



**Innovations in Primary Care: What's in the ACA?
Alliance for Health Reform
December 13, 2010**

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

[START RECORDING]

ED HOWARD: Let's try to get started. Those of you who are still looking for seats, there are as usual a number up front once you've filled in all those tables in the back. I'm Ed Howard with the Alliance for Health Reform.

Welcome to this program on the growing importance of primary care in America, and potential changes in the way that care is delivered, and paid for that might help meet the increases in primary care demand that are being anticipated. We've heard in recent weeks how the reform law, which for purposes of our discussion, we will call it the Affordable Care Act or the ACA, might affect the pipeline of those who provide the primary care.

Now today, we're going to look at how the provisions in the ACA and some private market forces might move our specialty-centric, poorly coordinated, uneven quality system into one that's better coordinated and higher in quality, more satisfactory to patients, maybe even more affordable by transforming the way we pay for and deliver care and the key to the changes, we'll look closely at today, is an increased emphasis on primary care.

We hope to hear today about innovative approaches to primary care from plans and players in the private sector from, I'm sorry, payers in the private sector. I guess payers are

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

players are they not, and from state and federal governments, some of that flowing from the ACA. So a lot going on. You're going to hear phrases like patient-centered medical home and accountable care organization more than once in the course of the conversation.

We're pleased to have as a partner in today's program The Commonwealth Fund, a philanthropy-based in New York and in D.C. that's been a leader in promoting a high performance health system with primary care at its heart. That's a goal that can't be reached without the kind of emphasis on primary care that we're going to hear about today. It's comforting in that context to know that my co-moderator, Melinda Abrams, who's a Vice President of The Commonwealth Fund, also directs its Patient-Centered Coordinated Care Program. With that, Melinda, thanks for being here.

MELINDA ABRAMS: Thanks Ed, and thanks everyone for joining us this afternoon. I'm just going to do a quick kickoff and turn it over to our speakers who I'm really thrilled who were able to travel to join us here today. Essentially this is a way of getting started just kind of in terms of the backdrop.

Let's start with the premise for which there is a lot of compelling evidence to show that primary care is really critical to achieving high performance. There are several

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

studies that indicate that with strong primary care, we will have better quality, better health outcomes, and lower costs.

Part of the problem is that for decades, we have underinvested and undervalued primary care and that foundation is crumbling. Patients are reporting access problems, coordination problems. One in five patients with chronic diseases are in fact going to the emergency department, instead of.....things that they could have had treated in a primary care setting but it's not just on the patient side.

The practitioner side, the provider side, they're also reporting a very difficult practice environment. They don't have the infrastructure, the tools that they need to provide highly accessible, coordinated care in terms of only minorities still have electronic health records but also our payment system. The way we pay and reimburse tends to value specialists and face-to-face visits and volume over the value.

So we have undermined primary care. Then as a result of the lower reimbursement, we are also seeing fewer primary care providers enter the field -- particularly in physicians but also really with nurses and physician assistants, nurse practitioners -- see them gravitating towards specialty and away from primary care.

So unless we shore up primary care in the United States, we cannot really save the money that we need to be

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

saving. We cannot slow the rate of health care cost growth. We cannot improve the quality. So primary care is the foundation on which we need to build to achieve higher performance.

The Affordable Care Act provides an opportunity to strengthen primary care. There are several provisions in the statutes, scattered throughout the statute's multiple sections, that when taken together put us on a path to strengthen primary care and put us on a path towards high performance. There's a paper that was available on the front that will be released by The Commonwealth Fund in the next week or so and really tries to lay out, tries to pull all of this together into a unified whole.

We did an analysis of the bill and can group the provisions into three large areas.

There's a set of provisions that call for changing payment and financial incentives to promote primary care.

There are a set of provisions that will test and be spread innovative ways to deliver new models of care such as the patient-centered medical home, which you will hear more about from our speakers but also currently most primary care practices don't function as a medical home providing the accessible coordinated personal care that they want to provide.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

There are a number of provisions that really try to seek to enhance the capacity of primary care sites.

Then finally there is a set of provisions that focus on ensuring an adequate supply of primary care providers at multiple levels -- physicians, physician assistants, nurse practitioners, community providers.

So I think part of the message is that these various provisions really need to be taken together. They're part of a whole and that understood and if implemented effectively, they can lead to better access, better quality, lower cost, and as well as better patient experience.

So the sum of the message is we hope that you take away from this briefing is that primary care is critical to improving quality and lowering costs, that as I just mentioned, the Affordable Care Act provides an opportunity to actually achieve some of the cost savings so many of us are eager to achieve as well as also the improvements in quality.

There are several states that have been pioneers and paved the way and had experience in strengthening primary care. That is why we're going to hear from Minnesota and Vermont, Dr. Schiff and Dr. Jones because I think the state perspective will give us a glimpse of what's in the Act and what it could mean. We'll also learn some about their challenges and how the

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

Affordable Care Act provides an opportunity to sustain some of their achievements, to spread them and to accelerate them.

Then finally, we will close with Dr. Paul Grundy of IBM who also from the state side will, reinforce the importance of multipayer initiatives, and how when we have Medicaid and Medicare and commercial payers working together, we have a better chance of really changing the cost curve and also improving quality and access and coordination for millions of Americans. So I think now we're going to turn and introduce.

ED HOWARD: Yes, thanks Melinda. Let me do a little housekeeping first just to remind people that all of the materials in your packets and a bunch of things that aren't in your packets are online at our website, allhealth.org. There'll be a webcast available on kff.org tomorrow. That's as a courtesy from the Kaiser Family Foundation.

At the appropriate time, fill out those green question cards to try to get responses from our panelists. There are also blue evaluation forms that we hope you fill out before you leave to help us improve these briefings.

As Melinda said, we have an all-star panel for us today. We're going to start off with Dr. Kevin Grumbach. He chairs the Department of Family and Community Medicine at UC San Francisco. He's Chief of Family and Community Medicine at San Francisco General Hospital. He's literally written the

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

book on how to improve primary care and with Dr. Tom Bodenheimer, he's also written the book on general health policy, which you would run into if you were in an academic setting this topic. He's won more awards, it's in the biographical information in your packets, than any one person ought to be able to I guess. Dr. Grumbach, lead us off if you would.

KEVIN GRUMBACH: Great. Thanks, thanks very much, Ed. It's a pleasure to be here. Good afternoon. Yes, I already had a Washington, D.C. moment though already at lunch time. I was talking to one of the people attending today's session and we were speaking. He said, oh excuse me, I have to go. I see my wife is here. I had no idea she was attending this meeting as well [laughter]. So I gather that happens from time to time in Washington.

So what I'm going to be speaking about briefly is to just try to summarize some of the recent really hot-off-the-press evidence about the outcomes of policies that have tried to innovate and transform primary care and whether, in fact, it's getting us closer to the triple aims of better quality, better patient experience, and more affordable care.

So as Melinda pointed out, there is just abundant evidence now that's accumulated over the past few decades in health services research that primary care makes a difference,

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

its systems whether you compare it to different countries, whether you compare it to different states in the United States, different systems within the United States, or just look at the experiences of individual patients that when care is delivered around the primary care-based model that people do better.

They do better for their health outcomes. They get better quality of care whether we're talking about flu shots every year for those who are appropriate to get it or better processes of care for diabetes. They get more preventive care and that, at the same time, costs tend to be lower under a care model organized around primary care. There's been also some very intriguing evidence to suggest that care is more equitable that it addresses health disparities but this body of research is mostly from looking at what is in descriptive ways. I'll give you a classic example.

This was a study done by researchers at Dartmouth and what this is showing is, comparing 50 states in the United States and Washington, D.C. -- it's looking at the supply of primary care, physicians in each state and then it's measuring it against quality indicators. These are Medicare standard quality indicators for Medicare beneficiaries in each state.

What it shows is a very strong relationship with the more primary care-oriented the workforce in the state, the

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

better that state performs in delivering quality of care to Medicare beneficiaries.

At the same time, the same study showed when they look at again supply of primary care physicians and the costs, Medicare expenditures per beneficiary, they see a strong inverse relationship. So that the more primary care-oriented states have lower costs per capita. So that's a remarkable achievement to get better quality and lower costs at the same time.

The question though is, as you know in health policy, it's one thing to say this is the way it is when you just describe what exists. But the real question is can you intervene with policies, whether at the federal, state level or through private actors in the policy scene, to actually change something and when you change something, does it actually lead to better outcomes rather than this is just sort of a naturally state of affairs.

It's sort of like saying we know that people who are obese maybe are more likely to get heart disease, which is very different from saying can we actually intervene with a program that will reduce obesity and lead to better outcomes. So that's where we are now. I have some exciting things.

The question is what actually happens to quality, access, and costs if you invest in better models of primary

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

care? I'm going to review a document. I'll give you the highlights of the documents in your packet, which is a report that Paul and I just did that we've just released.

