Patient-Centered Medical Homes: The Promise and the Reality
Wellpoint
Alliance for Health Reform
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ED HOWARD: I don't want to stop people from getting their lunch, but I do want to try to honor the timeliness of the people who are here and seated already. So, if we can, I'd like to try to get started. Feel free to continue through the line and our staff is here to help you find seats if you can't find them. They're pretty scarce because this is a pretty hot topic.

My name is Ed Howard. I'm with the Alliance for Health Reform and I want to welcome you on behalf of Senator Rockefeller, Senator Blunt, our board of directors, to this program looking at the primary care medical home—a sort of new way to organize primary care, to improve coordination and patient satisfaction using teams of providers.

Now, we're very pleased to have with us as a partner in today's program, WellPoint, operator of Blue Cross Blue Shield plans in, I guess, a dozen states or so. One out of every nine privately insured Americans is insured with WellPoint, and you're going to be hearing from Amy Cheslock, who is a vice president at WellPoint, in just a few minutes.

Primary Care Medical Homes, PCMH's, if you will, have been around for a long time, but really started attracting attention in 2007, or so, when the major primary care physician associations developed and endorsed a set of principles on the topic and the PCMH has since evolved into a widely accepted model for how primary care should be organized and delivered. A lot of different payers and providers have embraced this model but we also have some questions that have been raised about its effectiveness, most prominently in an article in the *Journal of American Medical Association* a few months ago by a team of Rand Corporation researchers, and there is a document in your kits. I think it's a press release about that article. And specifically, the questions arise around aspects of the PCMH ability to really improve quality and loser costs, and the length of time it might take for practices to meet these PCMH standards.

So, today we're going to take a close look at the various outcomes that have been shown to be generated by medical homes and how different payers are supporting this model, which is very important. It hasn't gotten a lot of attention. And, we're going to hear more about the experience of at least one practice that has made or, I guess, you would say, Dr. Frazer, that you haven't completely made the transformation into be a PCMH.

Now we have a few logistical items to bring to your attention. There are materials in your packets including biographical information on each of our speakers, more extensive than I have time to give them. Their PowerPoint presentations are in there also, so you can follow along and make notes on them. Those slides and the materials in your packets, will be available online at allhealth.org, our website, and in a couple of days there'll also be a webcast of the briefing available there. A couple of days after that we'll have a transcript mounted on the website so you can share this information with your colleagues and also review it at your leisure independent of the paper in your hands.

Two other pieces of paper in your kits I want to call your attention to. The green question card that you can use if you can't make your way through the maze of people to the microphones that are in each side of this room, and the blue evaluation form which we hope that you will fill out before you leave so that we can improve these briefings and respond to what you think that we ought to be doing to help you do your job. If you're part of the Twitter verse, I call your attention to the hash tag pcmh that will allow you to contribute to the chatter. And I would also ask, once you get to the question part, and I would say this to our panelists as well, this is one of the most beautiful rooms in the Capital Complex. It also has some of the worst acoustics of any room in the Capital Complex, so we will try to speak slowly and distinctly, despite what you've heard for the last few minutes, and we would ask, at the appropriate time, that you do the same.

So let's get to the program. We have some really interesting folks with lots of experience from a variety of viewpoints to help you develop a better understanding of PCMH's and the issues around them, and we're going to lead off with Amy Gibson. Amy is the Chief Operating Officer of the Patient Centered Primary Care Collaborative, and if you're not familiar with the PCPCC, its members are over a thousand medical home stakeholders and supporters trying to transform the U.S. healthcare system through delivery reform and patient reform, patient engagement, and employee benefit redesign. Did I get that pretty close? Okay.

Amy's been working on medical home related issues for a decade and a half. She has a nursing background. Her mission today is to give you a sense of what PCMH's are all about, how they fit into today's rapidly changing delivery and payment systems. Amy, thank you for coming to talk to us today.

AMY GIBSON: Thank you very much. Well, I'm so grateful to be here today with this very distinguished panel, that many of them that we've worked together for quite a while on these efforts. I'd like to say to people that I think I was the first person ever hired in this country just to promote medical homes, so in the 1990's at the American Academy of Pediatrics, we were really trying to formulate this idea of a medical home. And it was really established on the principles of better partnership with patients and families, better connectivity with the larger community, to really promote health in a coordinated, comprehensive way. And so what we've been doing over the last several years is really trying to embrace those basic principles of medical home, but really operationalize it. And I've got to tell you, we're still on this journey but it's very exciting, the work that's being done, and I'm so glad you're going to hear more about all the investments that are going on in primary care. But we really believe that this is a model of care that can really transform our overall healthcare system.

We've known for a long time that countries that have stronger primary care have better healthcare outcomes and so, when you think about medical home, I like to describe it also is, you know, think about your old time pediatrician or family physician who was practicing 20-30 years ago, was very integrated in the community, knew all his patients

and families very well. I actually used to work for my own pediatrician. When I was 15 years old I would go after school and take over for the nurse, and help room patients. But that pediatrician really embraced all of these principles but think about how much has changed over the last 20-30 years. A lot of what we try to do in primary care now is still based on that old model. But we have this opportunity now, within Medical Home, to really create this new model of care in which we're embracing new technologies, we're also making better connections with all these various specialties and, of course, also the communities. But if you think about what patients have to go through and their families and caregivers it's extremely complex. And so, when we talk about Medical Home—and you will hear it called lots of different things, you might hear it called Health Homes, Advanced Primary Care—it is truly a new way of thinking about delivering primary care. It is not just a program or a label, or a certification or a payment model. It's really not a payment model. It's a whole different way of delivering team-based care in a coordinated way that's connected with the community.

So we like to think of this team of primary care providers working in partnership with patients and their families, however they may define that, is really the anchor to helping them coordinate and navigate this larger healthcare system. So we've kind of put everything in these nice little boxes and think about the various elements that go into medical home, and it's really not just what happens within the four walls of a primary care practice. So, a lot of things go on there but it's a lot about how they're connecting and building out their team to people who are not just within that primary care structure or building. It's how we're using other technology around telecommunication or telemedicine and e-mail, and working in partnership with lots of other people across the health system.

You'll also see, on the right-hand side, those are kind of traditional medical services. And, again, a lot of them become part of that expanded care team, but really, even for pretty sick people who are out there with multiple chronic conditions, they don't live there. They might be in that system maybe even only 8 to 10 hours a year if they're pretty sick. So we also have to think about how we're connecting to all of these other systems and services and places where people are really trying to manage their care every day, most days of their lives, and that's in schools, that's in churches, that's in their workplace. So, we have to think about how all of this is being pulled together and so you can imagine how complicated that is. And then think about it from the primary care team's perspective, how challenging that is to really understand and know what's going on that impacts the lives of the patients that they're caring for.

So, one of the things that we do here at the PCPCC, and I know that just rolls right off your tongue, is to really try to pull together and share with everybody else in a way that we can all understand it what's going on around in the world of medical home. So, every year we put out an annual report, and you've got a lot of this information in your packets, and we try to share what's coming out from these medical home initiatives and programs and, again, I mention that we've been talking about medical home for a long time but a

lot of these programs are really just now starting to deliver on a lot of the outcomes and data that they've been collecting.

The Commonwealth Fund has shown that through some of their evaluations that it can really take up to 5 years after a practice has transformed into what we consider a medical home to really demonstrate health outcomes in their population. So these are not the kind of things that happen overnight, and we're always still tweaking this model. This is not a model that you can just carve out. I say, you know, you can't just order it on Amazon.com next week and put it into a primary care practice overnight and say now we're a medical home. Because think about what's going on in primary care and in our health system as well. We're asking them to do a lot of things that are totally contradictory to the way that their incentives are aligned. So we're asking them to, on the one hand, practice primary care the way that they were taught several years ago, but then also map under that do things in a different way and these are going to make better outcomes and improve health for your population. So it's really a struggle. It's very hard work. And it takes a lot of investment of time and leadership and resources.

So we're excited to see that we are getting a lot more information and data to come out about what's going on with these initiatives and these projects around the country. So this, our most recent annual report that came out in January, we actually looked at a total of 21 studies and these were a combination of peer reviewed, literature, articles, and it was industry reports as well. Now, when you see the breakdown of some of these percentages you'll better understand if you look more at the information in your packets, this does not mean to say that 61 percent of the studies reported positive cost improvements and the others said they were negative. This is—only the studies, the number of studies that actually reported on costs. And it's interesting, it was mentioned, you know—and there's more information in your packet—we found 20 articles that really focused on measuring outcomes around an intervention of medical home, around these four principles, looking for improvements in cost and quality and patient experience, and they all showed improvements. And the one article comes out and everyone says the medical home doesn't work. So, you'll see, there's some great information that's also included that really better explains, you know, some of the—the context of that study, not to say it was a bad study, but this is also one of the challenges in medical home. Each medical home does not necessarily look like the other and it shouldn't because they're caring for different populations and different areas of the country and they have access to different resources and different skill sets within their community. So we have to allow some flexibility in the model, but as you can imagine, when you're trying to compare apples and oranges it's a challenge, and then when you're doing an intervention that's for a segment of your population and not for the whole population there's also some dynamics that come into play that make the evaluation of the overall population quite challenging.

