

**The Right Care at the Right Time:
Are Retail Clinics Meeting a Need?
Alliance for Health Reform and WellPoint Inc.
June 18, 2012**

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ED HOWARD: My name's Ed Howard. I'm with the Alliance for Health reform. And I want to welcome you on behalf of Senator Rockefeller and our board of directors to a program that looks at ways to keep people out of hospital emergency rooms unless there's an emergency, using clinics and urgent care centers and other more appropriate places to deliver their care and as we look to the future and see that scary slope of the healthcare cost curve, making sure that those who are seeking at ERs or I guess, more properly, from our colleagues, EDs, emergency departments, are actually in need of that level of care. Not only can we save some money, non-trivial amounts, as you'll hear, I'm sure later today, but we'll make sure that those with the needs, with the true emergencies, will have less trouble getting care for it in the first place. We're going to sort out the different types of care settings that might be alternatives to the types of EDs and how they differ from each other, we'll examine the extent to which these alternative settings, which can improve access to care for those with no primary care providers and whether these clinics might ease access difficulties we might enter millions more Americans seek care after they get coverage under the provisions of the health reform law, assuming we have a health reform law at that point. And we're pleased to have a partner in today's program,

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WellPoint Incorporated, which I guess is best known as the Blue Cross Blue Shield Plan in more than a dozen states and covers more Americans than any other private insurer. It's a pleasure to share co-moderating duties and background setting duties with WellPoint's chief medical officer, among other of his duties, Dr. Samuel Nussbaum and who's gonna get us started on the substantive conversation with an overview of today's topic. Sam, thanks for being with us.

SAMUEL NUSSBAUM, M.D.: Ed, thank you and good afternoon everyone and welcome to what I believe is a [inaudible] discussion, a dialogue on blood [misspelled?] alternatives for higher quality and more cost effective care can be. You know, it's interesting, we're obviously in a historic building and what many of us say that independent of where the Supreme Court, how the Supreme Court will rule over the next few weeks, is that there's already significant transformation taking place in health care and people so often close to either patient centered medical models or even retail medicine emergent care, to use the expression, of course, the train has left the station, so it's just one of those examples where there's real meaning of the train leaving the station.

But what I'd like to do is, as Ed set up, help set the stage for today's discussion. We know that emergency room visits are dramatically increasing in our nation. We have 150

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million ER visits. And that's, to put in perspective, about 10-percent of all ambulatory care visits. Now you'll hear a lot of numbers thrown in terms of what percent of those emergency room visits could be avoided and they could be avoided for two reasons. One is that for better care coordination, children with asthma getting the optimal therapy and interventions maybe don't need to be in emergency room or people with heart failure on the right medications don't have deteriorating health. So there's one group can be prevented because of better care coordination. But another group can be prevented in large part through alternative sites and care; people with acute medical conditions that do need to be seen, but need to be seen in a more appropriate setting. So the numbers that you'll hear, maybe in the high teens all the way up to 40-percent and more, but it is a very sizable number.

There are also some myths in emergency room use. One myth is that the individuals that use emergency rooms do so because they don't have insurance and can't get into the care delivery system and when you look at emergency rooms all in, only about 15-percent of them represent those individuals who have no insurance and 20-percent Medicare, 15-percent Medicaid and the vast bulk are those who have private insurance.

Now why do people visit emergency rooms? We'll hear much more about that today, but in a National Health Interview

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survey, about 80-percent said they didn't have immediately available. That's what's key: immediately available alternative options and providers and about two thirds believed that their medical condition was so serious that it warranted a medical visit.

The other is true in all healthcare is the concept of hot spotters. You know, Atul Gawande in his New Yorker article talked about hot spotters in terms of needing healthcare services. At WellPoint for our 35 million members, 1-percent drive 28-percent of all healthcare costs. 5-percent drive 54-percent. Same is true for emergency rooms. About 5-percent of the frequent users account for 25-percent of all visits and those are visits where there also are not only complex illness, but a lack of social support networks.

Now there are many reasons why, and I've commented on some, why visits are increasing, but certainly lack of access to coordinated care is one. The complication and complexity of illness, knowledge gaps in terms of when emergency room care is most appropriate, so the idea of having a deeper knowledge of how emergency room services should be used. And also about not knowing always about where those alternative services are.

Now if we look at it from the emergency room perspective and again, we have colleagues up here who are on the front lines of care, emergency room departments are full.

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And if we were to look at what happened with H1-N1 flu a few years ago, we really overburdened emergency rooms, so that in New York, for example, waits were in the many hours. And if you look at a report card of emergency rooms, it's not a report card that you would be proud to bring home if you were students. So if you look at all of the elements of quality and environment and the liability environment, public health prevention and disaster preparedness in the overall emergency rooms have not fared well.

Now there is a horizon, there is a landscape ahead and that is of alternative sites and one of our themes today will be retail settings for care. And there are many emerging retail settings in addition to those that are available, you know, obviously in primary care offices, so we have pharmacies and Walgreens and CVS in their Minute and Take Care clinics. We have Wal-Mart and Target, supermarkets and if you look around the country, you see many, many of these retail centers as well as growing urgent care centers where there's a limited set of services, often focused on rather routine care and minor illnesses, generally staffed by nurse professionals, nurse health professional and physician's assistants. As many of you who have visited these sites know that they're convenient hours. The waits are shorter. And I'll show you some data in

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a moment, but the costs are appreciably lower both for the individual, for the employer, for insurers and others.

In fact, if we look at costs, we did a study in our health core outcomes health subsidiary, where we looked at 270,000 visits to emergency rooms, urgent care, and retail settings, and what you can see in the graph there is that if we look at cost, cost was far in excess of that in retail settings. So these are costs to WellPoint, not what the bill was, but what we paid and averaged about \$540 versus maybe one tenth of that in the retail settings. So usually expensive in – and if you look at these diagnoses, there are the -itises that are often self limited, faringitis, sinusitis, otitis as well as colds, and very common uncomplicated urinary tract infections. So we know that care can be provided less costly and we look to quality outcomes. We found the quality in the retail settings was higher, certainly comparable and likely higher than it was in emergency room, including follow-up care. And then we have more and more linkages that you'll hear about later from Manish, my colleague, about how we're building this into primary care programs.

So before I turn this back to Ed, the theme here is probably 5- to 6-percent of all healthcare expenditures in that range for us at least are occurring in settings where we know care can be more highly coordinated, individuals can be better

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served and it's our focus today that Ed and I will share with all of you and certainly our speakers will, and your engagement is how can we make this aspect of healthcare higher performing?

We turn it back to Ed as you introduce our panelists.

ED HOWARD: Thank you very much, Sam, let me do a little housekeeping first. You have a bunch of material in your packets. Please were generously proportioned biographical information for our speakers. We'll be able to give them orally today and a bunch of background material, all of which is available on our website at www.allhealth.org as well. We would, at the appropriate time would ask you to fill out the green question cards. There are also microphones at the sides of the rooms that you can use to ask your question and the infamous blue evaluation form which would ask you to fill out to help us improve these programs as we go along.

We've got an impeccably knowledgeable group of panelists today with a broad range of experience. You're going to get a brief presentation to meet them and then we're going to get to discussion and questions.

Let me introduce them all so we don't disturb the flow of the conversation. We're going to start with Tine Hansen-Turton, who's the founding executive of the Convenient Care Association, representing more than 1,250 retail health clinics with capacity to serve more than 17 million people with basic

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health services. She also finds time to be the CEO of the National Nursing Centers Consortium, which is a non-profit organization supporting the growth and development of about 250 nurse managed health centers, self-serving more than 2.5 million vulnerable people. We'll then hear from Dr. Ateev Mehrotra, a policy analyst at the RAND Cooperation and assistant professor at the University of Pittsburgh Medical Center. His research is focused on the measurement of healthcare quality and efficiency and applications in quality measures such as paper performance and using active innovations in healthcare delivery. Dr. Mehrotra is board-certified in both internal medicine and pediatrics. And then Manish Oza, who's a regional medical director for WellPoint based in Baltimore. He's a board-certified emergency room physician and he's the architect of WellPoint's emergency room utilization management initiative. And I know he's also involved in another project we won't be talking about today. That's WellPoint's Metro IBM to use Watson, you remember the Jeopardy champion computer to help physicians in real-time diagnosis driven treatment plans and we're talking with our colleagues at WellPoint on a future briefing on that topic, so we may be inviting Dr. Oza back for that discussion. And finally, we're going to hear from Dr. Rick Kellerman, chairman of the Department of Family and Community Medicine at the University

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of Kansas School of Medicine at Wichita. He oversees family medicine and education for medical students, three family medicine residency programs, post graduate medical education activities and he's the past president of the American Academy of Family Physicians. He's the chairman of the board and in the interest of disclosure, the chairman of our board, Bob Graham was for many years, was the executive director of AAFB and like Dr. Kellerman, is graduate of the University of Kansas School of Medicine. So he has to be good!

So let's start. Let's get off the ground with some real experience in the person of Tine Hansen-Turton. Tine?

TINE HANSEN-TURTON: Thank you very much and thanks both Ed, Sam as well as Alliance for Healthcare Reform and WellPoint for putting this session on this afternoon and thank you for all of you for coming on this rainy day to the Washington train station and I can feel the trains rumbling underneath. It's fun.

Anyways, I'm going to talk to set the stage for the retail based community care clinics and how we really talk about how we think and we know we meet the need for accessibility and affordability and quality of care in this country in terms of our model of care.

Before I get started, I want to put the retail clinic model in the context of what's going on in this country. You

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kind of know this because Sam already got us started with some of the statistics, but let's just look at what the situation looks like in the country at this point in time.