Now I guess the first question I realize I wanted to ask is how many people actually understand what this term patient-centered medical home actually means. Raise your hand if you feel like you have a clear definition. How about if you don't really understand, what is this patient?

All right, very sophisticated audience, all right. So basically patient-centered medical, the way I think of it is it's excellent 21st century primary care.

Now all right, so it begs then the question how many of you actually know what primary care really, have a clear definition of primary care.

All right, how many wonder what exactly is that primary care? So let me just be clear on terms because we tend to bandy about these terms. So primary care is essentially getting care in a way from a primary care physician or other primary care clinician where the care is about you as a whole person rather than just about one of your organs.

So it's about having a relationship in an ongoing fashion with a person or a team that can care for you as a whole person over time that is accessible so you can get care when you need it, is comprehensive to address your preventive

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

care needs, your health promotion, chronic care needs, as well as acute care needs that can integrate care and make sure that that primary care base coordinates services from specialists, hospital care, home care services, ancillary care, and the like to put it all together in a package that meets your needs in whole person care.

How many of you feel that that's the model of care you get today in your own personal care in the United States? A few, but the issue is this is not actually the care that everybody has access to in the United States. Even if you have access to a primary care clinician, it is not necessarily delivered in a way that we'd like to see meet the goals of accessible care.

Many of you can get an appointment when you need it. You can contact your primary care physician or clinician by email. You can log on, get your test results that the primary care physician actually knows what happens when you go to the cardiologist or to the physical therapist or what happened when you've been in the hospital and everybody knows the medications. Those are put together in an integrated way.

So the question is what happens when we intervene to try to create these high performing patient-centered, primary care medical homes in terms of outcomes? So it's an exciting

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

time in the United States. There are many of these initiatives that are springing up across the country.

Some of them are involving Medicare and state Medicaid agencies. You'll hear about a couple of these today. Some of them are actually from purchasers like IBM, some in collaboration with private health plans. Some are through the Bureau of Primary Health Care through HRSA around community health centers but there's now been evaluation data coming back from some of these innovations.

What we've done is summarize data that now includes over a million different patients in the United States, thousands of different primary care practices in very diverse settings, again community health centers, integrated health systems, independent office practice.

What I'm going to summarize is now the data back on innovative models of five integrated systems -- Geisinger Health System in Pennsylvania; Group Health Cooperative in Seattle, Washington; Health Partners in Minnesota; InterMountain Health in Utah; and probably the nation's biggest integrated health system, which is the Veterans' Health Administration.

There are also three initiatives sponsored by private health plans. These are Blue Cross/Blue Shield North Carolina, North Dakota Metropolitan, with Humana in Florida to Medicaid

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

state initiatives and then there's some other models that are included in the report.

What are the elements of these new models of patient-centered medical homes 21st century advanced models of primary care? Well, there are some ingredients in common across all these models in all these settings. One is to move towards a team-based model of primary care that this is no longer a matter of just that solo general practitioner trying to do it all alone.

It's about a team of clinicians, of health personnel working together in team model care. It's about proactive care coordination rather than reactive care. It's about health promotion, getting on top of chronic illness, management around diabetic care, asthmatic care, heart failure, and so forth. It's about enhanced patient access where you can actually call up the same day and get an appointment if you need it, where you can communicate remotely whether it's by telephone, by email, by WebEx as with your clinicians and their team. Systematic chronic care model, which is a structured way of proactively, as I say, addressing chronic care needs.

It's about having very explicit tracking of clinical measures whether it's flu shot rates in the population of patients you're caring for or the percent of diabetics that have gotten their eyes checked for diabetic visual impairment,

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

and then feeding that data back in a systematic way to the clinical team in order to both measure and motivate performance.

Then finally, it's about payment reform -- that we have to pay for this in a different way because the traditional fee-for-service model of care will not deliver the goods when you're talking about enhanced coordination, enhanced access, encounters that occur without the patient actually coming into the office, which is the traditional way of generating fee-for-service.

So it's usually, now I'm talking about mixed payment methods with fee-for-service with some monthly mini-capitated amount or bundled payments for moving to fully capitated models.

So the data, I'll give you sort of one slide and then a few highlights. The bottom line is remarkably consistent positive outcomes from all these essentially experiments going on across the country, better quality of care, better patient experiences, better access, better care coordination but the remarkable thing particularly in this environment of concern about budget deficits and overall health care spending is that it requires investment.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

You got to pay more to pull off this model of primary care. You need to hire more staff in primary care. You need to support it better.

You need to pay for it better but at the end of the day, you actually save money in terms of the overall expenditures on that population of payments because if you invest more in primary care, you get better care that leads to less use of expensive emergency department and acute hospital services. So that upfront investment is more than made up with the savings that you accrue downstream.

But this is not like we're not talking about invest in better preventive care and 20 years from now, somebody's not going to get cancer or heart disease from diabetes.

We're talking about within a year or two in these models, you see rather prompt, short-term return on investment to the tune of: 1) the Group Health Cooperative, five-percent reductions in per-member and per-month costs, 2) Geisinger, seven-percent reduction, 3) VA, \$600 saved per patients with emphysema through an enhanced primary care model.

South Carolina again, seven-percent. Metropolitan, 20-percent. North Carolina Medicaid over five, six years, almost a billion dollars saved compared to what had been expected to care for these Medicaid patients. A lot of this was better care for kids with asthma, keeping them out of the emergency

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

room, keeping them out of the hospital with more accessible coordinated care. In Colorado, Medicaid again about \$200 saved per child in the Medicaid and SCHIP programs in Colorado.

So in conclusion, excellent return on investment, excellent returns on investment. Investment in primary care yields benefit in better value, better patient experience, better outcomes, and actual net overall savings from what we're seeing.

The other good news is actually change is possible, with the appropriate investment and that's a caveat, practices in diverse settings can change their model of care to provide high performing primary care.

The final take-home message is this will not happen spontaneously. It requires concerted support from all stakeholders, from the payers, the purchasers, public/private alike, public/private providers to move towards these models of care and the unstated part of that final bullet are there are interests that actually are not necessarily aligned with this.

So frankly, anybody who's making money by keeping patients in the hospital and probing various orifices and body cavities with various tubings and things like that may not actually be standing to gain by these advances in primary care, which benefit largely by avoiding the need for more specialized expensive services in the hospital. Thank you.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

ED HOWARD: Thank you. Great. Thanks very much, Kevin. Next, as both Melinda and Kevin have previewed, we're going to hear from some folks that are actually doing this stuff at the state level. We're going to start with Dr. Jeffrey Schiff. He's the Medical Director for Minnesota health care programs within the Minnesota Department of Human Services.

He and his team are implementing the health care home, which is Minnesota talk for medical home in the accountable care model in Minnesota. So he's implementing the accountable care model in the Medicaid program in Minnesota. He works with the Minnesota Health Department to implement the state's health reform law, which pre-dates the national law by a couple of years, by the way. So we're very pleased to have him. We almost didn't make it coming from Minnesota but we're very pleased that you made it out.

JEFFREY SCHIFF: Thank you very much. I think Craig and I are really going to talk about what it's like to implement the medical home or health care home, as we say in Minnesota, at the macro-system level. I noticed that when I sent my biography and I said a small but mighty team is doing this in Minnesota, so I want to give credit to my crew out there who's done a wonderful job.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

I'm going to try to go through this pretty quickly. I'm going to spend a lot of time on one specific topic. It'll come up in a second. What's so different in Minnesota? We have a low rate of uninsurance for a long time. We have a collaborative non-profit culture, in that all of our health plans are required to be non-profit.

So as one of the CEOs likes to say -- he lives in Minnesota so he comes to a lot of meetings there. We have a highly integrated delivery system and where Melinda, on the report that's just coming out, talked about how many primary care docs are in onesies and twosies as we call it, one or two docs in a practice. In Minnesota, 85-percent of the providers are in 53 groups.

So we have way big groups and even in the rural settings, the groups are sort of a conglomeration. We have a strong primary care base and partly because we've had a medical school that's done that and the last thing I didn't write down here is we're used to getting measured so that Garrison Keeler can consistently say we're above average [laughter].

But this is actually the real cool thing here in that this is from our Department of Health is that the national GDP in 2008 on health care was 15.1-percent and in Minnesota, it's 13.4-percent. So we have a sort of economic stimulus going

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

because of our lack of funding for health care and some folks will want to use that to build a new stadium [laughter].

So I want to tell a story though first. I actually have the privilege of working still clinically and I work in the emergency room at Children's although I've done both primary care and pediatric emergency medicine. Six days ago, I saw a toddler who came in from their primary care provider because they were vomiting.

They had labs done and their labs weren't too bad but they were sent in because somebody was nervous and they felt like the child needed an IV. So the resident saw the patient and came out of the room and said the mom wants the IV started right away. I said well is the kid dry and they said no.

So I did one of three things you get to choose, A - Go ahead and start the IV. Go ahead and start the IV. I'm on fee-for-service and I get credit.