One of the other things that we're trying to do at the PCPCC is to make kind of one-stop shopping for all of you. So, when you want more information about what's going on in

medical homes in your state, in your community, in just a few short days, actually a week from Tuesday, we will be officially launching a medical home map on our website that we think will be a great resource to all of you. So what we'll be putting onto that map, we have over 500 medical home or advanced primary care related programs that have payment attributed, that are looking at improving quality and outcomes for patient populations all around the country. We'll be providing information at the state level and individual program information. We're trying to include any publically reported data that these programs have put out, and we're also going to be describing their payment model. So I think it'll be a really great resource to all of you and I encourage you to go take a look at that after June 9th.

A lot of this rests on the shoulders of all of you that are really working to improve the way we pay for healthcare services in this country because I'm here to make the argument that what we talk about in medical home and that type of care is truly incompatible in a strictly fee-for-service environment. All the incentives currently are aligned with volume of care. We have to do something in a better way that really allows for that larger team to provide care in a way that's nimble for individual patients and families and is responsive to the population at large that they serve. So we need to align the incentives in a way—and the metrics—that gives us some flexibility, but then also calls for certain changes in the way that healthcare is delivered in that primary care setting as well.

So, we're excited and you're going to hear more about a lot of the innovations that are going on around the country that are really trying to move us to this new model that will really support care in this medical home model that we talk about.

I've already talked a lot about these challenges and I think you can appreciate what most of these are. We need better measures around medical home, but again, measures that are flexible for the population that's being served. We need to appreciate that there's patient diversity and that there's different needs within those patient populations. So even though you might have a particular population of patients who have asthma you cannot necessarily map the exact care for each of those patients because they might be at a different place in how they're able to manage their own care. And we need to provide some flexibility and some resources to allow for that.

I mentioned that we need better payment models but we also need an investment for these practices that are trying to do this very hard work in transforming their practice. You're going to hear about the investment that it takes, both on the leadership and actually financial resources that are critical. And we need better partnerships with communities and patients in the practice. Not just on a patient-to-patient level but also within the context of quality improvement, ongoing improvement, in the healthcare system.

I showed you our little map of our medical neighborhood. This is actually a depiction from a patient. It's actually a parent of a child with special healthcare needs. So I drew

the circle around their medical home, and everything that's in blue there is our traditional medical services. But look at all the other things that patients have to navigate on a daily basis, and I think it gives you a better understanding and appreciation of how complex this is for patients and the challenge that we have moving forward in making these connections work more efficiently and effective for patients so we have better health and quality outcomes. Thank you.

ED HOWARD: Great. Thank you. Amy, before we go on any further, I just want to give us a little solid foundation on which to build. There is, in the packets, a piece by the National Committee for Quality Assurance (NCQA) that does the certification of PCMH's and on page 1 of that document there is a list of what they describe as the key facets of PCMH's, and I wonder if that is a pretty good place to start as a definition of exactly what a PCMH is.

AMY GIBSON: Right. It is. It's a good foundation. And what we found, too, is NCQA is certainly a great program that recognizes practices and helps establish, you know, because from a payer perspective, they need to understand and know what's the difference between this primary care practice that's doing a certain level of care and another primary care practice that might not be. But it really is a starting point and it's a foundational piece for practices because this really is a model of care that requires ongoing transformation and quality improvement as they respond to the needs of their population. So it's not I did the test, I get the certificate, and I'm done. There's a lot more that goes into being a medical home.

ED HOWARD: Okay. Very good. Thanks very much. Next, we're going to hear from Pauline Lapin. She's from CMS's Center for Medicare and Medicaid Innovation, CMMI, where she's the Deputy Director for the Seamless Care Model's Group. That is great. CMMI, as most of us know anyway, promotes improvement in payment and delivery systems through its grants and other initiatives. Pauline guides CMMI's efforts to stimulate innovative payment and delivery models related to advanced primary care and accountable care organizations, ACO's, like the Comprehensive Primary Care Initiative, and the pioneer ACL model, and the Comprehensive Renal Disease Care Initiative. So, we're very pleased to have the public sector look at PCMH's and we'll hear more about the private sector in just a moment. Pauline, thanks for joining us.

PAULINE LAPIN: Thanks for having me today. Can you all hear me? I'm going to bring this microphone a little bit closer. As Ed said, I'm the Deputy Directory for the Seamless Care Models Group in the Innovation Center. We are one of five groups, an innovation center that is designing and testing innovative payment and service delivery models, and I want to acknowledge that there are colleagues from other groups within our center here today. Jody Blatt is on our Medicare Demonstrations program group and she is the lead on the multi payer advanced primary care practice demonstration. And Ankit Patel is also here from the State Innovation Models Group and is working very closely with states on some of their innovative payment and delivery reforms.

When I think about primary care I always think about who am I worried about and I always come back to my dad. This is my dad. I've shown this slide before so I apologize if you've seen it. He's turning 80 this year. He has, I counted this morning on the train up, he has 6 chronic conditions. He takes, I would say, it's probably over 17 now, probably over 20, prescription medications and vitamin supplements. He sees a primary care doctor, an endocrinologist, a cardiologist. He goes to the Coumadin clinic regularly. A whole range of different physicians. He's very lucky because he has three daughters. My older sister is a pharmacist and my younger sister is a nurse practitioner, and then there's me. But we are the family that is coordinating his care. And one decision that we made was, he should see doctors that are all co-located in the same building, that all, we thought, worked together. So we co-located, made sure to select a primary care doctor, an endocrinologist, a cardiologist, a Coumadin clinic, all within one system, all located at the hospital just in case. And what did we discover? No one talks to each other. We called the Coumadin clinic when he started the Coumadin and said, we just want to make sure that all his labs are going to the cardiologist. Oh, well, you need to tell the cardiologist to call us and then we'll fax them to him. We were just astounded that we had to do all of this coordination for a bunch of doctors that all work in the same building, that pass each other in the hallways, that all know each other. We also had to settle an argument between the endocrinologist and the primary care doctor because the endocrinologist said, it's his diabetes. We need to worry about that, so I should be the quarterback for his care and everything should go through me. And we decided, no, we think it really should be the primary care doctor. So he's unusual. He's unusual because he has three daughters that are really able to help manage his care and help him coordinate through the healthcare delivery system. Many other Medicare beneficiaries are not so lucky. So we have a big job. We have to figure out how we can actually help primary care practices step up transform or redesign their processes so that they can support patients that are just like my dad who maybe don't have the social support at home.

So the Innovation Center has a range of primary care models and demonstrations. I'm going to speak mostly about the Comprehensive Primary Care Initiative because it's the one that we oversee in the Seamless Care Models Group. But, as I mentioned, there's also the Multi Payer Advanced Primary Care Practice demonstration, the FQHC Advanced Primary Care Practice demonstration. These three really focus on the patient-centered medical home or advanced primary care models. We also have two other primary care models: Independence at Home, which is focusing on delivering primary care in a patient's home where actually the practitioners go to the patient's home for these more chronically ill patients; and, we also have the Graduate Nurse Education demonstration, which is also looking at how to improve GNE.

As you can see from this slide, the Innovation Center has a number of primary care focused types of initiatives including our ACR models, I mentioned Pioneer. There's also the Medicare Short Savings program, which is a regular Medicare program. You can also

see, in this slide, that there are heavier concentrations in some areas, like the Northeast compared to others.

We estimate that about 5 million fee-for-service Medicare beneficiaries are receiving care from ACO's and participating in our primary care initiatives across the country and we're really proud of the reach that we are having. As I mentioned, the Multi Payer Advanced Primary Care Practice model, one of the first primary care models out of the gate, is testing the effectiveness of offering providers a common payment method for Medicare, Medicaid, and private health plans. In this initiative, the states actually invited Medicare to join in their existing state multi-payer health reform initiatives and so we said, sure, and 8 states. And as you can see those 8 states are listed. We currently have, as of, I guess, the end of 2013—and Jody might have more up-to-date numbers—we had 984 practices, about a little over 6,000 providers serving 557,000 Medicare beneficiaries as well as almost 3 million patients from other insurance programs.

In the FQHC Advanced Primary Care Practice demonstration, we are supporting practice FQHC's to advance their primary care practice in almost 500 FQHC's in 44 states now. This program started back in November 2011. It also was one of the first earliest Innovation Center Primary Care Practice models. And we are really helping these FQHC's achieve level 3 NCQA certification through this model.

