

THE BROOKINGS INSTITUTION

HEALTH CARE REFORM AND OLDER AMERICANS:  
ACHIEVING BETTER CHRONIC CARE AT LOWER COSTS

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PANEL III: PUTTING IT ALL TOGETHER: INTEGRATING PAYMENT REFORMS, PERFORMANCE  
MEASUREMENT, AND DELIVERY MODELS THAT WORK:

**Moderator:**

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**Panelists:**

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DAVID MARTIN  
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DAVID REUBEN  
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CONCLUDING REMARKS AND NEXT STEPS:

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Engelberg Center for Health Care Reform  
The Brookings Institution

CHRISTOPHER LANGSTON  
The Hartford Foundation

BRUCE CHERNOF  
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LONG-TERM QUALITY ALLIANCE INFORMATION SESSION:

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## PROCEEDINGS

MR. ALTMAN: Can we get people to -- I know we've had an exciting panel. Can I get people to -- for those of you who want to have discussions in the back of the room, maybe you can do it outside. I've been doing this a long time, but it's not succeeding either.

All right. Let me get this rowdy group together. I know this is an exciting -- and there are a lot of you who haven't seen each other for about five minutes, so.

All right. I'm Stuart Altman. And let me start off with two apologies. First of all, I'm from Massachusetts. I'm really sorry -- and for those of us who took this election for granted and didn't have a clue what was going to hit us.

So, before I give you the second apology I do have to come up with one little tidbit which I think has some relevance to what we are talking about here today. As the results of the election began to play out on television I was home alone. We have moved part-time to Chapel Hill. So my wife was in Chapel Hill, but I had run up to vote.

And I had learned from the medical profession you shouldn't drink alone, so I went to the nearest bar. (Laughter) I did. And I went to the nearest bar, which I had never been to before. And I sat next to somebody who then proceeded to explain to me how happy he was that the election was working out the way it was.

So I said, look, I don't want to have an argument. I just want to understand why you voted the way you did.

And he said, well, you should know something about me. He said I'm sort of an AC/DC guy. I vote Democrat. He didn't say it quite like that, but -- I vote Democratic, but I also vote Republican and stuff like that. But he said I want you to know I voted for Obama. I really believe in change. And he said -- but, he said, but I voted for the other guy.

And I said why?

He said, well, basically, this health reform will do nothing for me. And basically, there were a lot of bad things in it for me and people in Massachusetts.

I said, well, like what?

Well, first of all, it would seriously affect in a negative way Medicare and I've just gone on Medicare.

I said, well, I can't -- okay, I didn't want to go into a long discussion. I said, well, what else?

He said, well, you know, a lot of my friends are actually going to have to pay for care for people in other states. And we already have ours. Why should I do that?

And then there was a third or a fourth. But by that time my head was reeling. And I said, well, Medicare? I mean, why -- and we went into this long discussion.

And he said, well, you'd be surprised how many people in Massachusetts basically said there is nothing in this for us.

So everyone is going to take away from the election.

Now, let me bring this to today's discussion, in my little humble view. And let me -- my second apology -- and call this -- I'm really apologizing both to myself and to Jane, and call this the David panel because, as you can see, we've got a lot of Davids here. And I want to also bring in the analogy, many of you know the story about Little David and Big Goliath.

(Audio interference)

Is that mine?

So and recognize why not only is it a good example of this panel, but also of what we've been talking about. Because -- and in many respects I do -- I may not look it, but I represent Goliath in the sense that my career has really focused on how we pay for the big ticket items, how we focus on our big hospitals, what do we do with our big teaching institutions, how does Medicare operate, and this other stuff that so many of you have spent your life dealing with. It was like the other stuff. It wasn't focused on our day-to-day operations, whether it was here in Washington or out dealing with the big hospitals as I spend so much of my life.

Over the last five years I have switched gears a bit, but there is still that view out there about the main health care system and all the things that we're talking about today: end of life care, coordinated care for frail, elderly people with chronic conditions. Even though it consumes a

phenomenal amount of money, it's still viewed as "the other stuff."

So the question that I keep asking myself -- and as I was listening to the panel and would welcome as I turn it over to our panel -- is how do we do two things? How do we convince the guy that I sat next to in the bar that he really needs to care about this? He was a very healthy, I think, 65-year-old. Because his 25-year-old girlfriend looked very healthy. (Laughter) So, I mean, I'm just giving you the rest of the picture.

And he -- and there are a lot of him and hers out there that do not really see this issue. So as I look at, there are many populations -- much of the discussion, much of the life of those of you in the audience and most of you on the panels that have gone have focused on these populations disproportionately among our lowest income population, disproportionately among our disabled, disproportionately about people who didn't think very seriously about what was going to hit them, even if they were middle class, until it was too late. So that's one population.

But there is another population out there that is trying to take -- sort of trying to anticipate a little bit. They're middle class and upper middle class and maybe wealthy people that are moving into continuing care communities and different forms, trying to provide some degree. And then there is this great group of people who are not on the poverty side, but are on -- but have really -- are not really thinking about it. And I don't know if it's Carolyn's father, whether it's me or others, it's that group that we need to do it.

So here's my lament and here is my hope, and that is we will never solve this problem that we've been talking about if it is viewed as "their" problem. Just like the guy in the bar, as long as he viewed what was going on around the country in health reform as somebody else's problem, he was not about to do anything really seriously. I mean, he would have checked the box if it was free, but the fact that he thought he was going to have to pay for it in many different ways, he checked the other box.

So, I think it behooves us all to get more and more of the population that either doesn't think it's their problem, for whatever reason, but everyone -- it's going to be all of our problems, but they don't think of it that way -- into the mix. Because the kind of changes will require them to check the box.

And I just want to say one last thing. I started in this field in a major way back in the early 1980s, late '70s, when a group of us at Brandeis created what became known as the "social HMO." And it's very nice to see the SCAN Foundation help support this event, which SCAN was one of the delivery systems that formed the basis of the social HMO. And its idea was that if you coordinate care not only for people who need extensive long-term care services and homecare service, but a broader base of coordination, and provide them with more benefits, they will sign up for delivery systems that have the potential to do these things that we've been talking about: integrating care, coordinating care.

Life has changed a lot. We've done a lot. But the social HMO concept has not. And much of what we're talking about today, and much of what we hope for and may yet get in health care reform, really centered upon that concept of coordinated care, changing the payment system, bringing in a population, which is broader than the ones that need it at the time that they sign up, but that they see the value.

So, as we talk, bring everything together -- and now I want to turn it to our panel -- I hope you will address this issue of politically making what we've been hearing today a reality by recognizing that we need to convince a broader population. Several of you have mentioned that. And that means in some ways -- I hate to use the word because it's not English -- incentivizing them, making them feel that they get value by joining in to something that has this greater value. That's what I took away from the debacle in Massachusetts.

So, with that, I'm going to turn it over to our panel. As I said, we have a lot of Davids here.

The first one is Dr. David Dorr, who is professor of medical informatics and clinical epidemiology at Oregon Health and Science University and who has focused his career recently on linking up, I guess, informatics with care management and coordination of care. You have a more detailed discussion of his background, so I won't spend any more time. I'm going to turn it over to David.

DR. DORR: Great. Thanks so much. And I also want to thank the Brookings Institution and the SCAN Foundation for supporting this and especially the John A. Hartford

Foundation, which actually has supported not only this, but a lot of the research you're going to hear about.

Can everybody hear me okay? A little bit? Okay.

I'm going to talk about health information technology. But I'm not going to talk about it in terms of computers and other things, but the benefits it could provide. And some of the discussions that we've been having -- and especially the opportunities that are really out there already in terms of the investment we've made through the American Recovery and Reinvestment Act and some other legislation where there's a lot of money going towards health information technology.

