Transcript

The following transcript of our annual report's Conversations on Health Care Costs has been arranged according to which participant is responding.

BCBSMA Foundation 2011 Annual Report Participants

Deval Patrick
Governor of Massachusetts

Don Berwick, M.D.
Former Administrator, Centers for Medicare & Medicaid Services

Deborah Enos
President and CEO, Neighborhood Health Plan

Rick Lord
President and CEO, Associated Industries of Massachusetts

Kate Walsh
President and CEO, Boston Medical Center

Jeff Levin-Scherz, M.D.
Assistant Professor, Harvard School of Public Health

Governor Deval Patrick Responds

Governor Patrick first took office in January 2007, during the early stages of Massachusetts health reform implementation. He has made cost containment one of his administration's top priorities.

Q. *Don Berwick:* Governor Patrick, in order to have a health care system that is sustainable and high quality, we are going to have to make a lot of changes in the way health care is organized and there is going to be resistance to change. So how do you think about mobilizing a political force that is strong enough to overcome that resistance and that is going to speak for reducing cost and improving quality?

A. Well, there is always resistance to change under any circumstances for any change. But I think that the health care industry here, working with the business community, working with patient advocates, working with government and people from both sides of the aisle, have shown themselves to be leaders in innovation. That is how we got health care reform in the first place. And that broad coalition stuck together to refine it as we've gone along. Now we have come to the next big part, and in some ways the critical part, of sustainability for universal health care, and that is cost containment. And here again that broad coalition has come together, has fussed about it with each other, and already is making lots and lots of changes in the market. That's why we're seeing the moderation in premium increases – that's one of the main reasons why. And the question is, how do we scale that up and how do we sustain it? I have a lot of confidence in all the members of this broad coalition. I think it is incumbent upon us to talk in terms that regular people understand, and that when we squeeze out costs from the system, we're assuring the savings get passed on in the form of lower premiums for working people.

Q. *Deborah Enos:* Governor Patrick, you have clearly exhibited leadership in moving the debate on health care cost in our Commonwealth. Can you share with us what your view would be of the optimal balance of government intervention with private sector activities as we move forward with health care delivery redesign?

A. I would say that one of the beauties of health care reform here, and this will not make the single-payer folks happy, is that we came up with a hybrid system which strikes a balance between the involvement of government and the role of the private sector, frankly favoring the private sector and private insurance. And it's working, and as long as we can manage those costs down, it can be sustained. And I think that's going to be the solution to cost containment as well.

There ought to be parameters and benchmarks that are set collaboratively, which is what we're working on through the legislature. And it ought to be up to the market, it seems to me, to drive at those, and they'll have a number of different strategies for doing that. One of the most sensitive issues, frankly, is the accountability for missing those benchmarks. Folks worry about that more than they ought to, I think. They ought to be worried about – and we're starting to see some focus on – how to achieve those benchmarks and how we start to bend that cost curve.

Q. *Rick Lord:* Governor Patrick, you've been a strong advocate for changing the health care payment system and the way health care is delivered. How do you feel about what's been accomplished so far and what still needs to be done?

A. Well, first of all, I think it is absolutely critical to get control of health care costs because we have this fabulous success in terms of expanding access, but as costs go up, especially for small business and families, at double digits every year, it's squeezing out everything else. People are feeling it in municipal and state governments and in their own households as well. We've used a number of tools, some through the insurance commissioner, who has used existing authority to disapprove excessive increases in premiums. Premiums were rising at an average of nearly 18 percent a couple years ago; they are less than 2 percent now, which is really terrific progress. We have moved on limited network plans so that people can choose a health care plan that emphasizes care in a community setting – a lower cost, but high-quality setting. There is movement and great progress in making the forms and codes used by insurance companies and providers common, so everyone's using the same language, simplifying the administration. And kudos to the industry for stepping up in these and other ways. Now we need, I believe, some legislation which creates some parameters to ensure this is sustainable over time.

Q. *Kate Walsh:* Governor Patrick, what are the risks as far as you are concerned of not controlling health care costs both in the state and in the country as a whole?

A. In the first couple of years I was in office, while we were talking about what the strategies ought to be for containing health care costs, premiums kept going up in double digits every year. And with all of the fiscal pressures on the budget it was squeezing out investments in worthy programs – in education, in services for the most vulnerable in our communities. And that is a scaled-up version of a problem that people are feeling in their own households, when they sit around their own kitchen tables, trying to sort out which bills to pay and which bills not to pay. We have to get health care and the cost of health care within a reasonable proportion of our total spend, and it's out of line. It can be done, and it has to be done by changing the way we deliver and pay for care, and it's happening here in Massachusetts. So I think, that just as we have shown the nation how to expand care to everybody, we're going to crack the code here on how to contain costs.