In the Comprehensive Primary Care Initiative, we actually went out and did something unusual. We designed a program where we first invited insurance companies to participate with CMS in testing a common delivery model supported by a common payment model. So we basically sent a solicitation that invited these payers to come in and said to them, we want to support these five comprehensive primary care functions which we identified as being important for primary care, and we said, we're going to support it in Medicare by a nonvisit-based care management fee and an opportunity for shared savings for providers, and we got a lot of interest from payers. We mapped it out. We identified 7 regions of the country where we had good penetration, and we've been now, we're now in our second year of the model. You can see where we are. We have 483 primary care practices currently participating in the model with about 2500 practitioners and altogether we're serving about 370,000 Medicare fee-for-service and Medicaid fee-for-service beneficiaries. Of course, the patients that are not covered by Medicare or Medicaid that are part of these practices are also getting served and we'll talk about that in a minute.

Just to refresh your memory if you haven't looked at this before, this is our driver diagram that really describes the whole infrastructure or theory of action of the model. So the 5 functions that we asked these payers to support were: access and continuity; planned care for chronic conditions and preventive care; risk stratified care management; patient and caregiver engagement; and, coordination of care across the medical neighborhood. And we basically said, to really support this we need enhanced accountable payment from these payers. So we made sure that the payers were providing

payment to support practices in the delivery of these 5 functions, but we also made sure that the practices were also accountable for the funds that they are getting. We actually asked them to report a budget to us each year that explains how they plan to use that money to support these functions in primary care.

We also are giving them very strong learning support through a national and regional learning network and so we provide lots of opportunities for practices to learn about risk stratification, about shared decision making, and other kinds of tools and strategies that we really think will help them manage their patients and hopefully bend the cost curve. And we've had a lot of great input from the practices and participation in our learning.

We have 9 milestones that we require these practices to report to us on each year. I mentioned the annual budget; we also have asked practices to provide, for example, their care plans. We asked them to actually upload them into a secure web application portal where we can just see what their processes are for risk stratification, for care management, and what kinds of information they give to their patients. We asked them about the decision aids that they were using for which kinds of diseases or services. We've asked them to give us quality improvement run charts, for example, showing us changes in one quality improvement area. These milestones we keep expanding on. So, for year 1 they had to report on one set of functions. In year 2 they report on these same kinds of functions but we added a little bit more intensity. So, for example, for care management for high risk patients, practices had to select an area to focus on, and those areas included behavioral health integration, medication management, and support for self management. And what we've learned is that most practices were really interested in support for self management. I think that was an easier transformation than maybe medication management where we were requiring that they actually have a pharmacist integrated into their care team to help support them.

We also, for example, 24/7 access by patients. We're really talking about access to the electronic health record. This year we're asking that practices consider asynchronous communication such as a patient portal, and some practices already have them, some practices do not, so we're trying to raise all boats and hope that all practices are able to get to that point.

A few highlights from year 1. What we learned, based on what the practices uploaded into our web application because, as I mentioned, this is the one model where we ask these practices to record a lot of their processes and what they're doing. We learned that there are 2.6 million active patients and 2.3 million are impaneled to CPC providers. So that's across all payers that are participating in the program. We also learned that 100 patient family advisory councils have been formed. So, for our patient caregiver and patient experience milestone they had a choice of either serving patients or creating patient-family advisory councils and my favorite story is about a practice in New Jersey where the physician decided to hire a patient who had fired him to lead his patient family advisory council. And he did that because he realized if anybody is going to be able to

help me improve my practice it's going to be the patient that fired me from being his doctor.

This year we've actually asked, again, for practices to survey their patients to make sure that they're using the feedback and getting feedback from their patients regularly. And if they don't do a patient-family advisory council then we're actually asking that they survey patients monthly on some topic to get feedback, and then they have to show us how they're using that feedback to improve their practices.

The other point that I want to mention is that we have a range of practice sizes. We have small practices, we have larger practices. We have 85 small practices participating in the Comprehensive Primary Care Initiative. We recognize that this is a program that is a kind of a heavy lift. We are providing support both financially and through our learning and what we've discovered is that we have some rock star small practices that are really doing innovative things and learning how to pool their resources to be able to support each other in the program. So one thing that we've seen, and it actually struck me, at the Cincinnati kickoff meeting for the program, I was sitting in the room with all the practices and there were a bunch of small independent practices that actually were getting together to have a meeting. They organized themselves to talk about their EHR's and I thought that was really interesting and we've seen that kind of collaboration continue.

Hopefully, in the next year we'll have some more interesting information coming out of our program. As was mentioned earlier, it takes some time to get the cost outcomes and results that people are really interested in craving, but I think some of the process results that we're seeing are very positive and hopefully are pointing us in a direction that will actually get us to those results. So, thank you very much.

ED HOWARD: Thanks very much, Pauline. Amy Cheslock is next. She's the Vice President for Payment Innovation for WellPoint, our partners in crime for this briefing. And just as CMMI is fostering new payment and delivery models for public programs and trying to entice private programs into them, private firms like WellPoint are full at it to test out new delivery and payment methods to achieve that triple aim that we keep hearing about, better health, better care, lower cost. And we've asked Amy Cheslock to describe some of WellPoint's efforts and the progress you're making and the challenges that you're encountering. Amy.

AMY CHESLOCK: Excellent. Thank you. I'm sure you all can hear me okay. I'm also pleased to be here today to talk a little bit about maybe the private insurance perspective on how to develop and deploy these models. I always like to start on this slide when I give these presentations, particularly to remind myself that we have been paying under predominantly fee-for-service system as an insurer for over 40 years. And the result of that is significant in terms of the way care is delivered and the way care is experienced by the consumer, and I like to think about the fact that the introduction of this patient-centered medical home model and the movement we're going through is really not a

tweak to the fee-for-service model but a fundamental shift, where we're really working to align changes in the way we pay with the changes care is delivered and the way we interact as a health insurer with the delivery system.

One of the things that I think is important to note is, you know, we firmly believe that primary care is really the foundation of the healthcare delivery system. While primary care itself might account for only 5 to 7 percent of the healthcare dollar, primary care can have an impact on all of the healthcare costs in the delivery system and, for that reason, it's an area that can have significant value. But it's also an area that we have typically under-resourced in terms of our payment models as well as the time and attention we focus on primary care, particularly as an insurance industry. And, frankly, we have a shortage of primary care physicians in this country and that creates real access challenges for members in the future. But we also know that investments in primary care can have significant savings.

The Primary Care Medical Home model, I think Amy referred to, really started around 2007-2008. We, as WellPoint, began implementing patient-centered medical home pilots around that same time. And we have accountability for Blue Cross and Blue Shield plans in about 14 states and we piloted those programs across, really, different states across our geography. We stood them up in Colorado, New Hampshire, New York, Connecticut, and California, as you can see here, and, you know, after more than 1 year in the program consistently we saw really substantial results. You'll see here, in Colorado, we found that through a medical home pilot we could achieve 18 percent fewer admissions, and 15 percent fewer ER visits. In New Hampshire we saw 3.6 percent fewer admissions and 6 percent fewer ER visits. And the numbers went on from there, but it was very important because it demonstrated a few things for us: that there were real savings results to be had with paying primary care physicians differently, that this was a repeatable process, and it really caused us to believe strongly that this was a change we had to advance across all primary care physicians or as many willing primary care physicians as we could engage with. And it really gave rise to a decision to begin rolling out a scaled primary care initiative across all of our 14 states and thinking long and hard about what were the models or components of this system that were most important to the scaled primary care model. And what we have here are sort of the four, I think, building blocks to what we call our Enhanced Personal Healthcare Initiative, or our patient-centered medical home effort.

And the first of those is payment innovation. We know we have to pay differently and that's an important component and that's the first building block. The second thing is around provider empowerment. As an insurer, we have access to a lot of information in claims data. We have not historically put that information in the hands of physicians, and so we had to do a lot of work to figure out how you could create actionable recording from claim information that would be meaningful to a physician taking a different type of accountability for a patient population. And that's given rise to lots of reports that we're working to put in the hands of physicians around what patients in their population went to

the ER that week, who's in-patient every day, information about gaps in care that we see or what we call a list of patients we would describe as potential hot spotters, because our predictive models say that they, having a care-gapper, they're going to encounter increased costs.

The third building block is this population health notion, which is really helping to think about, as an insurer, how we partner with physicians so that together we're taking care of the full population of patients. I like to say it's thinking about the patients that you're not seeing as much as those that you are, and treating them and reaching out to them in a proactive manner.

