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## **Urban Medical Symposium: Shock to the System: Preparing Primary Care for the Baby Boomers Urban Medical April 4, 2008**

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**SUE COFFMAN:** I'm Sue Coffman. I'm the executive director of Urban Medical Group. I want to welcome everyone here this morning. We are really thrilled that so many people have come out; especially knowing how busy you all are that you've taken a Friday morning out to come and participate in what we think is a very important dialogue today.

Urban Medical has been providing primary care to people in Jamaica Plain and surrounding communities for 30 years, focusing in particular on the elderly, chronically ill, and complex patients. There is more about Urban Medical in your program book and I hope you will take the time to take a look at it.

An important part of our mission is to provide leadership around innovation and new models in primary care. Building on that mission and in honor of our 30<sup>th</sup> anniversary, we convened this symposium. Our goal is to look at the opportunity that we have to build a primary care system that can meet the increasing medical needs and demands of the aging baby boomer generation with high quality and with cost effective care.

We are absolutely delighted at the panel of speakers we have today and I want to say that none of this would have been

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possible without the support we've received from a wide variety of sponsors and we are very grateful to all of them.

I want to particularly acknowledge our prime sponsors, the Beth Israel Deaconess Medical Center and Care Link for their generosity. We are going to move straight into our first speaker, Dr. Harvey Fineberg and our moderator, Dick Knox. I'm delighted to say I have the pleasure of introducing our moderator Richard Knox. Since 2000, Knox has been a science correspondent for National Public Radio where he has covered a broad range of issues and events in public health, medicine, and science. As those of us in Boston remember well, before joining NPR, Knox covered medicine and health for the *Boston Globe*. His award winning 1995 articles on medical errors are considered landmarks in the national movement to prevent medical mistakes. At Urban Medical, we remember him both for his eloquent obituary of our founder, Dr. Marie Felton, and for his definitive 1983 article on our organization entitled "A Quixotic Medical Band in Boston, the Urban Medical Group Serves Needy Patients." Please join me in welcoming Dick Knox.

[Applause]

**RICHARD KNOX:** Thanks very much, Susan. It really is an honor to participate in this session on this occasion. Like many in this room, I can remember when Urban Medical Group was an innovation. As Susan mentioned, back in 1983 I called it in

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the *Globe* a "quixotic band of doctors and nurses." I meant that as an ironic compliment. My favorite people in medicine and public health have at least a touch of the quixotic and sometimes a virtually self destructive case of it. [Laughter] The Webster's collegiate definition of the word is "foolishly impractical in the pursuit of ideals."

Well I don't know about foolish although in an article about the Urban Medical Group, cofounder Marie Felton 13 years later, I quoted one former member of the quixotic band, Dr. Margarite Collins, described in the UMG as the most underpaid group of physicians that ever walked the face of the earth. [Laughter] Whether that's foolish or not, I leave you to decide.

Certainly the UMG was wise beyond its time in understanding what was wrong with the usual way of practicing medicine, metering out services, encounter by encounter, and procedure by procedure, without regard to the needs of the patient on the receiving end of care.

The UMG docs and nurses and NP's weren't the only ones who understood the wrong headedness of that. For instance, Dean Bob Ebert put Harvard Medical School's prestige behind another alternative called the Harvard Community Health Plan but the UMG set itself the hardest course by administering to those with the greatest needs and by validating that model.

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Even so, sadly, the alternative path at UMG and some others blazed while no longer a fresh new idea is not yet the mainstream model.

Meanwhile we stand around ringing our hands, so with this steady decline of even ordinary primary care, while the generation I represent inexorably ages into our medically neediest years with impossibly high expectations of medical and nursing care. It doesn't have to be this way.

This week I came back from Germany where I spent a couple of weeks talking to front line docs, academics, and policy makers about how they do it. How does Germany manage to provide health care for 99.78-percent of its population? That is their figure. They are very precise, with some of the most comprehensive benefits in the world at about half the per capita cost of our system? It's the same question I took to Germany 17 years ago when we all thought we were on the verge of an epic making health reform, and I thought Germany with it's complicated employment based system of non profit sickness funds provided a more likely model for reform than any other countries and comparably complex to ours.

I didn't come up with a satisfactory answer to the how do they do it question in 1991 and I can't say I have one now. I was impressed all over again with what I saw when I sat in on doctor patient encounters in the offices of general

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practitioners, went out with G.P.'s on house calls, yes the average German G.P. still does house calls, and spent 48 hours with a German G.P. over Easter weekend when he was the designated on call doc for his region.

All ambulatory physicians in Germany must do this duty or pay someone else to cover for them. Certainly German patients see their physicians more often than Americans do. Their expectations of medical care are very high, higher than ours it seems to me, and as far as I can tell the quality of care is very good. Certainly German doctors are very available to their patients, even to those in nursing homes.

Germans, like Americans, worry about caring for a population that is aging even more rapidly than ours. German doctors, especially primary care doctors, complain about inadequate reimbursement. That is an inescapable result of the fact that for nearly two decades, German doctors have been on a strict yearly budget and the average German insurance premium may not rise faster than the average German wage.

Remarkably there are actually fewer primary care doctors than here, one in 1400 Germans compared to one in every 1100 Americans. I am not suggesting that we could just emulate the Germans if we could and be okay. Clearly they are facing the same pressures and are rightly worried about the same things we are. One big difference between the two systems is

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there is a bedrock principle beneath the 125 year old German health system that we lack, the notion that every person is entitled to coverage and that the well should pay for the sick, the young for the old, the more advantaged for those with less. They call it solidarity.