Q. *Jeff Levin-Scherz:* Governor Patrick, we know that health care is very expensive in Massachusetts and we also know that health care is a major driver for our robust economy. How do we know what is the right amount of money to spend in health care for our state?

A. Well first of all, health care is really not more expensive here in Massachusetts than it is everywhere else in the country. Sometimes I listen to folks criticize our own experiment in universal care as something that is breaking the bank. In fact, it's added about one percent of the state's spending to the budget and the pace of increase in premiums is about in line with Mississippi, for example, which is a state that has not shown a commitment to universal care. This is a national problem. And I think that the strategy of moving toward accountable care organizations, more patient-centered and integrated care, is a very, very promising direction. We've seen those early results here in Massachusetts and we want to scale that up.

I do hear people saying, oh my goodness, that change means it's going to affect one of the most important economic engines here in the Commonwealth. I'm sensitive to that. But I do think we have to be about how we create sustainable systems, and not how we protect just one, albeit important, industry. I think there is going to be some disruption. But I think that disruption is more in the nature of a professional who might have been giving care on a hospital ward, now giving that care in the community somewhere, maybe even in someone's home. There will be new kinds of jobs is my point, and it will all come out well in the end, and bring costs down, which is the most important thing.

Don Berwick, M.D., Responds

Dr. Berwick headed the federal agency that oversees Medicaid and Medicare in 2010-2011, after he had co-founded and led a national institute devoted to improving patient safety and quality of care.

Q. *Governor Patrick:* Don, you have been an incredible advocate for how we improve health care and mange health care costs. Talk about patient-centered care and how that is a strategy to both improve the quality of care and moderate costs.

A. I think health care needs to learn what every other industry has, that when you really focus on the needs of the person you are trying to help, that is when you are most efficient. You avoid doing things that don't help and you absolutely focus every single piece of activity on the value added to the customer – the patient in health care. If we do that in health care, health care will get less expensive. And it will accomplish more because we will be focusing on the need. There's this myth that people will break the bank by asking for health care they don't need and they'll engage in silly behaviors. I don't believe it, maybe a few people will. But people are pretty smart. If they understand what can help them and what can't help them, they're going to want what helps. I say trust the patient. If we get a health care system that is oriented directly to the needs of patients, it will be the system that we can afford and be proud of.

Q. *Deborah Enos:* Don, your vision of the "triple aim" – a focus on an individual's health and experience, population management, and cost containment – has been a principle that we've all come to know. Can you share with us how you think we have progressed along the past decade?

A. Well, I've come to see the triple aim – better care, better health status, and lower cost through improvement, all together – as a pretty good read-back on the social need; that's where we need to go. We're seeing progress – there are communities in the United States that are beginning to come together and to understand that all three matter. They don't want defects in care, they want care to be safe. They want better health status, which means they are going to have to invest in innovations outside of health care to improve the health of the population. And they understand that it's their money. It's all wages; that's the only fund for health care in America. And if we can find ways to reduce costs and improve quality, that money gets returned to people. They have other uses for that money.

I'm seeing it community by community in the country, but it's still too little. There needs to be a kind of mobilization around that vision that people embrace. I personally have a lot more confidence in the ability to mobilize that vision at the community level because that's where the rubber's meeting the road, than I have for the nation as a whole. We should set the stage for it, but communities are going to have to act.

Q. *Rick Lord:* Don, you've said that 20 to 30 percent of health care spending is waste and yields no benefits to patients. Can you give some examples of the types of waste you're referring to, and how, if we take it out of the system, we will reduce health care costs?

A. Well, this will get a little wonky but let me explain what waste looks like and how you can get rid of it. At the moment I'm thinking of six kinds of waste; my recent research has been about that. First the waste of failing to coordinate care for patients. When Mrs. Jones gets home from the hospital after being treated for congestive heart failure, if we don't have supports for her at home, if she doesn't know the danger signals of things to watch for, she'll end up back at the hospital, raising cost and reducing her own quality of life. So failures of coordination.

Second are failures of reliability in health care. For example, we know how to prevent infections in hospitals; a lot of infections can be driven to zero. But we don't do it everywhere. That failure to be reliable about using the science we have, well, that costs money and it reduces quality.

A third area is just over-treatment. It is doing things for people that they don't want, they don't need, and don't help them. Giving people antibiotics for viral treatment is just scientifically unsound. Over-treating people with medications that just can't help them, doing tests with no value. There's a lot of that in health care.