And the last building block is really about the individual patient and how you create personalized care plans for patients that have complex needs. This is historically been an activity that insurers did, spent a lot of time and effort on, somewhat in a silo from the delivery system with their own care management resources doing care planning and engaging with our insured population. And in the medical home model it's really our objective to figure out how we do that in concert and together with the care coordinators in the practice and the physicians in our medical home model, and how we can decide jointly about the care planning that needs to happen and where we can help as the insurer and where the physician, the care coordinator, has the best access to the patient.
So we basically said these are the four building blocks. We need to create a model around this and we want to push it out to all willing primary care physicians. That basically resulted in a couple of things for us. One is a new contract for primary care physicians where we pay a monthly fee, we say a PMPM—it's a per-member per-month fee—to really pay for and cover things that are not traditionally paid for in the fee-for-service model. We pay the PMPM fee so that physicians can do this care planning and care coordination, that they can designate a person in the practice to provide that care planning support, and they can engage and interact with patients outside of the traditional office visit through consults on the web, e-mail, and other ways.

And then we give physicians an opportunity to earn a percent of the shared savings that are created if healthcare costs are lowered as a result of the model, not just on the care that they're giving but the totality of the care for that whole population. And then we've also invested in resources, a different type of provider-relations function in the health plan where we have staff in the field that go out and meet with our practices and work together with them on patient-centered medical home, either providing support for the transformation, or helping to access and understanding the reporting and information that we've begun to develop and roll out.

We talked a little bit about this. This is a nice, I think, graphical of the kinds of resources we have. On the left top box under Anthem, that's our health insurance brand in most of our states, the kinds of people we have supporting this transformation in the field, we have a community collaboration manager that is really looking at needs that are common to all primary care physicians and how we can create learning collaboratives around

them, whether it's ways to get at ER visits or efforts around pediatric obesity. There's a whole range of topics that we're working with our community of primary care physicians on. Then there's a care consultant, which is an individual that works directly with the practices one on one on the kinds of reporting data and information we have, and we have a provider clinical liaison in our care management organization that's really providing that care planning and linking the health plan efforts together with the practice. And that is all supported by tools and resources and data in ways that we haven't traditionally had it. We have a clinical registry or somewhat like a light version of a longitudinal patient record where physicians can see claim information so they can know if patients aren't filling prescriptions, they've gone to see a specialist and weren't aware of that, and they can access the reporting that I talked about—those hot spotter lists that the care planning information on the ER visits that are occurring.

I'll probably just stop here to give you a sense of where we are. In early 2013, in January, we had just a couple thousand primary care physicians contracted in this model and, as of today, we now have 32,000 PCP's across the country contracted in this new payment model. We have a total of 110,000 physicians, PCP's, and specialists in some type of value-based contract. It's a significant component. And the PCP fund, it's over 30 percent of the primary care physicians we work with are now contracted in this model. And we have 90 health systems in accountable care contracts, or accountable care organizations, which is very similar to the medical home model.

One of the things I thought we'd end on is just a little bit around, you know, we feel like we have very successful collaboration with government around these initiatives. If there were a couple of areas that we think there's opportunities on the policy front, you know, one is around measure of standardization. You know, physicians will say that all of these programs have an important foundation in quality and measuring quality, which is critically important, but there is a vast set of measures adopted by private payers and public payers alike, and that it would be very valuable to create a standard set of core measures for which all payers, private and public, worked on so that there's a concentration of effort around a key set of measures as opposed to diffusion across many. And we think there's opportunities to continue to enhance the ability to exchange data, particularly around behavioral health, which is an important component of a medical home model for primary care physicians to understand behavioral health issues with their population, but it is difficult in the current environment to exchange that kind of information. I think we could foster better communication around that to improve the overall care that's given.

ED HOWARD: Terrific. Thank you very much, Amy. Do you want to give Dr. Frazer the clicker. We will now turn to Dr. Mark Frazer. Pauline mentioned something about a rock star small practice. I'll bet she had his practice in mind. He is a primary care physician from Middletown, Ohio where he's been running summit family physicians for almost 30 years. He, and his practice, are in the midst of a transformation. Actually, they're probably a lot further along than in the midst would signal, toward becoming a

highly functional PCMH, and he's here to give us a report from the front where the struggle is really taking place. Dr. Frazer.

DR. MARK FRAZER: Thank you very much. I want to give you a little bit of snippet of what my day started at. It's 4:15. I rolled out of my driveway listening to the American Trucking Network. It's a network that begins in Cincinnati, Ohio but it's broadcast all over the country by hard working truck drivers throughout the country. And guess what they were talking about? Inefficient healthcare, not accessible, too expensive, and they just didn't get it. That's how it started.

Yesterday I opened up the paper that spoke about improving the access of healthcare. Do you think they were talking about primary care? No, they were talking about the 8.4 million dollars of investment within 20 miles of my practice putting up four independent emergency rooms, fully functional by healthcare systems. Does that sound consistent with what we're trying to share today?

I talked to the cab driver into this nice city. I said, how do you like your healthcare? He said, well, I've got Affordable Healthcare. I like it. Last time I went to the doctor it cost me $800. I had to pay $200 of it. He was concerned about the cost. As we begin this visit I'd like you, personally, to reflect about your last visit to your healthcare provider. If you have a primary care physician think about the service you received. If you access only urgent care centers, think about the service you received there and how does that impact your overall care?

I'd like to personally thank CMS and WellPoint as part of this panel because they are two of the major funders of the CPCI project, the Comprehensive Primary Care Initiative. Without their support this huge transformation would not be occurring. And I'd also like to thank Amy with the PCPCC because they've been leading the charge for a long time.

I recognize that I share the experience of one practice, Summit Family Physicians, in Middletown, Ohio. But I also understand the responsibility that I have that hopefully you will be able to understand what's happening across 500 other practices within the CPCI as well as the thousands of other practices that are trying to take this journey.

Summit Family Physicians was founded by myself as a solo, independent practice in 1985. Even in 1985 people weren't smart enough or stupid enough to start their own practice. I decided I'd return to my home town and give it a try. It's been an outstanding experience. Middletown is a blue collar, Appalachian-based community. They all left the coal mills in Kentucky and moved up to southwest Ohio because we had huge steel mills and paper plants. You can understand some of the economic challenges we are having today. We still make daily hospital rounds at our hospital. We care for newborns up to 104-year-old patients. And, as most of you may know, most primary care physicians are no longer taking care of their own hospital patients. They are relying on hospitalists which is further fragmenting care.

Our employees are highly dedicated. Three board-certified family practitioners, one certified nurse practitioner who works 50 percent administrative to run our EMR implementation, to run the PCMH transformation, as well as the CPCI project. That was purposeful, it was planned, half clinical half administrative. We have 18 dedicated employees that are doing far more work than they ever thought that was possible. Our patients number six to seven thousand. Two years ago I would've told you it was twelve to thirteen thousand, but as we manage our patient population and when you're committed to managing patient populations you want to know who they are. Forty-five percent of them are over the age of 65, many of them are over the age of 80. In the CPCI project we care for 984 CMS patients and they are characterized as having a higher disease risk acuity than the normal population. Our office costs are higher than the average, but our hospital costs are lower. Do you think that's by accident? Our ER utilization is considered to be the lowest 25th percentile. That means 75 percent of all the other practices have higher ER utilization than we do.

As I stated, I founded the practice in 1985. I work full time as a family physician. I'm the team physician for Middletown High School for the last 31 years and I've served 16 years on the school board there in the community. I guess Amy would call me an old-timer and integrated into the community. And for fun, when I get a chance, I like to fly hot air balloons. My balloon, by no accident, is called Release. It is my release from the daily grind of medicine.

Our PCMH journey was started in December of 2009. Three days before Christmas, the partner that I thought would take over the ship when I left decided he would join administrative medicine and told me he was no longer going to be part of the practice. I hope nobody has to go through that. November of 2010 we attended our first PCMH meeting in Dayton, Ohio. April, 2011 we signed an EMR contract. We were selected to the PCMH cohort by the Health Collaborative in Cincinnati so we had assistance in this transformation and we hired our CNP, our Nurse Practitioner that we talked about, having 50 percent administrative and 50 percent clinical responsibilities. August 22nd, a day that will go down in infamy, we went live on our EMR. Ninety-two days later we attested to meaningful use stage 1 and I didn't think that was a big deal. You just bought an EMR, you told it to do the things you wanted it to do because you had standards that you needed to meet, and you just did it. But I guess the people from our regional extension center thought that that was pretty amazing. I guess it doesn't hurt you what you don't know.

August 2012 we were certified as a level 3 PCMH by NCQA. A lot of acronyms here, but it's the highest level you can reach. Basically it said, as if you're a pilot, you've learned the skills that you need to do, now go out and learn how to fly the plane. We were given permission to go out and learn how to become a PCMH. We took one deep breath and were selected in September, one month later, as part of the PCP initiative and then the work really began. December this past year we successfully completed year 1 and are

currently in the midst of year 2. And Pauline was clear to state that the responsibilities just keep getting bigger and better.