We have limited access to routine and preventative care. That's something we all report, whether we have insurance coverage or not. Millions of consumers and patients don't have an established relationship with a primary care physician or other primary care provider or health insurance. Healthcare costs do keep rising to unsustainable rates. Our employers are facing it. And consumers, especially post 2008, are consistently pressed for time when it comes to accessing and fitting healthcare into their overall busy lives. And with industries, for example, like the transportation industries that actually can't fit in routine healthcare into their lives at all, well, alternative types of models of healthcare that is a good vehicle for them to get care. And all of this could get worse if we don't have a plan for treating 32 plus million Americans that may get health insurance post this Supreme Court's decision coming up. And all of that, of course, you'll see the graph, is enlightened the effect that for the past three or four decades, we have had a physician shortage in this country.

So one of the things that we've coined disruptive innovation, I think others are gonna talk about that by Harvard

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professor, Clayton Christiansen, but simply the value proposition of the retail-based community care clinic model is about being accessible because of our location and where we are. Affordable, the lowest cost options that non-subsidized by the federal or other government and we pride very high quality and you'll hear about that; also from Sam, some of his data and you'll hear something from Ateev later on.

So what are convenient care clinics? For those of you who have may not know about them, usually we go into the audience now, folks have visited one or are familiar with them. But let me just describe them simply. They're small healthcare facilities, usually with one or two of the same rooms that are located in high traffic retail outlet pharmacies. We have retail pharmacies as one type of location, we have them in supermarkets as a growing locations, especially with hospitals opening partnerships with local supermarkets. You see that in big box retailers, for example, Target.

The ownership of these clinics vary very much. You have the for-profits running them, you have some federal community health centers running them now as well. Then you have health systems that are increasingly opening and managing these healthcare facilities.

The clinics are usually staffed by nurse practitioners or physician assistants, but not exclusively. We also have

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clinics that actually have physicians in them, but all of them do it with local physician collaboration. And they have a very focused scope of services. I'm not going to go over that because it's in your packet, but you can get a sense of the more limited services. These clinics are not there to be ongoing primary care services. It's not a medical home, per say, but they are there to provide services on the more routine primary care level and some chronic disease maintenance and management.

So a little bit about the Convenient Care Association. We were started in 2006. We actually are a relatively young organization. In those days, we represented about 150 clinics. We focus very much on quality. Today that number is close to 1400. Our clinics represent most of the clinics operators that are out in the country. Our membership is pretty diverse because it includes for-profits, non-profits, as well as hospital members and others that are part of the industry,. When we started, as Ed mentioned, we were small. The concept was pretty novel and Rick and I were talking beforehand. You know, we've been on these sessions previously. It was a very novel concept. Clinics were mostly in the early days costly, cash-only, offered a very limited scope of services. That has since changed. Part of the change was that the consumer, the patient, the employee went to the employer and said, we wanna

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go to places like this rather than the expensive emergency room. And also they put pressure on their insurance companies and said, this is a good vehicle for us to get more basic healthcare services, rather than go into an emergency room or other care that would be more expensive. So a lot of us partnering with other insurance colleagues around the country was really a drive from the consumer early on.

Early on also, I think many questioned the liability of the model. I think that has since changed, certainly with the growth of the industry, I think we've shown that we're here to stay. We only plan to grow and be a stronger partner with the overall healthcare system. And there was certainly opposition early on with the more organized medicine. I think we certainly allayed the fears in terms of how we partner see the medical home and our physician colleagues and our hospital colleagues as key partners, we are part of the overall healthcare team and can actually alleviate the burden on some of the pressure points in the overall healthcare system.

So where are we today? As I mentioned, we put this PowerPoint presentation together. We had about 1,350 clinics and growing. We're probably closer to 1,400 today. There's generally been a greater acceptance publicly, a support for this type of model; and because it's patient centered. It's consumer friendly. We have a lot more partnerships with

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traditional healthcare providers and practices that are part of the overall stakeholder group when it comes to healthcare. And many healthcare systems also now operate these clinics and we really see this as very favorable to us because it means from healthcare, we want these types of clinics to be part of our overall healthcare system. How the healthcare systems do it, they do it a little bit differently. They tend to put these clinics and supermarkets a little bit different outside their catchment area. But part of that is really a way for them to actually serve a population that may live further away from sort of the flat sheet healthcare system. But it's also a way to gain new access to new patients as the healthcare systems grow.

The scope of services also is growing with an eye towards disease prevention and chronic disease monitoring, but all of that usually happens in a strong partnership with a medical home. In general, I was asked to talk about sort of traditional and nontraditional care growth. There is actually a movement in the country and part of that goes back to what has started out with the fact that we do have primary care physician insurance. There are other models out there. You have the nurse managed health clinic model that tends to be more of a model that serves the underserved population, Medicaid and uninsured. That's run by nurse practitioners by

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primary care and health promotion disease prevention services. We've got the urgent care model that's about a little shy of 9,000 of those clinics around the country, that like the community care model that also provides walk-in access, but have a broader scope of services. Many hospitals run urgent care as well.

And then we have another type of provider, telehealth programs that are opening. Some of them do kiosk-based kind of care. Some of them are more home based. But those are the types of healthcare services that we're now seeing in the country. And part of that obviously is to provide access to much needed care.

So what are some of the healthcare reform opportunities? We want to talk about that. Well, one thing we learned from Massachusetts in 2007 is that just because you provide somebody with an insurance card, doesn't mean they have access to care. If you all recall, about 400,000 people in Massachusetts, adults got access to an insurance card and what happened was emergency rooms began to get flooded and the physicians had to close their panels because they were overburdened. So part of healthcare reform is really having a plan on how to provide access to people when they can get healthcare. And the right access at the right place and we think that the community care clinic would fit a very sweet

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spot. We think in collaboration with the partners that are sitting on this panel because we can be a very early resource for healthcare services and also feeder into the overall healthcare system. We also see our members being included more and more in the medical home and accountable care organizations. Certainly in terms of accountable care organizations, we are the lowest cost option in primary care so it makes sense to have us partner an ACO and we really, again, are in the sweet spot. All of our members issue chronic health records. We did that from the get-go. It actually was in our climate to be part of the community care industry. And our association was that everybody used electronic health records and we thought that was critical for the model because from our onset was always, we don't want to be the ongoing primary care resource. We're going to need to be able to communicate with our physician colleagues, with the hospital colleagues and so forth.

Nationally there's focus on preventative care and wellness and obviously it's a sweet spot for us. We do a lot of immunizations and education in general. And I think we're engaging in a lot of creative partnerships with lots of providers like community health centers and hospitals and so forth.

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What does research show? It shows we're good for access, you know, we're open seven days a week, we follow retail clinic hours. That's a valuable proposition and there's no appointments necessary. We're good for the cost. Financially, we mentioned we're the lowest cost option. You heard that from Sam as well in his introduction to this panel and you're gonna hear a lot about the quality care that we provide. All of that is because we actually practice evidence based protocols and we have that built into our electronic health records.

Finally in terms of growth, we are in an expansion phase again and that's something we're excited about. You're going to see more clinics and you're going to see more clinic partnerships with hospital systems and others. You're going to see some of the scope of services expanding with an eye towards disease prevention and sub-chronic disease monitoring. You're going to see more health systems hospitals and more traditional providers getting into this type of care.

And with that I'm going to end and look forward to the dialogue following this.

ED HOWARD: Thank you, Tine, and let me get your slide advancer. And now we'll turn to Dr. Mehrotra.

ATEEV MAHROTRA, M.D.: Well, thanks. Sorry. So what I was hoping to do was in the couple minutes I have was to give

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you an overview of what do we know from the research perspective on one of the alternative to emergency departments is the focus today, is retail clinics.

So, one of the amazing things is that retail clinics have entered the healthcare landscape, it generated a lot of controversy. And the policy issues that are being addressed are very similar to the policy issues we're addressing throughout the healthcare system on quality, access and cost. And there's been debate about the quality of the care that's been provided at these clinics. Some have argued, hey! These clinics are great. They're gonna provide high quality care because they use well trained nurse practitioners, straight evidence based guidelines. And others have argued the concern that these clinics are gonna deliver poor quality care and in particular because the clinics are often owned and operated by pharmacy chains, maybe there's a lead to overprescribing antibiotics. And I think that's been a critical concern of physicians as well as patients.

There's also been a debate about access issues as people on the committee have already having a problem of getting patients into primary care and these are great alternatives to primary care, a great alternative so that people can increase access and maybe they can even go to underserved communities and become a new safety net providers

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and this has mostly been observed by the fact that when patients go to these clinics, they're gonna undermine primary care physician relationships. And what negative impact will that have?

And then the last policy issue that's been discussed or policy debated on, has been the issue of cost. Do retail clinics, maybe they'll use emergency department clinics as for how we started this conversation today. And maybe they can decrease overall healthcare spending. Well, others have been concerned, that, oh, these clinics are just going to drive healthcare spending up because patients are gonna go to the retail clinic and then they're gonna go to the doctor's office and then you're just gonna have more care and that's actually going to drive healthcare spending up.

So what I wanted to do is quickly go over with you some of the research that has been trying, that we have done as well as other have done, to try to address these policy issues.

On the issue of quality, what we did is a study where we looked at the care that was provided in four healthcare settings, retail clinics, physician offices, urgent care centers and emergency departments. So when we looked at a lot of different aspects of care for simple, acute problems, the kind of things that people go to retail clinics for. Contrary to the concerns that we had seen and had been expressed, we

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didn't find any evidence that these clinics were rampantly over providing antibiotics. We found very similar antibiotic prescribing rates for these conditions at retail clinics compared to other care sites.