Another difference which flows from this is that when things begin to go wrong as they will, the political system responds. It's amazing. Whenever slight inequities show up, there is bound to be another reform to keep the *gesundheit* system from running off the rails. Meanwhile, we Americans are waiting again to see if our political system is up to the task. That question is bigger than this morning's agenda but we are privileged to have some of the most experienced thinkers anywhere on the subject of primary care and the tasks ahead, starting with Harvey Fineberg, president of the National Institute of Medicine. He's been familiar to many of us for many years before he ascended to that august national position. I guess my first contact with him was about his and Richard Newstat's admirably clear analysis of Gerald Ford's decision to vaccinate all Americans against swine flu, which 30 years after its publication still holds lessons for us as we contemplate the next pandemic or possible pandemic.

Dr. Fineberg went on to author and coauthor many books on medical decision making, physician education, AIDS

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prevention, vaccine safety, and the perception and understanding of risk among other things. He found time to be dean of the Harvard School of Public Health for 13 years and then provost to the University between 1997 and 2001. At the IOM, Harvey has chaired and served on panels dealing with issues ranging from AIDS to new medical technology. With his long focus on how medical decisions get made and implemented, he is the ideal speaker to keynote today's proceedings with a talk on primary care as the key to patient centered quality. Harvey? [Applause]

**HARVEY FINEBERG, MD, PhD:** Thank you very much, Dick. It's really a pleasure to see you and Sue. It's a pleasure to be here with you. I have to say it's very much a feeling of coming home for me to be here.

When I hear Marie Felton's name for example, I think back when my wife Mary Wilson and I were both at the Beth Israel Hospital then, the Beth Israel not yet the Beth Israel Deaconess Hospital, in that time when Marie was a resident along with Mary, I think the only two women in that year as a matter of fact. How things have changed for the better in that respect, and even then Marie Felton was a pioneering spirit and just a wonderfully engaging and warm, caring physician and she's still a model for any of us who knew her at that critical time.

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And the Urban Medical Group was part, as Dick has said, of a set of innovative, imaginative, patient centered and absolutely dedicated new innovations for medicine and what I wanted to just put into context for today's discussion is the way in which thinking about quality of care for patients is connected intimately to the challenge of dealing with an aging population and the health care needs.

And I want to point out what I call a dangerous divergence between all of the forces which are acting on health care and on individual physicians and nurses and other care givers and patients and families as distinct from those things which we all know and which the Urban Medical Group has epitomized are necessary to provide high quality patient centered care.

You know when the Institute of Medicine looked at this question of safety and quality of health care, which were just a few years after Dick Knox' path breaking series in the *Boston Globe*, the Institute of Medicine said there are six dimensions that make up quality. Health care has to be effective and it has to be safe. Those are two. It has to be timely, it has to be efficient and equitable and it has to be patient centered and patient centered care in my estimation is actually the least well developed, understood and practiced component of all these dimensions of quality.

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I believe if we are going to respond to the crisis that is the back drop for today's program, we have to return and continue to think about patient centered care. What does that mean? And what does that require?

If you think about the challenge of quality of care for the whole of our population, we are falling short on many dimensions, despite the fact that according to a recent survey of the public, more than half the people in the United States believe that the United States has the highest quality care in the world. Maybe it does for those who are lucky enough to be in the privileged set, but on average and compared to many countries in the world, in fact a growing number, we don't really stack up. We are not in the top 30 countries in infant mortality any longer. We are not in the top 40 countries in life expectancy at birth.

Dick alluded to the experience in Germany, a study by McKenzie analyzing the difference between Germany and the United States and the way in which resources were actually deployed did not find big differences in the services that are actually delivered to patients, the amount of time and effort devoted, the big difference was in the administrative costs of managing the system. That was the largest discrepancy between the US and the German system.

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Mary and I were recently in the country to Singapore, this tiny island in the south of Malaysia, about 4.5 million people, a place that is just two degrees north of the equator. It's a tropical zone. It has no natural resources. It doesn't even have fresh water. It imports water. All it has are people, its people. That is the only natural resource.

In the mid 1950's in Singapore, life expectancy at birth was eight years behind that of the United States. In the year 2000, it was about comparable. Today it's estimated as of 2007 life expectancy at birth in Singapore is estimated to be almost three years longer than on average in the United States of America.

So while things in a sense have been improving in the United States, infant mortality, while it's leveled off in the last few years, life expectancy still increasing every year, we are not keeping up with the pace of what contemporary technology, organization and delivery can accomplish and is accomplishing in other countries around the world.

When you compound this general picture with the challenges of an aging population, a population which is expected to be 78 million strong in the baby boomer generation, coming of age, age 65 in just another few years, between then and 2030 another 78 million, you think about that just opposed against for example the number of people electing as physicians

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to go into geriatrics, which is as you know declining, approximately 230 per year, fewer than the number retiring each year in recent years, you think about a health system which is oriented still primarily around acute care, diagnosis and treatment of individual diseases, where the needs of elderly citizens are not acute diagnosis and treatment but management of chronic diseases, the typical patient 75 years of age has three conditions that are chronic diseases and on average is on four different medications and more.

And when you think about the way we test medications by the way, number one we don't test them in the elderly and number two, we don't test them in combination, one to the other, and so the risks that we are applying to our elderly population without an adequate database are very substantial, on medication, which by the way continues to this day to be the single area of greatest safety problems in health care, errors in medication. The problem is even if you get the medication intended in the dose intended, it may not be the right combination. It might not be the right combination of dosage and it might not be the right duration for patients in an aging group.

