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Primary Care Innovation: The Patient Centered Medical Home Alliance for Health Reform and Commonwealth Fund September 22, 2008

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ED HOWARD: My name's Ed Howard. I'm with the Alliance for Health Reform. I want to welcome you on behalf of Senator Rockefeller and Senator Collins and our Board of Directors to this briefing on one of the most widely touted ways of bringing greater value to our healthcare spending and better health to the American public, that is to say, the patient centered medical home. It's a sort of jargony way of describing an arrangement where a person can have full-time access to a primary care physician and a care team and coordination of all needed care with an emphasis on managing chronic conditions.

We're pleased to have co-sponsoring today's program the Commonwealth Fund, which is soon to enter its second century of philanthropy supporting work, now on a range of health policy issues, with an emphasis on vulnerable populations. Commonwealth's also done and funded, I should say, a lot of seminal work, specifically on medical homes, and we're definitely pleased to have with us the Fund's Melinda Abrams to introduce that topic and help moderate. You'll hear from her in a second.

The PCMH, how's that for jargon, has been around in one form or another for a long time, really, but only now is it starting to get a lot of attention. There are Medicare demonstrations. There is a certification by the National Committee for Quality Assurance. There's even favorable

mention of it in some of the presidential campaign documents. Today we're going to take a closer look at it and its potential to improve delivery and value of healthcare and its future in both government and private coverage arrangements.

Our learning, by the way, is going to be substantially enhanced by the current issue of *Health Affairs*, which features several articles about medical homes. Our thanks to the new editor of *Health Affairs*, Susan Dentzer, for making copies of the journal available to those of you attending this program today. If you don't already subscribe, by the way, you really should. There isn't any better policy journal around.

Before I introduce my co-moderator in today's panel, just a couple of logistical notes, you know you're going to be able to see a webcast of this briefing by Monday. No, that would not be right, by Tuesday morning on Kaisernetwork.org followed a couple of days later by a transcript and electronic copies of all the materials in your kits. We'll send you an email so you'll know when all that is available.

We have microphones that you can use to ask questions once we've heard the presentations. There are green question cards you can write on and hand them up so that we could ask them up here. And of course we really would like it if you'd fill out the blue evaluation form before you leave so that we can improve these sessions for you as we go along.

So this is the last Alliance briefing of the summer by about what, three hours? [Laughter] And I can't think of any better way of doing that last event as a wonderful sum-up and by examining medical homes and I can't think of anybody I'd rather have co-moderating than the Fund's Melinda Abrams.

I'm not going to take the time. I've already apologized to everybody for not giving them the introductions they deserve and that includes who actually directs the Fund's patient centered primary care program. She's done a ton of work on improving preventive and developmental services, especially for low-income children, and we're pleased to have her with us today. Melinda?

MELINDA ABRAMS: Thanks Ed. So, there has been a lot of discussion about the patient centered medical home, and I really want to thank everyone for showing up to today's briefing.

In many ways the notion, the concept of a patient centered medical home is an effort to try to strengthen primary care, and part of the reason we care so much about primary care, other than the fact that it has been under invested in in the United States, is that we know from decades of research that countries with strong foundations of primary care are more likely to have better quality, lower costs, and greater equity.

What you see on this chart is results from a study by Barbara Starfield, preeminent scholar on primary care at Johns

Hopkins University, that essentially shows countries with strong orientation to primary care and those with strong primary care scores, like the United Kingdom scored the best, and seem to on average less per capita on health care expenditures.

What you'll notice is the black diamond towards the bottom and all the way to the right is where the United States is, showing that not only do we spend more per capita, but also graphically displays and portrays how we have a weak system of primary care.

The principle driving patient centered medical home and patient centered care is really relatively simple. It is that the health system should be designed and organized around the patient and not around financing and physicians and administrators. And one approach to providing patient centered primary care is the patient centered medical home, which organizes care around the relationship between the clinician and the patient.

In February of 2007, more than 300,000 internists, pediatricians, family physicians, and osteopaths came together and released the joint principles for the patient centered medical home. The characteristics of which are listed here and include having a personal physician and a whole person orientation and better care coordination, but I still find many

times when I talk about this that there's lots of questions. Well, what does this mean in practical terms?

So I'm going to try to explain that, which is that in a medical home, a patient can expect to obtain care from the physician practice on holidays, evenings, and weekends without going to the emergency room. The patient could have medical questions answered either by telephone or email the same day that she contacts the office.

In a medical home, non-urgent care appointments could be scheduled one or two days ahead of time instead of weeks or months. And in a medical home, the primary care clinician helps the patient select a specialist. The patients are partners in their care. The clinical care team reviews treatment options, goes over conflicting advice from multiple providers that patients inevitably receive, helps explain that different advice, and regularly solicits feedback from patients about their experience, and also uses that information to improve the quality of care that is provided in that practice.

To work well, a patient centered medical home requires improved infrastructure, such as electronic health records or patient registries, or the ability to review test results remotely. But most importantly, and this is in many ways what distinguishes the discussion around the patient centered medical home in 2008 from previous discussions, whether it be

about managed care or the chronic care model, most importantly, the patient centered medical home also requires payment reform.

So, but I also want to make one other point, which falls into that, which is that for the medical home concept to flourish, it needs a greater organization in our healthcare system and that both doctors Diane Rittenhouse and Duane Davis will present the value and importance of organization when they speak.

The Commonwealth Fund commission on a health performance health system recognizes how the current fragmentation of our delivery system fundamentally contributes to our poor performance, and therefore outlines six attributes of what an ideal high-performing delivery care system would include, such as having clinical information available at the appropriate time, coordination of care, making providers accountable, helping them work in teams, making sure the patients have easy access to appropriate care, again more about accountability and that the system is continuously innovating.

And once again I will say, and that's what's presented in this graphic here, both of these last two slides are included in a report from our commission that came out in August called Organizing for a High Performance Health System which shows that with different kinds of payment and there was a relationship between more organization and different kinds of

payment moving away from fee for service and more towards bundle payments.

And so, again, I think that Dr. Berenson will talk a little bit about the payment and some of the problems that the medical home is trying to solve and we will also hear a lot about organization from our other speakers. So thank you very much.

ED HOWARD: How are you? We have some rambunctious microphones. Sometimes they turn on and sometimes they don't and with luck, every time I try to use them for your standpoint, they won't turn on.

But they will work for Bob Berenson, and we're going to start with Bob. He's a senior fellow at the Urban Institute. He's a primary care physician. He ran a small PPO in the D.C. area. He held a series of high-level posts in what is now CMS involving Medicare payment and with the White House domestic policy staff, and he is the lead author of the lead article of the special *Health Affairs* section on PCMHs. So Bob, thanks very much for being with us. We look forward to hearing what you say.

ROBERT BERENSON: And I want to thank the American College of Physicians and the Commonwealth Fund for funding our group that, amongst other things, did produce that *Health Affairs* article. I will dispense with my normal hilarious monologue because I have 20 minutes-worth of material to do in

10 minutes, and your thing isn't going there. So I'm still at 10 minutes, alright?

ED HOWARD: Whoops, got it going down.

ROBERT BERENSON: Keep going that direction. That will be fine. So I'm going to go through a whole bunch of slides fairly quickly. It will be in your handout so you can go back, but I wanted to make a bunch of points here.

First of all, there's a lot of interest in this patient centered medical home. I'm actually concerned, as are others, that it's beginning to attain the status of silver bullet solution to problems in healthcare, and we've seen some other silver bullet solutions that sort of were over hyped and then people were disappointed. We should be careful about that, but this is part of presidential campaigns. We've got purchasers of all kinds. The primary care groups, even some of the specialty groups are all supportive of the medical home.

And what problem are we trying to solve? Well, a few have been identified as problems that the medical home might be able to solve. There are recognized deficiencies in patient centered aspects of care, the ones that Melinda was talking about earlier. We don't do very well on international comparisons on these elements.

The growing challenge of chronic care, and I'll come back to that, and some people actually almost equate the medical home with better chronic care management. And then

there is the relatively poor primary care compensation that exists and that builds on the kinds of findings that Melinda had presented about health systems that have more primary care have in international comparisons polled together by Barbara Starfield, do better on quality and at lower cost. And yet we are having increasing shortages of primary care. So maybe the medical home is a way to get that flow going.

