Even our colleague Don Berwick in his earlier life had been institute for healthcare improvement and the whole model there was to share best practices with the hope of adoption.

If you really think of what we need in our nation velocity on some of these changes, we often have to start from what works as opposed to rediscovering what may take several years. I think there's a fine balance that we need to achieve and to not limit innovation, but to not allow the thousand points of light but to take and hopefully every health system, every nurse professional and doctor health plan can see as we're doing today sharing in best practices and building for that future.

ED HOWARD: Good note on which to conclude. Let me remind you we would very much appreciate you filling out the blue evaluation forms as you go out. I want to take just a moment to share some good news and some bad news with our audience. The good news is that we have a new staff member at the Alliance, Marilyn Werber Serafini most recently at Kaiser Health News and one of the most respected health policy

journalists in town has just begun her duties as Communications Director and Policy Advisor at the Alliance.

The bad news is that she's taking over for Bill Irwin an incredibly talented Communications Director at the Alliance for the last 14 years and he's going to be badly missed and I'd like to ask you to join me in thanking him for his service over that period of time.

I want to thank our friends and colleagues at WellPoint and especially Sam Nussbaum for not only helping to cosponsor this event, but to help us put it together in a very coherent way and bring this wonderful panel together. Ask you to join me in thanking both WellPoint and our panelists for an incredibly useful and thought provoking discussion. Thank you.

[END RECORDING]

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