We also looked at an overall assessment of quality where we looked to see whether the care provided retail clinics was consistent with evidence based guidelines and when we say evidence based guidelines, we're talking about guidelines that are published by physician groups such as the Infectious Disease Society of American, and again, a very consistent story that the quality of care that we received at retail clinics was very similar to what we saw at the other care sites. And this is also very consistent with other work that people have done where many of the quality concerns do not appear to be born out of the data. Patient satisfaction is quite high at these clinics and then in terms of quality looking at these things such as follow-up rates, accordance with guidelines, comparing to other care sites, consistently the story is that retail clinics appear to be providing care that's in equal quality to physician offices or other care sites.

On the issue of access, what we've done is some work where we've tried to look at where these clinics are located and what communities do they serve? Most of the clinics, 90-percent plus, were located in urban areas where most people of

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the United State live. And one of the things that I thought was really notable about this work is that Tine had mentioned that these clinics appear to be kind of, you know, early, kind of novel entries into the healthcare landscape, but what we found that was really interesting was that a large of fraction of the U.S. population already has access to one of these clinics, so really, they do have that potential to impact a large number of people in the United States in terms of how they receive care. We found that 38-percent of the urban population lives within a ten minute drive.

Contrary to the idea that oh, these clinics are gonna be the new safety net provider. We don't find any evidence that these clinics are preferentially located in underserved communities. They seem to be located in the same communities of doctor's offices. So we looked at what fraction of these are located in federally designated health professional shortage areas.

One of the common questions is, who goes to this kind of new novel source of receiving care? We've looked at this from a variety of perspectives. One study that we did was we looked at people go to retail clinics, doctors offices and emergency departments, so we looked at the age distribution for example one thing about who goes to these clinics. And we found that the largest fraction of patients are in this young

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adult group, 18 to 44. Very similar to what you see in the emergency department. But I think that the most notable thing is very different from patients who go to a doctor's office, a primary care office, where we saw, not surprisingly, people who go to a primary care office, tend to be a little bit more on the older side, as well as well as young infants. So the story here is that retail clinics appear to be attracting a different patient population than those who go to doctors offices.

Another critical concern is, are these clinics going to undermine primary care physician relationships? And one of the things that I thought was really notable from our results was just over a third of the patients who went to a retail clinic reported having a primary care physician. That's a problem in itself, but I think the key point being there is that the vast majority of patients did not have a relationship with this primary physician and therefore no relationship to disrupt. And so another key finding from our results of who's going to these clinics.

Lastly is on the issue of cost. We again looked at what was the difference in cost going to retail clinic versus some of these other care sites and we don't want to just focus on the visit itself. We wanna focus on the visit, the prescriptions, the follow-up test, the laboratory tests, what we have termed an episode of care. And what we found

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consistent with what Sam introduced was that the retail clinics were about 30- to 40-percent cheaper than a doctor's office or urgent care center and about average 80-percent cheaper for the care for a similar condition, for a similar patient at an emergency department, so at least potentially substantial cost savings.

The question we then wanted to ask was, you know, there's been a lot of debate about what fraction of patients who go to an emergency department don't need to be there. Well, what we wanted to slightly frame that differently and say what fraction of visits in an emergency department could potentially be addressed at an alternative care site. And so we looked a national sample of emergency department visits and looked at the diagnosis codes that were provided there and what our estimate was that about 27-percent of the visits at an emergency department could potentially be addressed at one of these other care sites. And those are the things that I just sort of mentioned, sore throats, conjunctivitis, pink eye, sinus infections, etcetera.

I think another key point to make was that the vast majority of emergency visits were for problems that cannot be addressed at one of these other care sites, more than, almost $\frac{3}{4}$ of them. If you say, well, a lot of those visits are in the middle of night, we limited it to the number of emergency

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department visits that were when these alternative care sites were open and that brought it down to about 17-percent of emergency department visits. But overall our estimate was that about \$4.4 billion could be saved if we could somehow find, and I think Manish will talk about this coming up, about how can you make, if people can move from the emergency department to these alternative care sites, how much money could we potentially save?

Now I think that \$4.4 billion even here in Washington, D.C. is a lot of money, but we should also be conscious of the fact - but first though that estimate is consistent with what others have found as potentially savings of retail clinics to come more prominent nationally, but we should also be very conscious that this is only a small piece of the overall healthcare budget, even if we were able to save these \$4.4 billion is less than one-percent of overall healthcare spending. So an important way to decrease healthcare spending, but certainly not a panacea for our healthcare cost issue.

So just to summarize that we and others have done in terms of the quality issues, we really find no evidence to support the concerns that have been raised that retail clinics are gonna decrease healthcare quality. On the access side, we would argue that the data shows that people are going to retail clinics appear to be a different patient population than who go

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to doctor's offices and the vast majority of them do not have a primary care physician. And on the cost side, at least there is a potential, and I should emphasize potential, for substantial cost savings if patients were to shift their care.

I'll end by just noting some things that we should be aware of and hopefully prompt further conversation. I think that most of you, the audience, are aware of the potential benefits of retail clinics, both the convenience and cost savings. We should also be aware of some of the issues as this moves forward. First is that as people start seeing more and more providers in the healthcare system, is this gonna increase the fragmentation of care? One of my common complaints I hear from my patients is, don't you guys ever talk to each other? How do we address those fragmentation issues? Emergency departments in the United States are already financially strained and what impact will this have if patients stop going there? And then we also have to be conscious of the fact that, are patients going to be able to effectively decide where their condition should be addressed? In other words, can they self-triage to the right site? And so these are just some of the issues that we should be thinking about as we move forward. So thank you.

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ED HOWARD: Thank you very much, Ateev. Now we'll turn to somebody who's been thinking about how to seize those potential benefits and address those concerns, Dr. Manish Ooze.

MANISH OZA, M.D.: Thank you, Ed. So, I joined WellPoint a little over five years ago, was a full time ER physician, still practice clinically here in Maryland and I got the challenge of how do you handle avoidable ER visits. So the first thing I and our team did is we started to talk to some of our clients and the consensus from the employees and the people we talked to was, it was very unclear in the market, where do I go for what? When do I go to the emergency room? When do I go to a retail health clinic? When can I access an urgent care? So it was clear when we were designing this program that was one of our missions to make as transparent to everyone possible.

The second challenge was how do you unravel the fact that a consumer knows, almost everybody in this room, that you can go to an emergency room 24 hours a day, seven days a week, without an appointment and get treated, whether you have one of the -itises that even Sam talked about, the otitis, the ear aches, the strep throat, the urinary tract infections. You know and I know that you can go anytime you want and you can get treated. So we started to talk about and think about program design. And we said, I need to change my slide, sorry.

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We need to have a viable program that gets the information out there to all of our members that's easily accessible, not behind a firewall so that anybody and everybody can access it.

The second challenge was how can we leverage technology and put the information where and when the member needs it at that point in time when they're having one of these potential - itises. So if they're having a sore throat and it's Friday and it's 7 o'clock and they can't access their primary care doctor if they have a primary care doctor, where do they go? So clearly there was an opportunity for us there.

And then the last part of this was we needed to be a little bit unconventional based on past programs; so we needed to be proactive and now what we commonly do is be reactive. So a mistake happens or a lost opportunity and then we slap potentially you on the wrist or we tell you after the fact, hey, you should have done that, you could have saved money. Well, our actuary tells us for our commercial population in California, 87-percent of the time, an avoidable ER visit happens only once in a calendar year. So are there frequent fliers to the emergency room? Yes. Do they potentially cost the system a tremendous amount of money? Yes. But why the frequent flier goes to the ER is much different from why the person goes to the ER for an avoidable ER visit. And hence this is an opportunity to educate this population.

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So we came up with this program which is not as complicated as it looks. We'll start on the top right corner. We have the 24/7 nurse hotline. We staff this 24 hours a day as the term says and these nurses are registered nurses that can triage our members. Some of the challenges there were the nurses used to ask a lot of questions that may not be relevant. IF you've got strep throat, the last thing is be on the phone speaking when you can't speak very well and it hurts a lot. So we streamlined the whole process so that the nurses asked only the relevant questions that were necessary to triage you to whether it be a retail health clinic or primary care doctor or the emergency room when appropriate. The second thing we did with our pilot group is we created a brochure. We created a lot of brochures. You get a lot of brochures in the mail. This brochure, I think is cut to the chase very quickly: it showed on members what the potential savings opportunity was. It explained what retail health clinics were, as Ateev explained them. And then also explained what urgent cares are and what they can treat. On the second page of this brochure, we listed the top 17 diagnoses or complaints that people could go to the emergency room for or were going to the emergency room for that could access a retail health clinic or an urgent care. So we mailed that to the pilot group. And then we said, well, do we stop there? Because we all know that a lot of

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these brochures end up in the garbage or filed away. And we kept thinking about, it's Friday, it's 7 o'clock, and this member's child or they themselves have a sore throat, are they gonna find that brochure? Chances are not. So we said, well, let's go one step further. Let's email our members reminders about ER alternatives during high peak utilization of the emergency room. So this is during allergy season where a lot of people have developed sinusitis. During the flu season, we know a lot of people don't feel well and rush to the emergency room. And then lastly, the summertime, where we are now presently, the weekend warriors, all the jogging is happening, the cleaning of the roses or the cutting of the rosebushes, a lot of lacerations, contusions, sprains, these things happened during this time. So we send out email reminders to members saying, hey, here's the information you need if you potentially have one of these conditions, you can access one of these ER alternatives.

We also created an online tutorial where if somebody wanted to learn more about retail health clinics or urgent care, they could go to this storyboard and it's an online tutorial that educates our members about ER wait times, costs, and once again, when is it appropriate to use the emergency room versus ER alternatives?

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The last two components: the Google map makes a whole lot of sense, right? Type in your zip code, find an ER alternative, have all the resources that the member needs to make an informed decision within a couple clicks, so make it really, really easy.

