Mark Masselli: This is Conversations on Healthcare. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: Margaret, our last show caught the attention of many of our listeners as those recommendations by the United States Preventive Services Task Force on breast cancer screening kicked off a national debate.

Margaret Flinter: Mark, you are right. And we heard from one listener from Boston who wrote; "Your program was the best and most balanced coverage of the breast cancer guideline issue I have heard so far, congratulations. The fact that a man and a woman were discussing breast cancer together was not lost on me or others, I am sure. We need more conversations like this around health, healthcare and health reform beyond health insurance reform.' And he went on to say "Mark's point on black women and breast cancer really struck home, personally and professionally for me.' Check our www.pinkandblack.org to learn about Boston initiative that could be replicated in communities nationwide and he said "I wear their lapel pin with pride.' Thanks for writing to us.

Mark Masselli: That's great. Conversations on Healthcare looks forward to continuing the dialogue as we focus in on issues of reform and innovation in the healthcare system. Speaking of healthcare reform, there is lots of activity in the United States Senate this week as the healthcare debate officially got underway this Monday. If the opening day is any indication of what's to come, there will be lots of heat before we see any light.

Margaret Flinter: Well Mark, Senator Reed believes we will be seeing the light and we will see it close to Christmas. He plans to have the Senate working nights and weekends so they can get a bill passed. Then it goes to the House-Senate Conference Committee then back to both chambers for that final vote.

Mark Masselli: The drama continues to unfold and the country is getting a great civics lesson as well as a doctorate level understanding of the complexity of the healthcare system.

Margaret Flinter: And speaking of doctors, today's featured guest is one of the country's leading innovators in primary care, Dr. Tom Bodenheimer. Dr. Bodenheimer is a renowned author, physician, and

researcher who will be talking with us about ways to improve cost, improve quality, and improve access in primary care.

Mark Masselli: No matter what the story, you can hear all of our shows on our website CHCRadio.com. Download the podcast or get transcripts of our show and we have some interesting links on the folks we interview.

Margaret Flinter: And if you have feedback, e-mail us at conversations@chc1.com we love to hear from you. Last week, we gave our listeners fair warning, get ready for our Pledge Drive and bring in open and generous heart as well as your checkbook because for the next two weeks our station is doing its Pledge Drive and we hope to raise $20,000 by the time the drive ends on December 13th.

Mark Masselli: WESU which hosts this show as a college radio station based on the campus of Wesleyan University in Middletown, Connecticut and our thanks to WESU as they have been so supportive of our efforts. Margaret you did a lot of cooking over Thanksgiving Weekend, I know last week you wondered aloud. What type of appeal could pull you away from the aroma of all that good food and contribute to Community Radio, what did you cook up for us?

Margaret Flinter: Well first off, I want to say I did cook a great Thanksgiving dinner and it's a pretty straight forward appeal we are making and it's as American as apple pie, helping out your community radio station, it's good for your health and we guarantee you will feel better right away.

Mark Masselli: I feel better already. But I do worry there are fewer opportunities to hear the voice of the people as big companies take over radio markets all around the country and even here in our Wesleyan area, that's why WESU is so important, it's radio content grown locally and we couldn't do it without the students and community volunteers who donate their time every week to produce alternative music and talk shows not heard anywhere else.

Margaret Flinter: But most importantly your contribution matters. Support WESU now by calling (860) 685-7700 or log on to wesufm.org to make your donations to our Third Annual Holiday Pledge Drive.

Mark Masselli: Just in case you lost track of time, the holiday season is upon us and many of you will be buying gifts for your

family and friends and those you care about. How about giving WESUFM Community Radio a gift? Your donations will help us continue to bring you wonderful community radio programs, give us a call at (860) 685-7700 or log on to wesufm.org to make your donations to our Annual Pledge Drive. And we also are offering some specials, a $25 will get you a brand new WESU T-shirt, a $30 donation will get you WESU long-sleeve shirt and a $50 donation will get WESU hooded sweatshirt.

Margaret Flinter: And I know my nephew Greg is going to love that hooded sweatshirt. One of the great opportunities WESU provided us was the ability to create the kind of program that mainstream radio and media just don=t offer. We hope our listeners value Conversations on Healthcare and do us a favor, call (860) 685-7700 and support community radio.

Mark Masselli: I am making my call right now. Hopefully, all of our friends and listeners are out there making their calls.

Margaret Flinter: If you are into celebrating birthdays, WESU has been around for 70 years.