B- Don't start the IV. We're on capitation now and I don't think this kid probably needs it. Or C - I went and saw the patient and did something with the family and talked to them.

So A, B, or C. I won't ask you to vote but anyhow [laughter] I did see and the kid wasn't that dry and the mom was actually very reasonable and it was this sort of patient experience thing but my point is this.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

It's on the bottom of the slide that a power imbalance exists between doctors and patients have been readily acknowledged. However the effects of this asymmetry can be mitigated through the establishment of trust between doctor and patient. I want to point that out to this audience because we talk a lot at this macro level about how we're going to put economic forces to work in health care.

The most important thing to realize is that for this to be successful is we have to have functioning effective medical homes that support patient and family-centered care because our citizens won't support anything less than that. It will blow the system up if we have too much emphasis on cost savings or too much emphasis on fee-for-service.

Providers act in an agency role for patients. That means that if you are a provider, you have to say: well, if you have back pain, maybe you should get physical therapy before you see the neurosurgeon. Maybe after physical therapy, you need an injection, there's a series of progressive events that happens for any disease process that you need an agent for in the health care system because most of us don't know how to be agents to ourselves.

Primary care has to fill that agency role but here's the challenge is that agency role, which I also put down as advocate has to be combined with a stewardship role. We have

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

to really balance that in the market and say what's the role of the primary care providers to be the agents effectively and after that, what's their role to steward resources?

If we've put too much emphasis on stewarding resources, we won't have that patient and family-centered care that we really need and want. If we don't put any emphasis on stewardship, we'll have unmitigated spending.

So our job, at this level and my job in the state, is creating and regulating the market in that area. So with that in mind, those underpinnings, I'm going to fly through the rest of this.

That is to say that we started in 2003, maybe even sooner with a grant for kids with special health care needs, 2007 - we had some legislation for complex patients, 2008 - we had major health care home legislation that really said that everyone the Minnesota State Legislature could touch would have a medical home.

And really the way to think about this in some regard and you'll see really quickly that there really aren't two separate populations but at the extremes, we have the very complex chronically ill patients who need a lot of managements.

At the other extreme, we have patients who are at risk for disease or have one disease or two diseases and those patients need some sort of panel management ongoing -- are you

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

taking your asthma medicine in the fall when you have symptoms kind of thing.

Then there's obviously a lot of patients in between and our challenge has always been how do you take care of the panel that has basic diseases, which are easy to measure -- to say okay, our diabetes is better and how do you take care of the complex patient who may have a mental health disease or chemical dependency, a lot of severe problems.

So we, in Minnesota, enacted this legislation in 2008 and it's been our job to put it in place. I'll just talk a little bit about a few of these and then I'll have a couple more slides. I'll talk about certification in a second.

The certification process is an ongoing process. One of the things I'm proud about -- this is just headlines -- is that our certification process includes patients on the certification teams. So when a certification team goes out to certify a practice, a patient goes out with them.

We have a learning collaborative, which I think is really an important thing because it creates a normative culture of change, which is really important because we are changing culture. The other things then, as we have outcome measurement, and in order to stay in our program in Minnesota, you have to get results to continue.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

So a few more things than on the other ones I didn't talk about, which are certification like Kevin talked about, we have really five major criteria for certification. They are access and communication. Can you get in to your provider and do they know who you are? Registry function to manage your panel, care planning for the folks who need complex care plans, do you actually produce that care plan?

Care coordination, who's doing that and the co-location of the care coordinator with the primary care doc, and then practice-based quality improvement. I'm emphasizing some of these things in that on our practice-based quality improvement teams, we emphasize that they have to have patients on that quality team in the practice and nothing changes the conversation in the practice when the patients are sitting there saying this is what's important to us.

Recently we actually turned down an application for a medical home when one of the big provider groups said well, our nurses are our patients. They may be but you get the difference.

Anyhow, we have a fairly interesting payment methodology, which I think is important to know. We actually decided in Minnesota, we pay based on patient complexity. We did a couple things. We actually allow our providers to decide what tier their patients are at for complexity.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

That may sound crazy because you may say, oh they're all going to make them complex. But the reality of it is the other alternative is to look at the diagnoses that were charged for in the past and create a model by which you look at the charges and the diagnoses and pay based on that. We know, for example, that 50-percent of the time, patients who have an ongoing chronic disease like a spinal cord injury are not coded that year. So how fair is that?

So we decided we'll let our providers do that. We looked at the number of conditions that the patients had and we were emphatic about not looking at utilization to drive this.

So we wanted to measure the number of chronic diseases that patients had, not how many services they use, because you could see all the skew that happens if you measure the number of utilization. If they didn't use services then they were penalized because they were going forward with a more efficient practice. We worked on providing a payment structure that was based on the actual amount of work provided, which caused us to have a fairly high rate, which we still expect to break even in.

Anyhow, so this is just a quick slide. I won't spend much time on this. It's to say that in our fee-for-service Medicaid population, about half the patients have one or more

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

chronic diseases. Our rates, based on this complexity, are between \$10 and \$60 per member per month.

Did I hear somebody gasp? But anyhow what I really wanted to say is that seems like a lot of money. But really what we're saying is if we invest about two-percent of the health care costs in this, we expect to get it back on the other end with decreased hospitalization, better medication compliance and use, decreased ER utilization. We fully expect that we can do that.

Our legislature required us to be cost-neutral by two years from now, we have to report to them on that or we have to tell them what we're going to take out of the system to be cost-neutral.

So just a couple other things to say really quickly, we are proud that we are one of the states that has Medicaid, Medicare joining us. We'll be joining them and they'll be doing the same thing. I will skip over most of this because I'm running out of time.

We can talk about it but I want to just talk for just a minute about ACO because from medical home comes this idea of accountable care organizations. We see our program as a logical bridge. If you build an ACO, which is really a way of rewarding with gain sharing or with some form of capitation,

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

this kind of coordinated model, you need all these things. You need primary care. You need an attribution model that works.

We need to figure out how to adjust for risk for complex populations because I'll remind folks that in Medicaid, which is now going to be the biggest insurer in the country, 46-percent of the costs are for dual eligible folks. If 46-percent of the costs are for dual eligible folks, those are very complex patients. We need to figure out how to manage the risk for them. We need some sort of a gain sharing cost of care methodology, which we're working through. We need measurements that actually are effective.

The last things I just want to say is that ACOs are not equal to capitation. There's a lot of work being done and these are just four of the programs within the ACA that look at ACOs and I think our push, as we have this discussion with CMS, is to make sure that we have a robust discussion that ACOs are brought up at a rate in which the system can handle the change. So at that, I'll stop.

ED HOWARD: Thank you. Thank you, Jeff. Could I just ask you on that last list of the components in this context, what do you mean by attribution being important?

JEFFREY SCHIFF: So a lot of the ACO models look and say we're going to take the entire population in the state and we're going to plug them into an ACO based on where they work.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

Now if they had one visit at a primary care doc in that system, we'll call it then going there. So I have this vision in my head because you get skeptical or at least concerned that somebody will come into a clinic and they'll be really complicated.

Somebody will say we're not going to charge for that visit or something will happen. You need to attribute patients in an ACO to where they're going to go so they can actually hook up. The attribution models have to be fairly sophisticated so that complex patients that are going to different sites are attributed to the person who's really responsible for them.

ED HOWARD: I see. Very good. Thank you. By the way, if there's anybody here who has not yet turned off their cell phone or pager, would you do that or at least put it on vibrate? We love your ring tones but keep them to yourself.

Craig Jones is up next. Dr. Jones runs the Vermont Blueprint for Health, which is that rarest of birds, a bipartisan effort in health reform. The aim is nothing short of transforming the entire state's health system, improving health and health care for all, making care more affordable. He has a background in treating allergies and asthma with an emphasis on kids. Now he's going to cure the whole state. So we're here to hear the story from Vermont, Dr. Jones.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

CRAIG JONES: First, can everybody in the back hear okay? Great. To Ed and Melinda, thank you very much for the opportunity to be here and speak to you. I'll quickly dive into what is just a concrete example of the types of things that you've been hearing about up here and why we're doing it.

The most important thing to start with is the context in Vermont. What do you really need to have in place to get good delivery system reform, to build this strong foundation of primary care? I will tell you the vision around building a strong foundation of advanced primary care and good preventive care, well coordinated health services is essential.

I think all of us remember what the health care reform debate was like and realize that most of it centered around issues related to coverage, insurance coverage, and not so much about the way health care's delivered. One of the key points to come out of this afternoon is how important the delivery system is. You could have almost any form of health insurance coverage you could envision and still not control the cost of health care or the quality of health care. We see that around the world.

So it's really important to put a focus on delivery system and not confuse that with forms of coverage. That's something that got lost in last year's health care debate. It didn't get lost in Vermont and several other states around the

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

country. Vermont has been working on health care reform for a number of years including universal coverage.