The last component: smart phones. I think we're all jazzed up about smart phones and I keep getting asked, when are you gonna create a phone application. And I usually answer that question by asking a question: creating a smart phone application with the Google map is very, very easy to do. We've actually created a beta version and we will one day have that. The challenge is getting a member to download that app and have it impact their decision. So when it's 7 o'clock on a Friday, are they gonna remember or even find that ER alternative app? That's debatable. So then we said, let's slice the data. Let's look at who the highest utilizes of the ER and it's exactly what Ateev shared with you. They are the 20 - 42 year-olds with kids that may not have an established relationship with a primary care doctor because they're relatively young and they're healthy, so we know a lot of these people don't have a primary care doctor and that same population also that the -itises, like everybody else, so where do we think this population is looking when they're ill and it's Friday and it's 7 o'clock? So we said they're probably

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going to Google, like I did, whether I'm looking for a pizza place, a restaurant or if I'm preparing for this lecture. I go to Google or Yahoo or Bing and I type things in and I try to become informed, so we said, wow, we've got all this great information on this brochure that probably got thrown away. We've got that email that we sent that may have gotten deleted. We've got all this great information that the member needs on this storyboard in Google map, so why not get it out there in cyberspace when someone googles urgent care or retail health clinic or Anthem Blue Cross Blue Shield, our ad will be there and they can click on it and everything the member needs is right there in front of them to make an informed decision. Also, the information about the nurse hotline is there so if they wanna talk to someone to reaffirm their decision, to go to the retail health clinic, the nurse can say, that's the right decision or they can say, no, if you're having chest pain, a retail health clinic is not the right place you should be going, you should be going to the emergency room.

So we opened it up in our fourteen states to all of our members and to anybody that lives in that state. So if you live in Virginia and you google Anthem Blue Cross Blue Shield, whether you're one of our members or not, you can access this information, whether your Medicare Medicaid, or with one of our competitors or have no insurance, and that was a decision that

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our leadership met, which was they felt was important to educate not just our population but everybody in one of our states.

At the back end here, you can see, if a member goes to the emergency room for an avoidable ER visit, we send them a message on their EOB that says you had an avoidable ER visit and if you want to learn more, you can google this information or you can yahoo or bing it. We also send out these automated phone calls that gives the member the option of giving us their email so that we can push them to this landing page that has all this information.

And then the last thing we do, is a MyHealth Advantage note, and this is something that our members get and it's a gaps in care alert that's proprietary. It's something that we created at WellPoint. So if you haven't gotten your preventative exams like a mammogram or a colonoscopy, we send our members a reminder and we also send them a message if they have an avoidable ER visit and say, you potentially could have saved time and money, if you wanna learn more about avoidable ER visits, access this webpage.

I'm gonna talk about really briefly Life Health Online. This is a new modality that we're gonna be working on in the near future. This is where you can go on the web and access a primary care doctor to be treated for one of the -itises.

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Where I think this has the biggest potential, is if we plug this into a patient centered medical home. So imagine a day in the near future, where you go to see your primary care doctor and you can do it via the web. Someone that knows you, that has access to your medical health record and can treat you, triage you to a retail clinic and urgent care or an emergency room when appropriate.

The last part, the last slide is our patient centered medical home model. We're big proponents of the patient centered medical home. The retail health clinics and the urgent cares are out there because there's gonna need to be increased access, but we are big supporters of the patient centered medical home, but we would prefer that members access their primary care doctor, but we realize that there's an opportunity and there's limited access, so retail health clinics and urgent cares will play a role as healthcare reform comes upon us in the near future. I'll stop there.

ED HOWARD: Thanks very much. Now we turn to Rick Kellerman.

RICK KELLERMAN, M.D.: Thank you for asking us to speak. I'm here with the American Academy of Family Physicians and first I wanna say that we agree with the concern about the overuse and inappropriate use of the emergency departments throughout the country. And we've come to this due to a

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variety of different reasons. First of all, we have a lot of members of the AAFP who have either part-time or fulltime jobs as emergency physicians. Secondly, if you go to a rural area of our country and have some kind of an accident or chest pain and you go to the emergency room, more than likely it's a family physician that's going to see you. And third, oftentimes it's our patients that end up in the emergency room. I think it might be important to kind of back up just a little bit and ask why are emergency rooms overburdened, overcrowded, and sometimes people access the emergency room inappropriately. And there are a number of reasons for that but I don't think that we can come to any other conclusion. At least one of those reasons is the neglect of the primary care system in the United States. Neglect through lack of policy making that supports primary care. Payment systems that support primary care and medical education system that works against primary care.

When we think of people that show up unnecessarily in the emergency department, we can divide this out in a number of ways. We've been talking about acute symptoms, sore throat, ear ache, that sort of thing, where a patient comes in because they need convenient care, they want it right now, they're having pain and either they don't have a family physician or their family physician is full and might even tell them to go

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to the emergency room. And there's a second type of visit that oftentimes we can help decrease with good primary care. Those are called ambulatory sensitive conditions. In other words, if I do my job treating heart failure or asthma and do a good job with preventative medicine, oftentimes we can keep people out of the emergency room. So I think there are a couple of things that both primary care and the emergency departments can work together so that we have the emergency departments, that if you and I have an accident and it's serious and there's trauma or severe chest pain, that the emergency doctors are free to take care of us.

A few years ago I was asked to chair a working group on retail clinics for the American Academy of Family Physicians. And the first retail clinic was actually started by a family physician in Minneapolis. What we did was we had several meetings with Tine. We met with the leadership of the various retail clinics that were existing at that time. We talked to patients and we also talked to family physicians throughout the country, had several focus groups. And so I'm going to talk a little bit about what we heard from the family physicians about retail clinics. And remember that we have over 100,000 of the AAFP, so we have opinions that are all over the place, but they kind of break down into some of the things that Ateev talked about.

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Here were some of the concerns that our members had. They were concerned about the fragmentation of care with the retail clinic. In fact, more than once, this is just one more thing getting between the doctor and the patient. There was concern about the relationship between the doctor/patient relationship, ongoing continuity of care and coordination of care. They were concerned about skimming of some of the, I would say, simple sort of things that they take care of the offices, sometimes actually contributed to the bottom line and made their days go a little bit faster. When you're seeing patients with dizziness and headaches and backaches all day, sometimes it's kind of nice to see an earache and a sore throat and oftentimes these are small businesses. They work on a very small margin and they were concerned about that.

Now to this point, I don't know of single family physician office that has gone out of business because of a retail clinic, so just to set that straight.

And another thing that they were concerned about and I thought this was interesting, and this is something they call the medicalization symptoms. That just because you have a runny nose or a sore throat, doesn't mean you need to go to the emergency room, doesn't mean you need to go to a retail clinic, doesn't necessarily mean you need to go to your family physicians, but sometimes we've actually encouraged people to

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get care that, at least when I was a kid, it wasn't very serious and you don't really need to go to the doctor, having a physician that can educate you about that can certainly help prevent some of those unnecessary visits. At the same time we heard from family physicians who were supportive of the concept of retail clinics. Some were very pragmatic. They realize there are problems with access, that we need better entry points in to the primary care system. Some members became the local physician supervisors for retail clinics. Some that were trying to build their practices with the retail clinics as a referral source into their practice. So I think Ateev really nicely summed this up in his research and I'd say our focus groups and our background really helped support what Ateev was saying.

As a result of the retail clinics, we challenged our members, that they need to look differently how to provide care. And we saw a number of innovations from members in terms of how to take care of patients who have acute illness and need to come in at that time. I think somebody in Wichita who works on the line at Spirit Arrow Systems and gets a call from the school that their kid has an earache, they don't wanna come into my office and sit in my waiting room for three hours for something that really takes me a couple of minutes to take care of. And so we told our members that if you don't like retail

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clinics or if you're challenged by them, you've got to change the way that you practice. We saw physicians extend their office hours. It's not just nine to five, extending office hours into the evening, early morning office hours, not taking a break at noon, but handling some scheduling. Some innovations like a quick clinic. There's a family physician in Texas who devotes her noon hour so that individuals who call in that day, she can get them right in and take care of them. Open access scheduling which means that you leave some appointment slots in your schedule each day for people that call in that day. And open access scheduling particularly on Mondays when people have tried to put off care over the weekend so that they don't get hit with the hit of a cost of an emergency room visit, but rather can wait, see the physician on Monday, come into the office and so particularly on Mondays during peak times, having open access scheduling.

Emailing patients. There are a lot of questions that come up that frankly we can take care of over an email system,. You don't necessarily need a face to face visit. We heard about the very frequent fliers. Individuals who use the emergency room very inappropriately and come in very frequently. There have been some studies that if you identify them and put them together and sit them down in a group visit periodically, you can cut the number of inappropriate emergency

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room visits that they make. So there are a number of innovations that the different physician practices have put into place.

Now since Tine and I started working on this about a decade or so ago, there has also been an evolution in the healthcare system, for example, great integration of the healthcare system. We see more physicians who are employed by hospitals and healthcare systems. That's going to play into the entire into their feelings about retail clinics.

The ACOs are part of that integration effort and then as you've also heard, patient centered medical home, as an innovation, which looks at team based care, primary care, trying to provide comprehensive care, good access, continuity of care and coordination of care all as part of a team. I think that there are some questions that remain about the retail clinics and some of these are going to be answered over time and with evolution of the healthcare system. Here's some of the questions.

Do retail clinics fit into the system of care or do they promote fragmentation of care and promote episodic care? Do they integrate into the system of care or are they standalone? What is the location of the retail clinic? If it's to offload the emergency department, is it close to an emergency department so that patients can access it? What is

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the scope of practice? When you start at the retail clinics were there for very acute sort of problems and as you saw from Ateev's research, urinary tract infections, sore throats and ear aches. There's been a move into chronic care and in terms of screening, there's a big different between screening for a condition like diabetes or checking a blood sugar periodically for somebody that has diabetes, that's a whole different ballpark than ongoing management of diabetes because of the medications, potential problems with medications, patients oftentimes have a co-morbid or other conditions.