Mark Masselli: And now we are going to hear our interview from Dr. Tom Bodenheimer.

Margaret Flinter: As the Senate Health Reform Bill is moved forward into debate there are big questions that are beyond insurance coverage. Certainly one of them is cost. Why our healthcare cost is rising and what can be done about it? Beyond that though is the issue of care itself and particularly primary care. Who will take care of us and how do we want to be taken care of? What transformations and innovations are necessary to make primary healthcare more effective, more affordable, and not insignificantly more satisfying; both for the providers and the patients who consume it. This week Conversations on Healthcare takes a look at what some of have called the crisis in primary care and like all crises there is hope and opportunity for a way forward. There are transformations and innovations already in place in a number of practices around the country that show the potential for solving some of our thorniest dilemmas in primary care. This week=s guest Dr. Thomas Bodenheimer has spent 32 years in primary care practice as a general internist. Ten of those years in community health centres, 22 years in private practice. He is also the adjunct professor of Family and Community Medicine at the University of California at San Francisco where he co-directs The Centre for Primary Care. His five part series on the rising cost of healthcare

published in the Annals of Internal Medicine are one of the most referenced works explaining the trajectory of healthcare cost in the United States and potential strategies to control them. So today, we take a look at both the issues of rising healthcare costs and practice transformation. The Conversations on Healthcare welcomes Dr. Tom Bodenheimer. Dr. Bodenheimer thanks for being with us this morning.

Mark Masselli: Dr. Bodenheimer, you have talked about transforming primary care, what does that mean to the average consumer of healthcare? What should a thoughtful consumer expect to find in a world class primary healthcare office or organization?

Dr. Thomas Bodenheimer: The first thing that I think a lot of people have trouble with their primary care practice or their primary care clinic is getting access. And when I say it, I don't mean financial access which of course is a huge problem, but in terms of the practice itself, calling up on the phone and having your issues dealt with in a prompt way, being able to get an appointment the day that you need it, which often is today, being able to get the care you need nights and weekends without having to go to the emergency department. These access problems are major-major problems for the patients of primary care practices, that being I would say number one. Number two is after you have gotten the access, are the patients and doctors alike hate the 15 minutes, because it is often just not sufficient to be able to deal with the problems that patient wants to have it to address. Lot of times there are, I think on the average there are like 3.5 diagnoses or problems in the average primary care visit and 15 minutes is not enough time to deal with those problems. I would say those are two things that we have to deal with in terms of improving primary care.

Margaret Flinter: So Dr. Bodenheimer that would lead to the observation that across the country we still find that most primary care physicians, I think about half are in small practices often one or two providers, often times no nurses and not a lot of support staff, so how do those practices make those transformations to achieve the kind of practice that you talk about. What support is out there for them to do it?

Dr. Thomas Bodenheimer: As you said, 46% of primary care physicians work in practices with one to two physicians only. Their practice team usually includes a front-desk person and a medical assistant. The medical assistants to you know take people's blood pressures and lay them and maybe check their sugars and do

electrocardiograms and draw blood. So there is not a lot of support for the doctor and the doctor really has to do an enormous amount of the work and usually these practices have patient panels around 2000-2500 patients, so it's just impossible for a doctor without more support to provide really good care for such a large panel of patients. So these small practices need to come together with one another somehow and I don't mean they have to join some huge poly clinic where there are you know 200 doctors in one building. They could aggregate with other practices on a virtual level, now that have you know they could have the same electronic medical record as other practices, they could share, if you have say 10 practices which each had 2 physicians, they could share you know a nurse, they could share a pharmacist, they could share people who could do some of the things that physicians don't have time to do, but without the practices coming together in some way, I don't see how a very small practice can really solve all those problems.

Mark Masselli: You know you have made a point that a small percentage of patients represent lots of the cost in healthcare and we actually have some good data on what makes the difference coordinating care, managing the transition first 30 days after patient leaves the hospital. When a large of patients gets readmitted, how do you do this and what are the models that have been shown to be effective and why aren't we doing it everywhere?