So let me briefly go through very quickly support for those problems that I identified. One of the best articles I've ever read on Health Policy by Ed Wagner and his group associated with group health at Puget Sound admits the press of acutely ill patients, it is difficult for even the most motivated and elegantly trained providers to assure that patients receive the systematic assessments, preventive interventions, education, psychosocial support, and follow-up that they need. He described that as the tyranny of the urgent.

This was from a *British Medical Journal* article that's gotten some attention across the globe. Doctors are miserable because they feel like hamsters on a treadmill. They must run fast or justice stands still. The result of the wheel going faster is not only a reduction in the quality of care, but also a reduction in professional satisfaction and an increase in burn-out amongst physicians.

So the hamster on a treadmill problem, how are patients affected by this? Asking patients to repeat back what the physician told them, half of them get it wrong. Patients making an initial statement of their problem were interrupted by their primary physician after an average of 23 seconds. In 23-percent of those visits, the physician did not ask the patient for his or her concerns at all. That's the hamster on the treadmill. The doctor's pushing people through.

On the spending issue, it's a whole bunch of studies are coming out that support this general finding that without going through all the details, if you have no chronic care conditions, which is about 22-percent of the Medicare populations, you spend less than one-percent on Medicare. If you've got five or more, that's about 20-percent, you're responsible for two-thirds of Medicare spending.

And more recent data found that 75-percent of high-cost beneficiaries had one of seven chronic conditions. And 70-percent of in-patient spending was with beneficiaries with one of these. And so the theory is that if we do a better job in our ambulatory management of these conditions, maybe we could reduce in-patient spending.

So, let's make this more concrete. If you've got chronic conditions, zero chronic conditions you get 3.7 prescriptions a year. If you've got five or more, you get 49 prescriptions a year. This sort of invites the question of

well, can something go wrong with 49 prescriptions in terms of incompatibility, redundancy, confusion by the patient as to what he or she should be taking.

And similarly, in relationship to chronic conditions, if you have no chronic conditions, you see 1.3 physicians a year and if you have five or more, 14 different physicians are submitting claims to Medicare on your behalf. This is again a Medicare population. Now, some of those are one-time events, an anesthesiologist or radiologist, but many of those physicians are providing concurrent, on-going care and that suggests that maybe there's some problems and we actually have some data on this.

Incidents in the past 12 months, I won't go through all of them, but it's interesting how things often cluster around. This is like Beth McGlynn's 55-percent of people get what they're supposed to get. Fifty-four-percent of people have been told about a possibly harmful drug interaction, 54-percent sent for duplicate tests, et cetera.

On the primary care issue, in '98, just as the sort of height of managed care when it looked like there was going to be a health system reform built around primary care, 54-percent of internal medicine residents chose general medicine. By 2005, it was down to 20-percent.

And a similar phenomenon is happening in family medicine. Residency slots are being filled with foreign-born

graduates of foreign medical schools. And so we're robbing other countries of their important work-force and not producing our own graduates to go into this important area.

And payment is part of the reason and why we think that needs to be addressed. I pulled a couple of specialties. Primary care between '95 and 2004 got a 21-percent 10-year increase. Dermatology got a 75-percent increase. It's not coincidental that medical school graduates are told to follow the road to success, where road stands for radiology, orthopedics, anesthesiology, and dermatology.

Our payment systems are encouraging entering into niche specialties. We don't only lack general primary care doctors, but nobody wants to go into general surgery either. The generalists are the ones who are not doing well under current payment systems.

The medical home concept has actually what brought together. There have been four, sort of, streams. Pediatrics have had medical homes going back 30 to 40 years. There's been a lot of work on primary care. World Health Organization convened in the '70s a sort of international conference and that generated primary care residencies in the U.S.

Primary care case management was what it was called by some managed care companies, and it got pejorative term of gatekeepers. Actually in Medicaid, primary care case

management was a positive thing providing a source of care for people who hadn't had good access to care.

And in more recent years, practice redesign was electronic medical records and the Wagner Chronic Care Model came along, this was all put together in, what I think, is sort of the best sort of, call it a synthesis of these various dreams by Karen Davis, Steve Shownbound, and Mario Day [misspelled?], two of whom are here today, sort of a potential pulling all of this together but still ambitious for a practice.

So what are the challenges, in my last two minutes? There is, in fact, a lack of agreement on operational definitions. Some people emphasize it's about chronic care management. Some think you've got to get traditional primary care and patient centeredness right and that means it should be available for all patients. Even if we paid practices more, what's going to deal with the tyranny of the urgent and with the shortage of primary care physicians?

There are still patients coming in with all of the acute problems that they've always come in with; will that practice be able to provide yet additional services? Practice size and scope are implicit here. I think we should really be distinguishing large organizations. You're going to hear about Geisinger and what they're capable of doing from a solo or small single-specialty practice and whether they can provide

that, whether that latter practice can provide all the elements of the medical home or should be part of virtual organizations in a community.

To whom should it apply? Again, all patients or limited to chronic care patients. I can make arguments on either side and we can come back to that. As Diane is going to be talking about, there're significant management challenges. Even in large groups with an interest, many elements are not adopted of the medical home.

We have an issue of whether this is really just for primary care physicians or what's called principle care physicians. That might be an endocrinologist taking care of a patient with diabetes or an oncologist taking care of a patient with newly diagnosed cancer. Do we expect the patients in any way to have a commitment to going through their primary care or their patient centered medical home before they go to see a specialist or not is an issue?

And what I'm going to finish with is this idea that everybody now seems to be hanging on the medical home everything that they want to improve the health system. And so that can be all sorts of good things-better attention to diagnosing and treating alcoholism or depression, or doing shared decision-making, being more attentive to health disparities.

I mean pretty soon you start hanging everything on this model and it dies of its own weight. And so let me finish with two final ones. Even though there's broad interest, and I showed you in the first slide that the payers are part of a coalition to try to promote this. There is some skepticism amongst the payers because they've been sold on other approaches that haven't really worked out—vendor based disease management, while it may have some marginal benefits in some situations, hasn't been sort of the panacea that some had hoped for it.

There is concern that the patient centered medical home is a stalking-horse for more money for services of practices they should already be providing. We're going to put more money into this and get what we already think we're paying for and then there are the consumer issues. Is this gate-keeper in track?

Let me finish with this slide, and this is interesting from an article five years ago before the current both the language about patient centered medical homes as well as all the current work. Primary care could also expand beyond its more restrictive role as provider of medical care. The danger of course is that primary care's new role will be even more expansive and varied than today's already diverse activities.

A redefinition of primary care must be cognizant of this risk, focused on optimizing primary care strengths and

avoid assuming too many peripheral responsibilities in its formulation. So with that, let me finish, and I'll be happy to discuss this more later. Thank you.

ED HOWARD: Terrific, thank you Bob. You laid out a whole range of things to think about as we consider this topic. Next we're going to hear from Diane Rittenhouse. She is on the faculty at the University of California-San Francisco and at the Philip Lee Health Policy Institute. She, too, is a physician and a researcher. She concentrates on the organizing, financing, and delivery of primary care, particularly for under-served populations and is the primary author of one of the single papers in the *Health Affairs* that you have in front of you. Diane, thanks for being with us.

DIANE RITTENHOUSE: Thank you and I want to thank the Alliance for Health Reform and the Commonwealth Form for bringing us all together around this very important topic of primary care innovation. It's certainly near and dear to my heart as both a professor of family medicine and health policy and also as a practicing family physician.

I'm going to present today some research that we've done around this issue and by its numbers and a sense of what's going on across the nation with regard to implementing the patient centered medical home.

So, you've heard from our prior speakers a couple of things, one that there's a large body of knowledge that tells

us that an emphasis on primary care is able to increase quality, increase efficiency in the healthcare system and potentially decrease cost. We've also heard about the patient centered medical home model as is currently formulated as a comprehensive model of healthcare delivery and payment reform that emphasizes primary care.

So this is the home. This is the vision. This is no panacea. There's no quick answer. This certainly isn't going to be easy, but there is a vision out there and there are people from many sectors. The providers are behind us. The plans are demonstrating and piloting this. The payers are certainly very interested in this. So we have a vision and I was interested in using some data that we had to learn a little bit about it.

So these are the joint principles that were agreed upon for the patient centered medical home and we saw this in Melinda Abrams presentation. They're also in your packet. There are seven different domains that are important to the patient centered medical home. We have national data on four of them.