They have most of the state's residents covered. I think we're up to 95-percent now but in line with that, Vermont has passed guiding legislation to really do extensive delivery system reform. The vision is moving toward well coordinated preventive health services for everybody living in the state with multiple insurers.

The focus on this is because of a key point. You saw the early slides that Dr. Grumbach held up on the quality. You notice Vermont was on the high end of the quality measures on almost every one of those. If you didn't notice, it is ranked very high in the country in terms of quality.

Yet, Vermont's health care costs are growing at the same rate as the rest of the country's, in some cases higher. So just being ranked high in quality on these types of measures has not translated into better control of health care costs.

One of the reasons it's believed for this is that we really have not invested in the strong foundation of advanced primary care and great preventive well coordinated health services. So Vermont passed guiding legislation in 2007 that began to move strongly on this and has since passed more legislation and it's leading to this model that I'm going to show you in a minute.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

The context is very important there because this is a place where you can have agreement and even though we had a Republican governor and a Democratic legislature, that leadership stayed together and stayed aligned on this and without that leadership, we wouldn't be able to be doing what we're doing.

So the number one key component of this, leadership. It's critical. Second, we have a strong congressional delegation that supports this in the ways that they need to. It really starts with maintaining that high leadership. Let me just walk you through what the model is intended to look like that's coming alive in Vermont right now around primary care and prevention.

So it's a complex slide, a lot of circles. I'll just spend most of the time here and tell you what it looks like and why. On the right hand side of the slide, you see a bunch of circles called medical homes. These are the same advanced primary care practices or patient-centered medical homes that you've been hearing about. Now imagine a community of primary care practices, could be rural, could be suburban, could be even urban by Vermont standards.

The first aspect of the model is that we have all our insurers paying differently. They are paying money into the primary care practices based on the quality of care that's

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

delivered in that practice. The idea of paying more money into the primary care practices is that they can hire the staff they need, do the types of changes that they need to really truly run a patient-centered medical home.

Do you really have access? Can you really get an appointment when you need it? Do they really have the teams to pull up a report? I want to know all the women who haven't had cervical cancer screening in the last year. We want to know all the men who are eligible for cardiovascular risk screening and haven't had it.

We're going to look at all our diabetics and see if they've gotten the treatment and the medications and how they entered in self-management goals. Can you really do that kind of preventive thorough care? Well, all insurers in Vermont are paying into primary care practices based on the quality score to allow them to begin to operate with that thorough preventive care but there was a strong belief in Vermont in the beginning that that wouldn't be enough that just investing in the primary care practices wouldn't be enough.

This good preventive health care for everybody is complex. So we also have second payment reform, all the insurers investing in what's called the community health team. That's that big circle in the middle of the drawing. The idea

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

of the community health team is it's multidisciplinary, nurses, social workers, dieticians.

It's a group of people that works on the ground in the community with the practices and helps support patients and families and practices, gives them what they need. So when a primary care physician is taking care of somebody and they're doing a better job of screening for depression and they find there's an elevated depression score, there's mental health or behavioral health counselors as part of the community health team that they can ask help to work with the patient and the family.

Now this mental health counselor can work. Maybe they find out something's happened in the patient's life. That's why they're not engaging in their diabetes care. They can begin to work on self-management goals and brief interventions and if need be, connect them to more advanced mental health services.

So if you think about that as an example, what are we really talking about here? We're talking about multi-insurer payment reforms that invest in better primary care practices and the care support teams so that patients get a continuum of services. They get what they need to help optimize their health and their preventive health and their preventive health care.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

So the goal of this type of model with medical homes and a community health team is so that patients can flow across a continuum of services. You notice I'm not using the word health care there. If you look on the left hand side of the slide, there are all kinds of things up there.

Sure, there's specialty care like cardiology or neurology but there's also social services, economic services, all types of services that exist in communities. The goal of the community health team and the insurance investments in that is that patients can really get a flow, a continuum, support across this continuum of health and human services. That's the vision. So we start with the payment reforms to support it and hopefully we're building a continuum of preventive health services. That's the intent.

Part of the model underneath it is the health information infrastructure with the funding of the High Tech Act and the investment of both state and federal dollars. We're building a statewide health information infrastructure that's designed to move information where it needs to be, make the type of reporting and population management that we've described possible. That's a key part of this.

So if you think about it, the state's been working with a lot of vision at every level of building more of a complete preventive health services model.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

So the payment reforms to support this, can it work? Is it viable? Right now, the insurers in Vermont, the commercial insurers in Medicaid are paying fee-for-service just like everywhere else in the country. That didn't go away. We couldn't undo that. That's still there.

Now that allows insurers to compete because they can pay different fee-for-service but it promotes volume. It promotes the kind of volume-based health care. The more I do, the more I get paid. That's still in place. There's a lot of people that'd like to undo that and we may move away from that.

The first aspect of payment reforms is what I told you, each practice gets scored by the University of Vermont-based team based on the quality of their score, national standards for patient-centered medical home. They receive an enhanced payment, so many dollars per person per month based on the quality of care they deliver.

Do they really give access? Do they really use electronic systems? Do they really deliver guideline-based care? So they can get up to \$2.50 per person per month based on the quality of that score. So now they can help have the money they need, that upfront investment that Jeff talked about to operate their practice differently.

Thirdly, the insurers share the costs of these community health teams. Now this is a novel thing. This is

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

the first time we've had potentially sustainable payment investing in care support for a general population. We've always had programs targeted at high-risk groups but not care support for a general population. It's different.

The reason the costs are shared, it puts the community health teams in as a core resource. There are no co-pays. There's no prior auths. There are no barriers for families. And if you think of the balance of these payment reforms, we're beginning to balance the pressure of volume and fee-for-service with quality payments and with better access for families and patients beginning to finally push and balance out the volume pressures. So that was the intent here.

So far we have Medicaid in our commercial insurers in Vermont participating. Vermont's been selected, as has Minnesota, as one of the multi-payer advanced primary care demonstration sites. So Medicare, this year will be joining our payment reforms and we'll truly have an all-payer statewide initiative because this model is being expanded statewide across Vermont.

Lastly, one component of it, there's many aspects to it. We talked about health information technology, payment reforms, medical homes, community health teams. One key thing to think about and this is important when we close out thinking about the Affordable Care Act, we're also putting in place the

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

infrastructure to help expand these models of advanced primary care.

You can't just put money in place and think that it's going to transform our health care system. There's great experience and evidence, some of it the expertise sitting up here at this table, you must have support for this.

So the state has developed the information systems in collaboration with the university, web-based, flexible reporting of performance measures, outcomes measures, putting in place a team of coaches or facilitators, skilled people that can work with practices and hospitals and community health teams across the state, how to prepare to be a medical home, how to implement it, how to look at your outcomes and refine your primary care on an ongoing basis.

So the goal here is to build a living, learning dynamic health system. That is what has been called for by the Institute of Medicine, evidence-based living dynamic learning health system and that's part of the model.

So here's some, so the snapshots out of the Affordable Care Act of a number of the different provisions. When you look at it, there's so many and they all seem scattered. There's one I love, 3502, that's the one that talks about community health teams.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

That got in there, which is great, but if you really read through this -- and I just pulled a few out, so many provisions in the Affordable Care Act that look scattered and segmented -- when you bring them together are the basis of this advanced model of primary care. These are the ways in which you can build this foundation and the Affordable Care Act is essential to make this happen. We could walk through the examples but I won't do that in the interest of time.

So lastly, states can be engines for this. There are so many resources coming out of ONC for technology, coming out of CMS and the Centers for Medicare and Medicaid Innovation, coming out of the NIH and other agencies for guidelines and measures out of ARC, all segmented things that have great value.

And through the model I just showed you, this is an example how states can bring all those things together and truly build a more comprehensive approach to preventive health services. That is the dynamics of the learning health system strategy map is called for by the Institute of Medicine. With that, I'll close out and thank you for the opportunity to be here.

ED HOWARD: Great. Thank you very much, Craig [applause]. All right, finally we're going to hear from Paul Grundy from IBM. At IBM, Dr. Grundy is in charge of health

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

care transformation. It sounds like a simple enough task, doesn't it?

When he's not wearing his IBM hat, he's President of the Patient-Centered Primary Care Collaborative, which is an initiative involving employers of some 50 million Americans along with consumer and physician groups and others that aims at promoting the patient-centered medical home in the United States. It covers a great deal of territory and gives us a sense of where the payers in the private sector are in promoting primary care and the patient-centered medical home. Paul thanks for being with us.

PAUL GRUNDY: It's such a pleasure to be with you. We had our first PCPCP meeting right in this room about five years ago. It's great to be back here.

I just want to, first of all, say that there are really two issues that have been at the table now for a number of years about what's going on in health care and health care reform.

There's the reform side or how it's paid for, who pays, coverage issues, and then there's the transformation side, which is what is it you buy. Regardless of whether you're covered or not, are you buying something of value and who pays? So there are really two kind of separate issues and what we're really talking today about is transformation.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

When you saw that last slide from my colleague, Craig Jones, of all the components that happen in the ACA, many of those were around transformation of care, some of them around reformation but many of them around transformation. I know that a lot of folks in the room here were active in making a lot of this happen.