What was our motivation? I'm always intrigued by what makes successful people successful and what makes the ship turn a different direction. Our motivation was we truly believed the three positions and our nurse practitioner that the medical system is broken. You've heard of a lot of different ideas and attitudes to justify that belief. Primary care must be central to the care delivery system. Future reimbursements would be largely based on patient population management, utilization, and quality and you haven't heard anything different from our previous speakers. We also believe that the PCMH model is improving healthcare delivery, patient health, and potentially has the ability to lower costs.

What have our patients experienced since we've become a patient-centered medical home? We've always been accessible. Even since the first days I opened my practice we had evening hours, we had early morning hours, and we had Saturday morning hours. We had phone conversations available to our patients 24/7, we now have the ability to logon to our EMR, in fact, at six o'clock this morning waiting at the Cincinnati Airport, I was doing chart responsibilities, reviewing labs, sending patients messages over our secure portal, and also sending their lab results. Hospitalized patients are contacted within 48 hours of your discharge to reconcile medications, to ask if everything's going okay. Even though we see them in the hospital we are shocked at the number of people that have no clue what happens when they get home. We are shocked.

Emergency room visits, they receive a follow up phone call, they receive education about our patient access and our capabilities and we encourage them to call the office first. We've established referral tracking to our specialist to ensure timely access and follow up. All patients are risk stratified to alert staff of the care responsibilities with appropriate staff training so that they are better able to take care of patients.

Pauline's father would be a 3A patient within our practice. He would receive care coordination from our care coordinator, he would receive monthly phone calls to make sure everything is going okay, and the minute he walked in the door every one of our staff members would know that he needed extra services.

Patient education classes are established by partnering with pharmaceutical companies. Pharmaceutical companies are not a bad word. Aligning community resources with patient needs, we've done a much better job with that through our care coordination. Outreach to patients not seen in our office for chronic disease management and preventative care procedures take place. If you don't have your mammograms done, if you don't have your colonoscopies done, now we are able to access those type of lists and we, hopefully, will give you a call in a timely fashion or at least put a reminder in our EMR to address that with you the next time you come into the office.

What have been the benefits of change? Even though our staff is working harder, longer, they have greater satisfaction. I've had one employee leave since we started the process. I've had two retire. One was my office manager of 19 years. I find that it is easier to hire quality people because we are in the midst of this transformation. Patients are receiving more comprehensive quality care. Diabetes, hypertension, elevated cholesterol, they are accessing the emergency room less. Even though we're in the bottom 25th percentile we reduced our emergency room visits by 160 visits last year, or about 12 percent. Very consistent with Amy's statistics through Anthem.

And it's been enjoyable to be able to collaborate with like-minded practices.

What are the costs of change? Change is difficult, energizing, and exhausting. Open access reduces your scheduling efficiencies. Added care responsibilities reduce the number of patient visits we can see each day. Some providers in our practice are down as much as 20 percent. Increased staff increases patient costs, care coordination, additional medical assistant time, and RN hours.

What are the financial realities? Our revenue, not physician revenue but the payments into our practice, were flat in 2011 and 2012 When we were in EMR implementation. Most people will tell you that's great because just the fact of the MR implementation slows you down.

What happened in our first year of the CPC? Revenues actually dropped by 5 percent and office expenses increased by 19 percent. Now, again, the revenue decreased 5 percent which did not include the CPCI monies. Office overhead historically was less than 50 percent in our practice, which anybody in the industry will tell you we're running a lean, mean, fighting machine. But I'll also tell you that even with the CPCI money our office overhead increased 52 percent.

CPC, PMP revenue covers only 45 percent of our patient population. CPCI was trying to get above 50 to 60 percent, I believe.

What are the national challenges of our healthcare system? We've heard these before. It remains broken. We still have a primary care shortage. I have very large concerns about our ability, even with all the transformation we're doing, that we could recruit a physician to our practice. But that's not to say that Certified Nurse Practitioners or Physician Assistants are not quality people to bring into your practice. CNP's are ideal for this type of care model. They care, they're empathetic, they know how to ask the second and third question.

Specialty care still remains more highly valued as shown through current reimbursement. We were told at one of our recent learning sessions the only way to control specialty costs is to use the primary care to refer appropriately.

Hospital's insurance company's providers continue to operate in vertically aligned silos, and you heard Amy talk about that. That's one of the great frustrations we have in this project is trying to bring all the people together that we're supposed to manage and break down these silos so that we reduce redundancies. And EMR's still do not seamlessly share information.

Again, funding of the care management must be sufficient and continued through PMPM payments to make the transition possible, and it needs to approach 100 percent of your patient population. We are expected to provide the same services to 100 percent of our six to seven thousand patients, yet we're receiving reimbursement on 45 percent, and that's why we're extremely grateful to WellPoint and CMS for providing those funds.

Time is the most critical factor that's facing us right now. I'm working 14 to 16 hours days every day and I can't figure out whether it's because of patient-centered medical home model, or the EMR, or a combination all the same. But we are having to deal with more and more information and we have to figure out a way to be more effective so that I can fly that balloon more.

Realistic expectations as to what services and offices should independently provide—Pauline mentioned about bringing in pharmacists into a practice, bringing in mental health specialists into a practice. We as a for-provider practice have to figure out prudent ways to make those dollars stretch so patients still receive the services they need without spending all the money in those type of areas if we don't need it. That's why each patient-centered medical home may look a little different.

Amy mentioned about receiving quality data from hospitals and insurance to empower change—that is important. That's huge. Doctors are competitive. If you give us the data we'll find a way to improve it.

Connecting all components of the healthcare community is important. We've got to reduce fragmentation. Moving forward, the principles of primary or patient-centered medical homes should be adopted across the industry. Primary care must remain the center of the healthcare system. Primary care shortage must be addressed and if you improve reimbursement for care management that will improve. A physician will receive as much money for a 5-minute cataract surgery as I will by working a half a week trying to manage diabetic's, congestive heart failure, hypertensive patient's lists of medicines. Primary care physicians are important and we're going to make this work.

And if I can click it forward I'll finish up here. Here's the last slide. Somebody mentioned an old-timer and this group seems pretty young, okay? Marcus Welby, Moonlight Graham, Hawkeye Pierce. Hawkeye Pearce was on *M.A.S.H.*, Moonlight Graham was in *Field of Dreams* with Kevin Costner, and Marcus Welby, if you're over the age of 40 you probably remember his shows. They were the pioneers in patient-centered medical home. They sat around their dinner table with their family each night.

They were never busy. Their appointment rooms or their waiting rooms were always empty and they always had time to spend and deal with the needs of each patient. People who come up to the Grand Canyon, get out of the tour bus, walk across the paved walk and stand on the wall on the side of the road and are awed and inspired by its beauty. Imagine yourself being the settlers who first approached that big hole in the ground and said how am I going to get around it? Patient-centered medical homes, through all these initiatives, through all these challenges, we're the settlers sitting at the edge of the rim saying how are we going to get around it? It's beautiful, it's massive, but we're going to find a way around it because that's what patients deserve. That is really why Summit Family Physicians, of all the things that you've heard—the system is broken, our patients deserve better, and we're going to find a way to get that care to the patients who need it. Thank you.

ED HOWARD: Thanks Mark. [Applause.]

Heartfelt. And so content-filled as well. I've got a new name for your balloon. I think you should call it the Winds of Change.

MARK FRAZER: Winds are not good for balloons. [Laughter.]

ED HOWARD: We have microphones that folks can go to to ask questions. We have green cards that you can hold up and people will bring them forward, and let me just exercise a little of the Chair's prerogative here and kick this discussion off, because we came back to it so often that, although money isn't the center of the model, money is at the heart of the problem of making the model work as you heard so eloquently from Dr. Frazer. And I wonder if we could hear from our panelists about the parts of this model that seem not to be in control of the primary care physician or the primary care medical home, that is, the specialist referrals or seeing specialists, the specialist expenditures that constitute, as we have heard, the vast majority of physician costs anyway in the system. Amy, do you want to start us?

AMY GIBSON: Sure. So, a lot of the care that Dr. Frazer described, you know, care that he was doing at the airport this morning that under fee-for-service would not be paid for. He's utilizing his skill and his expertise providing care in a different way but it's still quality care and it's making a difference for patients but he's not getting paid for that. So that's part of the issue. The issue with specialists, again, a lot of the care that we talk about with team-based care, it doesn't mean that they necessarily even have to be in the same walls or in the same building to collaborate. But right now, in our model, if Dr. Frazer would call a cardiologist in his community to consult about a patient neither one of them would get paid if that patient's not in front of them. So there's a lot of care and a lot of things that can happen in partnership with patients, but in that fee-for-service model it can be very frustrating because nobody feels that they can give the time or the resources to do that on their own. So if we go to more capitated models and we think about ways to support this larger team-based care approach I think a lot of the ways that

care will be delivered will start to change as well and so there won't be the specialist saying that patient needs to come into my practice for that care, they would be willing to be able to have these conversations with primary care clinicians or other members of the team because that reimbursement doesn't stand in the way.