I've spent a lot of my time focusing on how can we better use health information technology to care for this vulnerable, at-risk, older adult population and those with complex chronic illness. And we do this through a program we call Care Management Plus, which basically does some similar things to a lot of the programs you've heard here. It takes care managers, gives them special training to educate, coach, and motivate, and communicate with patients, their families, and caregivers who are at-risk for a variety of reasons. It does these in primary care clinics. And this was a special interest because these patients often represent, for instance, internal medicine, maybe 5 to 7 percent of the practice. And we were trying to find ways to really move them forward in the shortage of geriatrics practices that we really have. How can we spread that knowledge more broadly?

And so we use health information technology to basically monitor and track these kinds of crucial conversations about goals and priorities and health issues, barriers at risk for patients through the care manager. And then they use that to make sure that those elements get followed up on, that there's education about those, and that care program goes forward. Others have talked about the importance of information technology, as well.

What we've found is really it's a combination of those two things that leads to success for those populations. And without the technology they were limited in terms of how many people they could work with and making sure they stayed focused in their hectic days. But with it they were able to overcome some issues that are really pertinent that I'll talk about.

I think the main thing I want to leave you with is that we have an opportunity to really change the way that we deliver care that we've talked about here. Health information technology and measurement play a crucial role in that, but we need to be very conscientious, especially with the way things are currently defined, that we take advantage of this opportunity for that vulnerable population.

So what kind of challenges do they face that health information technology could address? Well, the first one is really that there are so many different providers of care, settings of care, and care plans that get created for these patients and their families. And that those -- there's no very good way to integrate those right now. Really nobody is incented to do it. We hear that caregivers are left doing it, but that we don't have a good way to address that.

Number two is that we also know that it's very important to talk to people about those care plans. And that more than half the time when patients and their family revisit in primary care, they don't know -- they don't understand the plan that was just laid out, that it wasn't explained in adequate detail. So we need to use it to better -- use it for education and make sure there's a persistent version of that plan out there.

And the third, and probably most important part, is that we need to engage them in conversations about their goals, their priorities, their needs, and track that through the health information technology. Right now this rarely happens in most care settings. That health information technology is used primarily to build the system we have. And I really -- I mean, I really think that we -- that to support the system that we have -- and I really think we could summarize this in the world of the informatics community by saying we, you know, we build health information technology to make it easy to do the right thing, perhaps despite your own experiences in it. And the truth is that it's the right thing that's frequently the problem -- that we build our systems to support kind of last generation of health care.

And so in our model we really try to build systems that support this process. So what do they do? Well, they specifically help people in a single workflow track all of these informations -- all of this information, share clinical summaries through a patient worksheet with the patient and their family, and bring that information together in a really aggregated way that then can

be acted upon and followed up on and tracked.

In our original studies in over 4,000 patients (inaudible) health care, we saw that this really did substantial things. It reduced exacerbation of illness, improved quality, reduced hospitalizations, actually improved mortality for these at-risk patients, and reduced costs for patients with complex chronic illness. And a lot of that comes from the things we've been talking about -- that if you're able to know what the barriers and risks are and you can track and follow up on it in a proactive way, that's really a successful component.

So I really want to offer kind of our experience. So the current health information technology legislation -- there's a lot out there. It's kind of rolling out. I would say we really have some opportunities. One is that in our mode, Care Management Plus, which we've rolled out now to more than 90 clinics, we've really found that you have to readjust the care first and then have the health information technology support that. So you can never lose that personal touch as many people have described.

It is possible to get that information in there, to have the assessments and monitoring and tracking, but that takes time and effort and the system really needs to support that. When we talk about primary care home and other elements, that's sort of the starting point to track all that information. That needs to be specifically rewarded in our systems. As well, we need to recognize the population at risk here might be a small percentage of some of these practices, and we need a way to identify them very proactively through the systems, which doesn't come in any health information technology.

And then probably, finally for now, I'd say as we're moving forward we really need to bring the experience of the people in this room into the discussion about what the health information technology needs to do and how we monitor it. We have a study now funded by HRQ where we're actively measuring and monitoring what the care managers are doing. And we've shown in the past that we can really kind of prescribe a pattern of care that really makes a difference in terms of improving patient outcomes. So there's a lot of optimism. There's some good opportunity I would say, and I look forward to talking about that.

MR. ALTMAN: Great. Well, June, as I said, you know, you represent a lot of



differences in this panel, not only -- but particularly nice to have a social worker on the panel since I had been deemed for almost 18 years at a school that prides itself on training a lot of advanced social workers at the Heller School at Brandeis.

So June currently is the chief executive officer of Partners in Care Foundation. But she also served as chief executive of the other side of Raphael's coast. She was chief executive of the Visiting Nurses in Los Angeles. So now we have our two coasts well represented and has been very much involved in community and home settings. So it's a pleasure to have you join us.

MS. SIMMONS: Thank you. It's a pleasure to be here. And I want to thank the Foundation and Brookings for all the investments you've made because we can hear with all the challenges before us. Actually, a lot of progress has been made because we're hearing today about a lot of knowledge, about what measurement has brought us in the way of proven elements that could go together into a combined system that, as you say, we're all in it together. How do we get that across? And to me you can hear today the complexity of this boundary-spanning issue.

And I'm thinking of this change. In the last discussion there was talk about how do we actually make this change. I'd like to think of it as a kaleidoscope. And when you look and you turn the kaleidoscope, you don't know which piece makes all the other pieces move. But you see that there's a concerted, organizing and reorganizing effort that comes around change from any point in the system. And so I think it's important for us to think about health care and its reimbursement and the fantastic contributions of health information about the patient and their family or the person-centered system and how we empower them and broad public awareness.

But then also about the community systems of care that the Administration of Aging and the Hartford Foundation and SCAN are -- have invested so much in moving that from -- also a very fragmented, uncoordinated system into what we hope is a single access point that could become a comprehensive community care partner to medicine. So I think we need to then integrate those around the person. And so we see it so multifaceted.

A nice example of how these can come together as system-crossing entities, I think, is the medications work the Hartford Foundation has advanced in home health, and then in partnership with the Administration in Aging advanced into Medicaid waivers. And now I hope will

advance in many others it crosses with IT. It crosses with new investments in adherence to medication that SCAN is investing in. The Hartford's funded program takes a look at medication reconciliation in the home beyond medication reconciliation, so it's a nice integrating symbol, I think, because it looks at all the meds that are in the home. All the ones that were prescribed before hospitalization, all the ones that were prescribed during and after hospitalization, and all the over-the-counters and all the foreign medicines, at least in California. We're not that far from Canada and we're right by Mexico.

And you find starting and amazing combinations of substances in people's homes -- that can contribute to significant demise or the appearance of decline that's quite reversible. And you combine that with the adherence issues. You can't really look at anything, even as focused as medicine -- the medicines people have available and are taking -- without looking at the concomitant signs of are there problems occurring. Is there confusion? Is there dizziness? Is there a history of recent falls?

And so I think it's a nice example of how the systems have to come together, what role the patients and families and neighbors and friends play, what role the medical system plays, and what role the community care system can play as a detective, as an identifier, as a coach. It combines well, I think, with some of the other investments that are being made that we hope will scale up, the ADRCs -- the Aging and Disability Resource Centers -- that are being built all across this country. Administration on Aging has really crafted a vision around that. Because I think we do need something like a single entry point combined with no wrong door that makes it easy for people to find what they need and to get some counsel on what they're faced with, what the questions are, and some community wisdom about how to rally what seem to be very universal issues.

And then the evidenced-based issues that can perhaps prevent the size of this advanced chronic care pool growing so rapidly by intervening earlier with prevention, with lifestyle change, and with self-management around great risks that advance harm, that again, Administration on Aging and CDC are advancing right now with our money. The Falls Prevention work, very important, but also the Stanford Chronic Disease Self-Care Management. Very, very important. Powerful consumer advancement tools that can engage all income levels and can show people

what's in it for them because, in fact, medicine alone, without patients and their families gaining insight and control, we can't slow the advance, the avoidable advance, the avoidable admissions Mary talked about so eloquently, as well as we could.