From the bottom of my heart, I want to say to all of you, bless your heart. There's some real power in this to do something important and God knows we've got to. This slide is a very powerful and important slide. This slide shows us that our health care system, our lack of a health care system has completely and totally failed us as a nation.

If you look at this slide and you look at the point up here, the most important indicator of whether a health care system works or not, measurement of it, is the years of life lived after 40, so a 15-year window is what this looks at. We're dead last and we're dead last at twice the cost price.

As I flew in this morning from New York, I picked up The Wall Street Journal; it happened to be the Friday issue and I kind of grumbled because I didn't realize I picked that up. I turned to a page and the page said that in Maryland, a cardiologist was arrested for doing procedures on folks who didn't need them done.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

I mean this is what the system has got us into right? So from the standpoint of a corporation like IBM, this isn't just cost. This isn't just an issue of cost to us. This is our most productive lives, from 40, 15 years on, that's our managers. That's our managers that are dying in the system. It isn't just cost. It's value, right?

So when you see this kind of data and this is the data that comes out of some of the studies that saw today that's coming out. This is the kind of data we're seeing. We're seeing this all over the country in places where more robust primary care is being delivered.

If you're a state and you're not beginning to step up to this and you're not to deliver this, hear the sucking sound, hear it loudly. Can you guys all do a sucking sound for me? That's your jobs. That's your jobs. When Minnesota can deliver care of high value at two-percentage points lower cost, hear the sucking sound.

If you're in a state that's delivering care in which the cardiologists are being arrested because they're doing inappropriate procedures.

I want to tell you that the core concept of transformation of getting at care of value is not partisan. Now there might be some partisan elements that are made of this

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

and you might hear rhetoric about it but both sides of the political aisle understands this.

Both sides understand that you've got to get at a value proposition that delivers greater value because it's an end game for us as employers. I mean we can't afford sustained. The change is not a benefits issue for us. It's a cost issue. Believe me, it's really important to us.

So I mean this, there is Newt Gingrich, Grassley, there is broad bipartisan support and we've really got to keep the feet to the fire as we go through political transformation and make sure that people understand that this is a value equation.

So business, I mean this is a conversation that we've been having as the large business community, the National Business Group on Health, the National Business Coalition on Health, the roundtable, HR Policy Association. We all agree on some thing. One thing we agree on is that fundamentally, there's got to be a robust base of primary care if you're going to have a sustainable system.

Everybody knows that you can't build a health care system without a robust base of primary care. There's got to be somewhere in the system some adult supervision, honest, or you get the guy arrested like you did in The Wall Street Journal.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

You get the story that, if you haven't read it, you should, you get the story that occurred in The New Yorker when Atul Gawande compares Grand Junction, Colorado with McCallum, Texas.

So I visited a major academic medical center recently and there was a sign on the road as I drove into this academic medical center that says: we do the best heart surgery in the country. I sat around that room with the CEO, the CFO, all the O's in the room, and I said that's not the sign I want to see. There's not ever going to be another job in this community.

It isn't going to happen. I want to see a sign that says: we do the most comprehensive, integrated, coordinated care. Your employees need one-third less heart surgery.

We're the largest corporate employer in Vermont. We're a large employer in Minnesota. I mean we get this. We understand this as a company that this is all about not only costs but this is about value. This is about productivity.

I know exactly what that sign says. That sign says: we know where the money is and we're going after it. That sign says: you know the high value procedures -- that's where the money is and we're going after it. We don't care so much.

I mean I literally have places in this country -- and IBM does data -- I literally have places in this country and

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

some of them are sitting at this table where I see one-third less heart surgery. The data's there.

I have places where I will have five partialists, all working on one of my employees, no adult supervision, no coordination, no integration of care and it'll cost me \$170,000 for the last six months of life if they're unlucky enough to die before they're 65 and then it's my bill right?

I have other places where it costs as little as \$17,000 but when I look under the covers of that, I find that that first slide they do better in the \$17,000 location. I don't have folks who are acting like that guy that was arrested in Maryland. I mean that's the bottom line.

So this is the trend line we're on. This is not sustainable. This is a business issue for us. This is not a political issue. This is a business issue.

So it's kind of like the Olympics. A few years ago, we go [US]; the very best basketball players in the world in 2004. We put them out on the court and they got whooped by the Albanians. Remember that? I mean we got the best players in the world. We have the best specialists in the world.

We have King Faisal fly over here to be operated on but what we lack is an ability to coordinate, integrate, we lack the base of primary care that allows us to function in some sort of system where we're beginning to get at value, where we

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

can look at a Grand Junction, Colorado and see a value proposition and we can look at a McCallum, Texas and we're not going to move our jobs to McCallum, Texas, not going to happen. Hear the sucking sound.

So we do twice as much heart surgery because we have to. We fail to have the robust prevention in primary care. I mean literally again, I see places where we need one-third less heart surgery. That's where we want to focus on. That's where we want to put our jobs. No more do I want to see a sign that says we do the best heart surgery. That's not the focus we want.

That's not the focus we could sustain, a system of accountability in which you have at the core. Attribution, you heard that term earlier, I mean I want to have a place in a healing relationship in which I can look across the system and understand whether care is being provided in a rational way or it's not being provided in a rational way.

For the first time in history, you guys, we're going to have the data to do that. We've never had that before. We're going to have this system in which we actually have data. So companies like IBM are investing with companies like Premier where we're really beginning to look at how we build accountability, how do we build transparency right down to and understand what's happening in that healing relationship.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

These are the joint principles of the medical home. They're very, very powerful. They're very powerful because they're agreed on. They're agreed on by the entire house of primary care. They're agreed on by all the buyers. It's the foundation of the medical home you talked about and this is the kind of care we're insisting on as the buyers of care.

Done a lot of work in Denmark. They're probably about 10 or 15 years ahead of us in terms of this journey. They've gone from 155 hospitals to 21 in 10 years.

There's something funny about ambulatory-sensitive conditions, you guys. You can actually be treated in an ambulatory environment. It can. It is and that's the kind of experiment, that's the kind of process that you're seeing in those numbers.

That's the data we're seeing. It isn't just in Denmark these questions are being asked. It's in central Pennsylvania where Geisinger's asking the same questions. It's in Vermont. It's in Minnesota. We're seeing the same kind of data that we began to see five years ago in Denmark. It's doable. It works.

This is a Hudson Valley initiative. This is a journey that we're on. IBM's the largest employer there. We have about 100,000 lives and this is the path that they're going on towards accountability, the same path that you've heard from

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

Minnesota. It's the same path you've heard from Vermont and it's happening all over the country.

There are probably well over 100 pilots that are ongoing now. Great to hear that CMS with the Innovation Center is really engaged in this. It's now become standard of care in the Department of Defense.

Every Department of Defense member will have a medical home. It's the standard of care in the VA. Those were the drivers the last time we changed our health system. So I'm very encouraged this is here. It's here to stay. It's not political. It's economic and a survival priority for all of us. Thank you very much.

ED HOWARD: Great. Thanks very much Paul [applause]. Okay, a lot of grist to be ground into digestible mass and if you can get me out of this metaphor before I drowned [laughter], there are microphones here in the front and in the back.

I remind you about the green cards that you can use to write a question and our staff will pick it from you and bring it forward and I also invite our panelists who, if they have heard something that they want to respond to or enlarge on that they should take the opportunity as well.

A couple of you mentioned the provisions in the ACA that are relevant to this discussion. It was a very long list

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

even if you count only the circled ones and I wondered how many of the ones that you're interested in and concerned about require additional action by Congress to actually appropriate the money and how much of it is already embedded in the legislation that was signed into law?

MELINDA ABRAMS: There are several that still need appropriation.

KEVIN GRUMBACH: Let me take a start, maybe Melinda and Craig. We're in this predicament where you know how lawmaking works. Things can get authorized, which means just the program is created and there's an amount that Congress says can be spent but that's different from actually appropriating the money.

So there are things, for example, Craig talked about having a support system to help practices become ready for change and help them through the change process. There's a measure in the Affordable Care Act for primary care extension programs, which is authorized at \$120 million a year but has no appropriations at this point.

There's a workforce commission that was authorized to really help think about providing some more guidance around workforce development. That's authorized but not appropriated. There are grants, programs for primary care training under Title VII and Title VIII in the Public Health Service Act.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

Those have been authorized but the appropriations are maybe, at best, 50-percent of the authorized amount and the funding there is much less than it was frankly 10 years ago for workforce planning.

So those are just some of the examples. So that, I guess for any of you in congressional settings, and those who are advocates and policy advocates, the work is hardly done just with the Affordable Care Act. There are a whole bunch of critical pieces that are on the list that Melinda and Craig showed that frankly there has not been the funding actually issued by Congress to make those programs move forward.