Then there's the problem of administrative waste. There's a tremendous amount of excess activity that is put into the health care system – record keeping, forms, and certifications – they may have had value once, but they have no value now. If we can standardize the procedures health care uses, then we can release the time for doctors and nurses to do what they want to do, to take care of patients.

The fifth kind of waste is pricing failures. We don't really have markets in health care for a lot of prices. Things that should have been commodities long ago are still priced way above what they should be. We can see this in differences in prices across the country, and between the U.S. and abroad.

And the last is an unfortunate fact, and that's fraud. Fraud and abuse. It's only a tiny segment of health care providers that actually steal, but there are some and we have to stop them. They not only take money, but then they force government and payers to do all sorts of surveillance of everybody that just adds costs to the system. If you just add up those categories of waste, I'm pretty sure it exceeds 20 or 30 percent of the total health care bill, and we should stop it.

Q. *Kate Walsh:* Don, how do you feel about the transformation that is taking place in health care; what will it feel for the patients, and what should it feel like?

A. There are a lot of changes we need that will be improvements for patients, but I think the flagship is coordination. The root cause of this insane cost of health care and the terrible experience that so many patients have; the root cause is fragmentation. We built health care in pieces. Even in a great state like Massachusetts, a health care system that in many ways is the best in the world, it is still fragmented. And as long as we're paying for pieces, we're not going to be able to afford the care. It's that simple. We need to put the pieces together into a coordinated experience. For individual patients that means it's going to feel like somebody's got your back. If you're journeying from one doctor to another, from hospital to home, they remember you, somebody understands the journey you are taking and can help you coordinate it, and is putting you in control. Because once we knit the thing back together, you become the center, and that's what we're after. So seamless, coordinated, patient-centered care produced by a system of cooperation, that's what we need. It isn't easy; it's really hard. The fragments are so well developed, the legacy is so long, that overcoming that's going to be a big deal. It's going to involve new ways to pay for care, it's going to involve new forms of communication and relationships, new corporate entities, a lot of shifting, And, I think, it will mean a change from a system that's centered on hospitals, which we need but that oughtn't to be at the center, to a system that's centered on home, where health and health care really ought to begin.

Q. *Jeff Levin-Scherz:* Don, you've said we need to reduce waste in health care and that we need to reduce it everywhere. That's a huge challenge – it's a political challenge, it's an economic challenge. Where should we start?

A. First, let's understand when I talk about health care transformation and making health care affordable, I'm not talking about taking away care that helps people. On the contrary, I'm talking about making sure that all of our resources are devoted to health care that helps. We can have the health care that we want and we need at a price we can afford. But we have to change, we have to take the waste out of the system and redesign care around the needs of the people who get the care instead of historical, legacy, fragmented systems. That's going to require a lot of change.

Why do I say we have to do it all now? It's because the clock is ticking. We've wasted decades trying to get the health care as a delivery system to be what it needs to be, and frankly we're headed for a cliff right now. If you look at the state of the country's economy, the state's economy, our position globally, the economic crisis, and you understand the role of health care in all of that, you understand that time is short. And so I think the era in which we could afford to think of small scales and pilots, and learning our way, and then going big – no, we're not there any more. We have to do it now. The good news is we know what to do, we have models for better care, and it's now going to take social will and political commitment to do what we know we ought to do, everywhere, now.

Deborah Enos Responds

Deborah Enos leads a managed care organization that is closely aligned with community health centers statewide. A majority of its 235,000 members enroll through MassHealth or Commonwealth Care.

Q. *Governor Patrick:* Deborah, I know you have given a lot of thought to some of the non-medical reasons why health care costs go up. Can you tell me a little bit about those?

A. I think for Neighborhood Health Plan and the populations we serve, effective cost containment really will enable, or has the potential to enable, us to reallocate the resources we are spending. Right now in our current system, an inordinate amount of resources goes toward acute and somewhat reactive care. We all know there are issues around prevention, particularly for the populations we serve. Many of these individuals have a multitude of social needs, all of which are important to their overall health and well-being, but are also important to their direct health. Issues such as adequate education, adequate housing, safe neighborhoods, access to food that is healthy, the ability to be safe, to be able to exercise in one's neighborhood, to be able to exercise and have physical education in school. All of these are factors that impact us all, and particularly for the people we serve at Neighborhood Health Plan, these are critical components. So I see cost containment in health care as an opportunity to reallocate some of those resources and to have an opportunity to focus on the some of the front-end preventive measures and the social issues that really impact the health care of the populations we serve.