So it does seem to me that there are major partnerships that have to draw on a variety of evidence-based tools. We invented a lot of tools. We have a lot of resources. We need to bring them together, and then we need to scale them. But they need to scale in locally customized manners because every local community is different.

And so I probably used my time, but an impassioned plea for us to work across boundaries together to create a whole wherever the best change comes from, to tilt the kaleidoscope. That's the one that will make the next beautiful picture.

MR. ALTMAN: Thank you very much, June.

You know, during his health care reform debate there's been a lot of bricks thrown, particularly at the private insurance market. And I must admit that I sit on a few health insurance boards that are really trying to do things, particularly for the frail, elderly, and the SNIP population.

So I'm more than a little interested in David, our next speaker, who after all, David Martin, who is a physician, but is the executive medical director and vice president for quality at our largest private health insurance plan, UnitedHealthcare. And for those of us who know the field, realize that United has been a major, major force in providing care to the elderly and particularly the frail elderly. So I'm more than interested, David, in the kind of interesting things that your organization is doing.

DR. MARTIN: Thank you, Stuart.

I'd like to start out by echoing the sentiment of many others, my extreme personal pleasure at being part of today's stimulating discussion.

I've been variably referred to by my colleagues as a recovering academic or a fallen geriatrician. I'm probably somewhere in between those two. And the microcosm that I inhabit in my current role is really in the area of translational research, which is sort of halfway between academics or where the rubber meets the sky and where it meets the road.

And it's a unique opportunity for me to be here because I think if one had to pick a

leitmotif that went through much of the discussion today it's been the difficulties people encounter regarding translating pilot projects that work into where things work practically. And it's an issue that I wrestle with every day.

I think that we know a lot about what works. Going back to Chad's review of the literature, a lot of the recent demonstrations that what is important is targeting, frequently touching people. We can't have care management just tacked onto the health care system. It needs to be tightly linked to the providers of care. In Chad's case, actually embedded right in it. I think that's the strongest model. And why is it taking so long for us to learn these lessons and, you know, using up multiple years to roll them out.

And Carol's remarks earlier resonated with me also when she said she felt sort of straight jacketed -- I think was your term, Carol -- by some of the academic requirements of implementing these new projects. And I think that's really true. I mean, in translational work people talk about the voltage drop when you go from bench to bedside. And that's true, whether you're studying the impact of a drug or a medical device or a new process of care. There's usually a significant voltage drop.

And there are probably a variety of reasons. I mean, one is you don't have the same esprit de corps that you would find in an investigational group that feels like they're pushing the envelope. But also, you know, the reality of being at the bedside is very different. And as Carol said, you need to be able to tweak these programs. And I think we need to get smarter in terms of how we tweak these programs because I think we can do it in a much faster manner.

I had occasion to refer back to Ron Fisher's classic book, *The Design of Experiments*, and he really revolutionized modern thinking about probability and more than anyone else is responsible for why we have p-values in virtually every medical paper. And if I may paraphrase what he said, it was something like nature will frequently refuse to answer a question, but can always be induced to respond to a questionnaire. (Laughter)

So, you know, the very person who revolutionized our thinking about probability was not a big fan of hypothesis testing -- single hypothesis testing. It's a laser-like focus, but it's very ponderous. And what Fisher proposed and we've lost sight of us we need to do multivariable

analyses to advance quickly.

And so I think that when we start to dissect out all of the little pieces -- parts of the kaleidoscope that you were talking about -- to see what's influencing what. Multivariable testing is a much more efficient and better technique to use, and it's one thing that we are experimenting with. So I think that we can advance the field much faster if we do that.

Another area I wanted to touch on briefly was in the measurement of quality. I think that I've had a chance to look at some of our efforts to get the provider community to begin competing in the quality arena. And had an opportunity to look at some data on how physicians are rated in quality when they're caring for geriatric patients versus young adult patients. And as you might expect, it's harder to achieve quality rankings in the geriatric population.

You know, Frank Williams, the first director of NIA, called geriatrics the "fruit of the clinician." Because in many respects it's the most difficult kind of medical practice because of the multi-morbidity that exists. And so I think that practitioners sometimes are overwhelmed by the complexity of geriatrics. And in fact, the complexity of modern medicine sometime in the memorable past has overwhelmed the capability of the human brain.

David, you may be able to -- I think it happened in 1964. You may have a firmer fix on when that happened. But the most common human error in medical practice is error of forgetting. And I think that we need to rely on health information technology to assist us with that.

But another issue in measuring quality, which I think is a little bit harder to get at is sort of in the following arena. We know that the most mature and experienced geriatricians apply an almost innate conservatism to their practice. And they prescribe drugs very parsimoniously. So if we adjudicate quality on guideline adherence, we ignore people who are maybe operating at a higher cognitive plane than guideline adherence. And we are working very hard and diligently to improve the algorithms by which we adjudicate quality to account for these issues of multi-morbidity which, Chad, some of your colleagues have done some really groundbreaking work in that.

So I think we need better tools of measurement. We need better methodologies to advance processes of care. And maybe we can shorten that time cycle of translation from a decade to months.

MR. ALTMAN: Thank you very much.

Our final panelist is Dr. David Reuben. I met and worked closely with David during our two-plus years at the IOM Task Force. And I have now decided if there ever was a primary care geriatrician that I would like to have it would be David. I mean, his thoughtfulness and his compassion was, you know, very evidence. But I hadn't realized really David's potential power. Now, we've talked during this daylong several times about communication and the importance of communicating what we think we know, what we would like to know, what we would like others to do. Now, who better can do this than the Archstone Foundation chair and the professor at the David Geffen School of Medicine. I mean, this is Hollywood. (Laughter) This is Disney. This is the -- after all, the capital of communication.

So, David, I think you should stop dealing with patients and start dealing with the people that are funding you to sort of get us to communicate better what we're all about.

DR. REUBEN: That's what my chair says, too.

MR. ALTMAN: That's right. He is a geriatrician.

DR. REUBEN: So, in any event -- not on my bio. You can look at my bio and see what I've done, but one thing that's not on my bio is I'm one of the charter members of the Society of Davids, which is committed to the principle that there are never enough Davids in any room. (Laughter) But I do not -- nothing I'm going to say is going to represent its values.

I also kind of feel like -- I feel like Paul McCartney. You know, they have all these concerts where Paul McCartney is always the last person. Everybody hangs around for him. There are a couple of differences. One is I don't sing like Paul McCartney, but I could probably clear the room pretty quickly. And the second, as my wife likes to refer, I have a rich fantasy life. So, I can feel like Paul McCartney, but I'm not.

So in thinking about this I've been doing some active listening and a lot of writing today. And I've come up with the title of this little session of "Caveats, Caution, and Optimism." And so that you'll know when I'm almost done -- you have to listen to it -- there are seven points I'd like to make.

So, the first point is everyone isn't us. And what we've heard today are really from

innovators. This is really good stuff, and maybe a few early adopters. But as Chad knows, I'm a great devotee of Everett Rogers. And there's five steps: There's the innovators, the early adopters, the early majority, the late majority, and the laggards. And we are just kind of skimming the surface. We are really just the vanguard who are out there.

I know this very well because a lot of what I do in my research is to try to recruit practices. And when you recruit practices you get a lot of nos. I would say I probably recalled a hundred practices and always chaos is going on. It's kind of like everything is in a storm. They're switching over to an electronic health record. These docs call me back at 10 or 11 o'clock at night. It's like totally chaos. But the practices that are actually doing the good work that we're hearing about are the Intermountain Health. They tend to be much more innovative types of practices.