Dr. Thomas Bodenheimer: There is some very good research that's being done that shows that both within primary care practices and in the transmission from hospital to home, if you have a RN care manager, a nurse, who is trained to manage complex patients, that nurse working with a relatively small panel of people like it might be only 50-60-70 of these very-very sick, complicated people who utilize a lot of healthcare and incur, I would say 70% of the cost in the United States. If you have a well-trained nurse care manager to work with those patients together with a physician, you can improve outcomes, improve care, improve patient satisfaction, improve quality of life and reduce cost and reduce hospital readmissions, significantly. The problem is hospitals don't have a financial incentive to reduce readmissions. They might get paid for readmissions, so why should they hire a nurse care manager with a relatively small caseload to do something that will hurt them financially. And primary care practices don't get paid for the work of that RN care managers, so they won't be able to afford it and they have no financial incentive to do it. So you really have to, so the people who gain when you have these nurse care managers or the payers, the insurers, most of, generally if these patients are Medicare patients. So Medicare should really incentivize practices

and hospital to hire nurse care managers to be able to reduce the cost and improve the care of this small group of people who is so complicated and incur such a large percentage of our cost.

Margaret Flinter: Dr. Bodenheimer in healthcare circles at least everybody seems to be talking about the patient-centered medical home, more healthcare jargon or really a fundamentally different way of delivering care?

Dr. Thomas Bodenheimer: I think the people who promote the patient-centered medical homes see it as a very-very different way of providing care. Number one, the patients would have access the day they need it. Number two, the practice would really think about the care of their entire panel of patients that have these electronic registries, that all the patients, all their clinical data would be there, so you could really see which patients were not doing well, bring them in for care, which patients need preventive services that haven't had them, bring them in for care, be proactive and really think about your whole population of patients, and have teams of people or the doctors and try to get out of that 15-minute visit syndrome, have longer visits for people who really need it and have other people perhaps care for people who just need very simple preventive care things with the doctor overseeing the team, but the doctor not having to do everything him or herself. So the problem is these are very difficult things to accomplish without payment reforms. You really have to pay for those aspects of the patient-centered medical home. So right now pretty much the practices get paid for either a doctor, a nurse practitioner, or a physician assistant visit, that's all they get paid for. They don't get paid for all the things needed to be done in between the visits, they don't get paid for, if they are doing a counseling, having a medical assistant do a counseling session on diet or exercise. They don't get paid for phone visits. Most places don't get paid for electronic communications with the patients which can really be very useful for both the patients and the practice. So all of the things that are part of patient-centered medical home that are new, don't get paid for, so that it's not going to happen unless they begin to get paid for.

Mark Masselli: Dr. Bodenheimer, you have asked if cost can be controlled while preserving quality, your answer seems to be reflective in what we are seeing in the proposed health reform bill strategy like disease management and care coordination to reduce use of hospital and emergency room departments by high cost patients, strengthening primary care, and reducing medical errors.

These are not simple and require both innovation and retraining. How do you see this happening?

Dr. Thomas Bodenheimer: Well first you know that's true that you can improve quality and reduce cost at the same time, but it's very, very difficult. Number one, you have to have enough primary care physicians, because we know that with enough primary care physicians that have panels of patients that are not so large that the patients can't even get an appointment, if you have enough primary care physicians and those physicians are willing to see people or at least care for people nights and weekends then you can really think to reduce emergency department visits because I think 40% of emergency department visits are by people who just couldn't get access to their primary care and don't need to be in emergency department. Once people get into the emergency department, it gets very expensive, certain number of them probably get admitted to the hospital unnecessarily, all the things about readmissions. You really can reduce cost but it is difficult to do. And I think people who think it's easy are going to fool themselves and I think most people feel that the most of the language in the Healthcare Reform Bills on the House of the Senate don't really do very much to reduce cost. Probably to reduce cost, we are going to have to get rid of the fee-for-service payment, as fee-for-service payment encourages more and more, more care to be done whether it's needed or not.

Margaret Flinter: Thanks Dr. Bodenheimer. And you know in addition to being a primary care physician yourself, you are also an educator and I know you are deeply engaged in training that next generation of primary care providers. How are you reaching these young medical students and what are you saying to them about choosing a career in primary care?

Dr. Thomas Bodenheimer: Well I work in the Department of Family Medicine, University of California in San Francisco. So we have family medicine residents that I work with and also medical students who rotate through family medicine. I feel one of great hopes you know I am kind of pessimistic about the healthcare system, but I am very optimistic about some of the people who are going to be our future generation, they are really fantastic. They really want to serve people. They want to do new things and I think just number one, teaching them some of these new concepts, because generally what they have learned is they have learned the clinical work things that they need to learn but they don't learn about how should I organize my practice. How do I really make sure that people can be seen the day that they need care? What do I do about working with

people given all our new technologies with electronic medical records, with patient portals, e-mailing patients back and forth when a visit is not necessary? They need to learn all these new things because they don't see them in most practices.