ED HOWARD: Craig would you add to that?

CRAIG JONES: I think that's about the, we'd have the same comments.

ED HOWARD: Okay. Yes sir? We'd ask you folks who are asking questions orally to identify yourself, keep it as brief as you can.

DOUG TRAPP: Hi, I'm Doug Trapp with American Medical News. Just a question about, is there a tension, this is for the whole panel, is there a tension between the push for a greater health insurance choices such as in the health insurance exchanges and the idea of trying to get more people into care coordination in some form or another in medical homes?

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

CRAIG JONES: Did you mean is there a conflict or a tension between them?

DOUG TRAPP: I'm just wondering if people are going to be able to switch plans back and forth, does it make it more complex to try and coordinate their care?

CRAIG JONES: One way to think about it is, at least the way we're viewing it, is the medical homes, community health teams, the health information infrastructure is basically a foundation. That foundation can work regardless of how many insurers or the forms of the insurance that are over it. It could work under a number of different scenarios.

So patients can choose and do and, at least in Vermont, their insurance and they can shift employers, change insurance, buy our subsidized Catamount Health plans and the whole idea of having all payers in for this new form is that regardless of which payer, they're getting that same high level of care. So the foundation can fit well with different insurers.

ED HOWARD: Jeff?

JEFFREY SCHIFF: Just a couple quick comments. This is my advertisement for the Congressional staff. If one of the issues about this is that preventive services in the new ACA are covered without a co-pay, we need the same for care coordination so that would really help out because one of the challenges for people who switch insurance is you have a co-pay

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

or a deductible and you have to basically pay yourself for care coordination.

People have to embrace the idea that this has value in the citizens. I don't know that people have quite gotten what's special about having their care coordinated yet. So that's on one issue. The other thing just to say real quickly is like Craig's program in Vermont, the more payers that are engaged, the better off we are in this regard because then there's less slippage from one payer to the other.

CRAIG JONES: Actually, a quick comment. Since the insurers are sharing the costs of that care support, there's not a conflict of interest to go between if that was part of your question.

KEVIN GRUMBACH: But some of the old financing models really undermine primary care because when you were, let's say when an employer had two options and then you lost your job or switched jobs and there's another two options particularly where they were in some sort of limited network panel, you could have to switch your primary care medical home if you change jobs, if you move from a private plan into Medicare.

So I think the key is to have, no matter how you structure the financing, to allow it so that people can stay with the same medical home, which requires more of a kind of coordinated payment model. I think that's actually critical.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

If you have the segmented ones and that's part of the idea of the exchange is to promote people so that they can stay, they don't have to change their primary care locus of delivering care just when their source of health coverage changes. That's absolutely key to preventing the kind of disruption that undermines continuity of care.

ED HOWARD: Yes, please?

REBECCA ADAMS: Hi, I'm Rebecca Adams with *Congressional Quarterly's Health Beat* and with ACOs coming online in January 2012, we're expecting a lot of regulatory activity on this issue and I wondered if you could talk about specific things, any of you, that you're looking for in the rule makings going forward over the next year.

PAUL GRUNDY: I wasn't quite sure that I heard the question but I think it was ACO rule making, is that what the question was? I think the first thing I would like to explain from the standpoint of the buyer of care, from the patient's point of view, PCMH and an ACO are the same thing. They're just different views of the same thing. From the patient's point of view, a PCMH is the bottom up. It's care that's integrated, coordinated. It's care that's accessible. It's care that's coordinated across the entire health care system in that kind of loop that you saw from Vermont.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

From the community perspective down, it's a structure that allows that to happen. So it's the infrastructure that allows that to happen. I think when you look at some of the initial conversations around ACOs, if you look at the NCQA conversations that are out there and if you've been to any of the meetings, I think there's pretty broad consensus around that.

I also think that studying what's happened at Geisinger would be a good example of perhaps what some of the rules are going to look like because Rick, who comes to us from Geisinger, is the person in the Innovations Center who's kind of leading that conversation, although there's going to be comments from others but we're very early in that process. We're just really beginning the dialogue and it's going to be pretty broad and open.

So stay tuned. Watch what's happening there and get your comments in. Again, I think you're going to see movement in supporting that. I know that IBM and Premier are stepping up together to join in supporting that kind of an effort and many others are.

ED HOWARD: If I can ask you to forbear at the microphone, we have just a ton of questions that you put on cards. I want to try to ask a couple of them before we go forward. Melinda?

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

MELINDA ABRAMS: Sure. So there are two questions that were asked about small practices and essentially what is the viability of the solo or the small practice within these new models of primary care such as the medical home or the ACO and what can be done to help prepare these small practices for changes in the delivery of care. There's a very similar question specifically asking about what's in the ACA. So I think several of us could answer this but Kevin, do you want to give it a first shot?

KEVIN GRUMBACH: That's a great question. It's really clear that it's really hard to make this transformative changes to new models of primary care alone as a solo practitioner or a couple of people in a practice. If you look at where the change is happening, there's really two options. One you're either part of an organized system that can invest in the HIT, that can have the training capacity that can help you deploy extra personnel.

So that's why you see groups like Geisinger, Group Health Cooperative, or the VA are really moving forward quite rapidly in the military system because they have a whole organizational wherewithal to do it but that's not to say it can't happen in smaller practices but there what you're going to need is really what Craig was describing, which I think is

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

largely independent practices still but there's still some structure.

There's these shared resources from a community pool of behavioral health workers or care nurses that could be shared among small practices. There is some technical support structure. That's very much analogous to the Ag extension service that work with small farmers to innovative farming practices.

So I think the message right now, I think it's not that you have to be in either completely organized system and it can't work in smaller decentralized practices but it's clear that larger systems have advantages and we have to find a way to build that transformational support in the small practice structure.

It's again what the federal government is trying to do with community health centers through the cooperative kind of collaborative learning models and that that has to be a part of it. I think Craig may want to speak but I think that's a critical to have. Vermont's thinking about this in a smaller practice structure.

CRAIG JONES: Yes. No, Kevin I appreciate that. In our three pilot communities that we started in, we had every mix you can imagine. The model was designed and whether you're a solo, independent, small provider, or hospital-affiliated, a

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

federally qualified health center, all of the different spectrum was included in the pilots in order to test it and help us build it to work that way. What the small, independent providers need is the support as Kevin mentioned.

So if you think about the model here, we have a team that helps get them ready to score as medical homes and prepare for that. We have that coaching and facilitation, that primary care extension team that helps them prepare with ongoing improvement. They have the community health team infrastructure that they work with for care coordination. So yes it's a solo provider but it's a solo provider working with a whole group of resources around it.

The results? We have several independent providers involved. The interesting thing is once they get set up and operating, begin to work with community health teams, they've actually been more nimble and flexible at transforming their practice than have been the bigger ones. So there's strengths and weaknesses, advantages and disadvantages. If the resources and the infrastructure is there, they can do it as well as the big guys.

PAUL GRUNDY: I would like to comment on that. I had the privilege of visiting probably well over 100 practices going through this transformation in the last four or five years that are 20 or less. It's difficult for a large

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

integrated system like with Kaiser. I visited some that are actually transforming to medical home and Kaiser, the largest other than the VA in our country.

It's just difficult for them to get small, for them to get personal, for them to really get into that whole relationship-based, healing-based care of really projecting themselves into that healing relationship, into part of a relationship of trust with a healer that is my healer. That's part of the reason why there's an attraction for both the docs and patients to smaller practices because of that.

So now I think it's as hard for them to get small as it is for the small practices to get large enough to have the kinds of infrastructure to allow that to occur. in the Adirondacks, 157 primary care docs, all small towns, all little communities, I mean in mid-Hudson.

We're seeing organizations that virtually arise and are beginning to connect together and that all across the country in places like Vermont and Minnesota, Pennsylvania, North Carolina, I mean Rhode Island, Maine, we're seeing states stepping up to providing this some sort of a common copper wire, an infrastructure in which there's an agreement with the health care plans that you're going to behave in a certain way in that common copper wire space that this is. That kind of conversation's happening all over.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

I think somewhere in the middle maybe it should meet but the patients need to feel that they belong to a healing relationship with trust where hard questions can be asked, where you're kind of protected in the system but there's enough structure to allow accountability, to allow transparency about what's happening. When you see that happen, in Sharp we're working in San Diego with some data where we actually see down to that healing relationship, who's actually taking care of the diabetics and who's not. You can begin to get some transparency around that, which is really cool.

ANDREA ROUSSARD: Hi, I'm Andrea Roussard [misspelled?] from AARP and I think it was two weeks ago, Alliance for Health Reform had a forum and we had Sue Hassmiller from RWJF and it was on the future of nursing and in the models that I've seen today, there's been a role for RNs in teams and coordinators but I haven't seen anything about advanced practice nurses as leaders of primary care homes.