The Urban Medical Group stands as a kind of light on the hill in contrast to all of these forces that are arrayed

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against high quality patient centered care for an aging population.

The needs of patients by teams of caregivers, meeting doctors and nurses and others who are going to deal with the problems where they are, in the home, in the nursing home, in hospital, wherever it is needed to give the care, a system of care that thinks first about the patient's needs and the way of managing and coping with illness, ailment, disability, immobility, incontinence, loss of reserve, which really epitomizes the key problem that characterizes an aging population, these understandings are not naturally going to arise just by virtue of experience treating patients in the acute care model.

Otherwise, every doctor would be a geriatrician. Every doctor is seeing patients who are an older population, they require a system, an orientation, a set of skills and an understanding that quality care means patient centered care.

So I am really proud and delighted to be part of the program this morning. My hat is off to the founders, the physicians, the staff at every level who make Urban Medical Group the symbol and the achievement that it is. My only regret and I was mentioning this to Tom just a few minutes ago, is that there are not 1,000 Urban Medical Groups around the country. That is really the philosophy, the practice, and the

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quality of care that our country needs and that our older citizens deserve. Thank you very much. [Applause] We have a few minutes for questions, if there are comments or questions that anyone would like to raise?

**MALE SPEAKER:** Hi Harvey. Thanks for those wonderful comments. You know, when you say that there should be 1,000 Urban Medical Groups, of course everybody would agree with you. The question is why there aren't, and the question is to me, as someone who has been so involved in policy, I wouldn't ask you to resolve the issue of how to create 1,000 of them but how do you start do you think the process of creating 1,000 of them?

When you see the *New York Times* two weeks ago pointing out that plastic surgeons make \$450,000 a year, dermatologists make \$460,000 a year, and family practitioners make \$170,000 a year, where you have a system if you have a market system what do you do? I mean you can see why the residents don't come in to family medicine with those incentives.

**HARVEY FINEBERG, MD, PhD:** Well let's start with the choice of specialty and practice, actually later this month the Institute of Medicine is going to be releasing a report on the health care work force for an aging population and what we need to do. It is certainly the case, actually for those of us who went through medical training a generation ago, it's truly impressive how interesting dermatology has become in the last

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generation [laughter] and I know skin is very interesting.  
[Laughter] It is. It is. But I still am impressed when you read the explanations of career choice that individuals put forward in terms of where they are choosing to go.

There is no doubt personally in my mind that how we pay for medical care is a serious part of the situation and the concern. In a way we have really you could say really three choices for doctors. They can choose the lifestyle practices. They can choose the procedural practices or they can choose the caring practices. That really, those are the choices. And what we need to do is be able to reinforce in every way from education and from incentives and payment the caring choices in my opinion. I would love to allow those who really, really are fascinated by specialty and procedural interest to pursue them but I would like to make it rewarding for those who elect the caring practices to pursue those.

And by the way, it's not dissatisfaction. Every survey that I've seen has geriatricians at the very top of the physician satisfaction levels in terms of satisfaction with care. There is a lot of satisfaction in caring for patients. That is the start I believe, then you have to deal frankly with the way in which we pay for care because all of our episodic individual service based reimbursement works directly against the systems of care.

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When we are thinking about chronic disease and patients who are managing and living with multiple conditions, the idea of looking at time and patient management and paying for that in greater numbers and there are some very interesting experiments and models to build off of that practice is a really I think important direction that would help improve opportunity.

There are you know now in a number of states a model for medicaid patients in which they also can receive funding to pay for their home care and it can include family members or other care givers. They actually get cash and counseling, too. That's the name of the program: Cash and Counseling, to pay for that care, I think that is an interesting model to help promote the kind of care that people need, but truly we could go down through every dimension of the way in which our health care is organized, financed, incentivized, choices that professionals as nurses or doctors or other care givers make, the way in which our institutions are organized and reimbursed, everywhere you turn in health care it seems to be working against the needs and interests of patients, especially older patients with chronic disease and that's the dangerous divergence that I'm concerned about and I think we've got to bridge the divide.

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**FEMALE SPEAKER:** My concern is that as a country it isn't even just limited to medicine. The caring professions, whether it's education, whether it's social work, as a country we don't pay for that so you're asking for - how do you fundamentally get over that huge hurdle?

**HARVEY FINEBERG, MD, PhD:** You get over it by making the decisions that it's worth paying for and paying for it. I mean, how many people think we pay our teachers enough? [Laughter] Well, what are we sheep? We can speak up. We have a public voice. We have a political say. We have a chance to influence how much we collectively pay to strengthen our public schools and to enable teachers to have careers that are fulfilling and financially satisfying, not that they're going to be like Wall Street but that they will have a chance to live well and reasonably. You are right, we don't do that either. We don't pay social service people nearly enough and by the way, social service is really the partner, the key partner, for nursing, physicians, for the care of an aging population.

Do we pay our social service personnel enough? I would say we don't. So, it's true. I mean, I believe does any doctor in training coming along actually know what they are supposed to get paid or how much each specialty is valued at or worth? They don't know. Nobody knows.

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The only way you know is you figure out, you look to the next person, you say how much is Tom Bodenheimer getting paid? I'm as good as he is. I should get paid at least what he is getting paid. That is the only standard any of us really has, I think, so we can change these conditions if we have a collective political will to invest in it and that, you're shaking your head no because you think that's a hopeless cause?