Mark Masselli: Speaking of new things, Dr. Bodenheimer you have obviously have a great eye for innovations. What are you seeing around the country that excites you and who should we be watching?

Dr. Thomas Bodenheimer: There are some amazing things going on, but most people don't know about it. So in the community clinic world, again I am not familiar with it, maybe your community clinics or maybe your particular clinic that you are in right now is doing all of these things, but the clinic that I have seen that has done all of the things that you would want a practice to do is Clinica Campesina in Denver, Colorado, just an amazing-amazing clinic. I am sure there are others like it, but it's one example. Then in terms of non-safety net practice, Group Health in Seattle has a clinic that's sort of their pilot clinic for becoming the patient-centered medial home, it's called the Factoria Clinic. It has done incredible things. Potentially one of the first things that they do is to reduce the panel size of the first physicians and to increase the visit time from 15 minutes to 30 minutes. Physician satisfaction went up like 500%. Patient satisfaction went up, quality outcomes improved, and they reduced their emergency department visits and hospitalizations and have actually paid for all the innovations that they did within a year. So there are practices that are doing amazing things but most of us don't know about them. There is not like a clear cut sort of, and if you go to the medical journals, you don't hear about these things because most of them are not studied, they are not researched studies, they are just improvements.

Margaret Flinter: Well we shared that philosophy with you and we believe we all ought to be contributing to the research, but Conversations on Healthcare is another way of helping to get the word out on those innovations and what is working and Dr. Bodenheimer thank you so much for being with us on Conversations on Healthcare today.

Mark Masselli: Thank you so much doctor.

Dr. Thomas Bodenheimer: It's been a pleasure. Thank you.

Mark Masselli: Margaret, Dr. Bodenheimer really pulled all the threads together on transforming the primary care office and I think

he has lots of physicians rethinking the way they are practicing medicine.

Margaret Flinter: He is really a respected and admired thought leader in the field and his working recommendations will make real some of the reforms that the country is looking for.

Mark Masselli: Speaking of things we are looking for; we are looking for you to give us a call at (860) 685-7700 or log on to wesufm.org to make your donations to our Annual Pledge Drive. Don't forget that we have some gifts for those of you who make that pledge. A $25 will get you a brand new WESU t-shirt. A $30 donation will give you a WESU long-sleeve shirt and a $50 donation will get WESU hooded sweatshirt.

Margaret Flinter: That's great. And one of the great opportunities that WESU has provided us is the ability to create just the kind of program that mainstream radio and media don't offer. We hope our listeners value and enjoy Conversations on Healthcare. We hope you enjoyed our interview with Dr. Bodenheimer and the many other guests we have had on over the past few months. So do us a favor call at (860) 685-7700 and support community radio by making a donation or do it online at wesufm.org.

Mark Masselli: Well we have a couple of bright ideas today. One is to give a gift and make a pledge to WESU and call us at (860) 685-7700 or log on to wesufm.org and now here is another bright idea.

Mark Masselli: Each week Conversations highlights a bright idea about how to make wellness a part of our communities in everyday lives. This week bright idea focuses on improving wellness and cutting healthcare cost in the workplace. According to the new Thomas Reuters report the current US medical system wastes about $7 billion a year. The source of much of this waste is the messy combination of unnecessary treatments and repetitive testing. Well the healthcare reform bills currently pending in Congress contain provisions to combat these sources of waste. Many employers have already taken matters into their own hands and are finding ways to reduce these costs through work place wellness programs. One such company is Johnson & Johnson which implemented a series of extensive workplace wellness programs in 1995. Company officials say that their employees have been reaping the benefits ever since. Johnson & Johnson provides its 100,000 employees with a wide variety of wellness programs including free smoking cessation classes, online weight loss and stress management programs in 30

onsite fitness centres. Other initiatives include Eat Complete, which provides employees with highly nutritional meal options at work and move and make it matter which helps employees fit exercise into their busy schedules. Other companies have experienced similar benefits after creating comprehensive wellness programs for their employees. In fact researchers for the Centre for Disease Control and Prevention recently concluded within 2 to 5 years of implementing these programs, companies can yield $3 to $6 in savings for every dollar they invest. With US healthcare spending to double in the next decade, cost cutting wellness programs like these will become increasingly important. Cutting long term cost and improving health in the workplace, now that's a bright idea.

Margaret Flinter: This is Conversations on Healthcare. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli. Peace and health.

Conversations on Healthcare broadcast from the campus of Wesleyan University at WESU, streaming live at wesufm.org and brought to by the Community Health Centre.