I was talking with one of my favorite geniuses over lunch, Diane Meier, and she was talking about rolling out the palliative care because she's done a terrific job with this. She mentioned this morning there was nothing going on a decade ago and now it's in 70 percent of the hospitals. But her strategy was to get it out there and then work on refining it for the fidelity. And I think, you know, I think that's just brilliant. But there is this disconnect between what can be done during the best case circumstances, the efficacy, versus what we can really disseminate out there.

Number two -- only six left. Don't worry; I'll take care of it.

So don't worry, I'll take care of it, is a lesson that I learned in going into some practices in the desert in South California when we were trying to have them address falls care -- to give better care for falls. And we had all these kinds of ways of delegating things. And we wanted them to delegate orthostatic blood pressures. That's, you know, lying and standing, et cetera, because that's an important falls risk. And they said don't worry; we'll take care of it.

So, the doctors said they didn't want to delegate it to the medical assistants and they had these structured visit notes that led them through it. And sure enough, the docs did it twice as often as the control docs, 10 percent versus 5 percent. (Laughter)

So, it turns out that, you know, we've done everything we can to beat up on physicians and cajole them, et cetera. And we can get them from about 30 percent quality for these geriatric conditions to about 60 percent. So that's about as far as we've been able to get them to do

this by themselves. There are certain things you can get docs to do. You can teach them how to do gait and balance evaluation. That I think is pretty cool. You will never, never, never get a physician to fill out a PHQ9. It's just against their religion. They just won't do it.

So, it does have to be a team. It has to be a team. And we still don't know who needs teams; who should be on the teams; what they should do and how they should do it. But we do need teams.

The third point. This is going to really date people. How many people in this room remember The Rough and Ready Show? A few. All right. The Rough and Ready Show. The Rough and Ready Show had a lot of things. It was a cartoon show in the '50s and they had somebody named Tutor Turtle. Anybody remember Tutor Turtle? All right. So Tutor Turtle used to always get into these situations and he would get in terrible, terrible trouble. And to get out of this trouble he had to go help Mr. Wizard. And Mr. Wizard would come out and relieve him from these kinds of terrible situations.

And that's kind of where a lot of our health professionals are, is help Mr. Wizard. I don't know what I'm doing. I don't know how to lead a team. I don't know how to provide chronic care. And this gets at some of the things that Diane and Chad were referring to. Just throwing money at dysfunctional practices isn't going to do anything. They don't know how to use the money. They don't know how to use the money. So I always -- a lot of people think about patient center and medical home and the premium that might come with it as a way of increasing the primary care physician's income. If that's what it's used for it is a huge mistake. It needs to be invested in developing teams there.

Okay. There are two professional -- two workforces that need to be developed. One are those who are in training -- the folks who are coming through and they're getting no team training. They're getting no training in chronic care. They're getting all sorts of other stuff. And then the much larger market of the people who are already practicing because they don't know anything and they're actually doing the work.

Fourth lesson. They aren't silos; they're grain elevators. Apparently, silos are where they store ICBM missiles. And anything that's above the ground is a grain elevator. I was just



corrected of that. So these aren't silos. (Laughter)

So why am I referring to this at all? And why is it a lesson? It has to do with scope of practices. And if you think health care reform is hard -- getting something through the Senate -- try to get something through your legislature and your state about scopes of practices. There's all sort of guilt problems. You know, anybody is willing to move up the ladder, but nobody is willing to delegate down because it's infringing on their scopes of practices.

Number five. Can we go back to paper? (Laughter) Has anybody heard this? So this is a really interesting thing. Some of these electronic health records come in and the docs in particular, particularly if you're over the age of 50, you hate them. We were just in a practice trying to implement something and none of the docs had ever used the electronic health record. It was amazing. It was amazing.

So the electronic health records -- a lot of the things that we've heard about today, things like guided care. So when guided care was developing their model I asked Chad, you know, what are you using? Are you using Logician? Are you using Epic? Are you using Centricity? He said, oh, we created our own. And the reason why we created our own -- did you create your own, too? All right. Everybody is nodding. We created our own. The reason why we created our own is because these don't work on the big ones. They just -- and it's incredibly difficult to try to do that. They are innovation hostile. So, you know, be careful there. They're not the panaceas right now.

Number six. Measures have teeth and they nip at your ankles. So, in fact, I was so pleased that Greg Pawlson talked about the limitations of outcome measures because there's this rush to move -- you know, process isn't good enough and we're really -- what we want is what really happens, what the outcomes are. And, in fact, they're truly limited. In fact, even process and structured measures are limited.

About a decade ago, there was this movement in Canada that stayed there and didn't come down south about goal attainment scaling. And it was really interesting. And they just couldn't get these articles -- they used them as outcome measures for research papers and they just couldn't get them through the journals in the United States. But, in fact, that's what you really want. Is this working for the patient? Is it working for the family? Is it working for the provider? And is it

working for the payer? So if you can get concordance on all of that, guess what? It's a home run.

All of the outcome measures -- there are whole industries -- excuse me, all of the measures that are being developed and used, there are whole industries developed to create -- learning how to game these measures. So you get about a six-month or a two-year lag and then they've caught up and you've got to stay ahead of the game. So it's really -- you've got to be careful there.

And the last one -- so you're done with me -- is everybody knows I'm a geriatrician, and one of the questions I always ask is what is today's date. Okay, it's a cognitive screen. What is today's date? So today is January 28, 2010. It's very difficult when you're jetlagged, but it is. And if you go back 10 years ago, all we could do is rant. And we did, we ranted. We said, you know, you guys don't know what's going to happen when the baby boomers are coming out. You know, it's going to be terrible. There are all these people. And we didn't have much more in our armamentarium.

And now we know so much more. We know so much more. All of these models -- everything that's in this room that was discussed today has been developed in the past decade or so. And we know so much more and we know that it works. And even better news, even better news is that people are listening. People are incredibly sympathetic to what's going on here, even people who do most of their work a couple of blocks east of here. Okay? They know it.

Now, when they go into the negotiations with the sausage making, this doesn't enter into it. You know, the decisions and the deals that are being cut, there's really no policy in that. It's, you know, it's what you can bring home to Nebraska or whatever. But, in fact, they know what the right answer is and they know that this is the means for getting there.

So I'm very optimistic. I think -- I think that all the forces are aligned. There are some stumbling blocks along the road, but I think that the work that we heard today is really the promise for the future. And they better get this straightened out before I get old. (Laughter)

MR. ALTMAN: It may be too late for me.

Well, all right. Listen, anybody want to bring any questions up before I open it up to the group? We can -- all right. Yes, ma'am. Yes. Great. Again, just introduce yourselves so we --

DR. POPLIN: I'm Dr. Caroline Poplin. I'm an internist.

And why do we hear so little about physician buy-in or provider buy-in? Or provider participation in setting up the goals and models? I think that's one reason you have trouble moving from academic models developed by people who practice one afternoon a week to physicians who practice all the time.

MR. ALTMAN: Does anyone want to take that on? David?

DR. DORR: I'm happy to take that on. It probably was lost a little bit. I actually put my notes on my phone which is an HIT thing to do, but not a good idea with the microphone. So we've actually rolled this out to 90 clinical teams. And that issue of physician buy-in is sort of a different conversation than the one where I was sort of having here, but is equally important.

Our care managers are embedded in the clinics. And the first kind of step is we talked to the providers about the things they really struggle with that takes up a lot of their time, that they don't have time for right now. Maybe they'd like to make time for it in the future, but they really feel this intense time pressure. And then we talk about how the care managers can help out with really acting as part of a team to collaborate, to help them do some of the things they really want to do so that they're operating -- they're doing all the very high level things that they want to be doing in terms of the medical management. There's high level things that our care managers do in terms of education and sort of coordination of care that are crucial, but the physician is pretty overwhelmed generally already with the hundreds of lab tests that are coming in, in the day-to-day practice.