**FEMALE SPEAKER:** [Inaudible].

**HARVEY FINEBERG, MD, PhD:** I would say we may not be aware of it but we are there. We are there.

**FEMALE SPEAKER:** [Inaudible].

**HARVEY FINEBERG, MD, PhD:** Well I would never bet against the lack of generosity of people. I guess you can't win by betting against it but I believe that it's our job to make the case and to build the coalitions of people who are going to make a commitment to change this.

**MALE SPEAKER:** Harvey thanks for those wonderful remarks.

**HARVEY FINEBERG, MD, PhD:** Thank you.

**MALE SPEAKER:** One of the things that we started with before we got to the payment, where I think we're going to go with Tom Bodenheimer here with Jeff Cogg, you started with the *New York Times* article with the student who was so fascinated by skin, you are wonderfully placed not only in the Institute

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of Medicine but from where you were before that to comment on the debt that students sleep with, you know, the conversation among the people in the Urban Medical Group who I ran into this morning was not about how to make \$1,000, it was how to keep the one going with people coming in the door, and is it realistic to lobby for no tuition to medical schools so you at least level the playing field with people not leaving with these huge debts?

**HARVEY FINEBERG, MD, PhD:** Yeah I want to hasten to add some of my best friends are dermatologists and I mean that sincerely. [Laughter] So I want to make sure I say that, but on this question I'll tell you what I think is more realistic in a way is the idea of tuition forgiveness for service. I would love to see a national service plan actually for the whole of the young population that can be taken at any stage between graduation from high school or graduation from graduate school.

And you can make that commitment and embedded in it if you are going into a caring profession like medicine, nursing, and so on, would be forgiveness of tuition based on pay back in terms of place and service that you provide. That I think is a way potentially politically that would have I believe broad potential appeal to accomplish the goal that you described. Thank you all very much. [Applause]

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**RICHARD KNOX:** I mean to ask earlier if there were any dermatologists here. [Laughter] Because I thought that might come up.

**HARVEY FINEBERG, MD, PhD:** Any skin emergencies.

**RICHARD KNOX:** It's a very telling article in the *Times*. Tom Bodenheimer is one of the nation's most prominent voices on primary care reform. It's possible that no one else is as prolific on the subject as he is. He is a general internist himself who got his medical degree at Harvard and did residency training at the University of California San Francisco where he is now a professor in the Dept. of Family and Community Medicine. He spent 10 years practicing in community health centers in San Francisco's mission district and another 22 years in private practice. Dr. Bodenheimer is coauthor of *Improving Primary Care Strategies and Tools for a Better Practice* and the text book *Understanding Health Policy*. We often see his articles in the *New England Journal of Medicine*, in *JAMA* and *The Annals of Internal Medicine*. He is also involved with primary care redesign in the safety net clinics of Northern California, so let's hear from him now. [Applause]

**THOMAS BODENHEIMER, MD, MPH:** I'm sure glad I had an imaging specialist to help me take care of this. I kind of came prepared to talk about the prices in primary care and

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innovations that might alleviate that crisis, but when I got here I was told that everyone is tired of hearing about the crisis in primary care and I also know that Urban Medical Group is the most innovative health care organization in the United States, so for me to talk about innovation with the Urban Medical Group doesn't make much sense.

So I really have nothing to talk about. [Laughter]  
But I'm going to try to explain how the specific nature of the crisis in primary care generates the particular innovations that I'd like to discuss.

Now as we all know, there are two interrelated parts of the crisis in primary care. There is the macro system crisis, which is inadequate payment, dysfunctional payment that doesn't relate to the problems that our patients have, and the pipeline coming in to primary care drying up and the pipeline going out of primary care expanding. The macro system crisis I think we all know about it, I do have a few slides about the macro system crisis so I'm just going to go over them real quick because I really want to talk about the other part of the crisis, which is the microsystem crisis.

What really happens in a primary care practice? We do know that not only do US medical students not want to go into primary care because of the money. They don't want to go into

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primary care because they see how dysfunctional primary care practices are.

So with that introduction, what we are going to do is why traditional primary care cannot provide consistent high quality chronic illness care, the challenge, and three models to transform chronic care within primary care, which should be panel management, care management, and coaching.

Okay we are going to start with the depressing part but things will get better shortly. Half of discharged congestive heart failure patients are readmitted in 90 days, less than half of people with atrial fibrillation who should be on Warfarin are on Warfarin. Only 21-percent of physicians provide smoking cessation counseling to their patients.

About two-thirds of people with hypertension, diabetes and elevated cholesterol are not in control and this is a primary care problem, 80-percent of people with high blood pressure cared for in primary care practices, about 70-percent with diabetes, et cetera.

These numbers are primary care problems. So who is falling down on the job? Is it a doctor problem? Sometimes doctors don't know the guidelines, don't follow them. Is it a patient problem? Patients, we might try as hard as we possibly can to have patients work with us to improve their chronic diseases. Sometimes they are unable to do so because of other

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priorities or difficulties in their lives. Is it a system problem? Always.

Ed Wagner who began analysis of the chronic care model talks about the tyranny of the urgent, which is that primary care clinicians have too many things to do in the 15 minute visit. Acute problems crowd out time for routine management of chronic and preventive care.

The question is what about the tyranny of the urgent? Shouldn't acute problems crowd out chronic care if you have a 15 minute visit? Someone comes in with a horrible headache, their hemoglobin A1C is out of control, their blood pressure is okay but their cholesterol is not too good, what comes first? The headache should come first. It's the patient's agenda. It's the patient's acute problem.