Do retail clinics contribute or detract from continuity and coordination of care? Do they detract from the financial health of primary care offices? And as I mentioned, this is important because most of the offices are small practices. And will they really offload the work of the emergency department? Ateev's research showed that 17- to 27-percent depending on how you count of office visits in emergency rooms are for non-urgent care. Most emergency rooms have adapted to this. They have triage centers, if you have a sore throat or earache; you go to one side of the office. And those generally don't take a whole lot of time to treat, so they may decrease a percentage of the un-urgent visits, whether they really save in terms of time and even cost is another issue. With that, I'll go ahead

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and turn it back over to Ed and I guess we'll open it up for questions.

ED HOWARD: You bet. We're also inviting our panelists, if they've heard anything, if they wanna take serious issue with or reinforce, that they can feel free to chime in at this point. I would add Dr. Nussbaum as somebody who's deal with this stuff. You can see some of your friends and colleagues in the audience holding up green cards. That's a good thing. It's where you write your question and someone from our staff will bring it forward so we can make sure it gets asked. The real way to make sure it gets asked is to go to one of the microphones and ask as concise a question as you can, after identifying yourself and your institutional affiliation, if you would. And we have a couple - let me just log your, while you're sorting those out, let me just ask the panel, just in general, I guess, we had asked you to sort of look at policy implications and each of you has really done that to one degree or another. One that has arisen already is some states, notably in the state of Washington, deciding to legally change the likely reimbursement, as I understand it, for an emergency room visit based on the classification of the reason for the visit after the fact. In perfect 20/20 hindsight, I guess it is. Now that law's been suspended in its operation by the governor and I wondered if you would have any

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opinions about the efficacy of such laws or if there are other ways to address this question in a policy arena.

ATEEV MEHROTRA, M.D.: Let me jump in with just a couple quick points with that. If I understand the state of Washington law that was proposed, which was that if a patient who has Medicaid insurance goes to the emergency department for one of a condition that based on the diagnosis codes is felt to be something that could've been treated elsewhere, that visit will be reimbursed. And obviously the patient will have to pay for it. And so I actually have a lot of concerns about that approach. It's a little bit like Monday morning quarterbacking to try to figure out what was urgent and what was not urgent and I think in a relatively blunt way is going to have some issues and I think we know from prior work that some of those, what you'll do is you will of course be effective in decreasing some of those patients going to the emergency department for that and I think that's a positive benefit, but I think the concern comes down to one of the points that I made before, is to ask the American citizen, the average American citizen, and say what's urgent and what's not urgent. IT's hard to know, you're not trained as a doc, and so how do you know what's urgent and not urgent and I think because the concern is, is that some fraction patients who have an urgent problem will say, oh, I don't wanna deal with those cost issues and

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therefore not seek care and that's going to have both public health negative impact as well as potentially negative cost impact too, so while I think that this is an urgent and important problem, I'm not sure that is the policy lever that should be applied.

ED HOWARD: Anyone else? Manish, you're still practicing emergency room medicine? How does that fit into your experience?

MANISH OZA, M.D.: I agree with Ateev. It's difficult to expect the common person to be able to diagnose themselves. If they could, then they wouldn't need physicians. So you know, potentially there's some opportunity, there's some very low hanging fruit, such as prescriptions refills, sometimes we still have people coming to the ER for tetanus shots, physicals, forced camp signings of forms, believe it or not, that still does exist. So perhaps there's a very, very small number of things you could, I guess, retrospectively penalize somebody for going to the emergency room for, but I still think that the tract that we're on and trying to empower and educate people, I think the common person, or at least most of the people in this room, don't wanna wait in an ER for three hours. Don't wanna be surrounded if you've cut your finger while you're cutting your bagel Monday morning by a bunch of sick people with the flu or any other ailment, so again, this is a

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real opportunity for us to educate people. And I think most people, especially the way the benefit designs are going, whether it's consumer driven health plans or increasing co-pays that are coming for the ER, don't wanna wait in the emergency rooms, so the challenge is, will we have enough retail health clinics? Will we have enough patient centered medical homes with open access and after hours? Let's face it. A lot of these things are happening after five. You come home, you pick your kids up from daycare and they've got a fever. So where do you go? What do you do if you can't get your primary care doctor? So a lot of opportunity I think, what Washington started is not the solution.

ED HOWARD: Very good. Thank you. Yes. Go right ahead.

CAROLINE POPLIN, M.D.: For Ms. Hansen-Turton? You mentioned that - oh! I'm Dr. Caroline Poplin, I'm a primary care physician. You mentioned that your clinics have electronic health records. How does that work in a city like Washington where everybody has a different one? The hospital center has one, and GW has one and Georgetown has one and Sibley has another. First of all, do they all use the same one? All of your clinics? And second, what do you that no two large ones have the same one unless they're in the same system?

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TINE HANSEN-TURTON: That's a great question. Thanks for the question. That's a great question. I think that's an issue we all face in the healthcare system now, what they call probability [inaudible] issue of those electronic health records. Right now, I mean really, what we do is, first of all, to share your record that you have that patient consent. I'll give you an example of how I get care. I happen to go to my closest retail clinic provider happens to be Minute Clinic. I take my 11 year-old son there. We happen to live about an hour and a half from outside the city of Philadelphia. We go to CHOP faculty practice. That's where his pediatrician is. When he goes to a Minute Clinic, what happens is he'll get whatever the diagnosis, if he need a prescription, he'll get a prescription. That record actually is integrated with, you know, it happens to be with the CHOP, you know, medical practice, so there it's online regulated; if not, that will be faxed the old fashioned way. I think we share with everybody probably in the room in the healthcare field that we would like to see a lot more of this done electronically. Now we know we have some of our colleagues and some of our members have relationships with hospitals and health systems where they are integrating in the record. I'll give you another example that happens to involve Minute Clinic. They have a partnership for example Cleveland Clinic where they are integrating their

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medical record with the Cleveland clinics and medical record, so it's possible, but you have, you know, obviously a contractual partnership there. But you know, share the challenges with you, but that said, you know, I would say, the force is with all of us if we can get over this hurdle, because it is truly how we can how we provide more integrated care. And that's where the benefit of an accountable care organization or an integrated medical home are the same thing where you can have records and you can see people going through the different systems and where there's partnerships.

CAROLINE COUGHLIN, M.D.: Don't you think that printing it out and giving it to the patient to take to his primary care physician?

TINE HANSEN-TURTON: I'm sorry, what was it?

CAROLINE COUGHLIN, M.D.: Do you ever think printing it out and giving it to the patient to the primary care physician?

TINE HANSEN-TURTON: Great follow-up question. You actually get when you leave as a patient, if you've been to one, you actually get your record with your as well, so it's a combination as well. So it's a combination. One, of course the patient has to consent to give that record, so not unlike going to your primary care practice, but yes, you get your record when you in some cases you also have patients have electronic, their own records, personal health records, it can

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be sent to you via email and you always get a follow-up that evening or the day after from the provider in the clinic to make sure that whatever the recommendations that you followed up on that.

CAROLINE COUGLIN, M.D.: Thank you.

RICK KELLERMAN, M.D.: I wanted to comment on that. I think that's a really good question. It brings up the issue of whether the retail clinic is coordinated or integrated with a larger system or whether it's a standalone out there. I can tell you though that one of the things that we heard from the docs and whether it's emergency room retail clinics or urgent care clinics, they can come in on Monday morning and sometimes they get faxes of a record or electronic record, so they're walking in on a busy day and here's a bunch of station information and now they feel responsible for it. That brings up all sorts of liability issues. Do they call the patient? Who's responsible to follow up? They have, let's say it's a paper record, they have a piece of paper that now they have to file and put in the record, so there's a lot of downstream practical things that come out of this. I think your question really touches on a lot of different issues.

CAROLINE COUGLIN, M.D.: Thank you.

ED HOWARD: Yes. Go ahead.

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BOB ROAD, BMA: I'm Bob Road, BMA [misspelled?], for Dr. Mehrotra. I noticed from one of your slides there that the data was published in 2009. This is a very dynamic changing area. Is there anything that would suggest that this data does not apply now because it's so dynamic and changing? Or do you think everything pretty much holds true today?

ATEEV MEHROTRA, M.D.: So let me share with you a bunch of different studies that have been published over the last couple years. We do have a couple of follow-up studies that are hopefully going to be published soon and most of those data are very consistent with what we've found and so at least to date, with this survey, this ongoing process, you're always looking to see if things change. None of the things that I've shared with you, I think, at least from the data, the more recent data that I have, have been refuted. I don't hear a different story right now.

WINIFRED GWEN: Hi. Winifred Gwen [misspelled?] with AARP. So Dr. Kellerman mentioned that as far as he knows no physician offices have closed as a result of retail clinics, however in states like Missouri, dozens of retail clinics were closed because of organized medicine's opposition to the retail clinic model and so I want to hear from the physicians what you think could be done in terms of working with organized medicine to help them come around on that.