And so it's a crucial element. It's something that almost all the providers at the end of our implementation cycle are very excited. Only about five to ten percent don't really participate heavily. And the reason is that they really feel like now I'm in a supportive practice and I can do what I need to do.

And this has been in some smaller rural clinics, although Dave's point is well taken that it really helps if you have some infrastructure as well. So I think that's our big lesson. It's part of the implementation strategy that we all have to learn. And I think we need to continue to focus on the way we talk about this to these different populations that are serving these patients.

MR. ALTMAN: Let me try to answer that in a slightly different way being what's left

of myself as an economist.

I was on a program the other day with Don Berwick. And Don says we have a health care delivery system that functions perfectly given the set of incentives that are out there. And that unless we're going to change the set of incentives we're never going to change the health care system. The providers are there providing care in a system that they've grown up with. And to ask them to change is, yes, okay, I know what's right. So part of it is education. But if you don't change the basic set of incentives that they operate under, you will never really, in my view, change their basic attitude. They almost have to run against each other.

And as David pointed out before, sure, you're going to get innovators. You're going to get the people on the top. They're always -- people are always changing, but they're not the rank and file. They're not the middle of the pack. And they're surely not the laggards. So we -- ultimately, to make the kind of changes and to get the buy-in, which I think you're absolutely correct, we have to get the delivery -- the physicians and the whole health care delivery system to see in their interest to do it. So it's a combination of doing right and also surviving.

So that's the first thing. But there's another side. And I thought about asking this. When Diane Meier made the comment and back and forth, I thought it was a very important one, but it has problems with respect to the patient. Because we also got to get buy-in from the patients. Now, if you get buy-in from the patients that basically say to patients you can go wherever you want. You can get any care you want and we will pay for it. Yeah, you probably are going to get a segment of the population that's going to say, well, I'm smart. I don't want this; I don't want that. And that sounds right.

I don't buy it. I don't see it enough. We need to also change the set of incentives for patients. And one of the things that we have learned is that patients -- like, take Medicare Advantage Plans, which have been beat up a lot, but we also have over 10 million Medicare people that have signed up for Medicare Advantage Plans. Why? Because they saw value in joining something that they got extra value for. So, yeah, it's nice to find that if you just talk to patients they're going to do the right thing. You also, I think, need to develop a package that puts the patient into a delivery system before they need it so that when the time comes the thing all works together.

And then the third is the system itself. People have a lot of nice things to say about what goes on in Europe as opposed to the United States. What do they do that's so innovative? Basically they pay differently. They have budgets. They also play tradeoff. People know from the beginning they're going to get more of X, Y, and Z, and they're going to get less of G, H, and I. And they're convinced that the G, H, and I doesn't help them.

So, the bottom-line for me is we need to figure out a way to get buy-in from the physicians and the delivery system; buy-in from the patients; and buy-in from the system. And right now we don't have any of them. We have a fee-for-service system that encourages doing. And we have a group of patient advocates who want more, more, more and more. And we have a system that really can't get its act together. So we've got to change all three.

Other questions or comments? Yes, ma'am?

MS. BERGER: Thank you. Sara Berger, Hartford Institute for Geriatric Nursing at New York University College of Nursing. I'm also head of the Coalition of Geriatric Nursing Organizations, which you may be surprised to find there are eight of them. So that's wonderfully encouraging.

I wanted to talk a little bit about the nomenclature that we're using the semantics, and it sounds picky. On the other hand, I'm thinking of the work you're doing and what will happen in the future. The words "medical home," Mark McClellan picked up this morning on that at the end of the first session and very rightly so. He said you're talking about interdisciplinary care, all the disciplines. You're talking about social and support services. And with that triumvirate, indeed it isn't a medical home; it's a health home or a health care home.

And so as you're going through the deliberations and looking for something -- some way of making this palatable to the public -- and I think the partnership being able to use this information, I would suggest you think carefully about the language because it's going to be very hard to explain what these new support systems are if you're still calling it a medical home, which is really old thinking. And you are definitely new thinkers. (Laughter)

MR. ALTMAN: Anybody want to jump in about the issue of medical home, either on the panel or several of you have used it -- our other panelists? Did you want to say something about

that?

MS. PINKOWITZ: Yeah, I just wanted to add to what Sara said about your language. When we think about -- oh, I'm sorry. Jackie Pinkowitz, just as a consumer advocate.

When we think about families and we think about their quality of life and quality of care, we are not talking about acute care; we don't call them patients. So I would love this particular, you know, moving forward, to think about a very different kind of a name where you're talking about person-centered care and services and you're trying to connect the person, their family -- a whole wraparound system with professionals, just like we talk about it for special needs children -- which I'm a special needs educator.

And in the world of advocates for the disability population, they talk about self-determination. They talk about the person is at the center. Then there comes the family, the natural support system. And then all the other professionals. And the physicians -- it's not one physician, you know, it's multiple physicians. And so if you asked boomers who are dealing with this year after year after year what we would like to see, we would like to see the professionals understanding that we have been members of our parents' health team way longer than any of you can possibly imagine. And we don't want you just educating us. We want you treating us as partners. We know so much about these people as people.

And for an entire day what I have heard is that you are all going to talk to us. You're not going to interact with us; you're not going to listen to us; you're not going to allow me to tell all of you what my father was like before late stage Alzheimer's so that all of the professionals can deal with him humanistically, the way I want all the partners in care to deal with him?

MR. ALTMAN: I think the comment that you raise is a very good one, but it's been raised before. And I thought several of the panelists in the previous discussions talked about bringing in the family member as part of the care management team. So I think there is a lot of support for your comment.

Do others want to say something? Go ahead, Jim.

DR. TALLON: Just that it's not all what health is going to do for us. And I think a lot of the tools that have emerged that are evidence-based are consumer mobilization tools to create

insight and to give people a platform. Much as we see in palliative care, we see in chronic disease self-management and falls prevention offering people the questions and some information and then room for dialogue to enhance decision-making because people have to mobilize themselves to these new solutions, even if it's using the health system differently how you communicate with your physician and other members of the team. It's more of a secretive process. That's why I think it's very important that the Administration on Aging is scaling some of these tools that are really motivational interviewing-based and help move people -- including us because it's really universal; it's all of us -- through a decision process about how we can contribute to better health for ourselves and those we love through changes in lifestyle and the way we live day-to-day because, of course, the interface with medicine is brief and the rest of life is large. And so the rest of life has to be managed as well.

So I think your point is well taken. It's a very universal and multifaceted, and very fundamental change that we're trying to drive here. And who said it was culture change? Mary, I think. And I think it is. It's culture change in subgroups of the society and the society as a whole. It's really big, but we have made so much progress as you say, and I think it's time and we're moving forward.

MR. ALTMAN: David, did you want to say something?

DR. DORR: Yeah, briefly. I mean, one of the core fundamentals we try to educate our clinical teams about is what you're talking about. Essentially that they come into this person's and their family's and their caregiver's life for this brief period and there's usually no successful solution that involves them staying there forever. So they need to plan their obsolescence and listen to them. So, for example, one of the first questions -- what worries you the most? What's your biggest priority? Very different things than you would keep normally in an electronic health record, which I think are crucial elements that we really need to disseminate -- that we hear the voice of the person and their family and their caregiver every time we look in that chart as professionals, and that becomes something that's so salient for us knowing them. That's really from the health information technology side. I'm really talking about trying to figure -- put the right things in there so we're thinking about that all the time.

SPEAKER: But that's driven with questions, not just advice. And so that's the

fundamental shift, I think, is asking, listening, and then interacting with that.

MR. ALTMAN: David, do you want to join in?

DR. MARTIN: Sure. I think I'm almost embarrassed because I was so late coming to the conclusion of how central patient activation is to care management. I mean, it's the substrate on which everything else is layered. And I think that, you know, Chad brought up the issue of motivational interviewing in his talk.