Acute problems should take precedence but then we have to figure out some other way to deal with the chronic and preventive care. The hamster syndrome, I'm sure everyone has heard of the hamster syndrome, maybe what you haven't seen is the really strange things that doctors will write in their charts when they are stressed out and too busy. "She is numb from her toes down." [Laughter] "Patient has two teenage children but no other abnormalities." [Laughter] "While in the E.R. she was examined, x-rated, and sent home." [Laughter]

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So what is it about the microsystem? What happens within the primary care practice? What is the pathology? What is the diagnosis? The pathology is the 15 minute visit. That is the basic fundamental pathology and if we don't do anything about the 15 minute visit, we are not going to really change primary care in a transformative way.

So what happens in the 15 minute visit? This was a study of 264 visits to primary care physicians. Patients making initial statement of their problem were interrupted by the physician after an average of 23 seconds. And 25-percent of the visits, the physician never asked the patient for his or her concerns at all.

This was a study of 1,000 physician visits. The patient didn't participate in decisions 91-percent of the time; 42-percent of primary care physicians say they don't have adequate time with their patients and that was several years ago so I'm sure it's probably more now and of course most patients say they don't have adequate time with their physicians.

I want to really emphasize these next three research studies because they all come up with almost exactly the same conclusion which I call the 50-percent rule. If you ask someone to repeat back what the physician told them, so the physician says okay I'd like you to take Metformin 500

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milligrams twice a day for your diabetes, could you please repeat that back just to make sure I was clear in what I said, 50-percent of people will get it wrong.

This was a study of Warfarin, give people a prescription for Warfarin, call them up in a week and say how did I want you to take your Warfarin? This is not how are you taking your Warfarin, it's do you remember how I, the physician, wanted you to take your Warfarin? Fifty-percent of people will tell you the wrong dose. Safety problem, a huge safety problem, and then another study by Debra Rotor at Johns Hopkins, 50-percent of people leave the physician's office practice without understanding what the physician said. This is really very fundamental difficulty with primary care and it really makes me think of the 32 years I spent practicing primary care, probably 16 of them were wasted. [Laughter]

And then we have the studies from the Duke Dept. of Family Medicine, which sort of are really the capper on this whole thing, primary care physicians with a panel of 2,500 sort of average patients with the usual prevalences of diseases, problems, risk factors, will spend 7.4 hours per day doing recommended preventive care.

So if you do everything that the US Preventive Services Task Force wants you to do, recommends you do, and you have a panel of 2,500 patients and the average panel in the United

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States is 2,300, 7.4 hours per day just doing preventive care, plus to do really good job with all the chronic care in that panel will take another 10.6 hours.

The conclusion is primary care as currently practiced, as currently organized, with the panel sizes that we have, is not a job that is possible to do. It can't be done. So either we have to reduce the panel sizes which of course would make our work force problem worse and that is what some people are doing with their concierge's practice, they are just saying well I'll take care of 500 people and I'll do a perfect job.

Well, it's great for those 500 patients, it's great for that physician, it's not great for the people who can't give you those practices or for the general primary care work force supply and demand issues in the United States.

So the pathology really is the 15 minute visit. Why is primary care broken like that? This is what I'm just going to go over. I'm not going to really talk about the fact that people aren't going into primary care. I think you all know that. I'm not going to talk about the income gap. I think you all know that.

But I am going to tell you the definition of specialists. Physicians who know more and more about less and less until they know everything about nothing. [Laughter] Of course, what are we? What are us primary care docs? Well we

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know less and less about more and more until we know nothing about everything. [Laughter]

And I think we all know that if you do a complex visit with the current RVS system, someone with diabetes, hypertension, congestive heart failure, depression and psychosocial problems, you'll get \$94 on the average by medicare whereas if you do a cataract extraction which takes the same amount of time you'll get \$670. This is the basic part of the problem.

So the primary care home and we'll talk a lot about the medical home now which is to me just another word for really, really good primary care [laughter]. Maybe that's what it looks like. I have to admit when I was a kid at a camp in North Carolina, I helped to build that cabin. [Laughter] So, if I'm as bad a doctor as I am a carpenter...

Okay so enough about the bad news, okay? Sorry about having to do it but it does link to what the good news might be. The challenge, you know there is a fabulous article in *JAMA* by Ezekiel Emanuel a few weeks ago about how access is completely related to costs, really if you look at it, it may be increasing costs of care may be really the fundamental problem in this country and the lack of access and the lack of insurance is secondary to the increases in cost.

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Cost is just an overwhelming problem, so two-thirds of Medicare costs are attributed to 20-percent of Medicare beneficiaries with five or more chronic conditions. I'm going to call these people patients with complex health care needs. These are the people that the Urban Medical Group is so wonderful at taking care of. Five-percent of medical beneficiaries incur 48-percent of Medicare costs. We cannot deal with costs without figuring out what to do about that small percentage of people that incur most of the costs.

The average medicare patient with complex health care needs sees 14 outpatient physicians, has 37 physician visits, 49 prescriptions per year, even with all this is hospitalized 100 times more frequently than patients in better health so people with complex health care needs, if primary care cannot figure out how to better take care of people with complex health care needs as some of the people here in Boston have figured out how to do, we are not going to solve this cost problem.

I would say that only primary care can meet this challenge. We know that patients with a regular primary care physician have lower health care costs than those without them. We know that states with more primary care physicians have lower medicare costs and improved quality compared to states with fewer primary care physicians and it's the opposite with

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specialists. States with more specialists have higher medicare costs and lower quality.

We know that more primary care is associated with reduced rates of hospitalization. So really in terms of meeting this challenge, it really has to be met by a strong system of primary care. So, what do we do? The macro system reform which we are not going to talk about today, health plans and medicare need to invest in primary care and need to change how primary care is paid.