PAUL GRUNDY: They're out there and they're doing great. I was just at one in Pennsylvania, 9th Street, fantastic. I mean the nurse practitioners delivering care in these clinics; they kind of have a support system just like that common copper wire. It makes them so much more efficient. I mean the ones that I visited, they love it and the patients love it. I mean you're going to see that model occur. Again

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

it's team-based care. So it's a concept where whether you're a nurse practitioner or a physician, you have skills that you add in that relationship that are different but it's—

ANDREA ROUSSARD: Because I've heard about practices out west, house call practices out west where they're more rural where nurse practitioners are saying well I'm just going to start a house call practice and see homebound patients and can they be transitioned into a primary care home model?

JEFFREY SCHIFF: The Minnesota legislation allows for nurse practitioner-based primary care with nurse practitioners at the head of the team and that's one role. The other role conceivably is in some group who's got a complex patient with the nurse practitioner as the care coordinator.

CRAIG JONES: It's the same in Vermont. The law allows it and in fact, in our model, nurse practitioners are running practices and teams.

ED HOWARD: I don't know, Kevin if your research gets to this but what we heard a couple of weeks ago was that in many states unlike what Jeff and Craig were talking about in their respective states, there are significant restrictions in the scope of practice laws that prevent practice at the height of their talents for nurse practitioners and other clinicians.

KEVIN GRUMBACH: Well we have to do a whole other session just on scope of practice, which is an important issue

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

but there are lots of kind of dimensions to it but yes, it's all state licensing rules. So there's not federal jurisdiction over the scope of practice. That's a state jurisdiction.

So there's huge variation across states on things like independent prescribing, the need for supervision, non-supervision from a physician. So it's just a huge diversity. I mean I think probably what will happen is increasingly states will look to which of the models where people are doing successfully with these and that may be an impetus to modify some of the more restrictive state licensing laws in some states.

LINDA NIXON-HAUGHTON: My question is, I'm Linda Nixon-Haughton, a member of Black Nurses' Association of Greater Washington, D.C. area and I was pleased with the concept you said, holistic care, and I'm also interested when you spoke of ambulatory care is deliverable and I thought about the clinics or the sites in malls and also in department stores like Wal-Mart. When you said health care ambulatory is deliverable, were you including those sites in your particular presentation as being a part of the delivery process?

PAUL GRUNDY: Absolutely and IBM working with Mayo Clinic has been on a pilot for our own employees for the last, I guess, three or four years in Minnesota and we've seen a zero trend line in costs, zero in four years. I think the rest of

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

the country was 31-percent during that period of time and we really integrated access points.

So we have integrated into those models weekend and after hours access points, convenient care points but beyond that, I mean when you take it one step further and you look at the technology coming down the road, I mean 32-percent drop in face-to-face visits from our employees who have access to a medical home environment where they can email their doc or they can email the nurse, the healer that's providing care to them.

So we're beginning to see a synchronist communication and that's now in Denmark 72-percent of the encounters. So you're having very different engagements with your care providers. By the way, a lot of what occurs, occurs for chronic disease is at home where there's actually monitoring at home for your diabetes, for your congestive heart failure, etc.

Again, there's going to be very different models of care. Access is going to be very important and certainly convenient access if it's integrated, if it's not fragmented is the key. So if it's just one more fragmented system then it's not of much value to me for somebody to go into a retail store when all they're going to get is what they would've gotten out of their medicine chest. They charge \$50 for that but if it's integrated into their medical home in sort of meaningful way, which is going to happen then it'll be a tremendous value.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

ED HOWARD: We have only about 15 minutes and I can hardly see Melinda under the green cards she has piled around her. So I would encourage you if you absolutely positively have to get your question asked that you go to one of the microphones. Having said that, she has sorted through them all and let's hear a couple from our—

MELINDA ABRAMS: Yes, this is one that we just haven't had a chance to touch on too much right now but, which is would you please comment on the intersection of primary care and federally qualified health centers especially given the expansion of Medicaid in 2014.

So I think it's, as I interpret this question, it's about primary care, medical home, and federally qualified health centers and getting ready for the expansions in 2014. So I think there are a number of, yes, so Craig did you want to go first? There are a number of us who can—

CRAIG JONES: Just in general, federally qualified health centers fit into this model of advanced primary care just like any other primary care practice. So in Vermont, a number of them have been scored against NCQA standards. Their payments are being added too in the same way any other primary care practice is and they're working with the community health teams the same way. So they're fitting right into the model.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

MELINDA ABRAMS: I would also just add to that that the Bureau of Primary Health Care, which is the agency overseeing all of the federally qualified health centers has made a commitment to helping all of the health centers become medical homes. In fact, they've got a contract now with the National Committee for Quality Assurance, NCQA, which does have some national standards where it will provide funding for those health centers to help them to pay for their application fees and also provide some guidance on making sure that they fill out the paperwork correctly but more than that, the Bureau's looking at building an infrastructure.

Jim McCray announced it at the last NAC meeting, building a quality improvement infrastructure to help all of the federally qualified health centers become medical homes. The Commonwealth Fund is supporting a national demonstration with 65 health centers in five different states and we are already, after about a year-and-a-half of the technical assistance, seeing improvements at all of the sites.

So I think that it is, the difference and I think this is in part is that for the federally qualified health center community, they are much more comfortable with the terminology of health home than medical home in part because of the leadership role of advanced practice nurses and second, because of the commitment to the integration with community services

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

public health as well as the medical care but I think that they could lead this and have been leading this at the ground level and all of primary care has a great deal to learn from our health centers.

JEFFREY SCHIFF: Just two real quick comments about the federally qualified health centers. Most of them are paid on an encounter rate, which means they get paid a certain amount only for visits by qualified providers and in some ways, that's very counterintuitive to medical home because in medical home, you want the patients to be seen less, managed more prospectively through cell phones and email and all that. So that sort of has to be fixed and you have to do an alternative payment methodology.

The second thing that I think is really exciting is if you think about care coordinators and medical home and add to them community health workers or some of the outreach stuff that Craig's doing in Vermont or North Carolina's doing, you have this model.

We have layers of support for patients to improve their health and a community health worker may be somebody who just does education around obesity or diabetes but can be based in a federally qualified health care center and can be an extension of a medical home into the community.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

PAUL GRUNDY: So the community health centers, the federally qualified clinics and other community health centers around the country in the last, I don't know, half a dozen years, I mean they deliver really good care. Statistically my employees are more likely to get the preventive services, the services that I would want them to get at a federally qualified clinic or a community health center than they would in the private sector now.

By the way, me and my family, we use, and we slap down our card and pay for it, we use the community health center in our community because it's the best care in my community. It's really superb care. It's delivered by the [Greater Hudson Valley Family Health Center] and by Open Door [Family Medical Center]. So I mean I've been really proud of what the community health centers have done and they're just delivering, in many places, fantastic. Again it's pretty tough odds.

ERIN TAYLOR: Hi, Erin Taylor from Mathematica [Policy Research]. Several of you have alluded to the fact that a good patient-centered medical home has to be situated within a highly functioning medical neighborhood and I'm wondering if you can comment a little bit more on this because it's obviously going to involve a big power shift from the current system and sort of thinking beyond some of the leading lights

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

up here, what sort of mechanisms and levers are out there to really bring along the specialists and hospitals and so forth?

KEVIN GRUMBACH: I mean this is really important. So this term, I really like this term medical neighborhood. I think Elliot Fisher coined it but it's just so clear. I mean a medical home is great but if it's in a ghetto of a neighborhood in a health system that is just working at cross purposes, patients aren't going to get that total integrated, well-coordinated, comprehensive care.

And even if you try your hardest as a primary care clinician, if the specialists aren't communicating with you, if your patient gets hospitalized and you don't even know they were hospitalized and the medications are changed and none of it gets sent back, it totally undermines your ability to accomplish the goals of high performing primary care.

So this gets back to the question about rules making and accountable care organizations and as the incentive changed, frankly there has to be an incentive for the neighborhood to move away from a fragmented, revenue-maximizing, acute care-focused culture into one that really understands that integrated, comprehensive, efficient care is what purchasers want whether it's public purchasers or private purchasers.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

So those are things like, I think that's the real impetus and as Paul says a top-down bottom. I think frankly you need a population level accountability to build that structure in. I think the incentives are going to have to change around rewards for managing a whole population of patients rather than just maximizing a particular episode of care for some acute care service.

I know I work at a more integrated system. I actually do my clinical work at a public health sector in San Francisco General Hospital in our clinic system run by the health department.

We have now an electronic referral consult system that I can use where our specialists are very well connected with our public primary care clinics and I can now embed it in our EMR, make a request for consultation and partly because our specialists are paid, they're salaried under the University of California, they make some money fee-for-service but get some under block funding from the city for uninsured care.

They don't have a huge incentive to see the next patient. So they sometimes just give me back advice without having to see the patient. They say, "Well, try this," or, "Maybe you need to work this patient up a little more and then I can see about seeing the patient."