So I just wanted to point out as we go forward that we're going to be looking at the domains that are highlighted in yellow: the physician-directed medical practice, the coordination and integration of care, the emphasis of quality and safety, and enhanced access. And the question that we

asked was to what extent is the medical practice infrastructure in place to support the implementation of the patient centered medical home in the U.S.?

Data that we have from the National Study of Physician Organizations and Care of Chronic Illness, and these are my co-investigators at both the University of California, Berkeley and the University of Chicago, and this work was funded by the Commonwealth Fund along with the RWJ Foundation and the California Healthcare Foundation. I won't go into detail on the methods other than to say there is no clean list of all the physician practices in the country.

We don't have a central repository where we keep track of physician organizations and physician practices. We set out to look at all the practices in the United States that have 20 or more doctors. So these were the larger medical groups we were interested in, and we started with a very large list. We called them all. We found that many of them didn't exist. Some of the preferers had gone out of the business. Some of them weren't actually medical groups.

We identified all medical groups in the country that had 20 or more physicians. And for this particular analysis and limiting this to the medical groups who said yes we care for patients with diabetes. We care for patients with asthma. We care for patients with congestive heart failure. We care for patients with depression. We do preventive care. So we're

really looking at those organizations that are heavily primary care-focused and have responsibility for caring for the entire patient.

So, back to the four domains that we were able to look at with this data, this is the first and it really is about team care. And we define that by saying that the organization has personal physicians that lead a team of individuals at the practice level who collectively take responsibility for the on-going care of patients.

The second domain that we looked at was care integration and coordination. And the kinds of things we asked about here were electronic patient registries with patients with diabetes. Do they have a way of identifying all of their patients who have diabetes to bring them in for routine care? Do they have a way of recognizing all their patients who used tobacco? Do they have electronic medical records in place? Do they have clear coordinated communication with other parts of the healthcare system and specialists and hospitals in the emergency departments? And do they use nurse care managers to coordinate care for patients who are particularly ill?

In addition to team-based care and coordination and integration, we looked at quality and safety. And the kinds of things that we asked about here were do you provide your physicians with point of care decision support? So do they have the evidence before them at the moment they're seeing the

patient and trying to make a decision that they can quickly access and make evidence-based decisions for treatment? Does the organization routinely feedback data to physicians about their performance and quality? Do they incorporate feedback in their own quality improvement activities?

And then finally we looked at access. So we were a little bit more limited here. We didn't have information about their hours and some of the things we would have liked to, but we were able to ask about whether or not they used email routinely with their patients and whether or not their patients were able to access their medical records online.

So we took these areas of quality and safety, coordination and integration, access, and team care and we made a list of 20 different components and that's all in the article, the details of how we did that, but we came up with a scale from zero to 20 and we assigned each one of these physician organizations a score based on how many of these different components of the patient centered medical home model they were employing.

And this is what we found: wide variation. Nobody scored 20 out of 20. Many groups scored one or two, so that is they were employing one or two or three of these things out of the 20 that we were asking about. And the average here, both the mean and the median here was seven.

So on average across the country among these large medical groups that have 20 or more physicians who are hypothesized to be well-positioned to implement these kinds of things, the average number of components of the patient centered medical home infrastructure that they're using is seven out of 20.

So you can look at that as glass half-empty, glass half-full, we can shake our fingers and say tisk, tisk. These doctors don't know what they're doing, these organizations suck and we should really try to figure something else out, and why aren't they working harder. And we could ask them to run harder on the treadmill and we could ask them to, back to the hamster idea that you saw earlier in Bob Berenson's presentation.

Or we can think about the fact that these organizations are existing in a climate where it is very difficult actually to implement electronic medical records and to get some of these coordinated activities going and where reimbursement is not strong for primary care. And yet, some other research we're doing that's not yet published looks like we're actually moving the needle on some of this so that these are actually improvements over time and that these groups are doing better than they were, say, five years ago.

Certainly you have to take away from this that there's a long way to go. This is looking at the score by size of

practice. So we just broke the practices into groups by quartile and said okay well if you look at the smallest of the large groups. Say they have 20 to 37 doctors. Their score tended to be lower and we saw the score go up with each size quartile. And it was really the groups that have 140 or more physicians. So the largest of the large that seem to have the highest scores.

We then looked at the groups that were doing very well on all of the components that we measured and we said let's call this high-performers and we looked the ones who were doing very poorly relative to their peers on access, quality, integration, and team care and we broke them out by signs as well and what we found is that the lowest performers were disproportionately represented among the smaller organizations.

Once again, these are not small practices. These are not solo practices. The smallest ones are 20 to 37 physicians. But we didn't see as many low-performers among the very, very large groups. And when you look at high-performers, they're disproportionately represented among the very, very large groups.

We also looked by ownership and you can see the yellow bar are the groups that are owned by a hospital or HMO or larger organization, AKA more resources and the orange bars are those organizations that are owned by physicians solely. And you can see across these three domains the organizations that

were owned by larger entities were employing more of these components.

So in summary we can say that on average the adoption of the patient centered medical home infrastructure components are low, that we see wide variation across all of the domains, that the largest of the large groups are doing more, and that those that are owned by larger entities are doing more. And again, this suggests that having more resources available to do things like implement electronic medical records or to set reminder systems and think about patients on a population level, the more able they are to do that.

And this is just to get back to the reminder that we didn't look at the entire patient centered medical home. So there are very important components of the patient centered medical home that we did not have data on and that we together need to think about how we're going to look at and analyze and measure going forward.

So we looked at the red structure there which is the infrastructure components. We did not look at whether or not the patients were each assigned a personal physician and whether that personal physician was easily accessible and had an ongoing continuous relationship with a patient because certainly a medical home is much more than an electronic medical record here and a reminder there. It's an ongoing relationship with a physician and a group of a team that

coordinates care over time and then we did not look at payment. And certainly this model not likely to be successful without a significant payment reform.

So, in summary I'd just like to say that we're working on building this medical home. The system that we have now is broken. We have a vision towards where we want to be and what I can say given our data today is that this is certainly a work in progress.

ED HOWARD: Thank you so much Diane. And I know for the record that you finished precisely as your time expired. That's what I call performance-based activity. [Laughter] We'll steer the tough questions to you instead of to her.

Finally, we're going to hear from Duane Davis, the Vice President and Chief Medical Officer of the Geisinger Health System. Bob mentioned Geisinger in passing. I'm privileged to have spent some time on the Geisinger campus. For those of you who are unfamiliar with it, you need to get up to speed. It's one of the highest-quality health systems in the country. It's based in rural central Pennsylvania. You may have heard about their recent offer and what amounts to a 90-day warranty on heart bypass surgery and also one of the most ambitious medical home projects anywhere.

Duane is also a physician. I think Melinda and I are outnumbered on the panel. And he's responsible for all of the

health services delivered by Geisinger. Duane, thanks for joining us today and let's hear your story.

DUANE DAVIS: Thank you, Ed. Is this working alright? I, too, want to thank the Alliance and the Commonwealth for inviting us and as Diane said, this is work in progress and I'm pleased to be able to come and share some of the progress that we've made so far. What I'd like to do first is just give you a little context. Ed did begin to do that.

But the first thing that's important is that's a real picture from the back of the campus. It is pretty and a very beautiful place to live. And it is quite rural; although, if you've been through central Pennsylvania, you know that it's becoming less rural. Although the towns are 10 to 15 miles apart, they're growing together, as they are in many places.

To give you a little context, the Geisinger health system consists of a large group practice over 700 physicians. Around 200 of those physicians are primary care. I'll talk to you about our struggles with primary care and with recruiting, et cetera in a minute.

We are spread across that geography of 41 counties across north-central Pennsylvania and we have multiple practice sites. We also have several hospitals that are part of the system. And importantly we have a health insurance arm of the integrated health system, Geisinger Health Plan that has a

little over 200,000 members, including 35,000 Medicare Advantage lives.

Some the data I'm going to show that's about those lives. One other context point, about one-third the care that the health system delivers is delivered to Geisinger Health Plan patients. On the other side of the coin, about 30-percent of the Geisinger Health Plan membership comes to Geisinger for care. So it's really quite a mixed model.

Almost three years ago when we were sitting thinking about how to redesign primary care for a whole bunch of reasons and thinking about our need to create value in central Pennsylvania and in healthcare, we thought that we should charge someone ourselves and then some part of our system with perhaps being that value agent that if we went ahead and did that that the medical home chronic care models, at least for us, would initially be an investment.