Microsystem reform, which I would like to talk about, we have to step up to the plate. You know, a lot of us in primary care, we whine. If they would only pay us more, we would do a better job. If they would only pay us more, we wouldn't have to see patients in 15 minutes. If they would only pay us more, we would get an electronic medical record and so forth.

All of that is true but if the payers paid primary care more, you might not do anything with that additional money. You might just put it in your pocket as a physician. And even though there is a huge primary care specialty income gap, most primary care physicians make a pretty reasonable income and compared with most people in the United States they make a great income.

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So it's not so much that amount of money that a primary care physician makes, it's the gap between primary care and speciality that is really the problem in terms of the pipeline.

So yes we need more payment, yes we need a different kind of payment, but we also have to step up to the plate and show the nation, show the payers, show the policy makers, that we can really try to improve and that we really want to improve how we do things in our own practices.

Generally speaking, primary care takes every kind of patient and kind of funnels them into the 15 minute visit. And if you look at a typical primary care practice, look at the different kinds of patients we have. We have people who need same day acute care and a lot of times we will give them an appointment in three weeks, which makes no sense. We have healthy people that need preventive care. We have women who need pregnancy and infant care. We have people with a chronic condition and I will be talking about that more. We have people with complex health care needs, which are multiple chronic conditions. We have people with mental health substance abuse issues, people who need care at the end of life, et cetera.

If you take your practice and you look at the different kinds of patients in your practice, you need different institutions, different structures, different systems for those

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different kind of patients. To put them all into the 15 minute visit doesn't make any sense.

So I'm going to specifically talk about two of these, this part of your patient panel, which are people with a chronic condition and people with complex health care needs. Okay what can we do to improve care for those two categories of our patient panels? I'm going to talk about panel management, care management, and coaching.

Now the goals of all of these innovations, there are really three major goals: To improve the patient experience, what is it like to be taken care of in this practice? To improve processes and outcomes, and also to make work life more reasonable for clinicians, and that is really a key goal also, because of this whole pipeline problem of people not wanting to go into primary care, again, some research shows that actually the money is only the second most important reason why US medical students don't go into primary care.

The most important reason is actually that they see the work life of the primary care clinician and they don't want that work life so we have to improve the work life partly to do better and partly to extract more people into the profession.

So what is panel management? Panel management means that you are worried about your whole population of patients, not just the patient that happens to come into the visit with

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you. You have to have a registry. You have to have some data system in which you know how many people who are eligible to get mammograms have gotten or have not gotten their mammograms. How many people, same with Pap smear, same with immunizations, how many people who have diabetes?

First how many people do you have in your panel who have diabetes? What percent of them have not had a hemoglobin A1C in the last six months? What percent have not had an eye exam in the last year? What percent have a hemoglobin A1C greater than eight, et cetera, et cetera. We now have powerful systems that can give us those registries and more and more primary care practices actually now do have these registries. A lot of the small practices don't.

So let's assume that we've come a long way in the last five years, having registries available for primary care practices. Let's assume that we do have a registry available. It's very interesting. Kaiser Permanente is an organization that is doing a lot of work trying to improve primary care. They have amazing data and in one of their practices someone figured out that they have this amazing data and they never look at it.

So a registry only works if someone works the registry. So, what they did at Kaiser Permanente and this is an innovation that we are trying to spread in the safety net in

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San Francisco and the East Bay in Northern California, you have to have someone designated to work that registry.

You can't assume that all that data is going to be used unless someone is available to use it so they took their best medical assistant and they said we would like you to become a panel manager. We want you to be responsible to make sure that every single patient on our panel has all the chronic and preventive services that they need, so that person goes through the registry repeatedly and constantly and calls up the patient, sends the patient letters, sends orders to the lab, etc, to make sure that everyone gets all the chronic and preventive care that they need.

And the Kaiser Permanente area that was doing that work was in a part of Northern California called Richmond, part of the Bay area. It's one of the poorest parts of the Bay area, it's one of the lowest socioeconomic groups within Kaiser Permanente and they had the worst chronic disease statistics in the whole Northern California region. After starting panel management, in two years they had the second best chronic care and preventive statistics in the whole Northern California Kaiser region, just by having someone do this work.

The other thing that happens when you have a panel manager doing this kind of work is it takes a lot of that stuff off the plate of the physician. You do not need an M.D. to

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figure out who needs a mammogram, to figure out who needs a hemoglobin A1C. It's something that in terms of this 15 minute visit, get it out of the 15 minute visit. That will allow the 15 minute visit to have more time for the patient's agenda because a lot of this stuff is done away from the visit.

They have gone even farther. Not only do they try to get all the services done, but the panel manager prepares lists of patients whose hemoglobin A1C and LDL cholesterol are not in control and the physician has 15 minutes twice a week. In each 15 minute period the physician goes over 10 patients, looks to see who needs intensification of medications, writes it down or puts it in the computer, and the panel manager calls up the patient and says your physician would like you to increase your Metformin from two pills a day to four pills a day, and your prescription is waiting at the pharmacy. So you can actually take some of the algorithmic medication intensification out of the 15 minute visit also and improve your outcomes for the patients and make life better for the clinicians.

Now some clinicians do not like the idea of delegating some of that, physicians still have the decision but the panel managers are actually implementing it. It is sort of like in the hospital you write orders and someone else implements them. It is analogous to that. Some physicians are not ready to go there. That is okay. Some physicians are going there. We

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will see how it works. The panel management is a very, very powerful tool to improve outcomes, to think about your whole population, and to take algorithmic and routine work out of the 15 minute visit.