Q. *Don Berwick:* Deborah, things are changing from the viewpoint of insurers, I'm sure. We can know much more about what is going to happen to an individual through their lifespan and some of the assumptions about spreading actuarial risk no longer apply. How do you think about the changing role of insurance in this new era of biotechnology and health care reform?

A. Well, I think it's an excellent question and I think the role of health insurers is evolving now and will continue to evolve. With respect to actuarial risk management, one of the interesting things is that, currently, approximately 50 percent of people who are insured through commercial insurers are in administrative services agreements. The health insurance plans are not bearing the risk. So, already we have begun to move to provide value in other ways. As health plans we have a focus on population management. More importantly, we have information about the whole population, not just patients. Because we process transactions, there's a wealth of information that we have that we can share with providers and others that really get at the questions of "right care, right place, right time."

The other area where I think health insurers provide considerable value and will in the future is with respect to the programs we develop, both those directed to outreach to individuals, and education, and also clinical programs. I personally believe that the best clinical programs are those that are closest to the patient and the provider. Having said that, there are a number of areas where health plans have developed programs that bring additional value to providers and to

patients, and also there's the issue of scale. We have an infrastructure such that we can provide an array of services even for those things that are rare and scarce, which would be difficult for individual providers or provider groups to do. So I really see the evolving role of health plans as working much more collaboratively with providers, and I'm really excited about it.

Q. *Rick Lord:* Deborah, you have been a member of the Massachusetts Health Care Disparities Council since it was established as part of health care reform in 2006. Can you tell us what are some of the causes of racial and ethnic health care disparities that exist in our health care system, and what can be done about them?

A. The issue of health care disparities is something that we are all concerned about. There are disparities across three areas – access, treatment, and outcomes. Under each of those categories, there's a variety of underlying causes. There is also the tremendous influence of socioeconomic factors and other social determinants – in terms of where people live, their access to healthy food, their ability or lack thereof to be free from violence in their own neighborhood or other toxins in their neighborhood. There's evidence that the construct of racism in itself and the stress related to that is a factor in poorer health outcomes. There are so many factors involved, and at times it seems so big, it's really easy to become almost paralyzed. I think the first thing we have to do is not allow ourselves to become overwhelmed.

One particular issue we have recently worked on is with respect to mammography screening. We saw we had a disparity with African-American women in the health plan. We worked with others on a multi-pronged strategy, with community education, outreach, advertising, provider involvement, engagement of the actual members and other women giving us feedback, which was critical, about what worked for them and what did not. We were able to put together a program and, I am happy to say, for two years that disparity has been eliminated and it is holding. It's one example; unfortunately there are many disparities. The health care council has recently developed and published a report card. It is excellent – it falls into that category of needing data – it is also extremely sobering. So there is good information and I think the key is, we need to start somewhere.

Q. *Jeff Levin-Scherz:* Deborah, you've led a health plan that takes care of many people of low incomes, and many underserved. What kind of lessons have you learned in making care more cost-effective that we can apply to the rest of the population in the Commonwealth?

A. I think we have had a unique experience at Neighborhood Health Plan in working with the populations we serve, and there are a few areas that I would point out. One is a bit back-to-the-future, but it really is the importance of primary care and the concept of a medical home. Neighborhood Health Plan was founded by community health centers and most of our members to this day still get their care coordinated through community health centers. And that concept of a place that offers comprehensive health care and that also helps an individual navigate the system has been extremely

beneficial for the populations we serve, but I think we are coming to learn it would be beneficial for most individuals. The other thing is the concept of integration of services, the integration of medical and behavioral health, and one that is not thought of that often but really is critical for serving vulnerable populations of any kind, the integration of what we call social care management. Many of our members, most, are living lives that are complex in many ways. In addition to dealing with their health care issues, they are often dealing with socioeconomic concerns and challenges – housing, food, you name it. So the concept of extending the construct of health care to include all of those items in an integrated way has really proven to be a model to best serve those vulnerable populations. I would say, moving to other parts of our commonwealth, the same concepts are applicable, particularly for those with complex health care conditions and those who are the sickest of the sick. We have seen this when we've had an opportunity to apply it to some other patient populations. I really think that is the construct that would be most beneficial and we could learn the most from as we move to reinvent our system.

Q. *Kate Walsh:* Deborah, what do you see as the responsibilities of individuals, both as patients and consumers, in solving the health care cost problem?

A. You know it's interesting in health care, it's something that we all need, we all use, and we probably know the least about in terms of anything that we do, or that we purchase or access. But I think there's a reason for that. Number one, there is a knowledge gap, if you will, between the individual as a patient and consumer and those that are providing the services. But also there hasn't been ample information. I think we are making some strides with respect to information and providing information, but I think this concept of engagement really is about more than just cost. I think it starts with individuals having the information, feeling empowered about their health care in general. That has to do with their access to health care and the quality of their interactions with providers, and then cost becomes a piece of it as well.