They would cost more. Hopefully we'll show over time that that's a good investment, but because we had to do that, because, like any business, we have a budget, et cetera, we had to look at ways that we could implement this in a way that would deliver both short-term and long-term value to us.

The prudent health navigator strategy that we had was this. It's quite a big mouthful of words. And in the discussion, we could perhaps discuss that, but I think it's probably more fun to describe it the way we do when we go to a

primary care site and we're talking to the care team. And what we say is think of redesigning this as if you were taking care of your children.

They have to have total access to you. You have to know where they are at all times. You have to get them out of trouble when they get into trouble. And you have to help them with problems that they have or at least help them solve those problems. And when you say that to the care teams they go "oh, okay, yes." And I think one of the things that we found is that really tried to simplified this to how would you do it has been a real learning for us.

We define value as these three domains. We're measuring basic experience, we're measuring quality outcomes, and we're measuring efficiency outcomes. I think those measurements are early and probably not the final measurements that everybody would like to have for a program like this. But we needed to start, and so we picked measures and I'll show you some of the results of those early measures.

We start with pilots. We did two pilots in two of our primary care sites in two different towns. One was a blue-collar town essentially and one was a university community. We didn't pick them for that reason. We picked them because they had very high numbers of Medicare lives in those practices. We also picked a third pilot that I won't discuss a lot today but we could potentially talk about it in a discussion period.

That was a non-Geisinger primary care site that worked with the Geisinger Health Plan and we chose a commercial population in that site primarily because they were champions at trying to do this. Those two different types of pilots have been very educational to us in terms of what we're learning.

The other thing we needed to do is to transform our primary care. We have pretty well resourced primary care. They all have electronic medical records. They have a salary. They work in our system. They're highly productive by the current productivity standards of primary care. But as you looked forward, it was without redesigning that we delivered care they would start to lose productivity. And they weren't happy in the way they were delivering care because they really wanted to deliver care in a way that the two speakers before me have described.

And so there were two reasons to do this, one, because we wanted to reinvigorate our primary care. Even though we have over two hundred primary cares, we have 20 open spots at one time. If we can't recruit them, they're hard to recruit. We also know that as a health plan, as an insurer, primary care's incredibly important to us. And so that was another reason. And then third, we really thought that we could potentially be innovative and redesign the way that we did this.

And then the last bullet point's my favorite because I followed my father-in-law through the health system over the past two years. And meaningful coordination truly doesn't exist. And to the degree that we can do that or make progress in doing it, I think that we can see some very early wins in this.

There are five functional components that we chose because we wanted to try to translate some of the things that you've heard about into a way to try to operationalize this in a way that we knew it needed to be patient centered. And so each time that we have a discussion or a meeting or a team or a group we'd say is that good for the doctors and the staff or is that good for the patient or the member. And after a while, we all, and I'm a physician too, we all recognized better that we are pretty much doctor centered and pretty much and pretty much health care delivery centered. And it really does take a different way to think about it.

The second thing we thought that was missing in primary care because we had the experience on the health insurance side was even though many of our sites perhaps would like to manage a population, they have no tools and no skill sets to manage it and an electronic record in its non-modified form isn't a very good tool to do that either. And so what we recognized was that there were a lot of things in the health plan that health plans do every day, insurers do every day that could be

leveraged to do this better if we could get the information to the medical home.

The care systems we'll talk about in a minute. We did put a quality outcomes program in a value-based reimbursement program. In the three minutes or so we have left, we can't go through all these but I wanted to get them into the slides so when we said what do those five functional things mean, you would have some of the bullet points that would lead you to understand some of that, so we just heard about 49 drugs and the Rx management program is a really, really important part of doing this well.

On the population management side, tools that we use in our insurance arm like predicting modeling that aren't in primary care sites ordinarily have become very valuable tools. And integrating our case management that we've had as an insurer and that was mentioned before in our disease management, into the sites themselves has allowed us to leverage that very significantly.

We don't have time to talk about all this but we do know that it's extremely important to know where these folks are at all times, to work with all of these different kinds of care systems to create ways that you can find out as quickly as possible what's going on, where it's going on, when someone's going to transition from one place to another, begin to work

with specialists, which also mentioned to say it's a work in progress.

We've got a lot of things to do, but we'd like to begin to work also with specialists to have them become a part of what we're trying to accomplish here. And likewise with radiology, ancillary services, we've gone to nursing homes and said here's what we're up to, here's what about, would you like to sign on. If you are willing to sign on, here's the way we could do it. Price of admission is just roll up your sleeves and help us try to design this.

The quality outcomes, as I said, we've got chronic disease measures, preventive service measures, and satisfaction measures. I'm absolutely convinced they'll morph with time, but we started with a set that I'll show you in a second. And likewise we changed the way we paid our primary cares. We continue to pay them fee for service, we gave them practice transformation stipends, both the physicians, the staff, and an infrastructure payment, and then we arranged for the results to be shared with them if the results were positive.

The initial results are promising. We've had these pilot sites up now almost two years. This is one of the pilot sites in terms of its baseline quality metrics and its follow-up quality metrics after a year. And I think you should concentrate on the first four there. The ability to get

desired appointments we haven't actually solved totally, although it isn't too bad at the present time.

But above that, the plan of care and the risk assessment essentially were things that didn't exist in our practices either. And by creating those and making sure that they're happening, we're seeing a lot of good things occur.

Finally, this is the efficiency result. And the way that we looked at this was— these are all, by the way, Medicare members in this data here— all the members in those pilot sites, which is about 3,000 Medicare members to begin with, were counted in our efficiency. And we saw those drops first in inpatient care and in readmission to inpatient. And that came because as we were able to coordinate care, we were able to keep folks out of the hospital and folks from going back into the hospital.

When you add drugs back in, which is the third line down, you see that the trends aren't as good, but they're still better than our other nonmedical home sites, which are also Geisinger sites which are resourced relatively the same although the care hasn't been redesigned.

And so we're very pleased with these results so far; although, we recognize they're early. We've expanded this to 12 more sites, and those sites have been up now about nine months. And while it's too early to say it's sustainable, the pattern is the same.

So what did we learn? We learned that there are tools that we have in our health system that we wouldn't necessarily see as part of this that are very valuable tools, such as predictive modeling, making case managers a key part of the team, but not just the team. It has to be a team, as Diane mentioned, is very, very important. Managing transitions of care from any spot to another spot is a great place to get an early win, both quality-wise and efficiency-wise.

Managing nursing home admissions is another great place. We looked at that and actually recognize that almost a third of our Medicare patients were getting readmitted from nursing homes within 30 days. And it had everything to do with lack of coordination, lack of medication reconciliation, even though those physicians, those specialists, those hospitals, and those nursing homes were trying to do as good a job as they could under the current situation.

And then finally, leveraging out electronic medical record, which is epic, in order to build in ways to do many of the things that Diane and Bob mentioned has also been extremely helpful to us. I do think you can do it without that, but it would be slow and laborious and probably a lot, lot tougher. Thank you very much.

ED HOWARD: Great, thanks very much Duane. Excuse me. I wonder if I could just follow up before we get going. I want folks to take advantage of the time now that we have for the

discussion. As I say, there are microphones that you can ask your question orally from. There are green question cards you can fill out and hold up and the staff will bring them forward.

And let me start off by just asking Duane to describe. So many of you have talked about the importance of payment, could you talk a little bit about the payment that you got for the people in the medical home experiment that you were describing.

DUANE DAVIS: Sure, thanks then. We decided to approach this by taking our Medicare Advantage lives, the 35,000 lives that we get premium for and modeling what we thought we could afford to invest in this redesign if it worked and if we were able to get this done. We also know they our primary care, because they live and work under the same kind of payment system that everybody else did, needed to be realigned. And so we went to them as the insurance arm of our integrated health system and said would you be interested in doing it this way? We'll continue to pay you fee for service, and in fact, we would expect your business to go up.

But we'll also give you an incentive because this is hard work. You've got to do extra here. You've got to come to meetings. You've got to act as a team. You've got to spend some times on Friday night saving that congestive heart failure patient from getting so bad that they end up in the hospital on the weekend.

That's hard work, so we're so convinced this will work we'll pay you ahead of time. We also gave them infrastructure payment at the primary care line because in our system, like everybody else, if they compete with capital for every other thing, they may or may not be at the top of the list.