But how do we activate patients? And this is an area that's complex enough that I think it's another area where multivariable testing can get us there faster. But I do appreciate the comment. I think that the dialogue needs to be more bidirectional than it has been between health care providers and patients.

MR. ALTMAN: David, do you want to --

DR. REUBEN: Yeah, a couple of things. And I'm going to go out on a limb and I may find myself in trouble for this, but I actually like the term "patient-centered." And I like it because it implies a responsibility of the provider. So, Stu was telling me that, you know, he'd like to have me as his geriatrician if he ever needs one. And that's fine. I'd love to be his doctor if he wants to move out to Los Angeles.

But that's different. Now, he's a person to me and he might run some things by me and I give him some advice and, you know, have a nice day. You're out of my life. But when I have a patient, I have a relationship to that patient. It's a covenant that I have established with that patient that I have a responsibility to them. And I don't have a responsibility to persons; I have them to patients. So I think there's something about that.

Now, that said, you know, the collateral information of who's a member of the team, that's, you know, if I didn't have patient families I'd be up a creek. I mean, they're the best source of information that I have frequently. And if I don't have them, that's when I really am in trouble. When I have a patient who comes in who is demented and nobody can speak for that person, then I'm really in trouble.

But, in fact, yeah. That's just saying we need to get all the information we can have to make the best decisions for patients.



MR. ALTMAN: Other comments? Yes, sir. In the back.

SPEAKER: Just to follow up on that last comment. I think the distinction here is between patient- or person-centered and patient- and person-directed. And that latter construct comes more out of the disability community and it really changes the discussion of who is making decisions -- who is supporting whom. And I think that's what we have to grapple with here. Patient-centered sounds better, but patient- or person-directed is where the consumer is given the resources, the power, the support to direct his or her own care.

MR. ALTMAN: Yes, Chad. Do you want to say something?

MR. BOULT: I just want to share with folks one important lesson that we learned in designing the Guided Care Model.

We knew from the beginning that this process of providing good care for people with chronic conditions was a multifaceted one, one that had multiple stakeholders in it -- patients, families, nurses, social workers, doctors, pairs. Lots of stakeholders. And we knew that for any new model that we would create, to be ultimately effective it would have to be satisfactory to every single stakeholder group. Because if it was unsatisfactory to any one, they basically have veto power. They drop out; it doesn't work.

So we convened what we called a Stakeholder Advisory Committee and we presented them our initial architectural drawings of what we thought would be a good model. And we said to them if the research shows this worked would you adopt it? Would your group say I want that? And what an eye opener that was. People -- we had our blinders on as I think some of the people here have suggested. The pointy-headed academics don't think about the practicalities necessarily of what it's like for the doctor in the trenches and the patient and the family members. But by bringing them together into the room at the very beginning and saying, well, tell us what's wrong with this model. Why wouldn't you like it? It was a great opportunity then to incorporate what they suggested into a model that ultimately turned out to be pretty robust and popular with all the stakeholder groups.

So for innovators it's a lesson that I would like to pass on, to broaden your perspective beyond your own and bring in everyone who would be ultimately affected.

MR. ALTMAN: We have time for one more question. Bruce, do you want -- over here. Here.

DR. CHERNOF: I just wanted to raise a challenge sort of building off of what we just heard and ask you guys to respond to it because I actually think this issue of language is really important. We talked a lot about all the really wonderful models that are out there; a little bit about how you bring them to scale; a little bit about how you measure them; about kind of changing the business care underneath them. You know, what's the value proposition and why should they work for those who work in those systems.

But I think language is really important. It's been one of the problems in the Health Care Reform discussion, frankly. So I'll give you an example outside of our discussion and then one in. The one outside is I don't think donut hole is a great way to talk to seniors about the piece of their drug coverage that's not funded. You know, you'll hear that, you know, inside the Beltway constantly, but it doesn't resonate with average people when you talk about it because it doesn't -- the construct doesn't make sense.

And so to bring it back into this discussion, you know, I think medical home is a challenging phrase. I mean, first of all, homes have a kind of paternalistic quality to them. They have like a mommy and a daddy or a mommy or a daddy. And so where do you fit in that family? You know, I've never -- whether people sort of explicitly bring that bias to the table, implicitly it's sort of there.

The other challenge it sort of raises is I'm not sure anybody considers the doctor's office or the hospital, or wherever the situs of care is, their home. And home has a location-ness to it, which may be different than what we're actually talking about in this model. I mean, maybe the doctor has an office or a place of practice, or a team may have a place that it's centered.

But that raises another really important challenge, which is, you know, the doctor doesn't consider it his or her home. Probably the care coordinator or the social worker or the nurse doesn't consider it their home because they all go home to a home. The patients have a home that they go to. So it's kind of -- it's sort of a dissident notion. I don't know that it's anybody's home.

And the problem with the medical system is it kind of gets linked to how charts are

written. You know, as a physician to all the other physicians who are here, you know, we have a habit of saying this 93-year-old and then you list in abbreviation all their conditions. So the average doctor note says this 93-year-old, hypertensive, diabetic, COPD. And then, you know, even if you do a really good note and you think about their social conditions and that electronic medical record may be set up in a much more patient- or person-centered way. But, you know, there is that kind of inherent notion in how medicine has been practiced for a really long time. And I have never met a patient when they pass away or a person that wants their tombstone to say I was a 93-year-old, hypertensive, diabetic.

So I just worry a little bit that the phrase “medical home” isn’t the best way to deliver this concept, even if the ideas held within the concept are good and deserve kind of a much broader play. And I’d be interested in how you’d respond to that.

MR. ALTMAN: All right. Comments? We’ll use this as the final set of comments. And I’ll turn it back to you.

That’s a good challenge.

MS. SIMMONS: Well, it’s one more than what we’ve had in the past, so perhaps it’s a sign of progress. But it has a more human tone to it. But then perhaps it’s not the end-all and be-all. And it’s point well taken to think what’s next. I still think it shows progress and centers things somewhere that’s a more caring and humanistic kind of a perspective on care. And less episodic and less functional, if you will.

MR. ALTMAN: David?

DR. DORR: You know, I think June said it just about perfectly. That, yes, the term has some issues, but it’s trying to drive toward something that we really haven’t seen before. And so, yes, semantics are always very important to be inclusive, and especially as we’re talking about selling or not selling, but explaining and getting feedback from the people who really matter, the people we see in our practices, and who seek health care in this country and their families. But it probably indicates that we need to continue to innovate as we also translate forward.

MR. ALTMAN: (inaudible)

SPEAKER: I think Carolyn hinted earlier at the need for a taxonomy regarding

processes of care. And I think we do need a better taxonomy. It's probably not going to be too useful to get a bunch of health care professionals around to craft it though. (Laughter) So I don't think we would make any progress. It would remain as jargon-ish as it always has been.

So if we do create that, we just need to have broad input from members.

MR. ALTMAN: David has to think about what we should call it.

SPEAKER: Yeah, I've always had a fondness for contests. Maybe we can have a naming contest. (Laughter) And maybe the Hartford Foundation and the SCAN Foundation would give a prize to the best name for this. And then they could work on Medicare Advantage and renaming that as well.

MR. ALTMAN: Well, why don't we do it right now. Can everyone write down on a piece of paper --

SPEAKER: No, no. A big prize here. A big prize.

MR. ALTMAN: He'll summarize it.

Well, let me bring this to a close as the final panel before I turn it over. Also, thank the Hartford Foundation and SCAN Foundation and Brookings for putting this on. It was a very productive and, in my view, very positive, even in a negative context, view about how we move. Let's face it. This is not the most exciting times.

So I'm going to turn it back to Mark and the team. And thank you. (Applause)

MR. McCLELLAN: Thank you all. Thank you all for a great discussion. And Stuart, thanks for starting out with those deep heartfelt apologies and ending up on an optimistic note, which I think is the right place to bring our meeting to a conclusion.