I think there are promising signs in some of the innovative ideas that are happening with respect to commercial product designs that create incentives for individuals to understand a bit more about cost and to be a part of the equation with respect to incentives. But I think that can't be the only answer. With the populations that Neighborhood Health Plan works with, for the most part, the financial incentives are not part of the equation. And so I think it's really important that we focus on patient engagement, consumer engagement in their health care – that it is okay to ask questions – and we need to empower people. As a rule, once that is done, we will begin to see more attention and engagement, not just to their own health care, but also to where it's provided, how it's provided, and cost, even if they personally are not paying the bill.

Rick Lord Responds

Rick Lord leads the state's largest association of employers. He has been a long-time participant in health policy and represented the state's business community on the board of the Massachusetts Health Connector.

Q. *Governor Patrick:* So Rick, how can the state best work with the private sector to manage health care costs down for everybody?

A. I actually give a lot of credit to the state legislature and your administration for spurring actions that are beginning to show signs in the marketplace that health care costs, at least the increases, are beginning to come down. And I would cite a couple of examples – the fact that the Attorney General and several state agencies really produced some meaningful reports that have shown us what are some of the cost drivers impacting our health care system. And probably even more importantly, your decision two years ago to disapprove the small group insurance rates that were filed by the major health plans. Although the health plans weren't too excited about that, I do think it put everybody on notice that double-digit health increases going forward weren't going to be tolerated. So where do we go from here? I actually think the role of state government now is to set meaningful targets for further reductions in the cost of health care, to monitor our progress in that regard, but then to step out of the way and see if the market forces can work to begin to address the high cost of health insurance.

Q. *Don Berwick:* Rick, in the end, health care costs, it's our money. Labor, business, stakeholders here in the state. How can we form a stronger collaboration among the people who are actually paying the bills?

A. I certainly agree with your premise that this is an area where labor and business have a very common interest. Certainly in the last ten years as we've seen these double digit rate increases for health insurance, they've been shared by employers who have been struggling to pay their portion of the premium and by their workers. And employers, unfortunately, have had to push more of their costs over to their workers, and I know many of the employers I talked to say they can't do that anymore. So we need to work together with consumers and labor to find ways to make our health care system more efficient. One area in particular that I think we could start at right away is implementing meaningful workplace wellness programs. If we succeed there, employees will be happier and healthier, and, hopefully it will save employers money in terms of health insurance premiums. So, I think that's a win-win for everybody.

Q. *Deborah Enos:* Rick, can you share with us your view of what is the role of business in health care cost containment; specifically I would be interested in hearing your view of what I, as a CEO, not just of a health plan but of a company of 400 employees, should and could be doing.

A. You do have an interesting role in that you head up a health care company, but you are also a leader of a major employer with 400 employees, and you are purchasing health insurance on their behalf. So I'm sure it's a major cost that impacts your bottom line. I believe that you as the leader of that business can play a very proactive role in terms of managing that cost. We encourage all of our

members to look at their benefit design, look at the types of plans they are offering. Today there's a lot more variety of health insurance products in the marketplace, some of which encourage people to receive care in more appropriate settings. I think every employer needs to look at that, and figure out what works for their particular workforce. But we really do believe that business leaders can be more empowered to take proactive steps to reduce their health insurance premiums.

Q. *Kate Walsh:* Rick, consumers most often think of health care costs as it relates to their deductibles, copays and premiums. How do we engage consumers to think about how health care costs affects the economy and their lives in general?

A. I'm not surprised that consumers think in those terms, because that's all they've known, that is all they pay when they go to the doctor, or go to the hospital, or use any facility. They have been totally sheltered from the real cost of the health care services they received. I think step one is to make transparent data on cost and also quality, so consumers can actually make intelligent choices. I think, secondly, employers can play a big role in terms of educating their workers. Most people who work get their health insurance through their employer, so part of the employer's job is to educate their employees at becoming better consumers and making more intelligent decisions.

Q. *Jeff Levin-Scherz:* Rick, employers agree that health care costs too much in Massachusetts, but on the other hand, health care is a major employer in the Commonwealth as well, and health care is a major driver of our economy. How do we balance making health care affordable, especially for small businesses and new businesses, with keeping the positive impact of health care on the Massachusetts economy?