And finally we said if this works and there's savings in it, we will accrue some of those savings to the primary care service line. And that's the model that we've chosen and so far it has worked well.

ED HOWARD: And how important is it that you have an insurance plan as part of this arrangement so that you get the payments in the first place?

DUANE DAVIS: I believe that it certainly was easier for us to sit down as an integrated health system and owning both sides and say okay how can we make this work? How can it be a win for everybody? It wasn't just super easy because each of those entities has their own goals and incentives and targets and everything like that.

I think it's possible with a non-owned insurer. I think that there is an opportunity for insurers or other folks who have a lot of data and information and infrastructure to be an important partner in this. Not sure that we have an exact way that that should be designed, but it was very important in order to get a start.

ED HOWARD: Thank you. In the absence of anybody standing there, we're going to start using some of the cards we got in advance, and the ones that are coming up now. Do you want to take a look at that? A person asks, what the panelists views are on which providers should a medical home be billed around. Many of the proposals he or she writes for a medical home speak of physicians, but given the shortage of primary care doctors and challenges, particularly rural or underserved areas, does it make sense to expand the list of providers to health professionals such as nurse practitioners? Bob?

ROBERT BERENSON: I'll give that a try. That was one of my challenges. If in fact there's a tyranny of the urgent, we have a shortage of primary care physicians and now we have a whole bunch of new expectations for what the patient centered medical home is going to do. We've got a sort of disconnect as part of the work we're doing for ACP and Commonwealth, we've actually visited a number of practices to get their sense as to what they're doing, particularly in relationship to the NCQA measurements that we haven't talked about yet but might come up and found that there's just a huge variety of responses to the current problem.

On the one end, you've got something called the ideal medical practice. It used to be called the ideal micro practice, which actually is a practice with one doctor and no staff of any kind and a very elaborate electronic health

record. The physician in the practice who we interviewed sees fewer patients a day, has much lower overhead, so, in this case, he did not have as much staff to support and feels that he was meeting the expectations of a medical home pretty well.

We went to a different practice with one full-time equivalent physician. It was a husband and wife sharing a one full-time equivalent slot and they had 13 people working in that practice, including a number of nurse practitioners. There's no question that they had adopted team-based care and were allocating or figuring out the most efficient way to see patients and there was no question that in that environment were the continuing care clinicians for a number of patients in the practice.

So clearly, we will have to develop a number of models. I think one lesson is that we should be looking for performance and not be too prescriptive of how to get there. And unless we do something about the primary care physician workforce, I would call it a crisis, we clearly will have to rely on nurse practitioners, physician assistants, other professionals to be perhaps first line, but certainly to be part of teams if we are serious about this.

ED HOWARD: Let me— go ahead Diane.

DIANE RITTENHOUSE: I just wanted to add. My comment is that one of the goals of the idea here is that you would have people doing what they're best trained to do and that

physicians who have traditionally done a lot of things that they didn't necessarily go to medical school and need to do. So you'd have physicians on teams with other providers, nutritionists, dieticians, physical therapists, nurse practitioners, whatever that team needed to be, social workers, to help.

That's part of the team concept that there are those who may be as well trained or better trained to do certain aspects of what needs to happen in care and that some of the coach, some of the counseling, some of the teaching, some of the prescribing and instructing and whatnot can be done by a team of providers and be there or more accessible to the patient and allow they physician and each provider to really do what they're both best-trained to do.

ED HOWARD: That's good. Yes, we'd ask you to identify yourself please.

SUSAN HANK: Susan Hank [misspelled?], I'm a Robert Wood Johnson Health Policy Fellow with the Senate Finance Committee. Medical homes are presented as a new concept. Can you explain how medical homes are different than community health centers?

ED HOWARD: Good question.

MELINDA ABRAMS: Well, the reason I think you should answer is because in your paper you talk about the four

evolutionary streams and then if I can follow on about the role for low-income—

ROBERT BERENSON: No, there's actually a bit of a debate I would say because there is a long tradition of primary care. It's been defined and involves access to care, meaning 24/7 access and availability. It means longitudinal continuity, which means an ongoing continuing relationship with a particular clinician.

The original definition suggests comprehensiveness that this primary care physician should be able to provide a very broad range of services without having to refer. And there might have been a fourth, which I'm forgetting on right now. But the point is that some people sort of assume that that's there and then see a special opportunity for the medical home to do chronic management, which does involve a whole new set of activities which have not been part of traditional primary care.

I would sort of label them under the category of proactive, visit planning, trying to figure out why the patient's coming in, what needs to be done during a visit so there's decision management support to identify what's missing in their care, registries to people back in, teaching self-management skills, relying on others besides a physician, just a whole set of activities which had not been part of the traditional primary care definition.

And so ideal, and it's in the paper I referred to, the medical home would be doing both. The traditional, accepted, primary care activities, which have been labeled relationship centered care or patient centered care, as well as the new activities, which for lack of a better term is the Wagner Chronic Care Model and that a practice could do both.

Whether or not a small practice is able to do significantly more to get that primary care piece right is a question and whether you need in that situation to have a complementary organization so you have, in a sense, virtual teams rather than assuming it's all going to be within one entity. Just specifically on community health centers, I think because of work that I'm aware, I haven't worked with community health centers for many years.

I actually used to be in HHS and work with them, but work that they've been doing in collaboration with Don Berwick at IHI about sort of developing the community health center model. I assume and I have some knowledge that they are doing the whole care continuum from primary care through adopting the primary care models. Is there anybody in the audience who has specific expertise on community health centers?

MELINDA ABRAMS: Well, I was going to say two things to follow up. I think community health centers are ideally situated to be patient centered medical homes. And I think that is actually the vision, and it's not clear to me that

that's exactly how they're all functioning and performing at the moment. And in part, it's most likely to do with the large numbers of uninsured for which they have to cross-subsidize in probably the low payments on the Medicaid side.

My colleague Anne Biel [misspelled?] and produced a report closing the divide that looked at medical home for low-income and minority patients and was able to show that having a medical home helped to promote greater equity. She also found in her analysis that based on— and this was just indicators of medical homes. It wasn't nearly as comprehensive as what Diane was able to do from her survey.

But based on these indicators, the respondents in community health centers were less likely to report having a medical home than those in private physician offices. However, when she did a follow-up analysis that looked among those in a community health center, those who had a personal physician, they were much more likely to have a medical home.

So I think, again, that they're ideally situated. I actually think the community health centers can help lead this effort and become models of excellence, not just for the safety net, but for all providers. But I think currently they're not necessarily fulfilling that promise, although I think they have the capacity to do so. The Commonwealth Fund hopes to help community health centers and primary care clinics serving low-incomes achieve that vision with a new demonstration that we're

launching to work with 50 safety net clinics in four regions of the country.

ED HOWARD: Yes, go ahead.

JASON SPANGLER: Jason Spangler from partnership for prevention. It appears that in going to a lot of these home discussions that the focus is on chronic care disease management. To many people that's mainly what the medical home's about. Dr. Davis talked a little bit about prevention and preventive service, but I'm just wondering if you think prevention is getting lost or the role of prevention in the medical home or preventive services could be expanded, especially when you talk about high-value. Most preventive services are high-value services. I'm just wondering what your thoughts are on prevention and preventive services in the medical home.

DIANE RITTENHOUSE: I think prevention is as much a part of primary care as chronic illness. Doing chronic care and treating chronic illness I think it does sometimes get a little bit lost in the discussion. But if you've got an organization that's truly functioning as a patient centered medical home and putting the patient at the center and helping them to identify their own priorities and to come in maybe when they didn't know they needed to come in, whether it be for chronic care follow-up because you need to see the ophthalmologist once a year because you have diabetes or

because you have diabetes or because you need to do a urine sample once a year because you have diabetes or because we need to check your medications on a routine basis with your asthma or whatever it is.

Those same kinds of systems that you put in place and the same sort of outreach and counseling and training and the way that the office has organized benefits and as long as the payment isn't specifically only targeted to a given disease, you should also benefit.

You should be able to identify those women in your practice who are of the age when they need routine mammogram screening or those patients who need colon cancer screening. You should be able to find them and identify them and provide them with that information that they would want or like I said tobacco. And we did measure that in Arizona. It was included in there. So it was chronic disease and preventive treatment.