ED HOWARD: I just want to chime in on that. Amy, how does WellPoint encourage this without a wholesale redo of the payment arrangement?

AMY CHESLOCK: It's a great question. So we've scaled our primary care model but we are in the process of piloting how we bring specialists into that model. There's a concept called the Patient-Centered Medical Home Neighborhood, which is really—Amy had touched on it in her slide. So we now have 100 physicians in a pilot program and specialists—cardiology, OBGYN—where we are actually paying them a little differently under a fee-for-service model to engage in a care compact with primary care physicians and it's that care compact that really sets out the expectations around communication with the primary care physician, particularly those in our medical home models. And we'll be incentivizing that to occur relative to the payments we make to the specialists and measuring their adherence to it and also looking at quality outcomes for that as well. And this is in a pilot phase but with lessons learned from that, that's how I see us sort of rolling out an incentive that wraps around the whole neighborhood of care, aligning it to the home concept.

PAULINE LAPIN: And from the CPC perspective, we saw, in year 1, that 24 percent of our practices were focusing on that coordination with the ambulatory sub-specialists in terms of the kinds of relationships and referrals that need to be made between primary care and those other physicians. I think we're going to see that increase as the CPC continues. I think it is a challenge and I think we have a lot to learn about how to do this in the most efficient way so that everybody sees the value of working together to actually take care of the patient. And it's not just seeing the value. I think everybody sees the value. But really figure out the right processes to put in place to make it easier to do.

ED HOWARD: And are the actual compensation mechanisms different from one demonstration to the other?

PAULINE LAPIN: In CPC, I mean, in CPC and MAPCP, and FQHC, I mean, the money that the practices get is a per-member per-month—

ED HOWARD: Which is basically another fee for service.

PAULINE LAPIN: It's nonvisit-based. It's not fee for service. Fee for service would be something like, you know, you do a service you bill for it. Here you get the payment, flat fee, for a whole group of patients that are associated with your practice at one time. So it makes it a little bit easier to actually have that investment up front to be able to put into other kinds of strategies.

ED HOWARD: I'm going to shut up now because [Laughter] I have a bunch of other questions along those same lines, but we have a bunch of other people with lots more experience in this field than I who ask questions as well. Please identify yourself and keep the questions as short as you can so we can get to as many of you as we can.

STUART GORDON: Stuart Gordon with the National Association of State Mental Health Program Directors. At a time when there seems to be universal consensus on the need to integrate general medical care with behavioral health and particularly mental health, and at a time when the ACA created the health home model which treats mental health—which is a medical home and treats mental health as a chronic condition, except for Dr. Frazer expressing some aspirational hopes to incorporate mental health, I didn't hear much today on mental health and integrating mental health with medical health in the health home, or the medical home, I was wondering if you could each tell me what you're doing to encourage that.

DR. MARK FRAZER: I'll start on that one. Our practice plan, since we are smaller but yet we do take good care of a lot of mentally ill patients that need assistance, we are working very hard on the compact that Pauline and Amy have both mentioned, and that's to really develop a strong interactive relationship with one of our larger healthcare facilities in that regard so that we can integrate in that way. We don't believe, with our size, that we could afford or physically manage having an embedded person within our four walls. That would be ideal, but we believe the compact will allow us to learn from their experience and allow us to more effectively treat more patients ourselves and minimize the whole referral process. But I agree with you. It's a huge part of our practice that must be dealt with effectively.

PAULINE LAPIN: In year 2 of the Comprehensive Primary Care Initiative, one of the—our care management milestone actually requires the CPC practices to select one area of focus for the year and to continue for the remainder of the program. One of them is behavioral health integration and when we looked at how many—and I don't know the numbers right now off the top of my head of how many practices selected it—but there were three topics and that was, I believe, the second one that they selected. That said, there were some practices that actually, when they started CPC, had already had some sort of embedding of a licensed social worker, whether it was part time or full time I can't tell you, but there were a handful of practices that had already considered that. In addition, I've been looking at the states, or the CPC regions that also have Medicaid health home, and, for example, in Oregon, there is overlap in 16 practices, where 16 of the CPC practices are also Medicaid health homes. It did not appear that we had any in Ohio, and we're waiting for numbers in New York, but it will be interesting to see sort of that natural experiment, too, that's occurring in those practices.

ED HOWARD: Okay. Yes.

BOB BREWER: Hi. Bob Brewer at the BMJ. There's been a lot of consolidation within the healthcare industry—hospitals buying hospitals, health insurance companies buying hospitals, and vice versa, small practices, specialty practices—all of this consolidation going on. Is it necessary for this sort of coordination or can the coordination be done between independent entities, number one; and then, number two, is there sort of a critical size that has to be there to make this work, and when does critical size then start to become monopoly, or is it going to change depending upon the jurisdiction? Say Middletown may be more of a national monopoly where as D.C. would be able to support a number of large enough systems that are competing?

AMY GIBSON: Well, I can certainly contribute a little bit of what we're thinking about at the PCPCC. What Dr. Frazer described is certainly the most challenging and a size of practice that doesn't have the ability to really shift resources like larger health systems can to support a lot of these activities that we talk about in medical home. If they're not part of larger initiatives like CPC it's really, really challenging. And we're fearful that if we don't get an investment on a large scale for smaller practices to get the resources that they need—so, the financial, the expertise, the assistance to really lead a lot of these—I mean, Dr. Frazer is really lucky that he was able to be, not only a part of CPC, but also to have a staff person who's skilled that can donate 50 percent of their time to these efforts because it really has to be somebody's job within the practice to monitor the overall population, to look at the data in a different way, and to really make these connections across the larger health system. So we are very concerned as an organization. We want to do whatever we can to help drive some of the activities not only through pilot projects like that are going on at CMS, but in states as well to make sure that it's not just after the fact that they're a medical home that will pay you for these services, but to really make that initial investment up front to help them make those changes.

AMY CHESLOCK: I'll tack onto that a little bit and say that, you know, we're very cognizant of the fact that there's a lot of consolidation going on. I would say it isn't—I don't feel that you have to be in that consolidated large integrated delivery system to make this work. We are working with hundreds of practices, many of whom are independent physicians in this model. You know, there are pros and cons to every situation. I think Dr. Frazer illustrated nicely what a well organized, independent small practice can do in terms of being nimble, and being able to really tackle these challenges. It's really about the experience at each patient level, and you don't have to be a huge institution to make those changes and to do that. Now, there's certainly, being in a large integrated system, there are resources, as Amy touched on, care coordinators and other things that are more easily financed, but there's challenges in terms of the communication and the pace of that evolution as well. So I don't think that consolidation is the most critical aspect for driving success.

DR. MARK FRAZER: I agree. I don't think size is the determining factor. It's your willingness to embrace the model. It's your willingness to ask the second and third question. I spent 20 years of my practice priding myself that I, how do you get through

your schedule? I only ask one question. Now my schedule is slower and I'm asking the third, the fourth, the fifth question because when someone comes in and fails and ends up in the hospital I don't think, oh, they're in the hospital. I think what should have I, what could I have done differently to keep them out of the hospital. So, it's not size, it's the attitude as long as the resources are there for both.

ED HOWARD: Yes. Go right ahead.

DR. CAROLINE POPLIN: I'm Dr. Caroline Poplin. I'm a board certified general internist. I see patients now at the Arlington Free Clinic. I was in a medical home in a large vertically integrated system and it was really awful. I had to meet all kinds of numbers that I had no control over. Many of them were kind of silly. I had to waste my time on that. We had an EHR that was a problem, not a solution. We had to work around it. And I have a father who is as sick as the father of the lady who presented. He has congestive heart failure, diabetes, peripheral vascular disease. He had strokes, he had diabetes, he had renal insufficiency and he was depressed and he broke his hip. And the problem was not that we didn't have a nurse coordinator or an educator. The problem was that—this was at the Partners in Boston, in these hospitals—but, which had electronic health records except, as far as I could tell, nobody ever read them. We needed an internist. We didn't need a nurse practitioner. We needed somebody who could look at the whole picture and see whether his heart failure medicines were making his renal failure worse. And our internist never had time to do any of that. So, we had special teams running around all over the hospital, working at cross purposes, and he died. He probably could've done much better and lived much longer with better care. But the point is, primary care is not a one size fits all. My father needed a lot of time and thought. Some of the people on this panel are young and healthy. They don't need primary care at all. They should be out of the medical system. Make a visit once to see who your doctor is and then don't come back unless you're sick. But the medical home requires that you take care of all of these perfectly healthy patients in order to generate some money to take care of the sick ones and it might make more sense to just pay for the sick ones. If you don't get paid for making phone calls pay for it. If you don't get paid for transitions of care pay for them. With a sick patient or a demented patient pay the doctor more to see that patient. Don't pay the same thing for everyone. Instead, we have this huge super structure of—okay. Comment. [Laughter.]