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RICK KELLERMAN, M.D.: Right. And I can only speak from the work of the American Academy of Family Physicians and work with Tine and some of the leadership with the retail clinics. I think the first retail clinic was about the year 2000 or so. We first became aware of it as an organization in about 2002. And then from the working group in 2004, 2005 and have continued to monitor. Tine early on set up a list of what we call desired attributes, if Tine remembers that, and that basically state, yes, you need to work with the family physicians. The physician groups coordinate with them, make sure the records are transferred. Limit the scope of practice, so at least from the Academy's viewpoint, like I said, we have 100,000 members. We've got some that hate retail clinics. And we've got some others, particularly those in Minnesota where they've been around over a decade that work very well with them. So at least from the viewpoint of the Academy, I think we've tried to deal with this and actually use it as a way to challenge our members that, you know, consumerism is alive and well and they better respond if they don't like the idea of a retail clinic, they better respond in their own offices in terms of how they improve access. Other organizations may have gone about it differently, but I think the AAFP was pretty much out in front and frankly, I was president and president elect

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at that time, the leadership of the AAFP took a lot of hits at that time.

ED HOWARD: Go ahead, Tine.

TINE HANSEN-TURTON: I think the question that if I may phrase a good one, I think that the reality is that healthcare is a state issue, we so we have state practiced laws that really regulate healthcare overall, so I would say how we operate, is really an impacts the cost of care you know, for retail clinics and I would say some of the states for example that have more stringent oversight regulations, like Texas for example, it's a more cost to the state to operate in. And then that the reality is with primary care, all of us know her, Kellerman talked about it early on. Primary care is really a low margin operation, so all of those costs potentially when you do have regulations that are more strict, you can't actually, you know, impede some of the access. And it's not just for us, it's for some of these other providers that I mentioned early on and others that I've mentioned to provide access to care.

WINIFRED GLEN: Thank you.

ED HOWARD: Dr. Nussbaum, are you studying the green cards? Did you -

SAMUEL NUSSBAUM, M.D.: First, as we would envision there are a whole series of questions that relate to cost. So

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let me sort of combine several of these. It's the discussion of cost savings, referring to a system's cost. You know the 2.3 trillion or is it from the patient's perspective? So for example, for an ER visit, has been shown as being significantly more costly, but some patients actually pay relatively little or nothing and so what about out of pocket costs and are really these cheaper or less costly for consumers, so maybe we could take those or that question. And then the one related to that is you know, questions that the cost of ER care are so high, why are we really, why should we be offended when retail clinics are skimming these easy cases, why don't we make sure that people get care in the most efficient, cost effective setting?

ED HOWARD: Perhaps we can speak to several of those, whose cost is it anyway?

ATEEV MEHROTRA, M.D.: I think I might – so I think that the question is a very important one which is that you can throw a number out there, but who's saving that money and a couple quick points. First is that there is a perception that there are a lot of uninsured patients who are going to the emergency department and getting free care and I think there are some people go to the emergency department for free care, but the majority of the population for these conditions are the insured populations, so I think that's a key point and I think

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Manish made that point earlier. So I just wanna dispute that contention or that idea.

Now, but I think it does, the question does raise a very important point, which is that it's well and good for us to say that we are saving the most of those dollars sums are accruing to society or health plans or the government payers, etcetera, and the patient itself, it matters upon their health plan product that is gonna save a relatively small fraction of those dollars, so I think it's an important point to clarify that most of those savings are going to the payers and the healthcare system. I don't know if you wanted to add anything.

TINE HANSEN-TURTON: Yeah, I think that we'll say about 35- to 40-percent of the people coming to the clinics now pay out of pocket. They elect to pay out of pocket. They may have a high deductible health plan, they may be uninsured, so it's a large percentage. An average cost about \$75 per visit, that certainly, again, is the lowest cost for the average cost of a physician visit, it goes, I think, \$120 and urgent care is around the same, based on Ateev's study and he can comment on that. But I will just get the counter to that is, and I just have a personal experience last summer where I was not in an area where there were either a retail clinic or operator or urgent care, but my mom who was visiting from Copenhagen, Denmark, where she was sick and she clearly needed to be seen

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and we ended up, we didn't end up in an emergency room and we had a \$5,000 bill. That was the different for something that had ended up being bronchitis, so it ended up being treated for about \$75 just to show, I mean, we all experience this in this audience as well, and that's a challenge where it is becomes personal and becomes something that all of us have to deal with as well.

AATEEV MEHROTRA, M.D.: I think the point with that is I just wanted to just really emphasize that that might have been where some of the comments I made were about today, but as we look at the figure of healthcare and health plans and where we're seeing so many patients get consumer directed health plans, where they have to pay a significant amount of money out of pocket, the issue's in who's getting those savings is gonna very much change over time and so in that circumstance, for a patient, it's gonna be much more cost advantage, it's gonna have an advantage of going to a retail clinic or some other care site. So we may see that dynamic change over time.

SAMUEL NUSSBAUM, M.D.: Just for background and pertaining to that question; health plans like WellPoint and peer companies basically have retail clinics in the networks so you actually get that care reimbursed if you go to a retail clinic and one of the other important pieces is that as we contract with these organizations, one of the requirements is

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that information gets back to the primary care physician's offices, that evidence protocols are followed, so there really is a series of sort of management opportunities that actually overcome some of the concerns that have been voiced here, to increase coordination of care as well as to make them affordable for consumers. There's another question I just wanna raise here and it's actually to Rick and it's one that I think we really have to take on as the way that physicians are organized today. First, as Rick said, that more and more physicians are now working for health systems or working in larger groups, but physician hours of operations are probably 4 by 6 as opposed to 24/7 and that's if you can get in, you know, in healthcare improvement [inaudible] and others you have advocated keeping flexible schedules, but have changing physician operations had a measurable impact on ER visits and what's helped the most? Because again, people would like to get convenient care from physicians that know them and have their medical history.

RICK KELLERMAN, M.D.: Great question. I don't know that it's measurable, I mean, if you look at the data, you should, Sam, number of emergency room visits continues to increase, so I'm not sure that we have any information that any of this is negative, has impacted decreasing emergency room visits. I don't know that the evidence is there, nevertheless,

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I think it's there's a larger amount of evidence that if you have a physician that you know and trust access them appropriately, there's really good evidence that the quality of care indicators go up and costs go down, so I don't know specifically in emergency room visits. It's pretty clear that if you have a primary care health system that works well, the rest of the system works better as well.

ATEEV MEHROTRA, M.D.: If I could make one other quick point on that which is the hours. So obviously, Rick, we don't have to support that, but I think that one of these things that I sometimes worry about is that we do a little bit of a blame game where we look at the people who are in the emergency department for what we've perceived to be a non-urgent problem and say, well, we think, that they go in there for something like that, but I think it's interesting to note from studies that have looked at patients that go to emergency department, about 1 in 5 say if you ask them why are they there, say, well, my doc told me to come here. So that might be potentially addressed by the idea of having after hours care or weekend hours. Again, we don't have the evidence, but at least you would think it would help.

TINE HANSEN-TURTON: One of the studies said, you know, when you wanna Ateev's colleagues out at the University of Minnesota and Wharton, they did look actually in Minnesota at

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United Care, they actually saw reductions, they looked sort of geographically around the retail clinics and the emergency rooms and hospitals and they saw a decrease in utilization in ER use as well as hospital utilization.

SAMUEL NUSSBAUM, M.D. (??): You know, one other element to decrease utilization, the program that Manish described, related to Virginia where we first studied it, it was about a 20-percent reduction overall in emergency room use and that was largely educational campaign and one that's engaged consumers for our new patient centered models, so we actually have patients centered medical home models that are up and running for a few years in Colorado, New Hampshire, New York, as well as a broader strategy and we look at the savings in those models and they're impressive savings, but those savings are largely occurring by preventing ER visits and re-hospitalizations, so that's really some of the greatest impact on the cost savings and I think as physicians have now care management fees paid to them in medical homes and ultimately move to shared savings off budgets, there will be greater and greater incentive to keep office hours more flexible, open to groups coming together to practice sort of virtually, but keeping office hours open on Saturdays and other times to create a far greater access than today.

ED HOWARD: Oh, go ahead. Yes, go ahead.

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MANISH OZA, M.D.: I just wanted to add that this so we're all accustomed to shopping for cereal or tires and a lot of people don't feel comfortable shopping for healthcare. I get that question all the time. Manish, great program, I haven't bought into retail health clinics. Well, Ateev has showed you data showing that the quality of care is there, and in the near future, and this is already occurring, you're gonna start to see branding of the retail health clinics or co-branding with academic institutes, known entities, I believe in Georgia, Minute Clinic is co-branding themselves with Emory. I think in the near future you're gonna hear something that impacts the DC/Maryland market and so this is gonna become more and more common. If you think about a lot of your computers or they might say IBM, but they're lots of times being made somewhere else, and that's gonna start to help with the understanding of what can be accomplished in this retail health clinics and for better or for worse, when you see X hospital system in that retail health clinic, I think the population is gonna feel more comfortable accessing these places because it's a name that they know, whether it be MedStar or whomever else. And I'm not saying MedStar that they're gonna partner with anybody, but I'm just throwing out a name that most people will probably know in this area. So that's coming and I just think

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that's important for this, while we're having this conversation.

ED HOWARD: Good. Yes?

SEAN KALLAMOTA: Hi, my name's Sean Kallamota, I'm with Metnal Strategies. I had a question that kind of went back to the insurance stuff that you talked about a little bit. Is there gonna be a movement on your end that tries to get insurance companies to better support some of these clinics and, you know, some of these, like, emergency care facilities like Right Time Medical Care or places like that because I know with a lot of, like, high deductible insurance policies that people are paying for individually out of pocket. You can get an ER is it paid for in full if you need an x-ray or anything like that, for \$75 up front which essentially is a co-pay, but if you go and you haven't met your deductible, to a place like Righttime Medical Care, cuz you need an X-ray and you don't wanna wait, you're gonna end up paying them like \$500, \$600, \$700 after you get the X-ray, the crutches and if they cash and those sort of things where, you know, in the ER would just cover it for \$75. Now I mean, obviously, somebody has a broken bone, that's a little more urgent than a runny nose, but I think it kind of is a one size fits all with a lot of these insurance plans, but they don't cover the visits to these sort of places where they won't cover in the ER and that's where

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they're part of the overburdening as well because people don't wanna pay all that extra money when they already have a high deductible that they're paying out for.