DUANE DAVIS: If I could just add to that, many of the things that Diane mentioned, we've tried to build into our approach at the primary care level and using our information technology platform, we'll find those folks who need things, send them reminders. We have over 100,000 patients now on a web portal to our electronic record where they can check to see what they need or what kinds of things that will be coming up. They can make their own appointments.

Our case managers, if they have a chronic disease, can send them a message. If they don't have a chronic disease we can still send them a message and say please come get your mammogram or your flu shot or whatever, so there's a lot you can do with electronics.

We've also created bundles of care. So for example with diabetes or with coronary artery disease, and you can do this with other things, we now have a preventive bundle that we brought up this year using electronic medical record where we used diabetes because it's easier. There are nine diabetic majors, nine diabetic things that we feel that the best practice would say that you should make sure they get done. And we track those using our reminder systems, et cetera.

But we track them and we give ourselves credit only if we get 100-percent of all of them for a given patient. So, if you look at slide 14 in the handout, our diabetes bundle score is nine-percent, went to 11-percent, but most of the individual metrics are in the 80s or 90s, very tough to get everyone every time. But that's how we measure it and you can do that with the IT systems and registries and things that folks have. Much harder to do in a paper world, but I think the approach is very similar whether it's chronic or preventive.

MELINDA ABRAMS: What I'd say in specific response to your question though is really do we feel that the demonstrations and a lot of the discussion is really about

chronic care. And I think that the chronic patient population tends to dominate sometimes in the public forum for two reasons, one, because they're the high-cost patient, two, because the way CMS has designed the Medicare medical home demonstration and that the screening criteria means that you have to have one or more chronic conditions to participate.

But the truth is just exactly reiterating what the others have said is that the prevention piece is as important as all the other pieces. We think that when we look at the cost savings we're going to see changes in utilization patterns, which means probably fewer hospital admissions and readmissions. And that will probably be on those with chronic care.

But really, again, it is about both pieces and if you look at a broader range of demonstrations, particularly those in state Medicaid programs or commercial payers, you're seeing that they're not necessarily selecting exclusively those patients with chronic conditions.

ROBERT BERENSON: Can I jump in also? I just want to follow up. It was actually congress who said that the Medicare-

FEMALE SPEAKER: [Inaudible] sorry.

ROBERT BERENSON: That all right- should focus on patients with chronic conditions. CMS actually took a very liberal interpretation of what that meant and was able to find

about 85-percent of Medicare beneficiaries would qualify. And I would just associate myself with all of the remarks that everybody needs patient centeredness

And I remembered the fourth element of primary care, which is basic coordination of care. Everybody will benefit from 24/7 access, basic continuity with a specific clinician, basic coordination of care with other physicians and other providers, and ideally comprehensive care from the same place.

On top of that, the way to rationalize this is there's an opportunity then to have special activities related to chronic care patients with multi-disciplinary teams and relying on other professionals as well as electronic health records to provide specific supports for that high-cost and difficult challenging population.

ED HOWARD: Yes, in the back?

MARY TIERNEY: Yes, I'm Mary Tierney [misspelled?]. I'm with the American Institutes for Research, and I'm a pediatrician. So I had to get up and say again, thank you to the first speaker who recognized that the American Academy of Pediatrics has been working on this for 35 years and I'm glad that this concept is finally coming into the adult population. And it's not particularly a new concept.

One of the things that we have found, and it's a question for anybody on the panel, is to what extent have you been incorporating care management, case management in this?

How are you getting it paid for? We in pediatric have been totally relying a lot on case management and luckily Medicaid up until recently when it's gotten fuzzy has been able to pay for these services. So anybody who can answer that I'd be interested.

DUANE DAVIS: We have case management as a very integral part of our team based approach. And in fact, while you could perhaps finance how to get that case management into a practice, one of our learnings has been that if we get those case managers into the practice itself, they are much more effective than when we had them even in our own integrated system in the health plan.

And so what we've done is basically funded them and said go ahead, put a case manager in. We have shared some case managers if there's a small satellite practice next to a larger one. I think it's critical in terms of a lot of this coordination. It's also critical in the sense that the folks that were in that slide that represent 85-percent need to have someone that they can rely on, that they trust, that they know they can get. Example infrastructure change, we put direct lines into the case managers in cell phones and educated the patients and their families that those were the folks that you would call. You wouldn't call the regular number.

I think the danger to it, though, is that case management just by itself is not what we want to do here and

we'll overwhelm that nurse or whoever's doing it fairly quickly. But if they're an integral part of the team and they do those things, as Diane said, that they're good at, docs are now freed up to do something else. Some of the electronic records frees other people up to do other things. Then it really starts to work. But they are absolutely critical in terms of coordinating this.

ROBERT BERENSON: If I could just jump in, clearly that question invited a whole discussion of how we're paying for this and should we be paying, how to pay. Clearly a lot of it is not happening today because there's no payment outside of face-to-face visits. There's no payment to a practice for case management.

So, one of the prevailing payment options is to continue paying for face-to-face visits but then providing monthly per person per month payment to support a whole range of medical home activities that would include case management. And then that invites a discussion of should we make that payment regardless of whether the practice is successful in these activities or should we assess the performance of the practice at holding down costs and if so, then provide the payment.

The payment options are another whole discussion, but clearly a lot of these activities are not happening today because in our fee for service system based around CPT coding

and payers being reasonably nervous that a whole bunch of medical home services it's hard to know what you're paying for. These are softer services, in a sense.

They've been reluctant and that's why we want to do extensive pilot testing to build a business case for if you do pay for case management for and these other activities you get a return on investment. That return on investment hasn't been proved, but it's certainly plausible. And Geisinger's sort of leading with some of this work.

ED HOWARD: Go ahead.

DIANE RITTENHOUSE: I was just going to say that the Commonwealth Fund is supporting a number of evaluations of these demonstrations to determine whether or not it really does slow the rate of healthcare cost growth. And we are seeing within these evaluations a range of payment options from the per member per month on top of the fee for service to a per member per month fee for service for the pay for performance, which is called the hybrid payment model that's being promoted by the American College of Physicians and the American College of Family Physicians, to more of a pay for performance, like a very generous pay for performance type model that's being tested in the mid-Hudson Valley region in New York to a global capitated risk adjusted payment for primary care that's also going to be tested in in nine practices in Massachusetts and Albany, New York.

So we are seeing a variety of payment models. And hopefully from these evaluations we'll learn some of the advantages and disadvantages of the various approaches being tested so far.

ED HOWARD: Yes sir?

JONATHAN PECK: Jonathan Peck [misspelled?] from the Institute for Alternative Futures. Let me take you back to back to the Community Health Clinics question. I did get to work with Community Health Clinics in Hawaii this summer, and they do reinforce what you've said Melinda, that in effect they don't have all the components of a medical home, but they have evolved towards many of them including much better care coordination.

And they don't have the electronic medical records for example, but they are using navigators, including volunteers from the community. And what was striking for me is that while these are set up for the medically indigent, they're now attracting in pay patients who are insured but who have heard that this is the best care you can get.

ED HOWARD: Thank you.

DIANE RITTENHOUSE: I think that that's true that there are certainly places and I've certainly visited places where the care that was happening in the community health center in terms of the organization and the efficiency, the patient centeredness, the whole person care, the onsite social worker,

the onsite other allied health professionals who could assist immediately in the onsite decision, there are some incentives built into that system in some places in this country. There are some supplemental payments, some collaboratives that you can participate in.

So I think it's a little bit of a myth that for some reason private practice is just simply better than community health center practice. I think that that's not true. I think that there are places where there's visionary leadership in a community health center where they're able to mobilize the very scarce resources and lead in a way that's very innovative and deliver care that's much more patient centered.

And actually we've seen some studies that have shown some very excellent outcomes among even the chronically ill and the very sick. So, I think there are some models out there that we could probably learn a lot from.

ED HOWARD: And if any of you have had exposure to the Denver health system, a lot of what Diane was just describing came to mind as I was remembering a field visit we did a few months ago to the Denver health system where the community health centers are completely electronically wired and are starting to attract paying patients precisely because they are delivering the kind of care that you'd want to see. Yes, go right ahead.

EVA POWELL: Thank you. I'm Eva Powell with the National Partnership for Women and Families and I'm leading a consumer oriented health information technology project. I remember back early when we first started with the session that it was mentioned something about patients and consumers trusting this or buying into it, but we've not talked a whole lot more about that.