Care management, panel management is really great for people with preventive needs and for less complex chronic illnesses, a person who just has diabetes, a person who just has cholesterol. Does it work with patients with complex health care needs? Probably not.

People with complex health care needs, needs someone much more trained than a panel manager to work with them and there the R.N. care management model and it could be NPA, it could be a pharmacist, R.N.'s are probably the best people to do this model, with intensive nursing individualized to each patient. Because these are really complicated patients, you need a well trained clinical person to do that.

But again a lot of care management takes a lot of time. You really have to work with people to understand their conditions, to understand the polypharmacy that most of them are dealing with and many fall prevention, there are so many things that you all know about better than I do. So R.N. care management is really crucial, again physicians just don't have time and they are not that good at doing some of these things.

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So there have been at least four studies and probably a lot more than that, that show that care management improves care and reduces costs for patients with complex health care needs. So the care management model is less for the less complex chronic disease patients, it's more for the patients with complex health care needs.

The coaching model, you know a lot of us in medicine we rescue people. Someone has a heart attack, we save them. Someone has a G.I. bleed, we transfuse them and we get the bleeding stopped, etc. Coaching is a very, very different concept. Coaching means helping people to have information and the skills that they need to work with us to get better on their own. It's much more of a sort of partnership model between the patient and the care team.

There is a wonderful model for coaching that is pioneered by Eric Coleman at University of Chicago, the care transitions model, I'm sure some of you are familiar with it, which they have advanced practice nurses coaching patients and families after they are discharged from the hospital, reduces rehospitalization, improves care.

We are working on the coaching model in primary care, which I am going to talk about in a little more detail which we call the teamlet model. So in terms of the post hospital coaching, of course it's extremely important for these kind of

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patients, it's targeted both to patients and families, one of the interesting things if you ask a nurse to coach a family and a patient, by and large that nurse is going to want to rescue them.

If someone has a leg ulcer, the nurse is going to want to dress that leg ulcer and change the dressings. That is not what she is supposed to do with Eric Coleman's model. She is supposed to teach the patient and the family how to do that, because if the patient and the family know all these skills, they are going to do much better than if they are just a recipient of care, so the coaching model really is very much a self management support model.

Major attention to polypharmacy, to make sure that people understand their medications, which is a big safety issue. How about coaching in primary care? What would you do if you were a coach in primary care? Well, number one remember the 50-percent rule? Fifty-percent of people leave the office visit not knowing what happened in the visit. We have our coaches recheck to make sure that people know what happened in the visit.

Skills training, coaches teaching people with asthma, it's so easy for a physician to write a prescription for asthma. That doesn't do anything. It's not easy to use inhalers, to use spacers, to know which inhalers, rescue

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inhalers, to know which inhaler is a controller inhaler, to know how to use your asthma action plan, those are skills that the coaches can train a patient that make a real difference in their asthma care. It takes a lot of time. There is no reason for a physician to do it. Most physicians don't even know how to do it.

Encouraging healthy behavior change, teaching people problem solving skills, assisting people with the emotional impact of having chronic disease and everyone has that emotional impact, and follow-up. A huge number of studies that show if you don't do follow-up, nothing is going to help, and encouraging people to become active participants in their care. That is sort of the content of coaching in primary care.

Well, how are you going to do that? Remember we said 7.4 hours just to do preventive care, 10.6 hours to do chronic care; we are going to add on all this coaching, how are we going to do that? Well, obviously we have to do it with someone else other than the physician.

So we are trying to put together a model that we call teamlet. We all know that there are teams in primary care. We also know that if you look at the research on teams, it's not very favorable. All the interactions you have to have among all the team members, the chance that someone on the team is going to be some kind of dysfunctional personality and make the

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team not very cohesive are higher the greater the number of people on the team.

So, as one, Harold Wise, who was a great physician in the community health center movement in the '60s said the best team is a team of one. So we are trying to do a team of two. We are hoping that - a team of one is not going to work but maybe with a team of two, so that is what our teamlet is. We prefer that it be a clinician and an R.N., in our case it's a clinician and a medical assistant or a community health worker as we don't have R.N.'s available in our primary care practices.

This is really a throw back to the old days. In the old days, a patient went to see their general practitioner and there was a G.P. and a nurse. Sometimes they are husband and wife actually, and that husband and nurse work together day in and day out for years and years and years and the patients learn to trust both the physician and the nurse and knew what things to go to for the nurse, to the nurse for, what things for the physician, and the nurse and the physician trusted each other and knew what each other was best at doing. That was a real teamlet. That is what I think we really need to reestablish a much more complex health care system now is teamlets.

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So we try to deal with a 15 minute visit through this teamlet concept. Remember the 15 minute visits, the fundamental pathology of primary care. Can't do acute chronic prevention, care coordination, all the things that we've talked about with a 15 minute visit so we expand the 15 minute visit to a pre-visit by the coach, a visit by the clinician, a post visit by the coach, and between visit care by the coach and I'm not going to go into details because I'm a little bit running out of time but I want to talk about the post visit and the between visit which are crucial.

Post visit, make sure the patient understands what the clinician wanted them to do, make sure the patient agrees with those things because patients won't take medications if they don't agree with it, do behavior change work, help them navigate the system, teach them those skills like how to use their asthma inhalers, and ask the patient is there anything you wanted to say that you didn't have a chance to say, which most people will have a lot to say.