ED HOWARD: Can I just expand that question a little bit? That it raises the question of ER pricing brackets, if you will. There is in your materials a piece that quotes some ER academy folks as saying that the marginal cost of going to the emergency room, depending on the time of day, isn't all that much higher and maybe even lower than some other places to get that care and I don't know whether WellPoint and other insurers have negotiated the kind of cash only deal that the gentleman was describing, more generally than their subscribers. Any aspect?

SAMUEL NUSSBAUM, M.D.: Let me take that and then Manish can add to it. First of all, in general, health plans cover urgent care and retail visits as I mentioned as part of their networks and as part of coverage and we negotiate as we do with others the reimbursement for those visits. So those institutions that you're mentioning are generally in our networks and we encourage, when appropriate, their use the same way we certainly endure support emergency care when it's needed. In fact, if anything, if you look at today's insurance products, those visits to emergency rooms that are viewed as routine care are very much at very high co-pays, I mean, \$150

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or more, so there is a financial set of payments to emergency rooms that are vastly higher than would be to a clinical setting.

Your question though gets to a larger issue and it's one of the questions that we got here is Florida Blues, High Mark, I think others, that actually insurance companies are operating retail clinics and I think you'll see more and more of investment in, support for these centers, the same way you'll see that support in primary care, so our new primary care strategy at WellPoint says that part of that of sort of agreement between the doctor and the insurance plan, the company would be to have far greater than you have today. So if we're paying a monthly coordination fee, which we are, or other fees that are about sort of the continuum of care, we don't want doctors for routine care to say, go to the emergency room, our office is closed. So that's part of the sort of agreement that we have going forward that would make the doctor's office more accessible. But the model that you talk about where we would encourage people to go to emergency room for non-emergency room conditions really doesn't exist to my knowledge. Manish?

MANISH OZA, M.D.: Yeah, so Sam, you asked kind of a benefit design question. I can tell you what we're practicing at WellPoint. We know for there to be financial drivers for

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people to utilize ER alternatives, if you're ER co-pay, just to give an easy number is \$100, we try to price the retail alternative, so that includes your retail health clinics and your urgent care at one third of that, so we wanna be somewhere between \$0 and \$33. That's something we try to do. Now the example you gave me of the ER actually turning out to be cheaper, I'm not aware of that, but that comes down to benefit design, but I can tell you from a 30,000 foot level, that's how we try to encourage these ER alternatives by using that ratio that I just explained to you.

SEAN KALLAMOTA: Thank you.

ED HOWARD: Sean?

JOHN GREENE: I'm John Greene with the National Association of Healthcare Underwriters. So, sort of stole a little of my thunder on that question because I took my son to Right Night or Righttime or whatever because I got to my primary care and their office was dark when they were supposed to be open. And it was for, he had, we thought, maybe he had strep, but it turned out he had a really bad sinus infection. I wanna twist this question about the cost out of pocket a little bit. I have a health savings account. And I love the medical, the electronic medical record. I love the convenience of it. I love being treated like a customer. It was kind of a nice experience, but it costs a little more than I thought it

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would. What about this issues relative to transparency of cost? If this is, if we're going to these sorts of facilities for what is deemed as kind of you're run of the mill sinus infection, why can't you post what the price is? So I would know? That's the one extra step that you could take that's different from our usual interaction with the healthcare system to know , this is what it's gonna cost and maybe I'll pay out of pocket and pay cash, maybe get a little better price than running it through the insurance company if I know it's gonna be \$75 to treat the strep or whatever it is.

TINE HANSEN-TURTON: What usually actually prices are posted and also if you go to the website, you'll see the general range of the price, not to exceed that, I mean, there are some tests involved in some of them, and that's where we're seeing the average price is \$75 but I'm surprised you know that you would not have a price list. That's usually what we see in our clinics. There is a range, you know, what tests they do, but the range, by far, it won't surpass certain amount, so yeah, maybe we can talk afterwards, which one you went to, because I'm curious about that. And that's something we actually pride ourselves that there is price transparency.

MANISH OZA, M.D.: Can I make one quick point on that, Tine? So, one of the as the you asked one of the unique aspects of retail clinics, at the ones that I'm aware of, they

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do have the prices online and on the little board they have in front of the clinic, so it's realize to the unique experience for the patient to know and we did a study where we interviewed a number of people who went to retail clinics and asked them what was driving their interest and for those who are uninsured, in that case there weren't that many consumer directed health plans, patients who are paying for it out of pocket, that price transparency was one of the critical drivers, so one of the mothers who brought her son here said to us, you know, I know how much this is gonna cost, if I go to my doctor's office, or if I go to the emergency department, neither the doctor, nor the emergency department provider, knows how much it's gonna cost and I think that this exorbitant bill in the mail afterwards and we know about all the issues about pricing in the healthcare system, so I think you've really hit upon a key point which is this price transparency and how much we can continue to try to encourage that. IN other care settings, I think it's really important.

SAMUEL NUSSBAUM, M.D.: Just one thing on that, and I agree, I like the price transparency, I think more physician offices should do it as well. When I see a patient though, sometimes we don't actually know exactly what that cost is going to be. For example, if I saw your son and he had a sore throat and pus on his tonsils, and I got a strep throat and it

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was negative, the second thing that might, I might think about is a mono test because mononucleosis sometimes shows up as a sore throat. So that's gonna add additional cost when I do the test, and I just say that because sometimes when a patient walks in with a sore throat, we don't know exactly what the diagnosis is going to be and strep throat is just one simple example of that.

LISA SUMMERS: Thank you. My name is Lisa Summers and I'm with the American Nurses Association. And we've worked closely with Tine's group and AARP and others to try to address some of the barriers that limit MPs and other advanced practice nurses from providing care in settings like this, so I wanted to say thank you very much for the panel and all the information.

The question that I wanted to ask, what really intrigued me was a very brief comment that Dr. Oza made; when you were talking about the 24/7 nurse line and you mentioned RNs being able to triage and you talked about they used to ask a lot of questions and you'd streamlined that. And I was very intrigued because certainly what we hear from nurses is they have a lot of skills and knowledge that can help patients get the right care at the right time, but very often, they're limited by these scripts and as you said, you know, I myself have sat and asked and answered a gazillion questions that were

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irrelevant. So I'm just wondering if you could expand on that a little bit in terms of how that went. I can imagine that the lawyers may have had some angst about that and if you see that as a trend with all we're depending more and more on nurses to do things like that, inter-care coordination, etcetera, etcetera.

MANISH OZA, M.D.: Yes, great question. So yes the lawyers did get very excited when we started the leading questions and so some of the questions we got rid of is allergies to medication. If somebody's got a sore throat, and not for all instances, but you know, allergies to medication of someone, you're triaging somebody with a sore throat: what do I want to know as an ER doc, are they having any shortness of breath? Are they having any trouble swallowing? Can they handle their secretions? Those are the kind of questions you wanna get to. And if none of those are yes's, then you start to get to, do you have a fever? And some of the other things that we may wanna know; so streamlining the questions that are pertinent. Another one is last menstrual period. Why is it relevant? Right? But these are a lot of questions that are in there and when you have a sore throat, the last thing you wanna be is on the phone answering your relevant questions.

When was her last tetanus shot? Well, why is that relevant? Right? Let's get rid of the things you don't need.

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This is a registered nurse. She's clinical. From a legal standpoint, we can't just let them, you know, totally practice medicine over the phone, but there's certain questions we have to ask and ultimately, it's the patient who has the prerogative to go to the emergency room or retail health clinic, but remember this is a service that we give our members that's underutilized, but a lot of people here weren't sure about where to go when for what and I just want to always drive home some of the things that we got with asking the irrelevant questions and it takes too long. Well, we made it one step easier. Is it perfect? No. But it's better than it was, so if somebody's calling with something like a rash or they just cut themselves and that's a perfect example of a cut. It happens all the time. Well, do I go to the ER or do I go to a retail health clinic? Well, a retail health clinic today would be wrong because they don't do stitches. If it needs stitches, the nurse has gotta go a little deeper. Well, can you approximate the edges of the wound? How much is it bleeding? Is it pulsatile? Right? Because that might mean you have an artery. So those are the kinds of things that they'll ask to triage. And again, we're guiding the member, if the member doesn't feel comfortable going to a retail health clinic, that's their prerogative. They still have a very - they can go to the emergency room or wherever they want, but one thing we

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wanted to do was to make sure the experience that the member had when they called the nurse hotline was a good one.

LISA SUMMERS: Well, kudos to you, I'm sure the nurses really appreciate it as well. Thanks.

ED HOWARD: We have a couple more folks here. We have a bunch of cards yet to be voiced that you've sent forward. So if you really need to get your question answered, you probably need to go to a microphone and also I would ask in these last ten or so minutes, that you listen to the back and forth of the Q&A while you take out the blue evaluation form and fill it out. Yes, go ahead.

SANDRA WILKNISS: Hi, I'm Sandra Wilkniss from Senator Bingaman's office and one of those is my cards, so you can get rid of that. My question is about behavioral health. I'm wondering what proportion of the visits involve a behavioral health component whether it's verbalized as chief complaint or identified as one and how you all handle those.

TINE HANSEN-TURTON: Well, in terms of, we don't, you know, there's two things going on in the retail clinic. The scope of services and certainly the scope of practice usually the clinician and a nurse practitioner. A lot of other healthcare issues are identified in the visit so part of it is that you have the right referral mechanism in place when you identify behavioral health types of issues and we certainly see

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that and hear that from our members, not only health, we see that with chronic diseases that we're not treating, where they need to be a connection for a primary care provider. Again, we see the relationship with the medical home as a critical one. The challenge always comes up when we identify those up to 60-percent that may not have a medical home, so getting that first and then getting them into proper care. But all of our members have relationships, referral relationships with health system and other providers, to account for what the kinds of issues that they see come up in the clinic.