We do have a few more items that I would like to cover. But before I do that I would like to turn to Chris Langston and Bruce Chernof for a few closing remarks.

MR. LANGSTON: So, it's gratifying to see all of you still here. And I know that I'm really excited because I've actually not dozed off once all day and I only had three hours sleep last night. So this has to have been very exciting.

I wanted to touch on a couple of points things that I heard and I thought were very interesting because I think we actually have some of the tools to make progress and to keep working

forward. So I wanted to feed that back to you all as perhaps a basis for future discussion. And then I was going to share a couple of bellyaches on things that I think we need to think more seriously about. So I'll just take a couple of minutes.

First off, I think we've talked about and heard about a couple of different culture problems. And we've talked about the need for culture change. And I think one of them is founded on the belief -- sort of amorphous out there -- that we have the best health care in the world. And obviously, people in this room know in lots of different ways that's not true. But there's an assumption within the health professions that they're prepared and they know what they need to know and it isn't until it's sort of too late that they find out that they don't.

We actually have some room for improvement on that. So the Elder Care Workforce Alliance, co-founded by the Atlantic (inaudible) based in Hartford, is working very hard to have health care professionals and paraprofessionals and family caregivers get the competencies they need to do their jobs better. I think that they also need -- health care workers need to be deployed better, used in more effective ways at the top of their competence -- when we get them competent -- rather than at the bottom of their competence. And that's another piece that we're trying to work on.

We talked about teams. And that's part of the deployment issue so that people do the right thing the right way. And I know that later this spring the ABIM -- the American Board of Internal Medicine -- is going to convene a meeting on education for teamwork in health care among the health care professionals, and the Macy Foundation is very interested in that. And Robert Wood Johnson might be getting interested again. I've detected some signs in the force.

We also have the cultural problem in that as people, as citizens, as family members, we have a strange kind of denial of aging, and a denial of disability, and a denial in many ways of death, although actually I think it's really disability and frailty that we're more in denial of. Death is okay. It's peaceful at least. But the campaign for better care I think is trying to harness the experiences of people who have really dealt with disability and aging in some of its very difficult, very challenging stages. And elevate awareness and lead people to take action with that. So we have some mechanisms for addressing those cultural problems.

I think we've also identified that we have a real need to create a culture of innovation and improvement. And until just like this week I would have said, you know, like Toyota. But maybe not so much. (Laughter) What Toyota was supposed to be.

And this has come up in a lot of different ways. We need to take action now. We need to work towards a better outcome and better set of value for what we're spending and what we're doing. We can't wait for all the signs to be clear. It's never going to be all clear. And yet, we also have to have the ability to continuously improve. And so I really think that Toyota model of continuous quality improvement is actually the right way. To do that we need measurement. We need the right kind of measurement and we need it fed back so people can keep making change over time. This is something I was very gratified to hear that AOA is interested in; ARC, obviously, is interested in; the Long-Term Care Quality Alliance is interested in; and we are certainly very interested in.

But it is a profoundly cultural change because you have to get over this point that we have the best health care in the world. We don't. We need -- it has to be an intrinsic responsibility to continually improve. You cannot just say, oh, I always did it this way. I can always do it this way in the future. Not good enough.

Obviously, we talked a lot about regulatory and payment policy. And I was really glad to hear Mark say that, in fact, CMS has an awful lot of the authorities needed to change payment and to create the conditions under which people can do innovative and new things and try to deliver better quality. Obviously, what is needed is capitation or some kind of gain sharing so that the incentives are better aligned for people to do new things and they have some money with which to do them. We can't ask people to do new things unless there's at least some start-up capital in the system; something to prime the pump so they can hire new staff, and deploy people in new ways, and train people to do new things. Otherwise, of course, they'll just keep doing what they know how to do.

So, this is where I want to bellyache a little bit. We've talked about some of the successful innovations and some of the difficulties in scaling and some of the problems out there. And we've also heard a little bit about the very exciting areas of translational science and

dissemination science or innovation. And I find that all a little frustrating because one of the things that it doesn't really acknowledge or address is the fact that all that scaling and innovation and spread costs a lot of money. It just costs money. You can't do it without new resources.

The Center to Advance Palliative Care got 70 percent of hospitals over 100 beds doing palliative care because there was a funding mechanism already based on DRGs because it was within the bounds of what they could do as feasible, was (inaudible) appropriate, but it also cost RWJ and Jet Foundation and others upwards of \$50 million to do that. So it costs money. And unless there is a willingness to do the extension service kind of idea to really invest in technical assistance, it's not just, oh, it's too complicated; oh, I don't want to do it. It costs money. We have to find the money somewhere in the system to create continuous improvement.

Toyota takes, I don't know, 10, 15 percent off the top every year. Reinvests in what it does to make it do it better and more efficient. And if we don't have that kind of discipline here, we're not going to get better outcomes over time.

One last bellyache and that is I think we've talked an awful lot today about the quality problems that emerge between the silos -- or, I'm sorry, between the grain elevators. I don't know. It depends -- you're falling a great distance, whether it's into the ground or from a height. Anyway, it's a bad thing. But we also, I think, have to look at the problems of quality within the silos as well.

So, again, we don't have the best quality health care. Primary care doesn't do what it should do all that well. Even with David's help they only get up to 60 percent, and most of them can't have David. Hospital quality is obviously not what it should be either. Long-term care quality, I'm not even going to go there. So, in addition to linking -- and of course, community service quality has its problems, too. It's great, but it doesn't always do what it should do either. We need to get quality within each of those domains tuned up.

So, thank you. (Applause)

DR. CHERNOF: Well, you weren't kidding. The room is really full. We all thank you very much for staying with us today because I think that this has been a tremendous and productive day at a very important moment. At a very important moment.

So whether health care reform passes or it doesn't pass, these issues cannot be allowed to just sort of get plowed under for 19.7 years -- the next time somebody decides it's time to have a health care reform discussion -- should that be the outcome. You know, we have an obligation to carry through on this work. And if we don't, we will be in a world of hurt the next time that discussion comes along because all of these things we've talked about today -- the state of the baby boomers and those who care for them -- we haven't even gotten into all of those issues today.

So, you know, how many children will there be to care for that next generation? So if the average family now has 3.4 children or something like that -- there's probably somebody who has the exact right data here and will hold me to it -- but it's small, but the reality is for the next generation, for the baby boomers, it's like 1.9 or 1.5. It's a much lower number. So for the generation that is receiving care now, the next generation for the boomers is half of what their parents had. So the whole system of care, even the family systems of care and the other supportive systems, will be different: sources of revenue, sources of care.

We're going to face an enormous challenge if we don't address these problems head-on. And I think today has really helped lay out nicely what some of the solutions are outside of the standard polls, which is, you know, just kind of continue to do something funny with fee-for-service. You know, it's an additional payment and it'll all be fine or the whole world can be solved by full capitation which only works in a certain percentage of the country. It's -- neither of those models alone can solve this problem.

So we are looking for innovative models. And payment and measurement drive change. So today really has been about models and measurement and money and how those all fit together and just how incredibly interrelated they are.

I want to pick up a little bit on some of the things Chris said because he stole a whole bunch of my thunder, I think, because we had similar thoughts. I kind of want to go to this translational point for a second which is we have to demand more of each other, whether we're in academics; whether we're in foundation life; whether we serve government roles. But we have got to get out of this place where there's always one more good thing we should test. And we've got this wonderful model, but if we just like twiddle the dial one more time we'll get a better care coordination



model.

You know, there's enough stuff out there that we know does work and enough stuff that we know where kind of the mistakes were so there are some lessons learned. And to Chris' point, we as a country, we as a, you know, kind of a group of organizations and entities and thinkers, need to be willing to take the next step. So that means, for example, for those of you who live in academic life, I'm not wholly convinced that the academic world values translational research. It feels to me the way health services research looked in the late '70s or the early '80s where it's like, well, you know, if you're not grinding a rat and running it on a gel, that's not real science.