Between visit, maybe even more important, phone call, I think that anytime that we prescribe a new medication, we shouldn't wait the three months before the patient comes back to see what's happened with that medication. We should call them in a week. That is what we have our coaches do. Were you able to get the medication from the pharmacy? Was there a

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problem with your formulary? Was there a problem with your copay? Do you still remember how to take the medication? Are you taking the medication? If not, why not? And are there any side effects? It's amazing the things, both the adherence issues that will come up and the safety issues that will come up by making those post visit phone calls.

So, coaching, care management, panel management, are some of the ideas that I think could help to deal with the problems in primary care microsystem. For people with less complex preventive and chronic care needs, panel manager. For people with one or two poorly controlled chronic diseases, coaching will work very well. For people with complex health care needs, you have to have a more clinically skilled care manager.

Can we do those things? We have to change our work force. Most of our primary care work forces don't have these particular individuals involved and I'm not going to go into like how we are going to change our work force. There are many different ways you can do it but we can't do it without changing how primary care is paid.

So again there is this interaction between the need for us to step up to the plate and make some changes, and the need for the macro system to pay us differently so that we can actually sustain those changes over time. There are a lot of

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organizations that are doing a lot of this, obviously, Urban Medical Group is one of them, and all of these things are things that we need to pilot and need to work on. They are all works in progress and any comments are greatly appreciated. Thank you much. [Applause]

**RICHARD KNOX:** Time for questions.

**MALE SPEAKER:** I have two questions, first is where did you go to summer camp in North Carolina? Maybe we played basketball against each other, and the second one has to do with your band-aids for the 15 minute visit. Thirty years ago I did research on compliance for chronic asymptomatic conditions and found that patients follow doctors' instructions because they sense the caring function of the physician. They don't take medicine because they are worried about having a stroke in 30 years. They take it because the doctor in a casual way cares that they take the medication.

So adding a coach before and a nurse practitioner after still doesn't get to the tyranny of the 15 minute visit. I would suggest that right to work rules for primary care doctors, limiting panel size, making sure there is enough time to see the patients is probably the most cost effective way to correct the problem, not adding several more layers. So I'd be interested in your comments.

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**THOMAS BODENHEIMER, MD, MPH:** Actually I completely agree. If someone were to say if you could do the things that you really think would work the best, it gets back to that whole team of one thing. It's really complicated to have more and more people on the team.

We all know that trust and continuity of care are very highly related to outcomes, to costs, to a lot of different good things, so if we could really reduce panel size, have physicians, nurse practitioners, P.A.'s, clinicians, care for people with enough time and with not so many people per day, it would be great. But we need more workforce to do that, so the question is what are you going to do if the prospect of getting more work force is not too good in the short term?

I think the other thing though is in terms of the 15 minute visit, how many people who come to a physician's office need to be there? I know Don Burwick says 50-percent of visits neither the patient wants nor the doctor wants, they just sort of happen. How much could be done by some of our new IT stuff using the telephone better, using e-mail, using patient portals and so forth, some of this chronic and preventive algorithmic stuff could be done in that way.

So no disagreement and it may be that these are Band-Aids but at this point we have to do something about the limited work force that we have and I don't think reducing

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panel size as much as I think that's the best answer I don't think it's going to happen soon.

**MALE SPEAKER:** I wondered if you had a critique of the shared medical appointment model that Ed Nofsinger has proposed as a valid microsystem reform?

**THOMAS BODENHEIMER, MD, MPH:** Okay there are several kinds of shared medical appointments. There are group medical appointments, the Nofsinger one is for acute patients where a number of people with all sorts of different problems come in and that is to improve their access to care and there are other models which are more chronic disease models in which the patients come to the group medical appointments over and over again, that is the way they get their care.

I don't know how many people have gone to a group medical appointment and observed one. They are really fabulous. I mean all the interactions between the patients. A lot of the times you'll have people with diabetes in a group medical appointment and this person has just refused to go on insulin for like six months and a lot of times another patient who has just gone on insulin will be the best person to persuade that patient that going on insulin is really a good idea and is really not all that terrible so I think group medical appointments are fabulous.

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They are a little bit hard to organize. They take a lot of administrative work but you could actually have a medical appointment with two patients and one clinician. It is called a mini group visit and it's been piloted in the state of Washington, works pretty well.

**FEMALE SPEAKER:** My question is specific to your coaching model, a lot of health insurance companies have programs and prevention and wellness, disease management, that try and serve as coaching on kind of a grander scale, and I'm curious if you think that's an okay role for health insurers to be in and if so how it would partner with PCP's taking on a more coaching model?

**THOMAS BODENHEIMER, MD, MPH:** Are you talking about health dialog?

**FEMALE SPEAKER:** Like Blue Cross/Blue Shield of Massachusetts has disease management programs we run with like health way so you have a coach that calls once a month if you have diabetes or chronic back pain and kind of coaches on what you are doing around that pain and what things you can do.

**THOMAS BODENHEIMER, MD, MPH:** Yeah. I don't have any research to back up this statement but I'll make the statement anyway. [Laughter] I think if all the money that was spent on disease management companies was spent to do similar kind of things in primary care, it would be much more effective.

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[Applause] There is some research that shows that people working with patients on disease management, if you've met the patient face to face it's more effective than just phone calls.

Ed Wagner had an editorial on the Annals recently about congestive heart failure post hospitalization. The studies did better if there was at least one face to face meeting and not only phone calls so I don't like these long distance phone calls even though some of these disease management companies have come up with some good stuff. I think that it could be done much more effectively in primary care. Well, thank you very much. [Applause]

**SUE COFFMAN:** You are all very compliant sitting there.

[END RECORDING]