MARK FRAZER: As a physician to physician I respectfully disagree with your position. I think that we can keep your father healthier longer under appropriate care and when we talk about per member per month it's not the same. Sicker patients get more per member per month payments. And all services are not allocated to everyone equally. My level 1 and 2 patients get much less services than my level 3 and 3A. But my staff know about every one of the patients because it's right there on the top of their problem list what level they are. Services are allocated appropriately. Younger people get their preventative services so that they don't get sick or at least get sick less often, and your father, again, is a 3A. They're going to receive more services and they're going to try to

be coordinated. But if a primary care physician, an internist, a family practitioner, is not coordinating that care you can't expect the other spokes of the wheel to coordinate that care as well as the quarterback and the center.

DR. CAROLINE POPLIN: Okay, but he needs to be paid for that.

DR. MARK FRAZER: Under this system we are.

DR. CAROLINE POPLIN: Not the same as you pay for a young healthy person.

AMY CHESLOCK: So, the PMPM payment is substantially different based upon the acuity of that patient, so there is a very, very amount paid for chronically costly versus young healthy.

ED HOWARD: Pauline.

PAULINE LAPIN: Yes. I'm very sorry about your story and, unfortunately, it's not the first story that I've heard like this. In CPC we actually require that the practices do risk stratification and empanelment to a care team. What that means is that these practices are looking not just at, you know, claims data, they're looking at socioeconomic factors, home life factors, what they can glean from being with a patient or in thinking about how to stratify, and that's what Dr. Frazer was referring to when he talks about the 1, 2, 3, and 3A. And then, the practices actually triage their resources appropriately. A young healthy patient is not going to get care managed. They're going to be identified as young and healthy and low risk, and they won't need all the services. The services that the practices have will go towards the people that are higher risk and those practices are going to be compensated. We actually pay on a risk stratified payment scale where the patients that are Medicare and low risk, those practices get $8 per member per month payment for them, but those at the high risk level, they get a $40 per member per month. So there is a big difference between what we are paying practices in terms of resources for taking care of people who are high risk compared to the lower risk.

DR. CAROLINE POPLIN: Well, I'm sorry but I guess nobody ever mentions that. And we, our patients were all treated the same. This was Bethesda Naval Hospital.

PAULINE LAPIN: This approach isn't uniform across all primary care across the country yet, but this is the approach that we're trying to take with advancing primary care. And hopefully, one day all patients will be care managed or stratified, impaneled to care teams for care. That is the hope, that is the goal. There have been studies that have been done around triaging resources to the highest risk, the importance of risk stratification, and so we know the value of it. But thanks for your comment.

ED HOWARD: And was it you, Pauline, who mentioned that there is an initiative that's built on the hot spotters' experience, where you're really channeling resources to the people who have high levels of acuity?

PAULINE LAPIN: We don't have a model per se—oh yes. Independence At Home is one that looks at, I wouldn't even call it hot spotter, but, yes, I guess they would be. These are patients who have trouble actually getting out to go to the primary care doctor, so the primary care doctors go to their house and take care of them at their house.

ED HOWARD: Alright. Thank you. Yes, go right ahead.

CLAUDIA SALZBERG: Claudia Salzberg, Johns Hopkins Bloomberg, and thank you to the panel for a great presentation, first of all. In the same way that we're struggling to define PCMH nationwide and we're struggling to implement it, we're also struggling to evaluate it. And so I was wondering if you could, any and all four of you, speak to the lag time between when you complete implementation and payment reform and when you start noticing these great effects that you quoted earlier. Thanks.

ED HOWARD: Yes. If Dr. Frazer is right it's a lousy business model. If you manage to do good but do poorly financially you're not going to be around in five years. So what's the turnaround time?

AMY GIBSON: Well, one of the things that we've seen with early outcomes on patient center medical home, one of the first things a lot of practices are able to address is the access issue. So you heard Dr. Frazer talk about, you know, decreased emergency room utilization, and Pauline as well, so when you improve access and you really structure your team in a way that you can respond to patients so that they don't end up in the emergency room when they don't have to that's one of the first cost savings that we see with medical home. And that can happen pretty quickly when you expand access. The next one is the rehospitalization. So, when you start coordinating care, when you start doing those follow up visits and start to find out what the needs of these patients are, or actually, for a lot of practices, even find out they've been in the hospital in the first place, because a lot of them don't even get that information. So that's another area where we start to see some quick cost savings. Then to see the outcomes change it gets a little more challenging, because then you have to really start to impact the actual health or whether or not a patient gets sicker down the line. So the idea is not to take away their chronic illness but to give them the skills and the support they need to better manage those chronic conditions so they don't develop more or develop more adverse outcomes from those and that's where it gets a little harder. And even in response to, you know, talking about patients that are kind of the hot spotters, the ones that are real high utilizers, some are saying they need a whole different set of services. Because if you've got patients that are dealing with severe mental illness, that are homeless, there's all these other things that are impacting their ability to even interface with the healthcare system in a way, or manage their chronic condition that's so exacerbated that they almost need a separate

level of services that's much more intense and it's more costly to do on the front end but they've shown that they can make some real strong outcomes on the back end. So, again, in the first couple years we can see some quick cost savings as it relates to access but then it's going to take 5 or 6 years to really start to see some of the impact related to health outcomes, is what we're finding.

ED HOWARD: Amy, your slide said that you had started some of the pilots in 2007, or 2008. So, are those pilots now beginning to show the kind of financial results that we would hope for?

AMY CHESLOCK: Yes. The pilots that I had spoken to, those results occurred earlier, so they started in 2008, but we began seeing those results after the second and third year. They were generally practices that were more advanced along this path, so we don't think it's exactly indicative of what you would see sort of universally starting with a more mass rollout, but we saw very significant results within the first two to three years on those pilots.

ED HOWARD: That should be encouraging to Dr. Frazer.

DR. MARK FRAZER: And that's the point I wanted—I'm not discouraged at all about the finances of patient center medical home. I give those numbers because, one, they're real and I wouldn't have increased expenditures by 19 percent had I not had the funding from the CPCI project. But I wouldn't be able to deliver the same level of services either. The message is, that if you want to fully implement PCMH in medical practices you have to provide adequate PMPM for each patient in that practice because you can't segregate and say, well, you're getting paid a PMPM so we're going to give you these services, and you don't give it to the person whose insurer is not paying you. It doesn't work that way. Practices, from an efficiency point of view, need to provide services for all and so, again, it's not a discouragement but, for the organizations you represent, for the legislators you represent, send clear the message that PCMH is a quality program that is going to improve the care patients receive, reduce costs eventually, and I think there are very short term cost savings immediately. The 160 people we kept out of the emergency room last year paid for all the funds that were paid to us is our belief.

AMY GIBSON: But let me be clear, too. We don't ever anticipate that the primary care costs are going to go down. Those will always go up as we expand the care and the team. And so, when you see those cost savings they're not in primary care they're elsewhere. So that's why other programs, like ACO's and shared savings programs, are so important because when those savings happen somewhere else in the healthcare system we need to figure out how to drive those savings back to primary care to support those services there.

ED HOWARD: Yes, ma'am.

SUZANNE MINTZ: Suzanne Mintz, Family Caregiver Advocacy. In your high acuity patients who have family caregivers I haven't heard any mention about caregivers being integrated into care teams at all and was wondering how that plays into all of your work.

PAULINE LAPIN: So, in CPC we do have, as part of the functions of a practice, we actually have patient and family caregiver experience of care as being an important piece. There's actual training. We're working with the National Partnership for Women and Families about how these practices can do this best. In terms of the care management, in some cases the patients are coming to the practice with a family member and when they meet with the care manager or the physician in the practice they're getting the same information, they're learning about what they need to be doing to help their family member manage their diabetes or whatever condition it is. In some cases, there are some practices that are having the patients actually submit their numbers, whether it's their blood pressure or their sugar levels. They're getting help from family members in terms of how to make sure that that is happening.

SUZANNE MINTZ: And are we doing anything to help the family members?

PAULINE LAPIN: Oh, you're talking about the social support to family members.

SUZANNE MINTZ: Education, social support—just looking at the whole picture and if the caregiver is doing all this stuff they really are care team members.

PAULINE LAPIN: Right.

SUZANNE MINTZ: And need to be integrated and treated that way.