Well, you know, I kind of hear some of the same things when it comes to thinking through how translation works. The reason why it takes 17 to 20 years to get something from, you know, the inside of JAMA into a larger system in health care. Any of these models is because, you know, we have not invested in what it takes to translate successfully the way other industries have. That's kind of your point, Chris. And I just kind of want to second it.

And I think we can start to demand that collectively. I mean, no one entity here is going to be able to do that themselves. And a lot of the best research on how to do it is going to come from places that are poised to do research on that. It can be academics or are other places. But we need to hold those things up as success and we need to help those organizations. We as foundations that fund those who do the work, we have to say that's really important. That may be more important from a priority perspective than some of the other things that we do. And that we need to expect the journals and the elected officials and the places where work is heard and seen and thought about, that it's valued. So that it's seen and heard in places where people are likely to act on it.

So I just want to really put in a pitch for finding a way to take the really good work the next step. And it is going to be expensive. And that means we're going to have to do it together. You know, I think one of the challenges here is how do delivery systems, foundations, kind of the civil society segment of the world, government, you know, how do we come together to really invest in change and then allow it to exist kind of in the exchange model where it's not going to be everything, every place, everywhere. But that there's a kind of set of principles that really work and a set of

outcomes you want. So how do you know that you're successful? And you leave some room for local innovation.

So that's really the challenge, I think, of translational science. And it's something that we should demand and foster. It's a better use of resources and continuing to do a whole series of little things. And people say, well, I don't know how to generalize that, and we're certainly committed to that. I guess I'm putting down a nickel where as a fairly small foundation we're looking for a merry band of crazy people to join us in this work. And we think they're out there.

I think we believe that language is really important, which is why I asked my question at the end. I wasn't asking it to be difficult. I really want the medical -- as an internist, somebody who believes passionately about the care of frail elderly, you know, we need the Medical Home Model, whatever you call it. But I think this issue of language becomes really appropriate. And it came up in the middle of the day. Right? We talked a little bit about where are the folks who want this with us? And I think that we have an obligation to work on that as well.

Long-term care to most elected officials is a total anathema. You know, long-term is just expensive, and care is just pejorative. So it's -- who wants that? And so we're going to need to find a better way to describe what it is we want because we all want it for our parents, but secretly we all want it for ourselves. I mean, there is something here to tap into which collectively we have not done successfully.

So I just sort of pose that as another challenge and that we're all really mindful of the language we use when we're developing things because it's a way, I think, to start to change the thinking. And there are examples of that.

You know, and that would be my next kind of major point, which is we have a funny way in the health care world of thinking about health care, but there have been other successful efforts, you know, at social change that we should look at. I mean, if you just look at, you know, FMLA, Family Medical Leave Act, you know, that work -- in that work they figured out how to talk about the needs of families. And I would offer to you that the care of a frail elder, the care of a family member with a serious disability, it's a family issue. There's really important parallels there.

And one of the things that they did really successfully in that campaign was to

understand how to cast the issue very broadly. So regardless of your kind of political leanings, you know, your belief about the roles of government, you know, the support of families, you could cast that argument effectively for all different kinds of groups -- for faith-based groups. And I think that there's a lesson there outside of health care. We're so used to doing it our way, but there are other ways of kind of effectively raising and communicating issues. And I think we should try to learn from some of those things. I think, you know, to the point of we've been talking to ourselves and we should probably pick -- have somebody else help us with language. I would just sort of accept that challenge and so I think it is something we should really think about.

The last challenge I would leave in front of us that I think is really important is that the long-term solutions to a better model are going to be solutions that make the medical model more person-centered and more effective and more efficacious. But there is also going to be a model that finds a way to link the social and medical services more effectively.

And that creates one last really important challenge. We can't medicalize the social service system, which is always one of the perils of when you do something like this. You know, in 2010, to build a tertiary care hospital bed in the United States costs roughly \$3 million, give or take. You know, and it costs, whatever, \$2,500 a day or something to buy a -- just a routine hospital bed -- something like that -- across the United States. You can't -- we can't take what we're proposing here and just sort of over medicalize it with all of the costs and, you know, the level -- the intensity of service, expectations that we create inside a hospital setting. It's not that we don't want high-quality service; it's not that we don't want good and appropriate and intense service, but we need to think about the environments that we're going to deliver those services and how we're going to pay for them. You're not going to be able to turn everybody's home into a hospital bed, I guess, is what I'm suggesting.

So we're going to need to think about, you know how we build those models of care, how we judge safety and quality in them. What standards do we think are appropriate? And I think that's going to be hard for us -- those of us who predominately work on the health care side of the ledger, that's kind of tough stuff because it's something we're less familiar with. And there will be a tendency to want to medicalize it.

But we should still set a high standard for quality. And we should be measuring. We should know that what we're doing actually is genuinely patient-centered, genuinely delivers quality outcomes for all those involved. And genuinely is a good use of money, whether it's public or private.

I just want to thank Hartford for giving us the opportunity to work with them on this project. And really, Mark, and all the Brookings folks, you guys have done a terrific job today.

(Applause)

MR. McCLELLAN: Thanks very much, Bruce, and Chris, and all of you.

You know, it seems like from the discussion today that what is emerging is a new focus for what has been health care reform. Not just medical care, but a broader emphasis on long-term services and support on the social networks, on what it takes to get to that emphasis on patient-centered or person-centered or patient-focused care. And I don't think the future health care debates are going to be the same if you keep doing what you're doing and if we keep building on this work today.

We may not have a name for it. Maybe we need a Brookings raffle or something for that. We may not have the best name for it yet, but there is an awareness of this in the general public at the personal level. And I think we're just a step away from it becoming a much greater awareness at the level of national policy reform and national cultural reform. And that's really the next step.

I was really moved by what seemed to be a pretty substantial consensus today that we know the general directions forward to do something about these problems. There are enough examples out there and we may not have all of the details worked out. We still may need to adjust the hot and the cold a bit and modify those showers or whatever the right analogy is a little bit more. But in terms of where we need to head in terms of measuring the right things and redirecting financing to support that and regulation to support that, and reforming delivery to go along with it. That all seems fairly clear.

The reason that we got to this point is because a lot of people did a lot of hard work. I want to thank the Hartford Foundation, especially. You heard from Chris just a minute ago, but

Corinne Rieder, for taking time to be here for the whole day. And also Amy Berman and Marcus Escobedo, who put in a ton of time for helping us get this together. The SCAN Foundation. Thanks, especially, to Bruce and Erin Westfall and Gretchen Alkema, and many others who made this event possible. That includes a lot of people here at Brookings -- Megan Carey, Beth Rafferty, Erin Wireter, Brynn Barnett, Nadia Nguyen, Sean McBride, and Aaron McKethan, in particular. And most of all, thanks to our panelists and thanks to all of you for the ideas that you brought to this meeting and this discussion, which is this nice, really rich mix of policy and politics, and scientific evidence and advocacy, and medicine and culture. I really enjoyed it. And you all made that possible.

And even under difficult circumstances of having to elbow into some crowded rooms -- an overflowing -- overflow room. I want to thank all of you who stayed with us today from over there and all of you who joined us on the web. There clearly is a lot more work to do, but clearly, as you heard from Chris and Bruce and everyone else here today, there are some very promising paths forward.

One of those paths forward is going to meet right here in this room in about 15 minutes. I want to remind you about the "Long Term Care Quality Alliance Information Session" to go over some of the practical details about the Alliance and its goals and plans. You get to hear from Mary Naylor and Doug Pace and others who have been very much involved in that if you can stick around.

But most of all, thank you, again, for a wonderful day, and especially for all you're doing to improve the lives of Americans. Have a great afternoon and evening.

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I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

/s/Carleton J. Anderson, III

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