A. I'll share with you one piece of data. A year ago we polled our members about their concerns in terms of doing business in Massachusetts and 97 percent cited health care costs as their number one concern. So it clearly is a problem that needs to be addressed. We appreciate the importance of the health care sector to the Massachusetts economy, but we pay for it because it clearly impacts the growth of other sectors of the economy. So there needs to be a balance. I actually think we would all be better served if there were fewer people employed in terms of taking care of the sick, and more people employed in terms of helping to make people well. Because if we are successful there, I think we will actually reduce the cost of health care, and we all will be better off for that.

Kate Walsh Responds

Kate Walsh leads the region's largest "safety-net" provider, a 508-bed teaching hospital that mostly serves low-income residents in conjunction with a health plan and affiliated health centers.

Q. *Governor Patrick:* Kate, give me your view, give us all your view, of some of the most promising innovations in managing health care costs and how we scale those up.

A. Well, I have a quintessentially Massachusetts solution to that problem. At Boston Medical Center we have been working with folks at MIT and their computer science lab to create something called project RED, which is the re-engineered discharge. And with project RED, we use a combination of nurses and a computer program that has an avatar that essentially quizzes patients on their readiness for discharge. The avatar's name is Louise and she can speak in multiple languages, and we think the combination of patients knowing what they are in the hospital for, what discharge medicines they are going home on, and what the follow up plan is, their family being able to review that at their leisure – any time you have a computer screen you can review this – and doing this in a language that makes sense to people, will really improve discharges and reduce readmission. As you know, one in five patients is readmitted to the hospital. If we could reduce that, patients would be happy, we could save a lot in health care costs and we think this is an imminently scalable, technologically based solution that has great promise and has demonstrated savings already at our own hospital.

Q. *Don Berwick:* Kate, you spend your time thinking about how to meet the needs of the most vulnerable and stressed parts of our population, people with multiple chronic illness, poverty, social stresses, and behavioral health problems. What do you think we can learn about good care for that segment of the population that applies to everyone?

A. Health care is a very complicated business; people's lives are very complicated and busy. I think those programs that meet patients where they come from, in the communities they serve – and I think a lot of what we do at Boston Medical Center is just that – are just as applicable and important to the population at large. I think of our Birth Sister program for example, which helps young moms learn how to become moms. Usually if they are from another country, we try to match them up with somebody who is culturally aligned in terms of belief systems and views. But frankly, as for any new mom it's very stressful – magical, but a little stressful – to have a new baby, so I wish the birth sisters were around when I was having my children!

Q. *Deborah Enos:* Kate, you have had extensive leadership experience in academic medical centers, some serving a very heterogeneous population, and now one primarily serving individuals most vulnerable. Could you compare and contrast the challenges of providing high quality, accessible care that is also cost effective in each setting?

A. As you and I have discussed, I think in many ways BMC is very well positioned for health care reform. There are two reasons for this: one, I think as you know the fee-for-service world hasn't been all that kind to us, but more important I think we are well positioned, between our network of community health centers, our hospital, our health plan, to really become responsible for the population of patients that we serve. And we have a critical mass of low income patients, for whom we can scale up innovative programs like our therapeutic food pantry, which is a prescription-driven pantry where patients can go for an emergency three-day supply of food for their family. We are able to envision a broader definition of health care and provide that for patients and their families. And we think it is one of the things that really distinguishes us at Boston Medical Center and will make us that much more successful when this system comes into alignment to support the goals we all share around access and high-quality, efficient care.

Q. *Rick Lord:* Kate, what kind of payment reform can lower health care costs and preserve access for people with few resources who have historically used safety net hospitals like the Boston Medical Center?

A. At BMC, we're very proud of our mission, which is to provide exceptional care without exception. And I think when you do this work, you quickly come to realize how important access is to that vision. People can't get exceptional care if they feel they can't get in the door. As we made the decision in this state to provide access for all, you quickly come to realize that the best way to secure access is to make sure it is a system we can afford, that the incentives are aligned, and patients are getting the right care, from the right doctor, in the right place. That they are not getting unnecessary utilization or wandering through a complicated system. So I think health care reform and the cost containment within it will actually do much to preserve the access we all cherish for our patients and their families.

Q. *Jeff Levin-Scherz:* Kate, what kind of safeguards would you like to see as part of health care reform that can improve access, lower cost, improve quality but not jeopardize services at traditional safety net institutions like Boston Medical Center that have long served the poor and the underserved?