I'm curious from Dr. Davis what has been Geisinger's experience in terms of how this model has really helped improve shared decision making because implicit and patient centered care is the shared decision making. And all of this of course is necessary for that. But if the patient's not part of that, it's not really patient centered.

DUANE DAVIS: Well, I think if the rest of this is early, this part is really early. And we recognize that we need to work on that piece. We've begun to work on it primarily by doing what we do and hoping that, like Hawaii, people say wow this is good, you should go there, as opposed to let's say, marketing it or something like that.

We have done several different kinds of things. We tried to make folks aware of what's different and then try to understand whether they actually see it as different because many of our patients are fairly stable. They've been in these sites and the question is do you notice anything different? Is this better?

The second thing we do is we try to use some of our customer service folks throughout our system to do proactive outreach and we're working on making those folks more virtual. Like many traditional call centers, ours have been centralized. But we want to make those virtual. We think we can with technology. And so one of the pilots has an outreach program where we basically touch base with the patients fairly frequently, get to know them, hopefully they'll get to know those folks on the team, and we'll be able to say anything we can do for you, anything going on, that kind of thing.

It's slow. We've got some really early antidotal evidence that people recognize it, that it's been recognized in the community, but we don't have data yet. We are planning on measuring that though.

ED HOWARD: Yes, go right ahead.

BEVERLY COLEMAN-MILLER: Yes, my name is Dr. Beverly Coleman-Miller [misspelled?] and I'm an internal medicine physician and a public health advocate and one of my questions is with all of the virtual dimensions to this, is there anything being done specifically to help with mental health in this, the chronic mental health disease patients?

ED HOWARD: Very good question.

DIANE RITTENHOUSE: Okay, I can just say that from our data we had focused on these four chronic conditions in our initial survey and they were congestive heart failure, asthma,

diabetes, and depression. And I'm actually in the process of analyzing the data and looking specifically at depression because we do know that some of these same issues.

And this is more the chronic care model, but some of these components of the chronic care model that have been touted for and really are beginning to gain some traction for diabetes and asthma. And I think there's a cost-saving argument there or a value-based argument there— are certainly also being studied. And there's data showing that these things also work for mental health and depression. But there's a much bigger divide between what we know should be happening with patients with depression and what is actually happening in depression.

So across the board no matter what we asked about, we found that organizations that were doing had care management on some level for these other diseases, the last disease to look at or the last chronic condition that they would then focus on would be depression. And so those numbers were the lowest across the board.

So, we're sort of in the process of looking into that and trying to explain it but certainly I think it doesn't help that we've segmented mental health. As a family doctor, we keep finding well these are the chronically ill and these are the ones who need preventive care and these are the ones who need mental health. And when you're sitting in a doctor's

office, that's not how they come in. It's all part of the same patient.

ED HOWARD: Melinda?

MELINDA ABRAMS: I was just going to add that I think it is part of the vision and not yet realized in any way that we would be content or pleased with. One area that I know that Diane and I are actually working on together where they're really trying to address this in the safety net and the mental and the physical together is in New Orleans. A number of the small primary care safety net clinics in that area are really trying to integrate it and tracking their chronic mental health issues just as closely as they're tracking the other chronic disease areas.

ROBERT BERENSON: My comment would be that in talking with nurses with the more traditional call center based disease management dealing with sort of single diseases, heart failure, COPD, what I heard was that concurrent depression seems to be common and that they don't make a lot of progress on the disease which ostensibly they're treating unless they can work with the primary care practice to work on depression also. And so just the logic as Dr. Davis has said of trying to lodge this disease or care management in the practice rather than through some distant call center.

The logic is there. We're just going to have to see how it plays out. The point I tried to make earlier about

unfettered expectations is that we've got to be careful about going from where we are today to putting so many expectations on the medical home that it doesn't have a chance to grow. But in 10 years or whenever this sort of hits its stride, there's no question that one of the objectives is that mental health problems that are amenable to detection and treatment or referral by the medical home should be much better handled than it is today.

ED HOWARD: Okay, yes, go right ahead.

ROBERTA LILLY: Yes, I'm Dr. Roberta Lilly [misspelled?]. I'm from the Health Policy department at George Washington. I'm interested in trying to figure out how to measure performance on a patient centered medical home. And I realize we could look at each practice and determine whether or not there were policies and procedures in place that cover the seven domains that are important to the patient centered medical home.

But wouldn't it be easier to look at the failures? In other words, if our denominator is all the patients, for instance, with chronic disease, and then we aggregated the number of those patients that visited an emergency department, were admitted to the hospital, or died, wouldn't that give us some degree of reliability in determining success or failure or efficacy in the aggregate purpose of the medical home, in other

words, to improve patient care overall? Do any of you have a comment on that?

ED HOWARD: Bob?

ROBERT BERENSON: Yes, I'm willing to try. That's why some people have recommended that whatever additional payments are made for medical home activities is contingent upon a performance analysis including things like hospital rates, ER visits, it might even be a per person. I use per person, per month rather than per member because these aren't technically members. They haven't signed up there. But that's my own hang-up.

But basically to do a cost analysis the problem is because this isn't new. Twenty years ago the U.S. Health Care Model of paying primary care physicians was essentially you get your monthly payment and then we're going to analyze your risk pool and see how you're doing on managing down-stream costs and we'll either give you your withhold back or we might even give you a bonus, I mean in a sense pay for performance. It has a new name, but it's not new.

What was a problem with that and what still is a challenge is risk adjustment, being able to be able to account for the fact that the doctor that may have a high hospitalization rate specifically gets a lot of referrals for very difficult patients to manage. I think we've made great

progress in being able to do risk adjustment at the individual clinician level.

But that is a challenge. But ultimately again, I think that ultimately, instead of being heavily sort of process oriented, which do you have the following systems in place; we ultimately do want to be outcomes oriented.

And let me, while I have the microphone, identify one of the real challenges here it seems to me in measuring performance is that we really want to be able to measure patients' experience. Is this practice patient-centered? And I don't think you can get that whether they're patient centered.

I think you really do somehow have to figure out. There's now measurement sets out there, and Melinda knows this more than I do, but we should have to figure out how to get, without spending lots of money on surveys and things, feedback from patients and being able to put that as a major sort of performance measure as the patient centeredness. I don't want to just be measuring performance on HEDIS measures, on quality and sort of on ER and hospitalizations.

MELINDA ABRAMS: Right, and actually that speaks to one of the questions here, which I feel also follows up on your question. I think part of the reason that the measures are done currently at the physician or the practice level is because the underlying philosophies of the concept is that it's

voluntary. And so that if a practice meets some object criteria it's eligible for enhanced payment.

So I mean that's part of why we have this and that's in many ways a philosophy of the National Committee for Quality Assurance's physician recognition programs. Whether or not they should be physician recognition or practice recognition is another story. I probably favor practice recognition which also help us get around some of these workforce issues around like which providers qualify if we just focus on the functions of a practice.

But I think that that's why you see it kind of done at this practice-by-practice level. Someone submitted a card here says most of the research and physician statements on the medical home by Commonwealth, AFP, et cetera, emphasize a personal relationship with a primary care physician enhanced access and care coordination. However, the actually NCQA scoring guidelines seem to emphasize infrastructure such as EMRs and registries and having a person doctor, open access care, teams, distribution. Do you think the NCQA scoring guidelines accurately capture the medical home?

And so I guess I just want to follow up in trying to answer question globally around measurement. I completely agree with Bob that you don't know if a practice is patient centered unless you ask the patient. It's just fundamental.

Where we are today on the measures is that we have some measures to look at the systems and infrastructure within a practice to monitor those systems that we think are associated with patient centered care. But those are really just supposed to in some ways just eligibility criteria. They don't tell us the performance of that practice. If we were going to look at the performance of the medical home, we'd have to look at clinical quality and patient experience.

And so really we need to be looking at three kinds of data. There is a lot of research going on right now. We are working or we're supporting NCQA to look at whether or not patient experience scores, the results of those surveys can be used for eligibility criteria because ultimately that's where we would like to go.

There are a lot of problems with that in terms of standardization of tools, even though we have the cap standardization of sampling. Practices aren't necessarily used to collecting at the practice-level in office surveys from patients. At least that's what I'm told.

So there are a lot of different issues in terms of how you would do this. And then Bob says to me that maybe our approach is we're trying to be too sophisticated. He might be right. So right now, we're trying to support a lot of different research to figure out how can we incorporate the

patient experience both for the eligibility and as part of the payment.