ED HOWARD: Could I just ask, Manish, in your diversion initiative at WellPoint, how do you deal with behavioral health questions that arise?

MANISH OZA, M.D.: Well, behavioral health questions, if they were gonna call up the nurse hotline, they would go through their triage system, the questions that were relevant to a mental screening exam to make sure if that person needed to be. When we talk about behavioral health, there's two things and I don't know if this answers your question or if I'm going off, but when Sam earlier talked about frequent fliers, a small percentage of the population, 5-percent accounting for 10 to 20- to 30-percent of the spend, behavioral health is a big component of frequent fliers. I see that when I'm working clinically. A lot of people with mental health coming to the

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emergency room out of desperation because they're lost in the system, they potentially have some drug dependencies and they're ending up in the ER, alcohol dependency and the other competent are the frequent fliers, the people with chronic conditions and they're just lost in the system. So they have chronic pain, whether it be belly pain, back pain, leg pain, and they're just lost. They've been to the neurologist, they've had all the MRIs you can get, but they're just lost in the system and no doctor has taken ownership of them. And they end up in the emergency room. And unfortunately we have no silver bullets in the emergency room, so I will rule out any life-threatening emergency and I will do appropriate scanning at sometimes unnecessary scanning because I don't have all the CAT scans and MRIs and X-rays that they've had in the past and then unfortunately, I'll give them a referral and then they'll still be lost in the system. A lot of these people have bounced from specialist to specialist to primary care haven't gotten a solution and I call them the lost souls. They're just going whether they can go, ER to ER, sometimes many of them we make worse by prescribing them narcotics and then they become addicted to the narcotics, and so unfortunately I don't have a great solution for them, but when I think of behavioral health emergency room, they're a big part of the frequent fliers that we see.

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SANDRA WILKNISS: I just wanted to follow up. Just quick thought, given the high prevalence there are some very brief interventions that can be incorporated into clinics like yours that can address immediate concerns and then refer out, so just thought?

RICK KELLERMAN, M.D.: As a family physician, I've gotta comment on this one. Every visit has some behavioral health component. We teach our medical students that patients do not experience a medical problem in a vacuum. And no necessarily all those need some kind of treatment, but the monitoring of that and screening for behavioral health issues and the amount of cost that the healthcare system absorbs because of behavioral health and mental health issues, is extremely important. You need to have one of these things on behavioral issues.

ED HOWARD: Indeed. We actually did, about a month ago. We have another one coming up in the fall. Yes?

JUSTIN JONES: Hi, my name is Justin Jones, I'm with Health Policy Project at the New America Foundation and my question was about the urgent care clinics and advertising. I've lived in communities where the urgent care clinics do very aggressive advertising up to having billboards with the current wait time at their clinic. And then I've been in communities where there's virtually none. Do you know is there any

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correlation between the advertising and making more use of these clinics?

ED HOWARD It would be un-American to suggest otherwise.

JUSTIN JONES: Or have there been any studies done, looking at that?

MANISH OZA, M.D.: So that's an interesting question. We've got emergency rooms doing the same thing. They're advertising their wait times, they're on the billboards, they're even creating slogs in the emergency room where you can go online and book your time. That's a head scratcher for me and Sam. If you're booking a time to go to the emergency room, then it's not an emergency, right? Then why are you there to begin with? But everybody it's the American way. Everybody's advertising anything they can do to get everyone into their facility, whether it be the emergency room or urgent care. I'm seeing it more on the ER side than I am the urgent care, actually, which is concerning for me. Hospital systems advertising wait times less than 15 minutes, there's a lot of systems out there that are doing it. And the reality of it is these quick -itises are cash cows for the ER. I, as an ER doc, are looking at your throat within 30 seconds to a minute and tell you what it is or do a rapid strep test and tell you whether it is, so what the emergency rooms are actually doing,

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catering to what you're saying is they're giving these quick wait times and you come in and go through what's called our rapid evaluation unit. You come in, you've got a sore throat, you take your Blue Cross Blue Shield card, somebody's swiping that, we swab your throat and our mid-level providers, the nurse practitioners, the RNs that you're seeing at the retail health clinics are the ones that are typically taking care of you in these rapid evaluation units in the ER, but you're paying an ER co-pay and WellPoint is paying an ER price for treating at that strep throat in the emergency room. It's the \$500 to \$600 potentially as opposed to the \$85 that would've been in the retail health clinic or a \$100 at your primary care or urgent care. Hopefully that answers your question.

RAFAEL SEMANSKY: Hi, my name is Rafael Semansky [misspelled?]. I'm a consultant. Just one quick comment and a question. I don't think anyone's been in an ER run in DC because we're talking about wait times of five to ten hours in DC. My second question would be just following up with Dr. Kellerman's comment. You know, I think there's a bigger issue around kind of how family physicians coordinate information from other providers, whether it's from a provider a Minute Clinic or a specialist. I can't tell you how many visits I've had with my primary care provider or specialist where they haven't even looked any of the other material they've gotten

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from any of the other providers. And I know from friends who have parents who have chronic conditions, what happens is the poor parent has to keep seeing the doctors so the doctor can get paid for his time to basically read the information from other providers and you know, I'm wondering to what extent the medical home is really gonna be able to deal with the lack of time that physicians spend using information that was available to them, whether it arrives on a Monday morning or through a fax or by a patient, you know, because obviously a ten to fifteen minute visit is too short a time period for someone to actually go through all the information. And I think there's an unnecessary reliance on patient recall. I can't tell you how many times my physician's asked me about questions about the electronic medical record. So I think it's a bigger issue than just the retail clinics.

RICK KELLERMAN, M.D.: Well, so many years ago, the Academy and other clinics organizations put out principals of the patient center medical home and they included things like we're talking about here. Improved access, quality measurement, the importance of health information technology. One of those principals was payment reform for primary care. Based on most of the current system, primary care physicians are primarily paid fee-for-service, so are only paid when we see the patient, yet there's an estimate that about a one sixth

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to one third of what a primary care physician does is unreimbursed. And it's unreimbursed not because the patients doesn't have insurance or it's unreimbursed because it went to bad debt. It's unreimbursed because there's no way to pay for it in a fee-for-service environment. And I know that WellPoint and other insurance companies are looking for different ways to pay for primary care and that has to happen if this is going to work. Again, I think that it points back to the neglect that we've had for primary care in this country. Sam might wanna comment on that.

SAMUEL NUSSBAUM, M.D.: Sure. I fully agree with Rick. We are developing models that medical home models where we pay care coordination fees and in addition we are increasing the payment generally overall and certainly want to make sure that we pay differentially for urgent care after hours care as we do today. But ultimately, it's the accountability for the continuum of care that appropriately would be in a doctor's office, so we and other companies are certainly moving in this direction and we need to do more. The last question that I'd like to pose is one that you've posed, sort of looks to the future. And it's whether patients will be willing to accept long-term chronic care management in retail clinics without visiting physicians. So it's sort of, as we look to the future and we think beyond these self-limited, often self-limited

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illnesses, how do you see, Tine, see retail clinics evolving, because we know many are thinking of moving in the direction education, chronic care management. Looking at these very different models, will consumers accept that, and if so, Rick, what's, now we're crossing a little bit of a boundary line, aren't we? With primary care? So what will the model evolve to?

TINE HANSEN-TURTON: Great, Sam, I mean, obviously the retail clinic providers and the clinicians participate in a very partnering with other providers to really meet the chronic care needs of many patients. We've always said it needs to be a partnership here with the medical home. And I think we agree on that in terms that there needs to be coordination with somebody that can see the whole spectrum of a patient and what we've seen now, we've put a lot of access in terms of retail hours, think about diabetes and he is hemoglobin Alc. Certainly he can go here in the mornings, at lunchtime, after hours or on the weekend, so it becomes a little bit more manageable to have a chronic illness.

Now we are seeing with our members, some co-management already a chronic disease management, I mentioned earlier, for example, one of our colleagues, a member the Minute Clinic that has affiliation with Cleveland Clinic where they are giving some bi-directional treatment. But again, Cleveland Clinic is

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...serving as a medical home where there's co-management of the patient and that those services and how they co-manage is reflected in the record and there's a lot of partnership back and forth between and both the clinic operator as well as the primary care operator.

RICK KELLERMAN, M.D.: Right and I agree. It has to be coordinated with the physician and there's a lot of difference between just taking the blood pressure and managing high blood pressure. You have to think about, well are there, for example, secondary causes of high blood pressure, renal artery stenosis, for example. A lot of sometimes we make it look too easy in medicine, I think, I used to send my patients to the fire department because they had firemen that checked blood pressures regularly, but bring those in so that I can take a look at them. So there's a difference between screening and doing a test and actually managing that patient's condition.

ED HOWARD: Okay, well, a good word on which to conclude. A fascinating discussion, one that's immediately relevant to a lot of people's lives and to some policy developments that are under way whether the train has left the station or not. Let me just take a moment to thank you for your participation and for filling out those evaluation forms at the cost of badgering by one of the moderators. I neglected to mention and certainly want to thank the Kaiser Family Foundation for providing the

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webcast that will be available tomorrow on their website

www.kff.org or through the Alliance at www.allhealth.org.

Certainly want to thank our colleagues at WellPoint for their co-sponsorship and support, an obvious contribution through their participation in this briefing and ask you to help me thank our panel for really illuminating discussion on a tough topic. Thank you. Thank you.

[END RECORDING]

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