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

So we cut down about a third of the visits that were needed in specialty care, which were actually over capacity. It's a much more cohesive primary care specialty interface but that was really predicated on the specialists being culturally part of a system that sees itself as working together in an integrated fashion and frankly having some financial incentives that didn't link their compensation exclusively to charging for face-to-face visits.

So I think it's clear the incentives are going to have to change. The culture's going to have to change whether it's through accountable care organizations, other types of initiatives. You can't solve this exclusively just by focusing on the primary care sector alone.

PAUL GRUNDY: I mean the key to all of this is really thinking about a system change in which primary care intervention, the medical home, the health care home is designed to keep patients out of the hospital not a food chain into the hospital. So I mean that's the fundamental, psychological shift that occurs.

When my employees are lucky enough to have a comprehensive list of primary care providers who provides their care, their normal source of care, I look at the data, they cost one-third less. They have a one-third lower, 19-percent

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

lower mortality in that window that I showed you in the first slide. So there's something about primary care itself.

I think part of it is, is that in a community, in a mechanism where they know what's going on, they know what's happening in the hospitals, they know what's happening with the specialists, those primary care guys are probably more likely to keep my patients out of the hands of that guy that just went to jail for doing too many stents.

I think that's part of it. I think there's a component of adult supervision that occurs just in that level of primary care but the next step is to really have a system that's designed to do what we wanted to do and that's to keep patients out of the hospital and not a food chain too. That's going to require a medical neighborhood. That's going to require integration. That's going to require prevention and wastage in the emergency room, etc., etc. So it's going to take both.

ED HOWARD: Jeff do you have a comment?

JEFFREY SCHIFF: I just wanted to say a few things about this. In our early experience the medical home in Minnesota, we found that the specialists, all of a sudden, started marketing to their primary care medical home colleagues and that they wanted, the specialists that wanted to take care of complex patients were really trained to do really started saying okay, I'm going to find these guys.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

We created this mechanism. This is just a very low tech where we required the specialists to fax back a form immediately upon the visit about what they did to the primary care docs. It became an expectation for practice. Like that, everybody who wanted to do that was fine. That's a great thing because those specialists are the folks who should be seeing those patients. It creates a market between primary care and specialists around that.

The other thing I'll say, in Minnesota, if you add some stewardship back in either through an ACO or through recertification, which is required where we are, you have the primary care docs looking to make sure they look for the best market because as I used to say in pediatrics, I knew who I would send my niece to for pediatric heart surgery and even if they were in or out of my system, the providers know. So we need to create that market for everybody.

CRAIG JONES: One quick slant on this with the hospitals and the specialists, it's interesting because at first glance for these things to be successful, there's new investments in primary care and the money's got to come from somebody if we're going to really reduce costs in the general implication is reduce hospitalizations, emergency room visits, and some reductions in expenditures on specialty care.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

At first, the hospitals looked at that and they said okay, if we're going to be partners on all this and help you gear it up around all of Vermont, which they are signed on as partners, we expect to lose revenues. We're going to do it anyway but then a couple of them looked very carefully at our return on investment business models and the investments.

Remember, hospitals are buying up primary care practices and supporting primary care practices all over the country in many different venues. What they found when they actually took the numbers and played with it, what happens now? They buy primary care practices and they have to find a way to subsidize it usually with some other discipline in the hospital, cardiology, radiology, whatever it is.

With the new payments to primary care practices, community health teams, the federal state investment in IT infrastructure, they actually said now wait a minute, this is a way we can build out a platform or a foundation of primary care we never thought of before and we actually can look at a three-to-five-year change in our fixed cost structure with some rational approach. So that's another angle that somewhat surprisingly emerged in our experience.

ED HOWARD: We have time for one more question, which you can listen to while you fill out that blue evaluation form that is sitting in your packets. Yes Bob?

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

BOB GRIST: Bob Grist with the Institute of Social Medicine and Community Health. I was intrigued by the diagram of the Denmark hospitals going from 155 to 21 within a 10-year period. Clearly in a competitive capitalist system, there'll be resistance to that kind of transformation even if it's in the public health interest.

I'm wondering what kinds of public health mechanisms of accountability can move in that direction. That was clearly the role of health systems' agencies in the 60s and 70s. In fact, IBM played a major role in that in the Rochester area providing the kind of adult supervision, as you referred to it, in the way the provider community operated or had a tendency to operate. In the HSA model, there was a role for consumer participation and I haven't heard much talk about consumer engagement in the process of prioritizing needs and particularly based on health disparities data.

I think these things could all fit together nicely but I haven't heard you talk about it exclusively. Vermont may be in a good position to do that through state regulatory authority but I'm wondering if there is a specific role for consumer participation in this process the way health systems' agencies did it when the feds funded them to do it.

PAUL GRUNDY: The consumers have been very engaged in this in all the places that I've been working and have played a

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

huge part. If you go to the [Patient Centered Primary Care Collaborative (PCPCC)] website, you'll see there is actually a whole group that focuses on just that issue that consumer and the role to medical home.

I know that in all the places where IBM is a significant employment base, we've gone out to our own employees and tried to get them engaged as a consumer and certainly done a number of surveys in those communities but in the Hudson Valley where I live, the consumers have been at the table since the very beginning of this. That would be true in Minnesota and Vermont. That's true in Pennsylvania. So there has been a very powerful consumer element of that. Comments from Minnesota and Vermont?

JEFFREY SCHIFF: I appreciate your question and I was not in health policy back in the days when we used to do certificate of need and all those kind of things but I think that's failed because it was sort of not really a market. People would say okay, how much can we do in this community and do it and figure out.

I think in some ways what I think is going to happen and we've already seen some of it happen is there's consolidation that happens naturally because the resources are less used.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

I'll give you one example. We have a high-tech imaging project in Minnesota where it's not exactly directly related to this but because of this project and utilization going down, one of the large radiology groups actually laid off radiologists this year, which was sort of startling to me.

I'm sure they're going to think twice about how many MRIs they buy or things like that or the primary care docs if an orthopedic surgery group has an MRI machine as part of their system and then somebody comes with another MRI, is a primary care doc really going to tolerate them doing another MRI? So I think, in some ways, we have really avoided going back to that sort of regulatory looking at resources individually because I think it's just exhausting and you chase your tail and sort of let the market work on that.

CRAIG JONES: I think it's a great point and there's several different levels at which you could engage consumers in this and we've done some of them and a lot of it we haven't done well, not as well as we should. One is the practices themselves, the medical homes and health teams take ownership and they've all done this over informing their patients and their families about what this means to have the practice as a medical home. So they begin to build expectations really within the base of people who use their practices.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

Second of all, we have planning groups in each hospital service area. They're the ones that plan how do you start up medical homes, community health teams in a hospital service area. You have to form these work groups and planning groups. Those are multi-stakeholder, multi-dimensional. It's not just health care people. It's the area agencies on aging, mental health folks, a lot of service providers, and there's consumers.

So they should be upfront on the planning side of this. Thirdly, as we evaluate the program, there's quite a bit of qualitative work done at assessing the feedback, input, and perceptions, and impressions of consumers and families. All of that's being done. That said, it's not as strong a footprint of consumer input as you would probably want to have. I think we're just at the front edge of building this foundation and it's really just a matter of time, an important issue though.

ED HOWARD: Melinda?

MELINDA ABRAMS: Two other quick points, similar to what Craig was saying about on the evaluation side, there are several evaluations going on of medical home demonstrations across the country, all of whom have certain kind of assessments, surveys, and focus groups of patients to kind of monitor and see whether or not in fact their experience with care is improving over time.

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

The second is that, mentioned a couple of times earlier, that the National Committee for Quality Assurance has this program by which it qualifies or recognizes practices as patients enter medical homes. The standards that will be coming out in January of 2011, that means next month oh my, next month actually has a standard in there that is very much about patient feedback and patient engagement.

To meet those standards in that area, it could be surveys. It could be focus group. It could be patient advisory council. Whether or not we think it's enough points, whether it becomes a must pass element, those things are yet to be decided. They probably won't meet most people in this room's standards. Nonetheless it's there and it's a big improvement from the current standards, the current measures.

ED HOWARD: Very good. Well we've come to the end of our time. I don't think we have heard the last word about ACOs or patient-centered medical homes and I can assure you, we're going to keep an eye on it and bring it back as these regulations and programs and demonstrations and pilots around the country develop over the next couple of years.

I want to reiterate our thanks to The Commonwealth Fund, Melinda and Rachel Nuzum, and Carol Davis and their colleagues for really helping us think through this briefing and structure it as well as co-sponsoring it and ask you to

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.

Innovations in Primary Care: What's in the ACA?
Alliance for Health Reform
12/13/10

77

join me in thanking our panel for a very rich discussion
[applause].

[END RECORDING]

¹ The Alliance makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material, this transcript may contain errors or incomplete content. The Alliance cannot be held responsible for the consequences of the use of the transcript. If you wish to take direct quotes from the transcript, please use the webcast of this briefing to confirm their accuracy.