A. That's a great question. You know this is a big and complicated system. It's going to be very hard to reform; it won't turn on a dime. So I think the most important safeguard is a stable funding platform, particularly from government payers. Government pays the largest share of the health care costs for vulnerable populations, and it would be really important that safety net providers like Boston Medical Center and other providers around the state have a stable funding platform that they can count on for a series of years. I think the most important thing is that we have the stability and time to deliberately address the parts of the system that need to change and come into alignment to preserve access for all while maintaining quality and reducing costs. It is a big sentence, there's a lot in that, and I think we need some time to move through it, at a deliberate and measured pace, but one that continues to move forward, because we can't afford the system we currently have.

Jeff Levin-Scherz, M.D., Responds

Dr. Levin-Scherz is an experienced clinician and physician-group manager who teaches at the Harvard School of Public Health and authors the "Managing Healthcare Costs" blog.

Q. *Governor Patrick:* Jeff, we've been talking a lot about innovation in the way health care is delivered. How we can improve the way doctors are trained so they are best prepared for this whole new world we're moving into?

A. Medical education is already improving pretty rapidly. In the past, medical students did an enormous amount of book learning before they saw their first patient, now, in almost every medical school, students are actually seeing patients by their first month of medical school. And instead of learning isolated pieces of facts that you have to apply to patients later, medical students are actually learning about facts that are related to real people. I think that is actually going to make for a dramatically better cadre of physicians in the future.

I think there is still room to go. Clearly one of the things we need to do in medical education is help physicians feel comfortable with uncertainty, because it turns out that with all the fancy scanners we have and all the great blood tests that we have that we can do stat, we actually can't always find the exact answer. In a lot of cases, people will get better on their own even if we don't find the answers, and chasing those answers can be very expensive, but more even than the expense, it can put people at enormous risk. So for instance, we don't want to be doing total body CT scans on people, where a quarter of the people who get them will need follow up tests and will basically be chasing a bunch of dead ends and potentially subjecting people to dangerous biopsies that they really don't need. So clearly, decision-making is going to be very important. There's already a good effort in medical education to increase medical students' sense of the importance of working on teams rather than being the lone isolated cowboy. I think that's also going to also make for much better physicians going forward.

One big concern is honestly that medicine is over-specializing, and it's hard to attract the best medical students into primary care at this point. Some of that is because medical education is still focused around hospitals, that's not where most medical care is delivered and that is certainly not where almost any primary care is delivered at this point. Part of it is that primary care doctors don't go to hospitals anymore. Most hospital care is delivered by hospitalists. The absence of primary care physicians in hospitals means that young medical students, medical interns and residents, actually don't have exposure to great mentors. I think that we need to move more medical education out of the hospital and into the community and into the offices, and that will show more young physicians how fulfilling it can be to be a primary care physician.

Q. *Don Berwick:* Jeff, our country has been struggling with health care costs for a long time, this isn't new, we've had many prior efforts to control costs. What have we learned from past efforts to control health care costs that we should be applying today?

A. We need to be very cautious of purported magic bullets for controlling health care costs. Health care is an enormously complicated industry; it represents 18 percent of the gross domestic product, every health care cost is somebody's income. Hospitals are almost always the largest employers in their communities. So when people say we've one simple answer and that one simple answer isn't going to make anyone feel badly, they're probably not right.

We have a long history of looking at things that looked pretty promising and actually disappointed. Disease management, highly focused on people with chronic disease, looked like it would help, it probably improves quality a little bit but doesn't have nearly the impact on cost that we'd hoped. There's a huge interest in wellness, but again the portion of the population which is well, which is most of the population, takes very little of the total health care resources, and we really need to be focusing on efforts that impact the one percent of the population that represents substantially over 20 percent of the total cost.

We need to try a lot of things; we can't simply say there is one simple thing that won't make people unhappy that will be our answer to health care cost. We can try many things, but most importantly of all we need to measure everything we try. We need to be willing to change midstream even if we thought we theoretically had a great approach. We also need to remember that in the final analysis the most important things that lower health care costs are actually efforts to improve the health of the entire population. Over my lifetime, the most important thing that has diminished the rate of increase of health care cost has been decreased smoking. The rate of people dying of heart disease has absolutely plummeted over the last twenty years. Some of it has to do with big new high-tech advances like angioplasties, some of it has to do with using drugs like statins to lower cholesterol, and an enormous amount of that has to do with much less exposure to cigarette smoke. So when we are thinking about ways of lowering costs, let's think about making the entire population healthier. Let's continue to lower smoking, let's make it easier to eat healthier, and frankly let's tax and make it a little harder to eat things that are less healthy. Let's build bike paths and make it much easier for people to exercise right. In the end improving the health of the entire population is the key to making sure our health care costs will be lowered later.

Q. *Deborah Enos:* Jeff, in almost every industry, technology has been used to improve both value and to decrease costs. Can you see a time when medical technology can help us contain health care cost?