PAULINE LAPIN: That's a great point. I think that we're beginning to build out, each year, as I said, we're trying to advance on each of the milestones, so actually thinking about how to provide more of that maybe even social support to the caregiver. I mean, being part of a care team, I think, is happening in some practices now around these high risk patients. Not in a form way, obviously, but learning and training about taking care of certain conditions along with the patient. But I think it is an area that would be worthy of further build out in the future.

SUZANNE MINTZ: I'll send you an e-mail.

PAULINE LAPIN: Thank you. What was your name?

SUZANNE MINTZ: Suzanne Mintz.

DR. MARK FRAZER: Our practice spent a lot of time developing a community resource book so, again, recognizing that we don't have to necessarily provide all the services, but we have to be aware of what services that can be accessed by those family

members and caregivers. So it's, again, the primary care office needs to be the quarterback of services that can direct people to services that we cannot provide within our office and then provide appropriate follow up to make sure that it's been secured and they've received the services they need.

ED HOWARD: Okay. We're going to go over here. I think you've been waiting.

CHARLATE SNAPELL [Phonetic]: Thank you. My name is Charlate Snapell [Phonetic] and I work for D.C. Medicaid and we are in the midst of developing a health home model that integrates behavioral health—

ED HOWARD: Could you stand a little closer to the microphone.

CHARLATE SNAPEL: Yes. Sorry. So, just saying that I work for D.C. Medicaid. We're in the midst of developing a health home model that's similar to kind of PCMH. And I wanted to just ask the question, Ms. Gibson, at the beginning, you referenced the *JAMA* article about the Pennsylvania PCMH model, and I think a lot of states are kind of looking at Pennsylvania because it had a lot of pieces that we thought were going to be really important including the multi payer piece and the quality improvement piece and, you know, I think a lot of us were surprised that it didn't yield more results. And, you know, that's not the only example. We know that there are health home programs that haven't yielded any savings after two years and so what we're really trying to get a handle on is what are the elements that are critical to making these programs successful? Maybe I'll just leave it at that.

ED HOWARD: And can I supplement that question. I was looking for a way to introduce this card-based question, and it has to do with the same general area, that is, the fact that some studies seem to say that PCMH's are saving money or improving care coordination, some do not. How are you going to tell how to compare these studies and make sense of the conflicting results?

AMY GIBSON: Well, let me take a first stab at that. So speaking specifically to the *JAMA* article, so we know that they've been working for quite a while on medical home around the chronic care initiative in Pennsylvania and interestingly enough, when they started to look at the data, in particular to this study, this was just the first of several studies that were coming out. Right on the heels of that we saw several studies that emerged that showed there were great improvements. One of the concerns we had about that study was that it looked at the population at large. So when they specifically started that program and they were looking at their interventions they were looking to change the way they were delivering care for asthmatics, mostly in pediatric population asthmatics, and diabetic patients. But in that study they didn't take that so much into consideration and looked at the broader population of patients, so they weren't specifically looking at where that intervention lay. The other concern that we had with that is, because we know that this is a model that is always evolving, there were several changes that were kind of

tweaked in that model along the way that weren't taken into consideration as part of that study. They introduced a care manager role that they hadn't had before. So they saw a lot of the major impact of that program happen after the data was collected and evaluated for that particular study. So, I'm excited to see that in your materials there were several follow up reports that came out as part of that larger study in Pennsylvania that did who positive outcomes. I think some of the very important things that need to happen to make medical home successful, what we've seen, is again, it has to be somebody's responsibility in the practice to make sure there's ongoing quality improvement. It can't be just someone coming in from the external and saying that you need to do this and that this needs to be all part of everyone's job. You know, if it's everyone's job it's nobody's job. There has to be someone dedicated in the practice to monitoring these quality improvements. Are they providing the right amount of care for the right population of patients? Are they addressing the concerns of patients when they come in? Another factor that we've seen has been so successful, and Pauline spoke to this, is actually getting patients from that practice involved in the process, and involved early on, because it's amazing the feedback that patients will give you, and they want to help. They don't want to be there just to badger you and tell you all the things that you're doing wrong. They really want to be a part of improving care in that practice and they can make some incredible suggestions for a way to improve care. And they also kind of hold your feet to the fire. They keep you accountable for doing all the things that you said you were going to do because they want to be part of that process. So I think that's really important. And then, really understanding the dynamics of the community. What are the resources that are available and how can you better connect those two to the medical home and to the primary care practice at large. So I think those are some of the things that we've found that really do make the efforts very successful.

ED HOWARD: We have time probably for the two questions that we have represented by the two folks standing at this microphone. Let me just ask, as you listened to this last bit of exchange, that you fill out the blue evaluation forms that I called your attention to at the beginning of this session, and Bob, go ahead.

BOB BREWER: Thank you. Bob Brewer, BMJ again. Much of what we've been talking about has been embedded in the concept of ACO's, Accountable Care Organizations. There's a lot of overlap with two of them, and we talked a lot about better coordination of care, resulting in better outcomes, often long term and better savings and things. Has anyone thought about, or did, better yet, is there data—it seems to me these systems reduce the incentives and the opportunities for fraud. Has anyone looked at that aspect of it or thought about it even?

PAULINE LAPIN: We think a lot about, actually, program integrity issues at CMS and have been thinking about how we monitor for this and we are incentivizing different kinds of behaviors. We talked with our office of Inspector General often, we have a whole center for program integrity at CMS, and are talking about how we put together a fraud prevention system, you know, geared to really monitoring potentially what could

happen as an outcome of these new payment incentives from these value-based kinds of models. I don't have any information to share today about what we're learning but I do want to confirm that we do think about it a lot and we have teams that actually that is their job, in Innovation Center, is to actually talk to the Inspector General, talk to the fraud folks in the Center for Program Integrity, and come up with how we're going to monitor all of our models for program integrity issues.

AMY CHESLOCK: I would echo those comments and just say, you know, I think there is the potential, over time, in a very different model with patients aligned to an Accountable Care Organization or a medical home that there's less incentive and potentially more protections to fight against fraud. I think it's still important, we believe it's still important to have strong fraud detection efforts as well underway. There will always be patients not attributed to this type of population and providers outside of that that have the ability to bill. So for the foreseeable future I think we have to keep a strong detection system in place. I think it could provide value over time. It's not one of the immediate areas we're targeting as an immediate driver of savings, but it's certainly an important component of controlling healthcare costs and being sure we're able to re-direct wasted spending into better quality care.

ED HOWARD: Okay. Go right ahead.

JINYANNA: Hi, my name is Jinyanna [Phonetic]. I'm a third year internal medicine resident in Philadelphia. I noticed that some of the panelists comment on patient satisfaction, and how is that going to be integrated in the PCMH, and I'd like the panel to comment on some of the conflicts that arises from patient satisfaction versus physician autonomy, particular on the issue of opioid abuse. My hospital in Philadelphia, and that's a very daily reality for us, so I want the panel to comment on how can physicians be able to do the right thing for the patients and not be penalized by patient satisfaction discourse?

AMY GIBSON: So I think what we do in medicine a lot and healthcare systems is we do patient satisfaction surveys but we don't really ask good questions. So I think one of the things that we're trying to advocate for and want to be a partner with at the PCPCC is to better ask questions of patients that reflect the model of medical home care. So what are the real experiences with the healthcare system? So, questions like did you get a care plan when you left the practice? Were you able to contribute your own personal goals as part of that care plan? Do you know who you can call in the practice if you have a question after hours? I mean, there are some questions that we need to ask in a better way that's actually going to give us good information on ways to make quality improvement decisions even within the practice. So, I mean, I think we're always going to have outliers, but I think we need to ask questions that are better than, you know, how long did you have to wait in the waiting room, not that that's not important to patients because I know it's important to me, but you know, I think we need to think of better questions to ask that really reflect the model of care and also reflect the care that's being provided by

the team at large so that you can have the data on the one end that you're reporting on the payment side or reporting within the healthcare system about the services that were provided, but then also balancing that with the actual patient's experience in that kind of care.

ED HOWARD: Alright. I believe that is the definitive final word, Amy. And I want to take this opportunity first to apologize to all of you who wrote questions on green cards. I've tried to integrate some of them into the conversation but we were blessed with a plethora of oral questioners that allowed us not to get to these cards and I don't want to discourage you from filling them out, but you can take your turn in the sun next time to make sure that your question gets asked.

Thanks also to our colleagues at WellPoint for helping us put this program together and co-sponsoring it. Thank you for asking lots of good questions and I ask you to join me in thanking our panel for a very enlightened discussion.

[Applause.]

And we'll come back to this topic, I'm sure. One final commercial that was raised by the last questioner, the Alliance is scheduled to conduct a briefing featuring a discussion of the pain killer abuse problem and how to deal with it. I think it's on June 20th. Does that sound right? So, watch your mailboxes and we'll try to pick up the thread then. Thanks very much.