What I will say is on all of these evaluations that we're supporting and considering, not only are they looking at changes in utilization cost and efficiency, not only are they also looking at clinical quality, they are all looking at patient experience between the patients and the medical home and those that are not, the comparison groups. And to also see these changes in the infrastructure, are they associated with better experience? And if not, then there's something else that we're missing in this current model and the current technical assistance to help practices transform.

ROBERTA LILLY: Thank you.

DUANE DAVIS: Could I add just one final add-on to that? It's a very interesting question. The only way we're going to ultimately, I assume, get the kinds of data that you were recommending, hospitalization rates and ER rates, is actually going into the payers database and getting it.

In one of the site visits we did, the physician was able to show us her patient experience survey that the payer went to the patients and asked them to rate their physicians on some basic questions, the kinds of questions that Commonwealth uses in their international comparison. After hours do you have a place to call where you're confident that you'll get a response? Some really basic things and she was able to just

show me that. So I actually think there's a role here for the payers to complement the evaluation at the practice-level on these issues of outcomes.

ED HOWARD: We have just over five minutes left to go. We have about, I don't know, 418 green cards up here. We're not going to get to all of your questions. I apologize for that. While we get to a couple of them, I would ask you to pull out the blue evaluation form and start filling it out so we can make use of your patient satisfaction surveys, if you will [laughter].

I wanted to synthesize a couple of comments and a couple of questions. And it has to do with size of the practices that we're talking about here, Dr. Rittenhouse's research centered on relatively large practices, 20 or more. And a questioner asks how will the model affect solo and small practices? Won't it encourage more integration and merging of practices in order to compete and survive?

And I have to say that one of the aspects of this that was most striking to me was just finding out what the distribution of practice size was in the United States for physicians. And I wonder if you could both try to answer the question and provide all of us with a little factual background about the onesies and twosies versus the twenties in this country. Bob?

ROBERT BERENSON: Well, I think this is one of the toughest issues on what needs attention because on the one hand you can argue that all of the good things that Geisinger is doing that I don't think can be done in a solo practice are such that we want to move all solo practices into being part of larger organizations. And what I've suggested in some of my work is that Geisinger and organizations like Geisinger should be especially working to capture those decentralized primary care practices.

Actually on the sort of responsiveness side of patient centered medical home, I think small practices have a lot to offer. And as I've observed for 35 years that I've been doing this business, Ed and I are old enough to have been doing it about the same about- I have been hearing about Kaiser Permanente, Intermountain Healthcare, Geisinger, and Mayo, occasionally Group Health of Puget Sound. It's the same organizations.

This model hasn't grown broadly. In work I've done for the Center for Studying Health System Change, we've documented there are single specialty mergers, not mergers into integrated multi-specialty group practice.

So I think our payment system has been a barrier to this and other public policy, but there may be something about decentralized independent practices that clearly the docs like it, although the recent graduates want to be a part of larger

organizations. The patients seem to like it. We need, I think, a larger evidence base before we want to make a public policy decision to really try to move all those little practices into larger organizations.

And so where I come out is that we need to be looking at virtual integration models. And I would point to North Carolina Medicaid, which provided a patient centered medical home payment to their primary care docs. And essentially, as I understand it, and I went down and I interviewed some people, essentially to do good primary care, to treat their Medicaid patients like they treat their private patients, meaning don't send them to the emergency room after hours. Take the phone call; work with them as they are any other patient. And that produced some cost savings just simply the 24/7 access to their regular source of care.

And then what North Carolina did is they embedded in the community some of the chronic care model activities. And in particular care management nurses were not located at a call center a few states off, but in the local hospital or local health department with that nurse developing personal relationships with the practices, with the patients, able to go to the hospital.

So until we're ready to simply try to have a public policy that says we don't want those little practices. I don't think we're there yet. I think we want to look at models that

have one kind of payment model for the Geisingers, which I wouldn't call a medical home. I would call it an accountable care system. They're doing things in subspecialty care and cabbage warranties and a whole bunch of things that go well beyond just medical homes.

We want one kind of model for larger organizations like that and then we want to try to move small practices in the right direction, but my view is you want to get them at least to be good primary care practices, many of whom have stopped being that. There are practices in this country now who don't answer their phones after five o'clock.

We want them to do primary care and try to compliment them. Whether they can get larger and bring those elements into the practice or whether they should be part of a community network, I think that's the kind of work that needs to be done to try to sort out what works best, and my hunch is it'll work differently in different places.

ED HOWARD: Diane, you want to—

DIANE RITTENHOUSE: I just wanted to comment that I think there are different issues and I think they're very important to address both. I agree with what Bob was saying. I think that the larger groups that are already doing it, the very, very large groups and the Geisingers and the Mayos and the Kaiser Permanentes, they're not taking over the country. They're not seeing 100-percent of the patients. They're not

doing all. I mean you would think that might be happening, but it's not.

So there's something about the healthcare system that says we cannot only look at those few organizations. We can look to them, but they are not going to be necessarily, unless things change dramatically going forward, the solution to the entire healthcare system problem. And so we need to also look at other places in the healthcare system.

And while some of these large groups have been very successful in transforming the way that medicine is practiced, they're still suffering from the primary care crisis in that they're not able to recruit the physicians that are trained to do the kinds of things that they want them to do. And they're having to kind of retrain them or bring them in.

I think in the small settings, you've got doctors out there practicing the kind of medicine they always wanted to practice, but they are not successful at transforming their practices. They weren't taught to do that in med school. They're not paid to do that. So we're asking them so you were trained and are paid to do this but we're now asking you to do this. And that's a very different kind of issue and I think unless we sort of recognize that these are different animals and we have different kinds of solutions for different sorts of organizations, we're going to stay in this mess.

And I think I keep falling back on it. I'm not sure. Is it easier to transform medical practice if you have 500 doctors or is it easier to transform medical practice if you have two doctors? And so for the people who say only the large groups can do it, I think maybe we're just not quite framing the issues and there needs to be some maturity in kind of what our ideas are and what we're actually asking people to do.

ED HOWARD: Duane?

DUANE DAVIS: Yes, if I could just add to that. I agree with both Diane and Bob, but just again, on the ground, some early personal experience with it. One of the things that we've kind of said to ourselves is we're not going to make our proprietary, although there are a lot of rules about how we can share it or not share it, some of those in the way of progress and some of them we can get fixed.

But we're also going to try to work with the small two-man primary care sites that contract with Geisinger Health Plan as part of Integrated Health System. And we don't have the answers to this but we really thought we should try it and see if we could learn what were the barriers and what kinds of things might work.

What's interesting and I don't think shocking to anybody is when you start doing something and the word gets out, they're in the same town, they go hey can't we get in on that? And so we said let's try it, and they don't have all the

things that you've mentioned. They have to be as a practice, willing to collaborate and to some degree trusting that you're not trying to disadvantage them in some way.

But we found that we could provide a lot of the information and the care manager or the case manager and those things that they might need to get going and get started. And while it's not a model for everybody, it did work. We were able to take one small two-man practice and work with them and use our resources to allow them to practice in that way and to begin to convert.

And I think you're right. Even in the big group practice, the folks in our place, including me, were never trained to do this. And so I think you have to somehow allow the time for all of us to relearn it and then to think outside the box and design it and be able to try something and see if it works and then go on. Now, you know there are restrictions to that. They're called time, money, and all those kinds of things.

But the experience we had with that one small two-man practice is it probably is doable. It's hard. They have to want to, but I think Diane is right. I think there are a lot of ways to skin this cat and you just have to keep trying.

ED HOWARD: Terrific. Melinda, any final words? Two down, several hundred thousand to go, right? [Laughter] I don't think this is going to be the last time we talk about

medical homes with you in this room. And I want to, while I finish my remarks and you finish filling out the blue evaluation forms, just say that this has been one of the more lively discussions that we've had that is going to occur not only 10 years from now, but in the context of health reform discussions over the course of the next year, I have no doubt.

I want to thank the Cracker Jack Alliance staff who made everything run as smoothly as it did. I want to thank Commonwealth and particularly Melinda and her colleagues who have expressed not only a strong interest in this, but put their money where their mouth is in backing research and getting involved in it.

And I want to ask you to join me in thanking the panel for an incredibly good discussion of a very complicated topic.
[Applause] To be continued.

[END RECORDING]