A. In most industries, technological innovation leads to lower overall cost, and that just hasn't been true in health care. For instance, I have a cell phone now that has dramatically more power than my first computer and costs a tiny fraction of that amount, yet the cost of an office visit or the cost of an electrocardiogram has basically continued to go up through my career as a physician. The reason for this is that in health care, we always demand the unequivocal best, best – period – the end. We are not willing to accept what Clay Christensen of Harvard Business School calls disrupted innovation – something which is not quite as good as the best but it's good enough initially for a small portion of people, and later for a large portion of people, and it gets better and cheaper very, very rapidly.

Last summer, *The Annals of Internal Medicine* had an article and a photograph, of a great new potentially disruptive innovation, which is a hand-held cardiac ultrasound. So I could, in the pocket of my white coat, I could put this small ultrasound machine and I could actually look at people's hearts and see what their valves were like. This could be absolutely amazing, and it wouldn't be as good as all of the hundred thousand dollar ultrasounds that we're now billing a thousand dollars or more to do but it might be good enough in a lot of instances. The kicker? The article wasn't suggesting disrupting the very expensive ultrasounds; the article was suggesting that physicians of the future would use hand-held ultrasounds to displace the stethoscope, which right now is doing a pretty good job at what it's doing and does not have a separate bill associated with it.

The way I think about it is, health care generally embraces accretive innovation, where we layer an innovation on top of everything that is already there and as a result, it just costs a lot more. Disruptive innovation basically displaces something that already exists and initially, might not be applicable to all, but over time it gets better enough that everyone could benefit from it. So if we really want health care to be higher value, we have to embrace the concept of disruptive innovation and we will see improvements in health care costs.

Q. *Rick Lord:* Jeff, a lot of people seem to be concerned about primary care, which many of us believe is one of the keys to controlling health care costs. Can you tell us what the problem is and how to solve it?

A. About six years ago, the American College of Physicians put out a white paper suggesting that primary care in the United States was on the verge of collapse. Honestly, since then, it's gotten a little bit worse. It's been hard to fill family medicine residencies; general internal medicine residencies have also not always filled. Many of the graduates go on to specialties even if they intended to go into primary care in the first place. So we have a serious problem with primary care. There are some things that are working well. There are more nurse practitioners and physician assistants practicing primary care, and often doing very exceptional jobs. So there are some things that are working well in primary care too.

What do we need to make primary care better? For starters, we need more tools. Primary care is complicated. The world of evidence physicians need to consider is very large. When I practice, I'm really relieved to have access to good decision support tools when I'm prescribing; I'm really relieved to have access to good electronic, up-to-date textbooks which I can consult in an exam room, and consult while I'm showing the patient exactly what I'm looking at, because it's really hard to keep up with everything. So primary care physicians clearly need tools to be able to practice in this complicated role. They also need a good ecosystem. Primary care physicians need specialists they can talk with, specialists who can give them good feedback about patients they have referred. We also need to be sure we have reasonable expectations. We can't always find answers to everything that people present us with; sometimes watchful waiting is the best course. We don't want to give antibiotics to everybody

who has a sniffle. It doesn't make just society worse, it gives individuals complications that they could avoid. And we can't cure everything we find. I think there is a real future for primary care but it will require tools, ecosystem, and respect.

Q. *Kate Walsh:* Jeff, the discussion of health care reform is incredibly complex – global payments, capitation – how will we make this conversation relevant for patients and their families?

A. We do want evidence-based health care policy. On the other hand, to make this really accessible to people, I think we also have to tell stories. So I want to tell you a story, something I heard last week from a colleague whose dad is retired and on Medicare and whose mom is younger, and therefore not eligible for Medicare. She also couldn't buy a health insurance policy on her own. And as an uninsured person she stopped her diabetes medicines, and she started having some difficulty speaking, and some numbness on her left side, was hospitalized, and this has progressed to a stroke.

This is a failure on many levels. She stopped her medicines because they were too expensive, and she probably could have been on less expensive medicines had her doctors been thinking about cost-effective care. She didn't have health insurance because she couldn't purchase it on the open market. We've solved some of these problems in Massachusetts – we have an exchange, people can purchase health insurance even if they're older, and even if they have pre-existing illnesses. We certainly haven't solved the affordability problem in Massachusetts. So it's fine to let the policy wonks talk about capitation versus fee for service. Let them talk about what are the best incentives for patients, what are the best incentives for physicians, what are the best incentives for hospitals. What we really need to do though, is focus on how we are going to deliver cost-effective, high-quality care to everybody.